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Pensions, Health Care and Long-term Care

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Table of Contents

1 Executive Summary **3**

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011) **4**

2.1 Overarching developments **4**

2.2 Pensions **6**
2.2.1 The system's characteristics and reforms 6
2.2.2 Debates and political discourse 10
2.2.3 Impact of EU social policies on the national level 11
2.2.4 Impact assessment 12
2.2.5 Critical assessment of reforms, discussions and research carried out 14

2.3 Health Care **17**
2.3.1 The system's characteristics and reforms 17
2.3.2 Debates and political discourse 19
2.3.3 Impact of EU social policies on the national level 20
2.3.4 Impact assessment 20
2.3.5 Critical assessment of reforms, discussions and research carried out 22

2.4 Long-term Care **23**
2.4.1 The system's characteristics and reforms 23
2.4.2 Debates and political discourse 25
2.4.3 Impact of EU social policies on the national level 25
2.4.4 Impact assessment 25
2.4.5 Critical assessment of reforms, discussions and research carried out 28

References **30**

3 Abstracts of Relevant Publications on Social Protection **34**

4 List of Important Institutions **38**

1 Executive Summary

The severity of economic recession constrained the Romanian government to initiate in 2010 a set of austerity measures, aimed in principal at reducing the public spending. These measures affected all the components of the social protection sector.

A legislative package was adopted in the pension system, the most relevant being the law on the unitary pension system. The reform integrates special regimes of pensions in the social insurance one, introduces a mechanism for recalculating the special pensions, and increases the retirement age to 65 years for men and 63 years for women. Early retirement is more strictly regulated, while disability pensions are granted under more severe conditions. The reforms are expected to bring important savings to the system and to reduce the number of beneficiaries. In parallel, as a policy for increasing the number of contributors, a new Labour Code was passed by the parliament, which institutes higher flexibility on the labour market. However, the estimated impact of pension reforms might be too optimistic in terms of savings, reduction in the number of beneficiaries and increase of the cohort of contributors.

In the health care sector, two principal measures were adopted in 2010: the introduction of a co-payment mechanism that will bring additional resources to the under-financed health system, respectively the initiation of hospitals decentralisation, which will pass under the responsibility of local authorities. The two directions of reform are expected to improve the overall efficiency of the system, the quality of medical services and the access of vulnerable groups to those services, but equally to produce important savings for the budget. Nevertheless, the final outcome of these measures is likely to be below the expectations. The decentralisation of hospitals will not solve the chronic problem of their under-financing; moreover, the insufficiency of resources might be accentuated by the impossibility of local authorities to raise the necessary funds to finance the hospitals under their responsibility. The co-payment will reduce furthermore the access to health care of a relatively large number of low-income persons.

The reforms in the pension and health care sectors were accompanied by a complete revision of the system of social assistance. A significant number of transfers were eliminated, other were reduced proportionally, while the eligibility conditions became stricter. This initiative may therefore augment the poverty rate within certain categories of population, in particular the aged persons, who represent the largest group of social assistance beneficiaries.

The long-term care in Romania is defined as social and medical services delivered to dependent persons in residential institutions, non-residential centres, respectively at the beneficiary's residence. The system concerns elderly and disabled persons; medical treatment for acute diseases or for the majority of chronic diseases is not considered as part of the long-term care. In 2010, the government decided to increase the number of residential institutions for aged persons from 25 to 96, by converting 67 hospitals in specialised centres. In case of institutionalised persons with disability, a government decision was drafted for restructuring the existing residential units.

Overall, the recent reforms initiated in the field of social protection are both necessary and urgent. They will certainly impact on the cost of providing the services by ameliorating the overall efficiency of each domain of social protection. Nevertheless, the negative effects have not been considered and consequently they cannot be prevented without complementary measures to protect those who will be affected the most. On the other hand, the expected positive implications of reforms might be over-estimated, as they are based on rather general assumptions and not on solid analyses for quantifying their impact.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

Two years of drastic recession, to which the Romanian economy was confronted, ended up with a drop of 2010 GDP by 10% as compared to its 2008 level. The decline was mainly the result of a 15% decrease in consumption, both private and public. The private component was significantly affected by the tremendous fall of remittances, which recorded only US$ 4.5 billion in 2010, as compared to US$ 9.3 billion in 2008.

The crisis induced a noticeable change in the structure of the economy, which consequently influenced the sectoral employment. As Table 1 shows, the contribution to GDP of industry and financial services increased, in the detriment of constructions, domestic trade and services. As a result, the contribution of the export sector to GDP formation increased, but the contribution of investment declined by 5 percentage points over the two years of recession.

Table 1: Contribution to GDP of economic activities (%)

Activity	2008	2010
Industry	23.0	26.5
Financial services	12.6	13.9
Constructions*	10.5	8.9
Trade	23.3	21.1
Services	13.6	12.5
Investment	31.5	26.5
Exports	31.0	36.0
Imports	43.0	41.0

The 2010 inflation – the highest within the EU area – almost doubled when compared to 2009, mostly driven by the increase of VAT rate from 19% to 24%[1], but equally by the rise in food prices.

By the end of 2010, the unemployment rate reached 6.9% of the labour force. The participation rate remains low when compared to the EU average: 60.2% for the population aged 15 – 64 years (64.3% in rural areas, respectively 57.3% in urban zones). The unemployment rate seems to be actually higher; according to Tugui (2011), 570 thousand additional persons were unemployed in 2010, but they disappeared from statistical records because the period for which they were entitled to unemployment benefits was over. In a year and a half of economic crisis, Romania lost more jobs that the Eastern European countries altogether; all the workplaces created between 2002 and 2008 – the period of high economic growth – were practically destroyed in less than two years of recession.

The crisis seems to have contributed to the flourishing of the informal economy: only from VAT evasion, the budget lost the equivalent of 4 to 5% of GDP, according to official statistics. To a large extent, the tax evasion in Romania is the consequence of instability of fiscal legislation. The fiscal code, for example, has changed 60 times since 2004 – 10 times in the last 12 months (Croitoru, 2010).

The corruption at all levels remains important. While the EU finds insufficient the efforts of Romanian authorities to combat the phenomenon (EU RAPID, 2010), the population remains sceptical with respect to the ability of the government to fight corruption[2]. Confronted with a

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[1] In average, each person will have to spend an additional amount of RON 32 (EURO 8) every month, for the same quantity of commodities purchased, as a result of VAT increase (Davidescu, 2010).

[2] 83% of Romanians think that the government is not able or not willing to combat the corruption (TI-RO, 2010).

multitude of difficulties, certain nostalgia for previous communist times gained the population: a recent IRES (2010) survey concluded that 41% of Romanians would vote for Ceausescu if he were a candidate to presidential elections.

In response to the crisis, the government initiated a package of anti-crisis measures together with a programme of austerity. The first element was supposed to re-launch the economy, while the second to reduce the public spending. The anti-crisis measures have been financed from foreign borrowing, in principal from IMF, which contributed to a rapid increase of the public debt. By mid-2010, the total debt was twice as high as in 2007, of which 94% represented governmental debt. As a result, the authorities initiated a set of drastic measures of austerity, most of them targeting the social protection sector. The public pension system – facing serious sustainability problems – started to be reformed through the adoption of a new law. The health care sector – confronted with severe under-financing – has been reorganised. The social assistance – highly inefficient and costly – has been completely revised.

The anti-crisis measures have not been conclusive in terms of their impact on economic recovery, but the austerity package will certainly improve the efficiency of using resources at least in some components of social protection – most probably the social assistance one. New principles and mechanisms are in place, supposed to improve efficiency and equity, which will definitely redefine and re-orientate the social protection policies of the country.

In order to bring consistency between anti-crisis measures and austerity policies, the Romanian government decided to revise the labour market conditions and adopted in March 2011 a new Labour Code[3], as well as a Social Code (currently under public debate). The later combines the Employer Law, the Social Dialogue Law, the Law on Work Conflicts, the Law on Collective Bargaining, and the Law on the organisation of the Socio-Economic Council. The most debated and contested document is the Labour Code. Aimed at increasing the flexibility on the labour market, the final version of the law is the result of thirteen rounds of negotiations between government, employers and trade unions. Nevertheless, the social partners have been unable to reach a final agreement and consequently the government had to assume its responsibility for the law, in order to have it implemented. The Labour Code eases the firing procedures and facilitates the use of temporary work contracts in the detriment of open-ended contracts. In most of the opinions, its provisions favour much more the employers than the employees (Bechir, 2010).

All the above policy initiatives have been largely debated and very often contested by opposition parties and various interest groups. Certain measures had to be abandoned because they were strongly contested by the population or declared anti-constitutional. Policy reversals have also occurred when the risk of losing political credibility proved to be high. The extent to which all these measures will be effectively implemented and will bring the expected effect remains uncertain. Since Romania entered a pre-electoral year, the political hesitation in finalising the reforms might persist all over the year 2011. The current coalition lost significant support from its electorate because of unpopular measures adopted. Consequently, it is very likely that the current opposition will get the power next year, which will bring a new orientation of reforms, most probably in the opposite direction.

[3] The Labour Code entrered into force on May 1st 2011.

2.2 Pensions

2.2.1 The system's characteristics and reforms

Main characteristics of the system

The Romanian pension system provides benefits for old-age retirement, disability and survivors. A social pension is granted if the individual's benefit falls below a minimum guaranteed income, currently set at RON 350 (EUR 87).

The old-age pension system is based on PAYG type of social insurance (first, public pillar) and privately administrated individual accounts, both compulsory (second pillar) and voluntary (third pillar). The second pillar, introduced in September 2007 as a DC system, is compulsory for all persons below the age of 35 at 1st January 2008 and optional for the age group 36 - 45. The third pillar was introduced in May 2007, equally as a DC type, and is alimented by voluntary contributions, limited at 15% of gross wage.

Both mandatory pillars are earnings related schemes. Benefits under the first pillar are calculated on the basis of individual's accumulated points, which are determined by his/her wages relative to the average wage. Second-pillar benefits are a function of individual's contributions and investment earnings. In the public system, the point value cannot be set below 37.5% of the average gross salary; since October 2009 the pension point has been frozen to RON 732.8 (EUR 180). Within the package of austerity measures to cope with the crisis, in May 2010 the government decided to reduce the point value by 15% (to RON 622.88), but this initiative was declared unconstitutional and therefore abandoned. The cut represented the IMF conditionality for disbursing the first tranche of the agreed loan.The disability pension is granted unconditionally when the person lost its working capacity as a result of a work accident or occupational disease. If the insured lost his/her ability to work because of diseases or accidents unrelated to the occupation, a minimum contribution period is required, which depends on the insured's age.

The survivor pension is granted if the insured was retired or fulfilled the retirement conditions when the decease took place. The benefit is paid either to the insured's descendants or to his/her wife/husband; in the second case, the pension is granted when the survivor reaches the standard age of retirement, but only if the marriage lasted for at least 15 years.

Romania does not have a non-contributory social protection scheme specifically for the elderly but they are eligible for the minimum-income guarantee program. The programme provides financial support to households whose income falls below a minimum threshold, which is a function of household's size and income; the amount of the benefit is adjusted to make up the difference between the minimum income threshold and actual household's income. In line with these provisions, the government introduced in the beginning of 2009 the minimum guaranteed social pension, entirely financed from the state budget. The benefit is granted to all social insurance pensioners residing in Romania.

Table 2: Minimum contribution for disability pensions

Insured' age when disability occurs (years)	***Minimum required period of contribution (years)***
< 20	1
20 – 23	2
23 – 25	3
25 – 29	6
29 – 33	9
33 – 37	11
37 – 41	14
41 – 45	17
45 – 49	20
49 – 53	23
53 – 57	25
57 – 60	26
> 60	27

Source: Ministry of Labour, Social Protection and Family (http://www.mmuncii.ro/ro/statistici-55-view.html)

The public system: main reforms

Three major legislative changes took place during the reporting period in the public system of pensions. The most important is the adoption of Law 263/December 2010 on unitary pension system, which replaces the previous law 19/2000. The act, which entered into force in January 2011, sets the retirement age at 65 years for men, respectively 63 for women, to be completed by January 2030. The minimum period of contribution is fixed at 15 years, both for men and women, and the complete contributory period, which gives rights to full retirement, at 35 years for both genders. In May 2011 the standard retirement age was 58 years and 10 months for women, respectively 63 years and 10 months for men; the full contributory period was 27 years and 8 months for women, respectively 32 years and 8 months for men; the minimum period of contribution represented 12 years and 8 months for both genders.

The retirement age is lower for persons working in arduous and very arduous conditions. The reduction is proportional to the number of years worked in such conditions: between 1 and 8 years reduction in case of arduous conditions, respectively between 1 and 13 years in case of very arduous conditions. Starting with January 2012, the pension point value will be increased by 25% for retired persons who previously worked in very arduous conditions.

The law also changes the mechanism of calculating the pension point value, which will be indexed at the end of each year by inflation (100%) and the growth in real average gross wage (50%) of the previous year. The first indexation will therefore concern the benefits corresponding to the month of January 2012. The workers who retire after 1st January 2011 will have their number of points indexed by a coefficient representing the ratio between 43.3% of average gross wage and the point value at the moment of indexation.

The contribution rates set by the law, starting with January 2011, are the following: 31.3% for normal working conditions; 36.3% for arduous working conditions; 41.3% for very arduous working conditions. The employee pays 10.5% in all situations, the difference being covered by the employer. These rates include the 3% contribution that goes to the second pillar.

In case of disability pensions, the law stipulates that medical certification of invalidity will be entrusted to a commission of experts in the field, which has not been the case before. It is also envisaged that all currently retired persons for invalidity reasons will pass new medical tests

in specialised laboratories for the confirmation of their handicap, as a relatively large proportion of currently disabled obtained fraudulently their pension.

Early retirement is more drastically regulated by the new law, as the country has been confronted with massive retirement before the standard age. If a person has contributed for at least 8 years longer than the full contribution period, s/he can retire five years before the standard age without any penalty. Those who do not fulfil this condition will see their pension reduced by a monthly percentage, according to the following scale (Table 3).

Table 3: Pension reduction in case of early retirement

Number of years of contribution above the legal contribution period	***Rate of pension reduction (%) for each month of anticipated retirement***
< 1 year	0.50
1 – 2 years	0.45
2 – 3 years	0.40
3 – 4 years	0.35
4 – 5 years	0.30
5 – 6 years	0.25
6 – 7 years	0.20
7 – 8 years	0.15
8 – 9 years	0.10
9 – 10 years	0.05

*Source: Ministry of Labour, Family and Social Protection (*http://www.mmuncii.ro/ro/statistici-55-view.html*)*

When the person reaches the standard retirement age, s/he is entitled to full old-age benefits.

The law eliminates the "special regimes" of retirement, from which certain professional categories have benefited (judges, diplomats, military, police and secret service employees, personnel from aviation, and parliamentarians). A specific law was passed by the parliament in this respect (119/2010), which represents the second important legislative change in the pension system. The occupational pensions were included in the social insurance system, which implies that the same rules of contribution apply to all occupational categories and all pensions will be paid according to the past periods of contributions. The retirement age for "special regimes" beneficiaries was raised at 60 years, to be completed by January 2030.

Prior to the adoption of Law 263/2010 and 119/2010, the "special regimes" were subject to specific rules for granting benefit. Consequently, very generous pensions were attributed to these categories, in some cases for a relatively short period of contribution – as early retirement was largely stimulated during the process of restructuring the police and military apparatus. As a result, in less than 10 years from the adoption of Law 119/2000, which is the reference for the pension reform in post-communist Romania, a significant number of pensioners enjoyed exceptionally high benefits, unrelated to the past periods of contribution.

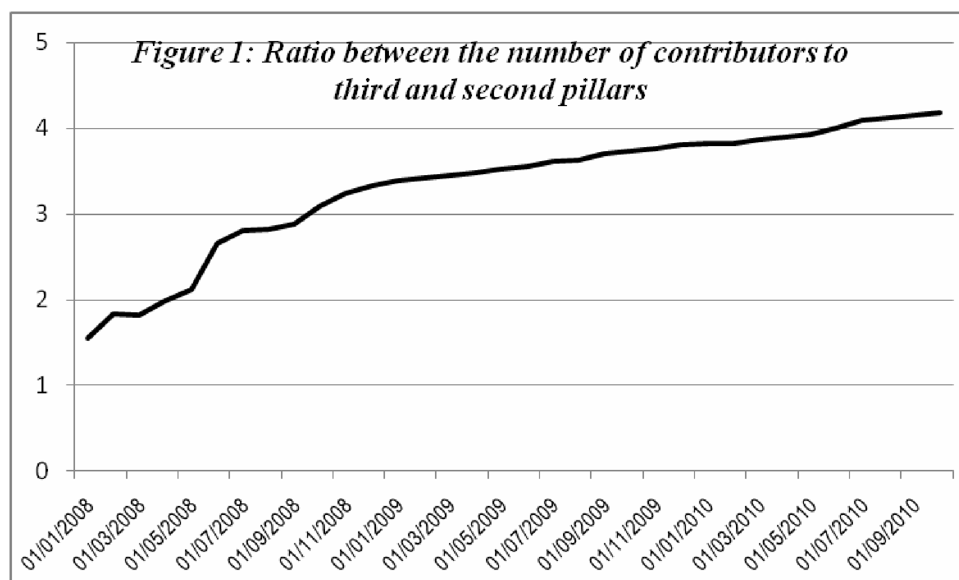
In order to eliminate this flagrant inequity, Law 119/2010 integrates the special regimes in the general one, while proposing a recalculation mechanism for the existing "special pensions". The recalculation concerned initially only the pensions above RON 3000 (EUR 750), in an attempt to reduce these benefits to "reasonable" levels. In its final version, the recalculation will be done for all pensions, such that – for equity considerations – lower benefits will be increased accordingly. The mechanism is currently under implementation and the recalculation is supposed to be over by the end of 2011. Nevertheless, many difficulties occur with respect to the work history of a large number of concerned pensioners, and consequently the process is slower than expected.

The third legislative change refers to the adoption of Law 118/2010 on budget rebalancing. In principal, the law reduces the wage rate in the public sector by 25% and the unemployment benefits and other allowances by 15%. It also replaces the term "social pension" by "social indemnity for pensioners" and stipulates that the quantum of the benefit (fixed yearly through the Budget law) may be changed according to the evolution of macroeconomic indicators and the availability of financial resources.

The private system of pensions

In the system of private pensions, the second (compulsory) pillar recorded in 2010 an average return rate of 15.1% (APAPR, 2011). At the end of February 2011, 5.244 million contributors were recorded, but contributions were paid that month only for 3.31 million persons. In average, the contribution amounted to RON 43.8 (EUR 10.5).

In the third pillar, the average return rate for 2010 was lower than in the second one: 11.5%. 226347 persons were registered at the end of February 2011 with the voluntary scheme. In December 2010, 13 funds were operating on the market, cumulating a total of RON 307 million in assets. The number of participants has increased continuously, as shown in Figure 1[4], where we represented the ratio between the number of contributors in the third pillar and the number of participants to the second pillar. The accumulated contributions are still low – affected drastically by the economic crisis – but the expectations are optimistic: the voluntary pensions represent the most important non-wage benefit for the companies (APAPR, 2011). The potential of the system is relatively high, representing 11% of the population aged between 18 and 55 years (Ghetu, 2010).



The most important legislative reform in the field of private pensions is the adoption, in February 2011, of the Law on the Guarantee Fund (GF). The fund is aimed at compensating the losses incurred to participants by the pension funds in the payment of benefits. The resources are constituted by a contribution of 1% from pension funds' assets. The contribution must represent at least the equivalent of EUR 50,000. The GF resources can be invested in monetary instruments, respectively in Romanian and EU bonds.

[4] Source: Calaculations based on data from APAPR (http://www.apapr.ro/statistics.html).

2.2.2 Debates and political discourse

The main topic of 2010 debates was related to the changes brought by the new pension law. Political opposition, trade unions, representatives of pensioners' associations, specialists and mass media have been actively involved in discussions and negotiations. Strongly contested by some of participants, the law took long time to be adopted. Even after its adoption, the contestations continue, sometimes in court, where the pensioners affected by recalculation call for the cancelation of their benefits' reduction. The APAPR[5] is the only non-governmental institution that publicly supported the law.

The increase of retirement age was also contested, in particular by the political opposition. The initial version of the law approved by the parliament set the retirement age at 65 years for both genders, but the Romanian president refused to promulgate the act and proposed the reduction of women's retirement age at 63 years. This was in fact the amendment suggested by the opposition during parliamentary debates. The presidential veto was officially motivated by equity considerations towards women. In reality, during the parliamentary debates the opposition initiated the procedure for the destitution of president Basescu through a national referendum.[6] Since a large majority of population supported this demarche, the risk of destitution was evident. Consequently, the president sent the law back to the parliament for re-adoption with a lower retirement age for women, in spite of recommendations formulated by the Presidential Commission for the Analysis of Socio- Demographic Risks, which suggested the gender equalisation of retirement age (Manea, 2010).

Confronted with insufficiency of resources for paying public pensions, the government envisaged to reduce the contribution rate to the second (private) pillar by 0.5 percentage points. In fact, the authorities intended to extend for the year 2010 the freeze of contribution rate decided in 2009. Facing a strong opposition from pension funds, specialists, trade unions and mass media, the government abandoned this idea. However, the whole system was seriously shaken by the eventuality of discretionary government intervention. The actors of the system, as well as the contributors, are very anxious regarding the future of the system. They are afraid that the government may attempt any time to confiscate their contributions. Many voices qualified this uninspired tentative as a clear intention to nationalise the private pensions (Stegarescu, 2010a).

Other measures adopted by the government, which diminish furthermore the pension benefits, have been strongly contested. All pensions above RON 740 will be subject to health insurance contributions, while the income tax rules will apply to all retirement benefits superior to RON 2000. Initially, the Romanian president proposed the extension of the taxable pensions to RON 1000, but this request was rejected by Senate.

The political opposition uses this tense situation to accumulate electoral capital for the next year elections. However, the parties in opposition are unable to propose alternatives that will concomitantly satisfy the sustainability of the system and the adequacy of benefits. Unfortunately, the specialists in the field have been unable to deliver solid analyses regarding the implications of status quo versus the already adopted reforms. No serious research papers exist on this subject and no recommendations or well documented alternatives are proposed by Romanian economists, whose opinions are usually limited to simple statements about the positive or negative aspects of reforms. The mass-media has been very active in debating these changes and is still arguing about the opportunity of the reforms, but the debates have been rather superficial, too much politicised, and with no sufficient scientific argumentation.

[5] Association for Privately Administrated Pensions in Romania.

[6] The destitution of the president was equally motivated by the suspicion of fraud touching the coalition in power, which was accused of falsifying the number of votes in favour of adopting the law.

Consequently, the population perceives the pension reforms as just another austerity measure dictated by the crisis, rather than a necessity. The previous governments have been rather generous when increasing the pensions and allowing early retirement, menacing the sustainability of the system. The crisis amplified the risks, forcing the current government to proceed with painful reforms. While the pensioners would like to keep the status quo and the same trend of benefit increase, those admitting the necessity of reforms accuse the authorities of not initiating them earlier, when favourable economic conditions would have facilitated such changes at a lower cost.

2.2.3 Impact of EU social policies on the national level

Whenever the Romanian government has to adopt painful reforms, the argument usually invoked to convince the population is that international organisations demand such changes. EU and IMF are the most mentioned institutions in this respect. The adoption of the law on unitary pension system, for example, was an IMF condition for disbursement of the contracted loan, while the main provisions of the law represented – as the authorities explained to the population – concrete requirements coming from EU.

It is true that most of the recent changes in the pension system are in line with the programmatic documents elaborated by the European Union (like the EU green paper on pensions or the EU 2020 strategy), but these documents are not sufficiently presented to the public and only sporadically debated within specialised circles. The mass-media makes sometimes reference to them, but only in specific contexts and by mentioning only certain aspects that not always pass the real and complete message of the documents.

The debates on Europe 2020 strategy, for example, have been too formal. The government created specialised working groups by main areas of interest, which then organised a series of conferences and round tables both at national and territorial levels to familiarise the public with the most important subjects of the strategy. However, the discussions concentrated on issues like energy and climate, research and development, environment, planned changes on labour market, etc. The social protection sector has been poorly approached, probably because most of the reforms in this domain are painful and therefore unpopular.

Consequently, the Romanian population started to perceive the EU as an institution imposing certain policies to national authorities, which have no alternative but to obey. This attitude is actually the consequence of the fact that the pension reforms are discussed and debated together with other subjects of major interest for the country, in which the EU plays an important role: the EU report on justice, the evaluation of the country progress in fulfilling the Schengen criteria, the assessment of the situation regarding the EURO adoption, etc. There is therefore certain confusion between what is required by the EU if Romania wants to join the Schengen area or the EURO zone, and what represents a reform necessity for the country, irrespective of the content of EU programmatic documents. In other words, there is no clear delimitation between requirements and recommendations formulated by the EU.

The discussions in the Romanian social protection field started to focus on OMC principles, which gains interest among specialists. Lambru (2010) published a paper that summarises the main OMC principles, while trying to link the method with the sector of social protection in Romania, in particular the social inclusions aspects. The NGO sector is equally involved in this domain: PACT[7] foundation implements at present a project for promoting the debates on

[7] Partnership for Community Actions and Transformation.

OMC in the social protection sector.[8] In March 2010, PACT organised a public conference on this issue. A similar project has been implemented by CERE (Centre for Public participation) in 2010.[9] At governmental level, the Ministry of Labour organised a conference on OMC issues, part of an EU project on raising awareness in the sphere of social inclusion.[10] The issue is relatively well popularised on Romanian websites, but much less in written mass-media.

In line with the Annual Growth Survey, the recently adopted reforms aim at increasing the retirement age and limiting early retirement, but no specific measures have been adopted to stimulate the employment of older workers – the most sensitive problem in the Romanian labour market. However, some actions have been undertaken in the field of Life-Long Learning (LLL), but they refer only to some legislative changes that will be part of the "National Strategy for Life-Long Learning", to be elaborated by the end of 2011. The NRP mentions that the document will set objectives that are in line with the Europe 2020 recommendations, as formulated in the agenda for new competences and new jobs.
Following the directions set by Europe 2020 strategy, the Ministry of Labour, Family and Social Protection submitted to public debate a draft law on occupational pensions[11], which regulates the way such regimes could be initiated, administrated and developed. The initiative is supposed to accelerate the development of private – complementary – pensions hat would supplement the benefits of future retired, while reducing the burden of public pensions on the budget.

2.2.4 Impact assessment

The legal changes recently adopted in the Romanian pension system are expected to restore its financial sustainability over the next decade, seriously affected by the recent crisis. This should normally be possible by significant savings resulting from the recalculation of special pensions and from revising the conditions for granting disability benefits, but equally by increasing the retirement age and discouraging early retirement. In parallel, the newly adopted Labour Code is expected to increase noticeably the number of contributors to the system, therefore balancing the ratio between the number of beneficiaries and the number of those contributing to the system.

The assumptions made by the government with respect to the effective impact of the reforms might not be sufficiently realistic. The official estimations in terms of savings, reduction in the number of beneficiaries and increase of the cohort of contributors, are too optimistic for the Romanian reality. It seems therefore that the authorities opted for the best-case scenario in their impact assessment of the pension reforms.

The recalculation of special pensions is expected to bring a total saving of EUR 800 million (Legorano, 2010), but in reality the recalculation might turn into higher spending than in the past for this category because the cumulated increase of lower benefits could be higher than the savings from lowering high pensions. Preliminary calculations predict that the expenditures have to be supplemented by EUR 72 million each year after recalculation (Capital, 2011). The main factor responsible for this opposite outcome is a legal provision in

[8] http://www.fundatiapact.ro/ro/mid/proiecte/proiecte-in-curs-de-derulare/Promovarea-dezbaterilor-in-domeniul-incluziunii-sociale-in-sprijinul-consolidarii-Metodei-Deschise-de-Coordonare-MDC-privind-protectia-si-incluziunea-sociala.html.
[9] http://www.ce-re.ro/mdc.
[10] http://www.mmuncii.ro/pub/imagemanager/images/file/Domenii/Incluziune%20si%20asistenta%20sociala/Evenimente/250809Cluj_HHauben.pdf.
[11] http://www.mmuncii.ro/ro/articole/2011-02-07/2059-articol.html .

the Government Decision 737/2010[12] (on the mechanism of recalculation) that converts the early retirement pensions in full-contribution type of benefits. This will augment the pension level for a relatively large number of beneficiaries, and the accumulated increase could be larger than the savings obtained from reducing the highest pensions.

The only measure that will effectively decrease the pension spending is the introduction of more restrictive conditions for granting disability benefits. This is the only category of retired that recorded a decline of the number of beneficiaries, as the medical re-examination cancelled the disability status of more than one third of those already checked. Consequently, 66.2 thousand less beneficiaries were recorded in January 2011 as compared to the same month of 2010. Nevertheless, the proportion of disability pensioners remains exceptionally high (15.7% of total in the beginning of 2011) because of frequent past cases of fraud in obtaining the disability status by bribing the doctors. The Romanian NRP estimates at 14% the proportion of fraud among disability pensioners. The government announced that all beneficiaries of such a pension will be re-examined[13], but this process will be time consuming, as almost 860 thousand persons need to pass the medical re-examination.

Some savings will be obtained from reforming the sector of social assistance, where a significant number of transfers will be eliminated. The mechanism for granting benefits, under the new law on social assistance, is expected to increase efficiency in allocating cash transfers under the Minimum Guaranteed Revenue scheme and to cut the cost of social assistance by 0.78% of GDP, while reducing the number of beneficiaries by 100,000 persons by 2013. This could be possible, as social assistance has been excessively generous in granting a wide range of cash benefits to a large number of beneficiaries (about 11 million persons in 2009). The reform was therefore necessary as long as the efficiency of the system has been poor: in spite of doubling the resources between 2005 and 2010 (from 1.4% to 2.86% of GDP), only 43% of low-income households were reached by transfers in 2009. Nevertheless, the reform will affect in principal the retired persons, who represented the largest category of beneficiaries of social assistance under the previous scheme. It is therefore expected that the poverty rate among old persons to increase significantly in the coming years.

Apart from savings, the Romanian government expects additional financial resources to enter the social insurance budget. Two fiscal measures are envisaged in this respect: the taxation of all pensions above RON 2000 (already adopted), respectively the introduction of a new form of income tax on rich households[14] (owners of a total wealth of minimum EUR 450,000), which is still under discussion. The two measures are expected to bring about EUR 3 billion to the 2011 budget. Both measures are evidently unpopular but necessary and equitable from social solidarity point of view. However, the revenues expected from the two sources are largely over-estimated (in particular from taxing wealthy households) and the effectively collected amount may prove to be well below the needs.

In terms of reducing the number of beneficiaries, the reforms are expected to end up with a decline in the number of pensioners by 284 thousand in 2020, which is equivalent to a reduction of pension spending by RON 24.12 billion (Cotidianul, 2010). Some 253,000 less pensioners were already expected in 2010 as a result of restrictions in early retirement and re-examination of disability pensions. The reduction was eventually less significant: only 46.8 thousand fewer pensioners in December as compared to January 2010. Moreover, for unknown reasons, the partial early retirement increased over the same period by 5.24%.

[12] http://www.dreptonline.ro/legislatie/hg_737_2010_metodologie_recalculare_pensii_serviciu_legea_119_2010.php.
[13] http://www.mediafax.ro/social/ministerul-muncii-toate-dosarele-de-incadrare-in-grad-de-handicap-vor-fi-reverificate-8129009 .
[14] Similar to the French Solidarity Tax on Fortune.

The most uncertain outcome of reforms remains the projected increase in the number of contributors as a result of new contractual rules brought by the recently adopted Labour Code. By bringing more flexibility on the labour market, the government expects that 1.5 million persons working at present in the informal sector will enter the formal one. Nevertheless, there is no clear argumentation for the expected migration of workers from informal to formal sectors, since the motivation for being informal is weakly linked to labour regulations. At the same time, the new code does not offer any stimulant for hiring and keeping senior workers in the market, but insists on facilitating the employability of young categories.

Although the set of policy measures adopted will bring important changes in the public system of pension, its long-term perspective still remains uncertain in terms of financial sustainability and adequacy. The pension spending is expected to increase significantly in the coming years, concomitantly with higher theoretical replacement rates and benefit ratios (EC, 2010). The old-related expenditures will reach 13.1% of GDP in 2020, respectively 21.3% in 2050; 14.8% of GDP will be spent in 2050 with pensions (S&P, 2010). Not surprisingly, the sustainability gap indicator S2[15] in case of Romania reached 9.1% in 2009 (Zaidi and Rejniak, 2010), which is higher than the EU average (6.5). With the increase of life expectancy to 86.6 years for females and 81.9 for males[16], the share of old population (above 65) will pass from 14.9% in 2010 to 20.3% in 2030 (EUROSTAT, 2010). This requires an adjustment for dealing with the long term cost of ageing equivalent to 4.9% of GDP (3.2% in case of EU average). Consequently, the old dependency ratio will increase from 21.3 to 30.3 over the same period. At the same time, the benefit ratio (both for public and private pensions) will grow from 29.4 in 2007 to 41.4 in 2060 (EC, 2009), which will determine an overall increase of pension expenditures by 7.4% between 2010 and 2060.

2.2.5 Critical assessment of reforms, discussions and research carried out

The reforms initiated in 2010 were largely dictated by major problems of financial sustainability and demographic pressures, to which the Romanian public pension system is currently confronted. The insufficiency of resources, which raises sustainability concerns, is principally caused by the declining number of contributors versus the total cohort of beneficiaries. The demographic problems refer to population ageing, which is common to all EU countries. However, in case of Romania the phenomenon is amplified by the rapid increase in the average age of population, which is caused by the migration of a relatively large proportion of young generations.

The financial sustainability of Romanian pension system should be regarded from two perspectives: short versus long term. In the first case the government has to deal with immediate needs to finance the deficit of each current year; the main concern is therefore the sustainability of the pension system. From long-run perspective, the sustainability problem touches the whole public finances of the country: high and persistent pension deficits in short run (financed from the state budget) accumulate over time, thus increasing the public debt, and therefore menacing the sustainability of the whole public finance sector.

When initiating the reforms, the government tried to cope simultaneously with short and long run problems. The first immediate objective was the deficit reduction in the public system of

[15] The S2 indicator shows the durable adjustment of the current primary balance required to fulfill the infinite horizon inter-temporal budget constraints, including paying for any additional expenditure arising from an ageing population.It therefore shows the difference (the sustainability gap) between the constant revenue ratio as a share of GDP that guarantees the respect of the inter-temporal budget constraint of the government (that equates the actualised flow of revenues and expenses over an infinite horizon) and the current revenue ratio.

[16] EC, 2009.

pensions, which in 2011 is expected to reach EUR 3.6 billion. Although this amount is not exceptionally high when compared to previous years, the financing of the deficit becomes more complicated in 2011 because all international organisations expressed their strong opposition to the use of external borrowing for paying pensions. Consequently, the Romanian government has only two options for solving the deficit financing dilemma: to cut the pension expenditures, respectively to find additional money from other source.

The cut in pension spending is to be operated through several measures already adopted. One of them is the freeze of the pension point value at its level from October 2009. Although the measure is necessary for re-equilibrating the ratio between average pension and average salary, it will affect disproportionally the lower benefits. The poverty is therefore expected to go up for a certain number of pensioners.

Another measure for reducing the pension burden is the penalisation of early retirement. The government decided in 2010 to outlaw this practice, but this decision was abandoned in January 2011 and the phenomenon restarted. For most of unemployed senior workers the premature leave is preferable because the pension benefit – although penalised – is permanent, as compared to temporary unemployment allowances. In addition, the unemployment benefits were cut by 15% in 2010, which makes early retirement even more attractive for persons aged above 50 years. The real motivation of early retirement – the lack of job opportunities for senior workers – has not been even tackled by the government. There is no clear vision or concrete initiative for keeping the elderly in the labour market, whose participation rate is very low: 40% of persons aged 45–65 years are currently inactive (Ziarul Financiar, 2011) and only 32% of the persons aged 55-64 years have a salaried activity (Preda, 2011). Consequently, either the early retirement will continue in spite of penalised benefits, or the older workers will quit the labour market and they will live from social allocations under the minimum guaranteed income scheme. In both cases, the poverty will affect disproportionately this category of population.

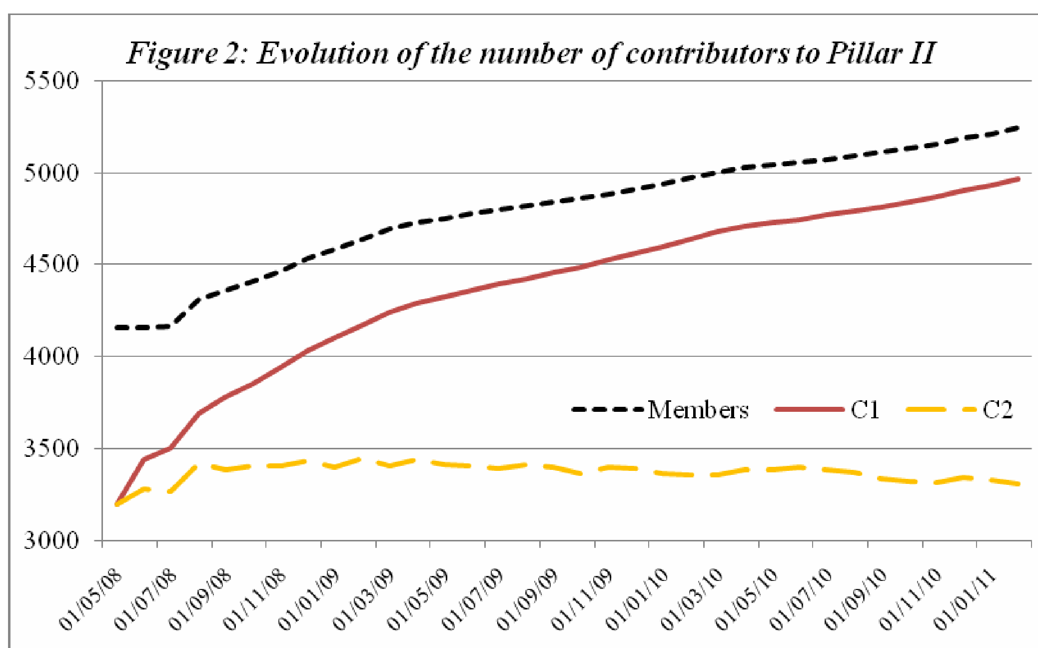
The revision of social assistance regime represents a complementary measure to drain the public finances of unnecessary spending. However, by reducing the number of transfers and that of beneficiaries, the government will not achieve the proposed objective to reduce by 580,000 the number of persons facing the risk of poverty and social exclusion by 2020. Particularly because the new law on social assistance sets a ceiling for the cumulated amount of social transfers that a household can receive (NRP Romania). The missing element of the law is a set of specific measures for helping the assisted persons to enter the labour market or to find another form of remunerated activity. At present, 20% of those receiving social transfers do not work and have never been involved in any form of training, retraining, education, or professional reconversion (NRP Romania).

While in the public system of pensions the sustainability problem remains of actuality, the situation in the second pillar is equally delicate. Since the beginning of the system, contributions have been paid for 4.966 million persons out of 5,244 accounts opened with the system; 5.3% of accounts are therefore empty, while for 38.86% of those with active accounts the contributions were not paid in February 2011. This proportion has been constantly low since the initiation of the system, as observed from Figure 2, where Members represents the total number of persons recorded with the second pillar, C1 is the number of persons with active accounts, and C2 the number of participants for which contributions were paid in the corresponding month. It follows that the employers keep a relatively large number of active accounts for their workers, but they pay only for about two thirds of participants each month. This is done by rotation, such that the accounts will not be closed, because the law stipulates that if the contribution for a member is not transferred for three consecutive months, his/her

account will be closed. It results that, in average, a participant receives contributions to the second pillar only 8 months per year.

There are hopes that this situation will improve after the adoption of a new law, which is planned to be drafted until the end of 2011, on the organisation and implementation of a payment system of pensions from second and third pillar.

Three main policy measures have been adopted for improving the situation in the public pension system in a long-term perspective. The first one is the gradual increase of retirement age to 65 years for men and 63 years for women. However, the gender difference in the age of retirement does not necessarily take into account the life expectancy issues, or at most this element is considered only partially. At the moment of adopting the law on the unitary system of pensions, the life expectancy at the age of retirement represented 13.94 years for men, respectively 17.15 years for women. Given this difference, the equalisation of age retirement between genders – as initially stipulated – would have been preferable.



The second initiative is the integration of occupational regimes within the social insurance system, which will make the rules of contributions and benefit entitlement more uniform. The draft law on occupational pensions has the advantage of brining a unique juridical framework for those willing to create such pension schemes, but the negative part comes from the ambiguity of its provisions, which leave room for a new proliferation of "special regimes" in the pension system. In some opinions (Bloom, 2011), the law is actually aimed at recreating a separate regime for military staff and possibly for other associated categories.[17] Conceived as a voluntary scheme, the occupational regime has no economic logic as long as Romania disposes already of the third pillar where contributions started to accumulate. The new occupational regimes will function either in parallel with the exiting voluntary scheme – which seems to be the case from the draft law – or will be included in the third pillar, which will lead to the atomisation of pension funds since a pension fund becomes fully functional with only 100 members under the new law.

[17] This hypothesis is confirmed by the retirement age stipulated in the draft law: 60 years, which is fact the age at which police and military staff are allowed to retire according to the already adopted Law on unitary pensions.

The third measure refers to the revision of conditions for granting disability pensions and – more importantly – the medical re-examination of existing cases. This represents the most radical intiative for reducing the pension spending, which in adition has immediate effects. Significant savings have already been recorded; the re-examination will take time, given the large number of beneficiaries, but the reduction of expenditures with this type of pensions will be important.

2.3 Health Care

2.3.1 The system's characteristics and reforms

Health care in Romania is provided primarily through mandatory health insurance. Voluntary health insurance is available, but the market is still insufficiently developed. The mandatory scheme is administered by district health insurance funds, which are responsible for collecting contributions and reimbursing claims from providers for health care services in their respective districts. The funds are regulated by the National Health Insurance Fund (NHIF). The health care is financed primarily by contributions, at a current rate of 10.7% of payroll, of which the employer pays 5.2% and the employee 5.5%. Children, people with disabilities, war veterans without income, and the dependants of insured people do not pay for coverage.

Health care services are delivered free of charge to the whole population, on the basis of registration with a family doctor, who prescribes consultations for specialised physicians when necessary. Dental care is free for all persons up to 18 years of age; above this limit, between 40% and 60% is covered by the National Health Insurance Fund. The drugs' coverage depends on the category to which they belong. Currently, there are three distinct lists of drugs: A, where the coverage is 90% of the reference price; B, covered at 50% rate; C, fully covered by the social security. Excepting the emergency situations, the admission to hospital is possible only on the basis of a prescription from the family doctor. No fees are charged during hospitalisation, unless the patient wants higher standards of medical services and accommodation.

After more than one year of preparation, the Romanian parliament adopted in March 2011 the most controversial reform in the health care sector: the introduction – from April 2011 – of the co-payment mechanism, which is based on the so-called "health ticket". The patients are asked to pay a contribution, which varies according to the type of medical service provided. No co-payment is required for: children up to the age of 18 and students under 26 years if they do not benefit from a remunerated income or social assistance; political dissidents of former communist regime and war veterans; disabled persons if they do not benefit from a remunerated income or social assistance; certain categories of sick persons, included in special health programmes, if they do not benefit of any form of income; pregnant women, if their income is inferior to the minimum gross wage. The co-payment is covered by the social insurance budget or the state budget in case of: persons in incapacity of work due to work accidents and occupational diseases; prisoners and repatriated Romanians without documents of identity; unemployed persons; families without remunerated income but benefiting from social assistance; retired persons, with a monthly pension inferior to RON 700; medical staff. Overall, about 8 million persons will be exempted from co-payment, which represents 40% of the country's population. The health ticket is limited to RON 600 per year and per person and does not apply to emergency care.

The mechanism represents a conditionality imposed by the World Bank and the IMF, to which Romania committed in 2009. Depending on the type of medical services demanded, the patients will pay the following tariffs (Table 4).

Table 4: Co-payments in health care

Type of medical service	***Co-payment (RON)***	***Particularities***
Consultation to family doctor or specialist	5 – 20	Per each visit
Hospitalisation – treatment – accommodation	 10 – 50 No limit	 Irrespective of duration Decided by each hospital
Medical analyses	1 (usual laboratory tests) – 200 (magnetic resonance X-ray)	
Drugs	0 – 50 % of reference price	Depends on the list of drugs
Dental care	0 – 40 % of CNAS tariffs	Depends on patient' age
Rehabilitation	35 – 40 %	

Source: Ministry of Health (http://www.ms.ro/?pag=14)

From January 1st 2011, all pensioners benefiting from minimum RON 740 per month will pay health care contributions, set at 5.5% of the pension amount. In absolute terms, the effective amount of contributions will be set such that the deduction of contributions from the pension benefit cannot reduce the pension below RON 740. In other words, if a person receives – for instance – RON 750 per month, the total amount of due contribution will represent RON 10; at the same time, for a pension reaching – say – RON 1800, the beneficiary will pay the corresponding rate of 5.5%, i.e. RON 99. Around 2 million persons are concerned by this measure.

Starting with the second half of 2011, the Romanian health care sector will be computerised by the introduction of the "health card". The card will be distributed in the second half of this year, such that the system will be fully functional in 2012. The process is largely financed from EU funds.

Another policy initiative concerns the localities recording a high deficit of medical personnel, in principal rural areas and small towns. The government decided to introduce a special type of contract with doctors willing to settle in those areas, who are offered special bonuses. These contracts, with duration of minimum 5 years, are expected to motivate the medical staff to opt for small towns and villages in practicing their profession. In this respect, the government plans to elaborate, by the end of 2011, a "Strategy for improving primary health care in rural areas".

The most important reform in the sector remains the decentralisation of hospitals. Initiated more than one year ago, the measure took a long period of time to be concretised. A strategy was elaborated in this respect, approved in March 2011, which sets the main directions of reforms. The process started in April 2011 and concerns 373 hospitals, out of 435 that will be evaluated by a special commission for accreditation. Local authorities will be in charge of administrating and (partially) financing the hospitals; in this respect, 60% of the contributions raised at the county level will remain with local authorities, the rest being transferred to the National Health Insurance Fund.

The decentralisation will take place together with an evaluation of hospitals, which have to be accredited by the accreditation commission. 10% of hospitals are supposed to be accredited in 2011, 50% in 2012, the rest receiving the accreditation in 2013. At the end of the process, certain hospitals will cease their activity, others will be merged, and some of them will receive a new destination. By a decision of the Ministry of Health from February 2011, 182 hospitals will lose their status of legal person and they will become annexes of other hospitals.

Out the 182 units concerned by this decision, 111 will be merged and the remaining 71 will receive a new destination. According to the Government Ordinance 212/2011, 67 (out of the 71 hospitals) will become residential centres for elderly. This measure is part of the government programme "The development of residential centres for elderly 2011 – 2013", which intends to increase the number of these institutions from 25 at present to 96. Overall, the hospitals' reorganisation will concern 794 physicians and 2,532 nurses, who will be redistributed to other medical units. However, 560 administrative positions will disappear from the sector at the end of the process.

In parallel, all Romanian hospitals will be re-classified in May 2011 according to a decision adopted by the Ministry of Health in April this year.[18] There will be five categories of hospitals, depending on the level of competence attributed to each of them. The highest competence (category I) is granted to regional units, while the lowest (category V – limited competence) to hospitals treating a single type of chronic diseases. Intermediate categories will include county hospitals treating complex diseases (category II – high competence), those treating less complex type of diseases (category III – average competence), respectively hospitals with basic competence (category IV) functioning at city/town level.

In parallel with the above reforms, the Ministry of Health intends to revise the package of medical services that will be covered by the social insurance. The measure, which was recently agreed with the World Bank, implies that certain services will be provided by the private sector (more complex laboratory tests, for example). This will stimulate the penetration of private medical units in the health care market. Subscriptions to private health care usually guarantee a minimum set of services; additional fees are charged for more expensive treatments. Most medical subscriptions developed in the field of dental services, laboratory diagnostics, maternity and gynaecology.

The preference of population for private health care is augmenting significantly: 44% of Romanians opt for this sector (52% in Bucharest), according to IRES (2010b). This preference is particularly important within the category of age 18 – 44 years, for highly educated persons with a monthly income above RON 750, and in localities with more than 50,000 inhabitants. However, for the time being the private clinics limit their offer to less complex type of medical services.

2.3.2 Debates and political discourse

Since the two main reforms in the sector – the co-payment and the hospital reorganisation – necessitated a long period of time for their adoption, the debates on these issues have been intense and numerous. The government motivated the two measures by the need to improve the efficiency and the quality in delivering medical services, but in many opinions these reforms will not achieve the proposed objectives. In these opinions, the co-payment will not eliminate or reduce the bribing practices in the system. In fact, the Ministry of Health admits that the reform was "received with resignation and indignation" by the population. The public debate on the document concluded that the "health ticket" will not change the behaviour of medical staff and consequently will not reduce the informal payments; at the same time, the quality of medical services will not improve essentially.

The hospital decentralisation will affect negatively the quality of services because the local authorities lack the necessary resources for financing the medical units under their responsibility. Until now, the process of hospital reorganisation has been chaotic and therefore inefficient; moreover, the health experts consider that the strategy on which the

[18] http://www.ms.ro/?pag=62&id=8983&pg=1 .

rationalisation of hospitals has been based is inappropriate and lacks important elements for achieving its goals (Naftanaila, 2011). There are therefore serious concerns about the effective outcome of decentralising the hospitals, perceived as a measure that will deteriorate furthermore the conditions in the system. As CMAJ (2010) report emphasises, the Romanian hospitals need to be run as professional service corporations, paying doctors and other staff decent salaries. Hospitals and clinics should receive performance based financing in order to solve the under-financing problems (Björnberg et al. 2009).

The most delicate issue that generated public debates in 2011 has been the new contractual conditions imposed by the National Health Insurance House (NHIH) to family doctors for the period 2011 – 2012. Because of these conditions, which in essence limit the revenues effectively earned by physicians, three quarters of family doctors refused to sign the contract with NHIH and they even went to court for obtaining the change of these restrictions. In parallel, the political opposition has initiated, on May 2nd 2011, the procedure for the destitution of the Health Minister, who is considered responsible for the disastrous situation in the sector. Most probably the destitution procedure will be rejected by the parliament, as it has happened with other similar initiatives of the opposition.

The chronic shortage of medical personnel in the Romanian system is subject of frequent discussions and debates, in particular in mass media. Many specialists consider that the decentralisation of hospitals will amplify the phenomenon, as a large proportion of the personnel concerned by this process will probably prefer to emigrate instead of moving to new hospitals, in general situated far from their place of residence. Although the reorganisation is in its incipient phase, there are already signals that the personnel concerned have difficulties to adapt to the new jobs. While the change is not so problematic for nurses, most of physicians refused the proposed positions because very often these positions do not correspond to their specialisation (Dan, 2011).

2.3.3 Impact of EU social policies on the national level

Although in line with the overall EU policy in the field, the reforms adopted by the Romanian government in the health care sector have been agreed in principal with the World Bank and IMF. Almost no reference is made to EU recommendations, and the country NRP mentions only the contribution of EU funds for implementing various programmes within the European platform to combat poverty, which is the only link to Europe 2020 strategy. No linkage is made between ageing and health care and therefore no initiative is planned for the year of active ageing (2012).

For the time being, the OMC issues in Romania concentrate on social inclusion; health care is not directly addressed from this perspective, but only indirectly and partially in terms of access to medical services of vulnerable groups of population.

2.3.4 Impact assessment

The recent reforms adopted by the Romanian government are expected to improve the efficiency of the system, while raising the quality of medical services and reducing the overall cost. The decentralisation of hospitals is aimed at reducing the number of beds by 9,200 and therefore the number of patients by 10% – as discussed and agreed with the IMF. This reduction is necessary because in 2008 Romania recorded 657 empty beds per 100,000 inhabitants (Nicut, 2010). The Ministry of Health is even more optimistic, projecting a 20% reduction of the number of patients in 2011, which will translate in a total saving of RON 1,433 million (EUR 350 million). This is equivalent to a reduction by 10% of 2008 level of health expenditures (MH, 2010). These expectations are motivated by the huge financial

burden represented by the hospitals in NHIH spending: 51.2% in 2009, according to the Ministry of Health. In addition, the ministry finances the investment and various national health programs.

In parallel, the hospital administration will be reduced to maximum 3 managers, which will imply a decline by 577 of the existing number of managers.

The co-payment is equally expected to bring about RON 420 million (EUR 102) per year (MH, 2010), but the measure is principally aimed at reducing the number of interventions in hospitals, as the Romanian health culture is clearly biased towards this form of treatment: the country record every year 215.13 hospitalisations per 1,000 inhabitants – the highest within EU area (MH, 2010).

Nevertheless, the two policies might be less cost effective than expected. The co-payment will certainly reduce the access to health care of vulnerable groups, inducing social inequality (Holt, 2010). The projected reduction in the number of patients may also be lower than projected, as the numbers of persons that solicited emergency interventions increased by 15% after the adoption of the two measures (Babeanu-Iosif, 2011).[19]

The most efficient measure that proved to bring important savings to the health budget has been the introduction in 2010 of much more restrictive conditions for delivering medical certificates. The fraud in obtaining sick-leave attestations by bribing the family doctors has represented a major problem of the Romanian health system. The new rules reduced the number of leaves by 45% in 2010, as compared to the previous year. This translated into a total saving of RON 140 million (EUR 34 million) for the health budget (Mediafax, 2011). In addition, the penalties incurred by family doctors who delivered fictive certificates amounted to EUR 400,000 in the first six months of 2010[20] (Realitatea, 2010).

Apart from positive implications of reforms in terms of financial resources saved through the adopted measures, the Romanian health care sector will record losses that are not taken into account by the government. Firstly, because it is not clear where local authorities will find the resources to complement the hospitals' financing. Secondly, because the emigration of qualified medical staff has a cost that is estimated at EUR 22 million in 2010 (Popa, 2011). From a social equity point of view, the co-payment will incur a loss to society through limited access to health care in case of poor categories of population; it is estimated that 40% of population will see the access to medical care reduced by the introduction of the co-payment scheme (Ailincei, 2010). The patients' association considers that the co-payment mechanism will increase the average cost of medication by 125%, as compared to only 10% projected by the Ministry of Health (Morosan, 2010).

The co-payment will probably have the most significant negative impact on population. The economic crisis forced 19% of population to postpone or to cancel the periodical medical checking in 2009 (TNS, 2009). The co-payment will perpetuate and even aggravate this situation, as the number of Romanians who visit periodically the doctor is already very low: 20% of them see their physician only once per year and 13% did not pay a visit to the doctor over the last 12 months, according to a recent survey (IMAS, 2010).

Concluding, the long-term sustainability of the health care system remains questionable: by 2050, the health expenditures are expected to reach 6.3% of GDP (3.6% in 2009), according to S&P (2010). At the same time, the recent reforms will most probably increase again the unmet need for care indicator, which in 2009 declined to 12.6 from 19.5 in 2007. The value of

[19] No co-payment is required by emergency medical units.
[20] Out of 800 family doctors checked, 12.9% delivered medical certificates to persons in perfect health. Among the 9,410 patients controlled, 35.5% did not present the illness prescribed in the certificate by their doctors.

the indicator is already the second highest in EU countries after Bulgaria; for comparison, Slovenia recorded 0.2 and Spain 0.4 in 2009.

2.3.5 Critical assessment of reforms, discussions and research carried out

The declared objective of recently adopted health care reforms is the increase of efficiency in using the allocated resources, while improving the access of beneficiaries to a better quality of medical services. The Romanian NRP is explicit in this respect, stating that the reform measures in the sector are aimed at improving the access of vulnerable groups by increasing the quality of medical services and by developing appropriate health infrastructure (page 40). However, a better quality and an improved infrastructure do not guarantee a higher access to services, as long as the cost of health care increases as a result of policy measures adopted by the government.

The real objective of the reforms is the cost reduction of medical act and the appropriation of additional resources, as the sector has been confronted with chronic under-financing. The lack of resources has been caused by two elements: lower allocations from the state budget, respectively declining amount of contributions from those paying into the system, as the number of contributors has shrunken continuously since the creation of the current health insurance system.

The 2010 health budget represented 3.9% of GDP – higher than in 2009, where it amounted to 3.6%. This is the lowest health budget in the European Union; even more dramatically, almost half of 2010 resources were already spent in advance in 2009 and therefore the year 2010 started with a major deficit (Gheorghita, 2011). The fiscal and budgetary strategy for 2011 – 2013 envisages additional cuts in health allocations. Consequently, the 2011 budget for the National Health Insurance Fund was reduced by 7% as compared to the 2010 allocations.

The second cause of insufficient resources is the sharp decline in number of contributors. When the current health insurance system was created (1999), about 11 million persons paid contributions to the health fund. Since then, several categories have been exempted through "special laws" (pensioners, judges, low income persons, etc.). Consequently, in 2010, the health care system recorded around 4 million contributors (Vasilca, 2010). The recent decision to introduce contributions for pensioners benefiting from more than RON 740 monthly pensions will bring about 2 million additional contributors. However, it is not clear why the government started the enlargement of contributory basis with the pensioners, while other professional categories remain exempted from paying such obligations.

As a result, the medical units lack basic medical supplies and the patients have to bring drugs, bandages, syringes to be cured (Holt, 2010). The large majority of hospitals are deeply in debt: by July 2010, the total debt to drug and medical equipment suppliers and utilities reached EUR 300 million. Patients needing laboratory tests are registered on waiting lists on which they are scheduled after several months for making the test. In these circumstances, the decentralisation process will not improve the dramatic situation of hospitals. If the accreditation takes place, maximum 20 hospitals will be granted the accreditation, while less than 100 will not pass the septic test (Marcu and Veress, 2011). Not surprisingly, the accreditation has been several times postponed and it is not yet clear when the process will start effectively, although the specialised commission was created in 2009.

The major problem of the Romanian health care sector is its lack of restructuring. 19 ministers have initiated various reforms over a period of more than 20 years, but the sector remains insufficiently restructured (Gheorghita, 2010). This weakness is reflected by the incoherence with respect to the effective number of patients registered with the family doctors: 27 million persons in 2008, for a population of 22 million inhabitants and 20 million of insured (Pocotila

and Naftanaila, 2010). This discrepancy of 7 million patients, which induces a yearly loss of EUR 39 million to the system, is caused by multiple recording of the same person with several family doctors. Either the patient has more than one doctor in order to benefit from a larger amount of drug compensations, or the physician records fictive patients to receive a higher amount of allocations from the health fund. The second situation could be explained by the fact that a family doctor must have a minimum of 1,000 patients to be fully remunerated by the Health Insurance. Although in 2004 the health system already recorded 4 million fictive beneficiaries, no measures have been taken until 2010, when the IT system of recording the patients was implemented; with the new system, the number of persons recorded with the family doctors declined from 27 to 17.9 million, while the number of insured persons was reduced from 20 to 18.7 million.

The disastrous situation of the Romanian health care system pushes an increasing number of professionals to emigrate. Around 8,000 physicians left the country during the last three years (almost 2,800 in 2010) and 50% of those practicing at present will emigrate until 2015 (Holt, 2010) because of inappropriate working conditions and low salaries.[21] Consequently, Romania records the lowest number of professionals per 10,000 inhabitants (19 physicians and 42 nurses), which represents around 50% of the EU average (Gheorghita, 2010). The shortage hits the most rural areas and small towns, where working conditions are toughest. Large university centres, though, remain overcrowded with doctors in most specialties: two-thirds of the doctors in the country are concentrated in six large centres (CMAJ, 2010).

Low salaries paid to medical staff encourage informal payments, which are estimated at RON 12 per month and per inhabitant, as 85% of Romanians believe that they will not get adequate treatment without bribing the personnel (Holt, 2010) and 81% admitted that they made informal payments. The cost of bribes depends on the treatment, ranging from $127 for a straightforward appendix-removal operation to up to more than $6,370 for brain surgery (Bilefsky, 2009). Bribes are expected at all levels of the health care hierarchy, from the top specialist surgeons and pathologists to nurses and auxiliary staff.

The co-payment system and the prevalence of bribery in the public sector favoured the development of private health care, which makes the total cost of treatment at public and private clinics comparable (PMR, 2010). Currently, the tariff paid by the National Health Insurance House for the same intervention is lower in case of private clinics than in public ones (Mediafax, 2010). By the end of 2010, NHIH had 50 contracts with private suppliers of medical services in 20 counties and Bucharest. Moreover, for salaries above RON 2,500 (EUR 610) the amount of monthly contributions paid to the public insurance fund is higher than a full private insurance that offers the possibility of treatment abroad (Stegarescu, 2010b).

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

The long-term care in Romania is defined as social and medical services delivered to dependent persons in residential institutions, non-residential centres, respectively at the beneficiary's domicile. The long-term care system concerns elderly and disabled persons. The medical treatment for acute diseases or for the majority of chronic diseases is not considered as part of the long-term care. According to Popa (2010), the Romanian long-term care system includes all medical and social services delivered over a long period of time to those in need

[21] In 2010, a resident doctor earned in average EURO 250 per month, while the average wage in the economy was EUR 350.

such as the chronically ill, terminally ill, the disabled and the dependent elderly who need help with activities of daily living or instrumental activities of daily living.

Dependency is categorised according to three degrees and several classes:

I. A. Persons who lost their mental and physical abilities and need permanent surveillance and assistance;
   B. Mentally able or partially able persons who lost their physical ability and need permanent surveillance and assistance;
   C. Physically able or partially able persons who lost their mental capacity and need permanent surveillance and partial assistance.

II. A. Mentally able persons who lost partially their physical abilities and need permanent or temporary assistance;
   B. Mentally able persons having difficulties to move and need partial assistance for certain household tasks;
   C. Mentally and physically persons who need assistance for complex household tasks;

III.A. Person who need regular help with daily life activities, but when placed in an elderly institution can be considered independent;
   B. Persons having complete autonomy who are able to perform daily activities without assistance.

LT care for (non-disabled) elderly is provided through community services that include temporary or permanent assistance at home or in specialised centres. Home assistance refers to household and socio-medical services provided by local authorities either through specialised social workers or by granting an allowance to relatives fulfilling these tasks. This form of assistance is preponderant in rural areas. No specialised institution at central level exists for LT care in case of aged dependant persons, which is under the responsibility of the Ministry of Labour, Family and Social Protection through the Department for Family Policies, Inclusion, and Social Assistance. MLFSP cooperates with the Ministry of Health in delivering medical type of social services to dependant elderly.

At central level, the institution in charge of disabled persons is ANPH – the National Authority for Disabled Persons. At the end of 2010 there were 689,680 disabled persons recorded with ANPH, of which 17,036 institutionalised. Out of the total number of disabled persons, 61,287 were children, 33 of them institutionalised. 372 centres were functional at the end of 2010, of which 320 were residential institutions.

At local level, several institutions are involved in managing long-term care, at county and municipal levels. Disabled people are in charge of countries' authorities, which assess the eligibility of demanders to services. Municipal authorities are responsible for organising, financing and providing domiciliary and residential care for elderly persons. A large part of financial responsibility is therefore with local authorities. The system is financed both by central and local budgets, but the beneficiary has to pay a contribution – according to the cost-sharing principle – that depends on the personal income. Only disabled persons with a high degree of handicap or single persons with low income are exempted.

The financing of institutions providing medical long-term care is ensured by the National Health Insurance Fund, the state budget, and the local budgets: NHIF covers health services, the central budget the investment (through the Ministry of Public Health), while the local budgets cover the maintenance expenditures. The institutions providing both social and medical care are financed from out-of-pocket payments, state budget, NHIF and local budgets. The out-of-pocket tariffs are set by the local authorities, which are *de jure* owners of these institutions. The investment is covered by the state budget (through the Ministry of

Labour, Social Protection and Family), while maintenance is ensured by local budgets. NHIF allocates to these institutions a global budget to cover the salaries for medical staff.

No major reforms took place within the reporting period. The only noticeable measures are the adoption of a government decision for restructuring a certain number of residential centres for disabled persons, respectively the conversion of 67 hospitals in residential units for aged individuals. The NRP Romania presents as an important achievement in this area the adoption of Government Emergency Ordinance 84/2010 on the protection of disability persons and the promotion of their rights. In reality, the ordinance brings some very minor changes to the existing Law 448/2006. These changes have no reforming character.

2.4.2 Debates and political discourse

The long-term care is given relatively little importance in Romania because traditionally the care of needy persons represents a family matter. Only the persons with severe disability and lonely elderly are assisted – usually in institutionalised form – by social protection schemes. Consequently, the debates are rare, the mass-media makes little reference to the subject, and the political discourse is rather general in this respect. The Romanian NRP does not mention the issue of long term care.

2.4.3 Impact of EU social policies on the national level

As the meaning of long-term care in Romania is somehow different from the standard EU definition, it is difficult to assess the impact of EU policies at national level. Ageing does not seem to be a priority issue in Romania and consequently there is practically no relationship between long term care and the ageing phenomenon. Old persons are generally in charge of their families or, if lonely, they will enter a specialised residential centre or will receive some assistance at home from social workers.

2.4.4 Impact assessment

The long-term care sector is still incipient in Romania (as understood from EU perspective), but the socio-demographic and economic developments will change the perception of the role that LT care should play. The institutionalisation of dependent persons – prevalent in former socialist times – started already to be substituted by the placement with a family or by home-care through specialised social workers. In a recent document published by the Ministry of Labour, Family and Social Protection the government admits that the ageing phenomenon will increase the demand for LT care (MMFPS, 2011). By April 2011, 4,800 persons were on waiting list to get admitted to a residential centre for elderly.[22] However, for the time being the only policy response to this tendency is to increase the number of institutions hosting old persons.

The demand for institutionalised care is unevenly distributed within the territory, as the number of institutions differs considerably across regions. The quality of services varies significantly, depending essentially on the financial resources that the local authorities are able to provide. At the end of September 2009, the unmet demand represented 22.6% of the existing capacity in public residential institutions, respectively 97.10% in case of centres administrated by NGOs (Table 5).

[22] http://www.incont.ro/imm-uri/caminele-de-batrani-izvoare-de-bani-pentru-oportunisti.html.

Table 5: Number of residential institutions for elderly, number of beneficiaries, and the number of persons on the waiting lists (September 30, 2009)

Region	**Number of institutions**		**Monthly average number of beneficiaries**		**Number of persons on waiting lists**	
	Public	***NGO***	***Public***	***NGO***	***Public***	***NGO***
North-East	9	5	825	148	264	602
South-East	19	4	1435	108	549	90
South Muntenia	14	1	430	15	81	4
South-West Oltenia	11	0	714	0	58	0
West	12	7	655	201	61	21
North-West	12	12	763	430	218	413
Centre	14	19	838	471	130	245
Bucharest/Ilfov	7	2	447	6	86	30
TOTAL	**98**	**50**	**6107**	**1379**	**1447**	**1405**

Source: Ministry of Labour, Family and Social Protection, Department for Familial policies, inclusion and social assistance (http://www.mmuncii.ro/pub/imagemanager/images/file/Domenii/Incluziune%20si%20asistenta%20sociala/Raportari%20si%20indicatori/160210Camine_Cantine_9l_09.pdf).

Confronted with such an increasing demand, the Romanian authorities proposed in 2005 a set of admission criteria in residential institutions administrated by the local authorities (Table 6). Aimed at prioritising the admission with an institution, not all criteria are relevant and some of them are difficult to be assessed.

Table 6: Admission criteria to residential centres for elderly

Criterion	**Scale**	**Number of points**
Age	<60	0
	60-70	5
	70-80	10
	>80	15
Degree of mental dependency	IIIB	0
	IIIA	5
	IIC	10
	IIB	15
	IIA	20
	IC	25
	IB	30
	IA	35
Degree of physical dependency	IIIB	0
	IIIA	5
	IIC	10
	IIB	15
	IIA	20
	IC	25
	IB	30
	IA	35
Personal residence	Private residence	0
	Viagere residence	5
	Rented residence	10
	Without domicile	15

Living conditions	Normal	0
	Non-hygienic conditions	5
	Insalubrious conditions	10
Existence of relatives	Close relatives, able to provide help	0
	Relatives outside place of residence	5
	Relatives with minor children or mono-parental families	10
	Relatives without income or in prison	15
	No relatives	20
Relationships with relatives	Very good	0
	Occasional	5
	Conflictual	10
	Very deteriorated	15
	No relationships	20
Monthly Revenues	> 300	0
	200 - 300	5
	100 - 200	10
	50 - 100	15
	< 50	20
	No revenue	20

Source: Anexa nr. 2 la H.C.L. S. 2 nr. 146 / 25.11.2005 (http://www.ps2.ro/Pagini/DespreNoi/ConsLocal/Hotarari/An2005/Hot_pdf/146_Anexa.pdf)

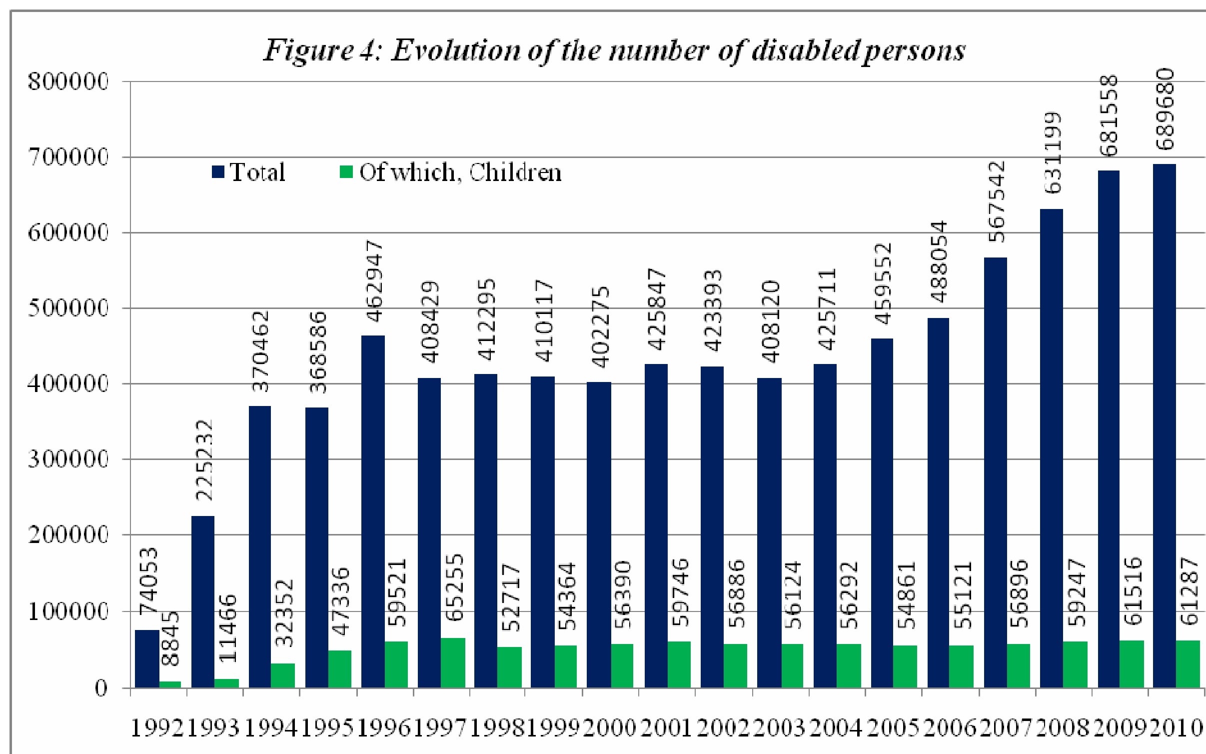
The principal difficulty in dealing with aged persons is that a relatively large share of them resides in rural areas, where the provision of such services is complicated by the fact that an important proportion of Romanian rural localities lack basic facilities in terms of sanitation, sewage, water, etc. Elementary medical services are equally in acute shortage in these areas. At the same time, the emigration phenomenon left at home an impressive number of lonely aged persons[23], who need assistance at their residence or in an institutionalised form. Consequently, there is an enormous demand for social workers; although this profession has developed rapidly, the unmet demand remains high: on one hand because the remuneration is not sufficiently attractive, on the other hand because the majority of existing social workers are involved in taking care of children left alone by their parents who have emigrated. In October 2010, the Italian journal *La Republica* estimated that the emigration of both parents left 300,000 Romanian children home alone.[24]

Over the last few years, the number of private centres has augmented noticeably. The quality of services is incomparably higher in those units, but the co-payment is equally important. Depending on the amount of his/her pension, of which 80%[25] remains with the centre, a person pays up to RON 1,200 (EUR 290) each month. The access to private structures is therefore limited to beneficiaries enjoying high pensions or those for which the family affords to pay the difference. In general, the patients of private centres are those whose children have emigrated.

With respect to disabled persons, the situation is even more complicated because the number of persons registered with a handicap is enormous: in 2010 there were 9.3 times more disabled individuals than in 1992 (Figure 4[26]). A relatively significant proportion of them obtained fraudulently a disability pension, and therefore they do not need any form of care, but they are still eligible for certain social services. In 2010, for example, 547,138 persons

[23] http://www.ziaresireviste.ro/index.php?page=revista_presei&details=on&id=21331
[24] http://www.ziare.com/diaspora/romani-italia/la-repubblica-parintii-mei-au-emigrat-depresia-celor-300-000-de-copiii-romani-1047940 .
[25] 60% in case of public centres.
[26] Source : ANPH (http://www.anph.ro/).

benefited from an average monthly indemnity for severe and marked disability of RON 178 (EUR 43.5); their number was by 3.8% higher than in 2009. The new medical tests imposed to all disabled persons by a recent governmental decision will reduce the number of those effectively needing this type of care.



2.4.5 Critical assessment of reforms, discussions and research carried out

The Romanian LTC system is regulated by different bodies with separate legislation. Consequently, there is no clear distinction in terms of legislative and administrative responsibilities between various institutions involved. At the same time, the involvement of both central and local authorities in LT care induces significant differences in terms of quality and availability of services among counties and regions. A Strategic National Report Regarding Social Protection and Social Inclusion (2008-2010) was elaborated with the scope of eliminating these problems, but still the evaluations, decisions and implementation of care are carried out in a disjointed way and without proper communication among specialists.

Minor policy changes took place during the reporting period, and therefore the status-quo prevails in the Romanian long-term care sector. The decision to increase the number of institutions hosting old age persons is a positive step in dealing with dependant elderly. However, the measure does not represent a distinct policy initiative of the Ministry of Labour, but rather a complementary measure to the already adopted decision to reorganise the hospitals. The process of transforming 67 hospitals into residential centres for aged persons needs a methodological framework for achieving the proposed objectives. Consequently, the MMFPS methodology (MMFPS, 2011) is not a programmatic document per se, but rather an accompanying set of actions that will make possible the transfer of hospitals from the Ministry of Health to the Ministry of Labour.

The crucial aspect related to the reform perspectives for disabled persons remains their insertion in the labour market. Although an action plan was elaborated in 2009 in this direction, no tangible result has been obtained until now. Only 4% of the total number of

disabled persons was employed in the beginning of 2011 (4.65% of non-institutionalised adults), which places Romania on the last position in the EU.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R4 ; R5] ICCV: Dupa 20 de ani: optiuni pentru Romania, Academia Romana, Bucuresti, June 2010, retrieved from:
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"20 years after: options for Romania"
The report makes an evaluation through a social perspective of 20 years of transition in Romania. A special attention is paid to the social protection sector and to the role of the state in improving the population wellbeing. In this sense, the poverty is analysed from various perspectives, together with the efficiency and the effectiveness of past and current social policies. The report closes with the conclusions of a recent survey through which the Romanians were asked to evaluate themselves their quality of life.

[R1; R5] Karam, Philippe; Muir, Dirk; Pereira, Joana; Tulandhar, Anita: Macroeconomic Effects of Public Pension Reforms, IMF Working Paper WP/10/297, December 2010.
The paper explores the macroeconomic effects of three public pension reforms: increase in retirement age, reduction of benefits, and increase in contribution rates. Using a five-region version of the IMF's Global Integrated Monetary and Fiscal model, the authors conclude that public pension reforms can have a positive effect on growth in both the short run, propelled by rising consumption, and in the long run, due to lower government debt crowding in higher investment. They also find that a reform action undertaken cooperatively by all regions results in larger output effects, reflecting stronger capital accumulation due to higher world savings. An increase in the retirement age reform yields the strongest impact in the short run, due to the demand effects of higher labour income and in the long run because of supply effects.

[R4] Marginean, Ioan; Precupetu, Iuliana: Calitatea vietii in Romania, ICCV, Bucharest 2010, retrieved from:
http://www.iccv.ro/node/190

"The quality of life in Romania"
The book represents a diagnosis of the quality of life in Romania, which has been done periodically since 1990. The diagnosis is based on surveys through which the respondents evaluate their quality of life on the basis of several elements: living conditions (personal income, housing) education (access, quality of education system), health care (access, quality

of services), employment and working conditions, family life, social environment, equality of chances in society, and political domain.

[R5] Ministry of Labour, Family, and Social Protection: Strategia privind reforma in domeniul asistentei sociale, Bucharest, March 2011, retrieved from:
http://www.mmuncii.ro/ro/articole/2011-03-10/2083-articol.html

"The Reform strategy of the social assistance field"
The document presents the main changes initiated by the Romanian government in the social assistance field. These changes refer to the revision of social services, whose number is reduced considerably, respectively the new eligibility conditions for those applying for such services. The objective of the strategy is the improvement of equity in service delivery and a better targeting of poorest groups of population.

[R2] Stegaroiu, Carina-Elena; Stegaroiu Valentin: Reforming the pension system in Romania with logical schemes, African Journal of Business Management Vol. 4(9), pp. 1691-1702, August, 2010, retrieved from:
http://www.academicjournals.org/AJBM
Starting from the current economic context of the Romanian pension system, heavily affected by the crisis, the paper proposes a mechanism of adjustment of public pensions using logical schemes. The authors suggest that the proposed mechanism can be further extended and developed as a model to be implemented in the whole Romanian social security system, which would contribute to rapid balancing of all components of social protection. However, the logical scheme described in the article is highly technical and therefore difficult to understand how such a mechanism could be correlated with sustainability issues of the pension system.

[R1] Zaidi, Asghar: Sustainability and adequacy of pensions in EU countries. A cross-national perspective, European Centre for Social Welfare Policy and Research Working Paper, Vienna, September 2010.
The paper enumerates the main sustainability concerns of EU member states in the area of pensions: population ageing, job crisis, fiscal crisis, and financial sustainability. These elements are analysed through the already implemented reforms by estimating their aggregate impact on the benefit ratio, on the structure of future pension systems, respectively on possible changes in the average first pension. The paper concludes with further policy challenges that the EU governments will face in the coming years in the pension area.

[R1] Zaidi, Asghar; Rejniak, Malgorzata: Fiscal Policy and Sustainability in View of Crisis and Population Ageing in Central and Eastern European Countries, Policy Brief, European Centre, August 2010.
The paper examines the interrelated aspects of recent economic and fiscal crisis (GDP growth, budgetary deficit and public debt, fiscal policy and austerity measure), as well as the long-term impact of population ageing on the sustainability of public finances in Central and Eastern European countries that joined the European Union. The threat posed to the fiscal sustainability of the CEE countries by the combination of demographic trends and a unique economic context needs detailed examination.

[H] Health

[H2 ; H3] ICCV: Dupa 20 de ani: optiuni pentru Romania, Academia Romana, Bucuresti, June 2010, retrieved from:

http://www.iccv.ro/node/193

"20 years after: options for Romania"
The report makes an evaluation through a social perspective of 20 years of transition in Romania. A special attention is paid to the social protection sector and to the role of the state in improving the population wellbeing. In this sense, the poverty is analysed from various perspectives, together with the efficiency and the effectiveness of past and current social policies. The report closes with the conclusions of a recent survey through which the Romanians were asked to evaluate themselves their quality of life.

[H3; H4] IRES (Institutul Roman pentru Evaluare si Strategie – Romanian Institute for Evaluation and Strategy): Perceptii asupra sistemului medical din Romania, Bucharest, October 2010, retrieved from:
http://www.ires.com.ro/articol/108/perceptii-asupra-sistemului-medical-din-romania

"Perceptions of the Romanian medical system"
The report is based on two separate studies: one carried out in April 2010, the second in September 2010. The aim of the survey is evaluate the level of satisfaction of Romanians with their health care system in terms of quality, professionalism, cost, role of private medical care, the reforms undertaken in the system by various governments, etc.

[H2] Jorgensen, Ole Hagen: Health, Demographic Transition and Economic Growth, World Bank Policy Research Working Paper 5304, May 2010.
The paper develops a link between four central components of the demographic transition: survival rates; fertility decisions; altruistic intergenerational transfers from workers toward their parents; and economic growth. An increase in child survival is found to reduce the fertility rate and altruistic transfers, and thereby increase the savings rate and the productivity growth rate. The analysis illustrates the key role of child health in the demographic transition.

[H3] Marginean, Ioan; Precupetu, Iuliana: Calitatea vietii in Romania, ICCV, Bucharest 2010, retrieved from:
http://www.iccv.ro/node/190

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The book represents a diagnosis of the quality of life in Romania, which has been done periodically since 1990. The diagnosis is based on surveys through which the respondents evaluate their quality of life on the basis of several elements: living conditions (personal income, housing) education (access, quality of education system), health care (access, quality of services), employment and working conditions, family life, social environment, equality of chances in society, and political domain.

[H7] Ministry of Labour, Family, and Social Protection: Strategia privind reforma in domeniul asistentei sociale, Bucharest, March 2011, retrieved from:
http://www.mmuncii.ro/ro/articole/2011-03-10/2083-articol.html

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[H4; H5] Romanian Ministry of Health: Strategia nationala de rationalizare a spitalelor, Ministrul Sanatatii, Bucuresti, 2010, retrieved from:
http://www.ms.ro/?pag=15

“National strategy for hospital rationalisation”
The programmatic document presents the principles for the decentralisation of hospitals in Romania, which will take place over the period 2010 – 2012. The main objectives of the strategy, as well as the expected outcomes, are detailed by the document. A set of monitoring indicators is proposed, such that the planned implications for the budget will be achieved. The strategy terminates with an action plan, listing the main activities to be implemented, as well as the institutions responsible for implementing them.

4 List of Important Institutions

Academia de Stiinte Medicale (ASM) – The Academy of Medical Sciences

Contact person: Prof. Dr. Laurentiu Mircea Popescu
Address: Splaiul Independentei 99–101 Sector 5, Bucuresti
Tel. 3115380 021 3115381
Webpage: http://www.adsm.ro/index.html

The institution, created in 1935, is subordinated to the Ministry of Public Health. It undertakes medical and pharmaceutical research, and coordinates various research programs at national and sectoral level (VIASAN[31] is the most important one). No publication is available on ASM site, although three scientific departments coexist within the institution: Biomedical Fundamental Sciences, Internal Medicine, and Clinic Surgery.

Agentia Nationala pentru Prestatii Sociale – National Agency for Social Services

Contact person: oredana Georgiana Tintareanu
Address: tr. Ion Campineanu 20, Sector 1, Bucuresti
Tel. 313 60 47
Webpage: http://www.prestatiisociale.ro/

The agency is subordinated to the Ministry of Labour, Family and Social Protection. Its role consists of administrating social assistance services provided from central budget, with the declared objective to ensure equity in the provision of these services. De facto, the agency deals in principal with the provision of family allowances and heating allowances. At local level, the agency disposes of territorial (county) units in charge of effective provision of services.

Asociatia pentru Pensiile Administrate Private din Romania (APAPR) – The Association of Privately Administrated Pensions from Romania

Contact person: Crinu Andanut
Address: Str. Ion Slatineanu 6, Sector 1, Bucuresti
Tel. 021 2072100
Webpage: http://www.apapr.ro/

APAPR is a professional non-governmental structure whose objective is to defend the interest of institutions and persons involved in the private pensions system. It is very active in formulating legislative proposals in the field and promoting the private system of pensions. In 2008, APAPR integrated the European Federation of Pension Funds and the International Federation of Multi-Pillar Private Pensions. The website offers good and up to date information on the privately managed funds – second and third pillar.

[31] Life and Health : www.viasan.ro.

Autoritatea Nationala pentru Persoanele cu Handicap (ANPH) – National Authority for Disabled Persons

Contact person: laudia Bratan
Address: Calea Victoriei 194, Sector 1, Bucuresti
Tel. 1 2125438
Webpage: http://www.anph.ro/

ANPH is a specialised governmental body, subordinated to the Ministry of Labour, Family and Social Protection, in charge of coordinating the policies related to the protection of disabled persons. ANPH is also empowered to elaborate the standards and norms required in residential institutions for handicapped people. There are two bodies under ANPH subordination: The Institute for Preventing the Social Exclusion of Disable Persons, respectively The Commission for Evaluation of Disabled Adults.

Casa Nationala de Asigurari de Sanatate (CNAS) – National House for Health Insurance

Contact person: Nicolae Lucian Duta
Address: Calea Calarasilor 248, Sector 3, Bucuresti
Tel. 0800800950
Webpage: http://www.cnas.ro/

CNAS is an autonomous public institution responsible for the overall coordination and management of the health insurance. CNAS has county branches and includes the special regimes of Transport, Defence, Interior, and Justice. The institution offers a wide range of information (studies, statistical data, budget execution, legislation), not all of them updated. The most recent activity report, for example, concerns the year 2008, and the budget execution ends in 2006.

Casa Nationala de Pensii si Alte Drepturi de Asigurari Sociale (CNP) – National House of Pensions and Other Social Insurance Rights

Contact person: Domnica Doina Parcalabu
Address: Str. Latina 8, Sector 2, Bucuresti
Tel. 021 3162830
Webpage: http://www.cnpas.org/portal

CNP is an autonomous public institution in charge of administrating the public system of pensions, as well as the work accidents scheme. The institution offers various information to beneficiaries and statistical data regarding the first and second pillar, but no studies or reports.

Comisia de Supraveghere a Sistemului de Pensii Private (CSSPP) – Commission for Monitoring the System of Private Pensions

Contact person: Mircea Oancea
Address: Calea Serban Voda 90-92, Sector 4, Bucuresti
Tel. 021 3301035 0213301037 0213301046
Webpage: http://w4.csspp.ro/ro/

Founded in 2005, CSSPP is directly subordinated to the Parliament and is responsible for prudential regulation and control of the private system of pensions. The institution also delivers the necessary permits to pension funds, administrators, depositors and auditors. In the legal domain, CSSPP adopts private pension norms, and elaborates and approves normative acts.

Institutul de Cercetare a Calitatii Vietii (ICCV) – The Research Institute for Quality of Life

Contact person: Catalin Zamfir

Address: Calea 13 Septembrie 13, Sector 5, Bucuresti
Tel. 021 3182461
Webpage: http://www.iccv.ro/

ICCV was founded in 1990 as a branch of the National Institute for Economic Research – a group of several public research institutions affiliated to the Romanian academy. It is the main institutional structure dealing with social policies, including health care, poverty alleviation, standards of living, pension system, regional development, minorities, etc. The institute publishes two periodicals (The Quality of Life Review – biannual, respectively the Social Innovation Review – electronic form).

Institutul National de Cercetare Stiintifica a Muncii si Protectiei Sociale (INCSMPS) – The National Scientific Research Institute for Labour and Social Protection

Contact person: Vasilica Ciuca
Address: Str. Povernei 6 – 8, Sector 1, Bucuresti
Tel. 021 3124069
Webpage: http://www.incsmps.ro/index.php?lang=romanian

Founded in 1990, the institute carries out surveys and research in the area of human resources management, social development and social protection. It has been involved in elaborating several important studies (National Human Development Report 2007, The System of Social Protection Indicators in Romania) and strategic documents (The Reform of Social Security in Romania).

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en