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Social Protection in Romania

1. INTRODUCTION: ECONOMIC, FINANCIAL, SOCIAL AND DEMOGRAPHIC BACKGROUND

1.1 Main influencing factors for social protection

1.1.1 Economic and financial indicators

One of the first strategic options, which Romania made at the start of the transition, was to withdraw the role of the State from the national economy. At the same time, it transformed the State's role and instruments of governance into a public estate management system. The first half of the 90s was mainly characterised by an unsustainable macroeconomic development - although most of the governmental programmes since 1990 had as main objectives the stabilisation, liberalisation and re-organisation of the economy. Economic reforms were gradually implemented after about nine years of transition and contributed step by step to the modernisation of the public administration, the liberalisation of the economy as well as the decentralisation of decision making processes. However, many fundamental economic issues have not yet been solved.

Economic growth is usually expressed by the growth of Gross Domestic Product (GDP) and this measure reflects the country's general economic performance. Growth of GDP during 1995-2001 (see table 1.1 from the annex) was positive for the first two years of the period and negative for the second part of this period. Since 2000, the economy has experienced some positive growth. For the GDP per head in PPS and GDP at current prices, a similar development could be noticed. Negative growth was observed mainly for the period when privatisation programs and the reforms started seriously. Since 2000, as a consequence of these reforms, the overall economic data for Romania improved: the growth rate of GDP at constant prices increased by 1.6% in 2000 and by 5.3% in 2001.

Despite this growth rate of 5.3% in 2001, the decrease of GDP growth rate from 1997, 1998 and 1999 could not be compensated, the overall decline being 11,7%. The GDP growth rate of 2001 represents approximately 95% of the level of the year 1996, in comparison with 90% in 2000.

Taking into consideration that an important part of the rise of the economy in 2001 was due to the fact that production mainly in industry and agriculture had been reduced in the previous periods, the service sector

registered a moderate rise, around 1,7%. However, considering that the rise of the added value in the service sector, which was 3,8% in 2000, was mainly a consequence of the rising volume of activities of those sectors directly affected by the general and local elections, then the increase in 2001 is substantial in comparison with 2000.

The Romanian economy experienced double-digit inflation during 1995-1996 (see table 1.1 from the annex). In spite of tight monetary policies, the inflation rate in 1997 was 154%. However, since 1998 the inflation rate has been less then 55% and continued to decrease at 40% in 2000 and 34.5% in 2001. Starting with 2000, inflation has been constantly decreasing, representing a positive signal regarding the efforts for regaining the population's trust in the national currency .

Therefore, at the end of 2001 the inflation was at 30,3% - well below the level of 2000 (40,7%). Significant changes were registered in the prices of services (36,2%) and non-food (31,4%), while the prices for food (27%) were below the average level of the consumption prices.

Social expenditure

To highlight the developments of the social services provision, it is recommended to use the social expenditure as percentage of the GDP, and the public social expenditure as a percentage of the state budget.

The provision of social services suffered due to reduced public revenues and tight monetary and fiscal policies, required by the macro-stabilisation process during 1995-1997 (public social expenditure as percentage of state budget: 29,7% - 32.9%). Starting with 1998 the public social expenditure, as percentage of the state budget, increased to 39.3% (an increase of 6.4%) and until 2001 remained at the same level. This growth was possible because the trade unions put the Government under pressure; the Health Insurance Fund was introduced. Starting with 1999, the Health Insurance System was build up and their compliance rate was higher than in previous years. At the same time, the Government took other social measures as follows: increasing the number of employees, development of the enterprising spirit of the employers and of those searching for a job, increasing the mobility, flexibility and adaptability of the labour force and granting equal chances, sustaining the fund of unemployment insurance, protecting those affected by collective dismissal, protection of families, protection of children, protection of old-aged people, protection of disabled persons, care protection in special social assistance institutions and fight against poverty.

Only the unemployment expenditures did not follow the growth of the public expenditures. The policy in the field of unemployment was the discouragement of unemployment and therefore the unemployment budget was always an exception. The unemployment expenditures as percentage of

the state budget follow a parabolic development with a maximum in 1999 (4.3%). For the first part of the period, growth was doubled in 1997 (3.8% in comparison with 1.8% in 1996).

The experience of the Romanian transition has evidence of the boom-and-bust economic cycles. Along with the structural strain and institutional fragility, this was caused by the inconsistency of policies pursued.

The first transformation recession (1990-1992) continued three years, after which a recovery period that lasted three years followed (1993-1996). The next transformation recession lasted three years as well (1997-1999), and starting with 2000 a period of growth has been registered.

The aim of the Government is to introduce more continuity and predictability in the social and economic policies, in order to induce more credibility in the business environment, to stabilise positive social expectations, and to avoid further boom-and-bust.

Inflation remained at high rates, presenting moments of expansion during 1996-1998, and it was the primary factor that induced uncertainty in the business climate and unattractiveness of the Romanian economy. The delays in the privatisation of public utilities and large state-owned enterprises, together with a very slow process of restructuring fuelled by the stop-and-go reforming policies, brought the Romanian economy very close to a major crisis in 1999. The very weak position the country had on the international financial markets and the lack of credibility needed a well-designed economic strategy, aimed at breaking the recession circle and at bringing back the potential for durable growth.

Growth reappeared starting with 2000, and during 2001, showed that the positive trend is vigorously supported by the new set of economic policies.

The private sector is still quite under-developed, with the state owned enterprises accounting for a significant share of economic activity. Private sector contribution to the GDP has been more than 60% during the last six years. In 2000, the private sector produced 65% of the GDP. The state owned enterprises still play a major role in many sectors of the economy, including the utilities sector, finance, and manufacturing.

The provision of social services suffered, due to reduced public revenues and tight monetary and fiscal policies, required by the macro-stabilisation process during 1995-1997. Starting with 1998, the public social expenditures, as percentage of the state budget, increased at 39.3% and until 2001 remained at the same level. The pension expenditure, health expenditure, social assistance expenditure follow the same trend like the public social expenditure. Only the unemployment expenditure did not follow the growth of the public expenditure. The policy in the field of unemployment was the discouragement of unemployment and in

consequence the unemployment budget was always exceptional. Starting with 2002, the unemployment benefits were decreasing (until now it was a set percentage of the last wages and now the level has been changed to that of the minimum wage).

Demographic indicators

The changes that have taken place since 1989 within the political system, economy, social life and people's mentality have influenced the population demographic behaviour.

The negative natural increase and the negative balance of external migration have caused a decrease in absolute population figures during the whole period of 1990-2002 (see table 1.6 from the annex). The change of the demographic behaviour of couples regarding their own reproduction, higher mortality, as well as the higher external migration have caused a decrease of the total population by 290.000 in the last seven years.

The age structure of the population reflects a slow, but continuous process of demographic ageing, caused mainly by lower fertility, resulting in an absolute and relative decrease of younger population (under 15 years) and higher share of elderly population aged 65 and over. The dependency ratio (see table 1.5 from the annex) has been decreasing during 1995–2000 (48.4%-46.6%). However, in both components of this dependency ratio have a different growth. For the group under 15 years, there is a negative growth (30.9%-27.1%). For the group of 65 years and over the growth is positive (17.5%-19.5%) which confirms the demographic ageing.

On January 1st 2002, the population of Romania was 22.390.400 people.

This century, except for the years of the two World Wars, the total population has been increasing. Starting with 1990, the population decreased, with an average rate of 0.15% for the last seven years.

During 1996-1998 the proportion of men and women in the total population remains constant (men 49%, women 51%). In the period 1999–2000 the proportion of women increased to 51.1% and the proportion of men decreased to 48.9%.

Fertility

During 1995-1997, fertility recorded the lowest rates of the last decades (see table 1.7). Since 1998, a slow trend of fertility recovery was noticed. Unfortunately, abortion is still the main method to control and reduce family size, although the abortion rate has significantly decreased each year. In the last years, a higher proportion of live births born outside marriage was noticed (24.1% in 1999).

Since 1997, the crude birth rate, the main component of the population natural increase, has registered a slight fall. Nevertheless, during 1995-2000 period, the crude birth rate recorded the lowest level of this century.

In 2000, 234.5 thousand children were born, which is almost one fourth less than in 1990. The liberty of couples to decide on the number of children, the high economic and social costs supported by the population during the transition period, the crisis of dwellings and the very high prices for the possibilities of youth wanting to establish a family, social instability and unemployment are some of the main reasons determining the fall of the number of live-births each year.

The decrease of the crude birth rate was more obvious in urban (from 12.9 ‰ in 1990 to 8.9‰ in 2000) than in rural areas (from 14.3‰ to 12.3‰).

In comparison with 1995, a slight increase (by 0.2 years) of the mothers' average age at the birth of their first child was noticed, reaching 23.5 years in 1999.

As a result of the changes in society, younger generations started to postpone not only establishing a family, but also their decision to become parents (in 1990 each woman under 30 years old gave birth in average to 1.5 children, in 2000 the number decreased to 1.0 children).

The life expectancy (see table 1.8) at birth for girls is higher than for boys. The difference was 7.8 years in 1995 and remained constant until 1998 and decreased by half a year from 1999 until 2000. The life expectancy trend is slightly increasing with 1.1 years for girls (73.1 in 1995 to 74.2 in 2000) and with 1.7 years for boys. For the period 1995-2000 this represents a change as compared to the obvious downward trend of the last years (65.3 in 1999 to 67 in 2000). Also, the life expectancy at the age of 65 keep the same distribution by gender (2.5 years between men and women in 1995 and 2000) and the trend is slightly increasing (from 15.1 to 15.5 for women and from 12.6 to 13 years for men, for the period 1995-2000), determining the increase of the social expenditure on a long-time period.

Family structure

During the period of 1995-2000, as a direct result of the major changes that took place in the Romanian society, the marriage rate has changed considerably (see table 1.9).

The transition to market economy, changes in the living conditions, growing requirements for a higher qualification and adequate education to assure a stable job, disappearance of certain specific advantages to stimulate the formation of new families, as well as no restrictions imposed in living together are only a few reasons determining youth to postpone marriage very often.

In 1999, the average age at first marriage increased by 1.5 years for men and by 1.3 years for women, in comparison with 1990. At the same time, the share of the population, which were married at least once during their lifetime, decreased for both gender to fewer than 70% (as against 95% for men and 92% for women, in 1990).

During the period 1990-1999, marriage rates registered a downward trend, however being kept at a very high level in comparison with that registered in other European countries. Although cohabitation or consensus unions started to become more frequent, they do not hold yet a significant weight as type of population living style. Tradition and powerful social values are in favour of legal marriage.

In 2000 the number of marriages was lower than in 1995. It should be noticed that, in 2000, the number of marriages celebrated in a year, as compared to the number of inhabitants, registered the lowest value in the last half of the 20th century.

During the period 1995-2000 the highest crude marriage rates were registered for the age group 20-24 (both for men and women), although their numbers (34.568 in 1995 and 27.963 in 2000) have significantly reduced.

In 1999, 66.0% of women and 52.9% of men who got married belonged to the age group 20-24.

The average age at marriage increased during the period 1995-2000, more obviously for men than for women. It determined the increase of the gap by gender, reaching 3.5 years in 2000. The higher average age at marriage resulted in lower crude marriage rates by ages, especially for younger people under 25 years of age.

In rural areas, both men and women got married at an average age lower than in the urban areas.

Divorces

Divorces have suffered no important changes during the period 1995-2000, registering values considered relatively low in the European context.

In comparison with 1995, both for male and female, the number of divorces of younger people under 20 years has increased. Most of the divorces came after less than 5 years of marriage

During 1995-2000, divorces had an oscillating evolution, being however kept at a relatively low level in the European context, confirming family stability within the Romanian society. Thus, the crude divorce rate was situated between 1.4% (2000) and 1.8 divorces per 1000 inhabitants (1998).

The analysis of divorces by gender and by age group pointed out the actual trend of younger generations to get divorced faster.

The differences in the crude divorce rates by gender and by age group are still kept.

For the younger population, under 25 years old, the numbers (6.265 women and 2.285 men in 2000) are higher for women. In the age group of over 25 years old, partly due to age differences between spouses, the highest rates occurred for men.

The average age at divorce oscillated each year, without recording significant changes during the period 1995-2000. In 1999, the average age at divorce was 37 years for men and 33.6 years for women.

Migration

Significant changes that took place since 1989 in the political and social system of Romania have determined the creation of certain regulations in favour of free circulation of persons. At the beginning of this decade, the regulations have caused a higher level of international migration, firstly of emigration, political motivation being replaced by economic one. Beginning with 1992, the number of Romanian emigrants exceeded the number of emigrants of other nationalities, for the first time in the last ten years. In the last years, external migration was also characterised by a growing number of foreign citizens who, from various reasons, entered the country for periods longer than 6 months.

The number of asylum seekers and persons who legally received the refugee status is very low. However, it was noticed a growing trend of foreign citizens illegally entering the country or whose temporary residence visas were expired. Negative balance of external migration has directly contributed to the population lower number since 1989. It should be noticed that at the beginning of 1995, negative balance of natural increase has exceeded in intensity in comparison with external migration. In the last years, the structure of emigration from Romania had different characteristics (see table 1.10).

Concerning the structure of emigrants by destination country, Germany has remained the main emigration country. However, the share of emigrants towards Germany has fallen from 35.1% of total in 1995 to only 15.0% in 2000. Instead, the number of legal emigrants towards USA and Canada increased from 17.8% in 1995 to 35.5% in 2000. Persons who definitively emigrated from Romania came especially from urban areas, the highest share being held by women.

Regarding the emigrants by ethnic groups, the Romanian represented 73% of the total emigrants in 1995 and 91% in 2000. The majority of the Germans, Hungarians and Jews emigrated during 1990 –1997.

In 2000, one third of emigrants were under 18 years old (4372), while 40% between 26 - 40 years old (5717), others shared approximately 30%.

The percentage of women is higher than men, with percentages between 5%-2%. In 1998 the minimum level was registered with 2%.

Most of the legal emigrants in the working age groups had a higher educational and qualification level. In the next years, it is expected a tempo in the intensity of external migration, especially of emigration and limited illegal immigration, according to international conventions where Romania has adhered. External migration will influence to a small extent the evolution, respectively the fall of the number of population in the future.

In the last years, following the oscillating evolution of the birth rate, mortality and external migration, the population registered different tendencies of growth. From 1990, the country population has been decreasing year by year, by an annual average negative rhythm of 0.15%, due to the negative natural output and the negative figure of the external migration.

The age structure of the population reflects a slow, but continuous process of demographic ageing, being caused mainly by lower fertility, resulting in an absolute and relative decrease of younger population (under 15 years) and higher share of elderly population aged 65 and over.

The difficult economic and social evolution of Romania during the transition period has strongly influenced the level of demographic indicators, especially population health. The growth in mortality level in the last 7 years places Romania among countries with a high crude death rate.

Before 1989, two characteristics were defining the attitude of the population towards marriage in Romania: relatively lower average age at first marriage and higher percentage of persons married at least once during their lifetime (over 90%).

During the period of 1990-2000, marriage rates registered a downward trend, however being kept at a very high level in comparison with that registered in other European countries.

Divorces have suffered no important changes during 1995 – 2000, the figures are considered relatively low in the European context.

In comparison with 1995, both for men and women, the number of divorces of younger people under 20 years has increased.

At the beginning of this decade, the regulations have caused a higher level of international migration, firstly of emigration, political motivation being replaced by economic motivation. The negative balance of external migration has directly contributed to the population decrease since 1989.

1.1.2 Social indicators

Unemployment

The development of the unemployment rate (see table 1.13) for the period 1995–2000 described a parabolic curve, which reached a minimal level in 1997 (unemployment rate from LFS was 6%). For 2000 the curve registered 7.1% and the trend is ascending.

Starting with 1995, the differences between genders have been decreasing until 1998 (women – 6.1% and men – 6.5%). Since 1998 the employment rate for men has become higher than for women, and in 2000 the number of unemployed men being with 7.7% much higher than the number of women. In 2000, 822,000 unemployed (ILO definition) were registered, of which 586,000 were men.

The unemployment rate is higher in urban areas. The rate of unemployment is 8,5% in the urban areas and only 3,6 % in the rural areas. The latter is mainly a consequence of the full-employment period during high seasons in agriculture. The evolution of the rate of unemployment during one year, as well as that of the rate of employment are influenced by the economical activities with seasonal character. The variations from one quarter to another are much more highlighted in the rural area, being influenced by the seasonality of the agricultural activities.

Employment

According to the data from NIS (see table 1.22), in the year 2000, the active population was of 11.585.000 persons, men being predominant (54%). The analysis of the registered values in the period 1995-2000 is highlighting a slight decrease of the number of the active labour market participants in the years 1997-1999 and a slight growth in 2000. In the year 2000, the rate of activity of the population of 15 years and more was 63,2%, with 70,6% for men and only 56,4% for women.

The rate of employment of the total population was registered at 58.8%, with a decrease from 60.9% in 1997. It follows the same trend like the economic activity rate. The majority of the employed persons are represented by men (65.1% of the male population or of the total population aged 15 years and over), the women having a lower rate (52.8%). From the point of view of age groups, the predominant group are those of 25-49 years

(62,9%). From the employed persons, only 17% are of age between 50-64 years, a small proportion (11,5%) consisting of youth under 25.

The age specific labour force participation (age 50-64, 65 and over; see table 1.15) is 58.2% active population in 1999 and 57.8% (the percentage of their age groups) in 2000. The employed population is 1.1% less than the active population in 1999 and 1.4% more in 2000. Gender differences are noticeable in terms when regarding unemployment (1.8% men in comparison with 0.5% women in 1999 and 2.2% in comparison with 0.7 % in 2000). In terms of employment, the figures for men (64.5%) are 14.2% higher than those for women in 1999, In 2000 the difference is 13.4%. Nevertheless, the differences between areas are relevant: in rural areas, the active population of age 50 – 64 years represented 76.9% of their age, which is 24.1% higher than the population in urban areas. Furthermore, the unemployment is higher in urban than in rural areas (2% in comparison with 0.3% in 1999 and 2.3% in comparison with 0.5% in 2000). For the age group 65 years and over the same gender and area differences are kept and moreover follow the same trends.

Depending on the activity sector, the employed population was approximately equally distributed in the secondary and tertiary sector, with preponderance in the primary sector (40% in comparison with 29,4% in the secondary and 30,6% in tertiary). In 2000, 43,7% of the women employed were working in the primary sector and 32,8% in the tertiary sector.

During the privatisation process, the employment in the industrial sector decreased (from 28.6% in 1995, to 23.2% in 2000). The employment remains approximately at the same level in agriculture (from 32.8% to 31.9%) and construction (from 5% to 4.1%). The only growth of the employment was registered in the services area (from 33.6% to 40.8%)

Labour force structure (see table 1.11)

During 1995-2000 the average number of employees decreased by 1.537.000. The percentage of the employees in labour force decreased by 1.7% in 2000 in comparison with 1999 (57,8%) because of the privatisation program. The number of self-employed increased by 1% in 2000 in comparison with 1999 (22.1%). Half of the self-employed are working in agriculture. The unpaid family workers, who develop their activity mainly in agriculture, represented an important group of the labour force (19.3% in 2000). The employers represent 1.1% of the labour force, which is 0.1% more than in 1999. In 2000, civil servants represent 1.8% of the labour force, which is 0.1% more than in 1999. Their number increased considerably (approximately 7.000 employees) in 1999, with the introduction of the health insurance system.

Poverty

In 2001, the National Anti Poverty and Social Inclusion Promotion Commission has defined - for the first time in Romania - an official poverty line, based on two concepts: Poverty and Severe Poverty.

Poverty is defined in accordance with the National Commissions' definition as being "the state of a person in which he or she cannot afford to spend, on a monthly basis, a specified amount of money which allow him or her to cover the minimum alimentary, non-alimentary and service consumption" .

The rate of poverty (see table 1.17) had an oscillating development during 1995 – 2000. The lowest value was registered in 1996 (23.3%), when elections took place. The poverty rate increased to 27.7% in the following year, when the government put in practice their austerity policy program - and collective dismissals started. In the following two years, the poverty rate remained at an approximate level of 27% although collective dismissals continued. In 2000, the poverty rate increased to 30%, which confirmed that the government had been unsuccessful to put the anti-poverty programs into practice (most of the programs for professional re-conversion failed). Also, the rate of severe poverty had a fluctuating development, which followed the same trend as the rate of poverty. The highest level of severe poverty was registered in 1997, as a consequence of the non-correlation between the collective dismissals and the programs for professional re-conversion.

The age groups most affected from poverty (see table 1.18) are the 0-25 years old (on average 30% are affected by poverty). In the period 1995-1998 they registered an increase of up to 10%. During the same period, the age group of 26-55 years old registered an increase of 10%. The age group which is less affected by poverty is the age group over 65 years, with a poverty rate of only 11.4% in 1998.

The same phenomenon can be observed inside the families with more than 3 children, of which more than half were poor. For the families with at least 4 children, one can say that the social protection system collapsed completely (71% of them were poor in 1995 and 83.6% were poor in 1998).

Vulnerable groups

According to the National Strategy for Prevention and Combat of Poverty from 1998, the following groups are in great risk of poverty:

- Families in which the adults have no permanent occupation, living from occasional earnings, from unemployment assistance or social assistance, from children allocation
- Families from villages, with less land or no land at all, living in areas with low offer of labour

- Families with a lot of children and small income, mono-parental families, especially with two or more children
- Old men with no pensions or other income sources, with very low pensions, especially ex co-operative farmers
- Young men with low educational level, with no qualification

The profile of poverty in Romania indicates a high level of vulnerability, being sufficient a one risk factor, for example an extremely deteriorated situation in the family (30% in 2000). On the background of the decline of the living standards, governmental programs have partially ignored some categories of the population affected by transition. Their problems are aggravated, being much more severe for the system to be resolved. The probability for a family to become poor is rising at the same time with the raising of the ratio between the number of members and the number of incomes.

1.2 How does the described background affect social protection?

1.2.1 Forecasts and projections

The potential future development of the Romanian economy is illustrated by the **forecast performed by the Ministry for Development and Prognosis (MDF)** on two scenarios that take into account potential positive or negative outcomes.

The baseline restructuring successful scenario is based on the Government's MDF official forecast, released in August 2001. It is checked for consistency with the help of the Romanian version of the World Bank's RMSM-X model. The results presented in Table 1.19 are based on several assumptions of increased consistency within the set of economic policies. The baseline scenario is based on the Romanian Government's commitment to stay close to the consistent macro and micro policies. Positive achievements highlighted by this scenario give an increased credibility in the Romania's potential for development. In the short run, immediate effects of the fiscal consolidation and of privatisation of large enterprises could be perceived as a risk to faster growth, but their stabilisation impact is expected to bear fruits towards the end of the period. The economy will grow with an average annual rate of 5.1%, reducing thus the gap between the economies in the European Union area.

The contribution to GDP growth will come equally from all components of the aggregate domestic demand, but investments will be the most dynamic factor. The assumption is based on several factors that may allow investments to grow at a rate higher with 5-7 percentage points than the annual GDP rate, during 2003-2005.

First, the increase in domestic savings due to the improvement in the business environment and the effects of the ongoing privatisation and restructuring will foster new investments of the domestic private sector.

Second, the steady growth of the FDI inflows into the economy will start producing positive effects on the economy, with their share in the total investment reaching around 15-20%, well above their average levels in the past.

Third, a large part of the EU transfers to Romania will be channelled toward public investments, while the expected increase in the share of budget revenues will allow a higher share for government investments in the budget expenditure.

Inflation will decrease, reaching a level below 10% (December-to-December), starting with 2004. Such accelerated reduction in the inflation rate is due to the better fiscal performance and to the realisation of the social pact envisaged to be implemented in Romanian society.

Alternative Scenario

The alternative scenario was run under assumptions of a prudent policy aimed primarily at the achievement of macro stabilisation. It has taken into account the trade-offs between economic growth and the need of ensuring social stability and fiscal consolidation within the economy. The alternative scenario also considers the possible constraints coming from the recent events in the world economy and from a slower step of the reform process, the pressure coming from restrictive fiscal and monetary policies.

The medium-term economic forecast, based on a more restrictive macro-stabilisation scenario, shows an average growth rate of the GDP around 4.3% for the period 2001-2005, under the assumptions of no remarkable changes occurring in the external conditions. The domestic policy assumptions that are responsible for the expected growth are based mainly on the ongoing process of restructuring and privatisation in the state-owned sector and on the consolidation of the fiscal bearing. The perceived risks are related to lower international flows towards Romania than in the alternative of the baseline scenario, to lower external demand following the slowdown in the world economy and to delays in restructuring induced by negative social reactions to the very fast privatisation programme proposed within the PEP.

Annual GDP growth rates will vary between 4% and 4.2% after 2003, while the inflation rate will steadily come down reaching levels of one digit by the end of 2005.

The quantitative alternative projection for the development of the Romanian economy during the next 5 years is shown in Table 1.20 The

forecast starts from the actual configuration of the variables, which implies a rather slow improvement in the external position and image that Romania currently has on the international markets.

Demographic forecasts

For the demographic forecast, the National Institute of Statistics uses the software Rural-Urban Projections (RUP) developed by the Census Office of the U.S. The software is based on the components method. The input data and the calculation formula are in the annex.

At 1st of January 2001, the Romanian population was of 22.430.500 inhabitants.

Until 2010, by maintaining the fertility, mortality and external migration rate constant, the Romanian population will be diminished by 491.000 persons. The decrease will be evident mostly in urban areas, the decrease of the population from municipalities and towns being 20 times more than in villages and communes.

The Romanian population will not increase in any alternative of projection. In an optimistic alternative (following a rise in the fertility and life expectancy) in 2010 there will be 215,9 less Romanians. In a pessimistic alternative there will be a decrease around 586.700 citizens. In a medium alternative, a decrease of the population of 458.400 thousand citizens seems possible.

In all alternatives, the population from the urban area will decrease. In the rural areas (except for the pessimistic alternative), the population will slightly increase (with a maximum 112.7 citizens in the optimistic alternative).

Changes in the population structure by age groups

The young population

In all alternatives of the projection, the young population will be significantly reduced, oscillating in the urban area between 12.4% (pessimistic alternative) and 13.1% (optimistic alternative), and in the rural area between 18.1% (pessimistic alternative) and 18.9% (optimistic alternative).

In 2010, under the conditions of the constant maintenance of the fertility, the young population will represent in the urban area only 13.2% of the population, and in the rural area 18.6% .

Population (15-59 years)

The labour force increased in the last two decades with an annual percentage of only 0.4%, because of the less numerous generations born during the war and during the period 1960-1965. Following this evolution, the quota of this population group did not change essentially, oscillating between 60.2-62.6%.

On a short term basis, until 2005, all alternative projections show that the population of this subgroup will be maintained at around 15 millions. After 2005, the less numerous generations, born after 1990, will enter into the labour force. Therefore, the group between 15-24 years will gradually decrease, reaching in 2010 between 12.7% and 14.1%. In all the projection alternatives, the population between 15-59 years will decrease in 2010, reaching 8.3 million citizens in the urban area and 6 million citizens in the rural area.

In the year 2000, over 30% of the 15-59 years population were over 44 years of age. In 2010 this percentage will decrease, oscillating between 29.3 and 29.5% (highlighting the continuous process of maturation of the population of age able to work). After 2010, this group of the population will begin to diminish, the "older" groups becoming part of the older population.

In all the alternatives of projection, this group of population will decrease in the urban areas and will increase in the rural. The values will range in the urban areas at around 22.2% and in the rural areas between 15.5% (pessimistic alternative) and 15.7% (optimistic alternative).

Dependency ratio

The total dependency ratio gradually fell in the last period of time. In 2000 from 100 adults, 18.5 were old persons, with 2.5 persons more than in 1990.

The total dependency ratio (number of young and old persons from 100 adults) fell from 51.3 (1990) to 45 (2000). This was possible due to the decrease of the dependency ratio of the youth from 35.6 to 25 (2000). In all projection alternatives, the number of young persons out of 100 adults will continue to fall, with bigger values in the urban area.

The labour force will be still well represented in the chosen projection interval, but the structure on age groups will begin to be unbalanced.

The dependency ratio of the old people will fall until 2010, estimating that after 2025 it will begin to rise constantly, as a consequence of the massive entrance of the population of 60 years and over. This is the generation born after the decree against abortion from 1966.

Labour market development

The forecast performed by the Ministry for Development and Prognosis on two scenarios that take into account potential positive or negative outcomes.

Given the forecast decline in the participation rate, the most important objective remains the improvement in the quality of work and education, aimed at enhancing labour productivity.

The forecast evolution of labour productivity shows (see table 1.22) an increasing trend, maintaining rates above the GDP rate with 0.5-1%, following the particularly good performances in the years 2000-2001. The measures taken on the privatisation and restructuring front, together with those envisaging macro-stabilisation will be the main factors for such a phenomenon. They will also bring new pressure on the already low level of the occupation rate. On the other hand, the FDI stock will come closer to a level that may start producing spreading-out effects within the entire Romanian economy. The SMEs are expected to contribute positively to the creation of new jobs, especially in the field of non-wage paid employment. Nevertheless, the labour market will remain tensioned in the medium term, and it is envisaged to undertake specific active measures, including programmes of labour force training and education.

In the field of the human resources, the sustained economic growth will come together with an increase of the number of employees, which will be between 1-2%, if there is an important improvement of the labour productivity. The unemployment rate will be maintained around 7%, with all the influences of the new law of the minimum guaranteed income.

1.3 Annex to chapter one

Table 1.1: GDP: absolute in EURO; annual growth rate in constant prices; GDP per head in PPS (inflation rate)

Years	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
GDP: absolute at current prices in EURO	27,1	27,8	31,2	37,2	33,0	40,0	44,3[1]
GDP: absolute (98 was used ESA 95 instead of ESA 79)	27,1	27,8	31,2	37,4	33,4	40,0	44,3[1]
GDP annual growth rate in constant prices	7,1	3,9	-6,1	-4,8	-2,3	1,6	5,3
GDP per head in PPS (YEARBOOK 2001 CCs)	5.600	6.100	5.900	5.800	5.800	6.000	
Inflation (HICP) - annual average rate	32,3	38,8	154,8	59,1	45,8	45,7	34,5

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat

Romanian Statistical Yearbook 2001. NIS

Table 1.2: Public social expenditure as percentage of state budget, expenditure by type (health care, pensions etc.)

Name of indicators	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Social expenditure as percentage of GDP	9,7	10,6	11,1	13,8	14,5	13,9
Public social expenditure as percentage of state budget	29,7	31,4	32,9	39,3	41,8	39,2
Unemployment expenditure as percentage of state budget	2,1	1,8	3,8	4,1	4,3	3,3
Health care total expenditure as percentage of state budget	**9,4**	8,8	8,2	8,8	11,1	11,0
Social Health Insurance Fund as percentage of state budget				5,6	8,4	9,0
Social insurance expenditure as percentage of state budget	18,2	20,8	20,9	26,4	26,4	25,0
Pensions as percentage of state budget	16,06	15,47	14,46	18,37	19,05	18,02

Source: The Social State Insurances Budget Law for 1995-2000.

[1] Calculated on the basis of the exchange rate form the National Bank

Table 1.3: Social Insurance State Budget as percentage of state budget

SOCIAL INSURANCE STATE BUDGET	1995	1996	1997	1998	1999	2000
TOTAL:	17,34	16,56	15,44	20,24	20,70	19,65
-Pensions	16,06	15,47	14,46	18,37	19,05	18,02
-Tickets for rest and treatment in spa	0,29	0,16	0,18	0,26	0,31	0,39
-Indemnities and social benefits, total from which:	0,99	0,89	0,80	0,58	0,54	0,46
-Indemnities for temporary labour incapacity	0,51	0,46	0,35	0,33	0,29	0,24
-Indemnities for maternity leave and for sick children leave	0,43	0,38	0,38	0,16	0,15	0,12
-Benefits for burial services	0,05	0,05	0,07	0,10	0,10	0,10
-Benefits for prothesis	0,01	0,01	0,01	0,00		
-Other payments	0,00	0,03	0,00	1,02	0,81	0,77

Source: The Social State Insurances Budget Law for 1995-2000.

Table 1.4 Male/female population:

Years	1995	1996	1997	1998	1999	2000	2001	2002
Population in 1000	22.681	22.656,1	22.581,9	22.526,1	22.488,6	22.455,5	22.430,5	22.390,4
Female in 1000		11.548,4	11.518,9	11.499,0	11.487,4	11.475,4		
Male in 1000		11.107,7	11.063,0	11.027,1	11.001,2	10.980,0		

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat

Romanian Statistical Yearbook 2001. NIS

Table 1.5 Age structure

Age structure:	1995	1996	1997	1998	1999	2000
Under 15 years	20,8	20,2	19,6	19,2	19,0	18,5
15 -24 years	16,7	16,7	16,8	16,8	16,6	16,0
25- 44 years	28,3	28,4	28,5	28,6	28,7	29,0
45 - 64 years	22,4	22,5	22,6	22,7	22,8	23,2
65 years and over	11,8	12,2	12,4	12,7	13,0	13,3

Table 1.5 Age structure (continued)

Age structure:	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Demographic dependency ratio[2]	48,4	47,9	47,1	46,8	47,0	46,6
Under 15 years	30,9	29,9	28,9	28,2	27,9	27,1
65 years and over	17,5	18,0	18,3	18,6	19,1	19,5

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat (95-99)

Romanian Statistical Yearbook 2001. NIS (2000)

Table 1.6: Net population increase

Indicators Name	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Net population increase per 1 000 inhabitants	-2,5	-3,3	-2,5	-1,7	-1,5	-1,0	-1,8

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat (95-99)

Romanian Statistical Yearbook 2001. NIS (2000 - 2001)

Table 1.7: Fertility rate, net reproduction rate

Indicators Name	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Fertility rate (Eurostat)	1,3	1,3	1,3	1,3	1,3	1,3
Net reproduction rate (NIS)	0,62	0,63	0,62	0,62	0,61	0,61

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat (95-99)

Romanian Statistical Yearbook 2001. NIS (2000)

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[2] Calculation based on Eurostat data, as percentage of population under 15 years and 65 years and over at 100 persons from the group 15 - 64

Table 1.8: Life expectancy at birth, at age 60-65

Indicators Name	1995	1996	1997	1998	1999	2000
Life expectancy for women at the age of 65 - in years	15,1	15,0	15,3	…	15,3	15,5
Life expectancy for men at the age of 65 - in years	12,6	12,5	12,8	…	12,8	13,0
Life expectancy at birth for girls	73,1	73,0	73,0	73,3	73,7	74,2
Life expectancy at birth for boys	65,3	65,2	65,2	65,5	66,1	67,0

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat (95-99)

Romanian Statistical Yearbook 2001. NIS (2000)

Table 1.9: Family structure

Family structure:	1995	1996	1997	1998	1999	2000
Marriage rate	6,8	6,7	6,5	6,5	6,2	6,1
Divorce rate	1,5	1,6	1,5	1,8	1,5	1,4

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat (95-99)

Romanian Statistical Yearbook 2001. NIS (2000)

Table 1.10 Migration: emigration and immigration: main trends, main developments in absolute figures, percentages of population, age groups, regions and ethnic groups

Indicators Name	1995	1996	1997	1998	1999	2000
Migration (Eurostat)	-0,9	-0,9	-0,6	-0,3	-0,1	-0,1
Emigration (Eurostat)	1,1	1,0	0,9	0,8	0,6	0,7
Main developments in absolute figures	25.675	21.526	19.945	17.536	12.594	14.753
Male	11.478	10.079	9.423	8.460	5.858	6.798
Female	14.197	11.447	10.522	9.076	6.736	7.955

Table 1.10 Migration: emigration and immigration: main trends, main developments in absolute figures, percentages of population, age groups, regions and ethnic groups (continued)

Indicators Name	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Age Groups						
Under 18 years	5.137	4.198	4.145	6.371	4.290	4.372
18-25 years	4.180	3.447	2.559	1.795	1.357	1.513
26-40 years	10.875	8.347	8.091	5.379	4.244	5.717
41-50 years	2.803	2.701	2.490	1.690	1.236	1.551
51-60 years	1.245	1.332	1.143	864	664	657
61 years and over	1.435	1.501	1.517	1.437	803	943
By ethnic groups						
Romanians	18.706	16.767	16.883	15.202	11.283	13.438
Germans	2.906	2.315	1.273	775	390	374
Hungarians	3.608	2.105	1.459	1.217	696	788
Jews	131	191	136	198	111	66
Others	324	148	194	144	114	87
By destination country						
Australia	136	165	207	206	124	143
Austria	2276	915	1551	941	468	270
Canada	2286	2123	2331	1945	1626	2518
France	1438	2181	1143	846	696	809
Greece	193	274	232	316	214	328
Israel	316	418	554	563	326	433
Italy	2195	1640	1706	1877	1415	2124
Germany	9010	6467	5807	3899	2370	2216
USA	2292	3181	2861	2868	2386	2723
Sweden	520	310	468	129	98	90
Hungary	2509	1485	1244	1306	774	881
Others countries	2504	2367	1841	2640	2097	2200
	0,2	0,3	0,4	0,5	0,5	0,6
Repatriate	5507	6265	8432	11287	10467	12442
Male	2935	4120	4573	6153	5473	6326
Female	2572	2145	3859	5134	4994	6116

Table 1.10 Migration: emigration and immigration: main trends, main developments in absolute figures, percentages of population, age groups, regions and ethnic groups (continued)

Indicators Name	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Age Groups						
Under 18 years	655	636	564	1020	1036	1979
18-40 years	2756	2416	4178	5621	4802	6090
41-50 years	1486	2379	2661	3607	3066	2308
51 years and over	610	834	1029	1039	1563	2065
By ethnic groups						
Romanians	4604	5332	7288	10289	9823	12138
Hungarians	259	311	361	355	202	176
Germans	196	225	268	248	141	40
Jews	76	??	144	85	72	42
Others	372	397	371	310	229	46
By destination country						
Australia	569	567	455	198	113	20
France	670	1075	1159	328	139	111
Israel	162	211	151	300	83	61
Germany	853	764	692	422	273	242
USA	487	420	441	259	255	172
Hungary	256	117	396	394	235	178
Republic of Moldova	1171	1752	4092	8109	8359	10365
Others countries	1339	1359	1046	1277	1010	1293

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat (95-99)

Romanian Statistical Yearbook 2001. NIS (2000)

Table 1.11: Household structure by number of persons

Years	**single**	**2 persons**	**3 persons**	**4 persons**	**5 persons**
1997	19,5%	24,9%	20,5%	19,4%	15,8%
1998	20,0%	24,8%	20,4%	19,3%	15,4%
1999	20,4%	24,7%	20,6%	19,2%	15,1%
2000	21,0%	24,8%	20,6%	19,0%	14,6%
2001	21,1%	25,2%	21,3%	18,3%	14,1%

Source: Integrated Household Survey, NIS

Table 1.12: Average household size

Years	Number of households	Average household size
1977	6807567	3,26
1992	7281441	2,72
1994	7686330	2,96
1997	7486749	3,01
1998	7566730	2,98
1999	7607608	3
2000	7672193	2,9

Source: Integrated Household Survey, NIS

Table 1.13: Unemployment rate;

Indicators Name	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Unemployment rate from LFS (ILO methodology)	8	6,7	6	6,3	6,8	7,1
Unemployment rate by gender - women in % from total	8,6	7,3	6,4	6,1	6,2	6,4
Unemployment rate by gender - men in % from total	7,5	6,3	5,7	6,5	7,4	7,7
Unemployment rate for people aged under 25	20,6	20,2	18	18,3	17,3	17,8

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat (95-99)

Romanian Statistical Yearbook 2001. NIS (2000)

Table 1.14: Employment

Indicators Name	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Employment rate (ILO methodology) NIS	60,7	60,4	60,9	59,6	59,1	58,8
Employment rate by gender - women in % from total	54,3	53,2	54	52,9	52,9	52,8
Employment rate by gender - men in % from total	67,5	68,1	68,3	66,8	65,7	65,1
Employment rate by area –urban	53,2	55	54,3	52,3	50,8	49,8
Employment rate by area –rural	69,6	66,9	68,9	68,4	69,2	69,8

Source: Romanian Statistical Yearbook 2001. NIS

Table 1.15: The aged specific labour force participation (age 50-64, 65 and over)

			1999				**2000**	
Total	Total	Employed	ILO unemployed	Inactive persons	Total	Employed	ILO unemployed	Inactive persons
50-64 years	58,2	57,1	1,1	41,8	57,8	56,4	1,4	42,2
65 years and over	36	36		64	35,7	35,7		64,3
Male								
50-64 years	66,3	64,5	1,8	33,7	65,7	63,5	2,2	34,3
65 years and over	41,7	41,7		58,3	40,8	40,8		59,2
Female								
50-64 years	50,8	50,3	0,5	49,2	50,8	50,1	0,7	49,2
65 years and over	31,9	31,9		68,1	32,1	32,1		67,9
Urban								
50-64 years	39	37	2	61	38,5	36,2	2,3	61,5
65 years and over	4,6	4,6		95,4	4,4	4,4		95,6
Rural								
50-64 years	76,9	76,6	0,3	23,1	77,5	77	0,5	22,5
65 years and over	56,5	56,5		43,5	56,4	56,4		43,6

Source: Romanian Statistical Yearbook 2001. NIS

Table 1.16: Labour force structure

Indicators Name	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Percentage of employees					57,8	56,1
Average number of Employees	6160	5939	5597	5369	4761	4623
Self-employed					22,1	23,1
Employer					1	1,1
Unpaid family worker						19.3
Percentage of civil servants					1,7	1,8
Average number of civil servants	130	125	130	134	141	148

Source: Romanian Statistical Yearbook 2001. NIS

Table 1.17: Poverty in Romania, 1995-2000

	Rate of poverty	**Rate of severe poverty**
1995	25,2	12,3
1996	23,3	9,8
1997	27,7	13,5
1998	27,3	11,8
1999	26,6	9,8
2000	30,6	12,2

Source: Review of the methodology to measure of poverty, Poverty dynamics 1995-2000, APPSIC

Table 1.18: Rate of poverty

Rate of poverty depending of the age and the number of children	1995	1998
1. Rate of poverty depending of the age:		
under 7 years	30,2	37,7
7-15 years	37,1	48,7
16-25 years	34,3	45,5
26-35 years	21,7	31,0
36-45 years	26,0	36,1
46-55 years	23,7	32,3
56-65 years	14,5	21,0
Over 65 years	9,7	11,4

Table 1.18: Rate of poverty(continued)

Rate of poverty depending of the age and the number of children	1995	1998
2. Rate of poverty depending of the no of children:		
Without children	16,4	23,5
1 child	24,6	35,0
2 children	30,1	43,6
3 children	52,8	64,6
4 children or more	71,1	83,6

Source: Teşliuc, Pop, Teşliuc, 2001

Table 1.19: Economic forecast – base line scenario

Macro-economic indicators	**2001**	**2002**	**2003**	**2004**	**2005**
GDP-annual growth	4.5	5	5.2	5.5	5.1
Investments-annual growth	10	9.7	11.2	13.2	12
Inflation rate	33.8	26	17	11	8
Government revenues(% of GDP)	32.7	31.8	32.9	34	34.6
Budget deficit/surplus	-3.5	-3	-3	-3	-3

Source: Pre-Accession Economic Programme, NIS

Table 1.20: Economic forecast – alternative scenario

Macro-economic indicators	**2001**	**2002**	**2003**	**2004**	**2005**
GDP-annual growth	4.5	5	4.2	4	4
Investments-annual growth	10	9.7	6	8	8
Inflation rate	33.8	26	19	14	9
Government revenues(% of GDP)	32.7	31.8	32.4	32.8	33.2
Budget deficit/surplus	-3.5	-3	-3	-3	-3

Source: Pre-Accession Economic Programme, NIS

Table 1.21: Labour market forecast - base line scenario

Labour market indicators	**2001**	**2002**	**2003**	**2004**	**2005**
Active population (end of the year)	-0.3	-0.4	-0.4	-0.5	-0.5
Employment	0.7	0.4	-0.1	-0.2	-0.2
Unemployment rate	9.9	9.2	8.9	8.6	8.4
Gross average wage	46	32.9	21.2	15.4	11.6
Labour productivity	4.7	4.5	5.4	5.7	5.4

Source: Pre-Accession Economic Programme, NIS

2. OVERVIEW ON THE SOCIAL PROTECTION SYSTEM

2.4 Organisational structure

2.4.1 Overview of the system

The social model provided by the Government of Romania is grounded on the balance of competition, partnership and solidarity. This means that the social protection measures, including the social assistance for certain categories or groups of persons must be combined with actions for job creation, but also with actions of social solidarity. At the same time, certain public funds (the public pension fund, the public health insurance fund, the public fund for unemployment insurance) are managed by administration boards, which include representatives from the government, employers associations and trade unions.

The following ministries and central public institutions in Romania manage social protection:

The Ministry of Labour and Social Solidarity (MLSS) – the main governmental institution having a synthesis role in elaborating, ensuring and co-ordinating the implementation of policies and strategies in the field of labour, social protection and social solidarity; specialised body of the central public administration. By analysing the socio-economic situation of the population, MLSS elaborates the social security and social assistance policy and strategy, providing programs, national plans, draft laws. It also ensures the supervision in the field of social security (public pension system and other social insurance rights, unemployment insurance system, labour security and labour protection system).

In the field of social assistance and family policies, the MLSS regulates and manages the protection and assistance measures for all social categories who are in need and in social dependence: families, children, elderly people, disabled people. The ministry also develops partnership programs with foreign institutions and throughout its territorial structures ensures the payment of social and family benefits.

The Ministry of Health and Family (MHF) is the central public authority in the field of securing, promoting and protecting the health of the population.

It creates, organises, co-ordinates, and implements the national public health programs, approves and sets their financing, organises, co-ordinates and oversees the social work activities provided for the public health, family support and disadvantaged population groups. The MHF co-ordinates and takes action for the prevention of the health-damaging activities, co-

ordinates, routes and controls the activities needed to protect the disabled persons. It approves the framework for providing medical care within the Social Health Security System, with the outline having been made by the NHIH and the Romanian College of Physicians, and which is submitted to the Government for approval. The MHF once a year compiles the list of drugs for the Catalogue of Human Medical Products, in partnership with the National House of Health Insurance and with the agreement of the Romanian College of Physicians and of the Romanian College of Pharmacists. The MHF establish the policy for human resources in the health care field.

The National Pensions and Other Social Insurance Rights House (NPOSIRH) is a public autonomous institution of national interest, which manages the public pension system and other social insurance rights regulated by law. NPOSIRH has organisational and financial tasks, administrates the social insurance state budget, supervises the fund collection and confirms the contribution period.

The National Health Insurances House (NHIH) is an autonomous public institution of national interest, a legal entity, with no profit purposes, with the main duty to ensure the unitary and well-co-ordinated functioning of the social health insurance system in Romania. NHIH has responsibilities concerning the financing of medical services, in terms of approving the budget of income and expenses of the health insurance houses, compiling proposals for the framework concerning the conditions in which medical care is provided within the social health insurances system, and preparing the list of drugs for the Catalogue of Human Medical Products.

The National Agency for Employment of Labour Force (NAELF) is a public institution of national interest, a central public administration body that manages the unemployment insurance system, regulated by law. NAELF has organisational tasks both in the financial field and the administration of the unemployment insurance budget. It also co-ordinates and supervises the implementation of labour market issues: prevention of unemployment and its social effects, employment of the jobless, ensures equal opportunities on the labour market, motivation of employers to create new jobs and motivation of the unemployed to search for new jobs and increasing of the labour force mobility.

The Labour Inspection (LI) is a public institution of national interest, a central public administration body that manages the labour security and labour protection system, regulated by the law. The main objectives of the LI are: supervising the implementation of the law concerning labour relations, health and safety at work, surveillance of dangerous jobs and technical assistance of the employers for preventing professional risks and social conflicts.

The Romanian Adoption Committee (RAC) is a state structure, which supervises the childcare through adoption and promotes international co-operation in this field.

The National Committee for Child Protection (NCCP) consists of 17 members representing the main central institutions involved in the field. It co-ordinates the humanitarian programs for child and family care, co-operates with the local public administration bodies, the international institutions and with Romanian and foreign NGO's on child protection issues.

The National Authority for Child Protection and Adoption (NACPA) is a specialised body of the central public administration, subordinated to the General Secretariat of the Government; elaborates and implements the strategies in the following fields: rights of children, disabled child care and protection and child adoption.

The National Council of Elderly People (NCE) has been established for the protection of human rights of the elderly people. It was established as a body, which grants social dialogue among old persons and public authorities, for a better management of the social assistance institutions and for a better participation of the elderly in social life.

The Department for Local Public Administration (DLPA) supervises and supports together with the MLSS, the Ministry of Health and Family (MHF) and the State Secretary for Disabled People (SSH) some activities as: tutor authority, civil status, child and disabled care, through specialised public services.

2.4.2 Centralisation/de-centralisation of the system

a). The following institutions are subordinated and under the co-ordination of the **Ministry of Labour and Social Solidarity (MLSS):**

The General directorates of labour and social solidarity for territorial districts, including Bucharest;

The Labour Inspection with its own territorial structures: the territorial labour inspectorates;

The National Office for Recruitment and Employment Abroad;

The Institutions for childcare and social assistance for elderly people;

The National Institute for Scientific Research in the field of Labour and Social Protection;

The National Institute for Research and Development in Labour Protection;

b). The following institutions are subordinated to **the Ministry of Health and Family** the Public Health Directorates (PHD) of the districts and of Bucharest, which are in charge of public health policies and national health programmes, sanitary inspection, monitoring the health status, and organising information from the statistic data. They are also responsible for the planning and running investments financed by the state budget. They take part in the negotiation of the contract for the medical services of the hospital, monitor the realisation of the hospital budget. They acquire and provide the mandatory vaccines (assigned by the health programs for the persons with a high risk), transfer the funds received from the Ministry of Health and Family through the national health programs (for tuberculosis, HIV/AIDS, cardiovascular diseases, cancer) to the medical services providers, for those persons suffering from chronic or communicable diseases.

After the transfer of the buildings of hospitals to the local authorities in 2002 , these are going to involve themselves in supporting the expenses for repairs, maintenance and some investments.

c) Subordinated to the **National Pensions and Other Social Insurance Rights House** (NPOSIRH) are the territorial pension houses, including Bucharest, and local pension houses supervised by the latter. In addition institutions for Spa and the National Institute for Medical Expertise and Labour Force Recovery are subordinated to NPOSIRH.

d) The National Health Insurance House has in subordination territorial health insurances houses (HIH), which are autonomous institutions at local level, a legal entity with non profit purposes, which administer and manage the budget of the social health insurances fund, observing the legal regulations, ensuring the functioning of the social insurance system at local level. The health insurance house for the defence, public order, national security and legal authority and the house of health insurances for the transport units are organised and function according to the social health insurances law. The Health insurance houses have responsibilities concerning the contract of medical services and drugs that are necessary for the insured people, keep evidence of, collect and control the transfer of quotas of social health insurances, organise the execution of the administration budget of the social health insurances fund, contract funds for financing health programs, commonly organised by the Ministry of Health and Family and the NHIH.

e) The Romanian College of Physicians has subordinated units from the districts

f) Subordinated to the **National Agency for Employment of the Labour Force (NAELF)** –are the territorial agencies for employment of labour force, including Bucharest, with local agencies and centres for professional reorientation.

g) The commissions for protection of the child in need are organised at the local levels of public administration, with territorial and local levels and they manage the problems of children in difficulty, suggesting protection measures for them.

h) Specialised public service for child protection can be found as public institution at territorial and local level and they execute the suggestions for child protection issued by the commissions and also administrate foster centres and receiving centres.

i) The caring and social assistance institutions for children or adults in need are subordinated financially to the territorial and local authorities and supervised by the territorial structures of the ministries involved (MLSS, Ministry of Education and Research, MHF and SSH). This is the reason why there are many parallel services. As regards effective social assistance, there are only few social workers and most of them are not properly trained in their field of activity. The role and functions of the social worker are not well defined.

j) The public health directorates are de-centralised units of the MHF. They are legal entities, representing the public health authority at local level. They approve the budgets of income and expenses of hospitals in their territorial array.

k) Hospitals are autonomous institutions whose work is based on the incomes obtained from providing medical services, on a contract basis with the house of social health insurances.

l) Family physicians and specialists with medical offices have the right to practice freely and most of them have offices by contract with the public health administrative centres.

m) The **non-governmental organisations** work in the field of reproductive health, health promotion, prevention of communicable diseases (TBC, HIV/AIDS), anti-drug and special protection of disabled persons in Cupertino with the Ministry of Health and Sanitary Units.

2.4.3 Supervision

a) MLSS ensures within its own directorates the methodological guidance and supervision of the institutions in its subordination, co-ordination or under its authority (covering the social insurance, unemployment insurance, labour security, labour protection and social assistance fields).

b) Supervision for the social insurance and unemployment insurance is organised within its own structure (at central and territorial level: MLSS and the territorial general directorates for social solidarity). Supervision of the contributions for the insurance covers the following activities: verifying the authenticity in declarations, as well as the accurate and exact fulfilment of the employer's obligation.

c) In the field of labour protection, MLSS and MHF organise, co-ordinate and supervise together, through their central and territorial departments. The responsibility of MLSS is to provide general norms and rules, standards. The general rules cover measures for the whole economy, including the ministries with their own special structures. The MHF provides mandatory norms in labour hygiene, assents standards and documents confirming employee's health.

Each employer must obtain functioning authorisations for labour protection in order to carry out any kind of activities: production, services or other. The authorisation is provided by the territorial labour inspectorate departments, which supervise from time to time the compliance with labour protection norms and standards. Each employer must comply with the norms, confirm yearly the maintaining of the approved working conditions, and immediately announce any changes in this field.

d). The Ministry of Health and Family is responsible for supervising the law compliance, in order to guarantee the right to medical assistance. In this regard, the Ministry of Health and Family organises, co-ordinates and controls the medical assistance that is provided through public or private health units and social assistance and takes action to support the health of the family. The Ministry of Health has the obligation to ensure the supervision and control of the application of the law by all the institutions which have responsibilities in the field of public health, and also by the social insurance systems and sanitary units from the private health care sector, co-operating with the College of Physicians of Romania, the College of Pharmacists of Romania and local authorities.

e) The public health directorates supervise the compliance of the law in order to ensure the insured person's right to medical services, and control the activity of medical services providers at the local level.

f) The College of Physicians of Romania and its subordinated units from the districts supervise the quality of the medical services act in the insurances houses and the medical services in order to meet the quality standards for any patient.

2.5 Financing of social protection

2.5.1 Financing resources

The social and unemployment insurance systems are financed through the social insurance budget and unemployment insurance budget, based mainly on contributions (presented at the paragraph 2.2.3.), which are paid both by employers and employed persons. The institutions involved in collecting the mentioned contributions and providing the insured services are NPOSIRH and NAELF with their territorial structures.

The funds for social assistance activities are provided mainly from the state budget. The Ministry for Public Finances (MFP) provides funds for the MLSS and SSH budgets; the two institutions are responsible for the way the money is shared within the territory. The same funds are also given to the local budgets. The involved territorial structures are directly responsible for the way the money is shared with the beneficiaries according to the existing laws and norms.

The connection between the state budget and the local budget is not precisely established; therefore it is not always clear which services are paid from the state budget. For example: the state provides the total funds for the local authorities without specifying which services they are meant for. As a result, local authorities must establish priorities. Unfortunately, medical and social assistance are not a priority for many local authorities.

The sources for financing medical care are:

- the fund of social health insurance consisting of contributions for social health insurance;
- allocations from the state budget for the national health programs, building
- hospitals, high tech medical equipment, public health and health promotion;
- small amounts come from the local budgets and non-governmental organisations resources.

The income of the health insurance fund consists mainly of contributions paid by employers and employees in equal quotas of 7% (14%); other categories of insured people like pensioners, unemployed persons and self-employed pay 7% from their income. The contribution for health insurance is compulsory for every person of Romania, with the exceptions mentioned

by law. The allowances from the state budget are made from the financial resources of the state created on the account of taxes, contributions and non-fiscal incomes. The non-governmental organisations co-operate, support and finance health programs organised by the Ministry of Health and Family or by the local authorities.

2.5.2 Financing principles

The public pension system and other social insurance rights are financed by the pay-as-you-go principle. It is organised as a unique system, granted by the state on the following principles: redistribution, equality, social solidarity, mandatory contribution, distribution and autonomy. The public system shaped by the new Law 19/2000 has integrated all the existing professional pension systems (artist, writers, farmers, etc.), has established mandatory contributions for employees, including self-employed, family business, extra-job system (civil convention) and the unemployed.

The new system introduces as the main criteria the period of contribution so that the main element for the amount of the insured services is strictly correlated with the period of contribution and not with the employment period. In addition, an upper ceiling was introduced which grants two issues: persons with high income are kept away from monopolising the budget and on the other hand the public system encourages the private social insurance system and the general savings.

At present, the MLSS is elaborating a draft for a new capitalised pension system (2nd Pillar). The 3rd Pillar, for private pension, is ensured for the moment by the existing life insurance societies.

The **Unemployment insurance system** is financed on the insurance of the unemployment risk principle. The funds for the unemployment insurance budget are coming from: the employers' contributions, employees' contribution, self-insured contribution, and other sources, including foreign financing. The budget covers the following services: the payment of unemployment benefits, compensatory payments, financing measures for employment motivation and unemployment reduction; financing of professional training for those who are looking for a job; financing of studies and statistics on labour market issues provided by the specialised institutions subordinated to NAELF.

The social assistance system is financed from the state and local budgets, through subsidies granted for allowances, paid benefits, food allowances and maintenance of the social assistance institutions.

Social health insurance functions on the basis of the solidarity and subsidiarity principle in collection and distribution of funds. Each insured person pays the insurance contribution according to their own income, but receives medical services according to his medical necessity. The financing

of the package of services to which the insured persons are entitled is made in a non-discriminatory and equitable way, regardless of whether the patient is poor or rich, or whether he/she has paid a larger or smaller insurance contribution. The houses of insurance have the obligation to conclude agreements with service providers only within the approved budget.

2.5.3 Financial administration

a). The public pension system and other social insurance rights are administered by NPOSIRH and its territorial structure. The contributors to the system are the insured persons (employees, self-employed, persons who contribute by themselves to the system), employers and NAELF (for the unemployed). The insured persons owe an individual social insurance contribution and the employer owes a social insurance contribution. Social insurance contributions levels are differentiated by labour conditions divided in normal, uncommon and special, and are yearly approved by the State Social Insurance Budget Law. The contribution is mandatory from the moment of earning the quality of being insured on the basis of the Law or from the moment of concluding the insurance agreement.

The individual social insurance contribution paid by the insured persons, except the unemployed or those with insurance agreements, is calculated as the third part from the yearly-established contribution for normal labour condition. The social insurance contribution paid by the employer represents the difference between the amounts of the whole contribution for the certain labour condition (normal, uncommon or special) and the individual social insurance contribution. The persons who have insurance agreements pay the whole amount of the contribution by themselves, according to the labour condition. The contribution for the unemployed is paid by NAELF, from the unemployment insurance budget, according to the level established for normal labour condition. Social insurance contributions are not taxable.

The monthly individual contribution basis for the insured persons is the total gross individual income, which comes from salaries together with other additions and supplements, or from the insured income. The basis of the contribution must not be higher than three times the monthly average gross salary established for the Romanian economy. The basis of the monthly contribution paid by the employer is given by the whole gross salary fund and cannot be higher than the product between the average number of the insured persons from that month and the according value of three times the monthly average gross salary established for the Romanian economy. For the unemployed, the contribution basis represents the monthly-unemployment benefits covered by the unemployment insurance budget.

b) The unemployment insurance system is administered from the financial point of view by NAELF and its territorial structure. The contributors to the system are the insured persons, the employers and the persons insured by the

agreement, who pay the unemployment insurance contribution. The contribution rate for the employer is 5% of the total monthly gross salary fund; the individual contribution rate of the insured persons is 1% of the monthly gross basic salary. The contribution rate owed by the persons insured by agreement is 6% of the declared monthly income in the contract.

In the case where the unemployment fund does not cover the needed financial resources, the budget deficit will be covered by state subsidies. Depending on the needed resources for covering the expenditures of the unemployment insurance budget, the level of the contributions rate can be changed by law.

c) The health insurance fund is managed by NHIH and health insurance houses and is formed of contributions for health care, which are supported as follows:

- employees and employers pay a contribution for the social health insurance, representing 7% of the monthly income;
- payment of 7% of the taxable income in the case of freelancers, taxable agricultural income annually declared by the natural persons, incomes from the pension rights and supplementary pension, in the conditions set by the law, incomes from the individual benefits of unemployed people.

Exempted from contribution payments are: children and people younger than 26 years, if they are pupils, students or apprentices and if they do not have any income from work; disabled persons who do not derive any income from their work or are being taken care of by the family; husband, wife, parents and grandparents without their own income, who are being taken care of by an insured person; politically persecuted persons, war veterans and widows of war, and revolutionaries from December 1989.

The insurance contribution is paid from the state budget or from the budget of social insurance for poor persons, persons being held in prisons, conscripted people and people in sick leave.

The budget of the social health insurance fund is approved by the Parliament of Romania and published in the Official Monitor together with the state budget annual law. The budget of income and expenses of the insurance house contains amounts for the payment of medical services and, separately, for the administration of the system. The budget of the houses of insurance is approved by the NHIH according to the number of necessary medical services for the insured persons of the respective house. It is used for the payment of medical services contracted with the providers of medical services. The level of income and the expense limit for medical services are set through the approved budget, as well as for the administration expenses, functioning and the capital for the redistribution fund.

The contributions of social insurance are collected by the houses of social health insurance and are used for:

a) the payment of the medical services, drugs, sanitary materials, prothesis and orthesis, for insured persons;

b) administration, functioning and capital expenses of the health insurance fund to a maximum of 5% of all the collected sums;

c) up to 25% of all sums collected are transferred into the account of the National Health Insurance House, of which 5% is used for the reserves fund (administration, functioning and capital expenses), and 20% for the redistribution fund for supporting the budgets of houses with financial problems, which are calculated according to the demographic data, morbidity rate and complexity of the medical services.

The national health programs are administrated by the Ministry of Health and CNAS with funds from the state budget and social health insurance fund. The evaluation of the health programs is based on the physical, efficiency and result indicators, for each program.

2.6 Overview of Allowances

2.6.1 Health care

The requirements for being insured for medical services are:

- payment of the insurance contribution by the insured person or from other funds or without payment of the contribution, according to the law;
- illnesses with severe consequences on the public health: immunisations, active TBC detection,
- pregnant women in the area established by the public health office;
- children from 0 to 16 years old;
- groups of people foreseen by special laws: persons who have completely or partially lost their working capacity, mutilated, injured, children and parents of those who were killed in the revolution of December 1989, persons who were imprisoned between 16th and 22nd December 1989 and persons who distinguished themselves between 16th and 25th December 1989; war veterans and war widows, persons who were persecuted for political an ethnical reasons, disabled persons.

The level of benefits includes:

a) medical services, of which:

- primary medical care is provided for all insured persons, covering the majority of the population, without supplementary payments. Primary medical assistance is provided by the family physicians for the insured persons on their list. In addition, emergency medical care is provided to any person, as well as medical services for situations which can have negative consequences for the public health: immunisations, active detection of TBC, supervising pregnant women in the areas established by the public health office;
- specialised ambulatory medical care for clinical, paraclinical and dental specialities, based on the referral from the family physician.
- hospital medical services, house calls, emergency pre-hospital services and other medical transport types, and also health recovery/rehabilitation services, based on a referral from the family physician or the specialist doctor.

b) drugs with and without personal contribution

The list of drugs with and without personal contribution of which insured persons benefit, on the basis of medical prescription is in the Catalogue of medicines and human use biological products. The Catalogue is made by the MHF, NHIH, CPR and the College of Pharmacists from Romania: drugs to be prescribed free and drugs to be prescribed with personal contribution.

c) medical devices for correcting and recovering organic or functional deficiencies, or correcting certain physical deficiencies. The medical devices are granted at the advice of the specialist physician. The health insurance houses pay entirely for the retail price of the medical device, if that is smaller than the reference price; if the selling price is higher, the insured person pays the difference directly to the supplier, as a personal payment.

Taxation of benefits: only services granted at the request of patients.

2.6.2 Sickness

In the public pension system and other social insurance rights, the insured persons can benefit, on the ground of a medical certificate, of a sick leave and benefits for temporary work incapacity. The insured sick persons have the right of a leave and benefits if they have paid contributions to the system for at least 6 months over the last 12 months or for at least 12 months in the last 24 months, before falling ill.

The sick leave and the benefits can be provided for 180 days at the most in a year, calculated from the first day of sickness; for the last 90 days is necessary the assent of the insurance medical adviser. The sick leave and benefits can be provided for a longer period in the case of specific diseases, such as: tuberculosis, cancer, AIDS, some cardiovascular diseases, and it

can reach 18 months for the two year period, this also requires assent by the insurance medical adviser.

The level of the benefits for common sickness is 75% of the calculation basis, which represents the arithmetical mean for the last 6-months income, and for which the contribution was paid. For special cases, including the above-mentioned diseases, as well as for medico-surgical emergencies and some infectious diseases, the level of the benefits is 100% of the calculation basis.

2.6.3 Maternity

The insured women have the right to maternity benefits for a period of 126 days that includes the pregnancy leave and postnatal leave. The same right is given to those women who gave birth to a child, even if they have lost the quality of being insured. Disabled insured women have the right, at their request, to a pregnancy leave beginning from the 6th month of pregnancy. If the woman gives birth to a dead child or the child dies during the maternity leave, the benefits are paid for the whole period.

The monthly level of the maternity benefits is 85% of the calculation basis, established for other social insurance rights, respective for benefits for temporary work incapacity.

2.6.4 Invalidity and long term care

The insured persons to the public pension system who lost half or all of their labour capacity as a result of occupational injuries, occupational diseases, TB, diseases and accidents that are not work related, have the right to a **invalidity pension.** The same rights are granted for insured persons, who are in military service as well as school children, apprentices and students in the professional practice period.

As regards the labour demands and the degree of lost work capacity, invalidity is divided into three degrees. The 1st degree of invalidity is the worst and supposes not only total loss of work capacity, but also loss of self-caring, orientation, which leads to a permanent supervision and nursing by another person. Persons included in the 1st degree of invalidity have the right in addition, to a guidance benefits to the pension. This benefit is established yearly by the social insurance budget Law and cannot be lower than the minimum gross basic salary.

Invalidity pensioners are submitted to a medical check-up at a 6-12 month period until they reach the standard pension age. Pensioners with permanent invalidity or those who have 5 years left until the standard pension age and who have full contribution period are not medically supervised. When reaching the standard pension age, the invalid person can choose the best

between the invalidity pension and the old age pension; regardless of the chosen pension, the person involved still benefits from the guidance benefits.

For the special protection of disabled persons, care and assistance centres are operational in each district. In these units, assistance, care, treatment, recovery, rehabilitation, professional orientation and advice on career development are provided, financed mainly from the state budget and from the local budgets.

2.6.5 Old-age

a) Pension for age limit is granted for those persons who fulfil both conditions of standard age limit and complete contribution period. The standard pension age is 60 years for women and 65 years for men. Reaching those standard ages will be realised in 13 years from the implementation of Law 19/2000 (1.04.2001), by increasing pension ages from 57 years for women and 62 years for men..

The minimum contribution period is 15 years, both for women and men. The increase of this period from the former value (10 years) will also be reached in 13 years from the law introduction. The complete contribution period is 30 years for women and 35 years for men. Insured persons with complete contribution period, who have worked partially or totally in uncommon or special labour conditions, disabled persons, as well as persons included in special laws (deported people, invalids and widows of the war veterans, revolutionists) can benefit from the old age pension for age limit, with the reduction of the standard pension age, as low as 50 years for women and 55 years for men.

Insured persons who have covered more than 10 years of the complete contribution period can benefit from an early (or advanced) pension and partially anticipated pension, with a maximum of 5 years before the standard pension age. Reaching the standard pension age, they will benefit from the pension recalculation by adding the assimilated periods and possibly the new contribution period. The level of the early pension is established in the same way as the level of the old age pension. The level of the partially anticipated pension is established by diminishing the level of the old age pension, depending on the contribution period and the age reduction.

b) Death benefit – is granted by the public pension system to all insured persons and is not related to a certain contribution period. The benefit level is established yearly by the state social insurance budget.

c) Community services for elderly concerning:

- Temporary or permanent home care;
- Temporary or permanent care in an old age people institution;

- Nursing in day-care centres, clubs for elderly people and social apartments;
- Providing meals through social help canteen;
- Providing burial services for lonely elderly people.

d) Institutionalised social assistance for elderly and persons with chronic diseases is ensured in the old age institutions. Persons accepted are entitled to full services including accommodation, meals, health care rehabilitation, ergo therapy, social and psychological assistance, etc. These institutions are subordinated to the local authorities and territorial ministry structures. The funds are from extra-budgetary incomes and subsidies granted from the state budget. Elderly people with their own incomes pay a monthly contribution established on the average monthly maintenance costs. The contribution is usually 60% from the incomes, but not more than the average monthly maintenance costs established for each institution.

e) Community services supply the elderly people at home with:

Social services that include nursing, supporting social rehabilitation, legally and administrative advice, support for usual services and obligation payments, providing house maintenance, help for housekeeping and food preparation.

Social-medical services that include: help for personal hygiene, home improvement for special needs, socialising activities, temporary nursing in day-care centres, night asylum or other specialised institutions.

Medical services that include: home medical consultation or in a health institution, drug administration, dental consultation, providing sanitary or medical equipment.

Social services and social-medical services are provided for free or against a monthly contribution established according to the monthly net income. The management of these community services is insured by the local administration directly or by convention with NGO's, religious services or other individuals.

f) Elderly People Mutual Fond (EMF) – are non-profit Romanian NGO's, established on territorial criteria with the objective of social protection and mutual help of pensioners and their families. EMF provides: loans, financial benefits, services for the elderly, different social, artistic and cultural activities. EMF has in their subordination workshops, shops, retirement houses, medical offices and clubs.

Their funds come from admission tax, monthly contributions, loan interests, incomes from workshops and shops, donations and other contributions.

2.6.6 Survivors

The survival pension is granted to the children and the surviving partner if the deceased was a pensioner or eligible to a pension. Children have the right to survivor's pension until they are 16-years old or if they are studying in a legally organised form of education they benefit until the end of their studies, the age limit however is 26 years; if the child is disabled and was in the deceased person's maintenance, he/she benefits of the survivor's pension without limit.

The surviving partner benefits from the survival pension for the rest of life, if he/she has the standard pension age and if the period of marriage was at least 15 years. If the period of marriage was at least 10 years, the level of the survivor's pension decreases by 6% for each year bellow 15. The surviving partner benefits from the survivor's pension if he/she is disabled and the marriage period was at least 1 year. If the surviving partner does not fulfil the presented requirements, he/she can benefit from a survivor's pension only for 6 months after the partner's death. If the surviving partner has his/her own pension and also fulfils the requirements for a survivor's pension, he/she can choose the better pension.

The level of survivor's pension is established by calculating a percentage from the average number of points accumulated by the deceased as follows:

a) for a single survivor	50%
b) for two survivors	75%
c) for three or more survivors	100%

The level of survivor's pension in the case of children who lose both parents are the sum of both calculated survivor's pensions of his/her parents.

2.6.7 Employment injuries and occupational diseases

In the case of occupational injuries and occupational diseases the public health inspectorate and the labour territorial inspectorate, through employer services, must approve the medical certificate. The insured person benefits from the benefits for temporary working incapacity without the conditions for a period contribution, starting from the first day of incapacity until the beginning of work or retirement. The benefits level is 100% of the basis calculated by law.

The insured persons who cannot get back to the initial work place because of employment injuries and occupational diseases, can temporarily change the activity. In that case and if the new work provides a lower gross income than the one realised 6 months before the event happened, the person benefits of a benefit for a temporary change of work.

For those who for health reasons can get back to the same work place, but for reduced hours, can benefit from the benefit for reducing working hours up to a quarter of the normal working hours. Medical recommendation is necessary with the assessment of the social insurance medical adviser. The above benefit can be granted for a maximum of 90 days per year.

The benefits for a temporary change of activity and the benefits for reducing working hours could not be higher than a quarter of the calculated basis.

Financing medical care for occupational diseases is supported by the state budget. The Health insurance houses have the obligation to notify the authorities in charge of labour protection, on professional toxic exposure or on situations with a high risk of injury.

2.6.8 Family benefits

a) The state allowance for children is given to all children up to 16 years of age or a maximum of 18 years if they study in a legally established form of education and it is a fixed amount.

b) For the children in difficulty, the commission for protection of the child in need establishes allowances for foster homes**,** the fund being provided from the local budget.

c) The Law 416/2001 establishes an allowance for new born babies which is a fixed amount and is granted once for each new alive-born baby, for the first 4 children; it is financed from the state budget.

d) The wives of those in the mandatory military period who have no income or incomes lower than the minimum gross salary, benefit from a social benefit which is a fixed amount granted for the military service period and it is supported by the state budget.

e) For the cold season, between 1st November and 31st March, each year, single persons and families with low incomes can also ask for a benefit for home heating**.** This benefit is established depending on the average monthly income for a family member and the heating source.

f) Solidarity allowances are granted to the persons in need and are provided by the territorial general directorates of labour and social solidarity on the basis of a social investigation made by the social assistance offices. The level of social solidarity allowance is a difference between half the value of the minimum gross salary and the monthly net income of each family member. For the families with children under 16 years, the allowance is granted for each family member.

2.6.9 Unemployment

Unemployed, by Law 76/2002, is a person who fulfils the following requirements:

- is looking for a job,
- has the age between 16 years and the retirement age,
- is in good health and mental condition for work,
- has no job,
- has no incomes or lower incomes than the unemployment benefit,
- can start work immediately,
- is registered at NAELF or another legally labour job provider.

In order to obtain the unemployment benefits the person must fulfil a minimum period of contribution (a period in which he has contributed, as an employed person, to the unemployment fund). The unemployment benefits is a monthly fixed amount, non-taxable, representing 75% of the minimum gross salary at the date of establishing the benefits.

The benefits are granted for a period of a maximum of 12 months, differentiated by the contribution period: for 6 months if the contribution period is between 1-5 years; 9 months for a contribution period between 5-10 years; 12 months for those with over 10 years of contribution. For persons with no contribution period, an unemployment benefit of a monthly fixed amount, non-taxable is granted for a six-months period. The benefits level is 50% of the minimum gross salary.

For the period in which the unemployed benefits from the unemployment benefits, they are also insured in the public social insurance system and in the social insurance health system. They have all the rights granted by law for those systems. The contributions for the two insurances mentioned are covered by the unemployment insurance budget.

2.6.10 Minimum resources/social assistance

The introduction of the minimum granted income is based on the social solidarity principle. Minimum granted income is ensured by a monthly social benefit that is calculated as a difference between the minimum granted income (established by law) and the monthly net income of the family or the single person. In order to receive the social benefit, persons being able to work must: do 72 hours of community work; prove that they are registered with the territorial agencies for employment of labour force; prove that they did not refuse a job or participation in a professional training program. Persons having one or more children, of less than seven years old

in care, persons who study (in school), persons who fulfil legal retirement requirements and disabled persons are excepted.

The monthly net income is calculated on the basis of the overall family incomes, including unemployment benefits, state children allowances, as well as the possibility of obtaining incomes from property. A person who is capable to work and who gets social benefits must renew all the above-mentioned information every three months.

2.7 Summary: Main principles and mechanism of the social protection system

The system is designed as a well balanced employment-centred and also citizen-centred system, all the categories of population being covered by the main distribution effects. The main values and principles of the social protection system refer to providing a good balance between the public and private sector, between protection and self-protection, between resources and needs, between the reform measures and transforming the existing systems, between the needs of the present and the needs of the future generations. These balances are targeted to reduce the social costs of the transition for the purpose to increase the individual responsibility and to assure the social stability.

a) The following measures are undertaken in **the field of employment and the protection of the unemployed:** increasing the number of employees, development of the enterprising spirit of the employer and of those searching for a job, increasing the mobility, flexibility and adaptability of the labour force and granting equal chances. Measures for supporting the unemployed refer to: sustaining the fund of unemployment insurance, protection of those affected by collective dismissal and the shift of protective policies from passive to active measures. As regards the security of labour, measures intended for health protection, self-security (social insurance) and also the protection of people working abroad are taken.

b) In **the field of social insurance,** the main objective is to reach the three pillar system, by complementing the existing 1st Pillar – Public old age insurance, by the 2nd Pillar – Universal retirement pensions (by funding and private administration) and the 3rd Pillar – encouraging the accumulation of the personal savings for supplementary pension.

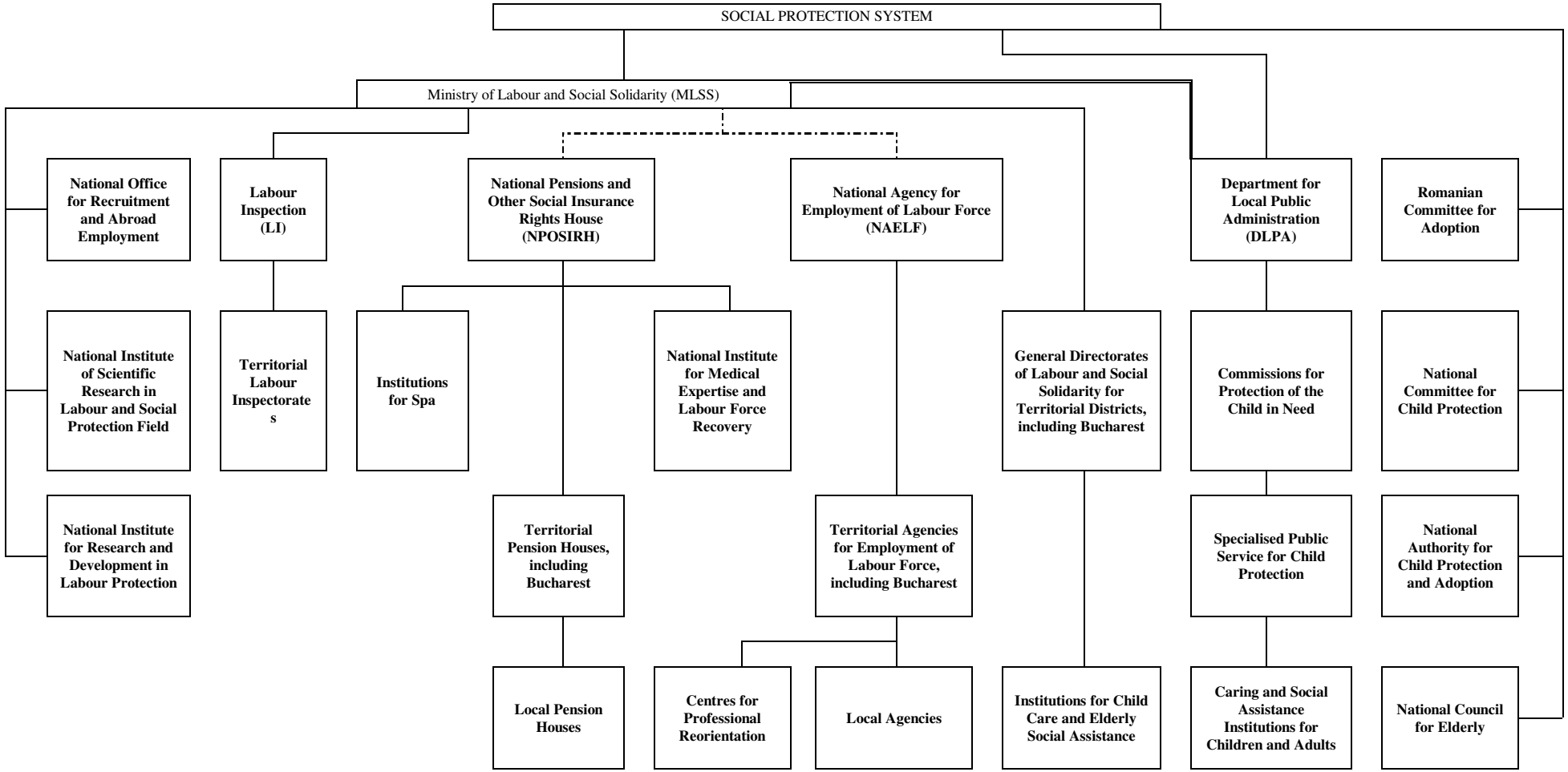
c) In **the field of social assistance,** the issues are focussed as follows: families, children, old age, protection for disabled persons, care protection in special social assistance institutions and fight against poverty. The implementation of a coherent policy in the field of social assistance is realised in association with the increase of the institutional responsibility in granting and providing help (proper care and rehabilitation programs), as well as the efficiency increase of the social assistance expenditures.

d) It is compulsory for all Romanian citizens with a residence in Romania, as well as for foreigners or stateless citizens who have taken up a residence in Romania, to be insured. In order to become eligible for medical care, any person must be insured. As shown above, the system provides a wide coverage of all categories of persons in Romania, thus ensuring access to medical services. The principles of the social protection system contain:

- -broad access to medical services for the insured persons
- -free choice of physician for the insured person;
- -payment of the insurance contribution at each insured person's level of income;
- -the insured persons do not officially take any other supplementary expenses for medical services;
- -the annual value of the services package usually exceeds the approved incomes of the social health insurance system, and the providers of medical services, especially hospitals and drug suppliers record debts that are paid for in the next year from the current funds of the health insurance fund;
- -drugs are prescribed free of charge or with a personal contribution according to a list approved by the Ministry of Health and Family;
- -insured people benefit of specialised medical services in ambulatory medical offices or in the hospital, with a referral from the family physician;

The framework specifies the conditions of coverage of certain preventive medical services, and primary health care for all citizens, immunisations, and balance exams for children, active TBC detection, supervising pregnant women- in the area established and assigned by the public health offices. Compulsory immunisations, some preventive and curative medical services for ill people with certain chronic diseases, certain drugs and sanitary materials are granted from the state budget and from the budget of the social health insurance fund, through the national health programs.

2.8 Organisational chart of the social protection system



3. PENSIONS

3.1 Evaluation of current structures

3.1.1 Public-private mix

The reality of some social phenomena in Romania, as population ageing and low demographic output, keep the attention of responsible factors in the social protection field.

The Ministry of Labour and Social Solidarity is the main governmental body responsible for the co-ordination of the politics in the field of social insurance.

Previous settlements in this field (Law no. 3/1977 and legislation which completed and modified this law) and the social phenomena have lead to the reform of the pension system, as a complex and long-term process. This process has – as a main goal - the increase of the pension amount and the assurance of a balanced social insurance budget. In 2000, the amount of money granted as pensions and social benefits was 2.675 billions EURO, 1.4 times bigger than the amount in 1999.

The reform of the social insurance system tries to give an adequate answer to the economic and social realities, which the public system of pensions is confronted with, by planning to improve the level of pensions and the requirements for using one's rights.

The analysis and the documentation concerning world-wide experience in the field, as well as the recommendation of some international institutions constitute the background of the reform of the pension system in Romania. The objective of the reform is to ensure the financial safety of aged people, so that the economical development can be better sustained if the pensions system is based on more components, like:

- **a re-distributive compulsory component, publicly managed** – the juridical frame is Law no. 19/2000 about the public system of pensions and other social insurance benefits (with subsequent modifications and completions) – 1st Pillar;
- **a compulsory capitalisation based component, privately managed** - the juridical frame will be the Law about organisation and work of universal pension funds. According to the Program of the Government, this component will be adopted when a reliable source to cover the deficit does exist – 2nd Pillar;
- **an optional capitalisation based component, privately managed,** which is addressed to people who have an income higher than the ceiling established in the public system – the juridical frame will be the Law

about supplementary pension funds, which will be adopted until 2003 – 3rd Pillar.

Provisions of the Law no. 19/2000 about the Public System of Pensions and Other Rights of Social Insurance have enlarged the contributors group by extending compulsory assurance toward all the persons who obtain professional incomes, in a ratio laid down by law. As presented in chapter 2 (2.2.3.), for the insured persons there is the obligation to contribute to the social insurance budget. These contributions are split between the insured persons and their employer. The individual social insurance contribution paid by the insured persons is calculated as the third part of the yearly-established contribution for normal labour condition. The social insurance contribution paid by the employer represents the difference between the amounts of the whole contribution for the specific labour condition (normal, uncommon or special) and the individual social insurance contribution. The persons insured by agreement pay the whole amount of their contribution by themselves and for the unemployed the contribution is paid from the unemployment insurance budget.

Public system contributors are the insurance holders who owe the individual social insurance contribution, the employers, the legal persons employed, the National Agency for Employment and the persons who conclude an insurance contract.

The social insurance contribution structure has been modified. The involvement of the insurance holders in contribution payment is looking for strengthening and transferring part of the contribution to the employee and make him responsible for it. For the normal work-conditions, the employers pay two thirds of the contribution quotes and the employees the other third quote. For special and uncommon work-conditions, the contribution quotes are larger and the employers bear the payment of the difference.

The legislation concerning the public pension system doesn't provide any kind of tax incentives for the pensioners. At the same time, the benefits offered by the law for pensioners refer to the possibility of buying a treatment ticket for Spa once a year (with a contribution of 75% from the pension fund). The treatment ticket covers a period of 18 days.

In order to adapt the institutional frame to the new provisions of legislation in the field, the National House of Pensions and other Social Insurance Benefits has been set up. It is a public institution with national interest, which works under the authority of the Ministry of Labour and Social Solidarity and its main task is to administer the public system of pensions and other social insurance benefits.

For the time being, in the social insurance system only the Ist and the IIIrd Pillar are functioning so far.

The I[st] Pillar – the public system of pensions and other social insurance benefits is organised as a mandatory system, granted by the state, based on the pay-as-you-go principle. This insurance offers basic protection for the insured persons, covering the risks for old age, survival, invalidity, sickness, maternity, raising children under the age of 2 years (all kinds of pensions and other social insurance rights are mentioned in Chapter 2 - 2.3.).

Table 3.1: The social insurances budget between 1995 - 2000

- millions EURO -

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
Income	1474,7	1506,9	1622,9	2336,7	2321,0	2549,8
Expenditure	1536,7	1554,5	1630,0	2658,0	2396,5	2780,3
Excedent (+) / Deficit(-)	-62,1	-47,6	-7,1	-321,2	-75,5	-230,4

Source: The Social Insurance State Budget Law for 1995 - 2000

Table 3.2: Income for the social insurances state budget between 1995-2000

- millions EURO -

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
TOTAL	1474,7	1506,9	1622,9	2336,7	2321,0	2549,8
- The social insurance contribution	1450,4	1422,4	1387,5	2035,8	1990,7	2347,5
- The contribution for rest and treatment in Spa[*)]	3,0	3,3	3,3	6,0	6,3	8,5
- Other sources	24,3	81,2	232,1	294,9	324,0	193,8

Source The Social State Insurance Budget Law for 1995 – 2000

[*)] The contribution for rest and treatment in Spa represents the individual contribution paid by the beneficiary for the ticket for rest and treatment

These figures show the expenses for social insurance benefits and the income provided to older people by the public insurance system. This income consists of all kind of pensions (old-age pension, survival pension, invalidity pension), Spa tickets, funeral benefits.

The families have also an important role within supporting the elderly, because of the very low level of the pensions that cannot cover the minimum elementary every day expenses (food and maintenance). Romania does not have an official poverty line, so that we have no correct indicator to compare the level of the pensions.

Table 3.3: Expenditures from the social insurances state budget between 1995 – 2000

-millions EURO-

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
TOTAL:	1536,7	1554,5	1630,0	2658,0	2396,5	2780,3
-Pensions	1422,8	1452,3	1526,8	2412,6	2204,8	2550,7
-Tickets for rest and treatment in Spa	26,1	15,3	19,0	34,7	35,5	55,3
Total indemnities and social benefits, from which:	87,4	83,6	84,2	76,8	62,8	65,7
-Indemnities for temporary labour incapacity	44,8	43,1	37,0	42,7	34,1	33,9
-Indemnities for maternity leave, for sick children leave	37,9	35,4	39,7	20,5	17,0	17,1
-Benefits for burial services	4,1	4,5	6,9	13,3	11,6	14,7
-Benefits for prosthesis	0,5	0,7	0,6	0,2	-	-
-Other payments	0,4	3,2	0,0	133,9	93,4	108,5

Source: The Social State Insurances Budget Law for 1995-2000.

The Law no.19/2000 extended the area of contributors to the public pension system: employers, employees, farmers, unemployed, self-employed, persons who are voluntarily insured to the public system. The public social insurance system is not a universal system for the whole population, but it offers to everyone the possibility to be insured, either on the effect of the law or by agreement with the public house of pension, by paying the contribution to the system.

The families have an important role in supporting their pensioners. In most cases, the children provide for their elderly parents food, medicines and even cover the maintenance expenses. For those pensioners who do not have a family, surviving is difficult.

The IIIrd Pillar – the optional capitalisation based component, privately managed, is covered on the Romanian market by the existing life insurance agencies and companies, which function according to the provision of Law no.32/2000. The contribution for this kind of insurance is voluntary and covers the risks for life, invalidity, hospitalisation, old age (as private pension), according to the type of the insurance.

The general provisions of the legislation concerning the life insurance companies offer the possibility for tax incentives to participate in a voluntary social insurance scheme. However, these provisions are not yet functional, because of the state budget deficit and the extension of the economic crisis.

The general provisions of the legislation concerning the life insurance companies offer the possibility for tax incentives to participate in a voluntary social insurance scheme. Although these provisions are not yet functional, because of the state budget deficit and the extension of the economic crisis.

The pension reform in Romania includes two components:

- A parametrical reform of the social insurance system – which has been accomplished by endorsement of Law no. 19/2000.
- A systematically reform – which is responsible for creating capitalised, private managed funds of pension.

In order to create new opportunities for growth of the pension benefits and to promote a stable mechanism able to resist to demographic and macro-economical pressures, the draft law of organisation and working of privately managed universal pension funds has been drawn up. It is the second compulsory component of the complex system of pensions in Romania.

The development of this component will be realised through allocation of a 10% quote from the actual social insurance contribution, in order to administer some private societies. Then, these funds can be invested on financial market, on the base of some principles and limits defined by law, so that, through gradual accumulations, a higher replacement income at retirement may be obtained.

Privately managed pension funds are an important potential resource for internal capital market. They provide prerequisites for enhancement of savings and economical investments growth ratio.

Privately managed pension fund will be supervised by an independent authority – the Commission for Control of Pension Societies – that has competence in drawing-up specific settlements and pursuit their application.

The draft law as concerns the organisation and development of universal pension funds will be present in the parliamentary debate. According to the program of the Government, this component will be adopted when a doubtless source to cover the deficit will exist.

In the field of banking the share of state-owned banks in total social capital and in total assets, has decreased dramatically during the period 1996 - 2000; hence, private capital represents 54% of total assets, and 45% in

total social capital. Furthermore, foreign capital accounts for 50% of total assets and 39% of total social capital in the Romanian banking sector. This evolution severely restricted the scope of resource misallocation through banking channels, therefore reducing the share of doubtful and overdue liabilities in total assets from 14.54% in 1998 to 0.25% in the first half of 2001, and improving the solvency ratio from around 10.25% in 1998 to 27.30% by the end of June 2001.

Key factors in this evolution were the dissolution (by acquisition) of Bancorex, the main state-owned bank financing foreign trade, the restricted operations of a number of ailing banks, the successful privatisation of two large banks (Romanian Development Bank and Agricultural Bank). Plans are set for further downsizing the state's stake in the banking sector, through the privatisation of the Romanian Commercial Bank (the largest bank in the system) and CEC (The Savings Bank). The completion of this privatisation would significantly reduce the quasi-fiscal deficit, and, consequently, would diminish the need for NBR's intervention to sterilise excessive increase in net domestic assets.

Another range of measures taken in the financial sector deals with the issue of transparency. A new regulation on credit co-operatives is already in place, forcing them either to turn into commercial banks under the NBR supervision or to cease functioning.

The institutional framework is also improving in the insurance business, as a reshaped supervisory body is in place. This is an emerging segment of the financial sector, given the expected involvement of the insurance companies in the administration of the private pension system.

Acting as a barometer of investors, confidence in the economic environment, **the capital market** did not recover significantly in 2000. The limited market size, and the persistency of causes preventing its expansion, among which the insufficient progress of structural reforms and privatisation, led the capital market not to respond correspondingly to outer signals, and not to reflect the beginning of a new cycle of economic growth.

Under these circumstances, the capital market faced a serious competition from t-bills offering high interest rates and minimum risk, as well as from high returns on banking products both in ROL and in foreign currency. Nevertheless, it is worth noting an upturn in demand for financial products, constituting the basis for future development of the capital market.

Following a crisis in early 2000, which occurred on the background of poor legislation, mutual funds started to recover, operating on higher risk due to the gap between interest rates and dividends. In the first half of 2001, the Stock Exchange witnessed a surge with 117% in the nominal value of its capitalisation (ROL); in the same period, the Rasdaq market also increased its capitalisation with 29.7%. During 2000-2001, there were adopted a

number of regulations meant to improve listing and transaction requirements on Rasdaq, resulting in increased transparency and more rigorous standards.

The supervisory and regulatory organism approved regulations for listing companies on three different levels, depending on companies' performances, allowing for better access to information and increased transparency. This will be implemented once the regulation of The National Securities Commission is finalised, containing the principles on regulatory bodies set by the International Organisation of Securities Commissions (IOSCO). The regulations adopted on the authorisation and operation of securities firms, the minimum requirements for establishing and functioning of securities firms were modified in line with the provisions of the Directive 93/6/EEC. Furthermore, on the Rasdaq market elements of securing transactions were introduced, by setting protection standards, limits to individual transactions (volume and margins of prices) variation.

The objectives for a better functioning of the capital market aim at: improving legislation in line with the acquis; establishing and functioning open investment funds and investment societies, as financial intermediaries institutions; diversifying financial products and increasing the level of capitalisation; preparation, of financial statements compatible with EU standards by listed companies. Capital market development is directly linked to regulating capital movements in accordance with EU provisions, with the final aim to fully liberalise capital flows. The Stock Exchange has been adopted in June 2001.

Transparency and market openness are fostered as well by the decision to allow securities companies that fulfil certain conditions to trade T-bills on the secondary market, and by underway-legislative changes that strengthen the payment and clearing system, including the development of an Electronic Payment System. This sequential approach is needed to accommodate the proper management of the monetary policy and to avoid excessive pressures on the exchange rate.

3.1.2 Benefits

As it is presented in chapter 2 (2.3.4., 2.3.5., 2.3.6.), the pensions provided by the public pension system are: the old-age pension, the invalidity pension, the survival pension, the advanced pension and the partially anticipated pension.

The amount of the old-age pension is determined by multiplication of the average annual score, realised by the insured person during the contribution period, and the value of a pension point. The amount of pension is higher, so that it covers also the contribution for health insurance.

The average annual score, realised by the insured person during the contribution period, is calculated by division of the number of points

(resulting from the totalization of the annual scores, realised by the insured person during the contribution period) by the number of years according to the complete contribution period.

The annual score is determined from the totalization of the number of points realised every month which is then divided by 12. The number of points realised every month is calculated by division of the individual month gross salary or the insured month income (that represented the calculation basis for the contribution), by the average month gross salary for the Romanian economy.

According to the Law 19/2000 the calculated annual score for the insured person can't be higher than 3 points in a year.

The value of a pension point is calculated on the ground of a coefficient that can't be less than 30% and more than 50% of the average month gross salary for the Romanian economy.

The old pension formula, by the time the new one has been introduced, took into account the realised income for a period of the best 5 years out of the last 10 years of activity.

The new pension formula for calculation takes into account realised/insured income over the entire contribution period. Some non-contributory periods are also taken into account as contribution period (for example the period of university studies, mandatory military service, the periods the insured person is benefiting from of social insurance benefits provided by the system, as sickness leave, maternity leave These non-contributory periods are taken into account only for the calculation of the old-age pension and not for the advanced or partially advanced pension. As elements of determination:

Table 3.4: The New Pension Formula

- national average gross salary (nags), predicted for year 2001	159.4 EURO
- the value of the pension point at April 1st 2001, based on a coefficient of 38% from the (nags) – Law 191/2002 – for adopting the state social insurance budget	60.6 EURO
- estimated average score	1,35
- average annual score of the pensioners	= the amount of the pensions properly to the previous settlement
- the value of a pension point	= from 30% to 50% from the national average month gross salary

- there are excepted those pensioners that acceded to pension in the 1.01.1998 – 31.03.2001 period, with higher income than the estimated average score for the persons who benefit of Law 19/2000	
- number of active persons	4,5 million
- number of pensioners	6 million
- percent pensioners/active persons	0,75

The replacement rate at the moment of the new pension law introduction was established to 38%.

Table 3.5: The average public pension during 1995 – 2000

- EURO -

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
Average public pension, total from which:	32,4	31,6	31,4	38,9	33,4	37,2
on age-limit, with total contribution period	40,9	39,9	39,8	49,7	44,1	49,0
on age-limit, with incomplete contribution period	26,5	25,6	24,9	30,1	25,6	29,1
Invalidity - I-st degree	34,4	33,3	32,9	40,0	34,6	4,1
Invalidity - II-nd degree	27,6	26,6	26,0	31,7	27,7	31,3
Invalidity - III-rd degree	20,0	19,2	18,5	22,6	19,6	21,0
Survival	19,9	19,9	19,7	23,6	19,5	20,3

The social program for 2001- 2004 includes measures for:

- re-correlation of pension in a three years interval, beginning from the fourth quarter of the year 2001, with the purpose to establish the natural proportion between different categories of pensioners. As corrections have been brought to the calculation basis for the pensions step by step over a certain time period, there appeared differences between the categories of pensioners.
- quarterly indexing the pensions with a percent that covers whole inflation influence;
- taxation of only those pensions which are higher than the amount of two times the national average gross salary.

During the period between the endorsement of Law no. 19/2000 until its enforcement, social-economical realities have recorded changes, which together with the commitments assumed by the new executive power in the rule program, have determined the need for revision and completion of

legislative frame that concerns the implementation of the public pension system.

Table 3.6: The comparison between the average public pension and the average net salary, during 1995 - 2000

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
Average net salary income	1.00	1.00	1.00	1.00	1.00	1.00
Average public pension, total from which:	0.41	0.39	0.40	0.37	0.36	0.35
on age-limit, with total contribution period	0.52	0.49	0.51	0.48	0.47	0.46
on age-limit, with incomplete contribution period	0.33	0.31	0.32	0.29	0.27	0.27
Invalidity - I-st degree	0.43	0.41	0.42	0.38	0.37	0.04
Invalidity – II-nd degree	0.35	0.33	0.33	0.30	0.30	0.29
Invalidity – III-rd degree	0.25	0.23	0.24	0.22	0.21	0.20
Survival	0.25	0.24	0.25	0.23	0.21	0.19

In favour of integral covering of inflation influence and of consumption prices growth rate on pensions, a quarterly indexing mechanism for these incomes will be applied, through resolutions of the Government. Pension indexing percentage will differ on beneficiary categories, depending on the date of accession to pension, in order to eliminate any lacks of poise and inequities in pensions level. This process has already started since January 2001, by an indexing granted for each quarter of 2001. Starting with March 2002 another adjustment and indexing scheme has been established only for those pensions that are established under the level of the maximum pension (regarding the new pension law, the maximum pension has the value of three points). The value of the pension point is up-dated by being indexed with 6%.

The public pension system exhibits efforts to make improvements with regard to income security in old age, but because of the poor contributions the funds are not sufficient. At the same time, the intergenerational distribution is functioning, but the reduction of poverty in old age is just a goal which is not yet fulfilled.

The provision of the previous pension law (Law nr.3/1977) established the calculation basis for pensions as the income of the best 5 years out of the last 10 years of work activity. Another measure introduced by the new

pension law is to assure a tighter bond between pensions and the average annual score (the number of points that form the calculation basis for establishing the value of the pension). At the same time, it provides the introduction of a re-correlation mechanism for pension income, using a gradual program.

It started in the fourth quarter of 2001 and will continue during a period of 3 years. This measure will permit elimination of distortions among different categories of pension or within the same category, depending on retirement year. It will also create prerequisites for re-correlation of pension amounts for those established according to the previous legislation and those that will be established according to the calculus formula stipulated by Law no. 19/2000.

The pension age will be gradually increased between 2001 and 2014 as follows: up to 65 years for men (raised from 62 years) and up to 60 years for women (raised from 57 years). Additionally, the contribution periods are going to be increased. The minimum contribution period will be increased from 10 to 15 years and the full contribution period from 30 to 35 years for men and from 25 to 30 years for women.

Also, a certain flexibility in the retirement conditions has been introduced, by creating new possibilities of anticipated retirement, as well as by creating incentives for the insured persons to participate actively in the labour market. Additional points are granted for the contribution periods achieved after cumulative fulfilment of retirement requirements. Thus, the insurance holders may express their personal options.

3.1.3 Financing of the pension system

Law no. 19/2000 concerning the public system of pensions and other social insurance benefits (enforced from April 1st 2001) represents the normative document whose provisions reform the entire system of pensions and other social insurance benefits. This law stipulates, as a main objective, the increase of financial sustenance of the social insurance budget, by increasing the incomes and reducing the expenditures. At the same time the public system is responsible for a better collection of the funds and recovering the arrears (the debts from the bad payer contributors).

The growth of the incomes is foreseen to be realised by extensions of compulsory insurance of new categories of persons and by a better social insurance contribution collection.

Expenditures are reduced by a decrease in the replacement ratio of salary through pension for the new beneficiaries and by a gradual increase of age and contribution periods necessary for retirement.

One of the new issues of the law is enlargement of contributors group by extending the compulsory insurance toward all the persons who obtain professional incomes, in a ratio laid down by law.

In order to assure a financial balance between contributions to the state social insurance budget and benefits from them, it has been included for the first time as a budgetary income source, the recovery of arrears. On these grounds, a program of recovery of the contributor's debts to the social insurance budget has been drawn up.

Also, Law no. 19/2000 stipulates an exact evidence of contributors, which may assure a better collection of contributions, owed to the social insurance budget. For delays in payment of contribution, late payment fines are applied. The law limits the insured income for which contribution to the pension funds is paid off. The law establishes the ceiling for the insured income at the level of three times the national average gross salary.

3.1.4 Incentives

In the field of social policy, the Government needs a radically changed approach. First, to create minimal conditions, so that citizens may participate in social life and second to grant collective commitment and individual responsibilities.

The social model promoted by the Government is based on the equilibrium between competition, collaboration and solidarity and will grant new jobs and better social solidarity. For that purpose measures in the field of social policy will be combined with assuring working places so that people will have permanent and increasing income.

The Law no.19/2000 introduces a new flexibility in the retirement condition, by creating incentives for the insured persons to remain in the labour market. There are also additional points granted for the contribution periods achieved after cumulative fulfilment of retirement requirements. For the period worked after the achievement of the pension age or when the person receives the old-age pension and thus contributes to the system, the insured person can benefit of additional points. These additional points are reflected in the pension by asking for recalculation of the pension, every 12 month of a contribution period.

The old-age pensioners who are still in employment have the opportunity to receive the old-age pension at the same time as the salary. They can chose between working by a labour contract and contribute to the public social insurance system, or working by a civil convention and not contributing to the system further on. When they choose to work on a labour contract, for every 12 month of contribution they can benefit from a pension recalculation.

By fulfilling the objective of increasing the number of legally working people, it also determines the increase of the contributors to the public pension system.

3.1.5 Coverage of the system

The insured persons to the public social insurance system are of two categories:

- those insured by the effect of the law: employees, elected people, magistrates, the unemployed, the persons who are working in co-operative systems, owners of land and forest and other;
- self-employed who contribute by themselves to the system and also the persons insured by the effect of the law that want in addition to fulfil the maximum level of contribution (three times the national average gross salary).

The law covers all the working categories of persons and it makes no difference between men and women, providing equality in chances. For the time being there is no difference between pension for men and women, because there used to be equal condition of payment, differentiated only by education levels. Although in the private sector some differences in payment between men and women start to appear.

Law no. 19/2000 and the law of organisation of privately managed universal pension funds – will make the juridical framework for 1st and 2nd components of pension system in Romania. The Law no. 19/2000 has been written according with the EEC Regulation no. 1408/1971 and 574/1972.

The Romanian law in the field of gender equality covers all the fundamental provisions of the EU legislation.

The main objectives established by the program of the Government are:

- ensuring the development of the legislation and institutional frame for equal chances in all the activity fields, mainly by introducing the national plan for gender equality action and adopting the law for equal chances;
- active participation at the EU programs in the field of promoting and granting equal treatment for men and women.

The principle of equally gender treatment in the field of social security is totally ensured in the national legislation through the Law no.19/2000.

For rising and caring the children until 2 years old, the new law grants paid leave for any of the parents (mother or father). The Law no.210/1999 ensures also the paternal leave so that the father can also participate to nurse the new-born baby.

Because of the importance of gender equality it was established the Interministerial Consultative Committee for equality in chances between men and women. Through the Resolution of the Government no.1273/2000 was granted the National Plan for Action concerning the equal chances between men and women, which will be ensured by the Ministry of Labour and Social Solidarity and the interministerial consultative committee.

3.1.6 Public acceptance of the system

The new public pension system established only from April 1st 2001 is very young and makes visible efforts for self-organising and completion in the most efficient way.

The administration of the system refers not only to the social insurance budget, but also to the database of the contributors, the way they accomplish their obligation to the system, as well as the evidence of the contribution period and the number of points.

The objective is so complex, that many times the activity of the system is not always as transparent as it should be.

Concerning the administrative effectiveness, the public considers it in a wrong way insufficient. The main problem is that the system doesn't have enough money for the pensions, because of the great amount of arrears. There are a lot of state institutions and economic agents, as contributors, which do not pay on time or which do not cover the whole amount of their obligations to the public pension system.

The public pension system does meet the general acceptance of the population, because of a very long tradition in Romania and a certain discipline created by the former legal settlements.

In spite of the generally dissatisfaction with the pensions amount and the decrease of buying capacity, especially for the pensioners, the public pension system meets the general acceptance of the population for the main reason that it is granted by the state and it offers security and stability.

3.2 Evaluation of future challenges

3.2.1 Main challenges

At the moment, the number of beneficiaries of the social insurance system in Romania – the retirees – exceeds the number of contributors. On an ascendant curve, the average number of pensioners registered in the fourth quarter of 2000 was 6,226,000 persons, with a 205,000 increase, in comparison with the same quarter of the previous year. The increase in the number of pensioners was partly determined by low retirements ages (until 1 April 2001, the retirement age was 55 years for women and 60 years for

men. In early 1990 for a short period of time there was the possibility for retirement at the age of 50 years.).

Within the social protection reform on the whole, a priority objective that became a main subject of economical policy is the public system of pensions and other social insurance benefits. The main challenges are the following:

- Decrease of pensions purchasing power,
- Unexpected increase of pensioners' number,
- Rise of inequity in regard of the pension amount among different groups of pensioners.

In the 10 year period of transition, pensions lost 60% of their purchasing power compared to 1990. In 2000, the pensions increase was realised by their re-correlation and the rise of small pensions (as it has been established in the Social Program for 2001 – 2004 – presented at 3.1.2.). On these grounds, by the uniform distribution of financial effort and from administrative consideration, the amount of pensions increased especially in the second half of 2000, as a result of the re-correlation process that covered the correction of inequity among different categories of pensioners.

The rise of small pensions was also a process of uniform increase of pensions, especially of those under the level of the national gross average salary. The first rise after the enforcement of the law consisted of 10%, which were granted in September 2000. Since October 2000, the pensions have risen in correlation with the gross income from the state social insurance pensions (that didn't exceed the level of two national net average salaries), by monthly corrections of 1.5%. These expenses equalled approximately. 0.2% GNP in 2000 and approx.0.7% of the GNP in 2001. Although, the state average social insurance pension for December 2000 was 53% higher than in December 1999 – which means a real increase of purchasing capacity with 8% - the process of the erosion of the pensions amount was strong and constant.

At the same time, the dependency ratio between pensioners and employees had a continuous increase trend due to the increase of the number of pensioners. This trend was faster in 2000 and the beginning of 2001 in comparison with the average of previous years. This appeared as a reaction of anticipation of altering introduced by the new law of pensions, starting with its enforcement on April 1st 2001.

Inequity increase phenomena among pensioners occurred after 1997 and were caused by the policy of pensions partial indexing, related to prices growth and changes produced in their formula for calculation. In 2000 the amount of money granted as pensions and social benefits was 2.675 billions EURO, 1.4 times higher than that of 1999.

The main challenges of the public pension system can be summarised as:

- The rapidly ageing of the population by the increasing of life expectancy

Table 3.7: Increasing of life expectancy

	1999	2005	2010	2020	2030	2040	2050
Men (years)	65.6	66	67	69	70	72	73
Women (years)	73.4	73.8	75	76.5	78	79	80

The population aged 60 years and more have been 15.6% in 1990, and are expected to become a share of 30% in 2040.

- The increasing of the taxation degree:
- the contribution for social insurance, from 14% (1991), 25.5% (1992), to 32.5% (1999)
- the contribution for supplementary pension, from 3% (1991) to 5% (1999)
- the debts of the state economic agents to the social insurance budget and the delay in paying the obligation to the system
- The continuos erosion of the real pension level and deterioration of the ratio between pension and salaries:

Table 3.8: The continuos erosion of the real pension level and deterioration of the ratio between pension and salaries

	Average real pension	**Average pension / net average salary**
1990	100%	44.7%
1997	50.3%	38.5%
1998	52.5%	35.6%
1999	45.5%	34.9%
2000 (April)	51.0%	30.3%

These are determined by the evolution of the inflation, economic instability, the increasing of the evasion, the pure revalorization policies.

3.2.2 Financial sustainability

The cost of pensions increase measures could not be covered by the social insurance budget income, which has a cumulated deficit of 1% GNP.

The deficit of the social insurance budget (occurred since year 1995) increased under the cumulated pressure related to the re-correlation and increase of pensions; in 2000 the deficit was 260 million EURO, to which is added the approx. . 241 million EURO deficit cumulated from the period 1995-1999.

Expenditures increase and the weak collection of social insurance contributions from companies with debts is also the cause of social insurance budget deficit. Moreover, the legislation encourages retirement and withdrawal from the labour market and determines budget burden growth.

The previous settlements in the social insurance domain (Law no. 3/1977 and the legislation which completed and modified this law) and the social phenomena have lead to the reform of the pension system, as a complex and long-term process. This process has – as a main goal - the increase of the pension amount and the assurance of a balanced social insurance budget.

The social insurance system reform tries to give an adequate answer to the economic and social realities, the public system of pensions is confronted with, by trying to improve the pensions level and the requirements for rights practising.

In order to improve the collection rate – according to an up-to-date procedure established by the law – some measures of debts recovery and grant of advantageous conditions would be used further on. The improvement of the rhythm and level of the contribution collection to the social insurance budget will be accomplished through sustained actions for recovery of outstanding budgetary obligations (provided from previous periods) and current obligations cashing at lawful deadlines.

In order to assure the financial balance between the contributions to the state social insurance budget and the benefits from them, the recovery of arrears has been included as a budgetary income source for the first time

On these grounds, the National House of Pensions and its territorial structures have drawn up programs of recovery of contributor's debts to the social insurance budget. The measures embodied in these programs will be put in use according to lawful valid provisions (forced execution, advantageous conditions for outstanding debt payment at the same time with payment of current bonds and self initiative).

Thus, Urgency Ordinance no. 43/2001 about execution of budgetary debts has been adopted. According to provisions of this normative document, through a disposition of the Minister of Labour and Social Solidarity, the requirements and competencies to grant advantageous conditions for paying the budgetary debts managed by the Ministry of Labour and Social Solidarity are established, with approval of Contest Council.

3.2.3 Pension policy and EU accession

From the prospect of the system of pensions and social insurance, Romania drew up a social protection system that can be compared with that of the member states.

The measures for reform of the system of pensions and social insurance take into account the change of the economic, social and demographic conditions and also the available resources. This action has been undertaken and made in accordance with the Council recommendation no. 92/422/EEC about convergence of objectives and social protection policies as well as Council Recommendation no. 92/857 about community principles as regard the retirement ages and Council Resolution no. 93/710 about the flexible retirement arrangements.

Law no. 19/2000 concerning the public system of pensions and other social insurance benefits was adopted in April 2000 and came into operation on April 2001. This law brings substantial modifications in areas such as: the establishment of benefit and the amount of pensions, the establishment of the categories of beneficiaries, the mechanisms for early retirement pension, the possibility to periodically adjust the pensions related to the inflation ratio.

The Rule Program stipulates the development of a system based on three pillars: the public system of pensions and other social insurance benefits, organisation and work of universal pension funds, and supplementary pension schemes.

According to the Governance Program 2001-2004 and to the Plan of Action, approved by the Government Decision no. 455/2001, pension system reform will be accomplished on the long run by introduction of the multi-pillar system of pensions:

- a re-distributive compulsory component, public managed – the juridical frame is Law no. 19/2000 about public system of pensions and other social insurance benefits, with subsequent modifications and completions (applied since 01.04.2001) - First pillar
- a compulsory capitalisation based component, privately managed - the juridical frame will be the Law about organisation and work of universal pension funds. According to the Government Program this component will be adopted when a doubtless source to cover the deficit will exist, (is proposed to be adopted until the end of 2002) – Second Pillar
- an optional capitalisation based component, privately managed, which is addressed to people who have an income higher than the ceiling established in the public system – juridical frame will be the Law about supplementary pension funds, which will be adopted until 2003 – Third Pillar.

Ministries and/or Governmental Institutions in Romania are, upon request, strengthened with short-term technical assistance in order to produce relevant background documentation, feasibility studies, project design schedules, terms of references and tender dossiers with the ultimate

goal to develop solid project documents feasible for implementation. Some of those short-term technical assistance programs are:

- Seminar as concerns the recent developments in the private pension's domain and the most critical strategic objectives to be achieved in order to successfully implement the second pillar (recent changes in European Regulations).
- Evaluation of administrative capacity of the both institutions involved in the social insurance system reform (the Ministry of Labour and Social Solidarity - politics and the National House of Pensions and Other Social Insurance Benefits - enforcement) concerning collection of data and revenues.
- Report about opportunities for individual account administration: collection and transparency of universal funds, supervision authority.
- Study of capital market in terms of minimum capital requirements and start-up expenses. Evaluation of necessary inputs and corresponding outputs.
- Feasibility study as concerns the size of the second pillar, the process of "phasing-in" the second pillar and balancing of the transition costs.
- Study of public opinion about universal pension funds and possibilities to increase population trust in the funds.
- Report as concerns technical specifications for the implementation of the second pillar of pension system and reference terms for a future PHARE Program related to the implementation (based on previous studies). Presentation of the report within a seminar.

The expected results of all these studies, seminars, evaluation reports refer to:

- Strengthening the knowledge and abilities of team members responsible for the future implementation of the Law concerning the universal pension funds.
- An overall evaluation of the present system and the process of first pillar adjustment in the light of introduction the second pillar.
- Identification of major problems and recommendations for possible solving mechanisms.
- Reference Terms for a future PHARE project concerning the implementation of Law about the universal pension funds.

The new public pension law includes special provision for the pensioners, Romanian citizens, who are settled in another country, to receive their pension for the period worked and contributed to the social insurance system.

3.3 Evaluation of recent and planned reforms

3.3.1 Recent reforms and their objectives

For the 1st pillar, Action Plan of Governance Program for period 2001 – 2004 stipulates the accomplishment of the following objectives:

Exclusion of inequity among different generations of pensioners concerning pension amount, by:

- pensions re-correlation based on a 3 years program;
- this pension re-correlation mechanism has operated since the fourth quarter of year 2001 and will create prerequisites for re-correlation of benefits from pensions established according to the previous legislation with those computed according to the formula introduced by Law no. 19/2000.
- Re-establishment of the financial balance of the public system of pensions; balance of social insurance contribution flux with pensions and other social insurance benefits pay off, by: expenditure reduction by correction of calculation formula and establishment of a minimal guaranteed by state value of pension point
- Adoption of a quarterly indexing mechanism, which fully covers inflation ratio; this process had already started in January 2001, with indexing granted for the first quarter of year 2001 (Government Resolution no. 294/2001 and the second quarter of year 2001 (Government Resolution no. 523/2001).
- a better contribution collection by strengthening the financial discipline;
- incomes growth by attracting new contributors;
- institutional consolidation for implementation of public pension system;
- consolidation of people and trade trust in pension system reform, in order to realise an information campaign.
- Review of pensions taxation system to protect purchasing power of pensions.

From an institutional point of view, the National House of Pensions and Other Social Insurance Benefits is the institution set-up on the basis of Law no. 19/2000 and Government Resolution no. 258/2001 regarding the approval of the National House Statute. This is a public national interest institution that works under the authority of the Ministry of Labour and Social Solidarity and that manages and financially administers the public system of pensions and other rights of social insurance. A state secretary leads it from the Ministry of Labour and Social Solidarity (who is the president, too) and the Council of Administration. The previous has a

tripartite structure, being composed by the Government, the employers and the insured representatives (trade unions and retirees organisations).

The National House of pensions has the following responsibilities:

- Co-ordinates and controls the lawful provisions of territorial houses and also of corporate bodies and natural persons who have rights and obligations devolved from valid legislation;
- Proposes to the Ministry of Labour and Social Solidarity the substantiation indicators of state social insurance budget and discloses the average gross national salary for the next year, foreseen according to the law;
- Assures the evidence of rights and social insurance obligations at national level, based on personal social insurance code;
- Issues, half-yearly, the report about its own activity;
- Collects and lays down social insurance contributions and other rights, according to the law;
- Supervises state social insurance incomes cashing, according to budgetary indicators approved by law;
- Applies the provisions of international social insurance conventions at which Romania is part and also community settlements and develops relation with similar foreign entities from social insurance field, in the competence limit required by the law;
- Endorses the yearly contribution period for every insured person;
- Guides and controls the activity of medical investigation and recovery of work capacity;
- Organises selection and professional training of personnel from the social insurance field;
- Assures representation in the court of law in litigation that it is involved in as an outcome of application of Law No. 19/2000 disposals.

The Ministry of Labour and Social Solidarity is the principal budget-holder for state social insurance budget and he commissions the duties stipulated by law to the executive leader of the National House of Pensions. A general secretary, civil servant, appointed by the president of the National House of Pensions, exerts this position.

The National House of Pensions was in fact established one year ago and has still a lot of organisational problems. The establishment of this institution is part of the public pension reform, because the whole system is dealing with new and very different principles, modalities of administration of the database, the funds and measures of recovering the debts.

3.3.2 Political directions of future reforms

The second compulsory component of the complex system of pensions in Romania is the **Law about organisation and work of pension funds**.

For the 2nd pillar, The Action Plan of Governance Program for period 2001 – 2004 stipulates the accomplishment of the following objectives:

- Build-up of compulsory pension schemes by adopting Law concerning the universal pension funds on year 2002;
- Institutional consolidation by:
- set-up of a supervision institution for pension companies;
- establishment of caution rules to avoid moral hazard of pension companies.
- Identification of economical resources in order to cover the deficit of public system of pensions, created by introduction of compulsory pension schemes:
- co-relation of 2nd pillar effective implementation with sustainable deficit of public system of pensions;
- elaboration of a mid-term financial plan to cover the deficit from the first years of the universal pension funds operation; negotiation of this plan with international financial institutions for sustenance of the 2nd pillar implementation;
- people and trade trust consolidation in the pension system reform by information campaign.

The Draft-Law about the organisation and development of pension funds – in course of elaboration – has as goal the creation of new opportunities of growth in pension benefits and promoting a stable mechanism able to resist demographic and macro-economical pressures. The law will define the legal frame concerning the set up, organisation and work of universal pension funds.

Privately managed pension funds are an important potential resource for internal capital market. They provide prerequisites for enhancement of savings and economical investments growth ratio.

These funds will be supervised by an independent authority that has competence to protect the interests of members, assure a prudential supervision of pension companies and pension funds, and also the supervision of annuity providers. It draws up specific settlements concerning the activity of entities, which offer services to the universal pension funds.

The draft law concerning organisation and work of universal pension funds is part of the draft laws package dedicated to a comprehensive and integrative reform of the pension system in Romania.

The main goal of introduction of the universal pension funds, privately managed, in the same time with public pension system reform consists of assurance of new opportunities of pension growth for persons who participate in the system.

As concerns the most important provisions of the draft law that regulates the second component, this may be synthesised as follows:

- All the persons who are entitled and obliged to contribute to the public pension system must adhere to a universal pension fund (chosen by them);
- A pension company will manage a single fund;
- The resources of the fund will be constituted from contributions and investment of contributions;
- Current social insurance contributions – an average of 37.5% - will be divided as follows: 27.5% toward the public pension system and 10 % toward universal pension funds;
- The National House of Pensions will collect contributions to private system.

The principles regarding investment of actives withheld by universal pension funds will be: security of funds active, diversity of investments, keeping of an adequate level of liquidities.

Every pension company will be obliged to contribute to the National Fund of Pension Guarantee, that will be used as guarantee of the contributed sums and of the minimum level of pension obtained, in case that the pension company or annuity provider don't pay off their obligations to such a beneficiary.

The Commission for Control of Pension Companies will be an independent authority, specialised in active control as concerns activity of funds and of pension societies, manners of investment and evaluation of funds, financing of pension companies activity.

The Mission of the Commission is fulfilled by the following activities:

- authorisation
- license
- supervision and control
- elaboration of settlements according to "prudent person" concept
- information and education of population

- co-operation with other institutions empowered to issue settlements in the field.

For the 3rd pillar, The Action Plan of Governance Program for the period 2001-2004 stipulates accomplishment of the following objectives:

- endorsement of Law concerning optional supplementary pension schemes on year 2003;
- creation of some institutions of supervision and settlement for the 3rd pillar;
- set-up of a Supervision Commission for pension companies;
- consolidation of people trusts in private pension schemes.

Related to the field of the other social insurance benefits, the Action Plan of Governance Program for the period 2001-2004 stipulates accomplishment of the following objectives:

- diversification of pension income sources, by participation at optional supplementary pension schemes;
- exclusion of fraud and abuse in grant of other social insurance benefits (indemnities for incapacity of work, benefits for health prevention, maternity benefits, allowances for child raising, death benefits, etc).

3.3.3 Conclusions

At the time being, the number of beneficiaries from the social insurance system in Romania – the retirees – exceeds the number of contributors. Also, the level of contribution to the social insurance fund is pretty high, with negative effect on employment of labour force. The social insurance budget registered yearly considerable deficits, the replacement rate of salary (insured income) by pension has steadily decreased, the real purchasing capacity for pensioners dramatically diminished in the last decade.

Analysing this situation, we cannot except enumeration of some of the principal tendencies that describe – from a social point of view – the world of today: extension of the life cycle, gradual or even steep expulsion of aged persons from the area of active participation in the social life, the influence of old fashion ideas and customs regarding the ageing process to politics and public opinion.

The reality of some social phenomena, as population ageing and low demographic output keep the attention of responsible factors in the domain that we are analysing.

Previous settlements in social insurance domain (Law no. 3/1977 and legislation which completed and modified this law) with all its registered flaws (emphasised especially in the last decade) and social phenomena

mentioned above have conducted to the pension system reformation, as a complex and long term process. This process has – as a main goal - the increase of pension amount and the assurance of a balanced budget.

Provisions of Law no. 19/2000 about Public System of Pensions and Other Rights of Social Insurance have implemented the objective, as follows:

- Enlargement of contributors group by extending compulsory assurance toward all the persons who obtain professional incomes, in a ratio resolute by law.
- Establishment of a pension formula that takes into account realised/insured income on the entire contribution period
- Limitation of insured income, for which contribution to the social insurance fund is paid off
- Division of duty about paying off the social insurance contribution between employer and employee (1/3 supported by employee, 2/3 by employer)
- Gradual growth of retirement ages and contribution period
- Creation of anticipated retirement mechanisms
- Introduction of some non-contributory periods in the calculation of contribution period (for example the period of university studies)
- Periodical adjustment of pensions in respect of inflation ratio
- Administration of state social insurance budget by a public institution of national interest, capable to assure transparency and maximal responsibility in financial administration of budget (the National House of Pensions and Other Rights of Social Insurance)
- Setting up of a jurisdiction specialised in solving litigation regarding social insurance rights.

One of the main challenges for the system remains the improvement of fund collection in order to equilibrate the financial balance. The strategy to increase revenues consists of the following measures:

a) Simplifying the tax system. The Government is committed to simplify and to unify existing tax regulations in a new tax code by the end of 2002.

b) Restore tax discipline in profitable firms. The tax authority and also the public pension system will increase pressure on these firms, so that they will choose to hold down wages or borrow from banks rather than accumulate tax arrears.

c) There will be avoided programs that write off or reschedule tax arrears for all categories of firms.

d) Changing the psychology in the tax administration, including the public pension system. The Government intends to upgrade the existing skills of the professional employees through continuous training and renewal of the staff with young employees. They will be encouraged and wage increases will be correlated with productivity.

4. POVERTY AND SOCIAL EXCLUSION

4.1 Evaluation of current poverty profiles and social exclusion

4.1.1 Social exclusion and poverty within the overall social protection system

The transition period after 1989 has generated deep poverty. It is difficult to give an accurate estimation of what the poverty levels were at the beginning of the transition process. What is certainly known from the empirical evidences is that, in the late eighties, the widespread alimentary, fuel and energy shortages were already creating a huge gap in between the nominal income and the real supply of goods and services available on the market. Therefore, most of the population was living in actual poverty due to shortages of all kind. What is for surely known is that, on the other hand, poverty risk, poverty gap and income inequality were at very low levels due to the social protection net that was provided by the state, mainly via its enterprises.

This lack of data and evidence about poverty coupled with the widespread presumption that poverty in itself will be a transient phenomena due to be absorbed naturally by the action of the market forces, has led the authorities in the early nineties to underestimate both its dimensions as well as its pervasion. Consequently, overall poverty rates increased - according to the estimates of the World Bank (see table 4.1. below) up to 70,9% in 1992. In spite of the conflicting statistics, it is fair to assume that from an average of around 20% at the beginning of the transition, overall poverty increased by at least 15,5% in the first three years.

Policy reactions were as follows: The first anti-poverty measures were directed towards the unemployed as it was widely believed that unemployment was poverty's main vehicle and employment the main safeguard against it. During 1990/ 1991, the policy was characterised by the seeking for a national consensus: a "new social policy" was elaborated in close co-operation with the trade unions and under the auspices of the ILO. The law on trade unions and the law for solving working conflicts has been implemented as well as the first unemployment insurance law which has been enacted in 1991. This insurance law, that has than been subsequently modified throughout the years until a new law has been finally enacted in 2001, was supplemented by an attempt to create an income support scheme. The so-called support allowance which was a flat-rate benefit, was designed for long-term unemployed and it was in practice considered as social aid, even though the period for receiving it was limited by law. Until 1995, when for the first time during the transition period an income-support scheme was introduced in the form of social aid, no benefit has been in place for those that exceed the time-limits for the support allowance.

Table 4.1.: Alternative estimations of the overall poverty rate (´89, ´92-2002)

	PrateCAS	Prate EUR	PrateRGE	PraRGWE	WBEst	TesliucEs	PraRGWO	WBAEst	Prate CASO
1989			*94,5*		3,9			17,7	
1992			*27,7*	*20,7*	70,9		*39*		
1993			*39,8*	*46,9*			*40,6*		
1994			*40,2*	*46,2*	27,5		*42,1*		28
1995	25,2		*35,4*	*58,1*		25,3	*43*		25
1996	23,3		*40,2*	*52,5*		19,9	*44,6*		20
1997	27,7		*34,5*	*65,9*		30,1	*47,6*		30
1998	27,3		*36*	*54,7*	44,5	33,8	*46,3*		34
1999	26,6	39	*39,4*	*47,6*		41,2	*47,1*		41
2000	30,6		*41,7*	*35,9*			*48,8*		44
2001	29,6		*38*	*39,3*			*39,3*		
2002	*23,4*		*39,5*	*31,6*			*31,6*		

*figures in italics stand for the independent estimates of the author of this paragraph (C. Ghinararu), computed after performing several regressions between overall poverty rate as dependent variable and several independent variables (notably GDP% growth and the share of wages in the total income of individuals);

1) PrateCAS-stands for the poverty rate as calculated by the National Anti-Poverty and Social Inclusion promotion Commission, after a methodology which was elaborated with the assistance of the World Bank, the UNDP and several Romanian think tanks (research institutes, universities). It stands today as the official poverty rate assessment;

2) PrateEUR – stands for the „at risk of poverty rate (poverty rate) before transfers, calculated by EUROSTAT, after its own methodology;

3) PrateRGE – stands for the reconstructed EUROSTAT series for poverty rate (at risk of poverty rate, before transfers), as computed by the author of this paragraph after performing a regression using GDP% growth as independent variable;

4) PrateRGWE – stands for the reconstructed poverty rate series (at risk of poverty rate before transfers) computed by the author of this paragraph after performing a regression using wage share as independent variable. At its turn, wage share has been computed after performing a regression using GDP% growth as independent variable;

5) WBEst – stand for World Bank estimates as published in the World Bank Development reports published throughout the period as well as in the dedicated World Bank study „Making Transition work for everyone. Poverty and inequality in Europe and Central Asia“, published in 2000;

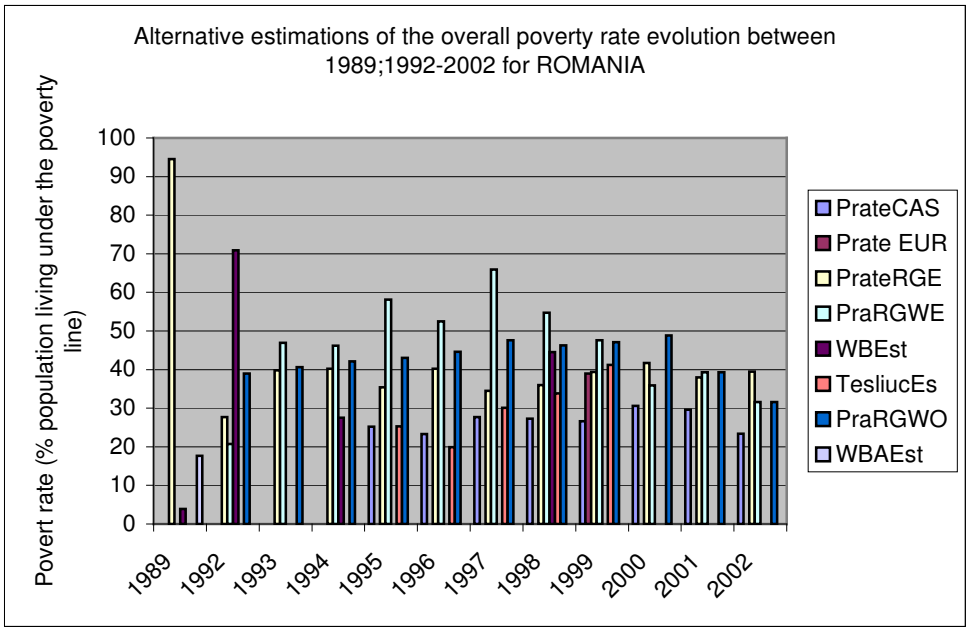
6) TesliucEs – stand for Emil Tesliuc estimates for the World Bank; Emil Tesliuc is a Romanian economist currently with the World Bank;

7) PraRGWO – stands for the reconstructed series of the poverty rate (at risk of poverty rate before transfers) as computed by the author of this paragraph after performing a regression using as independent variable the official series for the share of the wages in the total income of the individuals;

8) WBAEst – stands for another World Bank estimate published in one of the World Banks reports of the period, that assesses poverty rates at 1985 PPP rates;

9) Prate CASO – stands for series computed by the National Anti-Poverty and Social Inclusion Promotion Commission after an earlier methodology that has been replaced by the one elaborated with the assistance of the World Bank (this methodology is no longer in use).

Romania's third post-communist Government, that took office in late 1992, embarked on policy aiming at restoring the economic growth. As a result overall poverty rate decreased and was estimated at between 25% to 35% in 1995. Still, as the overall economic growth only emerged for a short period and as inflationary pressures have remained relatively high during this period, other more sensitive poverty measurements (poverty risk, poverty gap as well as the income inequality measures) did not reflect this decrease.



In addition, the hasty economic reforms overseen by the Romania's Government resulted more in enterprise closures and mass lay-off´s than in incentives for long-term investment and sustainable growth. In spite of the compensation schemes that have been implemented for dislocated workers, the prolonged recession which affected Romania's economy in the late mid-nineties let not only in a steep increase of overall poverty but also in an up-surge of income inequality.

As a result of these developments, a first attempt has been made by the Romanian authorities to deal with this phenomena more comprehensively in 1998: At the initiative and with the support of the UNDP representation in Romania, the *Commission for the Prevention and Control of the Poverty* under the patronage of the president of Romania was formed. In 1999, *The Commission* adopted *a Strategy for Prevention and Control of the Poverty,* which analysed the configuration of the phenomenon and formulated directions and general principles for action. It was supposed to be transformed in a *Governmental Action Plan,* but this did not happen.

As economic growth remained sluggish all-throughout the period, overall poverty peaked between 1997 and 2000.[3] Even though, during this period, overall poverty alleviation failed due to inconsistent approaches, poverty risk and therefore severe poverty were at a certain extent successfully mitigated. This was mainly due to the several compensation packages that have been provided to dislocated workers. They helped in keeping at least severe poverty at bay.

Therefore, it is fair to say, not until Romania's current Government came into office in January 2001, a comprehensive approach towards poverty and its alleviation has been taken. Romania's current executive team has put poverty alleviation at the core of its social and economic policies.

The "guidelines" for the governmental action have been a mixture of policies: Economic reforms focused on the creating of jobs and sustainable growth, fiscal reforms focused on low inflation rates and social reforms focused on poverty alleviation by the implementation of well-targeted income support measures for the extremely poor.

First results of these reforms have been reflected in the "healthy" growth rate of 5,6% in 2001. The main aspect of this growth has been its „job-richness". As it is also stated in the recently signed "Joint Assessment of Employment Priorities in Romania"- report with the EU, employment increased until 2001 and has reached again its 1994 level.

In spite of the global economic downturn, Romania´s estimated growth rate for 2002 will be at 4,55%. This positive forecasts enabled the Government to enact and implement Romania's first comprehensive and means-tested income support scheme, "the Minimum Guaranteed Income (MGI)". The MGI Act has been passed by the Parliament at the end of 2001 and started its implementation on the 1st of January 2002. It provides that each Romanian citizen is entitled by law to a minimum guaranteed income at a threshold that will be established on an annual basis (see for more details chapter 4.2.2).

Assessments of the effects of this act, performed by the National Labour Research Institute, have resulted in a forecasted drop in overall poverty, as a result of the application of the law, of around 10%. More important was the estimation made by the same national think-tank, for the impact on severe poverty, for which a 55% reduction has been forecasted.

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[3] It is worth noticing that most of the estimations on poverty rates made by different national and international organisations are convergent, albeit at different levels, in this respect. Some estimations are placing this all-period high in 1999, one estimation in 1998, while one alternative independent estimation is placing it in 1997 (see table 4.1. and its sources).

At the core of the recent government's effort during the first two years in office was the establishment of the National Anti Poverty and Social Inclusion Promotion Commission in 2001 (APPSIC). Established under the auspices of Romania's Prime Minister and effectively presided by the Minister of Labour and Social Solidarity, this body has embarked from its very beginning on the elaboration of a comprehensive national strategy - which has been turned into a national action plan in 2002.

Following extensive consultation with representatives from the Romanian civil society and the academic media, the National Anti-Poverty and Social Inclusion Promotion Action Plan has been enacted by the government on the 31st of July 2002.

The action plan has been elaborated with the support of the World Bank and UNDP experts as well as was drawing on the experience of several national think-tanks. The plan outlines the major challenges, assesses the risk factors and proposes detailed strategic objectives which can be described as follows:

- the complete alleviation of extreme poverty;
- the alleviation of the social exclusion cases and the promotion of social inclusion;
- the phased absorption of poverty for the economically active individuals as well as for the pensioners;
- social cohesion and social development promotion;
- providing decent living conditions and access to development opportunities for children;

The national plan contains also a breakdown of objectives and priorities on major domains like:

-employment;

-education;

-health care;

-housing;

-children;

-youngsters;

-handicapped persons and individuals with disabilities;

-Roma people;

The plan also outlines for the first time a comprehensive national poverty monitoring and assessment methodology and gives a national definition of poverty and also of severe poverty (see chapter 4.1.2) and assigns concrete responsibilities for monitoring, evaluation and reporting. The assessment

system will be constructed on the basis of the indicators agreed by the European Union (the Laeken indicators). They will be supplemented by a set of national indicators which have been elaborated by the National Anti-Poverty and Social Inclusion Commission with the assistance of the World Bank and in co-operation with several national think-tanks and universities (The Institute for Life Quality, The National Economy Institute of the Romanian Academy and the Bucharest University).

The following objectives have been formulated in the National Anti-Poverty and Social Inclusion Promotion Action Plan for the period of 2002 - 2004:

- the complete alleviation of the most severe forms of poverty, like the absence of any income as well as the absence of any kind of housing;
- the final absorption into the socio-economic mainstream of economically active persons through employment generation and an improvement in the primary sources of income from economic activities;
- correction of the imbalances in the current pension system and the launching of a pension re-balancing process;
- mitigation of the social impact of economic restructuring with special emphasis on the development of new occupational opportunities;
- improving the access to basic public social services for everyone (health, education and social assistance);
- enhancing the importance of the active employment measures in the job generation process (22% out of the Unemployment Fund in 2003);
- Reaching a final solution in the regulation of the abandoned children issue through the prevention family abandon and through the absorption of the abandoned children into family type placements. Regulating the adoption procedure and strengthening of the national adoption;
- Complete alleviation of the street children issue;
- Establishment of a new system for the prevention of juvenile delinquency;
- Establishing a national support system for the youngsters coming out of the abandoned children support system;
- Implementation of a new nation-wide social assistance system;
- The enhanced implementation of the National Strategy for the improvement of the socio-economic and living conditions of the Roma population;
- Establishing a monitoring procedure for the implementation of the National Anti Poverty and Social Inclusion Promotion Plan;

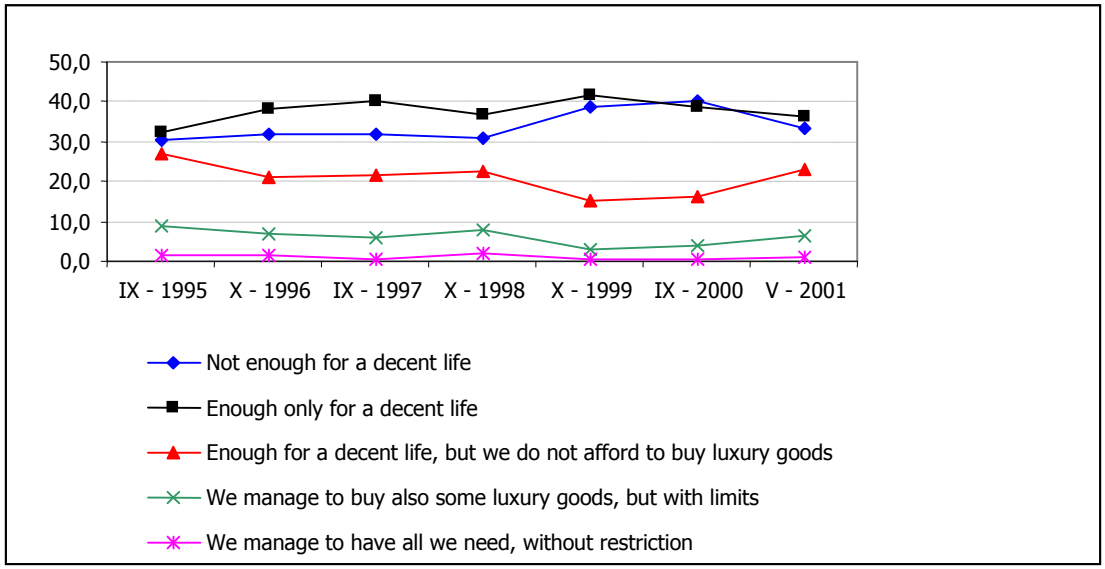
- Elaboration of county (judet) anti-poverty and social inclusion promotion plans;
- The initiation at local community level (villages, towns and municipalities) of rehabilitation plans for the severely damaged houses as well as for the production of public utilities at acceptable costs.

Early measures implemented by the current government during its first two terms in office are the enactment and the implementation of the Minimum Guaranteed Income Act, the enactment of the Social Exclusion Prevention Act as well as the enactment of the new Unemployment Insurance Act.

Public opinion on poverty from opinion surveys

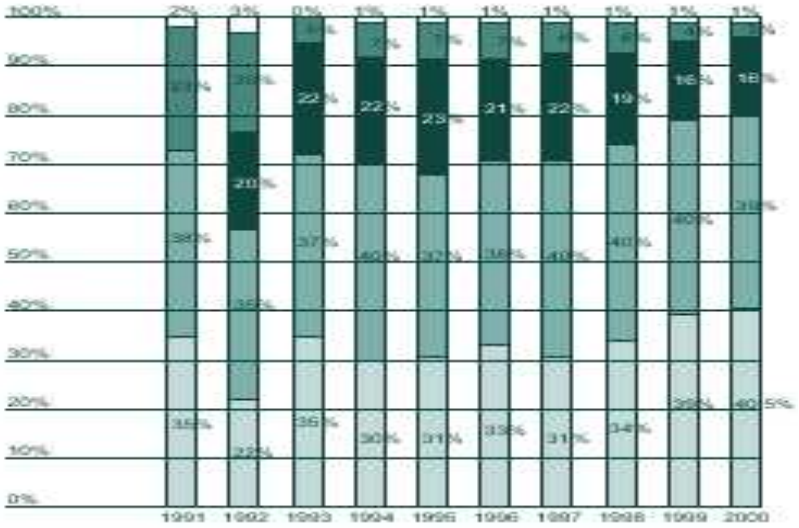
Romanians' self-assessment of poverty is presented in box 1. In 1998 almost half of the population considered themselves poor. However, income dissatisfaction has not varied significantly for the past decade and has remained steadily at high levels. Between 1991 – 2000 an average of approximately 70% of Romanians estimated their incomes as barely sufficient or insufficient to cover basic necessities. (Poverty in Romania, UNDP, 2001)

„How do you appreciate the actual income of your family?"



Source: Public opinion barometer, 1995-2001

Chart 1. Household incomes estimation (subjective living standard) (1991-2000)



Source: calculations made by authors by summing up the opinions in the RIQL survey data base.

4.1.2 National definitions for poverty and social exclusion

After 1994, an outburst of researches and studies regarding the poverty phenomenon has been registered in Romania. The most known methods adopted until now are:

- The utilisation of the normative method – ICCV (1994-1995), INCSMPS (1995),
- The utilisation of the relative method – NIS 1997-1999 (methodology took over by the Anti-Poverty Commission established under the Romanian Presidency in 1997)
- Utilisation of a Ravallion type methodology of 1994, used by the World Bank (1997)

Concerning the data basis, one can state that until 1994, the National Institute of Statistics gathered the information regarding the expenses and

income in a panel type research (Inquiry of the family budgets). The World Bank study of 1997 - which encompassed the years 1989 to 1994 - took this panel as a basis for their poverty and inequality estimations. After 1995, this panel was replaced by an inquiry integrated in the households which seemed much more adequate for the poverty studies (Teşliuc, Pop, Teşliuc 2001).

Table 4.2:Rate of Poverty

	1989	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Rate of poverty (1) %	3,7	NA	NA	NA	20,0	19,2	NA	NA	NA	NA	NA
Rate of poverty (2) %	NA	NA	NA	NA	NA	NA	25,3	19,9	30,1	33,8	41,2

Source: 1. World Bank estimations (1997), NA; 2. Teşliuc, Pop, Teşliuc estimations (2001) for 1995-1999

In the study *Methods and Techniques for Poverty Evaluation* performed under the aegis of the Presidential Commission for Control of Poverty and PNUD in 1999, a definition for social exclusion is stipulated which is based on the acceptance of poverty as a consequence of lack of economic, cultural or social resources. Therefore, the lack of resources presumes social exclusion; poverty and exclusion became interdependent in the official definition for the first time.

In 2001, the National Anti Poverty and Social Inclusion Promotion Commission has defined two basic concepts for the purposes of poverty assessments in Romania, respectively: Poverty and Severe Poverty.

Poverty is defined in accordance with the National Commissions' definition as being "the state of a person in which he or she cannot afford to spend, on a monthly basis, a specified amount of money which allow him or her to cover the minimum alimentary, non-alimentary and service consumption" This minimum threshold has been defined basing on the necessary amount of calories per day per adult equivalent, estimated by taking into account the alimentary preferences of those persons in the 2nd and 3rd deciles of consumption. This minimum threshold has been calculated at 2550 calories per day per adult equivalent. This limit is considered as the alimentary threshold of poverty. It has been further supplemented by a non-alimentary and services poverty threshold. Together they form the poverty threshold.

On the other hand, severe poverty, is considered to be "a state in which a person can only to a limited extent provide for other expenditures than the alimentary ones"

Vulnerable groups

According to the National Anti-Poverty Plan for the Promotion of the Social Inclusion (2002), the statistics of CASPIS and NIS show the following aspects related to risk groups with high risk of poverty:

Table 4.3: Rate of poverty on social categories (2001) (%)

	Poverty	**Severe poverty**
Total population	*29,6*	*11,9*
Families with 2 children	31,5	12,4
Age 0-15 years	34,4	15,4
Age 16-24 years	38,2	17,3
Unemployed	40,0	21,2
Independent workers	40,2	19,4
Peasants	48,1	22,6
Families with 3 children	58,4	30,6
Families with 4 or more children	68,3	44,2

Source: CASPIS and NIS, 2002

4.1.3 The 18 EU Indicators of Social Exclusion

The list of indicators established by the European Union is on its way to be calculated. The following table indicates the availability of data sets and their potential sources:

Table 4.4:EU Indicators

	Indicator	Match Romania	Comparable indicator	Data sources and most recent year available for indicators or comparable indicators
1a	Low income rate after transfers with breakdowns by age and gender[1]	ρ	Mean annual income per adult equivalent by activity status and age of head of household	AIG 1999
1b	Low income rate after transfers with breakdowns by most frequent activity status[1]	ρ	Mean annual income per adult equivalent by activity status and income decile	AIG 1999

	Indicator	Match Romania	Comparable indicator	Data sources and most recent year available for indicators or comparable indicators
1c	Low income rate after transfers with breakdowns by household type[1]	ρ	Mean annual income per adult equivalent by activity status and type of household	AIG 1999
1d	Low income rate after transfers with breakdowns by tenure status[1]	ρ	Mean annual income per adult equivalent by source of income and socio-economic status	AIG 1999
1e	Low income threshold (illustrative values)[1]	ρ	Mean annual income per adult equivalent by activity status and type of household	AIG 1999
2	Distribution of income	✓	—	AIG 1999
3	Persistence of low income	ρ	—	—
4	Relative median low income gap[1]	ρ	—	—
5	Regional cohesion	✓	—	AMIGO, 2000
6	Long term unemployment rate (≥12 months)	✓	—	AMIGO, 2000
7	Persons living in jobless households	✓	—	AMIGO, 2000
8	Early school leavers not in education or training	ρ	Rate of school abandon	Date MEC, 2000
9	Life expectancy at birth	✓	—	Demographic yearbook, 2000

	Indicator	Match Romania	Comparable indicator	Data sources and most recent year available for indicators or comparable

				indicators
10	Self defined health status by income level.	ρ	Structure of the population according with the health status declared on age groups, gender, areas, level of instruction	Health status of the population of Romania, 2001, NIS
11	Dispersion around the low income threshold	ρ	—	-
12	Low income rate anchored at a moment in time	ρ	—	—
	Indicator	Match Romania	Comparable indicator	Data sources and most recent year available for indicators or comparable indicators
13	Low income rate before transfers	ρ	—	—
14	Gini coefficient	✓	—	AIG, 1999
15	Persistence of low income (below 50% of median income)	ρ	—	
16	Long term unemployment share (≥12 months)	✓	—	AMIGO, 2000
17	Very long term unemployment rate (≥24 months)	✓	—	AMIGO, 2000
18	Persons with low educational attainment	ρ	—	-

Source: National Institute for Statistics (NIS).

The above-mentioned indicators will be at the core of the monitoring and evaluation procedures which will be implemented under the provisions of

Chapter 6 (Monitoring and Evaluation system) of the National Anti-Poverty and Social Inclusion Plan adopted by the Government in July 2002.

Adaption to the specific situation in Romania

In addition to this, the EU agreed indicators will be supplemented with the following nationally relevant indicators. The establishment of a set of national poverty indicators, poverty rates, totals with breakdowns by area of residence, regions, gender, household type and age groups etc. has been undertaken by the National Anti Poverty and Social Inclusion Promotion Commission with the assistance of the World Bank and in consultation with national think-tanks (e.g.: research institutes and universities):

- Poverty profoundness with the same breakdown as for the first two indicators;
- Poverty severity with the same breakdown as for the first two indicators;
- Monthly variation of the Consumer Price Index;
- Monthly level of the main categories of income of the population;
- Self-perceived poverty status;
- Inequality indicators;
- Infant mortality rate.

A review of the various surveys and assessments financed by UNDP in the region reveals that the majority of countries poverty lines were calculated on the basis of the value of income or expenditure per capita (or equivalent adult) in a household. Such poverty lines often were based on absolute criteria, such as the estimated minimum subsistence level or a social minimum. Other possibilities, however, were also examined. They included the setting of a relative poverty line, a subjective poverty line or a structural poverty line calculated on the basis of the share of expenditure per person assigned to food. (UNDP/ Grinspun, 2001)

For Romania, the experts used the poverty lines based on value of income in a household because the majority of the population has low income. This poverty lines show a relative level of poverty which is at a lower level than the poverty lines based on expenditure per person assigned to food.

4.2 Evaluation of Policy Challenges and Policy Responses

4.2.1 Inclusive Labour Markets

One of the main policy challenges in combating poverty and social exclusion for the Romanian Government during transition - and until today - was the restructuring of the labour market.

The next paragraphs are therefore dedicated to the situation of employment and unemployment in Romania. They are mostly based on the data published by the European Commission and the Romanian Government in its "Joint Assessment of Employment Priorities in Romania" of 2002.

Total employment

In 1990, total employment amounted for 10,84 millions of Romanians registered as active population (or ca. 70%). Throughout the nineties there was a decline, reaching its lower value in 1999 (8,42 millions). Since 2000 the situation has improved, accounting 8,68 million of active population in 2001 (or 64% of the population).

Employment by sector

Accounting from the beginning of the 90s, the most harmed sector by the decline in employment was the industrial, and to a lesser extent the service sector. Agriculture had an irregular development throughout the nineties, but in the whole period it increased its share on the employment of Romania, absorbing the employment losses due to the low growth.
In this situation there are two major problems which are to be solved: The considerable size of the agricultural sector, 41% (eight times higher as in the EU, 5%) and the insufficient development of the service sector, resulting in a very low contribution to total employment (31% in Romania, two times lower than in the EU).

Employment in the public and private sector

Employment in the public sector declined by 56% between 1994 and 2001, as a consequence of the privatisation and restructuring of state-owned companies, whereas private employment grew by 60% between the same period of time.

The development of the private sector has concentrated on agriculture. In the other two sectors it seems to go at a slower pace. In 2001, private employment represented 97% of total employment in agriculture, compared with 57% in industry and 45% in services. There is still a big number of large enterprises which are still owned by the state and this is delaying the modernisation process.

The new private sector, in particular the small and medium enterprise sector (SME) is the main driving force for economic transformation and job creation. Nevertheless there are still some problems in the Romanian economy which have to be solved; the total stock of credit is very low and there is difficult access to finance, the legal framework is not very clear, giving room for corruption, and there is in Romania still a heavy administrative burden related to both business setting and running. To

improve this situation the government created the "Action Plan for business environment", aimed to make further progress in this direction. This includes the principle of the one-stop-shop approach to set up a business and the setting-up of a single Agency for Foreign Investment.

Self-employment

Self employment has been growing since the mid-nineties. The number of self-employed and non-paid family workers increased by 11,8 and 9,7% respectively between 1996 and 2001. The majority of the self-employment can be found in agriculture (89,2% of all self-employed), while on the contrary 80,2% of the employers of the whole country are in the service sector (80,2%)

Informal sector

The informal sector grew in Romania from the 20% of the GDP in the mid-1990s to 49% of GDP in 1998. According to estimations of the National Labour Research Institute, 20% to 27% of the working population belong to the informal sector, representing between 2,4 and 3,1 million persons. This considerable informal sector has to be taken into account when interpreting data about the labour market in Romania.

Regional differences

In 2000 the differences on employment between the different regions were not very significant. Nevertheless, a significant part of the reported employment in all regions was in the agricultural sector and much of it represented low-productivity subsistence farming. With the exception of the Bucharest-Ilfov region (where agriculture represented only 5.7% of total employment in 2000), in the other regions agriculture accounted for at least a third to a 50% of total employment.
Excluding the agricultural sector, we could distinguish three groups of regions:

- The Bucharest- Ilfov region, whit almost 60% of employment in the service sector and 94.3% and 34,3% in the industrial sector.
- The West and Center Regions, where the service and the industrial sector account for 62% to 70% of total employment, the service sector alone accounting for 31% to 35%.
- The remaining regions, where employment in the industry and service sector together represents between 42% and 60% of total employment, the service sector alone accounting for 21% to 33%.

Labour mobility

Labour force mobility has been important during the last decade with the migrations flows between rural and urban areas, although this is not well reported by the statistics, because these flows do not imply mobility between sectors. Workers moving to rural areas may continue to have for instance an industrial occupation, while at the same time do some kind of agricultural activity. This thesis is supported by the growth of employment in agriculture during the 90s.

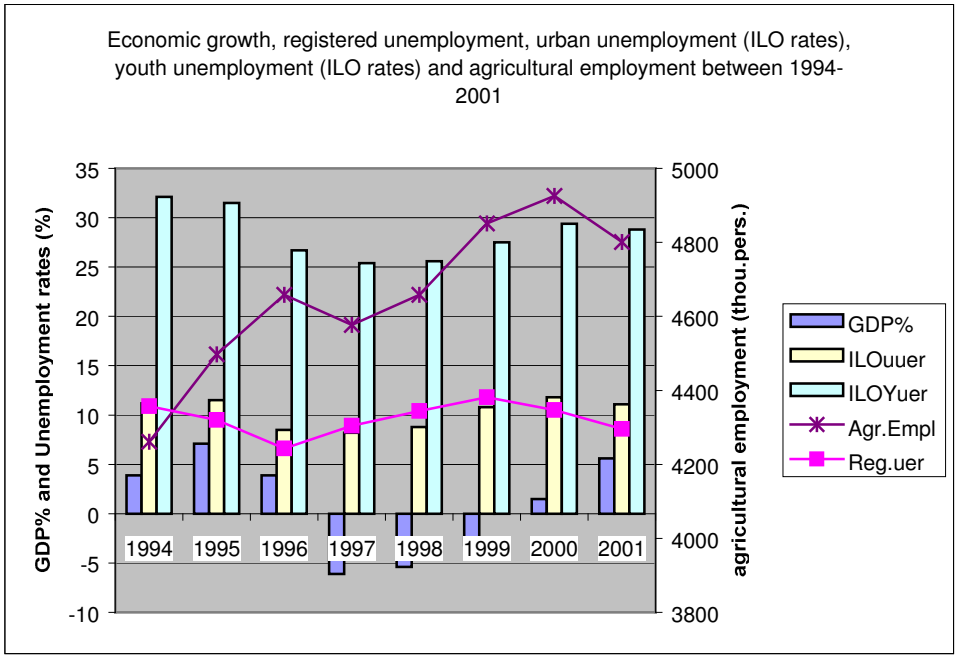
Gender

In average, wages of women represent approximately 76% of the men's wages. It is therefore significant that the preponderance of female employees is being found in activities with lower wages which applies especially to the health and social assistance sector (77% women), education sector (67,7% women), hotel and restaurant sector (61,3% women) and general trade sector (60,0% women).

Unemployment

The reduction of unemployment is a direct result of the Romanian economical restructuring reform process of the last seven years. The registered unemployment reached its maximum level in 1994, when the number of unemployed registered with NALFE was at 1,2 million - which represented an unemployment rate of 8%. Since then, unemployment rate has declined and stabilised at around 6.5% in 2001 - with 6.9% for men (EU average: 6.6%) and 6% for female (EU average: 9%).

Some general features of the situation in Romania are as follows: youth unemployment is higher than adults' unemployment. Long-term unemployment remains high despite the decrease of the overall unemployment level. Unemployment is affecting especially persons with high education, but also graduates of vocational schools and high schools, whereas unemployment remains relatively low for people with a lower education.



The main reason for becoming unemployed is discharge or the reduction of personnel; 38,5% of the unemployed who had previously worked are from the manufacturing industry, and 61,2% had worked in the public sector.

Table 4.5:Unemployment rate 1995-2000

Indicators Name	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
Unemployment rate from LFS (ILO methodology)	8	6,7	6	6,3	6,8	7,1
Unemployment rate by gender - women in % from total	8,6	7,3	6,4	6,1	6,2	6,4
Unemployment rate by gender - men in % from total	7,5	6,3	5,7	6,5	7,4	7,7
Unemployment rate for people aged under 25	20,6	20,2	18	18,3	17,3	17,8

Source: Statistical Yearbook on candidate and South – East European countries 2000, Eurostat (95-99)

Romanian Statistical Yearbook 2001. NIS (2000)

Policy responses: Active Employment Measures Programmes

The modest volume of resources dedicated to Romanian social policy reflects a pattern of minimal intervention by the state to correct imbalances in the distribution of wealth. Social protection did not focus on the support of the "poorest of the poor". Instead, social policy concentrated resources on compensation of the losses incurred by employees through the system of social insurance, rather than on the protection of those excluded from wage employment.

This is for example signified by the design of active employment projects financed by a World Bank loan from the beginning of 1995 which marked the real start of active programmes on a significant scale: They were limited to unemployment benefit recipients.

Until the mid-1990s, active expenditures represented less than 2% of the total expenditures of the Unemployment Fund. They reached a maximum of 15% in 1995 and declined sharply in the second half of the 1990s when they represented under 2.5%.

As those data also show, the need for other measures enabling to support employment emerged progressively and became particularly urgent after 1996-1997 when the privatisation and the restructuring accelerated and resulted in massive lay-off. Romania then introduced recruitment incentives for hiring young graduates as well as the allocation of loans to SMEs in order to recruit unemployed persons. However, the UNDP report of 2001 "Poverty in Romania" states that those first active measures - professional training/ retraining courses helped to reintegrate only about 1% of the overall recorded unemployed.

The Joint Assessment of Employment Priorities in Romania, signed in October 2002, designates the active employment measures as the main priority of the National Agency for the Employment of the Labour Force.

The new legal framework (Law 76/2002 on Unemployment Insurance and Employment Stimulation) builds on the experience gathered through the World Bank projects but provides a broader framework for active labour market programmes, in particular by widening access to ALL unemployed and not only benefit recipients.

The main active measures are recruitment incentives to employers, training and retraining programmes, support to job creation in SMEs and to business start-ups, community work programmes and mobility grants.

Recruitment incentives represent 32.3% from the total expenditures planned for active programmes in 2002, support to business start-up represent 31.5%, public works within the community represent 19%, vocational training 5.87% and mobility measures, 11.25%.

Employment subsidies can be granted to employers for a maximum period of 12 months, at the request of local public authorities, for each unemployed person hired with an individual labour contract for community public services and social services. The subsidy is 70% of the minimum national wage for each unemployed person. Other recruitment subsidies for the young graduates, the disabled and those above 45 years differ in duration and level depending on the nature of the contract and its duration.

Support to SMEs creating jobs, to business start-ups or independent activity includes the provision of counselling and assistance and the granting of low-interest loans (50% of the interest rate of the National Bank) for a maximum of 3 years. The counselling and assistance is free for unemployed receiving unemployment benefit. SMEs must recruit at least 50% of the new staff among registered unemployed.

Mobility grants correspond to a lump-sum payment amounting to two minimum wages if the unemployed takes up a job in a place distant from more than 50 km from the place of residence, to seven minimum wages if there is a change of residence.

Recently released data from the National Agency for Employment show that during 2002 more than half a million individuals benefited from the active employment measures programmes.

The share of the active employment measures expenditures has been on the rise from a 12,9% of the unemployment fund in 2001 to a 16,95% in 2002, respectively from a 0,12% share of the nominal GDP in 2001 to a 0,16% share of the nominal GDP in 2002.

The share of the individuals involved in one of the several active employment measures schemes has increased from a 4,7% of the labour force in 2001 to a 5,4% of the labour force in 2002.

The overall result of the active employment measures, or their net employment effect has been a 14% increase in the share of the labour force that has managed to find a job via the National Agency for Employment from 2001 to 2002.

The following tables give an idea of the results of the active employment measures for 2001 and 2002:

Table 4.6: Active employment measures results (2001)

Total number of beneficiaries (no. Of individuals)	Job counselling (% of total)	Job Fair (% of total)	SME support (% of total)	Subsidised employment for young graduates (%of total)
470644	73	9,8	4,0	3,2
Training programmes (% of total)	World Bank active employment measures financed programme (% of total)	Self-em-ployment scheme (% of total)	Persons employed by the dwellers' associations (% of total)	Other measures (% of total)
3,64	1,0	3,47	0,42	1,25

(source: National Agency for Employment,2003)

Table 4.7: Active Employment Measures Results (2002)

Total number of beneficiaries (no. Of individuals)	Job coun-selling (% of total)	Training program-mes (% of total)	Subsidies for unemployed persons going into employment before the end of the unemployme nt benefit period	Employ-ment of the sole family provider unem-ployed persons at or above 45 years of age	Mobility incentive
540416	58,5	2,6	19,6	3,2	0,73
Subsidized employment for graduates	Employ -ability support scheme for the handi-capped persons	SME employ-ment gener-ation loans	SME assistance and consultancy	Public works temporary employ-ment	Other measures
3,1	0,08	2,5	0,7	8,2	0,45

(source: National Agency for Employment,2003)

4.2.2 Guaranteeing Adequate Incomes/Resources

Economic inequality and access to income

Income inequality in Romania has increased by approximately 50% since 1989. The Gini index – the standard measure of inequality – rose from 21 in 1989 to 30 in 1994. This is within the range of the other transitional countries of Central and Eastern Europe. Between 1995 and 1999, inequality in Romania has remained relatively stable.

Table 4.8 Gini index in several former socialist countries (1989-1997)

	Gini index	
	1989	**1997**
Hungary	22.5	25.4
Czech Republic	19.8	23.9
Poland	27.5	33.4
Bulgaria	33.1[a]	36.6
Lithuania	26.2	30.9
Romania*	21.0	28.0
Russia	26.5	38.5[b]

*For Romania the source is Tesliuc, Pop, Tesliuc, 2001.

[a] 1992; [b] 1995.

Source: UNICEF, Regional Monitoring Report No. 6, 1999.

Table 4.9 Evolution of inequality (Gini index) in Romania

1989	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**
21.0	23.0	30.0	31.0	30.0	28.0	30.0

Note: Gini index has values between 0 (perfect equality) and 100 (absolute inequality).

Source: Tesliuc, Pop, Tesliuc, 2001.

The situation is nevertheless fragile, thus less characterised by income stabilisation but by income substitution - as the unemployed have shifted to home-production instead to income generating activities. Self-consumption (the use of home-made products) increased from 22% to 32% of the total household budgets between 1989-1997 (AIG, NIS). Without this subsistence-factor, inequality would be even greater.

Another characteristic is that the level of inequality remains relatively low: this means that an average income of the ”middle class” is very close to the average income of people classified as poor.

The rise in economic inequality results in an even smaller number of individuals owning an ever larger share of disposable income. The data on income distribution suggests that the poorest 20% of households are drifting away from the rest of society, while the difference in rates of income growth in the middle-income groups (deciles 3-9) is small.

The richest (D10, particularly the richest 5%) stand out. The income gap between the richest 10% of households and the poorest 10% has tended to increase over time, from ten to eleven times higher. The income of the richest 5% tend to grow compared to the rest of the population (Tables 4.9, 4.10 and 4.11) - in average 15 times faster than that the income of the poorest 10% of households. The data clearly reflect an accelerated rate of impoverishment and inequality.

Table 4.10: Growth rate of income between deciles, as % of the previous decile

	Poor 10%	**D2**	**D3**	**D4**	**D5**	**D6**	**D7**	**D8**	**D9**	**Wealthy 10%**
June 1994		74.0	22.9	17.9	13.2	13.1	13.6	15.1	21.6	108.4
Oct. 1998		85.7	31.8	19.8	14.7	13.9	15.3	16.6	23.8	85.2

Sources: RIQL – Quality of Life Diagnosis, 1994; RIQL and Bucharest University – Social problems and Standards of Living, 1998

Table 4.11: Indicators of the unequal distribution of the income

	Income d8/ Income d3	**Wealthy 10%/ poor 10%**	**Wealthy 5%/ Poor 10%**
Sept. 1994	2.0	10.7	14.4
Oct. 1998	2.1	11.8	15.7

Sources: RIQL – Quality of Life Diagnosis, 1994; RIQL and Bucharest University – Social Problems and Standards of Living, 1998.

Social benefits contribute to cover part of the needs of households exposed to the risk of losing or decreasing their income. They represent therefore a source to decrease inequalities. The percentage of social benefits from the income of households is larger in the inferior quintile than in the superior one. The ratio between the income that belongs on average to one person from the households in the superior and inferior quintile is smaller if the income includes social benefits.

Table 4.12 Social benefits as % of the minimum wage

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Average pension	71.0	75.6	73.3	95.0	118.9	122.0	129.6	127.8	139.2	122.5	133.0	121.7
Unemployment aid		-	69.8	64.4	73.7	102.5	95.8	97.9	135.8	106.4	138.9	111.2
Unemployment allowance		-	-	43.5	42.5	41.1	59.0	52.1	53.2	48.3	62.2	45.9
Social aid		-	-	-	-	-	60.0	46.4	39.3	41.1	38.6	27.2

Source: RIQL database

Table 4.13 The percentage of social benefits from the financial income and their contribution to the reduction of inequalities, in the year 1996

	Total	Households of:				
	Households	Employees	Employers	Peasants	Unemployed	Pensioners
The percentage of social benefits from the financial income, %						
Total households	22,6	4,6	1,9	15,2	28,2	59,4
Households from						
- quintile 1	25,1	7,4	10,6	20,7	39,5	58,2
- quintile 5	18,8	2,7	1,4	9,9	11,4	57,6
Ratio between quintile 5 and quintile 1						
Financial income,[1)] without social benefits	3,9	3,9	7,5	6,9	6,6	2,7
Financial income,[1)] with social benefits	3,6	3,7	6,5	6,1	4,5	2,7
Income from social benefits	2,7	1,4	0,9	2,9	1,3	2,7

1) Financial income by one person

Source: *Calculated on the basis of the data from the NIS (1997)*

Table:4.14:Beneficiary of social transfer 1995-1998

Decile of CONSUMPTION on adult (1995)	Unemployment aid	Allowance for children	Social assistance services	Any type of transfer
The poorest	18,3	60,2	4,3	83,3
2	15,4	53,7	3,3	83,2
3	13,2	47,6	2,9	83,7
4	10,4	43,2	2,4	82,2
5	8,5	39,5	1,6	81,9
6	6,7	33,7	2	80,3
7	4,7	29,0	1,3	79,2
8	3,4	23,8	1,4	76,2
9	2,5	17,9	1,4	74,9
10	1,5	15,2	1,1	71,8

Source: The impact of the social protection programs: the percentage of the households, beneficiary of social transfers 1995-1998 (Teşliuc, Pop, 2001)

Income-tested benefits

Income-tested benefits directed to support the poorest were introduced at the end of 1995. In June 1994, 659.000 households had an income per capita below the eligibility level for social benefits (adjusted accordingly to the consumer price index), constituting 11.8% of the total population (C. Zamfir, 1995). In 1995, when social benefits were introduced, the threshold set for one-person family was 87% of the threshold defining the extreme poverty rate (EPR), and 58% of the poverty rate (PR). After a sharp decrease in 1989, income-tested benefits represented 48% and 32% of the poverty threshold respectively (Table 4.15).

From January 1996, the financial responsibility for payment was transferred to local city governments.

Table 4.15: Level of social benefits and its degree of coverage

Level of social benefit granting threshold as % of the **threshold for extreme poverty and severe poverty**		
	Extreme poverty	**Severe poverty**
1995	87%	58%
1998	48%	32%
Degree of coverage by the social benefit		
Projected in 1994		Achieved in 1998
Nr. of families = about 700.000 = 10% of population		*Nr. of families = about 50,000 = 0.5% of population*

Source: MLSS

As a consequence of this fiscal decentralisation, the number of beneficiaries began to decrease (Table 4.16). Expenditures for social benefits fell in real terms from the beginning of 1996. In 1999, they represented in real terms just 15% of the expenditures made in 1995, and by 2000, this was only 6%.

Table 4.16: Number of families receiving social benefits at the end of the year, compared to December 1995

Year	1996	1997	1998	1999	2000
-%-	49%	26%	22%	15%	6%

Source: MLSS

Table 4.17: Dynamics of real expenditure for social benefits

Year	1996	1997	1998	1999	2000
-%-	144.2%	47.6%	30%	14.8%	-

Note: for 1995 the expenditures covered only the last three months of the year.

Source: MLSS

In order to increase the income of those in extreme poverty up to the defined benefit threshold, an 11.7% fold increase of the expenditures for social benefits would have been necessary for example for the year 1998.

Currently the system is practically frozen, as the social allowance was replaced by another benefit: the minimum guaranteed income (see below).

In 2000, a new system of income tested social assistance was introduced: the allocation of solidarity. The benefit is addressed to families with per

capita incomes less than 50% of the national minimum wage, and calculated as the amount necessary to bring their income level to this threshold. An obvious result of adopting this system is that city governments will not be willing to pay any social benefits, relying on this benefit financed from the national budget. In 2001, the fund was taken over by the Ministry of Finance.

The Minimum Guaranteed Income

The minimum Guaranteed Income Act has been passed by the Romanian Parliament in 2001 and is currently implemented starting with the 1st of January 2002.

It legislates the right of every Romanian citizen as well as the right of foreigners legally residing on Romania's territory, to a minimum guaranteed income, at a threshold that is established by law and is subject to annual indexation, through government decision and in accordance with the evolution of the consumption price index.

Differentiated minimum income thresholds have been established by this Act in accordance with the type of households, respectively in accordance with the number of persons per household.

The minimum guaranteed income is provided in the form of an income tested monthly benefit by the local authorities. These authorities are mandated by law to include the amounts necessary for the provision of the minimum guaranteed income into their budgets. If in some cases the local authorities cannot provide for the entire amount, then, a supplementary allocation is provided for this purpose from the central budget.

The recipients of this benefit are required by law to provide, on a monthly basis, a maximum of 72 hours of community work, at the request of the mayor.

The minimum guaranteed income is provided as a difference between the income a single person or a household is able to provide for itself through legal economic activities and the minimum income threshold for that particular type of household that is specified by the Minimum Guaranteed Income Act. Therefore, this benefit, is not only income tested but also employment conducive, as the full amount of the benefit is only provided if proven that a household cannot provide any income whatsoever from legal economic activities. Children allowances, as well as the allowances received by wives, whose husbands are satisfying their compulsory military service are taken in consideration as income and as a result they are deducted out of the minimum guaranteed income thresholds.

Local authorities are fully responsible for the provision of the benefit as well as for the administration of this provision.

The act also provides for a heating benefit to those individuals and households that are recipients of the social aid. This benefit covers the cold season period from the beginning of November to the end of March. It is also financed from the local budgets and its provision is the responsibility of the local authorities.

The Ministry of Labour and Social Solidarity through its county (judet) directorates is supervising and controlling the application of the provisions stipulated by the Minimum Guaranteed Income Act.

The Minimum Guaranteed Income Act allows local authorities to provide social aid also in kind, the form of subsidised or free of charge delivery of public utilities for those households proven to be in need.

Evaluation of the effects of this Act, performed by the National Labour Research Institute at the request of the National Anti Poverty and Social Inclusion Promotion Commission, have estimated that the application of this Act will result in a 10-20% reduction in the overall or relative poverty and a 40-50% reduction in severe poverty.

Table 4.18 Evolution of the Minimum Guaranteed Act recipients' number (persons), on a monthly basis (2002)

Month	Total number of recipients (households)	1 person households	2 person households	3 person households	4 person households	5 person households	Households with more than 5 persons
March	368628	85893	67264	69829	67608	39529	38505
April	375857	88966	69519	71037	67994	39708	38633
May	375028	89883	69928	70535	66841	39109	38732
June	367585	89452	69309	68868	64569	37937	37450
July	371450	91022	70237	69613	65033	38233	37312
August	381162	89882	69409	67932	63227	37147	53565
September	364088	90071	70290	67915	63197	36902	35713
October	370038	92750	71204	68979	63746	37346	36013
November	375413	93428	72530	69789	64724	37986	36956

Source: Ministry of Labour and Social Solidarity (jan.2003)

Recent statistics compiled by the Ministry of Labour and Social Solidarity show that, throughout 2002, around 1,15 million persons have benefited from the provisions of the law, or roughly around 5,25% of Romania's population.

Social work services

Social work services have developed with difficulty - and are mostly dedicated to help groups such as abandoned children, disabled people and elderly people. However, after 12 years of transition, there is still no integrated governmental strategy for the development of a social assistance services system.

- The social assistance of *abandoned children* despite national effort and special support from Western countries, is still in a critical situation.
- The services for the *elderly* were limited only to institutions taking care of elderly persons, not to individuals directly. In 2000, a new law for the social protection of the elderly was passed, stipulating their rights to receive medical care in their homes and even a social worker, according to the individual need.
- The only services addressing the poor directly are social assistance *canteens.* They started in 1993 and were organised and financed by city governments. Rural areas are completely excluded from this type of service. The average number of persons benefiting on a daily basis of this service represents 0.8% of the Romanian population.
- Services serving pre-school children - *nurseries*, *kindergartens* – steadily degraded after 1989, while parental costs rose continually. Nurseries were neglected as a consequence of the extension of maternity leave until the child reaches two years of age.

Access to other resources

Water supply: In Romania, 2910 localities have centralised systems for distribution of drinkable water (22,4%), out of which there are 265 municipalities and towns and only 2647 villages (17%).

Sewage system: Nowadays, a number of 637 localities (5%) have canalisation networks, out of which there are 265 municipalities and 347 villages. Of the 13000 existent villages, only 2500 have organised systems for collecting, transportation and depositing of sewage. 283 localities have public heating systems and can produce warm domestic water, out of which only 259 are functioning. According to the heating system, the households classify as follows: At the end of 2000, the number of localities connected to the national system for transport and distribution of natural gas was 1022, out of which 169 were urban areas.

65% of the Romanian population has drinkable water from the public network, that is 92% of the urban area and 33% of the rural area. The public canalisation service is available for 86% of the total urban population and only for 11,2% of rural citizens. The population who benefits from both above-mentioned services represents 51%.Those who benefit from water

supply, but not from sewage represent 14%, while the population who does not have water supply or sewage consists of 35%.

The taxes affect more the income of the households of the employees than the households of employers, peasants and pensioners. The data clearly emphasises the rise of expenditures for the payment of services in the urban area, and at the same time a drastic fall of the expenditures for non-foodstuff for both urban and rural areas.

4.2.3 Combating Education Disadvantage

The Romanian educational system includes 8 years of compulsory and free education (4 years of primary and 4 years of secondary school education), as well as one year of pre-school education. Pre-school education can be attended for 3 years (until the age of 7 years), but the participation is compulsory only in the last year. Secondary education is developed in two directions: academic education (secondary school) and vocational education. The forms of tertiary education can be attended after secondary school graduation and this means post-secondary schools or university studies and post-graduate schools. This education is, mainly available within the state system, but also in private forms. There are free public schools for 15 minority languages. The scholarship education network covers the whole country, penetrating even the most isolated villages. This represents the strong point of the Romanian education.

Table 4.19: The level of coverage in the pre-school education (%)

1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**
54,3	51,9	53,3	50,2	55,2	58,4	60,4	62,8	64,2	65,2	66,1

Source: NIS, 2002

For the compulsory education the evolution of participation is positive. A critical point is noticed at the pre-school education. Although, the rate of coverage rose in the period 1990-2000, the number of children from this level represents only two thirds from the population of that age.

Table 4.20: The level of coverage in the primary education (%)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
90,8	92,4	93,8	96,9	99,7	99,5	99,1	97,5	99,8	100	100

Source: NIS, 2002

Table 4.21 The level of coverage in the secondary education (%)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
90,7	76,1	65,7	63,7	66,1	68,6	69,1	68,6	67,8	69,4	71,7

Source: NIS, 2002

Another critical point represents the participation at the secondary education. The drastically reduction of the rate of coverage in the secondary education shows a tendency towards elitism in the post-compulsory education, especially of the high school. Although one of the priorities in the area of education was the reform of the professional education, sustained by an important external financial support, the demand of the school population for this level registered a decline generated especially by the crisis of a lot of economical sectors and the high rate of unemployment between the graduates (MET, The rural education from Romania, 2002).

The distribution of the pupils from the secondary level (theoretical, vocational, technological high-schools and professional education) between 1990-2000 present the following tendencies:

- a continuous decrease of the interest for professional formation in the technological high-schools, professional schools and schools for apprentices
- raise of the demand for education for a superior level of experience (theoretical high-schools)

Table 4.22: The rate of transition to the secondary education (%)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
		88,4	98	93,6	94,6	93,5	95,4	95,9	94	94,2

Source: NIS, 2002

Table 4.23: The number of pupils in technical secondary education from the total of pupils from the II cycle of the secondary education (%)

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
84,8	75,5	70,3	67,3	67,3	67,5	68,3	67,8	67,4	62,6	63,9

Source: NIS, 2002

In the high-school education, at the end of the scholar year 2000-2001, 3,5% of the pupils registered quit school. High schools with the following profiles are situated above this level: technological, agricultural, ethnic and agro-mountain. The vocational profile covers the sportive, arts, musical, cerographical, pedagogical, military and theological profiles. The level of promotion ability for this kind of education exceeds 99%.

According to the National Anti-Poverty Plan, the following problems persist:

- Access to pre-primary, primary and secondary education (free general access to all elementary forms of education is granted by law)

  Groups with high risk of stand-off scholarship
  - Children with physical, sensory or mental disability (in 1998, 40% of the 7-14 years old children belonging to this category were not registered in a form of education);
  - Gypsy children;
  - Children belonging to poor households.
- Stand-off scholarship – in 2000, about 5% of the young people between 16 and 20 years ceased to go to school. The above group have a high risk of poverty and social exclusion.
- Unequal access to secondary schools
- Professional and scholar guidance efficiency – Nearly 5% of the young people between 20 and 29 years left the educational system before completing the compulsory eight years of education. Their development possibilities are reduced. Their capabilities do not allow them to integrate in the employment system. As a rule, they are pushed to the black economy or to support the agriculture and the chances to improve their situation are extremely reduced.

Policy responses

The Ministry of Education and Research (MER) has been working on a complex project for preventing and fighting the scholar abandonment. The support of this project by other ministries and governmental agencies involved (Ministry of Health and Family, Ministry of Labour and Social Solidarity, Tutelary Authority, National Authority for Child Protection), as well as by local authorities and non-governmental organisations will constitute a key-factor for social inclusion promotion and poverty control. The project includes complex programmes for facilitating the access to education, increase of its appeal, stimulation of community's involvement in school life, and development of parents education.

The law regarding the social exclusion control provides measures related to the access to education – children at school age belonging to families who have the right to receive the minimum assured income and who have two or

more children will benefit from the scholarship throughout the school year. Considering the preparation for the new scholar-year (buying clothes, footwear, stationery and handbooks), the draft law provides a granting in advance of 40% of the yearly amount of the scholarship. The young people who attend pre-university and university forms of education whose families have the right to a minimum assured income will benefit from scholarships for continuing the education - provided they will participate at courses and will get the standards for promotion. The scholarships will be granted from the state budget and the minimum level of these will cover at least the equivalent value of accommodation and meals in student hostels, boarding schools and refectories. The amount is settled yearly by governmental Decision.

4.2.4 Family Solidarity and Child Protection

Table 4.24: Rate of divorce on gender and age groups:

Age group (years)	Masculine			Feminine		
	1990	1998	2000	1990	1998	2000
Under 20	4,8	14,4	20	8,9	17,3	16,4
20-24	11,7	16,4	16,4	13,1	16,9	14,6
25-29	13	16	13,1	10,8	14,8	11,3
30-34	10,5	14,4	10,3	8,8	11,6	8,6
35-39	8,2	10,6	8,1	7,1	8,1	6,4
40-44	6,2	7,9	6,4	4,8	6,1	4,9
45-49	4,4	5,3	4,3	3,2	4	3,5
50-54	2,8	3,5	2,7	2	2,5	2
55-59	1,7	2,1	2	1,3	1,6	1,2
60 and over	0,7	0,8	0,6	0,6	0,6	0,4

According to the report *The Situation of Poverty in Romania* (June 2001), elaborated by the ICCV in co-operation with PNUD, some social groups are especially confronted with severe poverty, with a high risk to become permanent. In Romania, the groups most affected by poverty are: children, young men and families with more than one child.

The highest rate of poverty can be found among children and young men. In 1998, approximately 38% of the children under 7 years and approximately 50% of the children between 7 and 15 years old were living in poverty. Families with 3 or more children present a high rate of poverty (over 60%).

Single-parent families have a high rate of vulnerability (the rate of poverty over 50% depending on the rate of sustenance calculated by the ICCV after the fundamental needs of consumption of the population).

As fundamental forms of support for the family and child can be distinguished the following (Zamfir, Elena, 2002):

- universal material support for the families with children (children allowance, deductions to the taxes, any kind of compensations)
- free education and support for scholar participation
- free sanitary assistance (for the maternity, for mother and child)
- special protection for children with special needs: handicapped children, delinquent children

Child allowance was, during transition, the most important instrument in fighting poverty. If before 1989 the child allowance was about 10% of the average wage, it currently represents barely 3% of a substantially lower wage. The introduction of a supplementary allocation for families with two or more children brought a slight improvement. However, the continuous decline in real incomes substantially reduced the ability of this benefit to compensate for the rapidly deepening impoverishment of these families. The present government intends to increase child allowances back to 10% of the average wage.

Table 4.25: Dynamics of the real value of the child allowance compared to 1989

1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
97.8	59.1	38.4	29.0	24.9	28.6	28.6	42.1	36.7	25.2	18.7

Source: MLSS

Poverty in Romania, UNDP 2001

After 1989, the great number of abandoned and institutionalised children was the consequence of maintaining a high birth rate in the families with severe poverty or affected by an accentuated social segregation, despite the general decline of the number of new-born babies.

In March 2002, in accordance with the ANCPA evidence, 87.521 children were in different special forms of protection, outside their natural family. Here are included the handicapped children, who live in special homes during school time, but return to their families during vacation. If we exclude these children, we could estimate that the number of children legally or de facto abandoned, despite the fact that they lose the normal relationship with their natural family (and live in residential institutions or in different forms of placement) is situated between 75.000 - 80.000, i.e. approximately 1,3 % from the whole population of children (PNAinc 2002).

Table 4.26: The situation of the children outside the family of origin, in placement or entrusted (31.03.2002):

Total nr. of children from institutions and substitutive families, *from which*:	87.521	100%
Nr. of institutionalised children (in public or private placement centres)	48.261	55%
Nr. of children in placement families, at professional maternal assistants or entrusted to relatives	39.260	45%

Source: ANPCA

Table 4.27: Number of adoptions between 1997 and 2001

YEAR	1997	1998	1999	2000	2001
National adoptions	n.a.	840	1.710	1.291	1.274
International adoptions	851	2.017	2.575	3.035	1.521
Total adoptions	851	2.857	4.285	4.326	2.795

Source: ANPCA

4.2.5 Accommodation

The lack of any accommodation represents an important reason to fall into poverty. Romania is confronting a severe crisis of accommodation deficit, generated mainly by the fast decline of dwelling construction, their price boom and the lack of regulation concerning the accommodation market.

A number of factors have contributed to a (as yet not established) number of families and individuals who are homeless and have little chance of finding shelter. In the current climate, the loss of home is a decisive event pushing families into a state of extreme poverty.

Two aspects of the problem should be noted here: the housing shortage and the crisis in utility costs. In recent years a new crisis with disastrous long –term effects has taken shape: the inability to pay maintenance fees. 22.4% of all families living in blocks of flats are more than 3 months in arrears in their maintenance costs (POP, November 2000). The accumulating debt pushes these families into a desperate situation with little chance of escape, the major risk being the loss of their home. The current heating system is technologically obsolete and providers charge excessive rates to cover energy losses. Voluntary or forced disconnection of many families from the heating system, and even from the water and power supply, for non-payment makes poverty a misery unacceptable in modern society. (Poverty in Romania, UNDP 2001)

An extremely severe problem is the absence of *social dwellings* for people confronted with urgent needs. The medium living space per inhabitant at the beginning of 2000 was approx. 12 sqm, the medium number of persons per room – 1.2 and the persons living in a dwelling – 2.9, the number of rooms per dwelling being 2.5 and the living space in a dwelling – 34.5 sqm.

Households with 3 or more persons inhabit approximately 26.5% of the dwellings, with 1 and 2 rooms.

The majority of the dwellings (55.7%) is inhabited by one family; in the rural area the ratio is of 98.5%. 71.7% of the urban dwellings (2.9 billions in 76.000 flats, with an average of 38 dwellings/flat) are in urban area flats.

There were 508.400 dwellings in 1992 (6.6% of the total number) with a total surface of rooms under 16sqm (1.13 rooms/dwelling) in which 905.300 persons were living - approximately 4% from the country population and having an average of 1.57 persons/chamber.

244.181 dwellings (3,2% from the total), that sheltered 435.804 persons, did not have any installation (electricity, water supply, hot water, sewage, natural gas, or central heating).

Another major problem is the over-crowding (inhabitants/dwelling; persons/room). For approximately 6.2% of the country's population (1.39 billion persons) the living space for 1 person was under 4sqm, and for approx. 77.000 persons the distributed surface was under 2sqm. Approximately 3.6 billion of dwellings (approx. 50%) were offering less than 11.56sqm/person. There are 895.570 dwellings with 1 single room (58% in the urban area), from which 106.521 dwellings (11.9%) were offering a surface/person under 4sqm (63.2% in the rural area), in which were living 527.877 persons.

Social groups at risk of shortage in accommodation are:

1. An important part of the gypsy ethnicity
2. Numerous families/ with a lot of children
3. Disintegrated families/ single-parent families
4. Families with long-term unemployed members
5. Street families, who live in improvised shelters
6. Children who leave the care institutions at the age of 18
7. Young families

A project in process which might help to solve some urgencies is the construction of dwellings for rent for young people, being financed (630 millions EURO) for the realisation of 38.000 apartments until 2004.

In autumn 2000 the MLSS initiated a program for social shelters; transit dwellings, which can rapidly shelter for a short term those affected by natural disasters and the total or partial destruction of their dwelling.

Another urgent program was initiated in the winter of 2001, designed for sheltering the people who live on the streets in extremely cold periods. This program has initiated a tight collaboration between the central and local authorities in order to find immediate solutions (for the spaces/necessary resources and the identification of the target).

4.2.6 Ethnicity

In a study realised in 1998 by the Institute for Research of the Life Quality, the following results were obtained: the Gypsy population is a young population (the average age of the population from the sample is 25.1 years. Also, 33.9% of the population has the age between 0-14 years; 4.3% from the population has the age between 65 years and over), and the fertility rate is double in comparison with the majority of the population (The Institute for Research of the Quality of Life, 2000).

The fall of communism has caused a fall in living conditions of the Gypsy (Rostas, 2000). The results are reflected in the bad living conditions - the average number of persons/living space is double in comparison with the predominant population, the living space/person is twice smaller in comparison with the other ethnicities and the average number of persons/room is twice higher than the other ethnicities. Besides, a quarter of the people from the sample do not have any act of property for the land on which they constructed their houses, moreover, their houses do not have any kitchen, toilets or adequate instalments (The Institute for Research of the Quality of Life, 2000)

The lack of identity papers is an extremely severe source of social exclusion for the Gypsies. Approximately 57.000 gypsies do not have any identity papers, representing 3.1 of the total of the non-identified population.

The access to medical assistance is worsening by the fact that a high number of Gypsies do not have the necessary papers. Persons, who have no access to medical assistance are usually illegal residents in a zone different from that mentioned in the papers therefore they have no access to their medical documents. According to the new Law of the Medical Social Insurance, the problems regarding the permanent residence along with the lack of a salary that would make possible the payment of the medical insurance have resulted in the absence of a family doctor for the majority of the Gypsy families (Save the Children, 1998).

The lack of education was a source of exclusion of the Gypsy population.

In 1992, C. Zamfir and E. Zamfir showed that only 51% of the Gypsy children in Romania at the age of 10 years were permanently attending school. Another 14% were interrupting school education, 16% were attending "from time to time" and 19% had never been inscribed.

The results of the research published in 1992 showed that 29.9% of the Gypsy children between 7 and 9 years of age have never been to school. In the case of the age group 10-16 years, the figure was 17.2%. The non-attendance of primary school (1^{st} to 4^{th} grade) results in the lack of elementary reading, writing and arithmetic knowledge, taught during these years. Moreover, the simple attendance of school did not necessarily mean

that a child would end his studies. The quota of the absentees is very high; the same study estimates that almost half of the children from the sample would not finish their primary education (1st to 4th grade) (Save the Children, 1998).

Illiteracy is a primary cause of exclusion, which is extremely significant for the Gypsy population in Romania. 39% of the illiterate and half-illiterate persons have a small chance to participate in the labour market.

The small presence on the labour market of the Gypsy is another major source of exclusion.

In the last years, the Gypsy problems are of a special interest to a large part of social players. On the governmental basis, the results were occasional, often at the recommendation of international institutions (EU, The Council of Europe, OSCE). The Department for Protection of Minorities was created, including an office for the Gypsies. In 1997 and 1998, this office drafted a program, financed by the EU, designed to improve the Gypsies' situation in Romania.

Only in March 2000 the program became functional. On the basis of this program, the strategy for implementing governmental programs was elaborated. The Ministry of Education and Cults created places for Gypsy inspectors at district level, the framework for recuperative classes for young people who do not have writing and reading knowledge.

The development of the Gypsy civil society is materialised in 100 organisations, out of which 30 are active.

Since 1990, several programs/projects who addressed the Gypsy population in Romania were initiated.

The identification of the main financers for Gypsy programs:

1. EU through the programs Lien, Democracy, Partner and Europe
2. The EU Program organised by the Civil Society Development Foundation
3. The Open Society Foundation for Romania
4. Roma Participation Program - Budapest
5. Japanese Embassy to Bucharest, British Embassy to Bucharest
6. MYS, The General Department for Strategy and Prognosis of the Development of Youth Activities
7. The Permanent Mission of the WB in Romania and The Council of Europe

The Gypsy NGO sector was hardly developed. At the beginning of the 1990ies, the number of Gypsy NGOs was very small. It grew visibly to almost 100 in the year 2000. Bucharest and Cluj are the areas with the biggest number of Gypsy NGOs.

After 1990, political structures meant to defend the interest of the Gypsy communities were created (ethnicity recognition, political representation through the electoral law, the appearance of Gypsy militants willing to assume the responsibility of representation on different plans - political, cultural, educational).

In 2001 the Government approved the Strategy for Improving the Gypsy Situation. For a period of 10 years the strategy created aims at improving the Gypsy situation and is addressed not only to them, but also to political leaders, the head of the central and local institutions and public authorities, the public employees.

The observed district areas refer to administration and community development, dwellings, social security, health, economic, justice and public order, child protection, education, culture and cults, communication and civic participation.

The strategy contains a general plan of measures that stipulate precise terms and responsibilities.

The poverty rate for minorities was: 87.1% for the Roma people, 30.3% for Hungarians and 36% for other groups. (Tesliuc, Pop, Tesliuc, 2001)

4.2.7 Regeneration of Areas

The poverty areas are social and geographic micro areas, within large communities, which are characterised by pronounced and chronic poverty and which have self-perpetuation mechanisms (The National Strategy for Preventing and Combating the Poverty, 1998).

Poverty areas are those affected by lack of economic activity. The alternative is the community and regional development, the promotion of a certain balance in the economical potential of the areas.

The poor rural communities include (Zamfir, 2000):

- Geographically isolated villages, without adequate communication methods
- Localities with low agricultural production (especially due to fragmentation of the agricultural area and lack of the necessary equipment)
- Localities in which the agricultural resources were completed through labour in the industrial units in the geographical proximity
- Localities with old-aged population
- Localities without adequate access to public services

- Villages in which a large percentage of citizens do not have land (in the case of the Gypsy communities)

The poor urban communities include:

- Villages whose industry suffered a sharp decline in the last years (mono-industrials, small and medium towns who were depending on a single industrial giant enterprise, which was closed or has reduced the production capacities after 1990)
- The areas/urban districts with inadequate living conditions (internal inadequate structure of the towns).

The study "Poverty in Romania 1995-1998", UNDP 1999, compiled by a team of national consultants includes a map of community poverty in Romania. The map was elaborated starting from the definition of the community poverty as the state of generalised poverty or dominant at the level of one community and having as objective the identification of the poor localities and their regional distribution.

It must be mentioned that the map is among the first which describes the poverty at the level of rural and urban localities in Romania.

Poverty is more significant in rural areas (in 1995 the extreme poverty in rural areas exceeded the poverty in urban areas). The differences have become smaller over recent years. In the period 1997-2000, the poverty rose more in the urban areas, reaching in 2000 60% of the value of rural areas. Alarming is the fact that, despite the similar evolution of the two areas during the period, in 2001 the poverty continued to rise in the rural areas, on the background of a substantial decrease in the urban areas.

Table 4.28: Percentage of persons below the poverty line by gender and area of residence

Area of residence	Rate of poverty (%)	Rate of the poor persons from the total
Urban	22,8	41,9
Rural	37,6	58,0

Source: CASPIS and NIS

The Government Ordinance no. 75/2000 for revision of the Government Ordinance no. 24/1998 regarding the regime of disadvantaged areas was approved, through which the economic agents who develop their activity in these areas benefit of several facilities. The disadvantaged areas include 145 localities, with a total population of 1.501.355 citizens, which represents 6,7% from the total population of the country (comparing with a number of 1.058.400 citizens before the declaration of the last 4 zones).

Distribution of poverty at national plan

The economic crisis of the last years has unequally affected the regions of the country. The poverty rate is bigger in the eastern and south areas of the country and smaller in the western part. The situation is most alarming in the north-eastern region, which covers the north of Moldavia (the counties Bacău, Botoşani, Iaşi, Neamţ, Suceava şi Vaslui), in which the rate of poverty exceeds 40% i.e. over 1,5 billion of poor people. Between 1995 and 2000, all regions registered a growing level of poverty (the maximal values belong to the Bucharest and West regions). The situation changed a bit during the period 2000-2001, when poverty rates were decreasing in 6 regions. However, the increase of poverty rates is continuing in the Southwest and North-eastern regions, i.e. in the poorest areas.

Table 4.29:Rate of poverty

	Rate of poverty		
	1995	2001	2001 in comparison with 1995 (%)
North – East	35.9	40.7	+13.3
South – East	25.5	33.2	+30.2
South – West	26.1	32.4	+24.3
South	28.4	30.4	+7.1
North – West	22.8	26.6	+16.2
Centre	24.9	24.8	-0.04
West	18.5	24.5	+35.7

Bucharest	11.7	15.1	+29.3

Source: CASPIS and NIS

Romanian Social Development Fund (RSDF). Community development programmes in poor communities are an exception in Romania after 1989. One of the few active measures adopted was the establishment of the RSDF in 1998, as a means of fighting poverty in rural communities

On 22nd June 2000, the Government Ordinance no. 75/2000 for revision of the Government Ordinance no. 24/1998 regarding the regime of disadvantaged areas was approved, through which the economic agents who develop their activity in these areas benefit of several facilities. The most important refer to the exemption from the payment of custom duties for the imported raw materials in order to achieve production in the disadvantaged areas (previous to the above date, the ease was to give back the custom duty).

The disadvantaged areas include 145 localities, with a total population of 1.501.355 citizens, which represents 6,7% from the total population of the country (comparing with a number of 1.058.400 citizens before the declaration of the last 4 zones). From the surface point of view, the disadvantaged areas are over 16.000 sq km, representing approx. 7% from the total surface of the country.

The distribution in the territory of the disadvantaged areas indicates their concentration in a proportion of over 51% in the North-Western regions (31%) and the West (20%).

At the end of 1999, the National Agency for Regional Development created 3 special programs for the disadvantaged areas, which were launched from 2000. These programs aim especially to help the investors from the disadvantaged areas to provide them with equipment and installations.

The main form of help is the financial non-returnable credit (grant) assured from the state budget through the Ministry of Development and Prognosis, in a maximum percentage of 75% of the value of the equipment. The selection of the beneficiaries of these programs was made through a bid of projects (mainly business plans).

In December 2000, agreements with 93 economic agents from disadvantaged areas were concluded, benefiting from the stipulations of the special programs, during the projects implementation for 2001.

4.2.8 Other factors influencing poverty and social exclusion

Disability

According to the National Plan on Anti-Poverty and Promotion of the Social Inclusion, 2002, the following problems exist for handicapped persons:

- Communitarian systematic services to help the non-institutionalised handicapped persons are limited, in type and number.
- Lack of services regarding the payment and contracting of social workers in charge of assisting handicapped people at home.
- Lack of capacities of the general social services, non-specific to adapt to the special needs of the handicapped persons.
- One of the existent problems at the level of the special education is the weak promotion of the inclusive education, necessary to the social integration of the handicapped persons, as a vulnerable group, with high risk of social marginalisation.
- The lack of opportunities to work for the handicapped persons determines for the majority, regardless their level of handicap, to become dependent from passive strategies for support and aid. The existent legislative framework focuses more on the employers stimulation to hire the handicapped persons (especially by penalising their non-involvement), and less on the creation of some productive and protected structures, that can offer the persons with special needs the chance to work.
- The inequity of the access to fundamental social services for poor handicapped persons in comparison to handicapped persons with higher material possibilities.

In 1990, the State Secretariat for Disabled Persons was established, a governmental agency with district agencies, Territorial State Inspectorates for Disabled Persons (TSIHP).

Rights and facilities for disabled persons

The special protection of disabled persons is regulated through the Ordinance no. 102/1999 regarding the special protection and the appointment of disabled persons, which is stipulating the rights and facilities of which this group of persons benefits.

A) Rights:

1. State allocation for disabled children: it is given in the conditions and ratio stipulated by the law, increased with 100%

In 1999, the average monthly number of disabled children, who benefited from the state allocation, was 49160 (79965 bill. lei). In 2000, the average

monthly number of disabled children, beneficiary of state allocation was 48.054, and the spent amount for their payment was 84.990 bill. lei.

- Special aids: are given to adults unable to work because of the disability, during the whole period of existence of the disability. The persons who have income of less than the limit stipulated by the law (195270 ROL) receive the difference until this limit of the special monthly aid.
- Social pensions for blind people: is allowed no matter of the age and the level of the salary income, with a value of 359.980 lei.

B) Gratuity:

1. Free spaces for rest in camps,
2. Free hotel services
3. Free urban transport
4. Free interurban transport

C) Facilities:

1. Exemption from payment of radio-TV and telephone taxes
2. Exemption from custom duties
3. Exemption from the payment of income tax
4. Discounts on the calculation of the rent

The State Secretariat (presently constituted as Department of The Ministry of Health and Family) methodologically co-ordinates the institutes for social protection of the disabled persons

The violence and abuse against women and children is a new problem of serious dimensions which has arisen from the social disintegration in combination with poverty. In 1999 , of the 2,131 registered cases of child abuse, 29% were sexual abuse (NAPCR, 2000). These children's ability to develop normally is severely affected. Family disintegration associated with extreme poverty has increased the risk for children to be neglected, abused and to humiliating forms of earning income (prostitution and pornography), which severely reduced their ability to lead a normal adult life. (Poverty in Romania, UNDP 2001)

Prolonged social and economic stress generate enormous risk of self destructive personal coping strategies: some withdraw into passivity, others into alcohol and drugs, others earn a living from illegal and degrading activities (begging, prostitution), others leave the country and others commit suicide (the suicide rate per 100,000 has increased sharply: from 14.0 in 1996, 15.8 in 1998 and 18.9 in 2000 (Annual report of forensic medicine network, 2001))

Table 4.30: Polls

Do you know anyone who, after losing his or her job, has started drinking?
Yes – 25%
Do you know anyone who, after losing his or her job, has started begging?
Yes – 6%

Source: Gender Poll, GALLUP – Romania, August 2000

4.2.9 Administration, Access to and Delivery of Services

The following summary is based on the World Bank report. Study on the provision of local social services in Romania, 2002:

Before adopting LLPF (The Law of the local public finances) in 1998, the fiscal autonomy of the public central administrations was limited. A couple of fundamental legislative reforms essentially modified not only the fiscal relationship between the levels of the fiscal administration, but also the structure of finances of the administrative units at different levels. LLPF creates the framework of the fiscal decentralisation, simplifying at the same time the system of transfers between the authorities of the local and central administration.

The local councils are the direct providers of the financial services for the families with small incomes. At the same time, the local administrations are responsible for assuring the social assistance services (the programs and the institutions for children and for the handicapped persons).

The decisions of the local administrations regarding the social services are based primary on the allowance of resources of different sectors and provision of the social assistance services.

The access to the social services vary from one administrative unit to the other, depending of the geographical position, the residence, the physical infrastructure, the lack of the qualified personnel in the isolated localities, the budgetary local restrictions, etc.

The MLSS initiates, co-ordinates and supervises the accomplishment of programs for social services in collaboration with the local public administration, the NGOs and other representatives of the civil society.

The application of Law no. 208/1997 concerning the social aid restaurants had a major impact on the social services area and helped to deflate the shock produced by the economic restructuring on the living level of some groups of the population and to mitigation.

The NGOs can organise restaurants for social help with the possibility to subsidise them up to the level approved for food allocation per person.

The Municipal Councils and the General Council of Bucharest have been establishing measures for preventing the situations of social exclusion and assure the human, material and financial resources necessary for solving the social urgencies at district and local level. They evaluate the NGOs' activities in the programs subsidised from the Municipal Council's budget and of the Municipal Council of Bucharest.

Through the implication of the NGO-s in the provision and financing of the social services, their range is becoming more and more versatile in Romania. More than 40% of the NGO-s registered are concentrating their activity in the social sectors.

Table 4.31: Types of activities deployed by the NGO-s in the "Social Services" area 1997

	Number of NGOs
For children	1327
For young people	1170
For old people	1136
For handicapped persons	1027
For families	957
Associations for mutual aid	928
Services in case of natural disaster	299
Social services for refugees	175
Material/financial aid for poor people	75
Other	87

Source: Methodological guide for applying Law 34/1998 – Parteneriates in providing social services

From 1998, the legislative initiative of the Ministry of Labour and Social Protection encouraged the collaboration between the non-profit sector and the local administration and, at the same time, stimulated the interest of the NGOs for offering social services.

In the context of Law no. 34/1998 and the G.O no. 539/1998 modified and completed by the G.O no. 800/1999, social assistance services are offered in two different ways:

1) At the headquarter of the social assistance unit:

- Centres which offer accommodation: student hostels/ doss houses, respectively a complex of services in a special protected place offered to

those beneficiaries who do not have the possibility to live temporary or permanently in a natural social environment;

- Daily centres/ social centres/ re-socialising centres, respectively a complex of services, without night accommodation, in accordance with the program of the unit, offered to those beneficiaries who come to the headquarter of the centre

2) At the beneficiary's home, respectively a complex of services offered to beneficiaries in order to prevent the institutionalisation, like:

- housekeeping services;
- services for the beneficiary's hygiene;
- social workers/ companion services;
- services for spending free time;
- services which offer food at home;
- counselling services;

The range of the services vary depending of the beneficiaries profile and their needs.

Allowing subsidies to NGOs

By implementing Law no. 34/1998 concerning the allowance of subsidies to associations and Romanian legal entities foundations that set up and administer social assistance units, the development, diversification and facilitation of social service access for persons or underprivileged groups were encouraged and sustained. This was also achieved through NGOs by increasing their capacity to develop social services.

In comparison with a big number of NGOs which mention in their status as object of activity the supply of social services to disabled persons, their interest for subsidies is limited. The main reasons for this are the following:

1. Insufficient advertising of the program
2. Limited access to information for the NGOs, and non-consultation of the Official Gazette
3. The poor relationship between the NGOs and the General Departments for Labour and Social Protection, which have information regarding the conditions and ways of granting subsidies
4. The incapacity of NGOs to respond to the criteria imposed by the normative papers
5. The hesitation of NGOs to spend public money, this activity being controlled by the Financial Guard, respectively the lack of trust in state structures

Differently from the public institutions, which offer only care of residential type (placement centres, houses for disabled persons), the NGOs are developing social assistance units with residential character, as well as with temporary character - in daily centres or at the beneficiaries' house.

4.3 Evaluation of future challenges

4.3.1 Main challenges

The main challenges have been laid down as objectives in the National Plan on Anti-Poverty and Promotion of the Social Inclusion:

- Eradicate extreme poverty
- Eradicate such social conditions as they are morally unacceptable to a civilised society: street children, institutionalised abandoned children, human trafficking, domestic violence, neglected and/or abused children, develop a victim support system.
- Gradually bridge the active and retired population's poverty gap
- Narrow down the existing regional disparities, promote revival of disadvantaged areas and prevent the emergence of new regional disparities.
- Give every member of society access to basic social services: health care, education, employment and social assistance
- Invest in the new generation: give children decent living standards as well as access to development opportunities
- Provide sustained support to young people for integration into adult life: young people should be seen as a key resource for development rather than a problem
- Complement and develop the social protection system:
  - Implement the national social assistance scheme
  - Move decisively from passive social protection to active use of individual and collective capacity
- Build national, county and local government capacity to identify social issues, develop and implement social policies and programs, as well as evaluate and monitor such policies and programs

4.3.2 Political directions of future reform

Substantial poverty reduction must be recognised as a central criterion of successful macroeconomic stabilisation. Growth, while necessary and desirable, is not an end to itself, but a mean for improving the welfare of the entire society.

Economic policy:

1. Resuming economic growth represents the strategic variable in Romanian society today. Therefore, economic policy is the core of any anti-poverty programme.
2. Economic activation policies are required to draw the poor into the formal economy and prevent their exclusion from the labour market.
3. The disintegration of the public utilities infrastructure runs the risk of turning into one of the major problems facing Romanian society, especially in urban area.

Social policy

1. Reconsideration of social policies. Current social policy is inadequate in comparison both to other European countries in transition and particularly to members of European Union. This is one of the principal causes of the unacceptable increase in poverty and for its remaining at unacceptable levels.

    - Social welfare budgets will have to grow substantially to bring Romania into compliance with European standards. Financing the necessary increase in public social expenditure will require both economic growth and major improvements in the effectiveness of tax collection, as well as a more efficient redesign of the budget.

    - Structural redesign of the budget.

    - Consolidation and improvement of social insurance components

    - Provide enhanced social protection for children, particularly for those abandoned in institutions or in street, as well as children neglected or abused by their families.

    - Fund an acceptable level of social support payments for the disabled, develop sheltered employment where possible.

    - Invest in health care and education systems.

    - A national system of social assistance services should be developed rapidly.

2. An efficient instrument for poverty alleviation and control is the protection of the population against exploitation by a corrupt bureaucracy and/or crime.

4.3.3 Social exclusion, poverty, EU accession

The National Plan of Action is set in the context of firm commitment to European integration.

With regard to **social policy and employment** a series of legal acts has been adopted according to the Community regulations, referring to the setting up, organisation and functioning of the Social Dialogue Commissions within some ministries and prefectures; the criteria and the methodology for classification of the working places with special conditions; amending and supplementing the Government Emergency Ordinance no. 102/1999 on the special protection and employment of the disabled persons; protection of the Romanian nationals working abroad; employment conditions, the rights and obligations of the private social assistant of the disabled persons. The Law on volunteering has been adopted and the Law no. 130/1999 on certain protection measures of the employed persons has been amended and supplemented. The law on employers' organisations and the law concerning the minimum guaranteed income have also been adopted, as well as the Government Decision on pensions re-correlation.

In 2002, for the chapter "Social policies and employment", some important bylaws are noticed for: combat of the social marginalizing, for implementing an insurance system for unemployed and for stimulating the occupancy of the labour force, for the work injuries and professional diseases, as well as for establishing the juridical framework necessary for putting into appliance of the principle of equality of chances between women and men.

These, together with the other laws mentioned will sustain Romania in accomplishing the above-mentioned objectives, regarding the combat of poverty and social exclusion.

The government approved the main document regarding the chapter „Social and occupational policy of the labour force", as well as the foundation dossier of this document.

Romania accepts entirely the "*Acquis communautaire"*, which came into force on 31 December 1999. Romania did not ask for any transition period or derogation and will be able to apply entirely, at the date of adherence, the acquis for Chapter 13 „The Social Policy and the Policy of the Labour Force".

4.3.4 Current tendencies in the policies for combating the social exclusions

Poverty is considered a severe problem in Romania, not only by the politicians but also by the representatives of the academic area and by the

public opinion. This became evident after 2001, when the actual government founded the Commission on Anti-poverty and Promotion of the Social Inclusion, which finalised the National Plan on Anti-Poverty in 2002. This can be seen as a major cornerstone in Romania´s recent policy development.

Other recent developments in the field of social assistance with an impact on social policies for combating poverty could be stated as follows: the adoption of the Law on social assistance in 2001, the adoption of the Law of the minimum guaranteed wage in 2001, intended to replace the social aid, and the adoption of the Law on combating social exclusion in 2002.

5. HEALTH CARE

5.1 Evaluation of current structures

5.1.1 Organisation of the health care system

The introduction of the insurance system in 1998 was followed by a major change in the organisation, operation and financing of the health system, involving the change of the centralised health system into a decentralised one. New institutions and responsibilities were created to decentralise the financing, organising and control of the health system from a single entity, the MHF. The MHF has attributions mainly concerning the strategy and the government policy for public health and health promotion, health provision. It organises and sets up the financing of the national public health programs and legislation compliance in the health care field. Locally, these are responsibilities of the PHD .

The institutions assigned to finance medical services from the social health insurance funds are the NHIH and the social health insurance houses**.** From the 1st of January 2003, after the health insurance law would be issued, the management of NHIH and health insurance houses will be performed by the Meeting of Representatives and the board of administration. At present, the management of NHIH is ensured by a president appointed by the Prime-minister and proposed by the Minister of Health and Family. The management of health insurance houses is ensured by a general director appointed by President of NHIH, provided a previous contest is succeeded. The district health insurance houses collect insurance contribution from insured persons and from employers, close contracts with providers of medical services and ensure the payment of the medical services that are provided.

The quality control of the medical act is provided through the professional medical association empowered for this purpose, the College of Physicians from of Romania. The CPR was created as a professional, non-governmental organisation, apolitical and without patrimonial purposes, representing the interests of the profession of physician. Also, the CPR has the responsibilities to accredit physicians, negotiate the framework and payment mechanisms for medical services. The rules of medical practice have not been elaborated yet and this lack of regulations has an influence on the efficiency and quality of the medical services.

Between the managing, financing and service quality control authorities, there is a co-operation relationship, as autonomous entities. However, there are still problems as to what concerns the boundaries of the attributions of these three institutions. This fact leads sometimes to the delay of certain decisions concerning the medical services.

The health care system in Romania covers all population through public and private facilities, financed mainly by the health insurance system. Private health insurance plans have not been developed yet; however, the patients can get private health services directly from private practices against cash payments.

Public health care and health promotion are state responsibilities, through the MHF. The Romanian health care system provides health care through:

a) public and private health facilities providing primary, secondary and tertiary health care. They are autonomous and function based on a contract with the health insurance system. These public or private health units need to be accredited as providers of medical services.

b) public health institutions responsible for public health and health promotion, which are financed entirely from the state budget and are subordinated to the MHF or to the PHD: public health institutes, district blood transfusion centres and the National Transfusion Hematology Institute, The Health Services Management Institute, The Centre for Calculation and Health Statistics.

c) medical practices and hospitals in industrial plants and companies, financed from their own budget; in some large companies there are medical practices and even hospitals, which provide medical care for their own employees and are financed from the company's budget.

d) private medical practices, organised as autonomous businesses, which are not in a contractual relationship with the social health insurance companies. The private medical practices, organised as businesses, which do not have contracts with the health insurance houses are organised for aesthetical services and paramedical services. The private medical practices can provide medical services with health insurance houses after accreditation. In the last year their number has increased, especially the laboratories.

Family physicians are the first contact point with the health services and they are meant to act as gatekeepers to the rest of the system. The access of the insured persons to secondary medical assistance is made on a referral basis from the family physician, except for the emergencies, which can be handled by any physician, if necessary. Due to a tradition, according to which hospital services are better than primary care, many patients request referrals directly.

The family physicians practices have been created after 1998, as a consequence of the free of charge assignment of the medical dispensaries (health facilities which provided primary care for the inhabitants from a certain area) and polyclinics, based on a contract (rent without payment), between the physicians and the PHD. For this reason, the number of

dispensaries decreased from 3956 in 1995 to 70 in 2000, but the medical practices were above 11000 in 2000 and the policlinics were replaced by specialists practices (see table 5.1). Together with the family physicians practices, specialised medical practices, dental care and medical laboratories were also created. Medical practices can be organised individually, grouped, associated, as medical civil society, medical centres, centres for diagnosis and treatment or as ambulatory services of the hospitals.

The hospitals provide specialised medical services through over 400 hospitals with over 160,000 beds, representing 7.4 beds per 1,000 inhabitants (see Table 5.2.). The hospitals are organised, according to the specific pathology, as general hospitals or specialised hospitals and can have distinctive areas, for the treatment and care of the patients with acute or chronic diseases. The hospitals can include in their structure hospitals' ambulatories, which provide specialised medical services.

In terms of property, hospitals belong to the state's public property (hospitals of national importance), the district public domain (district hospitals, the public domain of the villages, towns and cities) and private hospitals. In every district the local authorities supervise all medical facilities and co-operate with MHF and the health insurance system.

Hospitals work on the principle of financial autonomy, based on the incomes raised for the medical services provided to the insured persons through the contracts closed with the health insurance houses; they elaborate and execute the budgets. Because hospitals run yearly into debt, a management contract was introduced in 2002. This contract will have to strengthen the responsibility for the funds efficiency. The draft of the management contract, containing the activity performance indicators, is to be approved by the MHF.

The pharmacies are organised either as autonomous business, having contracts signed directly with the health insurance houses for the provision of drugs, with or without personal contribution; or within the hospital, having contracts signed with the health insurance houses through hospitals. In 2001 there were 450 public pharmacies in hospitals and 4100 private pharmacies with an open circuit.

Officially, for most medical services no extra fees are collected at their place of delivery. However, "under the table" payments are known to exist at every level of medical care; this happens according to the income of the patient or according to what the patients consider appropriate for that medical service, because the physicians are known to have low incomes. These practices are not prohibitive, meaning that they do not prevent medical services from being provided.

Recently, the Centre for Policies and Health Services has made a survey of the public opinion regarding the status of the health system in Romania

and the access to health services. The question "Did you pay unofficial fees/gifts for medical services in 2001?" received the following percentage: for people with high income: 39%, yes and 61%, no. People with income below average answered yes 33% and no 67%.

Another question was ”Are you aware of the rights your insurance grants you?". People in rural areas answered yes 30% and no 70%. In the urban area 43% answered yes and 57% no.

Although through the implementation of the health insurance system the insured persons pay every month for the service package provided by the law, regardless of whether they receive medical services or not, patients continue to offer money out of their own pocket upon receiving medical assistance. There are multiple causes for that, and it will be difficult to eliminate this habit in the short-term.

The health insurance houses pay medical services of the providers and ensure the keeping of the financial balance between the approved budget’s incomes and expenses of the health insurance fund. The National Insurance House should mainly have a role in regulating and supervising the system, and ensuring that the rights of the insured persons are respected. The NHIH have also directly involved themselves in the organisation of national bids and in the payment of the contracts for drugs, going around the district houses. Also, the re-distribution fund is managed by the NHIH, through a system which does not aim to provide equity in providing medical services, but to cover the expenses of some hospitals, without publishing the principles of re-distribution of the collected fund. It can be considered that the system is insufficiently transparent and efficient in the way in which it has functioned up to this day.

The relationship between the financing authority, the providers and the purchasers of services is done on the basis of the framework concerning the conditions of provision of medical services within the social health insurance system. The health insurance houses and the medical services providers must comply with the regulations in the framework contract and its application regulations regarding the payment of the medical services

The medical services control is provided by the special services within the NHIH and the health insurance houses, together with the CPR, organised at national and at district level.

Organising the public health system (promotion and prevention)

The Romanian Constitution stipulates that the state must take measures to ensure hygiene and public health. The public health care includes activities that are performed in order to prevent diseases, promote and ensure public health, as well as to control the application of hygiene norms, anti-epidemics and public health.

The public health system is organised by the MHF centrally and locally through the public health directorates, health state inspections and public health institutes. The MHF as central authority in the field of public health is responsible for public health and health state inspection and for the periodical reports to inform the Government about the health status of the population.

The PHD co-ordinate and take direct responsibility for the entire public health activity within the districts and within Bucharest, with the purpose to accomplish the national public health programs and policies, preventive medicine activities and health inspection, to monitor health status and to organise health statistics. The PHD organise :

- infectious disease detection, supervision of contacts, taking measures for the necessary treatment to be applied;
- the accomplishment of the compulsory and optional vaccines, based on the national calendar;
- control the activity of detection, treatment and prevention of sexually transmitted diseases, ensure the detection of HIV, HBV, HCV and other viral infections transmitted through blood;
- the detection of tuberculosis, supervises the treatment of the ill persons and contacts and is responsible for the achievement of the prevention program for tuberculosis ;
- direct and control the activity of detection of occupational diseases;
- the early detection of malign tumours, chronic diseases such as diabetes, cardiovascular diseases, mental diseases, kidney diseases etc. established through the public health programs;
- in co-operation with the local authorities, educational institutions, governmental and non-governmental institutions, educational activities for the public health.

The national health programs organised by the MHF in collaboration with the NHIH, use funds from the state budget, from the health insurance fund budget, internationally financed projects, donations and sponsorships. Through the national programs financing it is aimed the implementation of the measures promoting health and prevention care and drugs for some diseases from these (cardiovascular diseases, oncology, TBC, etc).

5.1.2 Benefits

Health care benefit

Insured persons are entitled to a package of free medical services, whose costs are supported by the social health insurance fund; the insured persons pay a personal contribution for some drugs, health spa and prothesis. 57% of

the social health insurance funds supported in 2001 the hospital care services, 14% ambulatory health care and 24% medicines (see Table 5.3)

Insured persons are entitled to choose their family physician, their specialist and the hospital from which to receive the medical services in the statutory medical package. Insured persons are indiscriminately entitled to medical services, in case of illness or accident, from the first day of the illness or from the date of the accident until the recovery.

Insured persons in Romania must be Romanian citizens with the residence in the country, or foreign and stateless citizens with the residence in Romania.

The social health insurance system covers the entire population of the country and does not exclude any category of persons. There is no official statistical data, but it is estimated that over 90% from the population is registered on a family physician's list.

The package of benefits comprises services of medical preventive assistance and health promotion, including early illness detection, medical ambulatory services, medical hospital services, dental services, emergency medical services, complementary rehabilitation medical services, medical pre-, intra-, and post-birth assistance, medical care at home, medicines, materials. Not included in the basic services package are medical services necessary in case of professional risk: work related injuries and occupational diseases, certain high performance medical services, some dental care services, professional diseases, high comfort hotel services. The framework establishes the cost of medicines, materials and therapeutically means that are to be supported by the insured person.

Primary care services are provided by family physicians within the 7 working hours-day program; in order to insure 24 hours a day of medical services, including Sundays and legal holidays, permanent centres are organised, with the support of the Public Health Directorate. Insured persons are allowed to choose their family physician for primary health care; insured persons will be able to change their chosen family physician, after the expiry of at least 3 months period from the registration with the respective physician. Insured persons on the list of the family physician receive preventive**,** curative and emergency medical services, included in the "per capita" payment.

The framework contract from 2002 established that the preventive controls are to be made according to a plan, provided by the family physician. The insurance houses have the obligation to publicly inform the insured persons about the obligation of having these controls done. If over 20% of them are not made by the fault of family physicians, the "per capita" payment for the respective trimester is to be decreased by 10%.

The health insurance houses pay in the "fee for service" payments system for certain medical services, like: immunisations according to the national immunisation program, children's health status check up to 7 years old, active TB detection, active detection of sexually transmitted diseases, supervising of pregnant women and post-birth, screenings for the detection of genital cancer.

Family physicians can recommend paraclinical investigations according to the regulations in the framework contract. The abuse of unjustified drug prescriptions or paraclinical investigation recommendations will incur in a decrease in the family physician's income.

Starting in 2002, family physicians have to provide the following medical services for the population in a certain catchment area established by the public health directorate, regardless of whether they are on the list of the family physician or not: immunisations, children's health status check**,** active TB detection, pregnant women and post-birth supervising, emergency medical assistance, activities in case of epidemics. Family physicians can provide medical services against fee, same as for medical services at request or requested by authorities entitled to know the health status of the person.

The specialised ambulatory care units provide their services from Monday to Saturday inclusively, in order to ensure the insured person's access to a length of maximum 35 hours a week; the program can be increased by 50% or respectively decreased, according to the appointments set. Specialised accredited physicians from specialty ambulatories provide specialised consultations, diagnostics and therapy treatments as well as paraclinical investigations. The access to specialised ambulatory care is made based on a referral from the family physician.

The hospital services are provided to the insured persons, if the ambulatory or home care are not effective. Medical services are provided in general or specialised hospitals, with health authorisation. The hospital medical services are provided to the insured persons based on the referral by the family physician or specialised ambulatory physician.

The list of medical services of which the insured persons benefit are services with a medical, surgical profile, investigations and are included in the framework contract. The high-performance services (scintigraphy, angiography) are provided only based on medical recommendation. The health insurance houses pay for these services for the insured persons for major nominated medico-surgical emergencies and for illnesses for which all other exploration possibilities have been exhausted. These services are provided to both patients in hospital and in ambulatory care. High performance services and other medical services, whose values are not supported from the Social Health Insurances Fund, are presented in the framework

At the end of a hospital stay, physicians practising in hospitals must send a medical letter to the family physician or to the ambulatory specialist, accordingly, stating the assessed health status of the insured patient at the time of the end of the hospital stay, as well as treatment and supervision indications for the following period.

The hospital medical services provided after a labour injury must be invoiced distinctively by the provider of the hospital medical care to the health insurance houses, indicating the unit where the accident took place. The health insurance houses must recover the respective amounts from the employer/insurer of the person who received hospital medical services.

Dental care services

Dental care services are provided through the practices of accredited dentists.

The payments of the consultation made within the preventive medical services is supported, for insured persons, integrally by the health insurance houses, in the following conditions:

- for children between 0-18 years old, unlimited, for youths of 18-26 years old, if they are pupils, apprentices or students and if they make no income, twice a year, for adults, once a year. Children between 0-18 years old are entitled to preventive medical dental services and to dental treatments that are paid for by the health insurance houses.
- For insured persons older than 18, the health insurance houses pay 40-60% of the list of preventive dental care services and dental treatments, provided for in the framework.

Emergency services

The insured persons are entitled to emergency medical services, with an integral settlement of the payments by the health insurance houses for major emergencies, medico-surgical emergencies of the 2nd degree and medical transport services, provided for in the framework contract.

Health rehabilitation medical services

The insured persons have the benefit of rehabilitation-recovery services in sanatoriums, on the basis of a referral from the specialist, with a personal contribution of 25-30% of the cost of the sanatorium per day. An insured person can benefit from these medical services under these circumstances once in two years.

Drugs

The insured persons are entitled to medicines, on the basis of medical prescription, as follows:

a) without personal contribution: children between 0-18 years old, pregnant and post-delivery women, drugs prescribed while staying in the hospital, drugs necessary for the treatment of communicable and chronic diseases listed in the framework and for national health programs;

b) with a 30% of the reference price paid by the insured person plus the difference between the reference price and the retail price of the prescribed drug. Since 2002, the list is included like reference price, retail price.

Drugs are prescribed by physicians only within the limits of their speciality, except for family physicians who can prescribe drugs both within their own competence and based on the written recommendation of the specialists. The number of drugs that can be prescribed with or without personal contribution for a sick person on one consultation is 1-3 products. Physicians can prescribe drugs up to a certain sum, which can be exceeded only with the approval of the health insurance house.

Home care

The insured persons are entitled to home care from accredited providers, on a contract basis.

Medical devices

The insured persons are entitled to devices necessary to correct and recover organic, functional and physical deficiencies, on the basis of a medical prescription issued by accredited specialists and a written request addressed to the insurance houses.

The price of the medical devices is settled by the health insurance houses, if they do not exceed the reference price established by the framework. In case that it is exceeded, the difference is to be supported by the insured person, as a personal contribution.

Medical services coverage

The medical services established by law and by the framework cover the requests of the medical services. In fact, there are many issues determined by the lack of complete package financing on the one hand, and by lack of human resources on the other hand, as they are not equitably distributed over the surface of the country.

These difficulties make medical services inequitable for all insured persons, and bring more advantages for those living in urban rather than rural areas.

In this situation, the insured persons are forced to search the services of the specialised clinics in towns.

5.1.3 Financing of health care system

Transforming the health financing system into an insurance system from the previous state budget financed system, which existed until 1997, has been expected to be a way of increasing the public financial sources for the health system. Starting with 1999, health expenditures have increased from about 2.8% (in 1997) to 4.1% from the GDP in 2000 (see Table 5.3). However, the health expenditure level in the GDP is still low compared to the EU average. Before the health insurance system was introduced, the health expenditures were financed 67% from the state budget, 21% from the local budget and 13% from the public health special fund. In 2000 the health insurance fund covered 84% of the health expenditure and the state budget covers only 13% (see Table 5.3).

The sources of financing the health system

The health system in Romania is financed from the following sources: the social health insurance fund, the state budget, external credits, local budgets, contributions, donations, sponsorships, the personal contribution of insured persons for drugs, health materials, prosthesis, orthesis, spa treatment and for the payment of private medical services.

Health insurance contributions

The social health insurance contributions are collected through the district insurance houses, through the Transport Insurance House and through the Defence public order, national security and judicial authority Health Insurance House. The social health insurance fund includes the amounts representing insurance contributions in equal quotas of 7%, from the employers and employees, 7% the contributions from retired persons and unemployed persons paid by budget fund of the pensions and the budget fund of the unemployed persons and optional contributions to social health insurance, contributions from some categories of people, who are covered by other budgets. No wage limit is established for the income to which the health insurance contribution quota is applied. Also, there are persons which are insured with the payment of the contribution from the state budget or from the budget of the state social health insurance fund, like persons in compulsory military training, persons in sick leave or maternity leave, persons executing a sentence with privation of liberty and persons belonging to a family that benefits of social aid.

The following categories of persons benefit from health insurance without paying a contribution:

a) children and youth up to 26 years, if they are pupils, students or apprentices and if they make no income from work.

b) the husband, wife, parents and grandparents without own incomes, in case of an insured person;

c) disabled persons who do not make any income from work or are in the care of the family;

d) politically persecuted people, war veterans, people disabled or widowed by war, as well as the revolutionaries of December 1989, if they do not make any other income than those from the allowances provided by Law and pensions.

Employers must keep and transfer the social health insurance contribution to the health insurance houses, in a quota of 7% reported to the salary fund as well as the 7% supported by the employees. All incomes obtained by the insured persons from contracted activities are assimilated to the incomes belonging to the salary fund.

The insured persons must pay their social health insurance in a 7% quota, monthly applied to the gross salary income, in the case of insured persons who are hired for a salary, or those who work on a part time contract, through the employer.

The social health insurance contribution of 7% will also be applied to the income of the following categories of insured persons: taxable incomes of freelancers, taxable farming income, annually declared by natural persons, incomes from individual allowances of unemployed persons. Self–employed evasion is possible; sometimes payments are made when medical assistance is needed.

The contributors for the Health Insurance House of Transport are the persons from the Ministry of Transport, subordinated public institutions, national companies, businesses under the authority of the Ministry of Transport, as well as business providing services in the field of air, naval, road, railroad and underground transportation, their family members, as well as retired persons who have worked in transport and their family members, using the Ministry's own health network. The Health Insurance House of the Defense, public order, national security and judicial authority has as contributors: the personnel of the ministries and institutions with own health networks from the field of defence, public order, national security and judicial authority.

The budget of the social health insurance fund is approved yearly by the Parliament at the same time with the law of the state budget.

The budget of the fund contains, as incomes, amounts representing health insurance contributions, and as expenses, amounts for paying medical services, for managing the fund and the reserve fund (see table 5.4). The health insurance budget incomes are mainly based on the employed persons' payments and have a level of collecting of over 90%. The health insurance system has a method to inform employees and employers about the obligation of paying the health insurance contribution. The payment control is performed also with the co-operation of the state treasury and the commercial banks, at the moment of the wage payment. In case the employers do not pay, they must pay penalties for the delay.

Every year, the health insurance budget is approved with surplus, which was each year between 6-8% and which was meant to allow an expenditure reduction. This was not realised and was very much criticised in mass media. Representatives of NHIH and CPR explained that all the incomes should be used for medical services in the same year. The surplus is carried forward to the next year and used for the same purposes as in the current year (see Table 5.4).

The expenses from the health insurance fund are used to 97% for medical services and 3% for the fund administration (see Table 5.4).

The analysis of the utilisation of the social health insurance fund reflects the proportion in which medical services were provided to insured persons. The most important amounts continue to be those for hospital services, as primary medical care is not consolidated (especially in terms of equipment) and this sends patients for hospital assistance. The medical services expenses accounted for in the last 3 years show that the amounts for the primary care have decreased continuously in favour of the hospital care expenses (see table 5.5).Because of this fact, the family physicians are not motivated to acquire medical equipment and computers. The hospitals are generally not efficient enough yet and deal with patients who should be treated in primary care. As for medicines, it should be mentioned that the differences come mainly from the increasing/decreasing of the list of medicines.

Generally speaking, the system can be considered as under-financed. The medical services and drugs are not covered through the contracts with the providers, hence debts are created yearly. The acute lack of funds has an impact in the area of medical equipment, much of which is over 25 years old; also, medical facilities are improperly maintained, so most of them have provisory functioning authorisations. Another aspect is the under-financing of the family physician services and of the medical services, in general. These sometimes have prices below other services within the economy (for example, staying in a 2 star hotel is more expensive than in a town hospital).

Because of this, the physicians cannot make investments in equipment and computers, unofficial payments are encouraged, the insured persons receiving often medical services of a lower quality.

Another financing resource for the health care expenditures is the state budget. The state budget supports national health programs, investments concerning the construction of health units, including designing, expertise as well as the consolidation of buildings in the administration of the MHF, high tech equipment. The state budget covers some major repairs, the supplementary financing of education and research within hospitals.

External credit entries, which are financed from the state budget, are approved through Government Decision and the Parliament within the law of the annual budget, and are regularly run for multiple years, according to the contracts closed with external partners. High tech medical equipment is financed from these sources.

The budget of the special public health fund was used for financing health care between 1992 and 2001.This fund was created from taxes for health damaging activities, including the 12% quota applied to revenues of legal persons from advertising tobacco products and alcoholic drinks, and the 2% quota applied to revenues of legal persons from selling tobacco products, cigarettes and alcoholic drinks, after the deduction of VAT and other taxes due to the state budget, the quota of 25% of fines applied by the health state inspection. The amounts represented 3-17% in that period of the total health expenses and were used for health programs and expenses of the public health directorate.

Until 1997, the local budgets covered some health expenses for materials and for blood donors, and have represented approximately 20% of the total health expenses.

The other health facilities budget sources have been made from incomes resulting out of medical services provided upon request, services concerning certain superior comfort conditions, donations, sponsorships, etc. which are included in the own budget. They cover the functioning expenses of the health units and some expenses established by sponsors accordingly.

The insured persons have to pay personal contributions for certain medical services. Beside the social health insurance contribution, the insured person must pay for drugs, materials, part of medical dental services, spa and recovery medical treatments, prosthesis and orthesis themselves.

The payment of medical private services

Besides the medical services provided through the social health insurance system, the population can benefit from medical services provided by private physicians organised in medical practices, who do not have contracts

for medical services with the health insurance houses. Also, the patients can receive medical services from pay-polyclinics upon request.

In the survey "Health expenditures in Romania 1996-1999" issued by the Health Services Management Institute, together with the National Statistics and Economic Studies Institute, it was estimated that the health care expenditures from private funds in 1999 were $305 million, representing about 22% from the total health care expenses or 0.9% from the GDP. A large amount of these reach directly or indirectly the public health care providers or their employees, either through the payment system or through "gifts" (illegal amounts paid to the health providers for services which are free of charge according to the law).

The context where these private payments appear, in the transition period to a decentralised economy, is economically difficult. The constraints of the health public budgets had a significant negative impact on the health services. It should be mentioned though that there is an acute lack of information concerning the character and the operating context of the health care.

The private medical insurance is applied in the case of the employees of a few foreign companies who have activities in Romania and it is used in most cases by Romanian citizens travelling abroad, as the compulsory medical insurance does not cover the cost of medical services for these situations.

5.1.4 Incentives

The incentive system is still insufficiently developed and the objectives of public health are less analysed from this point of view. Still, the framework does establish incentives through national health programs for the use of medical services for detecting, preventing and treating contagious diseases by increasing the points given to family physicians.

In the primary health care the incentives are implemented through the payment method of these services in the mixed system "per capita" and "fee for service", for the physician and for the patient as well. This way, the physicians are motivated to keep their patients on their list and to perform preventive care, because they get paid for this. At the same time, the patients get the medical care they need.

The settlement of medical services through fee per insured person is established according to the number of points calculated according to the number and structure by ages of the insured persons registered on the list, the number of medical services and the value of one point.

In the field of reproductive health, medical services offer free contraceptives to poor persons, pupils and students.

The payment of the services from ambulatory medical care for clinical, paraclinical and dental specialities is made through fees per medical service, taking into calculation the number of points related to each medical service and the value of one point. Increasing the number of points is proportional with the number of consulted patients. The system encourages increasing the number of medical services and improving their quality, both in favour of patient and physician.

The incentive system in hospitals is not clearly defined yet. There is a financial incentive type regarding the daily payment hospitalisation and the DRG model. Thus, in the first case the hospital services payment is not decreased when the hospitalisation per patient is reduced; this way, the hospital is stimulate to reduce the number of hospitalisation days. In the second case, the hospitals attempt to remain within the financial allocations contracted with the health insurance house.

The payment of medical hospital services are fee per hospitalisation day for most of hospitals, fee per inpatient (DRG), which applies to a small number of hospitals (see below) and fee per medical service. The payment through DRG has begun in 2002 and now applies to only 23 hospitals, which take part to a pilot project.

The number of staff, excepting the physicians, decreased because of the modification in the public health units financing and functioning. The number of physicians increased with over 2000 between 1995-2000 (see Table 5.5). At the same time, the number of nurses decreased, most of it being fired from the former dispensaries and polyclinics and not re-employed by the family physicians or specialty doctors from the specialty practices, because the activity of this staff is covered from the physician's income, which is considered to be insufficient for a larger number of employees. Also, the number of dentists and pharmacists decreased, since most of them moved to the private sector.

Regarding the use of medicines, insured persons have to contribute with 30% of the reference price of the drug in ambulatory treatment.

In order to encourage the use of the dental preventive medical services, the care for children up to the age of 18 years is provided for free .

5.1.5 System coverage and access to care

The social health insurance system covers the entire population of Romania.

No population category is excluded from the social health insurance system. As previously mentioned, the persons who cannot pay their contribution are either supported from other budgets, or from the social health insurance budget according to the solidarity principle. In fact, the health system in Romania has had a wide access character to the health

services even before implementing the health insurance system, but the health provider choice possibility was reduced.

Currently, the insured persons have the possibility to choose the family physician and the specialist, the public or private health unit in a contractual relationship with the health insurance house.

Insured persons can pay for medical services in private practices organised as businesses with a profit, who have no contract with the insurance house.

At present, there are no private health insurance organised. In practice, the major request is on university hospitals which have good equipment and have specialised personnel; there are waiting lists in these hospitals.

No information system regarding the number of patient in the waiting lists of the hospitals is organised. In order to get medical care from the university hospitals, the patients can address to these, based on the referral from the family physician or the specialty doctor. Most of the waiting lists concern the highly specialised investigation facilities in the university hospitals. Another problem in the rural area is the lack of pharmacies, the patients being forced to go to the nearest town to reach a pharmacy.

The insured persons can suggest the family physician the preferred health facility, but not the treatment. Also, they can require a certain specialty doctor or can inquire about what investigations and tests can help them and how these can be obtained. As a consequence of the new principles regarding the free choice of the physician and of the transforming the physician into a free practice profession, the relationship between both parties has changed; this relationship was improved, by bringing the two parties nearer, in order to establish the diagnosis and the treatment plan.

The distribution of family physicians is not homogeneous all over the country. They do not cover all areas, especially rural areas. The lowest number of physicians is in the south-eastern part of the country. In these areas the PHD have the obligation to insure the emergency medical care and weekly visits through delegate physicians, but in general the patients choose to go to towns, where they receive the medical assistance they need.

The infrastructure of the hospitals across the country differs a lot. In centres with university hospitals and clinics the facilities are by far better than in the rest of the country. Most sophisticated medical equipment, which has been acquired from external credits, have been installed in university centres, including Bucharest.

Women and men have equal access to medical services, no such discriminations are made. No restriction for either men or women regarding medical care has been observed.

5.1.6 Public acceptance of the system

The system's acceptance can be seen differently from the patient's, health care provider's and payer's point of view.

In order to test the patient's opinion**,** the Centre for Policies and Health Services has initiated a series of studies referring to the health status, as well as to the ways in which medical service respond to health needs. The survey has analysed the opinion of the citizens concerning the utilisation of medical services and the status of the health system

The question "When you have a health problem that is not serious, who do you call first?" received the following answers: 73% -the family physician, 8%-the pharmacy.

The question "When you have a serious health problem, who do you call first?" received the following answers: 33%-hospital, 40%-family physician.

The question "Do you feel you have easy access to your family physician?" was answered 77% yes and 4% no.

The question" What can you say, after the introduction of the social health insurance system?" received the following answers: "It is better now than before, in terms of health services" 20%, "it used to be better before in terms of medical services", 32%, " No difference", 34%.

The regulations concerning provision of medical services are published in the Official Gazette yearly. The insurance houses do not inform the insured persons directly about the package of services they are entitled to. The information is obtained from the media and from the physicians, providers of medical services.

Within the reform of the health system, once with the modification and multiplication of the decision actors**,** it has become essential for the providers of medical services and for the population to participate to the health reform.

From the physician's point of view, represented by the CPR, it can be considered that the system is accepted, since they are partners of the framework contract, which stipulates the medical care regulations. An important issue to be mentioned, however, is the physicians' disappointment due to the poor payment of their services.

From the financier's point of view, the social health insurance fund and MHF have difficulty to achieve the financial balance and the cost control measures. It is already clear that the amounts representing the social health insurance fund cannot cover the legal service package. Accepting the system

means, from the very first, the introducing of new cost monitoring mechanisms and expanding the expense coverage resources.

5.2 Evaluation of future challenges

5.2.1 Main challenges

The main health indicators in Romania, although improved in the last few years, show a precarious health state of the population, the average life span being of 70.53 years between 1998-2000 (67.03 years for men and 73.05 years for women), compared with and average of 69.76 years between 1989-1991 (66.59 years for men and 73.05 years for women), which situates among the lowest life spans in Europe countries. Contagious diseases are still quite largely spread, with an increased occurrence of tuberculosis (58.3 new cases per 100,000 inhabitants, compared to 101.2 in 1998). Infantile mortality stays at 18.6 deaths under one year of age per 1000 alive born babies in 2000, compared to 26.9 in 1989. The main mortality reasons in 2000 were coronary diseases (701.8 deaths per 100,000 inhabitants), tumours (184 deaths per 100,000 inhabitants), lung diseases (66.1 deaths per 100,000), accidents (64.2 deaths per 100,000 inhabitants) and digestive diseases (64 deaths per 100,000 inhabitants). Coronary diseases and cancer represent the cause of over 50% from the deaths of persons aged 0-64 and over 85% for persons aged 65 and more.

Health insurance system financing has still difficulties concerning the covering of the medical services for the population and also the efficiency of use of funds by the health care providers. At the same time, the harmonisation necessity with the EU requires new regulations, qualified personnel and new infrastructure.

Taking into account the precarious health state of the population, as well as the inefficiency of the use of funds, the Government strategy during 2001-2004 for the health system identified the following priorities for the health system performance improvement, for increasing the average life span and decreasing the general and infantile mortality:

a) improving and reorganising the hospital health care in obstetrics, gynaecology and new-born care. This goal is aimed at together with the rehabilitation program performed by the MHF, in co-operation with the Swiss Government.

The main points of the improving and reorganising the hospital care in obstetrics, gynaecology and new-born care regard the improvement of the population access to such services and increasing their quality, regionalizing specialty health care, providing social services in maternity hospitals and a better relationship with the social protection services, increasing the local public administration implication in the improvement of the health care

providing conditions, respecting the EU standards regarding the mother and new-born care.

For this purpose, MHF will evaluate and analyse the current situation of all obstetrics and gynaecology clinics and will take the necessary decisions from case to case. Also, MHF will evaluate the necessary effective costs and will include these amounts in the state budget project for 2003 and 2004. The implementation of the improving and reorganising the hospital specialty health care in obstetrics, gynaecology and new-born care program will take place in four stages until the end of 2004. MHF will constitute a national committee, which will evaluate, register and re-evaluate the obstetrics, gynaecology and new-born care hospital units and will implement a monitoring system of the health care activities and quality.

b) hospital reform aims at the participation in an integrated system of both primary and ambulatory speciality health care, in order to ensure an improved health state of the population. In this context, the main objectives are: improving the cost-efficiency relationship, through the optimum use of the resources; improving the access to the medical care offered by hospitals and modifying the structure of the hospital services (in hospitals and ambulatory), so that the necessary speciality health care is provided and the care quality corresponds to the patients' requirements. The necessary measures, at central or local level, include the defining of the organisation and functioning of the public hospitals as non-profit health units providing speciality services, and also evaluating the hospitals' performance through efficiency indicators: average hospital stay, bed coverage rate, number of patients depending on the hospital diagnosed morbidity, number of medical emergency, number of re-inpatients, number of transfers etc. At a hospital level, the main actions include the improvement of the hospital management, of its structure (buildings, equipment), the efficient use of the human resources and elaborating and implementing a monitoring system of the care quality.

c) the participation of the private sector in the health system performance improvement

The estimated benefits of the private sector implementation for the health system are:

- increasing the health care financing, through the additional contribution from the private system, which would also lead to the increasing of the health services quality; the possibility of providing additional options for the population and improving the health care access, especially for the cases where the public system is overloaded.
- the capital flow, which would ease the Government burden concerning the buildings' restoration and construction, as well as purchasing the high performance equipment; the budget amount would be significantly lower.

The World Bank estimations for the rehabilitation of 70,000 hospital beds is 1.5 USD for building rehabilitation and 1 billion USD for the equipment.

- increasing the efficiency through the implementation of the cost efficiency mechanisms, which function in the private sector will lead to the improving of the health care offer, a better cost control and a more efficient management.
- improving the health professionals image and the population satisfaction regarding the health care offer. By implementing the private services, where the prices are known by the population, the unofficial payments will be stopped and the physicians' income growth will be possible.
- The capital infusion would decrease the Government's task in what concerns the repairing and construction of buildings, as well as providing health units with high-tech equipment; the load on the budget would significantly decrease.

The increase of efficiency, the application of commercial cost efficiency principles that the private sector relies on, the improvement of the services package, with a cost control, in order to better respond to the general demand for medical services, and therefore, a more efficient management.

Also, another advantage is the transfer of risk, which varies from construction costs to unknown financial risks, related to the provision of clinical services which have no cost limit.

The forecasted results are expected after 3 years, while a significant number of private and public hospitals with private management will appear, which will determine to a small but stable extent a private social insurance market. It is estimated that after five years 15-20% of Romania's inhabitants will have a private health insurance and will get medical assistance in private health units.

The achievement of this challenge aims to fortify primary assistance in terms of equipment and in terms of increasing the insured persons' trust in the institution of the family physician, the main element that can improve the health state of the population, being closest to the patients.

5.2.2 Financial sustainability

The support of the health services package is a problem which has not been solved yet. Recent analyses of MHF, NHIH and government showed that the health care package in the social health insurance services system is too wide and can not be covered from the social health insurance fund. For this reason, it is planned that the health insurance system should cover a basic health care services and, at the same time, an additional health insurance, which could cover additional needs that are currently in the basic package.

Also, the local authorities should bear some expenses concerning the maintenance and repairing of the public domain buildings.

Starting from 2001, the budget is designed for 5 years and it identifies the main influences for the next years.

The major sources of financing of the system are the health insurance contributions and the state budget. Their growth depends on the privatisation of the industry and development of the economy. For the next years, it is assessed that the sources of health financing will remain approximately constant, which means that the system can still be financed through insurance contributions.

From the analysis of the number of insured persons per structure, it can be observed that the number of employees has decreased and the number of retired and unemployed persons has increased, which can mean a decrease in the funds collected for medical assistance, if the economy does not develop.

Until now, no supplementary measures were established to cover the cost of medical services.

An alternative for the future is the development of private hospital medical services and of the private insurance system, to cover a part of the insured persons, with higher incomes. For this purpose, the Government has approved The Strategy for Privatisation of the Health System this year, which defines the steps to be taken to approach privatising some medical services.

Since 2001, hospitals have entered an extensive assessment of efficiency, equipment and human resources, in order for them to be privatised.

The participation strategy of the private sector proposes the development of different models like the development of private hospitals, taking public hospitals into the private domain of the state and selling/renting them to the private sector, patients in public hospitals, can have private health insurances or can directly pay the cost of medical services, with the implication of supplementary payments, the development of private health units on the already existing area of a public hospital, management contracts with the private sector for providing services in the public sector.

These measures require identified legal modifications and adaptations. Presently, these regulations are being elaborated by Romanian and foreign specialists within an especially organised department of the MHF.

5.2.3 Health care policy and EU adhesion

Romania has ratified the reviewed Social European Chart**,** and has submitted the ratification instrument on May 7th 1999, with the occasion of the

reunion of the Committee of Ministries of the European Council, for the celebration of 50 years from the creation of this organisation. This international judicial instrument has been activated on July 1st 1999.

Article 12, paragraph 2 of the reviewed Social European Chart stipulates that contracting parties are guaranteeing to maintain the security regime to a satisfactory level, at least equal to the one necessary for the ratification of the European Social Security Code.

Romania has requested technical assistance for the ratification of the European Social Security Code, this activity being included in the Activity Program for Development and Consolidation of the Democratic Stability of the European Council for the years 2000 and 2001.

As a follow-up of the activities deployed within the Activity Program for Development and Consolidation of the Democratic Stability of the European Council, reports were written about the conformity of the Romanian legislation in the field of social security, which revealed the fact that Romania meets the conditions for ratification of the European Social Security Code, for the parts referring to medical care (part II), disease services (part III), old age services (part V), family services (part VII) and maternity services (part VIII)

The norms of the Regulation of the 71/1408/CEE Council from June 14th 1971 are present in the debates of the involved ministries.

This year, regulations are being elaborated. These regulations regard the medical devices, drugs, human resources, public health and health promotion - as well as the evaluation of financing necessities for the realisation of these objectives. Seminaries, courses and meetings are scheduled for the realisation of the provisions of the new regulations. The budget project of the year 2002, 2003 and the next 3 years contains budget provisions for the realisation of the stepped increase of the staff and necessary equipment, especially computers.

The EU adhesion will have a positive impact on the health care of Romania; we expect improvements in more areas such as quality, competition, transparency and efficiency . At the same time, brain drain might occur (physicians, nurses, computers specialists etc.). Already a number of nurses left to work in Italy and Germany. Some patients may require medical services in EU countries, especially if the Romanian services will be poor in quality and technology.

5.3 Evaluation of recent and planned reforms

5.3.1 Recent reforms and their objectives

The reform in primary health care started in 1994 and had the purpose to introduce family physicians and free practice, replacing the salary-paid physicians from dispensaries, incentive payments for the services, the free choice of physician and medical facilities, the cost containment by financial mechanisms. The objectives have been achieved and the system has worked between 1994-1998, when the new law was approved. All results were used immediately in 1998 for the entire country, as the experiments made a good base for a new system.

On July 7th 2000 the Loan Convention for Health Reform Financing between Romania and BIRD, in value of 40 million USD has been approved. This project supports the MHF program concerning the morbidity and premature death reduction, ensures equal access to the health care and improves efficiency in the health care field.
The project's objectives are:

- improving capacity in the planning, regulating, financing and management policy in the health field;
- improving the quality, the analysis based on the cost-results relationship and the technical efficiency of the primary health care, the main hospital, ambulatory and emergency services, especially in the poor and isolated areas; and
- modernising the public health care services concerning the tobacco consumption consequences, prevention of tuberculosis, prevention of HIV/AIDS, prevention of sexually transmitted illnesses and mental health care in the community.

With the planning and regulation of the health care providing system it is aimed to develop plans concerning the health care in all districts, to improve and build up the institutional capacity of the MHF concerning the health care planning and regulation. Regarding the essential health care services modernisation, it is planned to renovate the surgery rooms and intensive care units of the 24 district hospitals and clinics.

Developing the primary health care aims the national policy development for the vocational education, improving the equipment of dispensaries in isolated and poor areas, accreditation/certification and continuing medical education, developing and implementing at a local level the guidelines based on the statistical data for specialty diagnosis.

The project is going to provide equipment and technical assistance for the teams performing the emergency care at community level.

In the public health, disease control and information campaigns field it is aimed to improve MHF capacity to develop strategies regarding public health, improving the public health infrastructure and implementing the mortality and morbidity codes according to international standards. Also, performing the interventions in the public health field for priority areas, including measures for reducing tobacco consumption, developing a modern strategy of TBC control, informing the public opinion about HIV/AIDS and BTS, education and screening programs of diagnosis, establishing a demonstration for the mental health services at a community level and providing the technical support for the public health campaign.

The financing of the hospitals constitutes a very important issue within the reform of the health system. Since 2001, the national financing program based on DRG has started. In 2001 the 23 hospitals to enter the project were established, codifications were made, and the case-mix indicator was set for the respective hospitals.

In 2002, these hospitals contracted services according to the new methodology. The system has advantages related to the decrease of the hospital stay and increase of efficiency of the allocated sums. The new system's difficulties of application are related to the great variety of hospital structures and far more complex administration.

The first results of the new financing system - the identification of efficient and non-efficient hospitals - have favoured taking measures to extend the DRG to other acute hospitals for 2003 (about 100).

In order to improve the health status of the populations, MHF gets involved in the development, organisation and financing of the national health programs concerning the mother and child health care and the prevention of the chronically and contagious diseases, which have a major impact on the general mortality and morbidity. For 2003 there have been 3 health programs developed:

- The public health community program, regarding the prevention and monitoring the main risk factors for the population's health; the prevention, monitoring and the epidemiological control of the contagious diseases (TBC, HIV/AIDS, BTS). On a short term basis, the program intents to improve the contagious diseases monitoring and the epidemical focal points, including the unprivileged communities, to extend the immunisation programs by including new inoculations and health promoting measures.
- The non-contagious diseases prevention and monitoring program aims to better know the decisive factors of the non-contagious diseases, precocious diagnosing and monitoring of these diseases. The objectives of these programs are avoiding premature deaths through CV diseases, precocious diagnosis in malignant tumours, precocious diagnosis and monitoring of the diabetes patients.

- The child and family health program aims the decrease of the infantile mortality and morbidity, by dealing with the main health problems of mother and child, as well as by the family planning services.
- Health administration and health policies program aims mainly the improvement of the computer and information system of the health field.

In order to improve the health insurance system efficiency, there have been analyses run during 2002, in order to bring together all the contributions of the social, pension, unemployment, accidents and health insurances.

The unification of the funds collection through a specialised structure, subordinated to the Ministry of Labour and Social Solidarity has not been accepted by the MHF, because there is a risk of a decrease in the health care funds, a risk of losing the autonomy of the health insurance system and of the quality of medical services.

5.3.2 Political directions of future reforms

The governmental program in the field of population health starts from the fact that health care should be a collective social good, accessible to all Romanian citizens, regardless of their capacity to pay. The Decision of Parliament in December 2000 has stressed the continuation of the reform, taking into consideration the discrepancy between the health care needs of the population and the structures and utilisation of health services, the excessively large number of health units types, some being over-exploited while others are inefficient, and the excessive orientation towards hospital services, and insufficient to the ambulatory.

Consequently, measures are planned to be taken in the next period, of which the most important are attracting physicians and nurses in isolated or isolated areas, by providing some facilities, payment of primary care and specialised ambulatory care physicians, according to the work provided, efficiency and quality and re-structuring the hospitals through the reduction of the number of underused and inefficient beds.
Other planned objectives for the next years are the selling and concession of medical practices, organising medical centres of excellence.

The reforms within medical facilities and payments of medical services aim to increase the efficiency of the health insurances fund and of the existing base. On the other hand, the improvement of the payment in the rural areas aims to provide equitable services in the rural areas for all insured persons, through the direct involvement of the local authorities. The providers of medical services prefer these payments to be as large as possible, in order to improve, and to acquire extra medical equipment.

The unification of the funds collection through a specialised structure, subordinated to the Ministry of Labour and Social Solidarity has not been accepted by the MHF, because there is a risk of a decrease in the health care funds, a risk of losing the autonomy of the health insurance system and of the quality of medical services. A consensus has not been achieved for all these reforms yet.

However, the political factors agreed with the idea of granting a basic health care package for all the insured persons, completed by an optional package of health services covered through additional insurance. Also, developing the health care private system, covered by private insurance, which could complete the health services offer for the population, has been accepted. This option is the object of a modification in the social health insurance law, which is currently debated in the Parliament.

5.3.3 Conclusions

The health care policy is oriented towards prevention, strengthening of primary care and the role of family physician as well as reducing the number of hospital beds. The steps taken are still quite slow, compared to the population's expectancies and the health care need.

Important steps in the Romanian reform are the primary health care reform, followed by the implementation of the health social insurance system. Efforts are currently being made in order to improve the performance of the hospital care services and the public health services. The first steps in the reform had been received very well by the physicians and the population, but, at the end of 1996, just before new elections, there were some hesitations. A few years after the implementation of the health social insurance system, there are still difficulties in applying the existing legislation for the MHF, for the health insurance funds, for the health care providers and certainly for the insured persons as well.

The district houses often encounter misinterpretations of the legal regulations, and in many cases the insured persons go to the MHF in order to obtain their rights as insured persons. Generally, the health insurance houses, as well as the NHIH try to subordinate their service providers. They require for example written information about the providers financial activity, and this outside of what is regulated in the legal framework, as well as information about the salary levels and other data that are not relevant to the role of a social insurance system and thus - put a heavy bureaucratic burden on the health providers. Contracts with providers are often concluded outside legal regulations.

The insured persons are not systematically informed about their rights and obligations by the insurance houses, except by the mass-media. They are not informed about the way in which the health insurance fund is used either.

As an alternative, it was considered to include the private sector's participation in the MHF's strategic objectives. The hope is that the private sector will benefit to an increase of finances in health care, which would than lead to an increase in the quality of the provided services, the possibility of providing alternative options for the population and to improve access to medical services especially for the poorest.

5.4 Annex to chapter five

Table no.5.1: Medical practices , the dispensaries , polyclinics and number of medical services

	1995	**1996**	**1997**	**1998**	**1999**	**2000**
Medical dispensaries	3956	3960	3970	3972	164	70
Practices of the family physicians					10580	11200
Polyclinics	522	518	507	478	303	90
Practices of specialists						4900
Number of medical services (consultations) - in thousands	101536,9	101089,5	95284,3	89603,6	85646,3	80488,5
Number of medical services (consultations / inhabitant	4,5	4,5	4,2	4,0	3,8	3.6
Number of medical treatment- in thousands	77611,2	74944,6	68516,4	62826,8	57542,4	34725.4
Number of medical treatment/ inhabitant	3,4	3,3	3,0	2,8	2,6	1.5

Source: Centre of Calculation and Health Statistics and from the NHIH.

Table 5.2: The indicators of hospitals between 1995 - 2000

	1995	1996	1997	1998	1999	2000
Hospitals, total, of which,	412	413	416	414	425	439
territorial hospitals	391	390	396	398	408	408
enterprise hospitals	21	23	20	16	17	31
Number of beds in hospitals	173311	170954	166411	164526	164156	166817
Number of beds to 1000 inhabitants	7,6	7,6	7,4	7,3	7,3	7,4
Number of the days utilisation of beds/year	283	284,7	287,4	285,5	276,9	275.5
Average length of stay	10,9	10,4	10,1	10	9,5	8.8
Number inpatients - in thousands	4664,8	4863,6	4718,2	4577,8	4653,4	5025
Number of day hospitalisation- in thousands	49772,8	49631,4	47496,9	45769,1	44214,1	44816.9

Number of day hospitalization/100 inhabitants	219,4	219,5	210,7	203,4	196,9	199.8

Source: The Centre of Calculation and Health Statistics

Table 5.3:.Medical health personnel in the public sector

	1995	1996	1997	1998	1999	2000
Physicians	40112	40919	40378	41310	42975	42371
Number of inhabitants/physician	565	552	558	545	523	529
Stomatologists	6045	5974	5299	533367	5261	4983
Number of inhabitants/stomatologist	3752	3784	4255	4193	4269	4502
Pharmacists	2646	2578	1680	1642	1598	1588
Number of inhabitants/pharmacist	8572	8769	13341	13705	14054	14128
Nurses	128460	128038	116712	117719	114027	111326
Number of inhabitants/nurse	177	177	193	191	197	202
Auxiliary personnel	68164	68672	59441	60584	57493	57344

Table 5.4: The expenditure for health care (sources)

million EURO

Years	TOTAL	STATE BUDGET	LOCAL BUDGET	SPECIAL FUND FOR PUBLIC HEALTH	HEALTH INSURANCE FUND
1995	745,0	496,1	153,4	95,5	
1996	758,7	512,1	157,0	89,6	
1997	849,8	544,8	163,3	141,7	
1998	1.107,4	318,9	6,9	46,2	735,4
1999	1.199,3	215,2	5,8	31,1	947,2
2000	1.468,8	185,4	4,8	38,3	1.240,4
%					
1995	100	67	21	13	

1996	100	67	21	12	
1997	100	64	19	17	
1998	100	29	1	4	66
1999	100	18	0	3	79
2000	100	13	0	3	84

Source: The Ministry of Public Finances

Table 5.5: The total health expenditures in GDP

Total health expenditures in GDP	1995	1996	1997	1998	1999	2000
%	3.2	2.9	2.8	3.2	3.9	4.1

Source: The Ministry of Public Finances

Table 5.6: The health insurance fund

million EURO

	1998	1999	2000	2001	2002
Incomes	852,2	1.124,8	1.422,2	1603.5	1.802,2
Expenditures	741,5	976,3	1.276,2	1437.8.	1.693,5
Reserve fund	0,0	49,3	61,5	21.6	22,5
Excess	110,7	99,2	84,5	144.0	86,1

Source: The Ministry of Public Finances

Table 5.7: The health insurance fund %

	1998	1999	2000	2001	2002
Incomes	100	100	100	100	100
Expenditures	87.0	86.8	89.7	89.7	94.0
Reserve fund		4.4	4.3	1.3	1.2
Excess	13.0	8.8	5.9	9,0	4.8

Source: The Ministry of Public Finances

Table 5.8: The medical services payments %

Medical services	1998	1999	2000	2001
Primary medical services	9,1	9,1	8,8	7,3
Specialised ambulatory assistance	5,8	6,2	7,5	6,8

Hospital services	52,7	63,9	65,5	57,1
Pre-hospital emergency services	3,9	3,6	3,0	2,9
Stomatology	2,5	2,5	1,4	1,3
Drugs	22,1	13,3	13,0	23,6

Source: The Ministry of Public Finances

Table 5.9: The expenditures for medical services and administration the fund %

	1998	1999	2000	2001
Administration the fund	0.9	3,0	3.0	2.2
Medical services	99.1	97,0	97.0	97.8
Total	100	100	100	100

Source: The Ministry of Public Finances

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