ESPN Thematic Report on Inequalities in access to healthcare

Romania

2018

[Author(s)]
May 2018

EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion
Directorate C — Social Affairs
Unit C.2 — Modernisation of social protection systems

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EUROPEAN COMMISSION

European Social Policy Network (ESPN)

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Romania

2018

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Directorate-General for Employment, Social Affairs and Inclusion
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Summary/Highlights

Overall, although Romania has achieved progress in improving its health system, poverty and social exclusion remain among the highest in the EU, with major inequalities in healthcare coverage, the vulnerable population being the most affected. Improving access to healthcare services for the rural population in general, and especially in poor and under-served communities, remains a challenge. The ongoing healthcare reforms in Romania have so far delivered very little. However, the latest health reform measures are promising. The latter include: (a) regional health service masterplans, aimed at shifting service delivery to outpatient settings and concentrating expensive inpatient care in the planned regional hospitals, alongside investment in preventive healthcare; (b) early detection of the most prevalent communicable and non-communicable diseases; (c) a significant salary increase for medical doctors; and (d) removal of mandatory health insurance contributions on pensions lower than EUR 430 (RON 2,000). Yet, an assessment of improvements in healthcare coverage and health outcomes will not be possible for some years, as implementation is either in an early stage or delayed. Despite the continuing reform process, the systemic challenges that contribute directly to inequalities in access to healthcare remain the same, as set out below.

Underfunded healthcare system. Total healthcare expenditure (purchasing power standard) per inhabitant in Romania in 2015 (EUR 816) was the lowest across the EU. Similarly, the share of GDP accounted for by healthcare spending remains low by EU standards – 4.9% in 2015, compared with the EU average of 9.9%. Despite the fact that there is a yearly increase in the public healthcare budget (in 2017 it increased by approximately 6% compared with the previous year), the healthcare system faces serious sustainability challenges: (a) recent fiscal measures, considered unsustainable by the vast majority of experts, affect short- and medium-term outcomes; and (b) the expected costs associated with population ageing, in health and long-term care, affect its sustainability in the long run.

High turnover of policy-makers and institutional instability. These lead to discontinuity in policy formulation/implementation and to low administrative and managerial capacity at all levels of the system. In addition, the decentralisation process has deepened the problem, as local authorities have no capacity for planning health services or organising and controlling healthcare providers. As a consequence, there is no evidence-based policy formulation process or a formal process of strategic planning and priority-setting in the health sector.

Severe shortages of medical staff, especially in poor and remote areas, and ***outdated*** infrastructure ***and health technologies***. The number of physicians is low compared with EU averages: 2.8 doctors per 1,000 population compared with 3.5 in the EU (2015), the regions with a higher percentage of people at risk of poverty or social exclusion having the lowest number of medical doctors (Figure 1 and Table 1 in Annex). Retention of physicians is one of the most pressing health policy issues that Romania has to address. In order to mitigate the effects of emigration and retain young doctors, working conditions and career prospects are as important as the recent significant increase in medical staff salaries.

Fragmentation and lack of continuity in service provision, ***a poor referral system*** and ***questionable effectiveness of primary healthcare services***. These are reflected in an increased burden on hospital medical services. Romania is facing challenges in supplying adequate levels of good-quality health services, especially in rural locations and for hard-to-reach/vulnerable population groups. There are no tools to measure and monitor the quality of care delivered by healthcare providers, beyond the standards for the accreditation of hospitals, which are instead used as management and administrative tools.

Informal payments. These are not visible in official statistics, but their share may be considerable. According to a 2017 study (European Commission/Ecorys, 2017), corruption in Romania occurs across all types of healthcare stakeholders.

1 Description of the functioning of the country's healthcare system for access

Design of the healthcare system. Healthcare (governed by the framework law L95/2006), is organised as a mandatory health insurance system. At national level, the Ministry of Health (MoH) is the central authority responsible for health policy formulation and planning, initiating legislation and controlling the entire sector, while the county level is in charge of organising and delivering services to the population. This structure is replicated in national and county-level health insurance houses, which allocate funds and monitor expenditure of the various levels and types of healthcare services.

Despite almost ten years of decentralisation and transfers of responsibility to the elected authorities of the 42 Romanian counties[1], the system remains highly centralised and dominated by the MoH and the National Health Insurance House (NHIH), which decide all rules and regulations related to healthcare delivery. However, the central authorities are in a weak position to soundly plan/coordinate the continuum of care and to align national plans to local needs. Both the MoH and NHIH have decentralised bodies in each county.

The national health insurance fund (managed by the NHIH) is the main funding source for the healthcare system – a third-party payer. Based on the provisions of a yearly framework contract (issued as a governmental decision), the county health insurance houses sign contract agreements with accredited healthcare providers from all levels of care in the respective county and reimburse them for the healthcare services delivered to the population.

Healthcare delivery. This comprises outpatient care (primary healthcare physicians – PHCs – trained as family doctors, ambulatory specialised services, and emergency pre-hospital services) and inpatient services (hospitals).

PHCs are independent/private providers, who receive a mix of per capita and fee-for-service payments (around 50% each). In 2016, there were 11,256 family doctors contracted by the county health insurance houses, 61% in urban settings and 39% in rural communities[2].

Outpatient specialised care is provided by private clinics (the former polyclinics, transformed into independent medical facilities where services are contracted on a fee-for-service basis) and by hospital outpatient facilities. Specialists working in outpatient clinics may therefore be either independent healthcare providers or employees of private clinics/public hospitals paid on a salaried basis. Most specialist physicians divide their time between the public sector (hospitals) and private sector (ambulatory practice). From the patient perspective, outpatient specialised services in the present set-up represent a financial burden, as the number of ambulatory services contracted by the health insurance system is low, and therefore the common practice is for out-of-pocket payments (OOPs) (the exception is hospital outpatient services, provided the patient has a referral from their family doctor).

Inpatient care is provided by an extensive network of hospitals, most of them public. The overuse of hospital services is attributed to the failure of the 'gate-keeping' role of family doctors, a lack of free-of-charge alternative services in outpatient settings, poor care coordination, and a lack of formal referral networks (MoH, 2016 – Regional Health Services Plans).

Other types of healthcare services, in particular healthcare for elderly people, rehabilitation, palliative and home-care services are severely underdeveloped.

[1] Governmental Ordinance 162/2008.

[2] NHIF, Summary of the healthcare delivery by type of provider, 2016, available at: http://www.cnas.ro//theme/cnas/js/ckeditor/filemanager/userfiles/Rap_sit/SINTEZA_2016.pdf.

Access to health promotion and disease prevention is uneven, being based on available funds. Recently, the MoH has taken action to improve screening and early detection of non-communicable and infectious diseases. This includes the introduction and roll-out, with EU funding, of screening programmes for cervical cancer, breast cancer, tuberculosis, and hepatitis B, C and D, as well as prenatal screenings.

Healthcare financing. Total annual spending on health in 2015 in Romania represented 4.9 % of GDP, half the EU average of 9.9 % of GDP (European Commission, 2018), with the lowest total healthcare expenditure (purchasing power standard) per inhabitant (EUR 816) across the EU. The healthcare system remains underfunded, although Romania has constantly increased public health expenditure. From 2000 to 2017, the national health insurance fund budget increased tenfold, the 2017 budget amounting to EUR 6.18 billion[3]. However, the combination of low funding and inefficient use of public resources limits health system effectiveness.

Public sources accounted for 78% of total healthcare financing in 2014, similar to the EU average. By type of financing, 64% was represented by compulsory health insurance, 16% came from the state budget (mainly for the national curative and preventive health programmes, and including EU funding), 20% was OOP expenditure and 1% other (mainly private/voluntary health insurance)[4].

Voluntary health insurance (VHI) is poorly regulated and underdeveloped, despite fiscal measures that increased tax deductibility for voluntary/private insurance. It is not possible to opt out from the mandatory health insurance system and to purchase substitute insurance. VHI schemes offer supplementary services (mainly access to better hospital accommodation, choice of provider and access to private healthcare providers) rather than complementary services (access to services that are excluded partially or totally from mandatory health insurance).

OOP payments are the second largest source of revenue for healthcare, and in 2015 reached 21% of expenditure for the first time[5], raising questions about the **affordability of care** in a country with the highest level of income inequality in the EU (the richest 20% of the population earning seven times more than the poorest 20%) and with persistent income inequality between rural and urban areas.

OOP payments are represented by: (a) for insured persons, co-payments for pharmaceuticals and for services such as rehabilitation and balneary care; for better accommodation in hospital and at hospital discharge (a co-payment of EUR 2.50); direct payments for goods or services not covered by mandatory health insurance or by national health programmes; and services provided on request (without referral from a family doctor); (b) for uninsured persons, direct payments for diagnosis, treatment and care, with the exception of emergencies, by the services included in the minimum package or those covered by national health programmes; (c) direct payments in the private sector; and (d) informal payments.

Providers of both social and medical residential services are mainly funded from OOP payments, beyond some funds received from the local authorities, from the state budget and from the mandatory health insurance. The level of OOP payments charged to residents is set by local authorities that own these units for health and social services; the local authorities may also pay the monthly fees for these residential services on behalf of the residents without pension or revenue.

Informal payments are not visible in official statistics, but their share may be considerable. Romania ranks high in terms of perceived levels of healthcare corruption;

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[3] Calculation using national health insurance fund data, available at: http://www.cnas.ro//theme/cnas/js/ckeditor/filemanager/userfiles/FNUASS_ANUAL/Evolutia_FNUASS_1999-2017.pdf (exchange rate 1 EUR = 4.65 RON).

[4] OECD/European Union, 2016.

[5] Vlădescu et al., 2016.

according to a 2017 survey[6], corruption in Romania occurs across all types of healthcare stakeholders, from the widespread practice of informal payments for buying access to (better) medical treatment or false medical certificates providing entitlement to social benefits (such as invalidity/disability benefits), to the procurement of medical goods and services.

Resource allocation in the system consistently favours hospital expenditure and reimbursable drug expenditure over ambulatory care (PHCs, ambulatory specialised care, para-clinical investigations). In 2016 hospitals' share of total national health insurance fund expenditure was 44.22%, and pharmaceutical and medical devices accounted for 39.77%, while only 13.24% of the budget was directed towards providers of ambulatory healthcare services. This left less than 3% for pre-hospital/outpatient services and in-home care services (National Health Insurance House, 2016).

Healthcare coverage and the basket of healthcare services. Health coverage is de facto not universal, despite being a constitutional right (European Commission, 2018). Access to healthcare is especially poor in rural areas due to a shortage of infrastructure and PHCs, and is worsened by significant gaps in the coverage of health insurance. Although many categories of people are exempt from the payment of health insurance contributions (including children and persons with disabilities), the percentage of the population covered by health insurance is decreasing each year (77.02% in 2016, 77.29% in 2015, 86.1% in 2014, according to the NHIH annual report for 2016). However, these figures should be interpreted with caution, as at least 3 million Romanians are working abroad and may be still counted as being in Romania (the Romanian population has decreased to 19.6 million people). The uninsured consist of people without a formal income or without identity cards, including: (a) rural people working in small-scale agriculture; (b) people working informally in the private sector (such as in construction); (c) unemployed people who are not registered for unemployment or social security benefits; and (d) Roma or street people without identity cards. The uninsured can access limited healthcare services covered by mandatory health insurance (the minimum benefit package) or by national public health programmes funded from the state budget. Services covered include emergency care, pregnancy care, and treatment of communicable diseases.

Significant urban-rural differences in coverage persist, and the percentage of the rural population who are insured decreased to 65.64% in 2016 (compared with 66.29% in 2015 and 75.82% in 2014)[7]. The rural-urban gap in healthcare coverage is also shown in the uneven distribution of PHCs. In the three years to 2016, the mandatory health insurance system in Romania lost 732 PHCs, according to official national health insurance fund data. The urban-rural disparity was severe: there was a loss of 53 family doctors across rural areas in 2016 alone – apparently 14 of them moved to urban settings, while 39 left the system[8]. Ambulatory specialised care is almost non-existent in rural settings; apart from the shortage of specialists countrywide due to emigration, the providers of outpatient specialised services are concentrated in cities.

In the outpatient care system, the insured population has access to a comprehensive *'basic package' of medical services*, while the non-insured population has access to a 'minimum package' of health services that includes some preventive services, diagnosis and prevention of communicable diseases, and emergencies. For these services, the uninsured are registered with family doctors on a separate list, services included in the minimum package being reimbursed by the health insurance system. The uninsured are not entitled to outpatient para-clinical investigations or to medicines recommended/prescribed by a family doctor. Apart from care related to emergencies, pregnancies, and certain infectious diseases, the uninsured are obliged to pay for their

[6] European Commission/Ecorys, 2017.

[7] National Health Insurance House, 2017 (p.124).

[8] Calculations based on NHIH data (National Health Insurance House, 2017).

own medical care[9]. In 2016, according to national health insurance data, around 3.46 million uninsured people benefited from primary healthcare services delivered through the basic package of medical services.

The current payment system for primary care doctors encourages them to maximise the number of registered patients (insured and uninsured), but does not encourage them to provide a full package of primary and preventive care services. The payment system also does not penalise referrals to hospital specialists or high-cost pharmaceutical prescriptions. As a result, primary care providers are contributing to the excessive use of hospitals and over-prescription of pharmaceuticals *(*MoH, 2016, Regional Services Plans*).*

Inpatient care for the uninsured population covers diagnoses, medical investigations, treatment and care for life-threatening emergencies and for diseases included in the national health programmes funded from the state budget through the MoH (such as oncology, diabetes, and cardio-vascular diseases).

Availability of healthcare services. A shortage of medical doctors and an uneven distribution of healthcare professionals obstruct access to healthcare, people living in rural and poor areas being more affected than others. Romania has a low ratio of practising physicians (277 per 100,000 population in 2015), below the EU average. The low coverage of medical staff is mostly due to emigration to other EU Member States, by health professionals looking for a higher income and better working conditions.

There are also large variations across different (types of) health facilities and across geographical regions (another important cause being poor infrastructure and outdated health technologies); therefore, the distribution of healthcare services does not reflect the population’s health needs.

Accessibility is also more limited for the rural population due to the system that encourages the over-usage of hospital services compared with primary healthcare and outpatient services (as almost 90% of public hospitals are located in urban areas and transport costs can be high). The same applies to ambulatory specialised care: access is worse in rural areas than in urban areas (Vlãdescu et al., 2016).

For people living in rural areas, the healthcare services available are those provided by family doctors (PHCs): but there are villages without any provider (500 villages, as reported in 2017 by the National Society for Family Medicine[10]).

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The performance of the healthcare system remains poor. The Euro Health Consumer Index (EHCI), although controversial (Cylus et al., 2016), may still provide a way of measuring and ranking the performance of healthcare provision from a consumer viewpoint. The index published for 2016 ranks Romania the last across Europe: in 35th place, with 497 points. According to the EHCI 2016 report, Romania has severe problems with the management of its entire public sector. In healthcare, discrimination against minority groups such as Roma (around 3% of the population) is reflected in poor outcomes ratios. Romania is also suffering from an antiquated healthcare structure, with a high and costly ratio of inpatient to outpatient care (Björnberg, 2017, p.20).

Most recent studies and reports analysing the Romanian healthcare system consider its performance to be poor: the capacity of the system to respond to patients’ needs is low; there are significant inequities in access from all perspectives (rural/urban, regions and counties, age groups, vulnerable groups); there is low financial protection and service

[9] Except the diseases covered by the national ‘curative’ programmes funded from the state budget.

[10] Figures may vary depending on stakeholder and stakeholder interest (the MoH counted around 300 villages without a family doctor in 2016).

coverage; and there is questionable financial efficiency and sustainability. In addition, there is political instability, weak managerial capacity at all decision-making levels, and a general shortage of reliable data.

The MoH's vision to shift the healthcare services from inpatient care to outpatient care remains a challenge at the mid-point in implementing the national health strategy for 2014-2020. Reforms aimed at shifting services from inpatient care to outpatient and primary healthcare are slow to take effect. There has been a gradual decrease in the number of hospital beds, yet the system remains hospital-centred, with underdeveloped outpatient healthcare services, resulting in outdated and ineffective care. The continuity and integration of care (primary, ambulatory, and hospital) is not sufficiently developed. Nonetheless, there is currently some progress in shifting from inpatient care to outpatient specialised care, as the number of services contracted and reimbursed by the health insurance system in outpatient specialised care in 2016 increased by around 1.25 million compared with the previous year, while the number of inpatient cases decreased in 2016 compared with 2015 by around 181,000 cases, and more than 400,000 patients were treated in hospitals on a day care basis[11].

Healthcare access inequalities affect in particular rural settings and various socioeconomic groups. According to national data, health insurance coverage in rural settings is decreasing each year (as detailed and documented in the previous chapter). The low health insurance coverage in rural areas is strongly related to both poverty and the general characteristics of Romanian villages (rural communities), where a large share of the working-age population is unemployed and does not contribute to the health insurance fund. Thus, these specific socioeconomic groups (a large share of rural unemployed population, self-employed workers in agriculture, rural Roma population, casual and seasonal workers) are not covered by health insurance (up to 23% of the population – see chapter 1 above, under 'Healthcare coverage and the basket of healthcare services'). Lacking health insurance, they seek healthcare only at a late stage of ill-health (compounding the effects of poverty, poor housing and nutrition, unhealthy behaviours and low education), therefore contributing to the high burden of preventable and amenable deaths in Romania. Romania's population is exposed to poor health outcomes, with the highest share (47.6%) in 2014 of amenable deaths in the population aged under 75 in the European Union[12]. Cardiovascular diseases (in women) and cancer (men) represent the major causes of death. 66% of women and 52% of men died from cardiovascular diseases in 2014; lung cancer remains the most common cause of cancer mortality, while mortality from colorectal cancer has increased since 2000, by more than 30% (Eurostat). Preventable mortality is also high, particularly for alcohol-related causes of death. Major behavioural risk factors in Romania are smoking and binge drinking[13], in particular among men. In 2015, avoidable deaths in Romania were 2.5 higher than the EU28 average (Table 2 in Annex).

Another dimension of the rural/urban healthcare coverage gap is shown by the uneven distribution of PHCs. The significant increase in salaries for physicians working in the public sector (from March 2018) does not apply to family doctors, who are independent/private providers. Thus, the government should take immediate action to incentivise family doctors in rural settings, especially in the poorest and most remote communities. The measures promised for 2018 for primary healthcare providers (including reduced administrative burdens for family doctors, use of eHealth solutions, pilot projects to test pay-per-performance indicators) should be accompanied by financial benefits related to working conditions and other retention incentives. Diversification of primary healthcare delivery might be another option, even if strongly rejected by family

[11] Calculations based on NHIH data (National Health Insurance House, 2017).

[12] Eurostat new release, 14 June 2017, available at: http://ec.europa.eu/eurostat/web/products-eurostat-news/-/DDN-20170614-1?inheritRedirect=true&redirect=%2Feurostat%2F.

[13] Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

doctors, involving allowing local authorities to hire PHCs and to contract their services within the health insurance system).

The most commonly used subjective indicator – i.e. unmet needs for medical examination - proves that Romania is still facing **inadequate access to healthcare services for the poor and elderly,** despite some slight but consistent improvements over recent years. Unmet need due to the high costs of healthcare decreased in the last (available) year in Romania, from 8.3% (2015) to 5.3% (2016), although it remained more than three times higher than the EU28 average (1.6% in 2016). For people in the first (lowest) income quintile, unmet needs due to cost, geographical barriers or waiting lists decreased only modestly (from 12.2% in 2015 to 11.2% in 2016) and were still double the EU28 average (Table 3 in Annex).

A significant decrease in unmet need occurred in 2016 among the population aged 65 years and over, from 25% in 2015 to 15.2% in 2016; yet Romania remains one of the three EU countries with the highest figure in this area, after Estonia and Greece (Eurostat). Reform measures recently introduced (2017-2018) are targeted at increasing access for older people to appropriate healthcare services, but their effects may only be assessed in the coming years. The measures include: (a) income taxes removed for pensions below EUR 2,000 (RON 2,000); (b) 40% of the price of specific drugs to be covered by the state budget, in addition to the 50% reimbursed by the health insurance system, for those on pensions lower than RON 900; and (c) increased health insurance budgets for palliative and homecare services.

Children's access to health services is uneven. Among vulnerable groups are children from low-density rural areas, children living in poverty, Roma children, and children with disabilities or chronic diseases. Those most affected by uneven access to healthcare services are children under 5 years and teenagers, who are barely covered by either preventive care or screening/routine consultations. Emergency services and pharmacies are also unevenly distributed, increasing the probability of accidental deaths and increasing healthcare costs for chronically sick children. Rural areas have a barely adequate coverage of permanent medical care, emergency services and pharmacies. Access has not improved during the last two years, despite the growing emphasis placed on this area. In fact, the health situation of children coming from vulnerable families deteriorated. The proportion of vaccinations has decreased dramatically over recent years (Figure 2 in Annex), due to both social media (agressive 'anti-vaccination' campaigns) and the MoH incapacity to assure sufficient vaccines.**Roma people face multiple disadvantages**. Compared with the rest of the population, Roma are confronted with higher inequality of opportunity and higher poverty rates, low employment, poor educational attainment, low health coverage and adverse housing conditions (European Commission, 2018). Roma, mostly those from poor rural areas, have much poorer access to primary healthcare than the overall average. About two fifths (42%) of Romanian Roma do not seek healthcare when they actually need it (compared with 25% of their non-Roma neighbours), due to financial constraints, lack of insurance, or the costs of drugs/medication (World Bank, 2014). Poverty is therefore the most commonly reported reason for not consulting a doctor when needed − consultation would be 'too expensive' (84% of households that had foregone medical care when they needed it), with 'not having insurance' being the next most frequently cited reason (approximately 5% of households). A lack of identity documents for registration, coupled with a reluctance to visit healthcare facilities due to practitioners' attitudes and uncertainty about the cost of treatment are also major concerns among Roma (World Bank, 2014). In recent years, local and national interventions have been aimed at increasing Roma healthcare coverage, with significant EU funding. Integrated health and social services delivered at community level might be a solution for under-served communities (but this is still in its infancy). Several piloted models are considered to have been successful and are ready to be rolled out as cost-effective interventions (projects funded by UNICEF, Norway/EEA grants, and the European Social Investment Fund). Community nurses may provide basic care when needed, but mostly health promotion and education, whilst Roma health mediators may serve as facilitators

between Roma communities and healthcare providers. A law regulating the status of community nurses was passed in 2017 and the government is trying again to promote a comprehensive network of Roma health mediators. But both of these initiatives are still in their infancy.

The healthcare system faces serious sustainability challenges: (a) from a short- and medium-term perspective, there are the recent fiscal measures, considered unsustainable by the vast majority of experts; and (b) from a medium- and long-term perspective, the expected costs of healthcare and long-term care related to population ageing are of special concern. Apart from population ageing, Romania is facing major demographic changes, including a low birth rate and high emigration. Over the last fifteen years, the population has decreased by around 9%, and the median age has increased by 6.4 years (up to 41.4 years in 2016), compared with an increase of 4 years in the EU28 for the same period (Eurostat). Population ageing is likely to contribute to increased pressures on health spending in Romania, which remains at low levels. Romania needs to: invest more funds in preventive services; ensure coherence between curative services and the prevention, early detection and treatment of chronic diseases; and review its pharmaceutical policies. There is also a great need for better coordination in the provision of services for elderly people in Romania between the Ministry of Public Health, Ministry of Labour and Social Justice and local authorities.

Important health reform measures have been adopted during 2017-2018, yet a long-term strategic vision embedding all these measures is somehow missing. Some of the reform measures are as follows: (a) increasing healthcare financing, along with improvements in resource allocation, transparency and centralised procurement practices, and implementing mechanisms of financial accountability for healthcare providers; (b) reducing emigration by medical staff in the public sector through a significant increase in their salaries; (c) developing/implementing regional healthcare plans and slightly changing the paradigm of care, with a focus on outpatient care; (d) increasing social inclusion and access to care and treatment for the ageing population, through fiscal measures and increase of the number of compensated medicines; (e) better regulation of the pharmaceutical sector, continuous development of health technology assessment, a dynamic approach to innovative medicines, and legal measures aimed at ending the parallel export of drugs; (f) investment in ambulatory services, community services, prevention, screening programmes for non-communicable and communicable diseases, with the help of European funds; (g) considering tuberculosis (TB) prevention and control as a government priority, making new drugs available for TB and MDR/TB (multi-drug-resistant TB) patients and securing substantial funding for TB screening and for the national TB control programme; and (h) investments in infrastructure and new medical technologies using World Bank loans – radiotherapy units, emergency services (including emergency telemedicine systems) and outpatient diagnostic services (medical imaging).

Conclusions. Overall, although Romania has achieved some progress in improving its health system, poverty and social exclusion remain among the highest in the EU, with major inequalities in regard to healthcare coverage, with the vulnerable population (including children) being the most affected. Improving access to healthcare services for the rural population in general, and especially in poor and under-served communities, remains a challenge. The ongoing healthcare reforms in Romania have so far delivered very little. Despite the reform measures described above, some of them taken in an ad hoc manner, the systemic challenges remain as: (a) underfunding and unpredictability of resource allocation for some types of healthcare services (such as care for the elderly, in-home care, and preventive care); (b) high turnover of policy-makers and institutional instability (accompanied by low administrative capacity and weak planning and management capacities at all levels of the system, leading to a lack of strategic planning and evidence-based policy-making within the health sector); (c) severe shortages of medical staff and outdated infrastructure and health technologies; (d) a high degree of fragmentation in service provision (due to a poor referral system and an ineffective primary healthcare system); and (e) the low quality of health services, especially in rural

and poor communities. The lack of measuring and monitoring tools, along with the lack of systematic data regarding service provision and the quality of health services, aggravates the current issues faced by the health system even more. Most of the available quality standards serve accreditation purposes and are mostly used as administrative or, at best, as management tools.

Inequalities of access are also reflected in substantial levels of informal payments, with a higher burden on the most vulnerable segments of population. Perceptions of a high level of corruption in the health sector contribute further to the increase in informal payments.

Possible policy options[14]

The health sector would benefit from certain measures as follows.

1. Increasing and consolidating managerial and technical capacity (planning and monitoring) at all administrative levels − in particular at the county level, or at the local level, where these take over healthcare responsibilities. Promoting dialogue and broad participation in the planning process related to health services, in a dynamic and adaptive manner − such as addressing the ongoing changes in healthcare needs − could prove beneficial in reducing regional and urban/rural discrepancies.

2. Strengthening health services delivery in rural remote areas, by rethinking models of healthcare for hard-to-reach and vulnerable population groups, and thereby addressing the gaps in health services coordination and integration. Assuring the sustainability of prevention/screening projects funded through the European Social Investment Fund, and embedding them in the national public health programmes, becomes crucial.

3. Developing quality- and outcome-based payment mechanisms in outpatient care, in particular for family doctors, alongside financial and non-financial incentives for those practising in rural, poor and remote communities.

3 Discussion of the measurement of inequalities in access to healthcare in the country

Statistical data on health are almost impossible to obtain from national sources, except for those from the National Institute for Statistics. Demographic and healthcare resources data, including from the National Institute for Statistics, are available through the TEMPO-online database (http://statistici.insse.ro/shop/). Some of these indicators are available at the European level (Eurostat).

The MoH and its local agencies, despite the fact that they incorporate statistical data departments, do not provide any public data on health indicators or healthcare services (availability, quality or outcomes). However, some detailed data regarding healthcare coverage and accessibility of care are available in NHIH annual reports. The latter reports are most useful – along with some regional/county level data on basic health service indicators provided by the National Institute for Statistics – for assessing inequalities in access to healthcare in Romania.

Currently in Romania there is a high degree of fragmentation and duplication in data collection, with different parallel systems managed by the MoH, the NHIH and the National Institute of Statistics. However, in Romania the health/healthcare data collected are neither systematically analysed nor disseminated, and nor are they used in planning and decision-making.

[14] Based on World Health Organization recommendations (World Health Organization, 2017).

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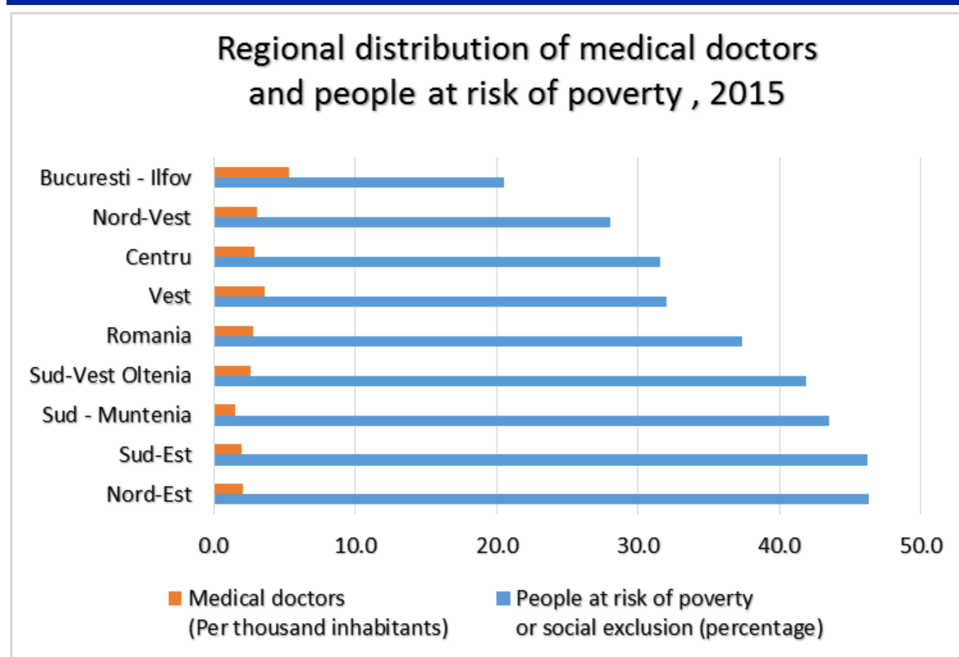
Annex

Figure 1: Regional distribution of medical doctors and people at risk of poverty, 2015



Source: Eurostat data, 2018.

Table 1: Regional distribution of healthcare personnel and people at risk of poverty, 2015

Region	People at risk of poverty or social exclusion (percentage)	Medical doctors (per thousand inhabitants)	Nurses and midwives (per thousand inhabitants)
Nord-Est	46.3	2.1	6.31
Sud-Est	46.2	2.0	5.97
Sud - Muntenia	43.5	1.5	5.18
Sud-Vest Oltenia	41.9	2.6	6.90
Romania	**37.4**	**2.8**	**6.58**
Vest	32.0	3.6	6.84
Centru	31.6	2.8	6.54
Nord-Vest	28.0	3.0	6.77
Bucuresti - Ilfov	20.5	5.3	8.82

Source: Eurostat data, last update May 2018.

Table 2: Amenable and preventable death rates, Romania, 2015 (per 100,000 inhabitants)

	Amenable death rate			Preventable death rate		
	Total	Women	Men	Total	Women	Men
Romania	318	233	420	363	215	536
EU28 average	127	98	160	216	143	299

Source: Eurostat, last update May 2018.

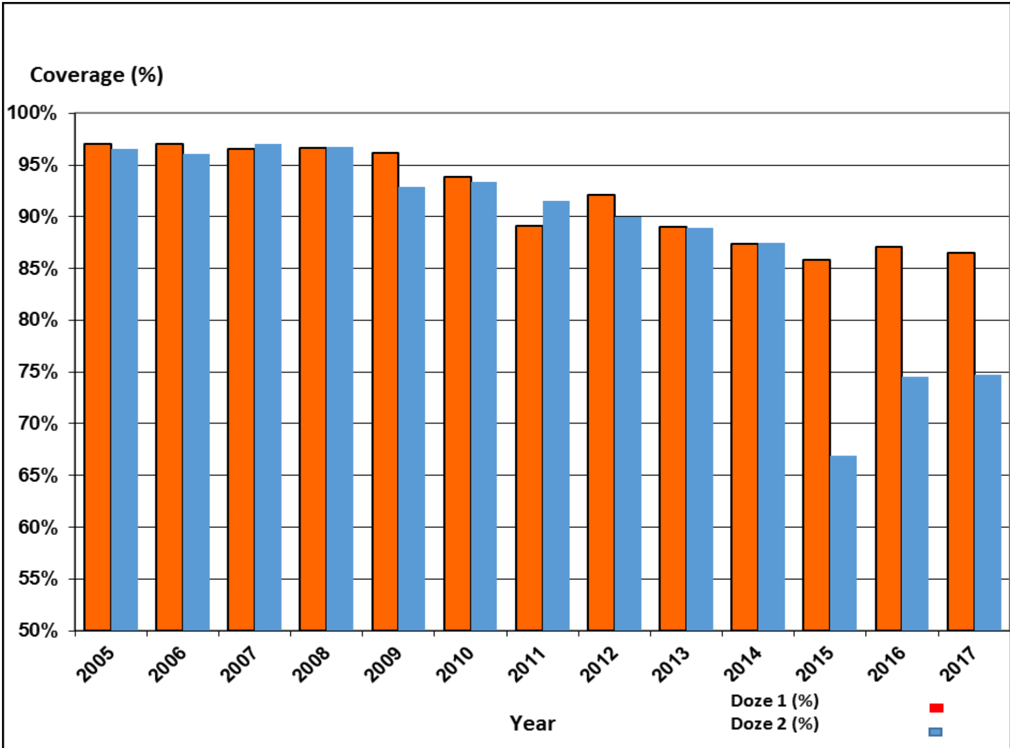
Table 3: Self-reported unmet needs for medical examination by sex, age, main reason declared and income quintile, 2016 (Romania and EU28)

Self-reported unmet need (%)	Category	Romania	EU28
Too expensive or too far to travel or waiting list	Total population[15]	6.5	2.5
	65 years or over	15.2	3.3
	Females	8.0	2.9
	First quintile	11.2	5.0
Too expensive	Total population	5.3	1.6
	65 years or over	11.4	2.0
	Females	6.6	1.9
	First quintile	9.9	3.9
Too far to travel	Total population	0.6	0.1
	65 years or over	2.2	0.3
	Females	0.7	0.1
	First quintile	0.5	0.2
Waiting list	Total population	0.7	0.8
	65 years or over	1.6	1.0
	Females	0.7	0.9
	First quintile	0.7	0.9

Source: Eurostat (hlth_silc_08), last update March 2018.

[15] Total population is considered to be population 16 years and over.

Figure 2: Immunization coverage, Romania, 2005-2017, ROR[16] vaccine



Source: National Centre for Surveillance and Control of Communicable Diseases/National Institute of Public Health, Romania, 2018.

[16] Measles/mumps/rubella.