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Pensions, health and long-term care

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List of abbreviations

ANOFM	Agentia Nationala pentru Ocuparea Fortei de Munca (National Agency for Employment)
ANRAOS	Autoritatea Naţională de Reglementare a Asigurărilor Obligatorii de Sănătate (National Authority for Regulation of Compulsory Health Insurance)
APAPR	Asociatia Pentru Pensiile Administrate Privat din Romania (Associatio of Privately Administrated Pensions of Romania)
COPAC	Coaliţia Organizaţiilor Pacienţilor cu Afecţiuni Cronice (Coalition of Organisations of Patients with Chronic Diseases)
CNPAS	Casa Nationala de Pensii si Asigirari Sociale (National House for Pensions and Social Insurance)
CRPI	Centre for Rehabilitation and Professional Integration
CSSPP	Comisia de Supraveghere a Sistemului de Pensii Private (Commission for Supervision of Private Pension System)
DPH	Directorate of Public Health
EC	European Commission
EFOR	Experts Forum
EU	European Union
GDP	Gross Domestic Product
IES	Institutul de Economie Sociala (Social Economy Institute)
IMF	International Monetary Fund
INSSE	Institutul National de Statistica si Studii Economice (National Institute for Stattistics and Economic Studies)
LTC	Long-Term Care
MLFSPAP	Ministry of Labour, Family, Social Protection and Aged Persons
MPH	Ministry of Public Health
NAFA	National Agency for Fiscal Administration
NAHP	National Authority for Handicapped Persons
NGO	Non-Governmental Organisation
NHIH	National Health Insurance House
NHIF	National Health Insurance Fund
OECD	Organisation for Economic Cooperation and Development

1 Executive Summary

The coalition of liberals and socio-democrats that won the 2012 elections has initiated several reforms in the social protection sector. In the *pension* sector the special pensions diminished after the 2011 recalculation returned to their initial level, and the government envisages the reintroduction of special regime, which will further endanger the financial sustainability of the public system. With low activity rates, Romania records 1.2 pensioners per salaried worker and the ratio is expected to reach 1.63 in 2030. Accordingly, the pensions' deficit will double in 2030, attaining RON 80 billion. However, the financial unsustainability is mainly caused by structural inefficiencies of the system, where only 40% of beneficiaries have fully contributed and retired at the legal age in March 2013. At the same time, low collection rate of contributions deprives the pension fund of an important part of resources, estimated in 2012 at 3.3% of GDP; for comparison, the 2012 pensions' deficit represented 2.4% of GDP.

Pension adequacy has improved significantly; in dollar terms, an average pensioner in 2011 benefited from a pension that was 3 times higher than the one received in 1990. The old-age pension represented 42% of the gross average wage in June 13. As a result, most of poverty and income indicators are close or even better than in EU27 average and at-the-risk poverty rate is much lower for older people than the average for the whole Romanian population. Increased adequacy was possible by doubling the average pension between 2007 and 2009 but this measure transformed the 2007 pensions' budget surplus into a deficit of RON 13 billion in 2011. As a result, Romania has one of the riskiest public systems of pensions in Europe.

Private pensions have developed considerably since their introduction, but a large share of accounts is empty: 39% in the second pillar and more than 50% in the third (June 2013).

In the *health care* sector the government drafted a new Health Care Law, which will bring major institutional and financing changes. These changes are supposed to improve the coverage and the access, which are limited because the services are financially unaffordable for a part of the population. This is mainly due to formal and informal out-of-pocket payments the patients are forced to make. Formally, the patients pay the price difference of drugs (40%) and the co-payment for hospitalisation. Informally the bribes represent the most important out-of-pocket payment. The restricted access to medical services induces an annual loss of productivity estimated at €2.5 billion.

In spite of increasing resources allocated (5.4% of GDP in 2012 versus 2.8% in 1990), at an annual rate of 23% between 2005 and 2008, the sector has accumulated large debts that endangers the financial sustainability. Debts have been generated by the poor management of funds (expensive externalised services, high administrative costs), low ratio between contributors (7.5 million) and beneficiaries (20.4 million), and insufficient attention paid to preventive care.

The *LTC* system concerns old and disabled people, the majority of them being taken care by their families. The access is relatively adequate, but the number of old persons living alone who need home attendance or residential care has increased significantly, in particular in rural areas where the provision of services is in serious deficit. Although the number of private centres has increased, the tariffs are affordable only for those enjoying high pensions. In case of disabled persons there is a major problem of accessibility to the labour market: only 6.88% of non-institutionalised disabled persons aged 15-64 had a remunerated activity in 2013.

The LTC sector is confronted with an important deficit of social workers (11,000 in 2012). The challenges are therefore numerous and they refer in principal to the reinforcement of social inclusion and employment policies for disabled, strengthening the capacities of local authorities, and elimination of urban-rural disparities in terms of access.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The current configuration of the Romanian system of pensions is the result of several rounds of reforms. The first was the adoption of Law 19/2000 (amended in 2005 and 2007), which changed completely the public system (pillar I), followed by the adoption of Law 411/2004 (amended by Law 23/2007) on private compulsory pensions (pillar II), and respectively Law 204/2006 on private voluntary pensions (pillar III). Starting with January 2011, the public system is regulated by Law 263/2010 on the unified pension system, which replaced the former Law 19/2000 on public pensions and other social insurance rights.

2.1.2 System characteristics

As a result of these reforms, the Romanian pension system is currently composed of four schemes: public, private compulsory, private voluntary, respectively special pensions. The public pillar offers pension benefits (old-age, early retirement, partial retirement, survivor, disability and social pensions) and funeral grants. The second pillar is compulsory for all individuals aged 35 years at January 1st 28 and voluntary for persons aged between 36 and 45 years at the same date. Special pensions are granted to judges and prosecutors, respectively the employees of the High Court of Accounts.

The pension system covers employed persons with individual labour contracts, civil servants, military personnel, unemployment benefit recipients, self-employed persons, and certain other workers. The contribution rates to the first pillar depend on the working conditions: 31.3% for normal conditions, 36.3% for arduous ones, and 41.3% in case of very arduous working conditions. The employee contributes by 10.5%, irrespective of the working conditions, and the difference is covered by the employer. Self-employed persons contribute by 28.3% of income, but the rate will gradually decrease to 25% by 2016. The minimum earnings used to calculate contributions are 35% of the national average gross salary, while the maximum is five times the national average gross wage.

In the private compulsory pillar the starting contribution rate was set at 2% of gross wage, to be increased each year by 0.5 percentage points until 2016, when the rate will reach 6%. In 2013 the rate of contribution is 4%. The contribution is not collected separately but is part of the social insurance scheme. The benefits are calculated on the basis of individuals' contributions and investment earnings.

The retirement age will be gradually raised to 65 years for men and 60 years for women until January 2015. Afterwards, the women's retirement age will continue to be increased to 63 years until January 2030. For military and police personnel the retirement age will be raised to 60 years in January 2030 for both genders. The standard contributory period, which gives rights to full pension, will reach 35 years for both genders, but earlier for men (January 2015) than for women (January 2030). In case of police and military personnel the standard period of contribution will be raised for both genders to 30 years by January 2030. The minimum contributory period will be raised for both men and women to 15 years by January 2015 (20 years for police and military staff in January 2030). The current retirement conditions are summarized in Table 1.

The pension benefits are granted on the basis of pension points. In January 2013 the value of the pension point was set at RON 762.1 (€170). According to Law 263/2010, the pension point will be fully indexed every year until 2020 by the annual inflation rate and will

additionally increase by 50% of the real growth of gross average wage in the previous year. If one of the two indicators takes a negative value, the index of adjustment corresponding to that indicator will be zero. If both indicators record negative values, the pension point keeps its value from the previous year. Starting with January 2021, the value of the pension point will be fully indexed with the inflation rate and will be additionally increased by 45% of the real growth of gross wage in the economy recorded in the previous year. The indexation by the real wage growth will be reduced every year by 5 percentage points, such that from 2030 the pension point will indexed only by the rate of inflation.

Table 1: Current retirement conditions in Romania (October 2013)

Retirement Conditions		Gender	Retirement age	Contributory period	
				Full	Minimum
Standard		***Men***	64y, 8m	34y, 4m	14y, 4m
		Women	59y, 8m	29y, 4m	
Military and Police personnel		***Both***	55y, 8m	21y, 5m	15y, 8m
Special pensions	**Judges, Prosecutors**	***Both***	60y	25y	25y
	High Court of Accounts	***Men***	64y, 8m	34y, 4m	14y, 4m
		Women	59y, 8m	29y, 4m	

y = years; m = months

Source: MLFSPAP: http://www.mmuncii.ro/nou/index.php/ro/protectie-sociala/pensii/844-varsta-standard-de-pensionare-in-functie-de-data-nasterii

2.1.3 Details on recent reforms

With the adoption of Law 263/2010, which entered into force in January 2011, the Romanian pension system experienced a new major reform. The law increased the retirement age, the compulsory period of contribution for entitlement to full benefits, and the minimum contributory period. It also set a new formula for calculating the pension point (see above). The most important change is the integration of special regimes of military and police personnel in the public system of pensions and the recalculation of their benefits. The law regulates more drastically the early retirement and disability retirement. In the first case early retirement is forbidden if the insured's age is more than 60 months below the standard age; in addition, a penalty of 0.75% per each missing month applies to those entitled by age to early retirement, which reduces the benefit by up to 45% in case of 5 missing years. On the other hand, the disability pensions are not anymore granted on the basis of a simple medical certificate attesting the handicap, but a complete medical report of expertise established by a specialist accredited by the social insurance system.

However, the 2012 elections brought a new coalition into power, composed of the former liberal and social democratic opposition. The government issued from that coalition initiated several reform measures that are in contradiction with the provisions of Law 263/2010. The first consisted of increasing all special pensions of military and police personnel that were diminished through the recalculation initiated under the law. Starting with October 1st 2014, the benefits will return to their level before recalculation. At the same time, the special pensions that increased as a result of recalculation (around 90% of them) will remain unchanged (Tempea, 2012). Moreover, a draft law was prepared in April 2013 for reintegrating the pensions of military and police personnel in the special regime, as it was the case prior to the adoption of Law 263/2010 (Fratila, 2013). The current government envisages having the special regime of pensions in place by 2016 (Popescu, 2012); the scheme will

function as an occupational regime and will include, beside the previous professional categories, the farmers and the medical staff.

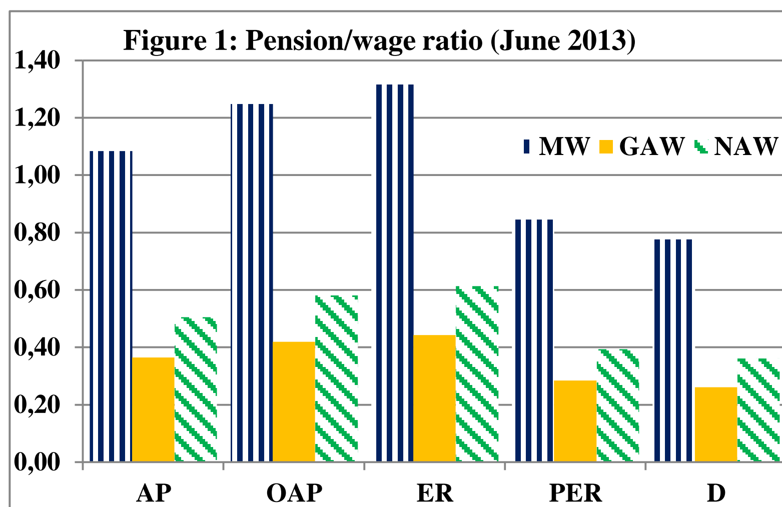
A second important envisaged measure is the gradual reduction of contributions paid by employers, which will pass from 10.5% at present to 5% by the end of 2016.

In the private system of pensions the government decided to increase by 50% (starting with January 2013) the taxes paid by the private administrators of pension funds within the second pillar. In September 2013 the Ministry of Labour announced that the methodology for paying the private pensions is under elaboration; the draft law under preparation stipulates the the beneficiaries can opt between a monthly fixed amount be paid for the whole period of retirement, and respectively a monthly payment for a fixed period of time comprised between 5 and 10 years (Dumitrache 2013).

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

The system of indexation used for updating the pension point allows for a relatively high adequacy of benefits. In June 2013 the average pension (all categories[1]) represented 36.5% of the gross average wage in the economy, and respectively 50.4% of the net average wage. At the same time, it was 1.08 times higher than the minimum wage. However, the old-age pension, granted for full contributory period, represented respectively 42% and 58.04% of the gross and net average wage (Figure 1[2]), and it was 25% above the minimum wage. The highest ratio between average pension and wage rate is observed in case of early retirement, with the average pension benefits representing 44.3% of the average gross wage, 61.2% of the average net wage, and 131.47% of the minimum wage. In dollar terms, an average pensioner in 2011 benefited from a pension that was 3 times higher than the one received in 1990 (Amariei, 2012).



Consequently, a major part of poverty and income indicators in Romania are close or even better than the EU27 average (Annex 1). At the same time, the risk of poverty rate is much lower for older people than the average for the whole Romanian population. Moreover, within

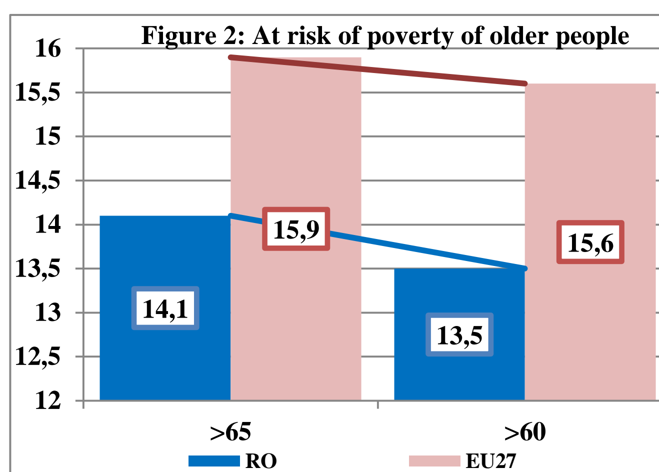
[1] Old age, early retirement, partial early retirement, disability, successor, and social pensions.

[2] Calculations based on statistical data from CNPAS (http://www.cnpas.org/portal/media-type/html/language/ro/user/anon/page/default.psml/template/generic?url=%2Fcontent%2Fcnpas%2Fstatistics.html&title=Indicatori+statistici+pilon+I) and INSSE (http://www.insse.ro/cms/files/statistici/comunicate/castiguri/a13/cs05r13.pdf)
Legend: MW = Minimum Wage; GAW = Gross Average Wage; NAW = Net Average Wage
AP = Average Pension; OAP = Average Old-Age Pension; ER = Average Early Retirement Pension; PER = Average Partial Early Retirement Pension; D = Average Disability Pension.

the old category of persons the poverty declines with the age (Figure 2[3]); this is also the case for EU27 average, but the decline is faster in Romania than in EU27.

A relatively good adequacy of pensions places therefore the old category of persons in a much more favourable situation than the young category of population in terms of poverty and deprivation (Annex 2). The persistent at-risk-of-poverty rate, for example, is almost double for persons below the age of 18, as compared to the +65 category of age.

However, certain gender discrepancies exist within older category of persons in terms of poverty indicators, with women being worse-off, as their at-risk-of-poverty is practically double than the men's rate. This difference comes from the fact that the average old-age pension for women is lower than that of men (87.5% in June 2013).



Overall, the pension adequacy in Romania has increased over the last few years. The median relative income of elderly people, for example, passed from 0.76 in 2007 to 1.01 in 2011. This was possible through a relatively generous mechanism of pensions' indexation as well by the adoption of Law 263/2010. The restrictions imposed by the new law in case of early retirement and disability retirement resulted in a significant reduction in the overall number of pensioners and the number of beneficiaries of disability and partial retirement (Table 2).

Table 2: The number of pensioners before and after the adoption of Law 263/2010

Number of beneficiaries	December 2010	March 2013	Ratio 2013/2010
Total	4771141	4678748	98.06
Old-age	3226851	3284996	101.80
Disability	846323	737597	87.15
Early Retirement	8750	12698	145.12
Partial Early Retirement	124474	104459	83.92

Source: CNPAS: http://www.cnpas.org/portal/media-type/html/language/ro/user/anon/page/default.psml/template/generic;jsessionid=E5A0F52C2539E202C81A50E325116398?url=%2Fcontent%2Fcnpas%2Fstatistics.html&title=Indicatori+statistici+pilon+I

The restrictions imposed by Law 263/2010 on early retirement were necessary for increasing the activity rate of senior workers (55 – 64), which is much lower in Romania than in the EU27 average (Table 3). However, those measures have produced very little impact on the indicator; moreover, the gap between the EU27 average and Romania widened in 2012 as compared to 2010. The principal reason for this relatively ineffective outcome is that the large majority of pensioners that retired before the standard age is concentrated within the low groups of pension benefits. As Figure 3 shows, the effective age of retirement is proportional to the pension level; consequently, those receiving low and very low benefits prefer to retire earlier because the penalty paid for incomplete contributory period is largely compensated by the social transfer they receive in form of minimum guaranteed pension, which represents RON 350.

[3] Source: EUROSTAT.

Table 3: Activity rate (%) in Romania and EU27

Age group		15-64			55-64		
		Total	***Male***	***Female***	***Total***	***Male***	***Female***
Romania	***2010***	63.6	71.5	55.8	42.5	52.7	33.5
	2012	64.2	72.1	56.4	42.9	53.6	33.5
EU27 average	***2010***	71.0	77.6	64.4	49.8	58.9	41.2
	2012	71.7	78	65.6	52.8	61.2	44.8
EU27 – RO differential	***2010***	7.4	6.1	8.6	7.3	6.2	7.7
	2012	7.5	5.9	9.2	9.9	7.6	11.3

Source: EUROSTAT.

2.2.2 Sustainability

As a consequence of low activity rates, Romania has at present 1.2 pensioners per salaried worker (Capital, 2013d). This ratio, combined with a relatively high adequacy of pensions, poses serious problems of sustainability of the public system. According to Vlad and Craciun (2012), if no major reform is adopted the ratio between pensioners and salaried workers will reach 1.63 by 2030. Consequently, the deficit of the pensions' budget will pass from billion 37 RON in October 2012 to billion 80 RON in 2030 (Table 4). Even in these circumstances the average pension of those who will retire after 2030 (born from 1967 onwards) will represent maximum 30% of the gross average wage. This is equivalent to a monthly benefit of RON 515 in 2012 prices, when the average old-age pension represented RON 896, thus a decline by 42.5% in real terms. In other opinions (CSSPP president) the average pension will be even lower in 2030, when the inflation rate will represent the only indicator used for indexation: for those born between 1967 and 1971, the average benefit will not be higher than 15% of the gross average wage in the economy (Dumitrache, 2012a).

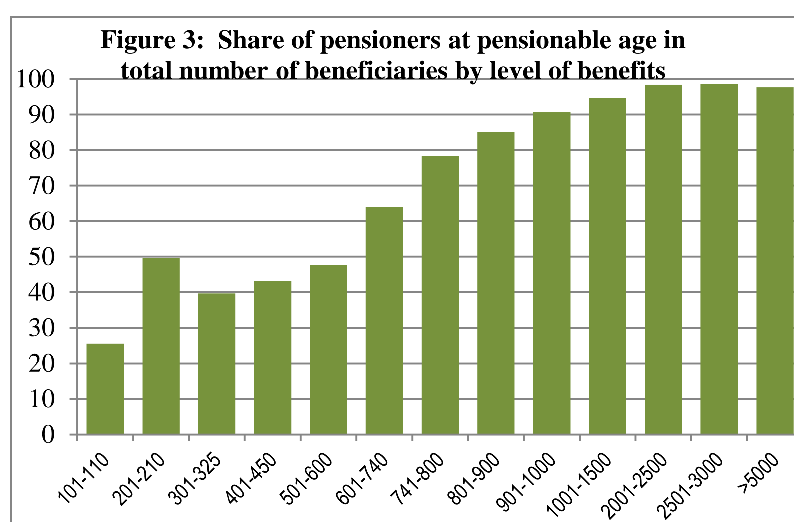


Table 4: Sustainability indicators of the Romanian public system of pensions

Indicator	Oct. 2011	2030
Number of salaried workers (million)	4.4	3.8
Number of pensioners (million)	4.6	6.2
Pensioners/Workers ratio	1.0455	1.6316
Gross average monthly wage (RON)	1719	5500
Pension expenditures (billion RON)	48	125
Deficit pension fund (billion RON)	37	80

Source: Vlad and Craciun (2012)

Romania records already a high deficit of the budget for public pensions: 85% of total budget deficit in 2012. According to the government programme, this deficit will increase further by 13.3% between 2014 and 2016, reaching therefore 90% of the total state budget deficit (Pirloiu, 2013a). The above estimations regarding the huge gap between the pensions' expenditures and collected contributions in 2030 seem therefore realistic.

It follows that a first factor menacing the financial sustainability of the public system is related to the sizable disequilibria on the labour market, where relatively few active workers sustain a large number of pensioners. However, the reality is even more complex, since 3.1 million persons in the private sector must support through their taxes and contributions: 5.3 million pensioners, 4 million children, 1.2 million public administration workers, 0.4 million persons from loss-making state owned companies, 3 to 4 million persons working in the shadow economy or in the subsistence agriculture[4], and 8.2 million beneficiaries of various forms of social assistance (Mihai and Anghel, 2012). The Romanian economy is therefore based on a model that is not sustainable in long run, and the difficulties in the pension system represent just a part of the overall structural problem of the economy as a whole.

A second factor of instability is of demographic nature. As a result of low fertility rates, the Romanian population will experience an accelerated process of ageing over the next decades. Consequently, by 2061 the +65 population will almost double, while the share of persons aged 20-55 years will reduce to half of its current level (EFOR, 2012). The highest increase is expected for the age group +80, which will represent 13.3% of total population, as compared to 11.8% the proportion of young generation (0-14). This will obviously affect negatively the labour market and implicitly the pension system. Moreover, the activity rate is expected to decline over the next decades if the labour market will not be able to integrate all persons that are statistically active (3 to 4 million); Romania is therefore the only EU country expected to record declining activity rates in the future, according to EC (2012) forecasts.

The massive emigration observed in particular after the EU integration represents another factor of instability, since the large majority of emigrants are active persons (Pirloiu, 2012b). The Romanian labour market has therefore lost a significant number of potential contributors to the pension system.

However, the most important element that threatens the sustainability of the public system is related to its inherent structural inefficiency, which has several roots. The first relates to the distribution of beneficiaries according to the level of pension they receive. Currently the monthly pension ranges from less than RON 40 (€8) to more than RON 9000 (€2045). Within this interval, the number of beneficiaries who retired at the legal pensionable age is preponderant (above 50%) only for an average pension superior to RON 600 (€136). Below this threshold we find early retired, disabled persons, successors of former pensioners, and beneficiaries of social pensions. The highest number of disability pensioners (50.6% of total) is situated within the interval of RON 221-230 monthly benefit. The highest number of persons receiving successors' benefits (65.7% of total) is situated within the interval of RON 121-130 monthly benefit. At the same time, the largest number of beneficiaries of an old-age pension (98.7% of total) is situated within the interval of RON 2501-3000 monthly pension (Pana, 2013a).

[4] In March 2013 there were 580,000 farmers receiving pension benefits but who have never contributed to the system.

This means that the benefit is low for those who have not contributed at all to the system or have not completed their contributory period. Those with full contributions during their working life received in average around RON 1100 per month at the end of 2012 (Pana, 2013b), which represents 70% of the net average wage in the economy. Overall, 23.94% of pensioners recorded in March 2013 have not paid contributions for the benefits they received and only 40% have fully contributed to the system and retired at the legal age (Pana, 2013b). This situation is responsible for the largest part of the pensions' budget deficit. Consequently, the average retirement age in Romania is 54 years, which is much lower than most of the EU countries: 59.3 in France, 61.7 in Germany, 64.1 years in Ireland (Benezic, 2011b).

A second systemic deficiency resides in the low collection rate of taxes in general and social contributions in particular. EFOR (2012) estimates that the fiscal evasion in collecting the social contributions represents 3.3% of GDP; for comparison, the pensions' deficit represented 2.4% of GDP in 2012. Having one of the highest contribution rates among EU member states, Romania should be therefore able to cover entirely the pension expenditures from contributions. However, this is not the case for two main reasons: the high proportion of underground economy, respectively the enormous arrears of state companies to the budget. According to a recent study (Visa, 2013), the underground economy in Romania represents 30% of GDP, which is almost 12 percentage points above the EU average (18.5%) and three times higher than in countries like Switzerland or Austria.

At the same time, the largest 10 debtor companies to the state budget recorded in June 2012 a total of €3.88 billion tax and social contributions arrears, which is equivalent to 2.7% of the GDP.[5] More than half of this amount represents social contributions to the Pension Fund, Health Fund and Unemployment Fund; 23.2% of these arrears (€0.9 billion) represent debts to the Pension Fund (Pele, 2012). It is interesting to mention that among the top 10 debtors there are two private (profit-making) companies, which recorded in June 2012 a total amount of arrears to the budget of €0.72 billion. This implies that the non-payment of fiscal obligations is not necessarily due to the losses made by the state companies, but rather to the weak fiscal discipline.

Concluding, the public system of pensions in Romania is one of the riskiest in Europe, in spite of the fact that the country has one of the youngest populations in the EU. This is mainly due to inappropriate pension policies, often altered by an exaggerate populism in designing and implementing the reforms. It is the case, for example, of the decision to practically double the average pension between 2007 and 2009, which transformed the pensions' budget surplus from 2007 into a deficit that reached RON 13 billion in 2011 (56% of consolidated budget deficit).[6]

It follows that not only the emigration and population ageing are responsible for the long-term financial unsustainability of the public system, but equally the inherent inefficiency related to contributions' collection, administration, and distribution of resources.

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[5] One single state-owned company (National Coal Company) detains 30% of those arrears. For illustrating the size and the role of this company in the Romanian economy, NCC is supposed to cover 15% of the total contributions to the unemployment fund.

[6] Between 2006 and 2008 the average pension increased by 91%, while the average wage by 54%. During the economic crisis (2008 – 2010) the average pension increased by 25% and the average wage by 6%.

2.2.3 Private pensions

Various measures are proposed by the specialists for overcoming this situation (see Annex 3 for a list of possible scenarios of reform); there is a clear unanimity that only two of such measures will be effective in restoring the sustainability of the system: to link the retirement age to the life expectancy, respectively to give more weight to the private system, both compulsory (Pillar II) and voluntary (Pillar III).

At the end of March 2013 the second pillar recorded 5.9 million participants (Table 5), where 8 pension funds were active. Most of the contributors (39.2%) were aged between 25 and 35 years, with women more numerous than men (51.8% versus 48.2%). Since its introduction until end of June 2013, the second pillar has accumulated RON 9.7 billion as contributions, which resulted into a total of RON 11.53 billion assets. The annual average return is therefore 11.4% and the total return since the introduction of compulsory pensions until the end of 2012 amounted to 56% (Pricop, 2012).

Table 5: Age and gender structure of contributors to Pillar II (thousand) – March 2013

Age / Gender	Total	Male	Female
15-25	740.6	339.6	401.0
25-35	2307.3	1089.2	1218.1
+35	2838.7	1408.5	1430.2
TOTAL	5886.6	2837.3	3049.3

Source: CSSPP (http://www.csspp.ro/evolutie-indicatori/pilon2/contrib-varsta/1-2)[7]

The third (voluntary) pillar recorded at the end of the first semester 2013 a total of 301848 participants. More than half of them (50.46%) were aged between 30 and 44 years, and 35.46% above 45 years of age. For 45% of participants the contributions were paid by the employer, 45% of them contributed personally, and the remaining 10% were joint contributions. At the end of June 2013 the total assets of the voluntary pillar represented RON 687.5 million, administrated by 10 pension funds, with an average annual return of 9.4%.

According to APAPR, the two private pillars are expected reach a total volume of assets of €11 billion by the end of 2017, from €2 billion in September 2012 (Dumitrache, 2012b). The private system of pensions represents therefore the only sustainable alternative for the country. However, the Romanian private pillars encounter serious problems related to the continuity of contributions' payment. Within the second pillar, 39% of participants recorded empty accounts at the end of June 2013; this means that out of the 5.9 million persons within the compulsory pillar, the employers pay regularly the contributions for only 3.6 million. Similarly, in the third pillar the contributions are paid regularly for less than half of participants (Pirloiu, 2013b).

Another difficulty to which the private system of pension is confronted is the reduced number of investment opportunities on the local capital market, which records practically the same level of development like in 2007 when the private pensions started to function (Pricop, 2012), with energy and financial/banking sectors being the most represented. Consequently, the pension funds are forced either to accept risky investments on the domestic market, or to look for external opportunities. Some pension funds opted for the first solution, but the risk

[7] *Source:* CSSPP (http://www.csspp.ro/evolutie-indicatori/pilon3/contrib-varsta/1-2)

exposure is high (13% in 2012). Others started to look for opportunities abroad, but in this case the invested resources contribute to the development of foreign economies, not the Romanian one.

The private pension funds are equally concerned about the government policy with respect to the planned increase of contribution rates to the second pillar by 0.5 percentage points per year. The freeze from 2009 created a precedent that fuels the fear of a new such episode in the future, if the economic conditions deteriorate. Moreover, some rumours about the eventuality of nationalizing the second pillar increased the uncertainty regarding the government future policy in the field.

The private pensions, especially the third pillar, are also confronted with a low level of saving-for-pension education of the population, habituated for decades with the idea that the state must provide a pension when old. In general, the insurance culture is underdeveloped, as 85% of Romanians do not have any form of private insurance (health, accident, life or private voluntary pensions); for comparison, only 14% of Slovenians are in this situation (Ghinea, 2012). After 5 years since the adoption of the private system of pensions, only a minor part of population understands how the system works and what its advantages are. Consequently, numerous contributors to Pillar II have been distributed randomly to the pension funds, as they have not expressed any option in this respect due to the lack of knowledge of the system. In Pillar III, on the other hand, the number of participants is low (5.13% of those registered with Pillar II); the voluntary participation is not therefore very popular.

2.2.4 Summary

Strengths		Weaknesses
Significant progress in reforming the system: private schemes introduced, retirement age increased, retirement conditions revised.	But	Reforms are insufficient for ensuring long-term financial sustainability of the public pillar. Additional measures are necessary for: (a) confronting the demographic challenges, the loss of active persons due to emigration, the imperfections on the labour market; (b), correlating the retirement age with life expectancy; (c) eliminating the intrinsic deficiencies of the system (distribution of benefits, low collection rate of contributions).
As a result, the pension benefits are adequate, preventing most of the old people to fall into poverty.	But	Exaggerate populism in designing the policies has favoured generosity in providing today's pensions by jeopardizing the future sustainability of the whole system. The essential goal of the government when planning the future reforms should be the inter-generational and intra-generational fairness. The first means that the pensions of future generations are not sacrificed by accepting unsustainable deficits today. The intra-generational fairness implies that "special regimes" are eliminated and all the pensioners – irrespective of the professional category to which they belonged during their active life – receive a pension strictly linked to what they have contributed.
After five years since its introduction, the private system of pensions proves its efficiency and its major role in providing adequate benefits.	But	Both compulsory and voluntary pillars record high number of empty accounts, which implies that a large share of participants will not actually benefit of future pensions. The Romanian economy offers insufficient investment opportunities to private pension funds; the development strategies need therefore to be stronger correlated with social protection perspectives and objectives, knowing that the private pensions represent a considerable source of future economic development, which ensures higher pension contributions to the system.

2.3 Reform debates

The growing difficulties to which the Romanian public system pension is confronted have recently increased the awareness among the specialists. As compared to previous years, the studies, the debates and the opinions expressed are more systematic, well documented and – more importantly – shared with the public through seminars, conferences and specialised websites. Forums of discussions and groups of analysis have emerged for proposing alternative solutions and recommendations to cope with the challenges. The mass media is not limited anymore to sporadic articles about the deficiencies of the system, but fully involved in grouping specialists from various domains who present their conclusions and solutions.

For example, the national debate organised in September 2012 by the journal *Ziarul Financiar* on the future of the public pension system brought to the attention new aspects of the demographic perspectives, while detailing the impacts on the system of those perspectives (Pavelescu, 2012). The event represents the first systematic approach of the consequences of the 1967-1969 baby-boom: in 1966, the communist regime issued a decree forbidding the abortion; as a result, the fertility rate exploded from 1.9 to 3.7. Consequently, 2 million persons will retire between 2030 and 2032 (Benezic, 2011a). For a population estimated at 19 million that period, it follows that Romania will have 10 million old persons. To face this situation, the specialists believe that the legal retirement age should be increased to 70 years by 2030 and the average retirement age should be 65 years (as compared to 54 at present).

An excellent on-line think-tank (*Curs de Guvernare*[8]) was created in November 2010, which groups well-known Romanian specialists who react promptly to the most important decisions of the government. The pension system has a primordial role in their analyses, which provide solid arguments for the necessity of reforming the system. One of their studies identifies the main reason for the current deficit of the public pension scheme: as compared to 2005, in 2011 the average real wage in the economy increased by 58.2%, while the average real pension by 102.3% (Pana, 2012a). The highest discrepancy is observed between 2007 and 2009: 33.6% increase of real wage versus 84.4% increase of real pension. The author concludes that if both wages and salaries were increased at the same rate over the analysed period, there would have been no deficit of the pensions' budget at present.

Another interesting study compares the effective retirement age and the legal age of retirement in Romania versus several OECD countries. While in OECD group of countries the two indicators are very close, in case of Romania the effective retirement age is lower by 7.5 years for men and 3.4 years for women than the legal age of retirement (Pana, 2012b). Consequently, even if the life expectancy in Romania is lower than in OECD countries, a Romanian male pensioner benefits from pension for a longer duration than an American, Irish or Central-European pensioner.

Another recently created think-thank (*EFOR – Experts Forum*[9]), member of *Open Government Partnership,*[10] is formed of a team of experts who periodically evaluate the most important public policies of the country. Based on EU programmatic documents, EFOR elaborated an extensive analysis of the situation in the pension sector (EFOR, 2012), identifying seven possible scenarios for the future evolution of the system. Each scenario is quantified in terms of the impact on the average pension benefit and therefore the necessary resources to cover the pensions' expenditures.

[8] Course of Governance (http://cursdeguvernare.ro/).
[9] http://expertforum.ro/
[10] http://www.opengovpartnership.org/about

The government, for which all those studies and analyses are destined, seems to be insensitive to the conclusions, proposals are recommendations formulated. This indifference is reflected by the policy measures adopted over the last two years in the pension domain, which are sometimes in contradiction with the experts' recommendations. While there is a unanimous opinion among the specialists about the necessity of unifying the public system of pensions by integrating the special regimes, the government announced its intention to reintroduce the "special pensions" for military and police employees, lawyers and magistrates until 2016 (Popescu, 2012). Law 263/2010 integrated in 2011 those special regimes in the public system, but the current government intends to change the provisions of that law.

Another contradictory measure, which will increase even further the next years' deficit of the pensions' budget, is the decision to reinstate the level of special pensions that were reduced through the 2011 recalculation. In spite of the fact that the recalculation ended up with an increase of the benefits in case of lower pensions for 90% of beneficiaries (Vlad and Craciun, 2012), which raised the average pension by 30% (from RON 1755 to RON 2289), the government maintained its decision. Motivated by fairness reasons, the measure was actually promised during the 2012 electoral campaign and the political coalition had to implement it despite the IMF reluctance (Tempea, 2012). The pensions increased by recalculation will remain at the exiting (recalculated) level.

Although the EC Country Specific Recommendations for the last three years do not mention any measure in the pension field, the decision to restore the level of special pensions is against the March 2012 recommendation for ensuring financial stability and fiscal consolidation (EC, 2012). In fact, the new coalition in power manifests a certain disregard towards EU in general and its recommendations in particular.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

Between 1990 and 1998 the Romanian health care system functioned on the basis of a series of decrees and ministerial orders. Systematic reforms started to be adopted with the adoption of Law 145/1997 on social health insurance, Law 100/1997 on public health, Law 146/1999 on hospital organisation, and Law 336/2002 on pharmaceuticals. These laws established the legal framework for a decentralized and pluralistic health insurance system, with contractual relationships between health insurance funds as purchasers and health care providers. Several changes and adjustments of this legal basis took place until 2006, when Law 95/2006 on Health Care Reform was adopted.

The new law has 17 components, of which the most important refer to social health insurance, private health insurance, hospitals organisation, community care, primary health care, pharmaceuticals, emergency services, public health, and national health programmes. According to the law, the system is organized at two main levels: national/central and district. The national level is responsible for attaining general objectives and ensuring the fundamental principles of government health policy; the main central institutions in charge are the Ministry of Public Health (MPH) and the National Health Insurance Fund (NHIF). The ministry defines the health policies and strategies, while NHIF is an autonomous public institution that administrates and regulates the social health insurance system. The law also stipulates that cross-sector approaches in health policy at central level are ensured through collaboration

between MPH, the Ministry of Labour, the Ministry of Interior, the Ministry of Education, and the Ministry of Finance. The district level is responsible for ensuring service provision according to the rules set by the centre.

The National Health Insurance Fund represents the main financial source of the system. NHIF receives the contributions collected by National Agency for Fiscal Administration (NAFA), which belongs to the Ministry of Finance. Through the Yearly Framework Contract, the health care services to be contracted are agreed with MPH and the College of Physicians.

According to Law 95/2006, private insurance companies are allowed to offer supplementary and/or complementary health insurance. The supplementary insurance covers fully or partially the services not included in the basic benefit package and higher-comfort hospital accommodation. The complementary insurance covers fully or partially the co-payments charged by providers for the services included in the basic benefit package. The insured persons opting for voluntary insurance are not excluded from participating in the statutory insurance scheme. In order to be eligible for supplementary and complementary insurance, the applicant must pay the mandatory contribution for the basic package of services.

Apart from the National Health Care System, parallel systems are in place for police and military personnel, for the employees of the Ministry of Transport and for those working with the Ministry of Justice.

3.1.2 System characteristics

Social health insurance is compulsory for all citizens and for foreigners residing in the country. Voluntary health insurance is available for members of the diplomatic missions in Romania, foreigners, stateless persons and Romanian citizens resident in other countries during their temporary stay in Romania. Exemptions from payment of contributions are granted to certain categories of non-wage-earners, children up to 18 years of age, persons with disabilities, war veterans, patients covered by the national health programmes and pregnant women. The current health contribution rate is 10.7% of payroll, of which the employer pays 5.2% and the employee 5.5%. The self-employed categories pay 5.5% of their earnings. The revenues from contributions are complemented by a monthly transfer from ANOFM, in charge of administrating the Unemployment Fund, which represents 0.75% of its collected unemployment contributions.

Apart from contributions, out-of-pocket payments are made by patients for: a) goods or services that are not included in the health insurance benefit package or covered by the national health programmes; b) direct payments for private providers c)co-payments charged for certain medical services; d) the difference between actual and reference prices of drugs; e) informal payments.

Medical services are accessed on the basis of a certificate that proves the payment of contribution. National health insurance cards, replacing the certificate, started to be issued recently. To receive primary ambulatory health care, the insured has to register with a family doctor. Dental care is free of charge until the age of 18 and between 40% and 60% is covered by NHIF above this threshold for those insured. 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; a co-payment comprised between RON 5 and 10 is charged when the patient leaves the hospital.

The private market for medical services reached €500 million in 2012, with an average annual growth rate of 20%; however, in 2013 this rate of growth is expected to reach maximum 10% because of overcapacity of existing providers, respectively the uncertainties related to the new health care law (Banila 2013e). The share of the private sector remains therefore low relative to other countries from the region: 8%, as compared to 37% in Poland and 32% in the Czech Republic in 2012 (Banila, 2012a). One possible explanation for this low market shares of private providers is that 70% of Romanians would not buy a private insurance either because of insufficient income or because the private health care does not provide yet emergency care.[11]

3.1.3 Details on recent reforms

After several delays, the Romanian government introduced in April 2013 the co-payment for certain medical services. The mechanism, implying a contribution between RON 5 and 10 per patient (Barbulescu, 2013), is payable at the end of hospitalisation period. Emergency care, family doctors and medical laboratories do not charge the co-payment. The following social categories are exempted from co-payment: children up to 18 years, youth aged 18-26 without income, pregnant women, war veterans, persons with chronic diseases, and pensioners receiving a pension benefits inferior to RON 740 per month.

In agreement with drugs' producers, at the end of 2012 the government changed the calculation formula for the clawback tax and adopted a mechanism for reducing the hospitals arrears for the period 2009 – 2010. Although the payment threshold was raised from RON 1.42 billion (existent in 2009) to RON 1.51 billion, the new formula will reduce the clawback tax from 30% to 20% according to the Ministry of Finance (Moise, 2012).

The most important and radical reform of the system since the adoption of Law 95/2006 is currently under preparation: a new Health Care Law was drafted in 2012, and a National Public Health Strategy is under elaboration. The draft Health Care Law brings several important changes in the system:

i) The existing 44 county Directorates of Public Health (DPH) will be replaced by 8 regional structures, which will reduce the administrative personnel by 4000 persons and will save about €50 million per year (Chitu and Dumitrescu, 2013).

ii) The present National Health Insurance House (NHIH) will be split into maximum 10 non-profit mutual insurance companies. Consequently, the health care contributions will be transferred to a newly established institution – the National Authority for Regulating the Obligatory Health Contributions – which will direct them to the mutual insurance companies (David, 2012).

iii) The National Agency for Health Care Investment will be created, in charge of health projects financed by the European Union.

iv) The insured persons disposing of a monthly income higher than the double of gross minimum wage will pay health contributions for their dependants; the contribution will represent 5.5% of the minimum wage (Banila, 2012d).

v) The medical services will be provided through 4 different packages: *the minimum package*, financed from the state budget through the budget of the Ministry of Public Health; *the basic package*, delivered to all insured persons; *the social package*, for low income groups of population, financed by the state budget; *the optional package*, financed through voluntary contributions to private insurance companies (Marin, 2012).

[11] IMAS survey (Banila, 2012d).

vi) The insured persons can choose to pay contributions either to a public insurance company or to a private one.

vii) Hospitals will be reorganised as non-budgetary institutions with full administrative and financial autonomy. Consequently, the medical personnel will become extra-budgetary and will be remunerated according to performance criteria.

viii) A National Agency for Health Quality Management will be established for accrediting the hospitals and for ensuring the quality of medical services; the agency will emerge from the reorganisation of the current National Commission for Hospitals Accreditation.

The National Public Health Strategy is aimed at improving the performance of the system, increasing the population access to basic medical services, redefining the national health-care programmes, improving the mechanism of financing the system, and raising the efficiency in using the available resources (Boariu, 2013). The strategy will be elaborated on the basis of local strategies at county level, which will be centralised by MPH.

The strategy is supposed to find solutions for the most important problems to which the health care sector is confronted. One of them is the poor infrastructure, for which €4 billion are necessary according to MPH (Ilie, 2013). The completion of hospitals' reorganisation, which started in 2010, represents another strategic issue. The process of accreditation and classification has been much longer than expected and consequently the deadline has been postponed several times, the most recent being the end of 2013 (Banila, 2013d).

3.2 Assessment of strengths and weaknesses

The recent reforms adopted by the government have been hesitant and sometimes contradictory, inducing significant uncertainty. This is due in principal to the general political approach of reform measures: every new minister in function considers necessary to change what his/her predecessor initiated. On the other hand, the envisaged reforms to be implemented in the coming months have been designed according to a controversial sequencing: the new health care law was drafted before the elaboration of the sector's strategy. However, the logical order is to define the overall strategic vision of the system, followed by the elaboration of the legislative basis for ensuring that the objectives of the strategy will be reached.

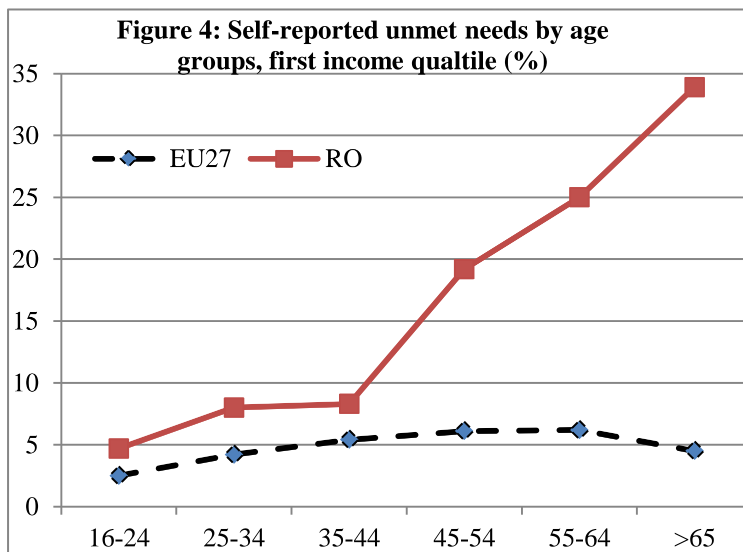
The co-payment was introduced after several years of delay and after numerous variants of the effective payment to be made by patients. In the end, the mechanism adopted has produced insignificant effects in terms of additional resources to the Health Fund (estimated at RON 40 million per year) because the amount to be paid is low and the majority of those using the hospitals services are exempted from co-payment (Banila, 2013g). At the same time, the utilisation of emergency services has suddenly increased (by 25% in the first month after its introduction), because the co-payment does not apply to emergency care (Banila, 2013a). As a result, the measure will not solve the problems of the system and will not rationalise the access to medical services (Astarastoae, 2013).

The clawback tax, although reduced according to the Ministry of Finance, remains an important impediment for the development of drugs market. The tax reduces the competitiveness of domestic producers, while its periodical adjustment increases the uncertainty and therefore blocks the investment (Banila, 2013b). Through this tax the drugs producers are obliged to cover the difference between the NHIF allocations and the effective consumption of medicaments. Since the reference amount was set by MPH in 2009 (RON 5.5 billion), each year the consumption is higher, which increases de facto the clawback tax.

The reorganisation of hospitals, initiated in 2010 and supposed to be finalised by the end of 2012, is still pending. 178 hospitals have been closed down, but this measure brought in 2012 only RON 4.4 million savings to the health budget, as compared to the expected RON 200 billion. Only those hospitals recording financial losses were supposed to be closed, but in reality many of those financially viable or located in populated areas were closed[12] (Banila, 2012e). Out of the 178 hospitals 67 were supposed to be transformed into residences for elderly but only 14 had this new destination by the end of 2012, when the deadline expired.

3.2.1 Coverage and access to services

The large majority of population is covered by a form of health insurance, which should normally give access to services to most of Romanians, who legally have unrestricted access to health care. In reality, the coverage and the access to medical services is restricted by several factors, responsible for the low rates of self-reported unmet needs for health as compared to EU27 average (Annex 4). The main reason is that the services are too expensive and thus financially unaffordable. It is interesting to note that financial affordability decreases with age (Figure 4), although the old categories of population record a lower poverty rate than the young groups, as shown in the previous section. This is exactly the opposite of the situation in EU 27 countries.



The financial barrier to health care is mainly due to out-of-pocket payments the patients are forced to make, both formally and informally. Formally, the patients have to pay the price difference of drugs and the recently introduced co-payment for hospitalisation. In average, the Romanians have to cover 40% of the drugs' price, as compared to 5.4% in Germany and 0.7% in the Netherlands (Banila, 2012f). Although the recently introduced co-payment is low, the specialists consider that low income groups of population will be affected especially with respect to preventive care (Dragomir, 2012).

The informal payments in form of bribes represent the most important component of out-of-pocket money spent for health care. A survey from April 2013 concludes that 63% of patients have bribed the medical personnel;[13] health care is the most corrupted sector according to 78.1% of opinions (Banila 2012f). In 2011, the average bribe in Bucharest's hospitals represented €200 (Ungureanu, 2012).

The second important factor that limits the access to proper health care relates to difficulties in drugs' procurement. Many hospitals lack basic medicaments and the patients are obliged to buy them. At the same time, the compensated drugs are in limited supply, much lower than

[12] It is the case of Caritas hospital from Bucharest, for example, which made large investments in modern technology just before its closure.

[13] 80% in Bucarest (Ungureanu, 2012)

the needs, and consequently only a part of patients can acquire. This is because NHIH records huge payment arrears to suppliers (€1.3 billion in March 2013[14]) and consequently many pharmacies refuse to deliver compensated drugs.

3.2.2 Quality and performance indicators

The restricted access to medical services has important consequences for the health status of the population. The loss of productivity due to poor health condition of workers is estimated at €2.5 billion each year (Banila, 2013c). On the other hand, the life expectancy of a Romanian individual is 5 years below the EU average because of poor quality of medical services and limited access to health care (Tinteanu, 2013a).

Consequently, the mortality rate in Romania is significantly higher than in EU27 average for all groups of age (Table 6), the highest gap being observed for persons above 65 years. The infant mortality, on the other hand, was 9.4 per thousand in 2011, as compared to the EU27 average of 3.9. Every year 60% of deceases in Romania are caused by cardio-vascular diseases, 18% by cancer, and 5% by respiratory problems (Banila, 2013c). It is estimated that Romania loses every year €1 billion because of cardio-vascular diseases (Pop, 2013b). This situation is also due to the low importance paid to preventive care (Zeana, 2013b).

Table 6: Standardised death rate (per 100,000 inhabitants) in Romania and EU27 (2010)

AGE	**Total**			**<65**			**+ 65**		
SEX	***T***	***M***	***F***	***T***	***M***	***F***	***T***	***M***	***F***
EU27	587.2	748.0	456.6	199.9	270.8	131.2	3721.0	4608.8	3089.9
Romania	948.4	1223.4	725.0	362.1	522.1	213.9	5692.1	6897.1	4860.1

Source: EUROSTAT (http://epp.eurostat.ec.europa.eu/portal/page/portal/health/public_health/data_public_health/database)

Not surprisingly, Romania is ranked 32 out of 34 countries according to the 2012 Euro Health Consumer Index, with 489 points out of 1000 maximum; for comparison, the Netherlands has the best health care system in Europe, with 872 points (Björnberg, 2012). The worst performance in case of Romania is recorded in the drugs and respectively preventive areas.

3.2.3 Sustainability

Since 1990 the Romanian government has allocated an increasing amount of resources to the health care sector, reaching 5.4% of GDP in 2012, as compared to only 2.8% in 1990 (Figure 5[15]). In 2013, the allocated budget was 30% higher than in 2012 (Gheorghita, 2013a). The resources increased significantly between 2005 and 2008, at an average annual rate of 23%; however, over the same period the financing needs increased faster. When the 2008 crisis arrived, the health care resources were reduced, but the expenditures became

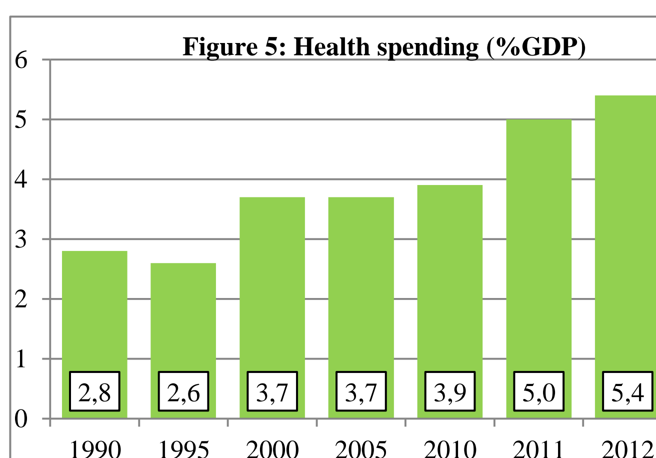


Figure 5: Health spending (%GDP)

[14] Gheorghita (2013b).
[15] Source: INSSE (http://www.insse.ro/cms/files/publicatii/Romania_in%20cifre%202011.pdf); Banila (2013).

uncontrollable and consequently the health care sector accumulated huge debts in a relatively short period of time. As a result, in spite of the considerable increase of allocations for 2013, an important share of resources must be redirected for paying a part of the accumulated debts between 2009 and 2012, totalling RON 4.5 billion. This will leave the sector with insufficient resources for covering the needs.

Although the allocations for health care have significantly increased since the fall of communism, the quality of services has worsened dramatically and the sector has been confronted since 2008 with a chronic lack of financial resources. The NHIH passed from a budgetary surplus in 2006 and 2007 to increasing deficits after 2008, as the total spending of the institution increased from less than €1 billion in 1999 (when it was created) to almost €4.4 billion in 2008 (Figure 6[16]).

There is therefore a serious problem of financial sustainability of the whole system. The main factor responsible for this situation is related to the very poor management of resources. Firstly, an important share of allocations is absorbed by very expensive externalised services (catering, security, communication, laundering, etc.), in particular at hospital level. All these services are paid at much higher prices that the market ones because the procurement procedures lacks transparency. In 80% of cases the tariffs and prices for externalised services is significantly above their market level (Hritcu and Banila, 2013f).

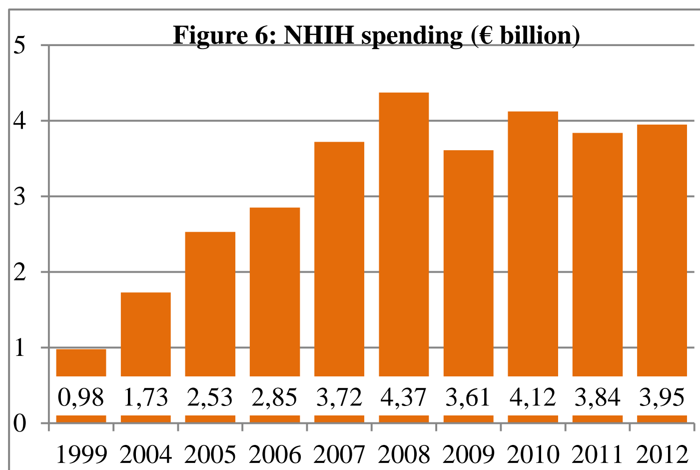


Figure 6: NHIH spending (€ billion)

Secondly, the administrative expenditures are very high, indicating an over-bureaucratic and therefore a costly system. The administrative spending of NHIH represented in 2010 more than 21% of total expenditures (Davidescu, 2011).

Thirdly, the ratio between the number of contributors (7.5 million) and the number of beneficiaries (20.4 million) is disproportionately low because of too many exceptions from paying contributions to the system (4.5 million in May 2013).

Fourthly, the Romanian system pays insufficient attention to the preventive health care: the family doctors were allocated in 2010 only 6% of NHIH funds, which represents less than 5% of total health expenditures (Davidescu, 2011). Consequently, the curative component – in particular in hospitals – becomes more expensive than it should actually be.

Confronted with such a dramatic situation, the authorities try to limit the expenditures, but the measures in this sense are often inappropriate. In April 2013 the NHIH stopped the financing of stomatology care, including emergencies. Consequently the patients were obliged to pay for this type of care; since 95% of Romanians have dental problems and 66% have not consulted a dentist during the previous 12 months in April 2013 (Chitu, 2013), this measure will have serious health implications for the majority of population.

[16] Source: Davidescu (2013).

Another measure envisaged by the Ministry of Public Health was to exclude the private providers from the reimbursement of expenditures, although the quality of care is incomparably better in those units, while the price for certain interventions are lower (by 20% in case of dialysis for example according to Davidescu, 2013). The unpopularity of such initiative forced the Ministry of Health to reconsider this option. However, for 2013 and 2014 the reimbursement of health care costs to private providers were drastically limited to maximum 5% of total allocations of the respective county (Viasu, 2013), although for ¾ of population the public and private providers should not be discriminated with respect to the reimbursement of health expenditures (Pop, 2013a).

The financial sustainability of the health sector is therefore endangered by the very poor management of existing resources, the improper allocation of funds (almost exclusively based on political criteria, without any mechanism of prioritising the expenditures), corruption, and lack of transparency in using the resources. This situation is caused by several paradoxes of the Romanian health care system, with serious implications for its financial sustainability:

i) Significant resources have been invested in modern equipment, but the system remains poorly endowed because some of this equipment is unused or only partial used; many hospitals closed down during the process of reorganisation were endowed with expensive medical technology prior to their closure, which is now subject to moral depreciation.

ii) In spite of higher resources allocated every year, the medical staff remains poorly paid, which favours emigration, respectively bribing, and worsening of quality of medical services for those remaining in the country. At the end of 2012 Romania counted 333,000 employees in the health care sector, receiving an average monthly wage of RON 1450, as compared to RON 1600 the average in the economy; a specialised physician received a monthly salary of RON 1900, which is less that €500 (Pana, 2013b).

Although the health contributions rates are among the highest in Europe, the resources available are insufficient because the effective number of contributors is almost 3 times lower than the number of beneficiaries.

3.2.4 Summary

Strengths		Weaknesses
The large majority of population is covered by health insurance	But	Services are financially unaffordable for an important part of population, with significant informal payments to be made.
Financial resources allocated have increased significantly (from 2.8% of GDP in 1990 to 5.4% in 2012)	But	Poor management of resources: Large accumulated debts (part of 2013 resources used to pay 2009-2012 debts); Shortage of drugs in hospitals and pharmacies; High administrative costs; Low attention paid to preventive care.
High rate of health care contributions	But	Only 5 million contributors for 20.4 million beneficiaries because of many exceptions from paying contributions.
The government has recently adopted several reforms and other major reforms are envisaged	But	Reforms have been hesitant and sometimes contradictory, with significant delays (co-payment, reorganisation of hospitals), while some of those envisaged are inappropriate (ex. limitation of financing for private providers)

3.3 Reform debates

The health care reforms have represented the most debated issue, given the multitude of measures adopted or envisaged to be implemented. A real reform has been asked both by the professionals of the sector and by beneficiaries, as the system has known 20 ministers since 1990, each of them with a different vision of the reform directions (Manu, 2013). However, the opinions about the new law and the planned strategy are not very optimistic. According to the Trade Unions of Physicians, the new law is full of good intentions but not very much different from the previous ones (Mihalache 2013) because the provisions are very general while the essential elements aimed at effectively changing the system are left for the subsequent secondary legislation to be drafted after the adoption of the law (Morega, 2012).

The new law was supposed to be adopted in the beginning of 2012 but its submission to the parliament has been postponed several times because the first debates on the draft generated a strong opposition from population (Calin, 2012), but equally from the professionals of the sector, researchers, unions, and patients' associations. Numerous critics have been formulated by the specialists, who consider that in its current form the law does not solve the problems of the system (Banila, 2012c). During the public debate on the health reform organised by Mediafax in the beginning of 2012, the president of Romanian College of Physicians (V. Astarastoae) declared that in his opinion the health care reform under discussion is almost exclusively driven by political and financial interests, while those of patients and medical personnel are ignored (Mediafax, 2012a). In fact, COPAC asked the government to explicitly include in the law a section on patients' rights as they are stipulated by the 2002 European Charter. This opinion is shared by the Public Policies Institute, which considers that the proposed reform ignores the quality aspects of medical services and is more oriented towards a centralisation of the system (Capital, 2013c).

In terms of financing, the reform is criticised internally but also by some foreign specialists. IMF, for example, considers that the financing mechanism needs to be reformed in two steps, the first being the improvement of the current management of resources, responsible for a considerable waste of money. Only after a better administration of existing funds the government should undertake the second step aimed at increasing the allocations to the sector (Capital, 2012a). The Romanian specialists, on the other hand, point out that the proposed reform pays insufficient attention to the financing of preventive care (Zeana, 2012a). The decision to limit the reimbursement of medical services delivered by private providers has also generated strong criticism.

The proposed measure to remunerate the medical personnel according to performance criteria generated both pro and contra opinions. While the concerned medical staff is in favour of such initiative, the Romanian Health Observatory considers that the implementation of the mechanism is practically impossible because the proposed criteria refer exclusively to the interest of health care providers and not the patients' interest (Jeles, 2013). Moreover, a performance-based remuneration does not represent an antidote for the current under-financing, lack of transparency in using resources, and corruption.

The institutional reorganisation foreseen by the new law is not satisfactory in most of the opinions. Although the NHIH will disappear, as it was proposed by the Trade Unions of Physicians in June 2012, it will actually be replaced by a new structure (ANRAOS) that is not very different from NHIH in terms of attributions (Trifan, 2012) and therefore no major

progress will be observed in this respect. The most ardent controversies have been generated by the reorganisation of hospitals. Several variants have been proposed to redefine their status (non-governmental institutions, foundations, commercial entities, autonomous public institutions, etc.) but the uncertainty remains regarding their situation in the final version of the law. At some point, the minister of health envisaged even the possibility to reopen the closed hospitals, or at least part of them.

The recently introduced co-payment mechanism has been the most debated issue of the health care reform. Strongly contested by the majority of population (53% according to Micu, 2013), the measure represents a conditionality from the EC 2011 CSR for Romania. This condition was partially fulfilled, as the means-tested criterion was not respected. In order to pass this reform, the minister of health justified it as an EU and IMF requirement, therefore a purely political decision, because in his opinion Romania is not ready for such a measure (Capital, 2013a). The mechanism was equally contested by the professionals of the sector, who consider that the measure is contrary to the ethical principles of the medical act (Ciurea, 2013) and that the co-payment will not solve the financing problems of the system (Astarastoae, 2013).

All these debates have mobilised numerous specialists in proposing alternative solutions of reform, the most important being suggested by the Romanian Academic Society (Bogdan, 2012). The government has considered some of those recommendations for the final draft of the law[17]; others proposals have been contested by MPH, which generated further reactions. For example, in response to the criticism regarding the ambiguity and inefficiency of the proposed financing mechanism, the minister of health advanced the possibility of eliminating completely the health insurance system and its replacement by a solidarity tax (Pirloiu, 2012a); this idea generated even more controversies among the specialists.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

The LTC system in Romania concerns old and disabled people. In the majority of cases the family takes care of persons belonging to these two categories; only those necessitating medical care are included in the public system. There is a legal distinction between the two categories of beneficiaries. The care for elderly is regulated by Law 17/2000 on assistance to aged persons, modified by Law 270/2008. The care for disabled persons is regulated by Law 448/2006 on the protection and the rights of handicapped persons, amended by the Government Ordinance 86/2008. In spite of this legal distinction, in reality many services and classifications overlap and a beneficiary could combine old age, invalidity or survivor benefits with disability benefits.

[17] Such as the transformation of National Health Insurance House by reducing the number of branches at territorial level; the possibility for beneficiaries to choose between public and private medical insurance; redefinition of health care package.

4.1.2 System characteristics

Most of LTC responsibilities have been transferred to local authorities. The financing mechanism combines the central and local resources, with NGOs playing an important role in the delivery of services. At central level financing is shared by the state budget and National Health Insurance Fund, the later providing resources for medical type of services. Out-of-pocket-payments complement the public resources; their level is set by local authorities.

Non-institutionalised beneficiaries of long-term care are entitled to community services and cash benefits. Three types of community services are provided: temporary or permanent *home attendance*; temporary or permanent attendance in a *residential centre*; attendance in *daily centres*. Home attendance implies the provision of: *household services* (prevention of social marginalization and supporting social reintegration, legal and administrative counselling, payment of certain household obligations, catering, etc.); *socio-medical services* (personal hygiene, socio-cultural activities, etc.); *medical services* (medical consultations, medicine administration, etc.).

Cash benefits are specific for each of the two categories. Old persons are entitled to either statutory pension or successor pension, which is complemented by social assistance transfers granted on the basis of means-tested assessments. The disabled persons who lost at least half of their working abilities are granted disability pensions and several types of indemnities and allowances. Since June 2012 there is no minimum contributory period for obtaining a disability pension when the handicap is caused by work accidents or occupational diseases. When the disability is unrelated to the professional activity, a minimum contributory period is required, ranging from 1 year for those aged below 20 up to 27 years for those above 60. The amount of disability pension is linked to the degree of handicap: 70% of the pension point for the first degree, 55% for the second degree, respectively 35% in case of the third degree.

The first degree disabled persons are entitled to an accompaniment indemnity representing 80% of the pension point. Since January 2006 the persons belonging to the first and second degrees of disability (excepting those with visual handicap) receive an additional monthly allowance of RON 158. The persons with visual disability (both adults and children) are granted a monthly allowance of RON 178 in case of very acute handicap, respectively RON 89 in case of an acute one. Those with very acute visual handicap are entitled to an accompaniment indemnity of RON 460. At the end of the first quarter 2013, the number of beneficiaries of such indemnities and allowances, and the funds allocated were the following:

Table 7: Number of beneficiaries and resources allocated as disability indemnities/allowances (2013 Q1)

<table>
<tr><th>Benefit</th><th>Number of beneficiaries</th><th>Funds (RON million)</th></tr>
<tr><td>Accompaniment indemnity for very acute handicap</td><td>43951</td><td>80.1</td></tr>
<tr><td>Indemnity for very acute handicap</td><td>195469</td><td rowspan="2">294.6</td></tr>
<tr><td>Indemnity for acute handicap</td><td>353424</td></tr>
<tr><td>Complementary allowance for very acute handicap</td><td>224312</td><td rowspan="3">143.3</td></tr>
<tr><td>Complementary allowance for acute handicap</td><td>365245</td></tr>
<tr><td>Complementary allowance for moderate handicap</td><td>76086</td></tr>
<tr><td>Special child allowance for disabled persons</td><td>7483</td><td>8.4</td></tr>
<tr><td>Allowance for family placement of disabled children</td><td>4689</td><td>2.12</td></tr>
</table>

*Source:*MLFSPAP (http://www.mmssf.ro/nou/images/buletin_statistic/Asist%20soc%20I%202013.pdf)

The long-term care of elderly is coordinated by the National Council of Aged Persons[18] but the institution has essentially a consultative role. In case of disabled persons, the institution in charge is the National Authority for Handicapped Persons (NAHP), belonging to the Ministry of Labour, Family, Social protection and Aged Persons (MLFSPAP). There is no precise information about the number of residential and daily centres or about the number of beneficiaries in case of old persons. Regarding the disabled, at the end 2013q1 699780 persons were recorded with NAHP, of which 61063 children. Only 16773 persons were institutionalised (15 children) with 330 residential and 59 non-residential centres.

Only few private residential centres exist for persons with disabilities, while in case of elderly the number of such private institutions has increased significantly in recent years, reaching 168 units by mid-2013.

4.1.3 Details on recent reforms in the past 2-3 years

No major reforms took place in the last few years in the long-term care sector. The only mentionable initiative is the adoption of Law 129/2012, which replaces the Law 487/2002 on mental health and protection of persons with mental troubles. However, the changes are of minor importance and mostly limited to redefinition of certain terms and notions. The law brings some progress in case of persons with mental disability (gratuity of medication and guaranteed access for NGOs to psychiatric clinics).

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

The access problems to long-term care are different in case of elderly and disabled. The changing social norms in the Romanian society, together with the phenomenon of emigration, have increased the number of old persons living alone who need home attendance or residential care. However, the provision of home attendance is difficult for many of them because the majority of aged Romanians reside in rural areas where the provision of such services is in serious deficit, as it is the case with medical services, basic facilities in terms of sanitation, sewage, water, etc. The demand for residential care has therefore increased faster than the existing capacities and consequently there are long waiting lists for places in specialised public institutions. Although the number of private centres has increased in recent years in response to this demand, the tariffs are affordable only for those enjoying high pensions or for which the family can pay the difference.

In case of disabled persons the institutional care is generally accessible. However, there is a major problem of accessibility to the labour market for those non-institutionalised: out of 421631 disabled persons aged 15-64, only 6.88% had a remunerated activity at the end 2013q1. The discrimination remains the main factor responsible for this very low activity rate.

4.2.2 Quality and performance indicators

The quality of long-term care is regulated by several ministerial orders. The general qualitative principles are stipulated by Order 383/2005, which sets the general quality standards of social services, respectively Order 246/2006, which defines the quality standards of long-term care in terms of organisation and administration, human resources, access to services, service provision, rights and ethics. Other legal provisions set quality requirements for daily centres, residential centres for children, etc. The quality standards for aged persons are set by Order 246/2006, which defines the norms for residential centres and for home

[18] http://www.cnpv.ro/

attendance. In case of disabled persons, the quality of services is regulated by Order 651/2008, Order 559/2008, and Order 175/2006.

In general, the quality standards refer to minimum costs associated with care services: for example, the monthly standard cost for institutionalised disabled persons is RON 1724. The lack of transparency in spending the money is never questioned and there is no official assessment of the quality of services delivered. In spite of a variety of LTC programmes implemented, the impact on beneficiaries remains modest because those programmes focus exclusively on financial and medical aspects. The large majority of actions and initiatives are resumed to the provision of some form of financial transfer. The active social integration of disabled persons, for example, is limited to granting a financial insertion stimulant to families accepting to host a disabled person – usually a child. What happens effectively afterwards with those placed with recipient families is often ignored and the mass media reports frequent cases of abuses and bad treatment in residential and non-residential institutions, as well as in recipient families, both for elderly and disabled. The medical care, on the other hand, is part of the overall health care system, and therefore the services are of poor quality and delivered by insufficient medical personnel.

The improvement of quality of services delivered to both institutionalised and non-institutionalised beneficiaries of long-term care remains therefore a priority for Romanian authorities, as well as the development of an appropriate network of qualified social workers. Those priorities are already stipulated in the 2006 strategy for disabled persons but no major progress has been observed since the adoption of the document, in particular for persons with psychical handicap. The strategy was practically elaborated under EC pressure, which in its pre-adhesion 2005 report was very critical with respect to the situation of mentally disabled persons.

According to MLFSPAP, the deficit of social workers represented 11,000 persons in 2012 (Capital, 2012b). The association Hopes and Homes for Children reports that because of insufficient personnel in residence centres for physically disabled children, 10% of those children were transferred in 2012 to psychical asylums although they had no mental problems (Mediafax, 2012b).

4.2.3 Sustainability

The financial sustainability of long-term care is directly linked with that of the pension system, since both old and disabled persons are entitled to a pension benefit, and to that of the health care system, as the medical services provided are financed from the health care fund. However, the ageing perspectives and the future increasing needs for specific LTC services will require more financial resources and consequently the system will generate its own sustainability pressure.

In order to cope with these problems, the Romanian authorities try to develop and implement specific social investment measures dealing with prevention, rehabilitation and enablement aspects. Nevertheless, the progress remains modest; the only important programme that concerns the elderly is the “National network development of shelters for elderly“, which is aimed at rehabilitating and modernizing 19 residential centres. By the end of 2013q1 MLFSPAP spent RON 3.13 million for this purpose, but there is no information regarding the status of rehabilitation of those centres. In parallel, the process of transforming 67 hospitals into residential centres for aged persons started in 2011 but only 14 were finalised by December 2012. However, it is not clear if these units belong to the mentioned programme of rehabilitation, or they are separate.

More attention is paid for the prevention, rehabilitation and social insertion of disabled persons, in particular the institutionalised ones. Among the 330 residential centres, 21 are specialised in occupational therapy and 2 in preparing the patients for an independent life (Annex 1). Four additional centres are pilot units for the recovery and rehabilitation of disabled. Among the 59 day-care centres 2 are specialised in occupational therapy, 2 in providing social services at the domicile of the beneficiary, and 4 offer social counselling. Overall, RON 71.2 million were spent in 2012 for medical rehabilitation of disabled persons. A part of these funds were given to private providers; in 2012 the National Health Insurance House concluded 469 contracts with private providers for ambulatory rehabilitation, respectively 17 contracts for preventive care.

Concluding, the challenges ahead in the LTC sector are numerous and they refer in principal to the reinforcement of social inclusion and employment policies for disabled persons, given the extremely low activity rate of those people. The capacities of local authorities need to be reinforced, since they were transferred most of the LTC responsibilities. The access to health care in general and LTC in particular represents probably the most important challenge in this field.

Significant regional disparities persist in terms of access, with rural areas being clearly disadvantaged. In 2012, 75% of rural population lived in precarious conditions, as 99.2% of farms are subsistence farms (IES[19], 2012). Since the demographic statistics show that ageing will be essentially a rural phenomenon, the urban-rural disparities should represent a top priority for Romanian authorities.

4.2.4 Summary

Strengths		Weaknesses
High degree of decentralisation of LTC responsibilities	But	Insufficient human and financial capacities of local authorities
NGOs play an important role in delivery of services	But	High deficit of specialised social workers
Large variety of cash benefits (pensions, indemnities, allowances)	But	Low transparency in using resources and low quality of services delivered
Increasing number of private institutions for elderly	But	Access limited only for those enjoying high pensions
Good access and coverage of old in terms of benefits	But	Changing social norms and emigration: more old people alone, especially in rural areas where access to specific LTC services is low
Good access of disabled to institutional care	But	Major problem of accessibility to labour market of non-institutionalised because of discrimination
Legislative basis for quality exists	But	Quality standards reduced to costs of services; No official assessment of the quality of services
Wide variety of LTC programmes	But	Impact on beneficiaries remains modest because they focus only on financial and medical aspects

[19] Institutul de Economie Sociala (Social Economy Institute).

4.3 Reform debates

Relatively few debates have taken place on LTC issues and they have concentrated on ageing issues. The Romanian Commercial Bank published in 2013 an analysis of the phenomenon (Tinteanu, 2013b), concluding that the process will have three major economic consequences: slow-down of economic growth, increased dependency of the country on foreign capital, and higher fiscal pressure on the state budget. Ageing is faster in case of population involved in agricultural activities, where one third of persons is above 55 years; this particularity requires specific policy measures, given that long-term care in rural areas is in deficit while the pension benefits in agriculture are very low as compared to the average. The report recommends the adoption of specific employment measures for seniors (+50), as their activity rate has declined considerably after the 2008 policy of massive early retirement: only 40% of persons aged 55-64 were active in 2012 (Mihai, 2012).

In response to this recommendation, the Ministry of Labour announced the elaboration of a specific legislative framework that will favour the reinsertion of senior workers on the labour market, but for the time being the document is still under preparation.

The ageing is equally analysed by the European Institute of Romania, which published in 2012 a comprehensive report (Vasile et al, 2012) on this issue. The report concludes that ageing will increase considerably the demand for LTC services and the only solution to respond to this demand is to give more importance to the private system of pensions.

Regarding the mentally disabled persons, the low effectiveness of government measures determined the non-governmental sector to initiate concrete actions for social insertion of persons with psychical disability. Three NGOs (Habitat for Humanity, ProAct Support, and Open Society Foundation) started in 2013 a pilot project for the construction of a social inclusion centre for six institutionalised mentally disabled children (Viasu, 2013). The Homes for Children association announced that by 2020 all institutionalised disabled children (not only those with mental handicap) will be placed with a recipient family (Capital, 2013e).

Similarly, the Centre for Rehabilitation and Professional Integration (CRPI) – through the project Insert – has been active in promoting the employability of disabled persons. The institution concentrates on occupational training and education, as the main barriers to job access for this category of persons, in CRPI's opinion, is the low level of education and respectively the inadequacy of the existing training programmes (Capital, 2013b).

Annex 1: Selected social indicators for Romania and average EU27 (2011)

Indicator		Total		Male		Female	
		Romania	*EU27*	*Romania*	*EU27*	*Romania*	*EU27*
At-risk-of-poverty rate	***Old people***	14.1	15.9	8.7	13.2	17.7	18.0
	Whole population	22.2	16.9	21.9	16.1	22.5	17.6
Median relative income of elderly people		1.01	0.89				
Aggregate replacement ratio (including Other social benefits)		0.64	0.54	0.7	0.56	0.6	0.52
Income inequality for older people		4.2	4.1	3.9	4.2	4.3	3.9
At-risk-of-poverty rate for pensioners		11.1	14.0	8.5	12.6	12.9	15.3

Source: EUROSTAT (http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database)

Annex 2: Selected social indicators by age group for Romania and average EU27 (2011)

Indicator	Total		< 18		> 65	
	Romania	*EU27*	*Romania*	*EU27*	*Romania*	*EU27*
Persistent at-risk-of poverty rate	16.7	10.0	25.0	12.7	13.2	11.3
Material deprivation rate	47.7	18.2	55.2	20.8	48.5	15.1
Relative median poverty risk gap by age group	31.8	23.3	34.7	24.3	19.6	16.7

Source: EUROSTAT (http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database)

Annex 3: Possible scenarios of evolutions of the Romanian pension system

Impact Scenario	Pensions deficit (% GDP)	Share of average pension in gross average wage (%). Currently: 37%
1. No change	2.5% in 2019 1.2% in 2042.	Declines to 24% until 2031. In 2032, with the benefits from Pillar II, reaches 34%. Declines afterwards to 26% in 2042.
2. Links the retirement age to life expectancy	2% in 2019, then declines to 0 in 2035.	Declines to 24% until 2031. In 2032, with the benefits from Pillar II, reaches 34%. Declines afterwards to 26% in 2042.
3. Earlier indexation of the pension point only by inflation	2% in 2017, then declines to maximum 0.4%.	Declines until 25% in 2042.
4. Raising the average pension at 45% of average gross wage	8.5%	45%.
5. Freezing the rate of contributions to Pillar II or its nationalisation	Declines to 2.1% in 2019, then to 1.1% in 2042.	After 2032: 12% in case of freezing 10% in case of nationalisation.
6. Reduction of contribution rates	3.4% in 2025.	Declines to 24% until 2031. In 2032, with the benefits from Pillar II, reaches 34%. Declines afterwards to 26% in 2042.
7. Increase of contribution rates to 10% instead of 6%	2.65% in 2019 1.9% in 2042.	39% by 2042

Source: EFOR (2012)

Annex 4: Self-reported unmet needs for health care in Romania and EU27 (%, 2011)

Age	Total			16-24			25-34			35-44			45-54			55-64			>65		
Sex	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**
Self-reported unmet needs for medical examination: too expensive, too far to travel, or waiting list																					
EU27	3.4	2.8	3.9	1.6	1.2	2.0	2.3	1.8	2.8	3.1	2.6	3.5	3.7	3.2	4.2	4.1	3.7	4.4	4.6	3.7	5.3
RO	11.9	9.6	14.1	2.3	2.4	2.2	4.3	3.7	5.0	6.1	5.3	6.9	12.2	9.1	15.3	18.3	16.8	19.7	27.7	23.8	30.4
Self-reported unmet needs for medical examination: too expensive (first quintile)																					
EU27	4.8	4.2	5.3	2.5	2.1	2.8	4.2	3.5	4.8	5.4	4.6	6.1	6.1	5.5	6.7	6.2	6.2	6.2	4.5	3.5	5.2
RO	14.1	11.6	16.5	4.7	4.9	4.5	8.0	9.3	6.6	8.3	6.7	9.9	19.2	13.7	25.3	25.0	25.2	24.8	33.9	29.4	35.6
Self-reported unmet needs for dental examination: too expensive																					
EU27	4.3	4.0	4.7																		
RO	11.7	10.0	13.2																		

Source: EUROSTAT (http://epp.eurostat.ec.europa.eu/portal/page/portal/income_social_inclusion_living_conditions/data/database

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Annex – Key publications

[Pensions]

CATALAN Mario, MAGUD Nicolas, A Trade-off between the Output and Current Account Effects of Pension Reform, IMF Working Paper 12/283, December 2012, retrieved from: http://www.imf.org/external/pubs/ft/wp/2012/wp12283.pdf

The paper compares the long-term output and current account effects of pension reforms that increase the retirement age with those of reforms that cut pension benefits, conditional on reforms achieving similar fiscal targets. The authors show the presence of a policy trade-off. Pension reforms that increase the retirement age have a large positive effect on output, but a small (and often negative) effect on the current account. In contrast, reforms that cut pension benefits improve the current account balance but reduce output. Mixed pension reforms, which extend the working life *and* cut pension benefits, can simultaneously boost output and the current account.

ECONOMIC FORUM, Cartea alba a pensiilor, Working Paper No. 3/2012, Bucharest, retrieved from http://expertforum.ro/wp-content/uploads/2012/11/Cartea-alba-a-pensiilor-RO_11nov.pdf

"The white book of pensions"

The report presents in a comparative perspective the situation of the pension system in Romania and in Europe. It identifies the main problems of the Romanian system, in particular, the public pillar, and proposes seven possible scenarios of future evolutions under various hypotheses.

KAWINSKI Marcin, STANKO Dariusz, RUTECKA Joanna, Protection mechanisms in the old-age pension systems of the CEE countries, Cambridge University Press, 2012, Page 1-25, retrieved from: http://www.apapr.ro/images/BIBLIOTECA/reformageneralitati/Kawi%F1ski%20et%20al%20JPEF%202012.pdf

The paper surveys various types of protection mechanisms in selected CEE countries that exist in the important and already most privatized element of the social security system – the pension system. While describing the safety measures and possible guarantees, special attention is paid to the new forms that have been built up recently. The paper covers both mandatory and voluntary pension markets and identifies present and possible threats in the existing frameworks that can harm the social security. In case of Romania, the paper analyses the main type of guarantees in the pension system (minimum pension, social assistance for elderly, pension point indexation, etc.).

[Health care]

BJORNBERG Arne, Euro-Health Consumer Index, Health Consumer Powerhouse, 2012, retrieved from: http://www.healthpowerhouse.com/files/Report-EHCI-2012.pdf

The report ranks 34 European countries with respect to the performance of health care sector, which is assessed through five areas: Patients' rights and information, Accessibility

(expressed in waiting time), Outcomes, Prevention, and Pharmaceuticals. According to this proposed index, the best health care system exists in the Netherlands (872 points out of 1000). Romania is ranked 32 (489 points), just before Bulgaria (456 points) and Serbia (451 points).

GRIGOLI Francesco, KAPSOLIL Javier, Waste Not, Want Not: The Efficiency of Health Expenditure in Emerging and Developing Economies, IMF Working Paper WP/13/187, August 2013, retrieved from: http://www.imf.org/external/pubs/ft/wp/2013/wp13187.pdf

The paper quantifies the inefficiency of public health expenditure and the associated potential gains for emerging and developing economies using a stochastic frontier model that controls for the socioeconomic determinants of health, and provides country-specific estimates. The results suggest that African economies have the lowest efficiency. At current spending levels, they could boost life expectancy up to about five years if they followed best practices. Romania records an Efficiency Score of 0.954, well below some of African countries such as Togo, Namibia, Liberia or Kenya.

SOCIAL SECURITY ADMINISTRATION, Social Security Programs throughout the World: Europe 2012, SSA Publication No. 13-11801, Washington, August 2012, retrieved from: http://www.ssa.gov/policy/docs/progdesc/ssptw/2012-2013/europe/

This issue reports on the countries of Europe and highlights features of social security programs (types of social security programs, types of mandatory systems for retirement income, contribution rates, and demographic and other statistics related to social security). The data reported are based on laws and regulations in force in January 2012 or on the last date for which information has been received. The country summaries show each system's major features. For Romania, the publications presents the main characteristics of the Old Age, Disability and Survivor system of pensions, Sickness and Maternity benefits, Work Injury regulations, Unemployment benefits, and the system of Family Allowances.

[Long Term care]

VASILE Valentina, TACHE, Ileana, TUDOR, Cristiana, VOLINTIRU, Clara, Analiza evoluţiilor politicilor sociale în UE în ultimii trei ani – pensii suplimentare/private şi impactul îmbătrânirii populaţiei, Studiul Nr. 4/2011, Institutul European din Romania, Bucharest, retrieved from http://www.ier.ro/documente/spos_2011/SPOS_2011_-_nr_4_RO-EN.pdf

"The analysis of the evolution of EU social policies in the last three years - supplementary/private pensions and the impact of an ageing population"

The report analyses the impact of demographic evolutions of the pensions system in terms of adequacy and sustainability, focusing on the role of private pensions for ensuring a decent level of benefits for old persons. The report concludes with specific recommendations for improving the adequacy and sustainability of the pension system in Romania, in line with active ageing principles.

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