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The Romanian Health and Social Care System - Funding Arrangements and Approach to Social and Medical Care Delivery

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Abstract: Demographic ageing brings us opportunities, but it also affects important issues of social sustainable development such as social assistance system or medical care system [Wang, 2010]. As a European Union member state, Romania experiences a slow but steady demographic ageing process. According to Eurostat, 17% of the total population was represented by elderly (65 years and over) in 2015. Given the multitude of factors generating demographic ageing (the decline in birth rates, the rise of life expectancy, the external migration flow), this looks like an inevitable trend for which Romanian policy makers must take appropriate measures to promote sustainable development, knowing that the total need for elder care (both social and medical) increases with the number of older people. National statistics show that, among the eight social protection functions, disease and old age have the highest shares in GDP (gross domestic product). The paper describes the health and social care system in Romania in terms of public expenditure and relations developed between different providers of medical and social care services within the system, in the context of budgetary austerity generated by the global economic crisis. The analysis reveals a series of weaknesses concerning both the financial resource allocation within the system, and the relations developed between providers of social and medical care services in Romania.

Keywords: Ageing of population, Health and social care system, Public expenditure, Budgetary austerity, Sustainable development.

JEL classification: I15, I18.

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Introduction

It is known the fact that European population is on a steady demographic ageing process which began several decades ago. The ageing process is reflected in the increasing old-age dependency ratio, i.e. the number of elderly people (aged 65 or over) as a share of those of working age (15 to 64 years old). According to the population projections produced by Eurostat using data for 1 January 2013, in 2054 the old-age dependency ration will reach the value of 50% at EU28 level, and the share of the working-age population in the total population is projected to fall below 60% in 2035 and maintain this level by 2080 [Eurostat, 2016a].

It is also expected that population ageing will have a major impact on the public spending at European level, according to the budgetary projections presented in the 2015 Ageing Report [European Commission, 2015]. The global economic crisis already diminished governmental expenditure for the development and provision of social protection measures, with direct impact on the ability of public institutions to provide the financial support for social programs [Ghența *et al.*, 2015].

On the other hand, there is a close link between social and medical care, which is why social services are often addressed in conjunction with healthcare services [Ghența, 2015]. With regards to future demand and supply of health care, it is hard to make projections of spending as it is hard to identify which socio-demographic variables have the strongest effect on health care spending: the number of people over a certain age, the number with given levels of disability or illness, or the number in the final years of their lives [Gray, 2005].

Public expenditure on both social and medical care depends on factors affecting supply and demand [European Commission, 2015]. Demand-side determinants include: population size, age distribution, health and disability status, individual and national income, rules regulating access to services. Supply side determinants include: availability of social and medical care services, distance to such services, technological advances, and the institutional framework regulating the provision of social and medical care services.

Overall, spending generally increases with the age of a person, which is why population ageing may pose a risk for the sustainability of health care financing from at least two perspectives: increased longevity, accompanied by a deterioration of health status leads to increased demand for social and medical care services, which further leads to increased public expenditures; since in most EU Member States, including Romania, public health care is financed by social security contributions of the working population, ageing translates into an increase in the old age dependency ratio which means fewer contributors to the service users. Analysing the population ageing trend is important for the governments, in order to take appropriate measures to promote sustainable development, even in a context of budgetary austerity generated by the global economic crisis.

1. Population Ageing Trend

The population of Romania on 1 January 2015 was estimated at 19,9 million people. Young people (0-14 years old) made up 15.5% of Romania's population, while persons of working

age (15 to 64 years old) accounted for 67.5% of the population. Older persons (aged 65 or over) had a 17% share in 2015 [Eurostat, 2016b]. Between 1995 and 2015, the share of population aged 65 or over increased by 5.2 percentage points in Romania (Figure 1). The old-age dependency ratio also constantly increased in the last 20 years, from 17.6% in 1995 to 25.2% in 2015. This means that in 2015 there were around four persons of working age (15 to 64 years old) for every person aged 65 or over [Eurostat, 2016c]. On the other hand, the young-age dependency ratio constantly decreased in the last decades in Romania, from 30.9% in 1995 to 23% in 2015. So, the increased longevity lead to the growth in the relative share of older population (ageing at the top of the population pyramid), while the low levels of fertility conducted to the decline in the proportion of young people in the total Romanian population (ageing at the bottom of the population pyramid).

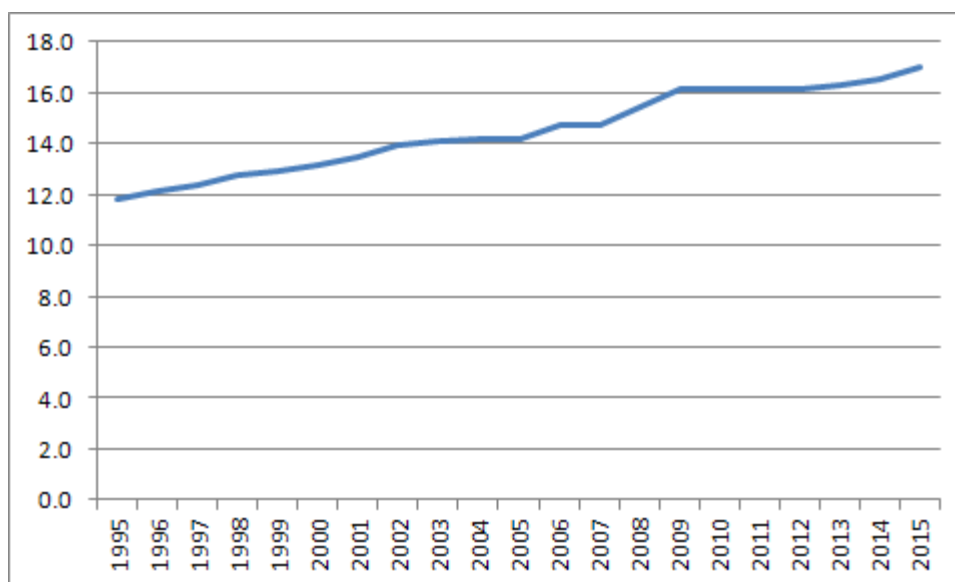


Figure 1: Increase in the share of the Romanian population aged 65 years or over, 1995-2015 (%)

Source: Eurostat, online data code: [demo_pjanbroad], 2016

Even Romania was among the European countries with the lowest life expectancies in 2013, this country is expected to have one of the largest increases in life expectancies at birth in 2060 [European Commission, 2015]. According to Eurostat’s population projections, in 2053 the old-age dependency ratio in Romania is projected to be higher than the EU28 average, reaching the value of 50.4%. Thus, the value of this indicator is projected to double between 2014 and 2050, indicating that population ageing will continue in future decades. The need for elder care, both social and medical, increases with the number of elderly. Since the pattern of population ageing is already being experienced in Romania, this will have a consistent impact on public expenditure, such as pensions, healthcare and long-term care costs.

In 2013, social protection benefits in Romania amounted to an equivalent of 14.5% of gross domestic product (GDP). Expenditure on benefits within the “Old age” and the “Sickness/Health care” functions predominates. Thus, in 2013, these benefits represented

50.1% and 26.9% respectively of total expenditure on total social protection benefits, equivalent of 7.3% and 3.9% respectively of GDP [Eurostat, 2016d]. However, expenditure on these functions grouped together (old age and sickness/health care) relative to GDP were one of the lowest in Romania comparative to other European Member States.

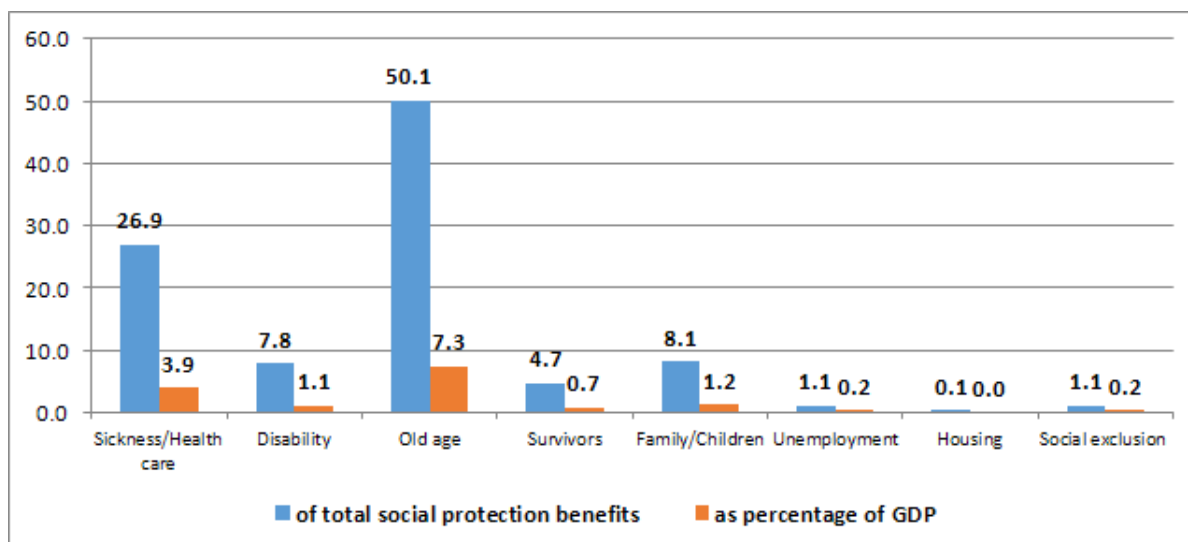


Figure 2: Expenditures by function as percentage of GDP and of social protection benefits in Romania in 2013

Source: Eurostat, online data code: [spr_exp_sum], 2016

2. Health and Social Care Expenditure

The health and social care systems from Romania face common challenges generated by the budget cuts since the global economic crisis. According to the data centralized by the National Institute of Statistics from Romania, within the period 2008-2014, the total public expenditure with health and social assistance sector (both state budget and local budgets) increased slightly in 2009-2010, and in 2014 returned to the level from 2008.

Since 1999, Romania is based on a system of health insurance to finance most of its health care services. Thus, the National Health Insurance Fund, administrated by the National Health Insurance House, represents the main financial source of the health system in Romania. With some exemptions from payment (such as children up to 18 years of age, disabled, war veterans, patients covered by the national health programmes), social health insurance is compulsory for all persons residing in Romania. Also, in 2013, the Romanian government introduced the co-payment for certain medical services accessed during hospitalisation. Supplementary and complementary health insurance offered by private companies are available, but only for persons paying the mandatory health insurance: the supplementary insurance covers services not included in the basic benefit package; the complementary insurance covers the co-payments charged for the services included in the basic benefit package.

According to statistics delivered by WHO Regional Office for Europe [European Health for All database, 2016], Romania spent 5.34% of the gross domestic product for healthcare in 2013, after almost reaching 6% of the gross domestic product in 2010 (5.95%). Analysing

the healthcare expenditure *by financing agent*, statistics show that approximately 80 percent of total public health expenditure are provided by the National Health Insurance House (CNAS), while the remaining 20 percent of total expenditures come from the private sector [Eurostat, 2016e]. One can say that Romania has a low rate of expenditure from private funds in the health sector, well below other European countries in terms of share of revenue collected from private sources.

Health-care supply network in Romania is strongly polarized towards hospitalization, since the communist era. Despite governmental policy over the last decade to reduce hospital services and increase the use of family doctors and ambulatory services, there is a small progress regarding the implementation of this change. In 2010, ownership of most hospitals has been transferred to local councils. Hospital expenditures are reimbursed by CNAS and the Ministry of Health for about 95 percent of their operating costs, and local councils have to cover 3 to 5 percent of the operating costs of the hospitals from their jurisdictions. The Ministry of Health is also funding, and in some cases co-funding with the National Health Insurance House, a number of national health programs. In terms of healthcare expenditure from the National Health Insurance Fund *by types of medical services*, there is a constant pattern over the years regarding the allocation of financial resources between different segments of the healthcare system, with a dominant share of funds directed to medical services provided by hospitals (around 41% in 2014) and a small percentage of funds directed to ambulatory healthcare services (13% in 2014). The second largest expenditure from the CNAS budget is allocated to *medicines and other medical goods* - 45% in 2014 [Annual activity reports of the National Health Insurance House, 2008-2014].

Fighting against poverty and social exclusion represents a national priority given the European Union 2020 Strategy targets regarding poverty and employment. Through the National Strategy on Social Inclusion and Poverty Reduction 2015-2020, Romania opts for an integrated approach regarding the provision of social, health care, educational and employment services. One of the objectives comprised by the Strategy for Social Services 2006-2013 referred to the development of a national network of good quality social services with adequate coverage in the territory and accessible to all beneficiaries nationwide. According to Law 292/2011, local authorities have the responsibility to develop social assistance services in order to implement the national policies and strategies in the field. Yet, over one third of the rural communities and 10 percent of the small towns lack the public social service [Romanian Government, 2015]. The lack of financial resources at local level represents one of the main impediments in assessing the need and developing adequate social services.

Between 2008 and 2010, public expenditure with social assistance sector experienced an increasing trend, followed by a downward trend in the last years. According to World Bank, public spending on social assistance programs represented only 3.1% of the gross domestic product in 2012 [World Bank ASPIRE database: The Atlas of Social Protection Indicators of Resilience and Equity, 2016]. The state budget consumes the majority of its financial resources on passive welfare measures (cash benefits). The share of expenditure on social assistance and socio-medical institutions in total expenditure with benefits and social services financed from the state budget ranged from 0.4% in 2008 and 0.2% in 2014,

the highest fall being recorded in the years 2011 and 2012, under the impact of global economic crisis [National Institute of Statistics, 2016].

3. The Relationship between Institutions Providing Health and Social Care Services

People who find themselves in a double risk (social and medical) are entitled to receive socio-medical care. According to the national legislation, socio-medical care services are provided in collaboration with healthcare providers, as a result of complex individual social needs assessment, conducted by multidisciplinary teams using standardized tools and techniques typical for their field of activity. Hosting a person in a social assistance institution is only possible when keeping the person at home is not possible. Thus, supporting the person at risk socio-medical should be done primarily through home care services. However, home care services are underdeveloped and limited to housekeeping and food supply and less to medical assistance [National Council for the Elderly, 2014]. The National Health Strategy 2014-2020 indicates that community services, including home care services for dependent patients, are offered in a volume far below necessary, they are insufficiently organized, coordinated, controlled and funded [Romanian Government, 2014].

The organization of social and socio-medical services is the responsibility of local councils, directly or under arrangement with NGOs, religious units recognized in Romania or other natural or legal persons. NGOs provide home care services, but most do not operate under a contract with the County social assistance directorate, which means that public-private partnership is not sufficiently developed at national level. This translates into the perpetuation of the dysfunctions in terms of care needs coverage and disparities between cities/regions within the country. The system of outsourcing/contracting services in Romania is over-regulated, making difficult the relationship between the entities involved in providing social and socio-medical services in the process of concluding public-private partnerships. To avoid bureaucratic procedures, some local public authorities prefer to fund NGOs providing social services on the basis of partnership protocols. This prevents auctions that may cause a malfunction such as those related to the discontinuity of services provided to beneficiaries. The legislation in financial field from Romania does not encourage financial transfers to the non-profit and private sectors, requiring a better correlation of normative acts from the social and health care sector for a common coordination and financing.

On the other hand, focusing on socio-medical home care services requires good communication and collaboration among institutions activating in the medical and social sectors. In Romania, health services are provided under the legal regulations on social health insurance. Providers of medical home care services must contract with territorial health insurance houses. When providing home care services to a person with socio-medical risk is not possible, based on the social and socio-medical assessment, the person is hosted in a social welfare institution or in a socio-medical assistance unit. The socio-medical assistance units can be set up either as residential or as day care centres, providing medical and social care services. According to the national legislation, in cases

requiring specialized interventions, assisted individuals are transferred to hospital facilities. Collaboration of such units with the medical system is rather deficient, as not all socio-medical institutions operate under a contract with the territorial health insurance houses. For this reason, socio-medical units have limited capacity to provide and support financially the medical care for the assisted persons. Legislation in the medical field does not encourage health care providers to contract with the territorial health insurance houses, and the amounts disbursed by the health insurance houses are considered insufficient to cover all the costs [National Council for the Elderly, 2009]. On the other hand, socio-medical units are faced with inadequate funding for maintenance and functioning, especially since most of them are subordinated to the local councils and are set up in rural or urban small areas whose local poor budgets cannot financially support their activity. In this context, there is a tendency to develop the private sector, with high costs for a person in need, favouring access to those who are able to pay for socio-medical care services [Zaman, 2014].

Conclusion

The paper provides basic details of how the Romanian health and social care systems work in the context of population ageing trend, by briefly describing the health and social care expenditure, approach to delivery and the relationship between institutions providing health and social care services.

The health and social care systems from Romania face common challenges generated by the budget cuts since the global economic crisis. Health-care supply in Romania is strongly polarized towards hospitalization, despite governmental policy over the last decade to reduce hospital services and increase the use of family doctors and ambulatory services.

With regards to the social care system, there is clear evidence that the national policy focuses on cash benefits (passive measures) rather than on social and socio-medical care services that are active measures to overcome a social need. Development of social and socio-medical services is determined primarily by the availability of financial resources of communities and less by the real need of specialized support. The lack of financial resources has negative effects in terms of professional human resources (social workers, doctors) who should assess people initially and periodically and make recommendations for drawing up individual intervention plans.

NGOs' participation in the provision of social and socio-medical services financed from public resources can provide an alternative, given the fact that neither the central nor the local government can provide these services, and public-private partnership is recognized internationally as a solution to the social problems of any kind - healthcare, education, social security, etc.. NGOs are important players in the market of social services in Romania, both in relation to their number and diversity. However, the non-governmental organizations are not evenly distributed in Romania, there are counties where the number of NGOs is very low as against the needs, especially in terms of services for adults in need of long term care.

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References

- [1] Wang, H. (2010) Research on Aging of Population and the Sustainable Development, Asian Social Science, Volume 6, Issue 12, p. 206-210.
- [2] Eurostat (2016a). Online data code: proj_13ndbims. Retrieved from: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=proj_13ndbims&lang=en
- [3] European Commission (2015) The 2015 Ageing Report: Economic and budgetary projections for the EU28 Member States (2013-2060) Available at http://ec.europa.eu/economy_finance/publications/european_economy/2015/pdf/ee3_en.pdf
- [4] Ghența, M.; Matei, A.; Mladen, L. (2015) Performance measurement in social care services for older people, Revista Românească pentru Educație Multidimensională, Volume 7, Issue 2, p. 97-109
- [5] Ghența, M. (2015) Performance Management in Social and Healthcare Services for Older Persons. Effects on the Relationship with Beneficiaries and Family Members, European Journal of Mental Health, Volume 10, Issue 2, p. 222–232.
- [6] Gray, A. (2005) Population Ageing and Health Care Expenditure, Ageing Horizons, Issue No. 2, p. 15–20.
- [7] Eurostat (2016b). Online data code: demo_pjanbroad. Retrieved from: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=demo_pjanbroad&lang=en
- [8] Eurostat (2016c). Online data code: demo_pjanind. Retrieved from: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=demo_pjanind&lang=en
- [9] Eurostat (2016d). Online data code: spr_exp_sum. Retrieved from: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=spr_exp_sum&lang=en
- [10] WHO Regional Office for Europe (2016) European Health for All database (HFA-DB).
- [11] Eurostat (2016e). Online data code: hlth_sha_hf. Retrieved from: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha_hf&lang=en
- [12] National Health Insurance House (2008-2014) Annual activity reports.
- [13] Romanian Government (2015) National Strategy on Social Inclusion and Poverty Reduction 2015-2020.
- [14] World Bank (2016) ASPIRE database: The Atlas of Social Protection Indicators of Resilience and Equity.
- [15] National Institute of Statistics (2016) Tempo-online database, online data code: ASS118A. Retrieved from: <http://statistici.insse.ro/shop/index.jsp?page=tempo3&lang=ro&ind=ASS118A>
- [16] National Council for the Elderly (2014) Asistența socială a persoanelor vârstnice. Available at <http://www.cnpv.ro/pdf/analize2014/Asistenta-sociala-a-persoanelor-varstnice.pdf>
- [17] Romanian Government (2014) National Health Strategy 2014-2020.
- [18] National Council for the Elderly (2009) Asistența persoanelor vârstnice în unitățile medico-sociale. Available at http://www.cnpv.ro/pdf/analize2007_2009/AsistentaPersoanelorVarstnice.pdf
- [19] Zaman, C. (2014) Pensions, health and long-term care. Available at <http://ec.europa.eu/social/BlobServlet?docId=12980&langId=en>