



Quality in and Equality of Access to Healthcare Services



Country Report for Romania *March 2008*

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1 Introduction

1.1 Country Profile

Romania is an East European country with a 238,391 sq. km (12th largest in Europe) area and 3,190.3 km border. According to the January 1992 census Romania have 22,788,993 inhabitants with a *density around* 95.7 inhabitants per sq. km.

Talking about the recent history of the health care system we underline that there were four decades, from 1949 to 1989 with a Semashko health care system. In 1989 began a big reform with a very important moment in 1995 when the very centralized and tax-based health care system had transformed into a decentralized and pluralistic social health insurance system, with contractual relationship between the health care providers and the insurance houses.

The system is insurance-based with mandatory membership, linked to employment, and contributions are a percentage of income, 6% - starting 01.01.2007 paid by the employer and 6.5% paid by the insured. The Ministry of Public Health is responsible for developing national health policy, regulating the health sector and dealing with public health issues. Unfortunately, legal changes of roles and responsibilities have not been associated with significant changes in skills and competencies. This means that the legislative changes must be done in the same time with the people's mentality changes. We are talking here about the people working within the system as well as the general population that benefit on these services. In the same time, the professional training of those working within the system is very important. Their training must be permanently upgraded through a system specially designed for their needs. The representative bodies of the Ministry of Public Health at the district level are the Local Public Health Authorities. In all the districts there are Local Health Insurance Houses responsible for collecting contributions, contracting services from public and private providers and reimbursing providers. There are also two countrywide funds, of the Ministry of Transport and of National Security Body.

In 1999, the National Health Insurance House sets the rules and regulations for the District Health Insurance Houses and has the right to reallocate up to 25% of the collected funds towards underfinanced districts.

In the same time, the National Health Insurance House negotiates the framework contract with the Romanian College of Physicians. This body has important responsibilities regarding all area of concern for physicians, who should be registered at the College in order to practice. The College of Physicians has also an influence – through negotiations on the framework contract – over the content of benefits package, the type of reimbursements in place, which of the drugs are discounted. A very good point for the system reform is that the private practice is now permitted, although hospitals are public-owned, with a few small exceptions, giving the opportunity to other different services to the population with a certain level of income. There is of course a category of services restricted for the population with medium and low income but in the same time, the existence of the private services can facilitate the access of general population to state services. Any new opportunity of medical service that leads to the development of the medical system in general can be very important.

From the financial point of view, starting 1998, earmarked payroll contributions became the main source of health sector funding. 25% of these funds must be set aside as reserve and also, no more than 5% of funding can be spent on administrative cost. According the health insurance scheme, till the first of January 2007 the working population pays a 6.5% payroll tax and the employer another 6% payroll tax to the fund. The mandatory health insurance scheme covers the whole population. Children, the handicapped, war veterans and dependants have free access to health insurance. Contributions for prisoners are covered by the Ministries of Defence and Justice. Taxes continue to be an important source for health care financing and the state budget retains responsibility for funding public health services and capital investment, as well as priority preventive activities.

The main institutions of the Romanian health system are:

Main institutions:

The Ministry of Public Health – this institution administrates the whole system, in general. It also has local representatives in all the country's districts: The Public Health District Authorities.

The National Health Insurance House – this institution administrates the health services and the social health insurance system. It also has local representatives in all the country's districts: The District Health Insurance Houses.

The College of Physicians – this is a disciplinary organism with attributions in the field of medical accreditation. It also evaluates the malpraxis cases. In the same category there is also The College of Pharmacists which is taking care of the politics of drug deliveries.

The Public Health Committees from the two Chambers of Parliament with legislative attributions.

The Ministry of Public Finances.

Secondary institutions:

Physicians' Organizations: The Federative Chamber of the Romanian Physicians, the Romanian Patronage of the Family Physicians, the National Society of General Practitioners etc.

Drugs and medical products suppliers: The Medical Products Suppliers Association in Romania, The Drugs Suppliers Association.

Health Care System in Romania – The components of the health care system in Romania is represented by:

Primary health care – Since 1998, patients are allowed to choose their dispensary or family doctor or general practitioner, and can change after a minimum of three months after initial registration. In parallel, general practitioner

changed from being state employees to independent practitioner, contracted by Health Insurance House, privately operating their medical offices. In order to cover the preventive and curative care, dispensaries provide prenatal and postnatal care, some public health care and health promotion and health education. After a survey carried on in 1998 the conclusion indicated that primary health services are generally speaking of poor quality and require continued reform attention.

Secondary health care – delivered by a network of hospitals, centres of diagnosis and treatment, office-based specialists. In the same time, private outpatient services may be accredited for all specialists, including outpatient surgery. Big part of the physicians practice privately as well as publicly.

Inpatient care – Romania have four categories of hospitals:

- Rural hospitals
- Town and municipal hospitals
- Districts hospitals
- Specialized units for tertiary care

From the point of view of the ownership, with the exception of a few small hospitals, all hospitals are publicly owned and under the state administration. The hospitals are led by a council board with a general director who holds executive power.

The public health services – it has the Ministry of Public Health as central authority, responsible for setting organizational and functional standards, developing and financing national public health programs, collecting data and drawing up reports on the population's health status. There is also a very important responsibility for the environmental health through the Institute of Public Health Bucharest. In parallel, the District Level Public Health Authorities are responsible for covering public health issues in their districts, the expenses

being covered by the Ministry of Public Health. Another responsibility of the Ministry of Public Health is related to the communicable diseases from the monitoring point of view but with financial support from the Health Insurance Funds. Among the others responsibilities of the MoPH there are also the screening for cervical and breast cancer, radiological screening for tuberculosis and compulsory immunization. After 1990, Romania developed a very efficient family planning network, including also eleven reference centres for reproductive health. A very important component of public health are the health promotion and health education programs which represent an essential duty of the Ministry of Health and are put in practice by the National Network of Health Promotion and Health Education.

In Romania, the existence of the Semasko health services system facilitated the development of an illegal practice: offering money or presents to the medical staff in exchange for their services. This practice is generally called “under the table payment”. The “under the table payment” was developed due to the extremely low financing of the health system that of course affected the staff salaries. Because of this, the “under the table payment” has become a current practice (continued even today), although the communist propaganda claimed that the medical services are completely free.

1.1 Promoting social inclusion through policy action at the system level

Talking about the national strategies for health and long term care there is a general consideration regarding the health system in Romania and also about the main barriers of access to the services for the general population. There are also some consideration regarding the quality of health care in Romania in the field of health system that can be found in the Romanian report on strategies for social protection and social inclusion 2007.

According to this report, the objectives of national health system were based on developing those programs through which equal chances between citizens were ensured, guaranteeing the access to basic medical care.

The insurance of a proper financing was one of the previous year's challenges, the budget of the Unique National Fund for Health Insurance registering a significant deficit, which was covered by available assets from the budget of the unique fund in the previous years and from the reserve fund formed in previous years.

During this health care reform the main objective was to achieve a balance between primary and community health care provided at local level, including home assistance and specialized medical and surgical services.

The Romanian government strategy has some goals for the future in order to avoid all this inconvenience:

- In order to increase the population's access to medical assistance, through Law no.95/2006 concerning the reform in the field of health and the framework-contract regarding conditions for providing medical assistance in the health care system in 2005 (Governmental Decision no.52/2005, with subsequent additions and amendments), the contract between the medical services suppliers and the health insurance funds agency settled the obligation of the medical services suppliers to inform the insured people. The information refers to the basic services package, the minimal package of medical services and the package of services for the people optionally insured.
- In order to promote universal access to medical services, family doctors have to provide medical assistance for all insured persons that are recorded on their own list. In this way, in accordance with the basic medical services package, medical assistance is provided in case of emergency situations for every person who needs these services; medical assistance is provided for persons who aren't insured and who don't pay any financial contribution to National unique fund of health

social insurance and also for categories of persons who optionally insure themselves, according to the law.

- By issuing the Order of the minister of health and of the president of the National House of Health Insurance 681/243/2006 for approving the methodological norms to apply the Framework-Contract regarding conditions for providing medical assistance in health care system in 2006, amendments by Ministerial Order no.845/2006, the list of medical services, medicines and the list of medical devices of which the insured people can benefit, registered in the package of basic medical services, the minimum package of medical services and in the package of medical services for optionally health insured people were established.
- For a more efficient health insurance system, the Law no. 95/2006 regarding the reform in health care and secondary legislation established that the co-payment for medical services provided in specialized medical assistance will be introduced. This measure represents a first step for removing the informal payments and for decreasing the number of medical services unjustified requested.
- There are three pylons of the legislative package adopted in 2006: efficient administration of the public funds, the beginning of some projects for infrastructure in order to rehabilitate the health system and rewarding medical personnel.
- The main effort will be directed to the renovation or building 15 county hospitals in the Program “County Hospitals” with deadline in 2008 and for improving the medical equipment quality.
- The closing of some sanitary units unable to operate properly, the externalization of some services, but also the redirection of some funds in order to finance medical services and to provide compensated medicines is taken into consideration; these measures will be carried out by The Ministry of Public Health which will take over some finance from the contributions that will be paid by tobacco and alcohol producers/importers.

- Health system informatization represents an important element in the reform in order to increase the system performances through a better access, efficiency and equity of the medical services provided to population. At the present moment, in Romania, there are some informational systems in health area which must be improved and integrated, by establishing a modern and integrated platform which could insure the interoperability security. The creation of The Integrated Unique Informatical Health System in Romania represents the necessary infrastructure needed for the access of the medical and pharmaceutical services suppliers and for the insurants to benefit of advanced services. The objective of e-health services is to set up a national program in order to connect the sanitary units to the internet through broadband connections and also to buy computers and to create e-health portals. As a result of the new legislative package, the structure and the operability of the system were reconsidered and, in this way, the autonomy of The National House of Health Insurance was established. At the same time, the normative framework which gives an important role to the family doctor and includes the introduction of the minimum package of services for reducing the costs in the sanitary system was defined.
- A greater attention will be paid to prophylactic medical assistance in the detriment of the medical assistance provided through the hospital system.
- Voluntary health insurances will be encouraged, in order to reduce the pressure on the health insurance system.

Another problematic health sector is represented by the mental health system. In 2006, The Ministry of Public Health allocated important funds for this kind of services. The funds allocated to the National Program of Psychiatry were five times bigger, from 20 billion lei to 100 billion lei.

- The money is used for setting up 10 pilot centres for community mental health and for partial rehabilitation of 7 psychiatric hospitals. The activity focused on:

- Elaborating and approving the National strategy for mental health, setting up, through a project financed by European Union, The National Action Plan for Mental Health. This action plan refers to:
- concentrating the attention towards the community assistance and not towards the hospital assistance as it used to be,
- starting some actions related to the setting up of a national mental health centre,
- the re-examination of the ill people who are in psychiatric institutions and in institutions which are in subordination of The National Authority for Disabled People,
- achieving a development plan (licensed in psychiatry) in order to train 300 psychiatric doctors who will cover the deficit, the preparation curricula in psychiatry license will be revised, focusing on legal aspects and with the respect to human rights, aiming to change mentalities within the system and society,
- Setting-up the National Centre for Mental Health within the National School for Public Health and Sanitary Management.
- Integrating the mentally ill people in the society becomes a short term priority for the Romanian authorities; as a result, in the last year, the legislative framework was created for setting up and organizing the mental health centres, by transforming the laboratories for mental health. These centres will administrate the therapy and the reintegration in the society of mentally ill persons.
- Developing information campaigns about health problems for citizens/communities; informing the patients about their rights represents an important step in improving the access to health services.
- The consolidation of national policies regarding social protection is established, starting with 2006, by extending the long term care, especially for elder people.

- The demographic changes from the latest decade have contributed to an integrated approach of employment policies, together with the welfare policies.
- The fiscal system guarantees efficiency and balance between material and human resources within these integrated policies, promoted for developing the long term care services.
- A major objective in the economic, human and social development is represented by the integrated policies of social inclusion through a permanent fitting for solving the social needs and problems concerning the employment.
- The strategies promoted on sector areas became tools for institutional coordination, adjusted to the individual needs, aiming to develop the community. Health care networks or services, public or private, were developed, by granting financial resources to the sector programs for developing the social sector. In this way, an administrative and institutional flexible framework was created, in order to solve the priority problems, identified by each community.
- A development of local assistance network is necessary in order to increase the access to health services, to give to the people the responsibility for their own health status and to increase the community involvement in answering the need of marginalized people.
- The integrated health assistance at local level includes the following activities: education for health and for prevention of the illness; social mobilization for health (vaccination programs, preventive controls, etc.), home assistance for the new-born mother and child, home assistance for chronically ill persons, for mental ill persons, for disable persons, support for medical recovery and social integration, palliative care.
- Services and activities of community assistance were developed for the following professional categories: social assistant, community medical

assistant, health mediator, psychologist, community medical assistant, and home care medical assistant.

- The new technologies brought more efficiency to the access to the social services (like the emergency ones) but they also created premises for taking part to the social life and for reducing the loneliness that many old persons are confronted with. It must be also mentioned that the advantages of this capitalization regarding the new informational technologies are reduced.

With all these concerns for promoting long term health care services, the system remains weakly developed and, in the future, it is necessary to find new solutions for promoting those measures which bring improvement for addicted individuals behaviour.

The long term health care should be for the old-aged persons, for individuals with disabilities, for persons who are in the terminal phase of an illness.

The development of care services for addicted persons concentrated especially on the residential aspect. Despite this, the capacity of these institutions is not big enough and the accommodation does not correspond to quality standards regulated by legislation in force. Reorganization, modernization and increasing accessibility to these institutions began in 2005, but the efforts must continue. Until now, the financing of the long term health care system has been ensured from funds allocated from the state and local budget or from the non-governmental organizations' own funds.

- A project of normative act was initiated in order to ensure the system sustainability regarding the social protection of the elder population.
- The new approach of the law project refers to instituting a dependency benefit for financing health care services, not only in residential system but especially at home. The benefit will be given in full amount which is different depending on the dependency level and on the place (at home, in day or residential centres) on the basis of testing incomes. Also, the law project suggests a compulsory insurance for long term health care;

the collected funds will insure the necessary amount for financing the dependency benefits. The implementation of this system will be done progressively starting with January the 1st 2007.

- The priorities for developing the system focus, besides the implementation of the project of normative act, are the following:
 - increasing the number of the residential institutions for long term health care and improving the living standard in these institutions;
 - The development and implementation of a quality system for the services provided in residential system or at the people's own homes;
 - Development of social worker's network for people in need, including granting facilities;
 - promoting and supporting temporary care;
 - improving human resources quality in the system, both for formal or informal network;

(Annex 3)

2 Major barriers of access

1.1 Introduction

It is considered that the health care access it is a fundamental right in every civilized country. For the EU-countries this access is guaranteed by law and by the EU Chart of the Fundamental Human Rights: "every person has the right to preventive health services and to medical treatment" (Health and care in an enlarged Europe, 2003, pg.1).

One of the main objectives of the legislative package mentioned above is to ensure a fair and wide access of the people to a clearly defined range of services. Studies show that there are many access problems, especially in the ex-communists countries. In the same time, there are important problems in the field of services' quality and financial sustainability as well as in the field of services covering. The access to health services represents an essential equity and social solidarity element and it shows the degree in which citizen's rights are respected.

The insured has the right to a clearly defined package of services.

1.2 Population coverage for health care under public programs

The primary health care is covered by the family doctor choose by the patient. In this moment, the family doctor has also a filter role for the patient's problems. The efficiency of this filter depends however on the financial investment made in the primary health care network, investment that can ease the access to the more advanced health care, excepting the emergencies, which must be treated in an emergency unit.

The family medical services have decreased comparing with hospital care, a common tendency of avoiding the general medicine offices being observed. The population registered on the family doctors' lists was of 20,108,284 insured people on September 30 2005, this representing 92.99% of the Romanian population. 96.08% of the total numbers of insured people are in urban areas and 89.25% in rural areas. In spite of all these, a large number of individuals are not registered on the family doctors' lists

The deficit in family doctors. This deficit represents 1009 doctors, 470 in urban areas and 439 in rural areas. There are 145,110 inhabitants in rural areas without family doctors, this representing 1.48% of the total population that lives in rural area. Of these, 24,359 persons are not assisted by any medical personnel. The statistical data show that in Romania the rural area population represents more that half of the total number of inhabitants. Despite this fact,

less than 40% of the total numbers of family physicians are working in the rural areas.

The number of family doctors, registered in September 30th 2005, was of 11,455, of which 3,676 were primary doctors (73.34% in urban areas, 26.66% in rural areas), 5,510 physicians (53.61% in urban areas; 46.39% in rural areas), and 2,217 doctors without professional degree (42.63% in urban areas; 57.37% in rural areas). With some disparities on regions, 222.2 physicians were registered for every 100.000 inhabitants. It is a known fact that almost 300 Romanian localities have no physicians at all (National Institute of Statistics – “The Social and Economic Situation in Romania in 2003-2004”).

Another barrier is represented by the fact that a similar number of localities are from isolated areas, with low accessibility or which are located at high distances from sanitary units that could offer specialized medical assistance.

The difficulties of access to the health care are also related to the decrease of number of beds in hospitals (from 7.4 in 1997 to 6.6/1000 inhabitants in 2004). This decrease follows the world tendency and because of this situation ambulatory care must be taken into consideration like a useful alternative. Regarding the beds utilization indicator for the hospital activity, the situation is the following: the hospitals' beds were used 300 days/year, the tuberculosis sanatoriums' beds were used 310 days/year, the observation sanatoriums' beds were used 257 days/year and the beds from medico-social units were used 213 days/year. The mono-specialized hospitals represent almost 32% of total hospitals from all the country (26% of the number of beds) and 3% represent the proportion of emergency hospitals (11% of the total number of beds).

Closely related to the number of beds there is also the problem of the hospitals' buildings which are between 50 – 100 years old or even older and are not very well equipped in order to provide medical investigations.

The territorial distribution of sanitary units with beds, the medical personnel and the facilities of these units is not homogeneous and that is why there is a different accessibility to the health services of this type. Most of the hospital

units are municipal units, but taking into consideration the number of beds, the percentage is higher in the county units.

After a serious evaluation, another important problem was discovered: in the last years, the activity of the family doctors was focused on medical assistance provided in their own cabinet only for persons covered by medical insurance and less on home visits or on active actions that could lead to the identification of public health problems. In this context, there are many situations where the patients, social cases, or persons which can not prove the payment of medical insurance are excluded from the family doctor list, and don't have permanent medical assistance. The lack of family doctors or non-registering on the assurance list generates incontrollable situations, with effects on population health status.

Regarding the Emergencies Intervention System in Romania – this operates through integrated units from national, local and district level, having as components fire brigades, social protection units and the SMURD personnel.

The assessment of their promptitude, carried out in 2004, indicates the fact that these are not capable to face important and emergency situation, mainly because there is not enough equipment or necessary materials; the organizational system also needs improvements.

The number of car ambulances indicated on September 30 2005 that there were 3,224 cars, with 2.3% less than 2004 (3,303 cars). Emergency medical assistance was provided for almost 1,300,000 individuals in 2005, and the expenses for emergency medical assistance were of 3.0 % from the total number of expenses allocated to medical services and medicines.

At present, the answering units for emergency situations are located in towns, in the rural areas operating voluntary services for emergencies. The quality of the protection and intervention equipment and the vehicles can be used only for fires extinction; the vehicles necessary for intervention in case of natural catastrophes are way below standards or even inexistent.

There are also the SMURD services which operates in case of rescuing situations (car accidents, drowning rescuing, mountains rescuing, closed spaces rescuing, collapsed buildings rescuing etc) and its purpose is to complete the ambulance services (The TAIEX expertise on October 2003, indicated the lack of prompting capacities of the ambulance service on national/county level and the fact that rural areas and small towns are not correspondingly insured) and to improve the services quality in critical situations and in special rescuing operations.

2.1.1 Main system of coverage

The reform process obviously generated a state of confusion at the medical staff level and large extra expenditures. The legislative regulations' delay generated a series of malfunctions within the system which led to malfunctions and problems of quality and accessibility of the health care services.

In the same time, the health services cover does not correspond to the patients' needs and the distance to the health services suppliers is very often a major impediment, especially because of the increasing poverty degree of the people who cannot afford to pay the transportation costs. Even though there is a clear developing process of the private health services system and pharmacies, the poor population segment does not afford this kind of services. Accessing the private health services is difficult even for persons with a medium income.

The poor access to quality health care services is increased by the poor health services covering, the absence of primary medical assistance in certain rural areas and the existence of poorly equipped medical units. Another problem is that of the very low salaries of the medical staff which increased the now usual practice of informal payment, under the table. This factor also contributes to the low covering, although the annual reports of the National Health Insurance House show a high percent of population which is covered by the social health insurance system.

The health insurance system application in 1997 led to the apparition of a double financial control system over the health insurance funds: the Insurance

House's control and that of the Ministry of Finance. This fact generated a series of distortions and conflicts caused by the fact that some of the health funds were turned over to other objectives.

The health insurance law was completely applied in 1999, and it has been many times modified since then, the last version being the one mentioned above. Unfortunately, the problem arise from the lack of independence of the health fund, which leads to increasing debts within the health system which also leads to frequent crises within the system.

Besides these financial management problems there are, as mentioned before, some other discontent of those parts involved in the health services system. On one hand there are the beneficiaries complains regarding the poor health services' quality, and on the other hand there are the medical staff complains regarding the low salaries, poor working conditions and lack of medical equipment. The National Health Insurance House's management believes that this situation appeared because of the discrepancies between the alleged politics and the way it has been applied in reality (the decentralization process, the institutional autonomy and resource allocation). As a result, the health system's actor's expectation involves increasing the quality of services, increasing the medical staff's salaries and improving working conditions. This could be done if the financial independency of the system would be applied and, in the same time, if the financial resources would increase and the process of resource allocation would be transparent.

Another important barrier is the financial problem generated by the constant conflict between the pharmacies and the National Health Insurance House. The conflict is generated by the failure of the National House to pay to the pharmacies the money for the free and discounted medicines. This situation had a great impact upon the patients who, for certain periods of time, were unable to acquire these types of medicines although they were entitled by law. In the same time, the pharmacies were forced to increase the medicines' price in order to recover the money owed by the National House. The medicines' price was therefore higher than in other countries, which generated another important barrier to health services for the majority of population.

The National Health Insurance House evaluation shows that the covering of the system is of about 90%, slightly different between urban and rural areas (urban areas is better covered – 95% - than the rural – 85%). This proves the fact that the level of payment of the health insurance contribution is quite high.

According to the law, all the Romanian citizens that live within the Romanian borders are insured. The foreign citizens (or the persons with no citizenship) with temporary residence permit are also insured, if they can prove the payment of the health insurance contribution.

The next categories have insurance without paying the contribution:

- a) all the children under 18 years old; youth between 18 and 26 years old, if they are students with no income;
- b) husband or wife, parents or grand parents with no income, being in an insurance person maintenance;
- c) handicapped persons with no income;
- d) special categories: war veterans and their widows, the heroes of the 1989 revolution, ex-politically persecuted persons;
- e) the persons carrying out the military duty;
- f) pregnant women and women in maternity leave; the parent in leave for taking care of children under 6 years old;
- g) prisoners or persons waiting to be put in jail, with no income;
- h) social help beneficiaries, according to the law;
- i) people with no income and having certain illnesses that are included in the national health programs established by the Ministry of Health, until they are cured;
- j) expelled persons or victims of the human traffic during the identification procedures;

k) members of families entitled to receive social help;

l) retired persons with less than 275 euro income per month;

Unfortunately, a big problem is represented by the fact that the population contributing to the health fund represents less than 50% of the population, so the tax base is really small. In the same time, the population under 18 years old that beneficiates of free services represents 23% of the population.

If we take into account the fact that poor countries have a resource problem in relation with the health status, problem that can be solved only by a long-term investment, we reach at the following conclusion: the resources distribution will be automatically made based on the what would be thought to be the first priority, therefore failing to solve all the population health status problems. Because of the political and electoral interest, the stakeholders usually choose to solve the short-term social problems, paying almost no interest at all to the health system's problems, which are more difficult to solve and which are huge funds consumers.

From a financially point of view, the health insurance house's report shows that the 2006 incomes are with 5.88% higher than the estimations. In the same time the same incomes from 2006 are with 46% higher than those collected in 2004. This led to the rising of the total health expenditure with 40% in 2006 than in 2004.

From the total budget of the Health Insurance House, the functioning and administration expenditures represents just 1.7%. 51.47% represents the health services payments for the hospitals, 21.07% represents the payments for drugs and 12.11% represents the funds for the national health prevention programs.

Within the medical assistance field, the highest funds allocation is made for:

- drugs, with or without personal contribution – 76%
- national health prevention programs – 54%
- medical equipment – 45%

- primary health assistance – 32%
- ambulatory health care – 32%

The same report is mentioning a series of measures meant to improve the insurance persons' access to health services and medicines, especially in poor areas:

1. New medical eligibility criteria were introduced in order to allow the chronically patients' access to the health sub-programs.
2. The pharmacies distributing free or discounted medicines are daily monitored.
3. The doctors that work in poor areas receive extra money.
4. The pharmacies received up to 80% from the medicines' consumption fund, depending on the addressability level.
5. The drugs' suppliers must offer the cheapest medicines first and only if the patient explicitly asks to offer the more expensive medicines that have the same effect.
6. The health insurance houses are allowed to sign contracts with non-clinical health services suppliers from other districts, if there are no suppliers within their own territory.
7. Medical assistance outside the family doctors working hours will be assured by the specialized units with emergency services.
8. The emergency medical assistance system was developed in order to assure emergency home consultation by the public and private suppliers, based on the agreements signed with the Health Insurance House.
9. New regulations and evaluation standards were elaborated at local and national level for the evaluation committees, in order to assure the health services quality offered by suppliers.

10. The insured persons are always informed about the new initiatives of the National Health Insurance House (e.g. the conditions in which the European Health Insurance Card can be obtained and used starting with January the 1st 2007).

2.1.2 People not covered directly by any health care system

The legislation guarantees the principle of equal treatment of the citizens. There is no discrimination in the access to the emergency services. There is no ethnical discrimination in the quality of hospitalisation (there are rich roma citizens, which can obtain the same expensive treatment, as well as the rich majority population).

The most important deficiency of practical access to health care can be observed at the level of GP-s, in the comprising of Rroma patients on their lists. This fact is determined by the objective reason of the lack of identity documents, and sometimes by prejudicial attitudes.

There are also problems in accessing the preventive services. These are caused by: cultural barriers, difficulties in the interpersonal communication, lack of information. These are just some of the behaviour problems that constitute barriers to health services' access. These barriers can be eliminated only by raising the information level and the number of sanitary mediators from the same ethnic group that can establish an equal communication with these groups of people.

The only solutions available proposed and taken in account by the government is represented by the model of work style of the Inter-ministerial Sub-committee on the Rroma. Working this way, the rroma solution has been identified and accepted: they need a bridge that they decided to call it "MEDIATOR".

The mediator is an rroma person, who is trained in a special field on the base of the non-Rroma rules, his mission being to inform and to advise the members of an Rroma community. The application fields in Romania are education – school mediators, and health – sanitary mediators. The mediator system has been tested in the last five years. So, the sanitary mediator is the KEY for the better

access to the health services. The introduction of this new occupation at national, institutional, and legal level is already started and continues to represent an emergency.

The main operational tasks for the Ministry of Public Health during this implementation of global strategy for the improvement of the Roma situation are:

- To continue upgrading the process of developing the mediators system
- To offer the appropriate support of the Ministry to the Committee for Roma Health, as the instrument of the implementation of the future strategy
- -To elaborate the model for the health insurance of the children from the partial-sedentary communities
- -To introduce the Roma population as target group in the existing National Preventive Programs
- -To list the local projects on Roma health and to conduct them to the financing institutions/organisations
- -To improve the communication and collaboration with all the involved parts

All this information represents part of the Ministry of Public Health evaluation “Roma Access to Health Services: Present and Perspective”.

A very important barrier is represented by the content of the social health insurance law. In conformity with the social health insurance law, in order to be acknowledged as insured persons- those willing to ensure themselves and who cannot prove that they paid the contribution have to pay the legal contribution for the last 6 months, in case they did not have any income. In this case the contribution is calculated in accordance with the lowest income at the country level. Some penalizations for the delay are also added. The level of these penalizations is considered to be the one that is active at the payment time.

Example of calculations for this situation:

A person had the obligation- of paying the social health insurance without having had any income in the last 5 years, which represents the prescription term. At the 1st of August one goes to the Health Insurance House in order to become insured. As a result of the verification, the Health Insurance House finds out that the person had no taxable income during the prescription period, which lasted between the 1st of August 2002 and 1st of August 2007. In order to obtain the main insurance package one has to pay the contribution for the last 6 months (1st of February 2007 – 31st of July 2007), calculated for the lowest income at the country level at that date. Penalizations for the delay are also added, in accordance with the penalization level established by the law at that date. The 6 months period is taken into consideration starting with the 1st of August 2007. After paying this sum, the person has to pay the contribution to the insurance fund every month. In case the person has no taxable income, this payment will be calculated in accordance with the lowest income at the country level at that date.

The persons willing to insure themselves and who cannot bring the proof of the contribution payment are obliged to pay for the whole period of prescription if they had taxable income in this whole period, in order to become insured. They also have to pay the extra payments mentioned by the Financial Procedure Code.

The persons willing to ensure themselves and who cannot prove the contribution payment have to pay to pay the legal monthly contribution and the extra payments mentioned by the 28th section of the law for the period in which they had taxable income in order to become insured. In addition, they also have to pay the legal monthly contribution and the penalizations for the period in which they had no taxable incomes more than 6 months.

These dispositions are available for those certain situations in which the person had a taxable income but not for the whole prescription period of 5 years. If the period with no income was shorter than 6 months, the person has to pay the legal monthly contribution proportional with that period. The person also has to

pay the penalizations for the delay and the extra payments. The level of the increase is the one that is active at the time of the payment.

2.2 The scope of the health basket

Everybody admitted that the health **promotion and the health education** are very important subjects, but as usual, and not only in Romania, the financial support from the government is lower than expected. The important point for Romania was the presence of the International Health Organizations Representatives here who were very much involved in all the educational programs, their role being to sustain the Romanian Government in this process. NGO's and civil society played a very important role and they became part of a big team including the governmental network of health promotion and health education. In this way it was possible to make a very strong lobby in front of the decision makers and push them to pay much more attention to the subject.

Because we succeeded to keep the health promotion and health education network in function (this network meaning offices of health promotion and health education in each district of the country in very close relationship with the central methodological coordination and with financial support from the Ministry of Health) we created a national coverage of the population for both areas: urban and rural, of course much stronger in urban area. The lack of resources was the main barrier of the entire activity because, but we succeeded to train our specialists and to enlarge our partnership with all the institutions interested in this area. There is also a weak point regarding the rural area and small cities coverage in the country not only because the education level is sometimes very low but also because of the lack of resources: people don't usually have access to the main communication channels.

Home visits are commonly seen as an important part of the general practice. However, in the past decades, there has been a world-wide decrease in home visiting rates. Although there are strong variations between countries, as well as between GP's, this decrease was found in most European countries.

Previous studies showed that home visiting rates are affected by demand, as well as supply-related factors. GP's will be more likely to visit patients who are seriously restricted in their ability to come to the clinic. These restrictions can be related to age or disability but also to the motive for which the GP is consulted. A non-medical reason for a home visit may occur if a patient has no transport.

On the supply-side, the GP's style of work has an influence. Some GP's will be more likely to address the wishes of their patients than others. The criteria for the level of discomfort that is acceptable for patients vary across GPs. Also workload related factors and the location of the practice have an influence. GPs in smaller practices make more home visits and the proportion of elderly on the GP's list is also positively related to the number of home visits. Furthermore, previous studies showed higher home visiting rates in rural areas than in urban areas. Unfortunately there are not studies to motivate very clear these sentences. All this information comes from daily experience and from the patients' opinion.

Medication - the subject was already presented and we should underline that Romania have a very big problem; in fact the most interesting subject for media and patients is related to the medication and way to provide this medication to the population. There is a list of compensated drugs but each month the amount of money is not enough to cover the population needs and this generates a huge problem for the patients, especially for those with chronic diseases which totally dependent by those drugs. As a result, elderly people, people with chronic diseases and other disadvantaged categories are very affected. This represents a major barrier for the old people and also for those with disabilities to have access to the appropriate treatment in short time. Unfortunately this is a perpetual issue and continues to represent a very important challenge for each government team.

Some considerations regarding the maternity services:

Health care service reform started late and the quality of many services is still far from what is desired. More emphasis needs to be placed on community-based, better quality and more accessible services, especially for vulnerable

groups. Because people in rural areas and poor communities have less access to health care, it has been observed, for instance, that the infant mortality rate in such areas is higher than in other parts of the country. The infant mortality rate among Roma children was found to be two times higher than that of Romanian children.

The maternal health situation is equally of serious concern. Romania still has an unacceptably high rate of maternal mortality, higher than in other European countries. Of the some 75 maternal deaths recorded every year, half are abortion-related, and half are obstetric-related. Women sometimes use abortion as a means of controlling the number of children in the family. Another piece of data pointing to the need for improvement in the system indicates that only 60% of pregnant women consulted a doctor in their first trimester. It is estimated that half of the women who died during delivery did not benefit from any pre-natal care.

Another barrier is the fact that doctors and nurses avoid working in rural areas. This led to a Ministry decision in 2004 to offer a EURO 2,500 start-up bonus to any doctor who decides to take a job in a rural area.

These are some of the UNICEF conclusions after many years of work in Romania

- Family planning - Romania emerged in 1989 from decades of pro-natalist policy, under which the government heavily restricted access to both contraception and abortion. Due to a desperate desire to limit fertility and in the absence of contraception, abortion rates were extremely high, with most Romanian women having multiple illegal abortions. Reliance on abortion has continued to be high following legalization, although rates are declining. Knowing this situation, the ministry of health policies was oriented to growing up and developing the quality and accessibility to this kind of services for all the population, focused on poor and low educated population.

In partnership with UNFPA, USAID and many NGO's, the Ministry of Health designed a national project to offer free contraceptives to the

disadvantaged categories of population in order to avoid the barrier represented by the lack of resources, and have initiated many education campaign and training to avoid the lack of knowledge.

- Dental services – The patients beneficiate of free stomatological services only theoretically. Every month, the sums allocated by the Health Insurance House are not sufficient. The money are spent in just a few days and the dentists are forced to pay the emergencies from their own money (the law stipulates that the emergency have to be free of charge). Because of this, the dentists prefer to work in the big cities and the population living in poor areas is almost completely uncovered by specialized services. Also, because of the lack of funds, the dentists are not interested to sign contracts with the Health Insurance Houses. In Bucharest there are 4,000 dentists and only 470 of them have contracts with the Health Insurance House, although the whole population is paying the health insurance

Minimal access to dental services

At the current date there are 12,000 working dentists in Romania. Most of them started their own cabinets since 1990, because the state was unable to pay them. As a result, 95% of the dental services in Romania are private and most of the dentists are working in the big cities. This is the reason why in many areas there is a total lack of dental services. The public system includes only the school cabinets and those serving some special ministries with internal network.

A dentist is making money from the services offered to his patients. The poorer the population, the fewer will be those going to the dentists. And then, all a dentist can do is move to a big city, with a low unemployment rate, or move abroad. Living in a small town can easily lead to bankruptcy, taking into account the fact that the minimum endowment of a stomatological cabinet costs about 10,000 euros and in order to recover that investment a dentist needs patients.

As a result, the elderly population and those with small income have very limited access to treatment. According to the declaration made by the president of the

Dentists College, there is an important need of finance in order to offer services to the poorer population. In order to solve this problem, the president considers that every district college has to establish its own strategy in order to draw the specialists to this kind of areas. A first step in attracting the dentists to the poor areas would be that the Health Insurance House would pay all the services a dentist offer. Every area already has a medical unit. The community would have to buy all the instruments needed for a stomatological cabinet, and so the cabinet would be owned by the community. Then a dentist could work there for a certain period of time. This way, the dentist would have a job and its services would be paid. The College is suggesting that the dentists could also be helped in other ways: lower taxes, loan facilities.

The rights of the people mentioned in special laws

There are some special categories of persons with special rights. These are: people persecuted by the communist regime for political reasons, people deported abroad, war prisoners, people fighting in wars, war invalids and war widows, heroes-martyrs and their offspring, people fighting and wounded in the 1989 Revolution.

These categories have access to certain free medical services. This is also applying to children between 0 and 18 years old. For these, the preventive dental services are offered once in three months and for those between 18 and 26 years old (students or unemployed) these services are offered twice a year.

2.3 Cost-sharing requirements as barriers to access

Very interesting information regarding the patients' opinion on health services access and quality can be obtained from a series of annual studies don by The Centre for Health Politics and Services from Bucharest, the most recent being developed in 2006 (see Annex1). The conclusions of this last research are as follows:

Regarding the hospitalization, 1 of 10 patients admitted that the medical staff directly asked for extra money in order to supply certain services (graph 3) but a third declared that they were suggested to pay extra money by the medical staff attitude (graph 4). At the last hospitalization, the interviewed persons offered money or presents to the doctor (a third), nurse (3 of 10 persons), sick nurse (2 of 5), and guards (1 of 10).

A third of the interviewed persons hospitalized during 2006 admitted that they needed to use their personal savings in order to pay the health services, 1 of 5 needed to loan money and 1 of 10 had to give up buying other goods. For 15% of them paying the health services was no special effort.

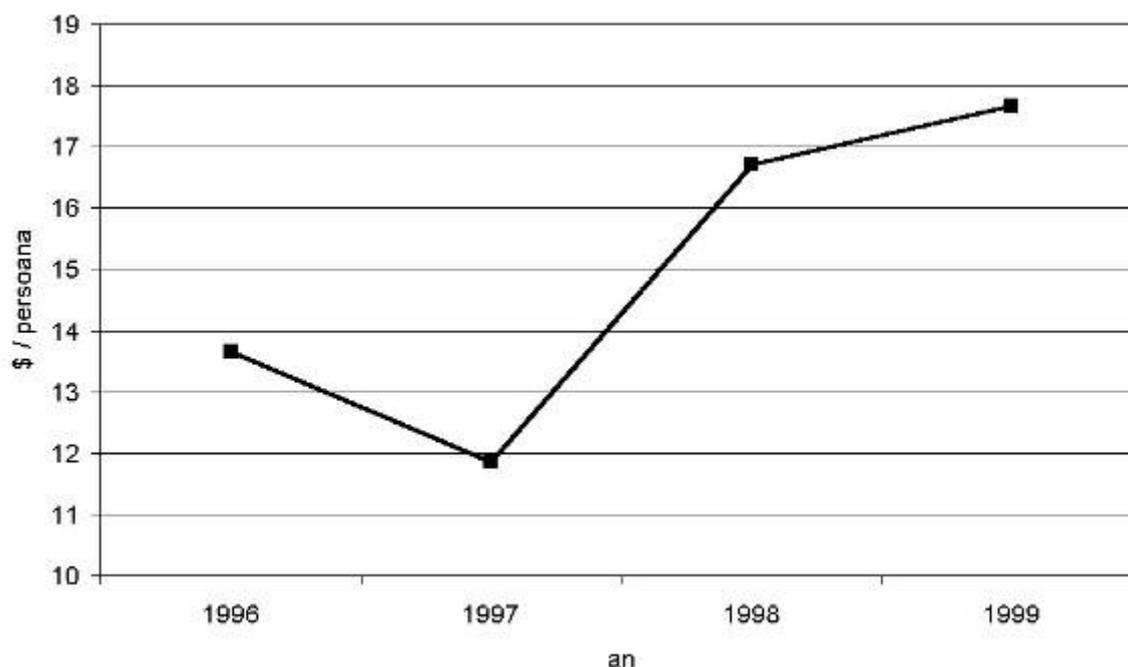
3 of 5 persons believes that rising the medical staff salaries would be the appropriate solution to eradicate the unofficial payments, 1 of 10 believes that these payments should be declared and a tax applied to them and 1 of 20 persons believes that the situation can remain the way it is. A quarter was not able to come up with a solution.

More than 80% of the interviewed persons are not pleased about the unofficial payment within the health system while 6% agree with them or are indifferent.

Unfortunately there are no statistical data concerning this type of payment. But there is an interesting study carried on by the National School of Public Health and Health Management between 1996 and 1999 which evaluates the population's expenditures for health during this period. The study was interested, among other topics, in the health expenditures of every household, even though the medical care was considered to be free.

The study shows that between 1996 and 1999 the health expenditures increased.

Graph 2.1 – The evolution of the medium annual/person expenditures for health (total), 1996-1999, in USD



The following table shows the expenditures made by the Romanian population for health services, although the existing public sector was strong and offered, at least theoretically, free services, and the compensation system for drugs was active:

Estimation of the population's expenditures for health, millions USD/year

	1996	1997	1998	1999
Total	309	267	376	396
Of which - drugs	162	156	220	240
- tests and consultations	43	31	56	50
- stomatology	23	17	21	22

This section of the study, named „Expenditures for services – medical tests, consultations, treatment, hospitalization” includes the amount of money paid for these services, including the gifts or the „under the table payments” offered to

the medical staff. The study shows the existence of an ascending trend from this point of view.

The same study analyzed the frequency of the ill persons who refused to access medical services.

The following table shows the proportion between these people and the total ill population.

The frequency of the ill persons who refused to access health care services, % from the total number of ill persons.

Disease group	Year			
	1996	1997	1998	1999
Respiratory diseases	38	41	35	29
Cardio-vascular diseases	43	40	40	32
Digestive diseases	35	34	30	27
Genitally diseases	25	24	21	19
Nervous system diseases	34	43	43	35
Skin diseases	16	19	23	22
Blood diseases	22	27	22	19
Senses organs diseases	34	32	35	22
Endocrinological diseases	38	40	38	29
Infectious diseases and parasites	37	14	25	14
Locomotors diseases	48	47	42	32
Accidents + other diseases	24	27	22	24

The increase of the disease burden, because of the high costs, can be one of the factors that could explain the refuse of the ill population to access the health services (between 1/3 and 1/5 of the ill population refused to access the health care system).

Unfortunately there are no other recent studies to prove this situation, although the „under the table payment” is still largely in use and a generally acknowledged practice.

2.4 Geographical barriers of access to health services

The population access to the family doctor’s services was explored through a series of three questions: „which is the distance between the patient’s house and the doctor’s office?” „How long does it take for the patient to reach the doctor’s office?” and „does the family doctor live in the same locality as the interviewed person?”

For almost three quarters of the interviewed persons the doctor’s office is less than 2 km away from their home. For 15% of them, the office is located between 2 and 5 km away and more than 5 km. For three quarters of the interviewed people living in South and North-East the doctor’s office is very near (less than 2 km). In the same time, for almost half of the people living in North-West the office is at more that 2 km away.

The family doctor’s office is usually in the same locality with the patient’s home (90.9%) and in order to reach to the office the patients need less than 15 minutes. Almost a third of the patients need about 30 minutes in order to get to the doctor’s office, and 1 of 5 needs between 30-60 minutes and even more than an hour.

For the people living in rural areas is the most difficult to get to the doctor’s office. 33% of them need 30-60 minutes or more than an hour to get there.

2.5 Organisational barriers

95.5% of the interviewed persons are registered on a family doctors’ list. The differences between genders, residential area, and the registering degree are not significantly different. This led to results that can be compared.

A third of the persons with no family doctor declared that the main reason for this is the lack of a job and another quarter declared that they didn't need a doctor till the time of the interview.

Regarding the use of the health services within the Primary Health Care system, 3 of 5 persons needed the family doctor's help in 2006. More women needed the family doctor's help than men (69.5% to 56.4%), within the 50 years old age group and in urban area. The primary health assistance services were more frequent accessed in Bucharest (79.5%) than in other development regions, the lowest percent being in the South-East region.

A third of the interviewed persons that contacted the family doctor during 2006 declared that they needed more than 5 visits or 2-3 visits, while 1 of 5 persons asked the doctor's help just once. Persons over 65 years old needed most often the family doctor's help – more than a half of the persons within this category. Accessing the family doctors' services is different depending on the region: the highest rate is found in the South-Vest and Bucharest region – 40% of the persons in this region.

The main reason for the interviewed persons to visit the family doctor during 2006 is represented by the consultation for an acute illness – 1 of 3 persons. 1 of 5 persons addressed to the doctor for a recipe, and 1 of 10 needed a consultation for a chronically disease or for a document emitting, such as medical certificate etc.

1 of 20 persons declared that the family doctor was not at work during the schedule (7% of the people in rural area) and 2.5% declared that the family doctor refused to release a free or discounted recipe. In very few cases (approximate 1% of those who visited the family doctor during 2006), the family doctor refused to offer medical assistance or medical assistance at home (graph 1).

Almost a third of the interviewed people were summoned by the family doctor for a health control, the values being similar with those in 2003. The patients' addressability to the family doctor's call is higher in the North-West and South region (almost 40%) and lower in Centre and Bucharest (approximate 18%).

1 of 5 interviewed persons considers that nothing needs change in the family doctor's activity and 1 of 10 considers that the medical equipment and the cabinet's furniture should be upgraded. 7-8% of the patients believe that the issues that would need improving are: the doctor's schedule, more discounted recipes, and the doctor's way of treating the patients. The medical equipment or the furniture existing in the family doctor's office is less important for persons living in North-East and North-West (6.1% and 4.7%). For them it is more important that the doctor should reside in the same locality he/she has the office (12.5%) or that the doctor should give more free or discounted drugs (10.8%).

Almost a quarter of the interviewed persons declared that, in 2006, at least one member of the household needed the hospital's services and 1 of 10 persons was hospitalized during 2006. Almost three quarters of the hospitalized people were hospitalized just once, 1 of 5 twice and 1 of 10 thrice. 4% of the interviewed persons were hospitalized for four times or more.

Usually, the hospitalized persons stayed in hospital less than 2 weeks (half of them were there for 1-2 weeks and a third less than a week). 15 % were hospitalized for 2-3 weeks or more.

While checking out of the hospital, three quarters of the hospitalized persons declared that their health status is better, a quarter had the same health status and for 3% it was worse.

During hospitalization 90% of the interviewed persons received explanations about their diagnosis, 85% received information regarding the procedures and interventions they suffered or regarding their illness evolution (graph 2). Only half of those hospitalized were informed about the possibility of refusing the medical intervention, of asking for a second medical opinion or about other alternatives of treatment.

Half of the hospitalized persons declared that there were also negative aspects regarding the health services, but only 1 of 10 complained about that to another person (family, medical staff). Three quarters of those hospitalized during 2006 would go to the same hospital if they would need another hospitalization.

1 of 5 persons declared that the behaviour of the medical staff is the first thing that should be changed within the hospitals (graph 5). 15% declared that the most important changes are needed in the area of the medical equipment and unofficial payments. The medical staff's professionalism, the quality of the furniture and the cleanliness are important aspects mentioned by 8.5%, 8.7% and 9.9%.

The quality of the hospital's medical services in Romania is considered to be good or very good by a third of the interviewed people (graph 6). Also a third declared that these services are average and another third declared that these are low or very low. People living in the South area are the most pleased with the hospital's services quality (50%) while those living in the North-East are the most displeased (2 of 5) (graph 7).

2 of 5 persons consider that the hospital's medical services are accessible or very accessible, about a similar number of people qualifies them as of average accessibility and 1 of 10 persons consider them to be inaccessible or very inaccessible (graph 8).

Half of the interviewed persons living in West, South-West and Bucharest consider that the accessibility of these services is high or very high, while a third of the people living in Centre consider it to be very low (graph 9).

People were asked questions regarding the population's perception about the health system's reform in Romania, the Ministry of Public Health and the National Health Insurance House. Another objective was that of evaluating the people's knowledge regarding the national health insurance system: the covering of health insurance, alternative health insurance systems etc.

Results:

1 of 10 people declared that he/she is very pleased with the Ministry's of Health activity during 2006 (graph 10), a quarter declared that they are pleased and 15% are displeased or very displeased.

More than a quarter (27.5%) consider that the Ministry's of Health activity during 2005-2006 is worse than during 2000-2004, 12% consider it is better and 2 of 5

consider it is the same. 1 of 5 persons were not able to evaluate the activity of the Ministry of Health.

A quarter considered that during 2005-2006 the Ministry of Public Health equally represented the interests of the patients and those of the medical staff. Only 5% believe that the Ministry represented the patients' interests and 25% consider that the medical staff's interests were more important for the Ministry of Health. Almost half of the interviewed people couldn't answer at this question.

People believe that the most important problem within the health system is bad funds allocation (25%), the problem of the discounted drugs (16.2%) unofficial payments, lack of medical equipment and the medical staff's lack of interest (approximately equal percents - 8%) (Graph 11). Less than a third of the interviewed persons consider that the health system's reform is on the good track - 28%.

1 of 10 persons is very pleased with the National Health Insurance House activity, almost a third is pleased, while 13% are displeased or very displeased. 10% consider that the National Health Insurance House activity is better in 2005-2006 than in 2000-2004. For 40% the situation remained the same and for 20% the activity is worse. More than a quarter couldn't answer to this question.

Two thirds of the total number of the interviewed persons (66.7%) declared that they are paying the health insurance contribution but only 8.4% of them knew which is the exact percent that is taken from their income for health.

Just 1 of 10 persons from those paying the contribution knew exactly which are the services included in the basic health insurance package, and 1 of 5 knew only partially the content of this package. Only 1 of 20 persons knew the content of the minimum health services package available for those who are not insured and 1 of 10 partially knew its content.

Almost half of the interviewed people consider that the state should pay additional insurance for every citizen in order for the citizens to receive extra medical services that are not covered by the basic package. 1 of 10 people consider that every citizen should pay for this kind of insurance to other private

health insurance houses and 1 of 5 consider that those in need of extra services should pay an additional sum, depending on the needed service. A quarter of the total number of the interviewed people would agree to pay extra money to a private insurance house in order to receive extra services.

Television, discussions with friends and papers are the most important information sources about the health services in Romania for 66.4%, 8.1% and 6% from the interviewed people.

Regarding the accession to the EU, half of the interviewed persons are optimistic regarding the Romanian health system's improvement.

The Centre for Health Politics and Services declared that the study was applied on a number of 1,452 persons, nationally representative and with +/- 2.8% possible inaccuracy.

2.6 Supply-side responsiveness

Important access barrier can be found among some ethnical minorities and especially among the rroma population. These barriers are linked to their educational level as well as to their specific behaviour and religious beliefs. For example, the rroma patients are very assertive and they go to the doctor aggressively asking for free or discounted drugs. In the same time they have a low hygiene level and they refuse to be checked by medical staff. Generally, when a medical problem appears, the patient is coming to the doctor together with the entire family or even with the entire community, which leads to agglomeration, tensions and even aggressions within the medical unit.

Most of them are nomadic and have no identity documents, which makes it impossible to track them during the vaccine campaigns. The lack of education usually generates the refusal of vaccination, especially if after the vaccination there are some side effects (fever, fatigue, post-vaccine reaction). The same lack of education makes them interrupt the treatment the moment they feel a little better, without taking into consideration the medical advice; after this, the

reappearance of the disease is considered a prove for the medical staff's incompetence.

An rroma pregnant woman is not allowed (by her family) to go to a man gynaecologist and, in fact, they are hardly allowed to consult any doctor at all during pregnancy. They also refuse to use birth control measures, this kind of practice being considered as low morality.

These are just some of the behaviour problems that constitute barriers to health services' access. These barriers can be eliminated only by raising the information level and the number of sanitary mediators from the same ethnic group that can establish an equal communication with these groups of people.

The three categories representing the main target of this evaluation need special attention and a special system adapted to their necessities.

2.7 Health literacy, voice and health beliefs

Also within this study people were asked about their knowledge regarding the emergency services in Romania (112 service, the Emergency Unit, SMURD emergency service) and the addressability and population's access to this kind of medical services. The results proved that there are some access barriers in this system too:

The lack of necessary information:

Less than a half of the interviewed persons knew the telephone number that can be used to announce an emergency situation; 1 of 10 persons are mistaking this number for other similar numbers of other services (211, 411, 951, 961 etc.) and 2 of 5 didn't know this number at all. The 112 emergency numbers is less known in the South region (29.7%), best known being in the Bucharest, West and North-West regions (55.1%, 66.4% and 55.1%). The 112 emergency number is better known by men than by women (52.4% against 41.4%), in urban area than rural area (56.9% against 34.5%), by young people within 18-29 years old than by people over 65 years old (63.9% against 25.7%)

and by people with higher education than by those with average or low education (71.8% against 51.4% and 22.5%).

Big differences between the country's different regions were noticed - 6% of the interviewed persons declared that they called 112 at least once. The emergency number was more frequently used in Bucharest (9.1%) compared with other regions where the number was used by 5%. The 112 emergency numbers was less used in the South-East development region (3.9%).

More than a half of these people didn't know the areas in which this number is available. Almost a third consider that this number is available only in Romania, 6% believes that the number is available only within EU, 4% only in Europe and 6.8% believes that the number is available all over the world.

2 of 5 persons didn't know what can be announced by dialling this number. Half of the people believed that by dialling 112 one can announce a car accident or if a person suffered an infarct or a stroke. A third considers that 112 is for informing about a train accident or a fire.

In the last year, the Ambulance System was used by 7% of the interviewed persons. This service was mostly used in Bucharest, North-West, South and South-West (8.3%, 8.8%, 8.7% and 8.8%) and less used in North-East – 2.8%.

14% of the interviewed people needed help from the hospitals' emergency room or from the Emergency Units during 2006. The emergency units were more needed in Bucharest, South and South-East (15.6%, 15.9% and 16%).

Lack of information about the existence of some specialized emergency services or about the way in which these services can be contacted:

4 of 5 persons heard about SMURD, the main information sources being: television (88.1%), radio (16.5%) or newspapers and magazines -11.6%.

The SMURD activity is appreciated as being good or very good – 98.4%. The grades from 1 to 10 were grouped two by two as follows: 1 and 2 very bad, 3 and 4 bad, 5 and 6 average, 7 and 8 good, 9 and 10 very good).

A third of the interviewed people consider that the Public Emergency Service's activity is the same in 2006 as it was in 2005 and another third were not able to make a comparison. Almost a third considers that the activity is better and 7% that it is worse.

The emergency rooms/ emergency units' activity is considered the same in 2006 as it was in 2005 by 2 of 5 persons. 12% consider that this activity is better, 5.7% that is worse and almost a half were not able to answer this question.

3 Improving quality of and access to health care for people at risk of poverty or social exclusion

3.1 Migrants, asylum seekers and illegal immigrants

In the current international situation, Romania – East European country situated at the crossroad that links the East to the West – is a part of the „Balcanic Route” of illegal migration. In case of an inefficient management, this fact could affect all the important areas of our society, including the state security and that of the citizens.

This geographical position together with the fact that Romania has joined the European Union on the 1st of January 2007 will lead to the following situation: very soon Romania will no longer be just a transit country but it will become a destination country for the economical immigrants from the East and from the Asiatic South.

The data supplied by the latest study carried on by the Romanian Government in 2006, (a study that analysed the migration phenomenon in Romania after 1990) show that the immigration fluxes started once again to see Romania as a potential destination country.

In 1991 the number of immigrants was of 1,602. After that year the tendency was ascendant, with certain variation from year to year. Between 1991 and

2002, the highest number of immigrants was registered in 1998 (11,907 persons, with 80.4% higher than in 1997 and over 7 times higher than in 1991). Between 1999 and 2001, the immigration phenomenon was constant (about 10,000-11,000 persons per year); in 2002 there was a decrease in the immigrants number (6,582 persons with 36.4% lower than in 2001). From 2002 the number of immigrants was constant, 4 times higher than in 1991.

The profile of the immigrant coming to Romania is the following:

- **Mostly men** – this is because most of the immigrants are coming to do business; as soon as the business is steady the businessmen (especially Turks and Chinese) are also bringing their families, which increased in some degree the number of women immigrants.

Initially (in 1991), the number of women immigrants was overwhelming (63.7% women and just 36.3% men); this characteristic disappeared and the proportion of men immigrants became the majority. The lowest number of women immigrants was confirmed to be in 1996 (35.7%).

Overall though, the genre structure of the immigration phenomenon was relatively balanced, with women representing about 47% and men 53%.

- **Young and adult persons, with high odds of finding jobs.**

Those over 51 years old never outrun 20% of the total (with one exception, in 1992); between 1991 and 2002 the average number of the immigrants older than 51 years represented 15.4%. Young people under 25 years old represented between 17%-35% of the total, and in the last years it was stabilized at 32-34%.

The most important segment of immigration was represented by the persons between 26-50 years old. This category, which is also the most interesting for the job market, represented 50%-59% of the total number of immigrants.

- **Favourite destination – urban area and especially Bucharest.**

The Romanian capital is on the first place in the immigrants' preferences. The second place as a favourite destination for immigrants is occupied by the North-East region (in 2001, this region was on the first place, instead of Bucharest). The North-West region is on the third place, west and Centre is on the fourth and the South-East region is on the fifth place. The South and South-West regions were least affected by the migration fluxes coming to Romania.

An estimation of the migration phenomenon for the period between 2007 – 2010, taking into account the tendency of the last years when the number of legal immigrants increased, showed that the number will rise to about 15,000-18,000 persons per year.

This figure is not meant to worry the Romanian authorities at the time being, but it has to be taken into account in order to create an appropriate system of managing the immigration. This complex system should be able to manage an eventual „crises situation” (*some analysts estimated that Romania's role as a buffer area for those willing to enter on the European Unions' territory – taking into account the fact that Romania has to manage 2,000 km of external EU border – could bring a number of 25,000 – 60,000 immigrants*).

This system should take into consideration the evolution tendencies of the Romanian population (birth rate, mobility etc) and to provide the social and integration means for the future immigrants.

Although huge efforts were made in Romania in order to improve the refugees and foreign citizen's situation, these services are not yet fully developed, because of the lack of previous experience, the low number of refugees and immigrants and also because of the limited financial resources.

As a result of these efforts, a new series of institutions appeared:

- The National Office for Refugees and Emigrants;
- The Ministry of Administration and Interior's departments; ex: Authority for Foreigners;
- The Romanian National Council for Refugees;

- The Romanian Forum for Refugees and Migrants;
- Many associations of the Turkish, Chinese or other nationalities' businessmen working in Romania;
- A great number of NGOs (Save the Children, The Jesuit Refugee Service Romania, The Organization of the Refugees Women in Romania etc.) that are trying to solve the refugees and immigrants' problems.

All these organizations have important results and are offering legal counselling, education for a complete integration within the Romanian society, training for different types of professions, courses in Romanian language, educational assistance, material assistance, psycho-social support, moral and emotional support and, of course, medical assistance. In partnership with the foreign businessmen living in Romania, these institutions are also involved in organizing schools, cultural activities, editing of magazines and newspapers in different languages, providing special services etc.

There was already mentioned that most of the refugees are living in Bucharest. There is a welcoming centre (Gociu) and an accommodation centre (Stolnicu), both in Bucharest and with place for 264 and 400 persons. Another centre was open in Timisoara (close to the western border) and another one in Galati (close to the eastern border). In the future it is expected that the number of refugees and asylum seekers in Romania will increase as a result of the general increase of the migration phenomena, of the fact that Romania is now an EU border and of the fact that Romania has acceded to the EU. There are also expected changes regarding the refugee's origins.

From a legally point of view, their access to the Romanian health care is as follows:

- Illegal refugees have no rights

The foreign people with a tolerated status in Romania (in conformity with the foreigners' law) have no socio-economical right and no access to health insurance.

- the Romanian Office for Immigration (as part of the Romanian Ministry of Internal Affairs) is taking care of all the immigrants' problems, including those related to health care
- there are active NGOs which can assist the immigrants in their efforts to obtain asylum and also another NGO, "Jesuit Refugee Service (JRS)" which is taking care of the illegal or tolerated immigrants.

A special problem is that of the vulnerable groups (e.g. unattended minors) that requires special welcoming, instruction and interviewing techniques in order to avoid some psychic trauma that could occur.

The evaluations showed that Romania had no major problems regarding immigration until now, especially if we compare it to other countries. For the future, Romania's accession to EU will lead to a better living standard which will attract increasing numbers of refugees and immigrants.

For now, there is a need of a modern informatics system that should collect the primary data and would allow a permanent contact between the local, national and international authorities. This would allow an effective surveillance of the phenomena and the comparisons with the global situation. The migration mechanisms would also be better monitored, taking into account the many changes that appear in time: the apparition of new migration forms, new migration motives etc.

The legislation referring to the migration phenomena can be divided into 3 categories:

1. Migration laws,
2. Work force market laws,

3. Diploma and grades' acknowledgement laws.

The present national legislative frame has the following configuration:

- a. Law no. 46 from 1991 for the inclusion of Romania as a member in the Geneva Convention (1951) and in the New York Protocol (1967) regarding the refugees statute;
- b. GD no. 44/2004 regarding the social integration of the foreigners that received a form of protection in Romania; the law was then modified by the GD. no. 41/2006
- c. [Government Decision no.1483/2004](#) for approving the methodological frame of applying the GD no. 44/2004 regarding the social integration of the foreigners that received a form of protection in Romania
- d. Law no. 122/2006 regarding asylum in Romania;
- e. Government Decision no. 1251/2006 for approving the methodological frame of applying the Law no.122/2006 regarding the asylum in Romania.

In order to accede to the European Union, Romania has done a series of progress:

- EU citizens need no visa in order to enter Romania and they don't have to explain the motives and conditions of their trip. Citizens from other countries, outside EU, need visas and residence permit;
- In conformity with the actual Romanian legislation, the Romanian state can offer three forms of protection: refugee status, conditioned humanitarian protection and humanitarian protection. The foreigners' social integration process can be added;
- A legislative frame has been developed in order to fight the human traffic. This includes cooperation with other countries, including those from EU.

- The law says that all foreign citizens need work permit in order to have jobs within the Romanian territory. Exceptions are the EU citizens and those coming from countries that signed the European Accord.

The last settlements adopted between 2005 and 2007 bring new elements regarding the refugees' status and the free circulation of the EU citizens. Also in 2005 the Government developed a long-term national strategy regarding migration, strategy that is closely monitored. This strategy is involving, among other things, the idea of fair access to health services.

In the future Romania will raise its institutional capacities in order to be able to cope with the migration phenomena. Being an EU border is not an easy task, so Romania will have to solve all the problems related to migration.

Regarding the health services, the National Health Insurance House uses the following guidelines:

1. Persons receiving a form of protection in Romania before the integration law (GD 44/2004) are obliged to pay the contribution to the national health insurance fund in conformity with their income, starting with the applying date of the foreigners' social integration law (art 259, line 11, Law no 95/2006).
2. Persons receiving a form of protection in Romania after the integration law (GD 44/2004) are obliged to pay the contribution to the national health insurance fund in conformity with their income, starting with the date of obtaining that form of protection (art 259, line 10, Law no 95/2006).
3. If the persons mentioned above have no taxable income, they will pay the health insurance contribution calculated as 6.5% from the minimum country income.
4. For the persons mentioned above (1. and 2.) no increases for delay are applied.

5. The persons, who receive no income on Romanian territory and are not insured, will pay a monthly contribution of 6.5% applied to the minimum country income.

A foreign citizen that lives in Romania will have to get the insurance from the regional social insurance houses. Otherwise he/she will support the costs of the health services needed.

According to the art. 211, Law no 95/2006 stipulations, all the Romanian citizens living within the Romanian borders and all the foreign citizens that obtained the residence permit or are living in Romania are insured if they can prove the payment of the contribution.

According to the art 214, Law no 95/2006 stipulations, insured persons coming from countries with which Romania has signed international agreements regarding health care are entitled to receive medical care and other medical services within the Romanian territory.

The social health insurance is optional for the following persons:

- a) members of the diplomatic missions accredited in Romania;
- b) foreign citizens that are temporary visiting Romania;
- c) Romanian citizens living abroad, visiting the country.

“Visiting the country” means being in the country for a short period of time, for tourism; mission; transit; sportive, cultural, scientifically and humanitarian activities, short term medical treatment etc.

The governmental and non-governmental organizations as well as professional associations are working in partnership in order to help this foreign people with information regarding their rights and duties from the health point of view. They organized seminars, round tables and workgroups with public authorities, NGOs and refugees on themes like “the right of the refugees to physical and mental health”. This effort eliminates the problem of language, the migrants having the opportunity of learning Romanian. In Romania, the Arabic population

represents an important percent since the time of the communist regime, when they were studying here. A very important number of Arab citizens have graduated medicine in Romania and are still working within the private or public health system. This is an important advantage for this ethnic group. There is also a higher understanding of their habits and religious beliefs.

The sustaining and advocacy actions for the improvement of the legislative frame regarding the refugees access (and especially of children) to health insurance led to an improvement of the laws. For example, foreign children are automatically registered in the national health system and are allowed to use the medical doctor's services, no matter if their parents are paying or not the health insurance. Unfortunately there is no report system of the National Health Insurance House that could inform about the number of health services needed by refugees. Most of them however, are paying for the services needed.

The migrants' discrimination has disappeared from the Social Services Law; the settlements with discriminatory potential were eliminated from the Refugees Social Integration Law project; foreigners and refugees received personal numbers since 2002, which allows them to access the social benefits system and the social protection system.

3.1.1 The Internal Migration

The internal migration process started in Romania during the period of the totalitarian regime, 30 years ago, as a result of the massive industrialization of certain regions of the country. This industrialization created a huge need of work force in these regions, which led to an impressive migration from rural to urban areas. And this led to the appearance of those heterogeneous communities living in huge blocks of flats, in the new town districts.

Today the Romania's population has a clear and continuous dropping tendency. Romania has now a population of 21 millions (15 years ago there were more than 23 millions people in Romania). The studies show that this tendency will continue and we will be the witnesses of a dramatically dropping of population, determined by the dropping of longevity and of birth rate and by external

migration. This proves that the life standard in Romania is dissatisfactory, the United Nations Development Program's (UNDP) study placing Romania on the 72nd place in the world from the point of view of the personal income. As a result of the continuous dropping of the birth rate and of higher life expectancy (20% of the population is over 60 years old), Romania is affected by a constant ageing process, the average age already being of 38 years old.

The National Institute of Statistics' information shows that 54% of the Romanian people live in urban areas, and only 53% of all the house holdings have running water (people from rural areas or small towns does not have this facility).

According to this study, presented by the team of sociologists, regarding some aspects of internal migration in Romania, the year of 1990 represents a very important moment when more than three quarters of a million people are legally changing their residence and thus raising the rate of internal migration to 33.9 per thousand. The internal migration fever is suddenly decreasing after 1991, but then another increase is registered between 1995 and 1997. Among the factors that contributed to that phenomenon we can mention the following: the changes made in the territorial-administrative organization (the number of villages is decreased with 37% and that of the cities is increased with 38%) and the economical events (the rate of investment, the increasing of the industrial production). Another migration factor is the commutation and the temporary or seasonal migration.

People use to migrate from rural to urban areas also because the big cities are more interesting for investors, the unemployment is much lower and the salaries are much higher. Sometimes, desperate people are coming to cities with no preliminary arrangement, no work place and no housing possibilities. These people are temporary outside the health care system and have no insurance. The only service available for them is the emergency one.

The same study shows that in the last years the tendency of the four migration fluxes (urban – urban, urban – rural, rural – urban, rural – rural) is to balance themselves: in 1994 the maximum was oriented towards the rural – urban direction, in 1995 the rural – rural direction is dominating, in 1996, urban –

urban and in the last years the urban – rural direction becomes dominant. Starting with 1997 the urban – rural migration becomes, for the first time in the Romanian contemporary history, the main direction of internal migration. This was caused by many reasons: lack of jobs, life in the cities is more expensive, lack of houses for the new families, a better life opportunity in the rural areas for elder people. Moreover, as a result of the land law, many of the people living in cities have become owners of pieces of land in the rural area. It is easy to understand that a piece of land can generate a profit, even if is not cultivated with modern tools.

Clearly, encouraging the people to move to the rural areas is not a solution at a macro-social level. Another interesting fact is that the urban – rural migration tendency is higher among the families than among the individuals.

However, people continue to migrate from rural to urban areas still today, in smaller numbers. This type of migration was replaced in some extent, in the last years, by the external migration.

The study of this migration form is based on two types of data:

- a) those from census
- b) those offered by different other institutions (E.g. the Ministry of Internal Affairs)

The last census was made in 2004 and shows that the situation was as follows:

- In 2004 - 174,447 people were moving to urban area
- 195,445 people were moving to rural area

The migration continued in both directions:

- 55% of the population coming to cities is between 20 and 39 years old.
- The population over 40 years old is preferring the rural areas (56,922 people moved to the country while 38,706 moved to the cities).

- So, young people prefer the urban area while people over 40 years old prefer the rural area.

The active population in Romania is represented by 10.5 millions people from which between 500,000 and 1 million are unemployed. The highly educated people are least affected by unemployment. The statistics show that two thirds are employed and one third is freelancers. The rest of 11 millions is represented by inactive population: 50% are pensioners, 40% are in the school process and the rest is represented by housewives, people in prison and other depended categories.

The same statistics consider that in Romania there are 6,000 very poor people, from which 41.6% are living in extreme poverty, although the Gross Internal Product has reached the value of 5000 euros per inhabitant in 2006. These huge differences between the people's contribution to the Gross Internal Product and the quality of their living determined the people from rural areas to work abroad. This phenomenon has already taken an impressive extent (almost 1 million Romanian families have one member working in other country) and it generates a series of very important social phenomena which must be solved: the families' breaking-up, the extreme suffering of the children left alone with no care and affection and which develop psychical trauma and even suicide.

There should be taken measures in order to eliminate the major differences between the country's different regions and to orientate the investors towards the smaller towns and rural areas. The number of people working in agriculture is dropping, being now of 32% of the occupied persons.

The actual and future politics have to generate opportunities in order for this category to be involved in the Gross Internal Product's development, which would also decrease the people's desire to emigrate. It is incredible that at this point, Romania has an important workforce deficit which would be solved only by political-economical measures designed to stimulate people and to determine the citizens working abroad to come back home.

The health system also has a problem from this point of view: a surveillance system must be developed in order to monitor the population's health status,

the chronically diseases, the children, the pregnant women etc. These population categories must also be monitored from the epidemiological point of view, vaccines, registered etc. Taking into account the fact that in rural area there is a total insufficient number of family doctors, it will be a real challenge to the system to succeed in offering the basic health services to the whole population coming in the rural area. As an important part of the population is represented by old people with their chronic health problems, a conclusion could be that the system is not in best position to solve this issue.

Conclusions regarding the impact on the health status:

- Difficulties for the migrating people to beneficiate from a family physician's services in case they do not have papers to prove a constant residence in the area.
- Usually, the local administration have no information regarding the new people coming to the Region
- The Roma population usually have no identity papers and it is impossible to determine their legal presence in a certain area or another.
- These people are temporary outside the health care system and have no insurance. The only service available for them is the emergency one.
- As a result, the new-comers do not beneficiate of:
 - o Discounted drugs
 - o National immunization campaigns
 - o Health education
 - o Health promotion
 - o Other preventive interventions
- There are 145,110 inhabitants in rural areas without family doctors.

- 24,359 persons are not assisted by any medical personnel.
- Almost 300 Romanian localities have no physicians at all.

(National Institute of Statistics – “The Social and Economic Situation in Romania in 2003-2004”).

- An important part of the people migrating to the rural area is represented by the older population (10%), pensioners with not enough money to support themselves in the cities.
- Especially for this category there is an important lack of specialized services in the rural area.
- plata asigurarii la casa

Conclusions and Recommendations

- Taking into account the fact that in rural area there is a total insufficient number of family doctors, it will be a real challenge to the system to succeed in offering the basic health services to the whole population coming to the rural area.
- A surveillance system must be developed in order to monitor
 - o the population’s health status,
 - o the chronically diseases,
 - o the children,
 - o the pregnant women etc.
- These population categories must also be monitored from the epidemiological point of view, vaccines, registration etc
- Urgent measures are needed in order for the social insurance system, the health care system and the educational system to be able to cope with these changes and with the constant migration process

- In October 2006, the parliament established the conditions needed in order to avoid the negative consequences of the internal migration in Romania:
 - o All the official institutions and the Civil Society must collaborate and join their efforts.
 - o The decision factors must take action in the areas that influence the population's situation.
- Following other EU countries' example, a structure has been created within the Romanian Parliament.
- This new structure has attributions within the population and the development area.
- The main attributions of this structure should be:
 - o Supplying the Parliament and other institutions with data and research regarding the evolution and migration of the Romanian population.
 - o Creating and developing a legislative frame in order to solve the population's problems.
 - o Using the national resources in order to solve the population's problems.
 - o Monitoring the activity of the governmental institutions responsible for developing and population.
- The UNFPA Report from this year considers that people with low income are a very important component of the migration towards the cities and the cities' growth is depending on natural growth and migration.

Three types of measures are needed:

1. Accepting the poor people's right to live in cities and cancelling the politics meant to discourage migration.
2. Adopting a long term strategy regarding the use of the urban areas. This would lead to the construction of new living areas and new city borders.
3. Initiating an international effort in order to sustain the strategies for the future urban areas.

3.2 Older People with Functional Limitation

In the last 10 years, Romania's population registered a constant tendency of decreasing, as a result of the low birth rate, high mortality and external migration.

From over 23 millions people in 1989, in Romania are now living 21 millions people; the same number of people were living in Romania 30 years ago. An American study consider that the tendency will remain the same and that in 2050 Romania will have a population of only 15 million people. The main causes for this situation are: the decrease of the longevity, low birth rate and emigration.

According to the UNDP (United Nations Development Program) classification, Romania finds itself on one of the last places in Europe and on the 72nd place in the world regarding the personal income, life hope and educational level of the population. These three elements define the life quality index. Population in Romania is getting older. The average age has risen with 3 years in the last decade, being now of 38 years. Almost 20% of the population is people over 60 years old and, according to the National Institute of Statistics, 54% of Romanian population lives in cities.

Talking about older people, especially those with functional limitation, the Romania government has some precise strategic targets in order to improve the social protection system in Romania:

- The reduction of poverty and social exclusion;
- The improvement of the life standard for older people;
- The access to the social insurance system will be proportionally with the contributions level;
- The progressive reduction of the number of assisted people and encouraging these people to find alternative sources of social security;
- The improvement of conditions leading to equality of chances and social participation of handicapped and marginalized persons.

Therefore, according to the government program, the Romanian Government will promote the following measures:

1. The reformation of the public pensions' system.

One of the Government priorities is that of improving the life standard of older people by reforming the social insurance system. In order to solve the main problem of the pensions' system, the Romanian government will apply a unitary set of legislative measures targeted on three main objectives:

- the financial consolidation of the public system of pensions thus allowing a decent income for the people within the system (pensioners);
- the reconstruction of the public system of social insurance;
- Introducing new alternative of financing and administrating the pensions, such as capitalized pensions with private administration.

The Romanian government strives to eliminate the inequities existent in the pension system and to raise the buying capacity of the pensioners by speeding the recalculation of all the pensions, in order to apply the principle: "for equal working conditions, equal pensions, regardless the pensioning year". The recalculated pensions will be paid according to the pensioners groups, the first group being that of the persons that were pensioned until the 1st of January

1990. In order to protect the buying capacity of the pensions, all the recalculated pensions will be increased with the prices' raising index.

2. Pensions' increment.

The pensioners have to beneficiate of the economical raise advantages. Therefore, the pensions will be raised with approximately 30% until 2008.

3. The increment of the buying capacity for the pensioners from agriculture.

The necessary sums for the pensioners coming from agriculture will come from the state budget and will be administrated by the National Pensions House, in the same conditions as the public system pensions. Pensions from agriculture will be raised with the same index as the public pensions.

4. Increasing the social insurance budget.

The aim in this case is to reach financial, administrative and functional consolidation of the current public system of pensions. This will require the following measures:

- Increasing the pensions' collecting degree
- Reducing the delays within the pensions' budget
- Increasing the number of people contributing to the system by:
 - Active politics within the job market in order to create new workplaces and to increase the number of legal workers.
 - Drawing the people working in agriculture and freelancers to the system.
 - Including the Romanian citizens working abroad in the social insurance system.
- Strengthening the institutional and management capacity of the pensions' system by:

- According the decision and management autonomy for the National Pensions House.
 - Internal reorganization of the National Pensions House in order to create flexible structures, clear delegation of responsibilities etc.
 - Changing the number of employees from the central structures and orienting them to the local structures in order to build a transparent relation with the public and to improve the efficiency.
 - Speeding up the IT structure's development (networks, database, software and training).
 - Creating a selection and attitude instruction system for the National Pensions House employees.
- Introducing new private administrated components in the pensions' system in order to improve the pensioners' life quality
 - Introducing the facultative private pensions schemes
 - Improving the law project regarding occupational pensions (contributions, discounts, covering degree, rules and surveillance, investments and guarantees)
 - Supplementing the occupational pensions' system with legislative components regarding the employees of the budgetary system and of public institutions
 - Introducing the compulsory pension's funds with private administration, with a transparent and efficient public control regarding their administration.

From the moment of the communist regime fall, the state's role in our lives has changed. Its role of complete master over people is gradually diminished by the more concrete, private and nongovernmental interventions. As a result, after the parliament debate over the private pensions problem, it was decided that starting with 2006, the employees younger than 45 years old were able to pay

for three kinds of pensions: public, public but with private administration and occupational. Therefore, they will receive three pensions.

From the point of view of health services' quality, the sanitary system's reform is way behind at this moment. This is the reason of the low quality health care, of failing to increase the population's access to these services and failing to decrease the mortality and morbidity indicators. An important segment of the population does not have access to health care because of financially and transport difficulties. There are also a series of health and demographical indicators that continue to place us on unacceptable positions within the European classification. The health budget and the total health expenditures for each citizen place us on one of the lowest ranks among the EU countries. Because of this chronically under finance, the health system's management is of poor quality and has dramatic effects over the efficiency with which the population's health contributions are spent.

The Law regarding the Health Reform has an important role because in chapter 5 is talking about the community medical assistance and the services it delivers. According to this law, the programs and services of the community medical assistance are carried on in conformity with the strategies and politics elaborated by the Ministry of Public Health, Ministry of Work, Social Solidarity and Family, National Authority for Handicapped Persons, National Agency for Family Protection and other local authorities.

In order to coordinate the community medical assistance and the implementation of this program, a new institution has been created: the Interdepartmental Commission for Community Medical Assistance, directly under the prime-minister's authority. The commission's role is that of designing the national strategy in the field of community assistance, organizing the priorities at the community level and establishing the necessary funds. The people beneficiating the community medical care services are living within a certain geographical area: district, city or village, and are members of the vulnerable categories. A very important category of vulnerable people is

constituted by older people, especially those with chronically diseases and disabilities. The community assistance programs are financed by the state budget, the local authorities' budget and other sources, including donations and sponsorships. According to the information published on the www.medic.ro website, all the actual governs share the same problem: the health care costs are rising over the people's capacity to pay, specially using collective means, such as social insurance. The most affected category is that of older people, since they have the lowest income and the highest need of health care.

According to the UN report, the old population has reached 500 millions in the entire world and it is expected to rise to 1 billion until 2025, which means 14% of the entire population of the planet. In Romania, older population represents 17% of the general population. This phenomenon is correlated with the decrease of the birth rate in the last 20 years in many countries, with the effect of youth migration and with the increase of mortality. The National Institute of Statistics observed the fact that in Romania the number of people over 60 years old is considerably higher in 2002 than it used to be in 1992. In the same time, the number of children between 0-14 years old is dropping. There were an average number of 6,187 pensioners in the 1st semester of 2005 and the average monthly income of the social insured pensioners was higher with 3.4% in this semester than in the 4th semester of 2004.

As a result of the higher number of older people, the percent of chronically diseases associated with this age, such as cardiovascular diseases, hip fracture and Alzheimer, is also higher. The persons affected by these diseases are high health care consumers and require home care. As an example, the hip fracture causes physical limitation, hospitalization, continuous morbidity and excessive mortality. In Romania these people have a very difficult situation because of the very limited funds. The hip fracture and physical handicaps involve institutionalization but the most important factor remains the cognitive invalidity. In addition to these problems, population nowadays has certain opinions and preconceptions regarding older people. They are considered completely inadaptable to changes, conservatory, old fashioned, dominated by strange mentalities, selfish, irascible, helpless, depending on others, ill and useless. Therefore a conception change is needed, in order to create a favourable

feeling towards the older people and their problems, because there is more and more difficult for them to find their place within the modern society.

Old people's first contact with the system is made through the family doctor, which solves many of their health problems. But in many cases the old patient needs hospitalization and then home care. There is a series of diseases such as arthritis, osteoporosis, cardiac diseases, cancer or Alzheimer

At this age there are also a series of changes, including hearing problems or taste problems (lack of perception for salt and sour). The antibodies' number is rising with age; a third of the men and half of the women over 60 years old have the symptoms of arthritis. Half of the people over 65 years old are losing all their teeth. Generally speaking, half of the people over 85 years old have between 3 and 9 associated pathological conditions and usually their cause of death remain unknown.

The development of some effective programs that would help older people to work after their pension age should be a state politic.

According to the study realized in 2006 by Mrs. Ana Bleahu, sociologist at the **Institute for Quality of Life's Research**, there are certain mechanisms of social exclusion from the health services regarding certain population categories, such as older population:

- Formal exclusion: all the people who does not fulfil the legal conditions in order to beneficiate of medical assistance using the health insurance system;
- Informal exclusion: the insurance people that fulfil the legal condition but have no access to services (they don't know their rights as insured persons, they have not enough money for transport or are unable to pay eventual supplementary costs). The rejected persons usually have very low income or are living within areas with very poor medical services; they have a low educational level, a minority professional or ethnic status, and old people with low or very low income.

All these problems are caused because of certain phenomena:

- Uneven distribution of the medical units;
- The formal and informal costs of the medical assistance. It is a known fact that in order to receive certain health services that are supposed to be free, the patients have to make informal payments. In case of hospitalization, the costs are considerably higher. Recent national level studies showed that 41% of the interviewed persons paid extra sums of money to the medical staff, while 63% were treated very good although they didn't offer any informal payment;
- Another important element is represented by the low quality of the medical activity (sanitary units working without authorization, very low quality medical equipments etc);
- The obvious disproportion between the prophylactic health care and the curative health care. The curative medical activities are much more developed, despite the constant efforts of raising the health education level;
- The difficulties of the family doctors, suffocated by the bureaucratically and administrative problems: they have to pay large sums of money for their offices, the extreme bureaucracy does not leave time for them to check their patients, their salaries are completely discouraging, they have much more patients than they can handle (sometimes their patients lists contain more than 3000 patients while the optimum number is of 1000 patients), their patients have sometimes a complete lack of information and they don't have time to explain to them what they should now. Moreover, many of them are living far away from their offices, which very much hinder their possibility to help their patients in certain cases. Another big problem is the low number of nurses and pharmacies in certain areas.

At this time, Romania is confronted with a major deficit of services destined to help the older people with different degrees of functional limitations, those with no families or those in need of special permanent services offered within specialized institutions. A new system of medical assistance has been

developed for the people with Alzheimer, but this system is totally insufficient. The recovery services used after strokes are also poor. There is no such assistance as „hospice” or even medical units which could provide temporary care for old people, in order to ease the family’s life. A great problem is the lack of institutions that could offer lifetime medical assistance for people without family.

The lack of these services increases the people’s fear of these kinds of inevitable life situations. Decent living for older people is an absolute necessity and this problem should be rapidly solved in a civilized society which respects its elders.

3.3 People with Mental Health Disorders

According to the Ministry of Health declaration, there is a big concern related to the health problems in Romania. Unfortunately, in Romania, we do not have recent epidemiological studies (which are very expensive) but there is no reason to believe that Romania is situated below the theoretical level presented by the WHO Annual Report 2001 which underline that five out of ten leading causes of disability are represented by psychiatric conditions. Of course Romania have enough indicators suggesting significant higher values for the last decade, comparing with the European average like: the increased number of abuses and addiction to psychoactive substances, a higher suicide rate, the general deterioration of the health condition of the population, the higher unemployment rate, the development of the aggressive and violent behaviours and generally speaking a supra-saturation of the people with stress factors. From the point of the access of the people with mental health problems to the somatic care services, Romania doesn’t have representatives studies, but according to the interviews with the mental health NGO’s representatives in Romania there is some very important issues to be mentioned :

- Regarding the people with mental health problems who want to benefit of other medical services, a big barrier is represented by the very long waiting lists
- Other medical consultations are considerably delayed because of the amount of additional papers needed by the patient with mental health problems
- There is no official co-payment system but in this case too the under the table payment is in use
- Unfortunately in Romania there are no crises intervention centers or shelters for people with mental health problems with no family or no one to take care of them. There are no reconciliation centers, no specialized help and no national programs to help them integrate in the society.
- Regarding the discrimination, a very serious thing is that the physicians with other specialties have a worse opinion about the patients with mental health problems than the general population. The teaching process has the same problem: the medical school students are going to hospitals where they get into contact only with seriously affected patients without seeing the final effect of the therapy. This leads to the preconceived idea that the patients with mental problems are impossible to treat and taking care of them is a waste of time.
- Patients who reported a mental illness diagnosis showed greater access problems across all access measures when they were examined separately – the measures including delays in the programming of appointments, in the waiting time to see a doctor, in physical access to the doctor's office, in financial access, counseling, access to regular check-ups and access to specialized services such as dentistry or oculists.

Besides that, a psychiatric condition of a person represents a source of alteration of the social micro group – familial, professional - an equilibrium within which the person lives.

The Ministry of Health recognizes that the mental health care in Romania is focused in present on the psychiatric hospitals and they are subordinated to an excessively biological model. Despite this situation, the number of psychiatric beds is one of the lowest in Europe – 76.1 beds for 100,000 inhabitants. In the same time, there is no formal communication between the long-term care institutions and the ambulatory ones, the continuity of care being limited to the level of administration of a certain psychotropic drug. On the other hand, there is no certain specialization, the concept of therapeutic team and community care is inexistent. Unfortunately, among the population there are still some negative images regarding the psychiatric illness, psychiatric patients, structures and professional help. From all this reasons, the Ministry of Health proposes itself to adopt an appropriate mental health policy.

First of all the MOH pays attention to the prevention aspects and takes into consideration three types of prevention, according to the target population:

- General prevention that have a target general population
- Selective prevention that has as target population groups that are exposed to a significant higher risk than the average population to develop psychiatric conditions (institutionalized children, children and teenagers with heredo-colateral antecedents for alcohol and other drugs addiction, convalescent children after brain aggressions etc.)
- Focused prevention targeting the high-risk groups (minimal symptoms, genetic predisposition without fitting the international diagnostic criteria for a clear mental illness).

The main direction in the field of preventive interventions is oriented to the educational, medical and social assistance programs.

One of the very important concerns of the MOH is related to the secondary and tertiary health care based on the territoriality, therapeutic team, continuity of care, community orientation. The main structures involved in the mental health programs should be: mental health centres, psychiatric hospitals, psychiatric

wards from the general hospital, crisis intervention centres and also specialized networks focused on addiction, geronto-psychiatry.

The second step of the MOH reform strategy was oriented to the actual care system. The mental health infrastructure is realized by 38 mental hospitals and 75 psychiatric sections in general hospitals, 16,700 beds (76/100,000 inhabitants), 4,800 are for chronically patients and 66 Mental Health Laboratories (outpatient services). See Annex 2.

After the system evaluation we can anticipate the needs of training and specialization of the cares, needs of raising the competences in the domain of management and attracting of resources for existing services, needs of increasing the teamwork abilities and developing also new skills in the establishment of partnership with the representatives of the community, representatives of services users and also other institutions or organizations interested in the field.

On the other hand, the community mental health services are only experimental, the services for elderly people are underdeveloped, the sheltered housing projects are only experimental and the care model is old fashioned (not client centred). The third issue is related to the legislation framework and the evaluation of the financial resources and finally the monitoring processes.

From the point of view of the values that the MOH respect, one of them is represented by the quality and accessibility to the mental health care. That means to make the services known by the persons that need care. In to the MOH strategy there is included the idea of the therapeutic teams in social action, working in the communities and belonging to the communities in order to solve all the problems related to the linguistic accessibility for the minorities, related to the easy locations to identify and reach, involvement of the team in to the information, education and communication campaigns to the general population in order to decrease the level of the discrimination and stigma for the people affected.

From the financial point of view there are some problems, recognised by everybody, such as: the low national budget on healthcare, the mental hospitals

are all state owned, the National Health Assurance House is the unique financial body and the budget is very small, the same with the budget from the MOH and there is also a imperative need from the local authorities to provide the buildings to be dedicated to the mental health care system.

A very important input is represented by the Peer Assessment Mission on Mental Health in Romania, which took place on February 2006. This event is being run as part of the priority peer reviews set up by the European Commission. According to this mission report, the MOH measures are very general and they do not contain concrete solutions concerning the real program of restructuring involving a target network of facilities and showing the planned sources of funding, division into health and social policy domains, or definition of the timetable for proposed changes. The consequence is that the state support for the existing local initiatives, including those proposed by NGOs, has to be an integral part of the restructuring effort. The MOH action plan for the strategy implementation established the principle of covering areas for mental health services having like focal point the Community Mental Health Centre staffed with a multidisciplinary team. The complete process of the Action Plan implementation may be difficult and expensive at present and the specific feasibility of its gradual implementation should be analyzed.

Among the conclusions of the report we can underline:

- There is a certain improvement of the life conditions in to the metal health hospitals if we compare it with the year 2004 and also a process of undertaking of necessary reconstruction and repairs has started, particularly regarding the heating systems. This means that an effort has been made to satisfy the most basic needs.
- Another very important conclusion is that one of the major problems of the psychiatric hospitals is represented by the resident patients. Mentally retarded patients are a separate, distinct group for which psychiatric hospitals are not the proper place to be.
- As already mentioned, “the psychiatric hospitals are very “medically” oriented. Their work is based on the biological model of metal illness

and this makes rehabilitation difficult. The staff has a paternalistic approach to the patients and is afraid to share responsibility with patients with respect to both the treatment process and the running of the institution”

- After many contacts with the doctors, the conclusion was that the pharmacotherapy varies greatly from hospital to hospital and seems to depend on local conditions rather than on the general principle of pharmacotherapy and its funding.
- One of the main problems is the fact that there is no community psychiatry on a broad scale, the community-oriented centres being developed by NGOs and not supported by local (country) or central authorities. “The location of hospitals is an additional impediment to the development of community psychiatry. These hospitals are often out of town where they are very inaccessible. This does not help patient-community relations, either during visits or during patients’ independent outings”.
- “A problem which all hospitals share is the lack of generics on the market and the tendency to withdraw cheaper drugs. A factor which apparently seriously affects the methods of treatment is the very short period of reimbursement of acute treatment”. Seventeen days is too short a period to evaluate the effectiveness of e.g., antidepressant treatment.
- “Another impediment is the lack of legal regulations concerning patients’ stay away from the ward (so-called liberty tickets). Most hospitals agree to one-day, chaperoned patient outings to arrange essential business (e.g., apply for pension etc.). Longer outings are impossible because it is not clear who is responsible for the patient at the time and how the National Health Insurance House is to reimburse the days when patients are absent”.

The legislation framework is represented by some initiative of the government in the last time, focused on mental health problems like The Law on Mental Health

and Protection of People with Psychological Disorders which came into force in August 2002 and prescribed the procedure for the placement of patients for involuntary treatment. A special psychiatric commission should confirm within 72 hours of a person's admission to a hospital. Furthermore, this assessment should be reviewed within 24 hours by the public prosecutor whose decision, in turn, may be appealed before a court. A commission should review the need for involuntary treatment every 15 days. However, the regulations necessary for enforcement of the Mental Health Law are still unavailable.

The basic legislation framework is represented by the Law on Mental Health and Protection of People with Mental Disorders signed in 2002 and the application norms of this law validated in 2005. Inside this framework, the most recent progress in the field of mental health politics are focused on some issues related mainly to the quality of mental health care and also to the accessibility to the mental health services.

From the point of view of the staff, the absolutely insufficient number of nurse and medical doctors in to the network represents a real barrier. For example, the number of psychiatrics is around 4.2 to 100,000 inhabitants, almost all of them working in the big cities. Also the number of psychologists and the number of psychiatric hospitals are very low. Besides that we can associate this with a low number of social assistants and with the low level of knowledge and skills in the field of psychiatric problems, among the family doctors which are the gatekeepers of the system. There was also o sort of delay regarding the implementation norms of the legislation and also in the process of Community Mental Health Centres building.

The mentioned law pays attention to the improvement of the social and legal position of the people having mental disorders, through the improvement of the quality of the mental health care system, the mental health promotion and increased level of knowledge among the people, the improvement of the mental health status evaluation and diagnostic procedures. The law also pays attention to barriers like: the fact that the mental health care at the community level is just experimental, the services for older people are very low developed, the projects for sheltered housing are also just experimental and the mental care system is

very old. From the financial point of view, the state budget allocated to the health system is totally insufficient and for all the psychiatric hospitals, the state is the owner. The application norms of the law pays attention to some aspects regarding different procedures, the mental health patients rights, aspects related to confidentiality and effort dedicated to stigma elimination.

A strong international cooperation just started through projects like SEE Mental Health Project, PHARE Twinning Light Project for the action plan, MATRA project on forensic psychiatric hospitals started in April 2006, and PHARE Project 2006 – Community Mental Health Centres Development. In 2006 some actions were implemented:

- The National Centre for Mental Health was officially built
- 110 observers for mental health patients' human rights started to work within the psychiatric hospitals
- 7 hospitals received funds for rehabilitation
- 10 Community Mental Health Centres started to function in the whole country.

As a conclusion, it is very important to mention the recommendation of the Peer Assessment Mission on Mental Health in Romania at the end of the contact with the mental health care system.

“1. The deinstitutionalization program should be linked up with decentralization which enables the development of local plans and investments based on local regional needs. Deinstitutionalization should proceed in two directions: a program for “resident” patients and prevention of the institutionalization of new patients. As far as patients hospitalized for years on end are concerned, the first step should be to begin actual rehabilitation within the hospital framework. This means “demedicalization” of the institutions, at least as far as these patients are concerned. The patients should be allowed to have personal belongings, learn to care for themselves, prepare meals and undertake various activities on behalf of the community. In other words, the first step would be to develop more

homely conditions at the hospital. Patients should also be able to leave the premises freely. Hospitals should be able to employ social workers responsible only for this group of patients. It would be their job to evaluate the situation of each of these individuals and the feasibility of them living away from hospital. Some NGOs in Romania manage to track down patients' families after many years and even if families are unwilling to look after the patient, revival of family ties is an important rehabilitation factor. The next step would be to create community-oriented institutions other than the hospital for this group of patients, i.e., hostels, protected dwellings etc.

As far as new patients are concerned, it is necessary to modify the system of psychiatric care with respect to both treatment and rehabilitation and in the same time, the mental health community centres should be developed.

2. The situation within the hospitals needs to be changed – therapeutic community principles need to be introduced, staff needs to be increased – this applies mainly to staff responsible for rehabilitation – and personnel needs to be trained in community psychiatry. Personnel training should be conducted on site because, since staff is so scarce, large-scale training off site just doesn't seem to be feasible. On the other hand, group training, especially at workshops, may encourage therapeutic team development. Patients should also be able to integrate with the community with the help of liberty tickets and day care.

3. Actual implementation of the Law on Mental Health by means of adopting the necessary regulations, and training of hospital staff, emergency service staff, police, judges and prosecutors so that they are able to interpret the Law's regulations properly. It is also necessary to clearly define the procedures for restraint and enforcement of seclusion.

4. Treatment of "acute" patients should be longer so as to prevent the revolving door effect. Term of treatment at day wards should definitely be prolonged so as to promote this less expensive and socially more beneficial treatment system.

5. Application of electroconvulsive therapy should be limited and never be applied without anaesthesia.

6. Special restructuring programs for large psychiatric hospitals should be developed and the existing programs should be used.

7. Special commissions should be appointed to investigate abuse of patients at the level of hospitals”.

This short presentation regarding the health care problem in the mental health field shows that Romania should start to build a very modern, cost-efficient and non discriminating system. In this moment could be a good opportunity to use the decision makers' interest and the European Union support to put in practice a good strategy and an efficient action plan that already exists. All the people involved in the mental health network express their wish to start to build a modern system with trained mental health specialists, with an appropriate infrastructure using a very efficient communication system and also to contribute to a serious mental health education to the general population, decision makers and medical doctors in order to eliminate the mental health disorders stigma.

4 Conclusions

There are some very important conclusions regarding the future access barriers to the health care system. For example, the increasing differences between different social categories from the rural and urban area from the income point of view will affect, of course, the rapidity of the health care access of this people. It will be easier for the people living in urban area, and having a reasonable income to use the services of high performance medical units that exist near their homes. In the same time, the rural population living far away from these advanced medical units have a series of extra inconvenient regarding the transportation problem and extra costs. These inconvenient are very important for a population with very low financial resources.

Also, the health educational level and health promotion have evolved very slowly. The stakeholders have only admitted the importance of these actions

through declarations, but this was not reflected in the health education and promotion budgets. This fact, combined with the problematic primary infrastructure, with the lack of medical staff, especially in the rural areas and with the frequent legislative changes generated confusion and lack of confidence and determined a dropping of the medical services used.

The system is currently under a reform meant to increase the health services quality and access through the implementation of certain legislative measures. In the same time a new process is taking place: introducing the private health insurance that can become a good alternative for a certain population category.

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