

ROMANIA

Country case study on the integrated
delivery of long-term care



WHO Regional Office for
Europe series on integrated
delivery of long-term care

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Abstract

This report describes the main findings and policy pointers of an assessment of the current conditions of integrated delivery of long-term health and social services in Romania. The country has advanced in enacting legislation to regulate the provision of long-term care. Service provision is limited to social services, whereas the health component is not defined by law. The current provision of long-term care is insufficient, services are fragmented and there are no defined pathways of care. The system relies heavily on families to provide care, but services for unpaid caregivers are underdeveloped. There is an acute shortage of workers, caused by migration of workers to other European countries.

Keywords

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Abbreviations

| | |
|------|--|
| EU | European Union |
| GDP | gross domestic product |
| IHME | Institute for Health Metrics and Evaluation |
| OECD | Organisation for Economic and Co-operation and Development |

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Input was provided by various stakeholders in Romania, including representatives from the Ministry of Health; the Ministry of Labour and Social Justice; the National Authority for People with Disabilities; the National Health Insurance Fund and the County Health Insurance Fund Bucharest; the General Directorate for Social Assistance Bucharest; the General Directorate for Social Assistance and Child Protection for Sector 4; the National Centre for Mental Health and Drug Abuse; the Center for curricular development and gender studies FILIA; the Romanian Institute for Human Rights; the Association for Freedom and Gender Equality; the National Council of Older People; the Research Institute for Quality of Life; the National Agency for Equal Opportunities between Women and Men and the National Institute of Statistics. Site visits were conducted in Social Assistance Centre Number 1, Sector 4 (Bucharest); the Saint Andrew Public Residential Care Home, Sector 4 (Bucharest); the Saint Nectarie Palliative Care Centre; a non-profit palliative care centre operated with the support of the Romanian Patriarchate; the Red Cross and the White Yellow Cross; and the GERON Foundation Dementia Care Centre. Other parties providing input included representatives from nongovernmental organizations (foundations, associations and philanthropic, charitable and other non-profit institutions), agencies involved in disability and long-term care, health care providers, unpaid caregivers and legal experts. The Belgian Embassy in Romania and ADR-Vlaanderen/Open Network facilitated the round-table part of the country assessment.

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Introduction

The European population is ageing rapidly (1). Low fertility rates and higher life expectancy are the leading causes fostering this shift (1). In the WHO European Region, births per woman have remained at around 1.7 between 2000 and 2019, below replacement level fertility (2). Average life expectancy has increased from 73.0 years at birth in 2000 to 77.1 years in 2015 (2). In the same period, life expectancy at age 65 years has increased from 16.4 to 18.4 years (2), and the percentage of the population 65 years or older has increased from 13.3% to 15.5%. In European Union (EU) countries, the proportion of the population older than 80 years is 5.6%, which is expected to increase to 14.6% by 2100 (3).

As the proportion and total number of older people increases, their needs and care should be considered. In 2017, cardiovascular diseases, cancer and nervous system disorders were the leading causes of death and disability-adjusted life-years among people 70 years or older, whereas musculoskeletal disorders, sense organ diseases and cardiovascular diseases were the leading causes of years lived with disability (4). The re-emergence and persistence of communicable diseases is an added challenge. In the WHO European Region alone, an estimated 72 000 people die every year from seasonal influenza (2). In EU countries in 2014, almost 50% of people 65 years or older reported long-term restrictions in daily activities, whereas more than two thirds reported physical or sensory functional limitations (3).

As a result of these changing scenarios, health systems have been compelled to adapt to meet the needs of older people (5). Meeting these needs is not limited to addressing the symptoms or disability associated with disease. It encompasses promoting the development and maintenance of the functional ability that allows well-being in older age, a process known as healthy ageing, and which enables people to live a fulfilling life in accordance with their values (6).

As part of the response to addressing the needs of older people, the 2016 Global Strategy and Action Plan on Ageing and Health calls for every country to implement a sustainable and equitable system of long-term care (1). Long-term care refers to “the activities undertaken by others to ensure that people with, or at risk of, a significant ongoing loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity” (1).

Long-term care covers a wide range of health and social services that can be delivered in various settings, including the beneficiary's home, hospice and day-care facilities (7). Fragmentation of services is not limited to the delivery of services; it also can be seen during needs assessment, when accessing benefits and packages, in data collection and in the diversity of quality improvement efforts (8). Fragmentation of services has been linked to dual administrative procedures, hindrances in access to care and longer waiting times (8) and has been identified as a barrier to reducing hospitalization for ambulatory care sensitive conditions (9).

In the European Region, the Strategy and Action Plan for Healthy Ageing in Europe 2012–2020 provides policy directions for ensuring healthy ageing (10). The WHO European Framework for Action on Integrated Health Services Delivery aims to streamline efforts for strengthening people-centred health systems and to promote integrated care models of primary, hospital and social services that are effectively managed and delivered by a coordinated array of providers (11). These efforts are in accordance with the recommendations of WHO's 13th General Programme of Work for integrated services delivery based on a primary health care approach (12).

Addressing the needs of older people is underpinned by a strong gender component that goes beyond biological factors and their differential effect on ageing (13). The multiple facets of gender, understood as the social norms, roles and relationships of and between women and men, influence the provision of long-term care services (13). Older women report lower self-perceived health status and higher rates of unmet health needs (3) and are traditionally responsible for providing unpaid, informal care to older relatives at home (14). Men are affected by higher rates of risky behaviour and lower overall and healthy life expectancy (3). The Regional Office's strategies on health and well-being for women (15) and men (16) highlight the importance of incorporating gender as determinant of men's and women's health to design policies that are responsive to their specific needs and contribute to achieving gender equality.

Promoting the availability and quality of long-term care services that are integrated, people-centred and properly managed is a right step for ensuring healthy lives and well-being in old age, in accordance with the United Nations Sustainable Development Goals (17).

Background

Romania's long-term care system has undergone major reorganization and restructuring in recent decades, mirroring the political and economic changes after the transition from communism. The first important legislative act establishing the support system for dependent older individuals was Law 17/2000 on Social Assistance for Older People (Legea privind asistenta sociala a persoanelor varstnice), which regulated the provision of support services for older dependent individuals both at home and in residential care settings. In breaking with what had been the dominant philosophy in the system, the new legislative framework explicitly gave priority to developing home-based care solutions, in a move towards deinstitutionalization. The same law introduced the National Evaluation Grid for the needs of older people, a sociomedical needs assessment instrument that has since functioned as the national standard and de facto entry point for the long-term care system.

Subsequent legislation in 2003 and 2006 (Decrees 318/2003 and 246/2006) have specified further organization and functioning norms for home-based care delivery and established accreditation criteria and minimum quality standards for long-term care provision in both home and residential settings. The new legislation was an attempt to ensure a minimum quality of care, although the focus has been on inputs and processes (such as norms for provider organization and administration and human resources management) rather than outcome indicators. Further, the new legislation emphasized access to services, user rights and ethical aspects in care provision.

Decentralization of social services from the central to the local governance level was established in 2006 via Law 195/2006 Framework Law of Decentralization (Legea cadru a descentralizarii). Social service planning and provision was transferred to local councils, including budgeting for sociomedical centres, care homes and other residential care facilities operating in their territory. Decentralization aimed to facilitate the organization, planning and provision of social assistance to better respond to local needs. The process has also led to increased fragmentation in the system and to large disparities in the geographical distribution and availability of services.

In 2011, Law 292/2011 on the Social Assistance Framework (Legea-cadru a asistentei sociale) introduced the first definition of long-term care: "the care of a person requiring support to meet basic and instrumental activities of daily living for a period longer than 60 days" (Art. 32(2)). The text went on to clarify eligibility criteria, the settings in which long-term care can be provided and that services can be provided temporarily or permanently. Law 292/2011 finally defined the characteristics and the boundaries of Romania's long-term care system, although a careful analysis of the system reveals that long-term care has not yet developed its own identity but rather emerges from the loosely coupled operations of the social services the health care sectors. In 2012, the legislation on accreditation

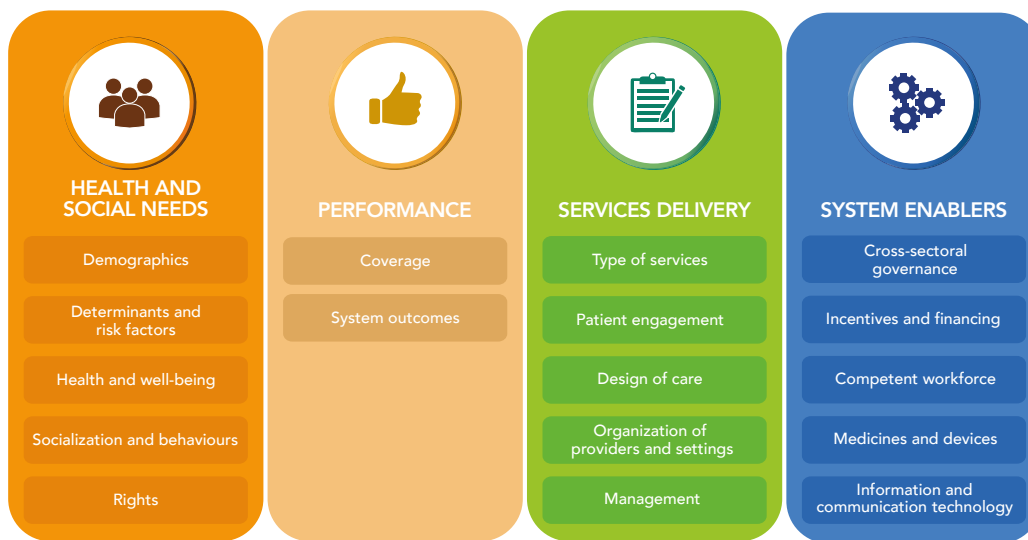
and quality assurance for all types of long-term care providers was updated via Law 197/2012.

Despite important advances in the past two decades, the long-term care system is presently struggling to respond to growing demand for care under conditions of severe budgetary and human resource constraints. Ever in flux, important updates to the existing legislation are expected in the near future: on quality assurance and monitoring, funding mechanisms and budgetary transfers between governance levels, harmonization of health and social services standards and prevention of elder abuse.

Methods

This assessment was completed following the principles of systems thinking (18), people-centeredness and integrated care (11,19), a life-course approach (20), healthy ageing (6), human rights (21) and a gender perspective (22). The conceptual framework underpinning this assessment is the European Framework for Action on Integrated Health Services Delivery (11). This policy framework calls for designing models of care based on the health and social needs and the alignment of the system enablers accordingly. Based on this, the assessment is developed along four domains: health and social needs, performance, services delivery and system enablers (11,23). These domains and their respective features are illustrated in Fig. 1 and listed in Table 1.

Fig. 1. Framework for assessing integrated delivery of health and social services for long-term care



Source: Country assessment framework for the integrated delivery of long-term care (26).

The assessment was structured in the following four domains.

- Health and social needs.** This domain explores the main demographic and epidemiological trends at the country level, with an emphasis on people 65 years or older. The main determinants of health and lifestyle risk factors affecting people's health are listed, together with the underlying health needs of older people. The latter includes self-assessed outcomes and measures of disability and daily life limitations. The specific profile and needs of caregivers are investigated, together with measures to ensure older people's rights, dignity protection and support from the community.
- Performance.** This domain encompasses an appraisal of long-term care services coverage. It also compiles information on quality of long-term care

using waiting times, hospital length of stay, hospitalization rates for ambulatory care sensitive conditions, safety incidents prevention and reporting, among other performance measures.

- **Services delivery.** This domain exhaustively explores the existing services available to older people and their caregivers and the procedures in place for completing needs assessment, for diseases and transition management and the available care pathways. Policies for fostering patient engagement are also covered. The profile of service providers, whether they are public, private for-profit or not-for-profit and the different settings in which services are provided are also compiled. There is consideration of the quality assurance efforts within settings and the initiatives to ensure information exchange among providers.
- **System enablers.** This domain includes those health system facilitators that intersect with health services delivery, including governance, financing of and allocation of resources for long-term care, the planning, production and update of dedicated workforce and the availability of information technology.

Table 1. Overview of the components of the assessment framework

| Domain | Subdomain | Feature |
|-----------------------------|---|--|
| Health and social needs (*) | Demographics | Population structure and dynamics |
| | Determinants and risk factors | Socioeconomic status of older people |
| | | Lifestyle and risk factors |
| | Health and well-being | Health and social needs of older people |
| | | Disability and well-being of older people |
| | Socialization and behaviours | Social inclusions and networks |
| | | Gender behaviours when seeking care |
| Rights | Rights of older people | |
| | Rights and needs of caregivers | |
| Performance | Coverage | Long-term care services coverage |
| | System outcomes | Quality of care for older people |
| Services delivery | Types of services | Health services for older people |
| | | Social services for older people |
| | | Services for caregivers |
| | Patient engagement | Self-management support for older people |
| | | Shared decision-making with older people |
| | | Peer-to-peer support and social inclusion |
| | Design of long-term care | Needs assessment |
| | | Pathways and integrated services delivery |
| | | Disease management |
| | | Management of transitions |
| | | Care/case coordination or management |
| | Organization of providers and settings for long-term care | Long-term care settings (public and private) |
| | | Long-term care providers |
| | | Out-of-hours services |
| | | Cultural, social and gender patterns of caring |
| Management | Facility management | |
| | Autonomy and decision making | |
| | Quality management including quality improvement mechanisms | |

Table 1. continued

| Domain | Subdomain | Feature |
|--|--|--|
| System enablers | Cross-sectoral governance | Integrated long-term care priorities |
| | | Governance and accountability arrangements |
| | | Shared planning |
| | | Allocation of resources |
| | Incentives and financing | Provider payments |
| | | Financial coverage |
| | Competent workforce | Planning, recruitment and staffing |
| | | Workforce composition (*) |
| | | Continuous professional development |
| | | Professionalization of long-term care roles |
| | Medicines and devices for older adults | Mechanisms for the responsible use and management of medicines |
| | | Access to medical devices by older people |
| | Information and communication technology | Data capture in health and social sectors |
| Application of new technology and online platforms | | |
| Information exchange | | |

(*) Disaggregated for women and men to ensure gender-responsive assessment and policy recommendations.

Source: Country assessment framework for the integrated delivery of long-term care (33).

Data sources

This report was constructed applying mixed methods, relying on qualitative data, literature searches, observational facility visits, semistructured interviews and round-table discussions with key informants. This design was adopted to consolidate a comprehensive view of long-term care in Romania. The specific sources and process for data collection are described below.

Database data

Initial desk research was completed for existing, standardized indicators. Data were extracted from international databases: Eurostat (3), the Institute for Health Metrics and Evaluation (4) and the Organisation for Economic Co-operation and Development (OECD) (24) as well as Romania's National Institute of Statistics (25). These data have primarily informed analysis of the current health context in the scope of depicting the health and well-being of older people in Romania.

Scientific and grey literature

The literature search targeted scientific and grey literature on Romania's long-term care services using the topics listed in Table 1 as keywords. Searches for grey literature included the WHO database WHOLIS for Romania-specific reporting such as the Health Systems in Transition series (26). Other grey literature included reporting from such organizations as the European Commission and the OECD. Searches for scientific literature were conducted using MEDLINE (PubMed) and Google Scholar on the topic of health and social services. Literature was reviewed in English.

Field evidence

Field evidence was obtained via two country visits and a round-table discussion. The first country visit comprised a five-day journey to Romania covering Bucharest

and the surrounding areas, including semistructured interviews, site visits and a workshop (Fig. 2).

Semistructured interviews during the country visit included representatives from the Ministry of Health; the Ministry of Labour and Social Justice; the National Authority for People with Disabilities; the National Health Insurance Fund and the County Health Insurance Fund Bucharest; the General Directorate for Social Assistance Bucharest; the General Directorate for Social Assistance and Child Protection for Sector 4; the National Centre for Mental Health and Drug Abuse; health care providers; and unpaid caregivers.

Site visits were conducted in six institutions delivering long-term care: (1) Social Assistance Centre Number 1, Sector 4 in Bucharest; (2) the Saint Andrew Public Residential Care Home, Sector 4, in Bucharest; (3) the Saint Nectarie Palliative Care Centre; (4) a non-profit palliative care centre operated with the support of the Romanian Patriarchate; (5) the Red Cross and the White Yellow Cross, nongovernmental organizations providing home-based care and (6) the GERON Foundation Dementia Care Centre, a privately operated Alzheimer care centre. The workshop brought together representatives from nongovernmental organizations (foundations, associations and philanthropic, charitable and other non-profit institutions) and agencies involved in disability and long-term care (CRED Foundation and Alzheimer Romania). More than 30 experts provided input and during this country visit (Fig. 2).

The second country visit, conducted between 12-14 November, 2019, comprised semi-structured interviews with representatives from the Ministry of Health; the Ministry of Labour and Social Justice; the Centre for curricular development and gender studies FILIA; the Romanian Institute for Human Rights; the Association for Freedom and Gender Equality; the National Council of Older People; the Research Institute for Quality of Life; the National Agency for Equal Opportunities between Women and Men and the National Institute of Statistics.

The round-table discussion was conducted on 13 November 2018 in the Belgian Embassy in Romania. The main topic of discussion was the organizational, financial, human resources and judicial conditions needed for a sustainable long-term care services system in Romania. Participants included stakeholders from public and non-profit agencies, researchers and legal experts (Fig. 2).

Fig. 2. Field evidence components and informants

| Semi-structured interviews | Site visits | Workshop | Roundtable discussion |
|---|---|---|---|
| <p>Experts and stakeholders from:</p> <ul style="list-style-type: none"> • Government • General Directorate for Social Assistance • Regional Directorates for Social Assistance • Health insurance agencies • Public and nonprofit long-term care centres • Health providers (Family Physician) • Unpaid carers | <p>Six site visits to institutions delivering long-term care:</p> <ul style="list-style-type: none"> • A social assistance centre • A public residential home • A health social centre • A nonprofit palliative care centre • The Red and the White Yellow Cross • GERON Foundation Dementia Care Centre | <p>Fora and open discussions with representatives from:</p> <ul style="list-style-type: none"> • Government • Not-for-profit social and charitable agencies • Foundations and philanthropic agencies • Public and nonprofit long-term care centres | <p>Roundtable discussion with representatives from:</p> <ul style="list-style-type: none"> • Government • Nonprofit social and charitable agencies • Foundations and philanthropic agencies • Medical associations • Legal, health policy experts • Research institutions • Diplomats |

Health and social needs of older people

About this section

The demographic and epidemiological data presented in this section provide a snapshot of the main characteristics of the older population and their needs. Data are disaggregated by sex when available. Data were mostly obtained through initial desk research; country experts filled in information gaps and validated the findings.

Demographics: the population is decreasing and ageing rapidly

Romania's total population in 2018 was slightly more than 19.5 million people, or about 3.8% of the EU total (Table 1). Total population has declined from 21.3 million in 2005 and 20.3 million in 2010 (25). Total population is expected to decline to 18.3 million by 2030 and to 16.3 million by 2050 (27).

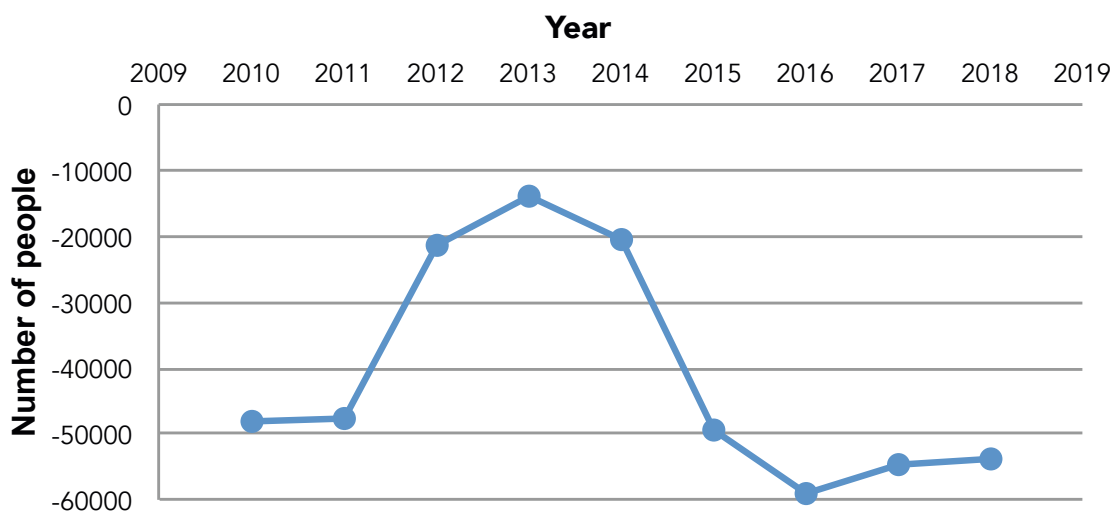
Table 2. Main demographic indicators

| Measure | Total | Year |
|---|-------------------------|------|
| Total population^a | 19 530 631 | |
| Women (%) | 9 977 382 (51.1) | 2018 |
| Men (%) | 9 553 249 (48.9) | |
| Population 65 years or older^a (% of total population) | 3 550 261 (18.2) | |
| Women (% of population 65 years or older) | 2 116 909 (59.6) | 2018 |
| Men (% of population 65 years or older) | 1 433 352 (40.4) | |
| Population 85 years or older^a (% of total population) | 373 991 (1.9) | |
| Women (% of population 85 years or older) | 247 599 (66.2) | 2018 |
| Men (% of population 85 years or older) | 126 432 (33.8) | |
| Net migration^b | 54 468 | 2017 |
| Fertility rate (births per woman)^b | 1.71 | 2017 |
| Median age^c | 43.9 | 2015 |
| Life expectancy at birth^b | 75.3 | |
| Women | 79.1 | 2017 |
| Men | 71.7 | |
| Life expectancy at age 65 years^d | 16.7 | |
| Women | 18.3 | 2017 |
| Men | 14.7 | |

Sources: ^aTempo online – Baze de date statistice [online database] (25); ^bPopulation statistics at regional level (3); ^cProfiles of ageing 2019 (27); ^dEuropean core health indicators (28).

Three are three main reasons for Romania's declining population: (1) a negative balance between the number of live births and the number of deaths, which has gone from -21 299 in 2000 to -47 524 in 2010 and to -55 910 in 2017 (25); (2) a high number of emigrants since 2001, when most EU countries liberalized visa requirements for Romanian citizens (25); and (3) fertility rates around 1.6 births per woman during the past two decades, similar to the EU average and below replacement-level fertility (28).

Fig. 3. Adjusted net migration



Sources: Population statistics at regional level (3).

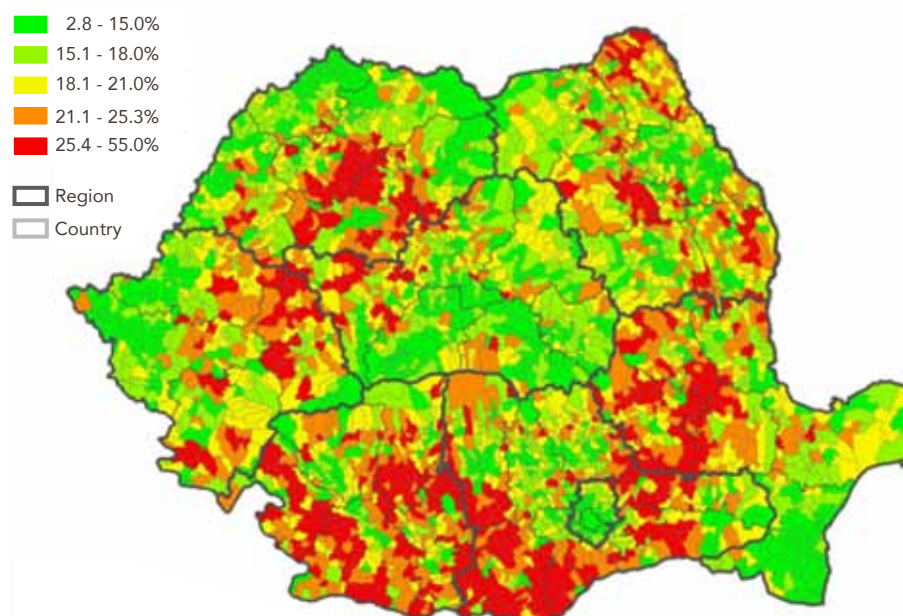
Life expectancy and the share of older people in the total population are increasing

Life expectancy at birth has increased from 71.2 years in 2000 to 75.3 years in 2017, lower than the 80.9 EU average (Table 2) (28). Life expectancy is higher for women than for men; the gender difference of 8.4 years is larger than the EU average of 5.4 years (Table 2) (28). Median age was 43.9 years in 2015 and is expected to increase to 49.8 years by 2030 and 52.2 years by 2050 (27).

Higher life expectancy and a declining number of residents have resulted in an increasingly ageing population. In 2018, Romania had more than 3.5 million people 65 years or older, of which almost 60% were women (25). The share of older people varies between urban (16.4%) and rural (20.2%) areas. Fig. 4 provides more detailed data from the 2011 census at the macro-region, regional and municipality levels (25).

The proportion of older people in the total population is currently 18.2%, 2 percentage points higher than in 2010 (25). Romania is expected to have 4.8 million people 65 years or older by 2035 and 5.9 million by 2050 (27), accounting for 21.0% and 27.7% of the total population, respectively. The total population 85 years or older is about 373 000, less than 2% of the total population (Table 2); this population segment is also expected to grow to 408 000 by 2030 and to 604 000 by 2050 (27).

Fig. 4. Share of population 65 years or older by macro-region, region and municipality, 2011



Sources: Tempo online – Baze de date statistice [online database] (25).

Household size is steadily decreasing

Intergenerational cohabitation has traditionally been more prevalent than in the rest of the EU. Household size is currently 2.6 members, lower than the 2.9 in 2006 but still higher than the 2.3 EU average (3). According to 2011 data, 35% of people 65 years or older live with a couple or partner, 28% live alone and 37% live with children, extended family or non-relatives (27).

The old-age dependency ratio in 2017, defined as the number of people 65 years or older who are economically inactive divided by the number of people 15–64 years old times 100 is 26.7, lower than the EU average of 29.9 (28). The old-age dependency ratio has increased from 20.7 in 2005 and 23.7 in 2010. The combination of smaller families and higher dependency ratios compromise the ability of families to cope with the expectation of ensuring the welfare of older individuals and providing most forms of needed support.

Key points

Total population is declining, although life expectancy, especially among women, is increasing. Smaller household size and higher dependency ratios may compromise the ability of families to ensure the welfare of older people.

Older people are burdened with functional limitations and chronic conditions

The latest available data indicate that the leading causes of death and loss of disability-adjusted life-years among people 70 years or older are cardiovascular conditions for both men and women (4). The main causes of years lived with disability were low back pain, falls and ischaemic heart disease, whereas the main risk factors associated with disability were metabolic and behavioural (4). Table 3 presents data disaggregated by sex.

Table 3. Causes of death and disability, 2017

| Measure | Women | Men |
|---|---|--|
| Top causes of death among people 70 years or older | Ischaemic heart disease Ischaemic stroke Alzheimer's disease Intercerebral haemorrhage Hypertensive heart disease | Ischaemic heart disease Ischaemic stroke Intercerebral haemorrhage Alzheimer's disease Hypertensive heart disease |
| Top determinants of disability-adjusted life-years lost among people 70 years or older | Ischaemic heart disease Ischaemic stroke Alzheimer's disease Intercerebral haemorrhage Hypertensive heart disease | Ischaemic heart disease Ischaemic stroke Intercerebral haemorrhage Alzheimer's disease Chronic obstructive pulmonary disease |
| Top determinants of years lived with disability among people 70 years or older | Low back pain Ischaemic heart disease Falls Hearing loss Chronic obstructive pulmonary disease | Falls Low back pain Ischaemic heart disease Hearing loss Chronic obstructive pulmonary disease |
| Top risk factors associated with disability among people 70 years or older | High systolic blood pressure High body mass index High fasting plasma glucose Low bone mineral density Smoking | Smoking High systolic blood pressure Alcohol use High fasting plasma glucose High body mass index |

Source: Institute for Health Metrics and Evaluation [website] (4).

Hazardous alcohol consumption and obesity among older people are less frequent than the EU average, while daily smoking and hypertension are more frequent. Women have higher rates of obesity but lower rates of daily smoking than men (Table 4). The standardized death rate for alcohol consumption is 42 per 100 000 population, the highest in the EU. Deaths from lung cancer are increasing and comprised 4% of all deaths in 2014 (29). The National Strategy for Promoting Active Ageing and the Protection of Older People 2015–2020 highlights the insufficient development of prevention efforts and early diagnosis and treatment for the most common chronic diseases and the insufficient attention to preventing risky health behaviour.

Older people, especially women, are at higher risk of poverty and social exclusion compared with the EU

The risk of poverty or social exclusion for the entire population is 33.0% versus 19.9% in the EU. The risk of poverty or social exclusion among older people is slightly lower, 29.1%, but still higher than the EU average of 15.2% (3). Income inequality (the ratio of the total income received by the 20% of the country's population with the highest income and the total income received by the 20% of the country's population with the lowest income) for older people in 2017 was 4.4 versus 4.1 for the EU (28). This ratio is lower than that for people younger than 65 years (7.0).

Poverty and income inequality affect women more than men, a pattern applying to the EU as a whole (3). Pensions for men are higher, since women devote more hours in their lifetime to unpaid care at home. New legislation on pension reform, which aims to revamp the algorithms to calculate pensions, will most likely further exacerbate this problem.

Table 4. Selected measures of lifestyle risk factors and determinants of health

| Risk factor or determinant | Romania (%) | EU 28 (%) | Year |
|---|-------------|-------------------|------|
| People 65 years or older reporting hazardous alcohol consumption ^a | 3.3 | 3.6 | 2014 |
| People 65 years or older reporting high blood pressure in the past 12 months ^a | 51.2 | 49.2 | |
| Obese population 65 years or older, measured (%)^b | | | |
| Women | 15.1 | 20.7 | 2014 |
| Men | 12 | 18.8 | |
| Daily smokers by age – 65–69 years^c | | | |
| Women | 7.5 | 11.0 ^d | 2015 |
| Men | 19.0 | 16.0 ^d | |
| Daily smokers by age – 70–74 years^c | | | |
| Women | 3.5 | 7.8 ^d | 2015 |
| Men | 15.0 | 11.0 ^d | |
| Daily smokers by age – 75–79 years^c | | | |
| Women | 2.8 | 5.5 ^d | 2015 |
| Men | 10.0 | 8.4 ^d | |
| Daily smokers by age – 80 years or older^c | | | |
| Women | 2.0 | 3.3 ^d | 2015 |
| Men | 7.2 | 5.6 ^d | |
| Risk of poverty or social exclusion for people 65 years or older^b | | | |
| Women | 31.2 | 17.3 | 2015 |
| Men | 27.1 | 12.8 | |

Sources: ^aEuropean core health indicators (28); ^bPopulation statistics at regional level (3); ^cInstitute for Health Metrics and Evaluation [website] (4). ^dWestern Europe only.

Older people experience a short span of healthy life-years and report poor health status

Although overall life expectancy at birth now exceeds 75 years, women and men can expect to live 58.3 and 59.2 years in good health, respectively (3). Life expectancy at age 65 years is 18.3 years for women and 14.7 years for men (Table 2). Of these, 5.6 are healthy life-years for women and 6.2 for men, both about 40% lower than the EU averages (28).

Life expectancy in good self-perceived health from age 65 years is 13.6 years for women and 12.3 years for men, and less than one in four older residents assess their health as being good or very good (28). Both measures are lower than for the EU as a whole (Table 5). The proportion of people 65 years or older reporting long-term restrictions in daily activities is 64% versus 49% in the EU (28). Older people self-report longstanding health problems, severe bodily pain and severe sensory functional limitations at rates that are higher among women and higher than in the rest of the EU (Table 5). Since life expectancy is lower than in the EU, these numbers should be viewed with caution, since self-reported health measures tend to worsen as people reach 65 years of age.

The pronounced sex differences in self-reported health status can be tracked to gender roles and expectations. According to qualitative studies on the quality of life, women are more burdened with home chores and responsibilities and have a narrower network of friends and support. This in turn leads to poorer lifestyle choices and engaging in risky behaviour, such as a sedentary lifestyle, resulting in low satisfaction with life and health status.

Table 5. Self-rated measures of perceived health among older people¹

| Measure | Romania | EU 28 | Year |
|--|---------|-------|------|
| People 65 years or older who assess their health as being very good or good (%)^a | 23.4 | 39.6 | 2017 |
| Life expectancy (years) in good self-perceived health from age 65 years^a | | | |
| Women | 13.6 | 16.6 | 2016 |
| Men | 12.3 | 15.0 | |
| People 65 years or older reporting any longstanding health problem (%)^b | | | |
| Women | 63.4 | 63.2 | 2017 |
| Men | 47.6 | 60.3 | |
| People 65 years or older reporting severe or very severe body pain (%)^b | | | |
| Women | 20.4 | 19.0 | 2014 |
| Men | 13.7 | 10.2 | |
| People aged 65 or over reporting severe physical and sensory functional limitations (%)^b | | | |
| Seeing, women | 7.0 | 6.8 | 2014 |
| Seeing, men | 4.9 | 4.0 | |
| Hearing, women | 22.4 | 12.0 | |
| Hearing, men | 18.9 | 12.4 | |
| Walking, women | 24.2 | 25.3 | |
| Walking, men | 18.0 | 15.7 | |
| Overall, women | 36.2 | 32.1 | |
| Overall, men | 29.6 | 24.3 | |

Sources: ^aEuropean core health indicators (28); ^bPopulation statistics at regional level (3).

As of 2012, Romania had an estimated 270 034 people with dementia, or 1.38% of the total population, slightly lower than the 1.55% EU average. About two thirds of the people with dementia are women (30). Among people 60 years and older, the prevalence of dementia in 2018 was about 4%, lower than the EU average of 7% (39). The proportion of women 65 years or older reporting chronic depression in the previous 12 months in 2014 was 3.5% versus 1.5% for men, both of which are lower than the respective EU averages of 11.1% for women and 5.8% for men (3).

Data on oral health are scarce, but 7.9% of older people reported in 2014 unmet needs for dental care services because of financial barriers, waiting times or travelling distances. This number is higher than the 2.8% average for the EU (28). Regarding social services, 32.5% of women and 31.3% of men reported overall poor social support in 2014, both higher than the respective EU averages of 18.3% and 18.0% for the same year (3).

¹ Cross-population comparability of self-reported data should be interpreted with caution.

Roma have higher morbidity and dependence than the general population

The Roma population was 619 000 in 2011, about 3.2% of the total population (31). The percentage of Roma without an income is twice the 20.2% non-Roma average, and the employment rate is 47% versus the 62% national average. Roma have an increased prevalence of infectious and chronic diseases and engage more in risky health behaviour (32,33). The Roma minority has lower life expectancy and poorer health status in terms of morbidity and dependence than the general population. Beyond these markers, there is limited information on the health status of the Roma, especially since no data are disaggregated by ethnicity at the national level (31).

Families are expected to care for older relatives, but Romania has no needs assessment protocol for unpaid caregivers

The long-term care system heavily relies on the care provided by family and other unpaid caregivers. Families, and primarily middle-aged women, are called on to fill in for the shortcomings of the system. A small-scale survey among employed women with care responsibilities carried out in 2015 in Bucharest found that 50% of respondents strongly disagreed with the statement "A woman should not let care for an older relative stand in the way of her career". Further, 31% strongly disagreed that a woman could assume responsibility for providing financial support for the household while their husband provides unpaid care to a relative (34). The findings emphasize the strong attachment to traditional gender roles in Romania, especially the role of women.

Strong cultural values prevail regarding the desirability of family-based care and the responsibility of adult children to provide care for their ageing parents. Data from a 2007 Eurobarometer survey show that 78% of respondents in Romania believe that family members and other unpaid caregivers are the best arrangement for the care of older people, much higher than the 54% EU average (25). Only 5% of respondents, versus 10% in the EU as a whole, considered care in a residential institution a good option.

Knowledge about the characteristics and needs of family and other unpaid caregivers is limited. According to the 2016 European Quality of Life Survey, 9% of the respondents (10% of women and 8% of men) provide unpaid care for a relative, neighbour or friend at least once a week. This number is about half that for the EU as a whole (36). According to this survey, caregivers in Romania represent 11% of all people 35–64 years old, 9% of those 65 years or older, and 10% of people 18–64 years old. In addition, as of 2018, the government employed 7000 people as personal assistants for older people, equivalent to less than 0.2% of the total population older than 65 years. Of 737 885 registered people with disabilities, their families cared for 97.7% (26).

Because training, counselling and respite care services for unpaid caregivers are acutely lacking, numerous concerns arise with respect to their well-being, such as burden and decline in mental and physical health status. There are also concerns about the quality of the support they can provide and the potential for older people abuse and negligence.

Several laws and legislative strategies protect older people against stigmatization or abuse, but these policies are insufficiently implemented and monitored

Patient rights are protected under Law 46/2003, including the right to health care, health information, consent, confidentiality and privacy. Legislation has also incorporated some aspects of Directive 2011/24/EU of the European Parliament and of the European Council on patients' rights to preventive measures, free choice, respect for patients' time, observance of quality standards, safety, innovation, avoidance of unnecessary suffering and pain, personalized treatment, complaints and compensation rights (26). Every agency providing residential long-term care services must implement a charter on patient rights, including the right not to be abused, neglected, abandoned, punished, harassed or exploited. Confinement cannot be used as a form of punishment, part of health care or as a solution for lack of health care personnel (37).

Romania has no legislation to prevent the segregation, stigmatization or abuse of older people. The Strategy for Social Inclusion of People with Disabilities 2014–2020 aims to provide barrier-free participation of people with disabilities in the community, specifically related to accessibility, participation, equality, social protection and health, among others. Information on the successful implementation of Law 46/2003 or the Strategy for Social Inclusion of People with Disabilities is unavailable (7).

Newly enacted strategies for gender equality and protecting women aim to reduce domestic violence and to raise awareness of gender roles and expectations. More than 11 000 cases of domestic violence were reported in 2018 and 3000 restraining orders were issued, but evidence indicates underreporting. No data disaggregated by age are available. The National Health Strategy 2014–2020 and Romania's Sustainable Development Strategy 2030 include initiatives to improve health education, health lifestyles, intersectoral cooperation, economic development, transport infrastructure, environment, social inclusion and living standards. They emphasize targeting the Roma and older people (29). The available literature on community involvement and health literacy programmes does not have data for Romania.

Highlights

Population is declining as a result of high migration rates, low fertility rates and a negative balance between the number of live births and the number of deaths. Concomitant with longer life expectancies, the share of older population over total population is increasing.

Although life expectancy is increasing, especially among women, the country lags behind the rest of the EU in several health outcomes, included self-reported measures.

The share of older people population is increasing, average household size is declining and the old-age dependency ratio is increasing. This is a matter of concern, since the country relies heavily on family and other unpaid caregivers, especially women, to care for older people. Lack of data hamper efforts to assess the needs of unpaid caregivers.

Performance

About this section

Long-term care services coverage and system outcomes such as amenable hospitalizations, falls and ulcers and other preventable adverse events, waiting times and barriers to access are indicators of long-term care system performance. The data presented in this section were obtained from international databases and registries that allow Romania's system to be compared with those of other European countries.

Long-term care coverage is insufficient countrywide and almost null in rural areas

Social health insurance is mandatory and currently covers 86% of the population (29). Uninsured people are mostly self-employed people, unemployed people not registered to receive social security benefits and Roma people without identity cards (26). The Healthcare Access and Quality Index, a measure of health access and quality, increased in Romania from 66.8 in 2000 to 78.3 in 2016. The latest score, however, is lower than that for most EU countries (4).

There are very limited data to assess the coverage of long-term care services. The National Institute of Statistics provides estimates of the number of users in adult assistance units (Table 6) (25). About 14 600 older individuals used care homes in 2016, both public and private (25). The 2019 European Commission joint report on health care and long-term care systems and fiscal sustainability estimates that, countrywide and in 2015, 193 000 people received long-term care in an institution and 210 000 people received long-term care at home (7).

Table 6. Number of beneficiaries per type of unit for adult assistance

| Type of unit for adult assistance | Number of beneficiaries | |
|---|-------------------------|--------------|
| | 2010 | 2017 |
| All units | 26618 | 19985 |
| <i>Care and assistance centres</i> | 6447 | 6535 |
| <i>Integration centres for occupational therapy</i> | 1550 | 1091 |
| <i>Recovery and rehabilitation centres</i> | 11077 | 12359 |
| <i>Public hostels for older people</i> | 7544 | 0 |

Source: Tempo online – Baze de date statistice [online database] (25).

A 2014 report from the Ministry of Labour and Social Justice revealed that about 2% of the more than 700 000 people with disabilities were institutionalized, the remaining 98% being cared for at home. As mentioned in the previous section, in 2013 the government employed 43 836 people as personal assistants for people with severe visual impairment (26).

Consultation with experts reveals that long-term care provision is insufficient in coverage. The Caritas Confederation estimates that about 6–7% of older people need home care services, but only 0.23% actually get these services. The situation is more complicated in rural areas, which are almost entirely uncovered and are disproportionately affected by financial barriers to care and lack of access (such as transport) to health care facilities. Other sources reveal that residential care coverage (nursing homes and other home care facilities), semi-residential care (respite care or day care centres) and home care coverage are all 1% or less and rank among the very lowest in the EU (38). Covering the long-term care needs of older people who need these services would require creating 9000 jobs providing long-term health and social services.

Data on the performance of long-term care services are very limited

Amenable mortality or avoidable deaths per 100 000 people that could have been prevented by providing appropriate health care (19) interventions has declined throughout the previous decade but remained at 239 for women and 415 for men in 2014. Both are higher than the respective EU averages of 97 and 158 deaths (29). Avoidable hospitalizations for common chronic conditions (diabetes, hypertension, heart failure, chronic obstructive pulmonary disease and asthma) in 2015 were among the highest in the EU at 8.5% of all hospitalizations and 1.7 discharges per 100 population (39).

The average hospital stay in 2016 was 7.5 days in general, about the same as the EU averages. Disaggregated by sex, this rate was 7.1 for women and 8.0 for men (3). Hospital inpatient discharges were 21 per 100 population, higher than the EU average of 16 for 2016 (7). The share of day surgery for three high-volume eligible surgical procedures were all below EU averages: cataract surgery (32% versus 84%), inguinal hernia repair (2% versus 31%) and tonsillectomy (28% versus 29%) (39).

The number of fatal falls reported to the WHO Regional Office for Europe in 2010–2012 was 556, or 24 per 100 000 older people. This rate was among the lowest in the countries providing data (40). Information on the incidence of pressure ulcers and waiting times for various types of health care is not available (26,41). Regarding patient satisfaction, perceived general practitioner quality was 7.1 of 10 in 2016, about the same as the EU average (39).

Five-year age-standardized net survival for breast cancer between 2010 and 2014 was 75%, lower than the EU average of 83%. Five-year age-standardized net survival for rectal cancer in the same period was 58%, the same as for the EU as a whole (39).

Key points

The available data on the performance of long-term care services indicate high rates of hospitalization and institutionalization for care that could be provided in primary care. Self-reported unmet health needs are also high. Further data need to be systematically collected on beneficiary satisfaction, experience with providers and other patient-reported outcomes.

Financial barriers disproportionately affect women

Besides the barriers to dental care access presented above, further indicators illustrate the financial barriers to care. The proportion of older people with self-declared unmet care needs because of financial barriers, waiting times or travelling

distances in 2014 was higher than the EU averages for prescribed medicines and for health, dental and mental health care (Table 7) (3).

Table 7. Self-reported unmet needs for specific health care services for financial reasons among people 65 years or older, 2014

| Type of care | Romania (%) | EU 28 (%) |
|-----------------------------|-------------|-----------|
| Medical care, women | 11.9 | 6.1 |
| Medical care, men | 12.2 | 4.7 |
| Dental care, women | 13.0 | 10.1 |
| Dental care, men | 11.0 | 8.3 |
| Mental health care, women | 2.0 | 2.0 |
| Mental health care, men | 1.7 | 1.2 |
| Prescribed medicines, women | 10.9 | 5.6 |
| Prescribed medicines, men | 11.4 | 4.5 |

Source: Population statistics at regional level (3).

Highlights

Assessing system performance is difficult because country-level data on long-term coverage and system outcomes are lacking. However, the available evidence indicates that long-term care coverage is very low. Although data on hospital length of stay and on falls are encouraging, amenable mortality is high. Financial access to care may exacerbate this problem. There are some data on health outcomes disaggregated by sex, but information on long-term care utilization, satisfaction with care and waiting times for women and men is lacking.

Delivery of services

About this section

An important requirement to assess the integrated delivery of long-term care is understanding the services available to older people, the organization of providers and settings, the needs assessment process and the care pathways. Obtaining this information exclusively via desk research may not provide the entire picture. In this section, data obtained from the published literature were complemented with information from semistructured interviews and discussion with key informants, including government representatives, managers, health practitioners and unpaid caregivers.

Services available to older people are not comprehensive, and some require out-of-pocket payments

The basic health benefits package is defined yearly between the National Health Insurance Fund and the Ministry of Health and subsequently approved by the government (7). Coverage includes health services, medications and medical devices (26). Specific coverage is explained below.

Vaccination. The National Programme for Immunization, part of the National Institute of Public Health Vaccinations, provides immunization coverage free of charge (26). Influenza vaccination coverage for older people has declined from 54% in 2007 to 5.5% in 2014 (Table 8) (4,29).

Disease prevention and public health services. These services are managed under the jurisdiction of district public health authorities and delivered with the support of primary care centres. There is no coordination with health care providers, and the services provided are anecdotal (29).

Dental care. The national health system does not include dental care coverage except for a few groups, including children and war veterans. Dental care is provided for fees in ambulatory facilities, most of which (86%) are private (26).

Diagnostic services. These services are provided in public hospitals and in specialized private ambulatory centres. Laboratory and imaging services are paid for by the public system or district health insurance houses on a fee-for-service basis (26).

Population-level screening. The National Programme for Cancer Screening, part of the National Institute of Public Health population-level screening, provides screening services, but there is no dedicated strategy to implement this programme at a large scale (26). Breast and colorectal cancer screening levels are low, especially compared with EU averages (Table 8) (28).

Physiotherapy and renal dialysis. These services are provided in public or private institutions and subsidized via the district health insurance houses (26).

Mental health. Mental health services are chiefly provided in the hospital setting and covered by the public system. There is a recent initiative to shift care to community centres, although this has not been fully implemented (26).

Medications. Beneficiaries are entitled to medications covered by the public system. Generic medications prescribed in the ambulatory setting require a 10% co-payment for generics and 50% for branded or innovative drugs (26). There is a mandatory electronic prescription system for medications covered by the national health system. Disbursement of drugs takes place via the network of pharmacies. Distribution of pharmacies is unequal, and there are no requirements for the number of pharmacies needed per geographical area. Romania has about one pharmacy per 2000 residents in rural areas and one per 2700 in rural areas (26).

Medical devices. In 2016, Romania had six magnetic resonance units and 13 computed tomography scanners per million people, both well below the EU averages (7,39). The number of magnetic resonance imaging examinations was 11 per 1000 population (76 in the EU), whereas the number of computed tomography examinations was 27 per 1000 population (122 in the EU), both below the EU averages (39). The health system insurance does not cover medical devices for beneficiaries except for wheelchairs, which are covered by the National Health Insurance House.

Rehabilitation. Rehabilitation services provided in inpatient settings are reimbursed by the government via the National Health Insurance Fund for a maximum of 21 days a year. Those provided in ambulatory settings are reimbursed for up to 14–21 days and a maximum of four procedures per day. There are long waiting lists to access rehabilitative care, which is not integrated with other forms of care (26).

Palliative care. Palliative care is paid for by district health insurance houses and provided by 57 care providers (19 public, 26 nongovernment organizations and 12 private centres) in various settings, included day centres, ambulatory facilities, hospitals, hospices, hospital mobile teams and the beneficiary's home (data from 2012) (26).

Table 8. Screening and vaccination rates among older people, 2014

| Measure | Romania (%) | EU 28 (%) |
|---|-------------|-------------|
| Women 50–69 years old reporting a mammography in the past two years | 6.6 | 68.7 |
| People 50–74 years old reporting colorectal cancer screening in the past two years | 3.7 | 31.3 |
| Women | 3.8 | 31.4 |
| Men | 3.5 | 31.3 |
| People 65 years or older reporting influenza vaccination in the past 12 months | 5.5 | 45.9 |
| Women | 5.9 | 44.5 |
| Men | 5.0 | 47.7 |

Social services encompass assistance and home care

The Ministry of Labour and Social Justice is responsible for social assistance. Local authorities are responsible for managing centres providing services and for budgeting (Law 292/2011). Non-profit and volunteer organizations are the main agents responsible for delivering social services.

Social services in the regimen of home-based care are provided according to need and not subject to time limitations. The number of hours provided depends on the specific needs of the beneficiary, although they usually amount to 15–20 hours per week. Common services in home-based care include (1) support for personal care, such as physical hygiene and dressing; (2) support to accomplish household tasks, such as cleaning; (3) support for social integration, such as cultural activities and occupational therapy; (4) phone lines for company and older people; and (5) health follow-up and monitoring, such as medication administration and health advice (40). Health services are limited to 90 days per year according to the rules of reimbursement of the National Health Insurance Fund. Health services provided by health care practitioners at home or in health facilities are under the responsibility of the Ministry of Health and funded through the National Health Insurance Fund.

Roma mediation programme

The Roma mediation programme aims to facilitate linkage with the Roma population to foster access to education, health and social services. As of 2018, 470 Roma mediators were employed under this initiative. This programme has very limited coverage, and many mediators have not received the proper training on the available services or the strategies for connecting Roma people to services. The success of the programme so far is very limited, and the government is exploring alternatives for reaching out to the Roma.

Key points

Social health insurance is mandatory, but 14% of residents lack coverage. Some indicators relevant to older people have worsened in recent years, including influenza vaccination and cancer screening. Several services are fee for services or require co-payments. The bureaucratic process for obtaining social services coverage is cumbersome and lengthy.

Services available to unpaid caregivers are restricted to trivial financial support and limited training

Although most older people are cared for by their families and other unpaid caregivers (26), the long-term care system offers no structured and systematic support for this type of care. Counselling and training programmes for unpaid caregivers are scarce and limited to training on daily tasks provided by social personnel.

Since 2000 (Law 292/2011), people with severe or accentuated care needs have been able to opt to have their unpaid family caregiver be employed as a personal assistant. For the caregiver, this is the equivalent of being employed by the local authorities and being paid as a junior social assistant. Personal assistants are employed eight hours a day, 40 hours a week, although part-time employment is also possible. They are entitled to annual leave and, in some cases, free public transport (26). Personal assistants participate in a specialized training course when first appointed and, once a year, are supervised in their activities by social personnel. The supervision aims to update their skills and to provide advice and

support. After 2006, with the application procedure simplified and eligibility extended, the number of beneficiaries increased considerably (43).

Respite care is available for 21 days per year. Uptake of this benefit is limited because the application process is cumbersome and because the agencies and staff offering respite care are very limited.

Financial support for families with older people with disabilities or health needs is underdeveloped. The amounts provided are sometimes negligible and mostly depend on household income. The current leave of absence for taking care of dependants is not subject to time restrictions; during the leave, the replacement salary equals the gross wage of a junior social assistant. In practice, however, limited budgets have led to the imposition of strict limitations on the length of this entitlement (38).

There is no patient engagement policy or strategy

The country lacks policies or legislation to promote the engagement of beneficiaries. There are no data to assess the level of patient involvement or their families in shared decision-making or self-management. There is no strategy to systematically inform older people of the rights and services to which they are entitled or that they can hire for pay. Independent websites and other informal outlets such as blogs, forums and chat rooms are used for obtaining data on patients' rights, covered services and indicators of patient-reported satisfaction (26).

Beneficiaries are entitled to select providers without geographical restrictions, although the health system does not cover travel expenses. Beneficiaries may choose to select university hospitals over district facilities; in these cases, general practitioners provide a referral to the desired facility. No measures have been taken to address this practice (26). Beneficiaries can change providers at any time, except for general practitioners, which can be changed after six months (26).

Since medications are prescribed based on their generic name, beneficiaries may choose any product containing the same active ingredient. Similarly, beneficiaries may choose among different types of medical devices. In both cases, the National Health Insurance House will only cover the cheapest prescribed option, the rest being paid out of pocket (26). Beneficiaries also have a right to a second opinion, although there are no data on whether this right is practised (26).

Care mix design: delivery of long-term care is fragmented

Primary health care, hospitals, public health and the social sector lack integration and have insufficient mechanisms to ensure the continuity of care (29). The 2014–2020 National Health Strategy set as a priority coordinating care across these sectors, building care provision around community centres and primary care and implementing information and communication technologies to increase efficiency and facilitate the integration of care (29). This strategy is being implemented under the oversight of the Ministry of Health (29).

Overall, the health system is oriented towards hospital care at the expense of primary and ambulatory care. To address this issue, funding for outpatient care and primary care has increased while the health care services and diseases that can be treated in outpatient clinics and via outpatient hospitalization have

been expanded (7). Salaries in the outpatient health sector have also been increased (7). These measures aim to reduce hospital admissions and to encourage the treatment of conditions in day-care facilities, ambulatory centres and primary care settings.

Long-term care legislation is limited to health services

Long-term care is defined only from a social perspective, as “the care of a person requiring support to meet basic and instrumental activities of daily living for a period longer than 60 days” (Law 292/2011, Social Assistance Framework (Legea-cadru a asistenței sociale)). Long-term care encompasses three types of social community services: temporary or permanent home care, temporary or permanent care in a residential centre and care in day centres. Home care includes household services (such as catering, household chores, legal and administrative counselling and paying bills), sociomedical services (such as personal hygiene and sociocultural activities) and health care services limited to consultation and administration of medicines (7).

The health care component of long-term care is not defined by law. Instead, the National Health Insurance House contracts health services provided as part of long-term home care. The classification of these services as part of long-term care or their integration with social services has not yet been clarified. Social and health services for older people are thus insular and fragmented in different administrative levels and governing bodies and funded via uncoordinated arrangements. There is no strategy to classify services or settings or standards to define service provision that could facilitate regulation, reimbursement, accreditation and quality assurance activities across settings and levels of governance (37).

There are ongoing plans framed within the National Strategy for Promoting Active Ageing and the Protection of Older People 2015–2020, the National Health Strategy 2014–2020 and the Strategic Action Plan 2015–2020 to revisit the legislation on entitlements, funding and delivery of long-term care. Government Ordinance 31/2015 enabled for-profit operators to provide social services for pay, in order to increase the services offered for those willing and able to pay (37). A new long-term care directorate within the Ministry of Labour and Social Justice will integrate the governance of all benefits and services with the aim of increasing access to care (7). The state budget has also devoted nearly €2 million for developing social home care services infrastructure for older people at risk of social exclusion and will fund programmes to further develop the public network of community household services (Box 1) (7).

Key points

Long-term care legislation and protocols on needs assessment focus on social protection for people with disabilities, regardless of age. Income is a key factor for determining eligibility for entitlements and co-payments. The establishment of well-defined care pathways is hindered by a lack of coordination among providers, the limited role general practitioners play as gatekeepers and a lack of electronic medical records, which have not yet been implemented.

Box 1. The stakeholders' perspective: unpaid caregivers

In the absence of structured transition management, beneficiaries and their families are exposed to high pressure in navigating the systems (both health and social services). Services are often implicitly preconditioned by health practitioners charging informal payments. This leads to significant inequities between well-off and poorer beneficiaries.

Although individuals insured in the social and health care systems are entitled to an array of services, timely diagnosis highly depends on accessing private services or paying out-of-pocket payments (including informal payments) in the public system. One informant explained how receiving an initial visit from social services took longer-than-expected, after which the beneficiary was granted a 300 lei (about €63) payment with no paid caregiver, even though the beneficiary was unable to dress, cook or move. The family appealed the decision, but the meeting with institutional

representatives to discuss the case was scheduled after the beneficiary had died.

Another informant received information on entitlements to medical devices for a sick relative, and had to contact nongovernment organizations to obtain them. The family also had to manage medicine reconciliation. Speech and physical rehabilitation were not presented as options, and the family did not receive any information or training on how to take care of the beneficiary.

A recurring complaint is the lack of information available to families and the lack of communication among providers. For a beneficiary diagnosed with dementia and Parkinson's disease, the family reports no communication with the neurologist and the psychiatrist. In the absence of formal support mechanisms, caregivers provide support even for other beneficiaries or unpaid caregivers in the form of knowledge, skills and care.

Sources: expert opinion; Rostgaard (50); Aspinal et al. (51).

Entitlements: household income remains a determining factor

In accordance with Law 17/2000, social assistance is awarded to older individuals who have no family and are not under the care of a designated guardian, have no or insufficient income, cannot independently maintain their household, require specialized assistance or are not able to fulfil their social and health needs because of disease or physical or mental health problems. In accordance with Law 292/2011, vulnerable older individuals who have lost or are at risk of partly losing their autonomy are eligible for support depending on their degree of dependence (Table 9) (44).

Any person with disability, regardless of age, is entitled to cash benefits: attendance allowance and complementary personal budget. Although these benefits are not explicitly intended for supporting older people with long-term care needs, because of overlaps in legislation and eligibility criteria, one third of beneficiaries are thought to be 65 years or older (43).

Even though long-term care entitlements depend on assessing dependence (needs assessment), household income remains a key factor for assessing eligibility and for determining co-payments. Needs assessment includes the following areas: (1) social, including housing conditions, household structure and social participation; (2) economic, including the income and wealth of the household; (3) health status, including clinical history and neurological and psychological examination; and (4) level of dependence. The level of dependence includes the individual's functional status in terms of activities of daily living, instrumental activities of daily living, sensory perception and mental and emotional status.

Table 9. Degrees of dependence according to the needs assessment grid for older individuals reasons among people 65 years or older, 2014

| Degrees of dependence | Subcategories of dependence |
|--|--|
| Complete or severe loss of autonomy | <ul style="list-style-type: none"> A. The person has lost autonomy and needs continuous care B. The person cannot perform daily activities and needs help and health care for most activities throughout the day and night C. The person needs permanent surveillance and help because of behavioural disorders and regular care for activities related to personal hygiene |
| Moderate loss of autonomy | <ul style="list-style-type: none"> A. The person has perfect mental abilities but partial motor ability and needs daily care for basic activities B. The person needs help in getting up and partial help with daily activities C. The person has no motor problems but needs help with daily activities related to personal hygiene |
| Little or no loss of autonomy | <ul style="list-style-type: none"> A. The person needs regular help with daily activities but can be considered independent when placed in an institution B. The person has complete autonomy and can perform daily activities without help C. The person can perform daily activities without help |

Source: Popa (44).

Multidisciplinary teams assess needs. These include at least two social workers representing the local government and the county directorate of social assistance and child protection and a health specialist, who can be a general practitioner or a specialist physician who has followed or provided care to the beneficiary. Representatives of nongovernmental organizations or associations representing the rights of older individuals can participate in the needs assessment, but this does not happen often (43). Family members and other unpaid caregivers have no involvement or recognized role in this process or in the subsequent care planning.

The needs assessment is used to direct beneficiaries towards the services to which they are entitled: for example, individuals with dependence level I or II are entitled to an attendance allowance or a personal assistant. The needs assessment establishes whether the criteria for priority admission to a residential care facility are met, such as complete absence of family and other unpaid caregivers.

This needs assessment is differentiated from the assessment of individuals with disability of any age, which is used for certifying disability. Under current legislation, beneficiaries who have one or more chronic condition or degenerative or terminal diseases are granted a disability certificate; for example, Alzheimer's disease is considered a disability condition (26). These certificates are then submitted to the general directorates for social assistance, which are part of the local government authorities (26).

Box 2. The stakeholders' perspective: providers of long-term care services in three private, non-for-profit settings in Cluj-Napoca

These agencies offer health and social services provided by a multidisciplinary team. A specialist doctor provides the treatment plan. The family is responsible for additional health services such as dental care or eye or hearing examinations. In case of complications or if a beneficiary needs hospital care, the family is contacted to arrange these services. There are no prespecified care pathways. Transition between providers is complex because of a lack of interconnected electronic medical records. For beneficiaries admitted to a hospital, a medical letter from a general practitioner is the usual means of communication among providers. The family is responsible for post-discharge follow-up. Nursing home personnel perceived stigma from external health care practitioners towards older people, manifested, for instance, in longer-than-usual waiting times for ambulances.

Nursing home fees are mostly paid out-

of-pocket by the families with, in some case, some form of support from the government. Social workers provide help with paperwork for beneficiaries who need to complete applications for disability assessment and social entitlements. Sustainability is threatened by difficulty in recruiting and retaining staff, since they are attracted by higher wages and benefits in the public sector. Hiring nursing assistants is especially difficult, since salaries are not much higher than social benefits.

Managers have considerable freedom to recruit, hire and dismiss personnel. According to current legislation, the facility needs to be licensed first for one year and then apply for permanent accreditation. Licensing procedures includes filling up paperwork and at least one site visit. Fragmentation of institutions that oversee the provision and funding of social services severely impairs appropriate provision of services and integration of care with the health sector.

Care pathways: no mechanisms for joint working between health care and social services providers

The establishment of well-defined care pathways is hindered by a lack of electronic medical records, reduced coordination among providers and the limited role general practitioners play as gatekeepers (7,29). Once the needs have been assessed, older people and their families can choose a provider. The list of accredited providers is available on the websites of the Ministry of Labour, Family and Social Justice or subnational authorities. However, access is not user-friendly and there is no indication regarding performance, type of services, quality or fees. Families rely on informal networks to gather information about providers.

Because of the lack of accessible information regarding providers, orientation services or preventive home visits, beneficiaries commonly come in contact with the system after a hospital discharge or when referred by a social worker, a community nurse or a general practitioner (43). The referral of these practitioners usually influences the choice of provider. Health care practitioners are not always informed about the availability of long-term care services, especially since many providers, mostly privately owned, appear in and disappear from the market within short periods of time. Health care practitioners can use their influence to promote self-interest, for example by orienting individuals towards certain private for-profit providers rather than nongovernmental organizations or public providers.

Romania has no standard discharge procedure from hospital. This has led to arrangements between hospitals and home care providers: hospital doctors refer beneficiaries to a specific private provider or these private providers informally contact beneficiaries when still in the hospital to recruit possible clients (43).

Arrangements for integrated delivery are mostly informal agreements among practitioners

The current arrangements are not conducive to coordination between governance actors or service providers (such as health and social, formal and informal and public and private). The decentralization of the delivery of social services affected the coordination between providers (Law 195/2006) and created large disparities in service availability among regions. Coordination and integration of services has not improved although the Ministry of Health and Ministry of Labour, Family and Social Justice are represented by the same authorities at the county and local levels. If any degree of coordination exists, it is mostly carried out informally between providers. Previous attempts to improve linkage and cooperation between different stakeholders have had limited success (43), and national documents have acknowledged the resulting shortcomings in the past (32).

Some private, non-profit organizations providing health care services also provide social services. These social services include mediation with family members, support in completing paperwork for assessment of disability and social entitlements and leisure activities. There are also situations when health care providers extend diagnosis or mediate the hospital admissions of homeless people or people living alone who cannot be referred elsewhere.

Organization of providers: public and private services coexist

Primary care is provided in solo, private practices; general practitioners work as gatekeepers, but their role in coordinating care is limited in practice (29). In general, the role of nurses in primary care is limited. General practitioners have to pay for nurses working in their practices out of their pockets, without external or government funding.

Beneficiaries can directly access specialist and ambulatory care provided in hospitals and polyclinics, specialized medical centres, centres for diagnosis and treatment and individual specialist offices (7,29). Publicly owned hospitals provide inpatient care. The number of acute care hospital beds in 2015 is 518 per 100 000 people, higher than the EU average of 402. These beds are used not just for acute care but also for long-term care services, resulting in bed-blocking (7).

According to Law 292/2011, long-term care encompasses social and health services and health services limited to consultations provided in public health institutions or in the home (44). Long-term care services can be provided in residential settings, day-care centres or community settings or at home (Fig. 5).

Residential care and home care can be provided on a temporary or permanent basis, depending on the individual needs. Providers can be public or private; in general, private providers are relatively small without an umbrella organization. Only a few nongovernmental organizations and other private non-profit providers have county, intercounty or national reach, such as the White Yellow Cross and the Red Cross. A few for-profit providers have sprung out in the past decade, operating outside the public system and accreditation.

Fig. 5. Long-term care settings

Source: Authors' own.

The services provided in day-care centres mostly depend on funding from grants and projects. Once these funds run out, the projects stop providing services.

Services in community settings are provided mostly under a community-based medical assistance programme, created to address the great geographical disparities in access and to expand services to rural areas. The National Strategy for Promoting Active Ageing and the Protection of Older People 2015–2020 established a strategy to improve coordination and joint planning between government and administrative levels: local, county and national. This strategy has resulted in the creation of integrated community centres and of the community-based medical assistance programme, jointly funded by subnational budgets and the Ministry of Health. As of October 2019, 1556 nurses were employed and responsible for (1) actively identifying, in collaboration with social assistance authorities, the health and social problems of the community, emphasizing vulnerable groups, such as the Roma; (2) facilitating access to health and social services for all individuals; (3) implementing public health initiatives adapted to the needs of the community and promoting healthy lifestyles and (4) providing health services in accordance with the competencies of the available providers. The community-based medical assistance programme currently covers more than 1200 rural communities, but there are insufficient providers, compounded by low salaries and working conditions.

Provider capacity: waiting lists for residential care are in the thousands

There were 1.3 beds per 1000 people in residential care facilities in 2013 (26). The share of the public care home capacity dropped from 80% in 2007 to 44% in 2016. The number of residential care providers for older people has more than tripled, from 106 in 2007 to 369 in 2016 (Table 10).

The number of applications that cannot be accepted because of lack of capacity indicates the acute shortage of residential care places. Data on the number of older people on waiting lists for public care home at the end of each year show an average of more than 2500 applicants over the past decade (Tables 10 and 11). According to data from the Ministry of Labour and Social Justice in December 2017, only four respite care facilities (three public, one private) and four palliative care facilities (three private one public) were accredited.

Table 10. Number of inpatient residential and day-care facilities by type of provider, 2007–2016

| Type of provider | 2007 | 2010 | 2016 |
|--|------------|------------|------------|
| Public care homes | 68 | 88 | 123 |
| <i>Operated by county authorities</i> | – | – | 45 |
| <i>Operated by local authorities</i> | – | – | 78 |
| Private non-profit care homes | 38 | 63 | 246 |
| Total care homes | 106 | 151 | 369 |
| Care and assistance centres | 95 | 99 | 115 |
| Integration centres for occupational therapy | 16 | 19 | 17 |
| Recovery and rehabilitation centres | 202 | 254 | 316 |
| Total day-care centres | 419 | 490 | 448 |
| Total inpatient care facilities | 525 | 641 | 817 |

Source: Tempo online – Baze de date statistice [online database] (25).

On this backdrop, private providers have seized the opportunity to enter the market. The number of private non-profit residential care facilities is almost double than those publicly operated. There are coverage disparities across the country, with the southern and south-western macro-regions having one non-profit care home in 2012. At the other extreme, more than 30 private non-profit care homes were functioning in the centre macro-region and 30 in the north-western region (44). Data on private-for-profit providers do not exist.

Table 11. Residential care capacity by type of provider, 2007–2016

| Type of facility | 2007 | 2010 | 2016 |
|--------------------------------|-------------|-------------|--------------|
| Public care | 5588 | 6438 | 7630 |
| <i>On waiting list</i> | – | 2834 | 1017 |
| Private non-profit care | 1429 | 2160 | 9659 |
| Total | 7017 | 8598 | 17289 |

Source: Tempo online – Baze de date statistice [online database] (25).

Regarding day-care centres, 448 public social assistance centres for adults with disabilities were functioning in 2016 under the coordination of the National Authority for Disabled People. There are no data on capacity and occupancy rate besides a provider survey carried out in 2014, which found that day-care centres have 290 users on average every month, mainly older individuals. One in four surveyed day-care centres reported having an average of 38 individuals registered on waiting lists (43). In 2019, Romania had 70 accredited community care centres, 16 of which were operated by public authorities. Their distribution shows significant variations (45).

By 2017, the Ministry of Labour and Social Justice had accredited 209 home care providers: 170 privately operated and 39 publicly operated. The dominance of private providers can be explained by the historical development and the practice of public authorities to contract out home care services, often to private non-profit providers already established in the community. Not all home care providers are accredited by the Ministry of Labour and Social Justice or have contracts with the National Health Insurance Fund: as of 2017, 85 providers had contracts with the National Health Insurance Fund, serving about 13 000 individuals, not all of whom were older people.

Home-care facilities are unequally distributed across the country (33). The mostly rural southern and south-western macro-regions are underserved, since most providers are concentrated around urban centres. By 2017, five counties had no registered home care providers for older individuals (Harghita, Ialomița, Ilfov, Olt and Vâlcea) and seven counties had only one registered provider (Vrancea, Prahova, Teleorman, Mehedinți, Gorj, Dâmbovița and Bistrița-Năsăud).

Lack of out-of-hours service in primary care results in unnecessary use of hospital services

Out-of-hours service is limited or non-existent in most urban and rural areas. This further exacerbates the problem of excessive reliance on hospital services for ambulatory-care sensitive conditions (29).

The White Yellow Cross offers the Red Button programme, an initiative for older people who live alone and with disabilities or chronic conditions that enables them to call, using free mobile devices, at any time in an emergency, when in doubt about medication or health care or to request social services (46). Dedicated staff members answer phone calls around the clock and to refer beneficiaries to other services, such as calling an ambulance. The programme currently serves about 600 people and is funded via various grants.

Data capture: electronic medical records are being developed

The country is currently working on developing and implementing an electronic medical records system that spans primary, secondary and tertiary care facilities. A parallel system, independent from the electronic medical records, oversees the implementation of electronic national health insurance cards. These cards were introduced in 2015 and are used as a mandatory tool for the reimbursement of health services (7). Romania has no laboratory, pathology or public health information systems (47).

Managers have autonomy in hiring and budgeting

Managers of agencies providing services have significant leeway to recruit, hire and dismiss personnel. Managers are required to have higher education and to be certified via a manager course or master's degree provided by the National School of Public Health, Management and Professional Development. Managers of larger facilities, with jurisdiction over more than one agency, are required to hold a medical, psychologist or social worker degree with at least two years of experience in the special protection system or hold a financial, law or public administration degree with five years of experience in the special protection system.

Quality is not systematically monitored within settings

Professional associations are responsible for setting regulations for their respective professions. Primary care physicians are independent practitioners accredited by the National College of Physicians (26). Most secondary and tertiary health care providers are under state administration, and hospitals are accredited by the National Commission for Hospital Accreditation (26). Private providers who wish to enter contractual agreements with the district health insurance houses need to meet

professional competence and technical equipment requirements (26). Licensing or accreditations are conducted in accordance with Governmental Decision 867 and must be renewed every three years, ensuring that operating providers continue to respect and fulfil the set standards. The process is entirely paper-based and does not include a site inspection. Accreditation activities at the national level are under the jurisdiction of the Ministry of Health and the National Health Insurance House (26).

The National Agency for Quality Management in Health Care is the institutional body responsible for accreditation and quality monitoring in hospitals and health facilities. Since 2018, the Agency has been tasked with accrediting home health care providers, while the specialized department under the Ministry of Labour and Social Justice continues to be responsible for accrediting home social services providers (26). The new quality standards for home and residential services accreditation and for performance monitoring are currently under developed. These new standards will follow the International Society for Quality in Health Care guidelines and will mirror the current process, which includes initial accreditation for one year, followed by monitoring and the possibility of permanent accreditation.

Quality assurance processes are not systematic

The Ministry of Labour and Social Justice is responsible for monitoring and quality assurance of the performance of long-term care services (26). Quality is not systematically monitored in residential facilities or in-home care. All providers are bound to minimal quality standards (Law 197/2012), including feedback mechanisms, registries, managing critical situations and annual thematic control missions.

Inspectors from county or local authorities can carry out announced or unannounced on-site inspections. There are no guidelines on the frequency of such inspections; their frequency varies between localities, and they are often triggered by the accumulation of complaints. Providers who do not fulfil minimum quality standards are often allowed to continue their operations because of a general lack of alternative solutions. Since supply is already undersized compared to demand, public authorities are reluctant to close publicly operated providers since their residents could not be cared for elsewhere due to capacity limitations.

Highlights

Several services available to older people are fee for services or require a co-payment. Entitlements to care are well defined, but the needs assessment process is lengthy and care pathways and transition management protocols are lacking. Despite an increase in the number of providers of long-term care, capacity is overall insufficient to cover demand, thus resulting in long waiting times. Integration of care has been addressed as a policy priority, but coordination of actors and links between stakeholders remains limited. Information on long-term care-related services utilization, including use of benefits available to unpaid caregivers and data related to clinical pathways, is not disaggregated by sex.

System enablers

About this section

Integrated services delivery is fostered by implementing measures that enhance governance, funding, adequate staffing and information technology platforms. This section describes these system enablers. The data was collected from published evidence, databases and from consultation with stakeholders.

Governance remains highly centralized

Law 95/2006 is the basic health care law, legislating the role of social health insurance, private health insurance, organization of providers, services covered and reimbursed and national health programmes (7). At the national level, the Ministry of Health provides stewardship, policy direction and regulatory oversight, while the National Agency for Quality Management in Health Care is responsible for accreditation activities and for monitoring that quality standards are upheld (26). At the regional level, the National Health Insurance House is responsible for defining remuneration systems and for administering the social health insurance system (7,29). A total of 42 district-level branches of the National Health Insurance House are responsible for contracting and reimbursing services according to a national framework contract (7). Both the Ministry of Health and the National Health Insurance House are responsible for developing the technical norms for accrediting providers and for quality norms (29).

Long-term care is mostly under the responsibility of the Ministry of Labour and Social Justice, which proposes legislation and coordinates the provision of social assistance and social benefits, including residential care and home care. The Ministry of Health plays an important, albeit less prominent, role. Since 2006, the county and local authorities have been responsible for organizing social assistance (Law 195/2006). County and local authorities organize and operate the public provision of services (26).

The Ministry of Labour and Social Justice is subnationally represented by the directorates-general of social assistance and child protection, subordinated to the district (in the case of Bucharest), county and local councils. The directorates-general of social assistance and child protection apply national policies generating strategies for the development of services and monitoring the implementation of national quality standards. The directorates-general of social assistance and child protection collaborate with other public institutions.

County and local authorities are responsible for providing social assistance. They organize, develop and administer services for a wide range of vulnerable groups, including older individuals. County and local councils operate and fund social

assistance centres, residential centres and most care homes. County and local authorities also negotiate subsidies and procurement (43).

Long-term care is funded via different sources

At less than 1 000 Euro per capita and about 5% of GDP, health expenditure is the lowest in the EU (39) (Table 12). Public expenditure on health is 4.2% of GDP, about half of the EU average in 2015, and 11.7% of total government expenditure is dedicated to health, also below the EU average of 15% in 2015 (7). The National Agency for Fiscal Administration transfers funds from taxation revenue to the National Health Insurance Fund, which is the main funder of health care (7). Out-of-pocket expenditure accounts for 21.3% of total health expenditure versus 15.9% for the EU as a whole (Table 12) (7). Private, voluntary health insurance coverage in 2015 was about 1%, lower than the EU average of 5% (29). Private health insurance pays for services not included in the social health insurance scheme, co-payments and higher-comfort services (7).

Table 12. Selected system enablers: health expenditure and workforce

| Measure | Romania | EU 28 | Year |
|--|---------|-------|------|
| Expenditure on health (euros per capita, adjusted per purchasing power) ^a | 983 | 2773 | 2017 |
| Expenditure on health (% of GDP) ^a | 5.2 | 9.6 | 2017 |
| Expenditure on health as a percentage of total government expenditure ^b | 11.7 | 15.0 | 2015 |
| Out of pocket (% of total expenditure on health) ^b | 21.3 | 15.9 | 2014 |
| Public expenditure on long-term care (% of GDP) ^c | 0.3 | 1.3 | 2016 |
| Expenditure on long-term care as a percentage of total health expenditure (%) ^a | 6.0 | 13.0 | 2016 |
| Number of physicians (per 100 000 population) ^b | 277 | 344 | 2015 |
| Number of general practitioners (per 100 000 population) ^b | 62 | 78 | |
| Number of nurses (per 100 000 population) ^b | 641 | 833 | |

Sources: ^aHealth at a glance: Europe 2018: state of health in the EU cycle (39), ^bJoint report on health care and long-term care systems & fiscal sustainability. Country documents – 2019 update (7), ^cThe 2018 ageing report: economic and budgetary projections for the 28 EU Member States (2016–2070) (48).

Health expenditure in 2015 for inpatient care (25.5%) significantly outpaced outpatient care (12.1%). The proportion of inpatient care expenditure was similar to the EU as a whole, whereas outpatient care expenditure was about half the EU average of 24.0%. Primary health care expenditure was 6.2% of total health expenditure (26).

Expenditure on medications as a percentage of health expenditure was almost three times as high as the EU average (38.4% versus 14.6%) (7,29). Commonly used generics are reimbursed at 90%, originator medications are reimbursed at 50%, medications for chronic conditions included in the national health programme are fully reimbursed and medication without proven effectiveness is reimbursed at 20% (7). Expenditure on retail pharmaceuticals in 2016 was €255 per capita, of which 44% was paid out of pocket (39).

Public expenditure on long-term care, at 0.3% of GDP, remains well below the EU average of 1.3% in 2016 (Table 12) (48). Long-term care expenditure in 2016 accounted for 6% of total health expenditure, less than half the EU average (39). Most long-term care expenditure was devoted to in-kind benefits, with close to zero expenditure on cash benefits. At the EU level, in-kind benefits represent 80% of long-term care expenditure compared to 20% in cash benefits (7).

Although there are no reliable figures on private long-term expenditure, there is a widespread conviction that long-term care is financially out of reach for many families. After small increases between 2008 and 2010, budgetary allocations declined considerably in 2011 and 2012, followed by small increases in subsequent years. In 2014, total public expenditure on health and social assistance had not yet reached the levels of 2010 (34). The decline mainly affected social assistance expenditure, whereas public expenditure on health increased. Various government authorities, with different funding logics, sources and eligibility criteria, participate in funding long-term care:

- The Ministry of Labour and Social Justice and the county and local governments fund home care provided by public and private non-profit providers, as well as maintenance, administrative and social expenditure for residential care. 10% of the residential care expenditure can be transferred from the national budget since 2016. General taxation funds this expenditure. Subsidies are provided directly to providers; for home care, subsidies cover a maximum amount per beneficiary set by county and local authorities, usually about 10% to 20% of average costs.
- The Ministry of Health funds up to about 20% of the remuneration of health care practitioners working in some residential homes, such as multifunctional social and health centres.
- The National Health Insurance Fund pays fees for home care services provided by nurses and other health practitioners up to 90 days following hospital discharge per year per beneficiary. The National Health Insurance Fund also pays for non-acute long-term care provided in hospital settings (26).
- County and local governments fund personal assistants, who can be social workers or family members of the beneficiary (7).
- Romania's Social Security System pays the cash benefits to which people with disabilities and older people are eligible; disability benefits are not cumulative with old-age pensions.
- Co-payments vary according to the local government and provider. In residential care, out-of-pocket payments range between 15% for public providers to 56% for private non-profit providers. For home care, private non-profit providers charge about 10% of the fee. Non-profit providers report that public subsidies and co-payments are usually not sufficient to cover operating costs, and they must resort to other sources of funding, such as donations and grants by international organizations or organizations outside Romania.

There is a payback, claw-back system for recouping expenditure from providers over a predefined threshold. This system is an effective measure to limit pharmaceutical expenditure but is under scrutiny because it has prompted pharmaceutical companies to withdraw cheaper generic drugs from the market (7).

Providers are mostly paid fees for services

Primary care physicians are paid based on a mix of age-weighted capitation and fees for services, including health promotion, disease prevention and disease management activities (7,29). Physicians working in hospitals are salaried (28). Nurses are salaried in both public and private settings (29).

Ambulatory care settings are paid fees for services, except for services rendered in hospitals, in which personnel are salaried (7,28). Hospitals are paid fees for services or flat rates for different conditions determined by diagnosis-related group system (29).

Out-of-pocket and informal payments pose barriers to care and foster inequality

Out-of-pocket expenditure includes co-payments, direct payments for services not covered by the public health insurance and informal payments to providers (29). Out-of-pocket expenditure accounts for 21.3% of overall health expenditure, higher than the EU average of 15%. Co-payments are required for hospital care (€2.50 per discharge), rehabilitation services and pharmaceuticals, the latter accounting for more than 70% of out-of-pocket expenditure (29). Co-payments are not required for emergency care, primary care or medical laboratory services. People younger than 18 years, people 18–26 years old without income, low-income pensioners, pregnant women and war veterans are exempted from co-payments (7).

The Association for the Implementation of Democracy conducted a nationwide study and found that 37% of hospitalized beneficiaries had offered informal payments to hospital personnel. Of these, 10% had been actually requested by hospital personnel (26). Informal payments have become an additional financial barrier to care and do not promote the effective and ethical use of services (7). The recently enacted Good Governance in the Health System project aims to collect notifications from beneficiaries and families of informal payment requests. The uptake and effectiveness of this initiative have not been monitored (7).

There is an acute shortage of long-term care workers

The Ministry of Health regulates the number of practitioners allowed to provide services in the system, both via quotas for workplaces in the publicly owned facilities and by ensuring the geographical distribution of providers. Medical universities decide class sizes based on teaching capacity and not on system needs (26).

There are 277 physicians per 100 000 population versus 344 in the EU and 62 general practitioners per 100 000 population, also lower than the EU average of 78 (Table 12) (7). Romania has 641 nurses per 100 000 population versus 833 in the EU (Table 12) (7). A survey of residential care providers found that while the official minimum standard for the ratio of nursing personnel to residents in care homes is 2:1, the average ratio in practice is 15:1 for registered nurses and 8:1 for nursing assistants (43).

Shortages of human resources for long-term care remain widespread. There are reported shortages of general practitioners and other health care practitioners in several communities and nursing personnel in care homes (43). These shortages are caused by significant migration of mostly young, working age health and

social practitioners to other EU countries. For example, nearly 46 000 health practitioners received secondary training from health schools between 2004 and 2008 (Romania joined the EU in 2007) but less than one quarter were then recruited into the health system (25). The migration of health care and social services practitioners is explained by lower salaries (43), limited career prospects and perceived poor working conditions in Romania.

Health care practitioners earn lower wages when employed in the long-term care system. High personnel turnover, including personnel with low qualifications, has been reported, and positions have remained vacated for significant periods of time. Low subsidies strongly constrain increases in wages.

The Ministry of Labour and Social Justice has put in place a plan that aims to increase the salaries of social workers to €1000 per month by 2022. Similarly, the Ministry of Health has pledged to increase the salaries of physicians and to facilitate the return of Romanian physicians practising abroad (29). Steps have also been taken to improve the training of practitioners working in the long-term care system, with nongovernmental organizations playing an important role in providing specific training and expertise, especially in social assistance.

Continuing education is required for physicians and nurses to remain accredited. The professional associations set up the education requirements for periodic accreditation (26). Physicians interested in obtaining a higher professional title need to acquire competencies in medical or non-medical skills, the use of medical devices or new technologies or the ability to perform interventions.

Key points

Romania has a workforce shortage, mostly because qualified workers migrate to other EU countries. The government is committed to improving salaries and working conditions to motivate these workers to return. Staff shortages in the private sector have worsened during the past few years; salaries and working conditions have not improved at the same pace as in the public sector.

Box 3. Stakeholder's perspective: a general practitioner

The key informant owns her practice in Cluj-Napoca and also works in a nursing home and in a palliative care department. One third of her patients as a general practitioner are 65 years or older.

The transition of services for older people is insufficiently structured and tracked; families are mostly responsible. For instance, admission to palliative care or to psychiatry departments may be forced by families who cannot afford a nursing home or who cannot care for the beneficiary at home.

Integration with other types of health practitioners and social services is poor and almost exclusively managed through

personal connections. Follow-up with hospital physicians is based on medical letters that beneficiaries present after discharge. In general, no contact details are provided, which hampers communication.

Each general practitioner is responsible for professional development. Patient schools are rarely available, mainly provided by pharmaceutical companies, which general practitioners can attend with their patients. Burnout is not addressed formally and is thus managed at the individual level. The key informant's strategy is to treat younger patients, for which treatment leads to healing.

There is no specific guidance for fostering the responsible use of medicines

Mandatory electronic prescriptions were introduced in 2012 and have been credited with reducing reimbursement errors and fostering responsible, traceable prescription among health care providers (7). Regarding eligibility for reimbursement, the list of covered drugs was not updated between 2008 and 2015 (29). A basic health technology assessment programme was then set up in 2015 to facilitate this process; medications without proof of benefits have been disinvested, resulting in budgetary savings (7). There is a commitment for extending this health technology assessment programme to medical devices and other technologies (29). There is no clinical practice guidelines or specific guidance for prescribing (29).

Uptake of new technologies across sectors is limited and fragmented

The National Centre for Statistics and Informatics in Public Health at the National Institute of Public Health manages the oldest and largest health information system in Romania. This system collects data on morbidity and health services and utilization (such as length of hospital stay and bed occupancy). Data are aggregated at the district level, but access to disaggregated or individual data for various providers is not possible (26).

The National Health Insurance House has long operated electronic reporting systems for reimbursement of services. In 2008, with the launch of the Integrated Unique Health Informatics System of Romania (Sistemul Informatic Unic Integrat pentru Sănătate din România), previous electronic reporting systems have been harmonized and consolidated into a single system. All care providers who contract health and care services with the National Health Insurance House, such as primary care practices, hospitals, ambulance services, rehabilitation and ambulatory care providers, home care providers and pharmaceutical and medical devices providers must use this system for reporting. This database also coordinates the implementation of the electronic national health insurance cards.

Besides these resources, several smaller databases are connected with various clinical activities and gather data on the provision of services and patient-level clinical data. The available databases are largely independent from each other. Data collection is duplicated, and data are highly fragmented across databases (26). The collected data are not comprehensive and since different software, definitions and standards are used, interoperability among databases is unfeasible (26).

Other initiatives to improve the delivery of long-term care services

The National Health Strategy 2014–2020 has a specific component to enhance the coverage and provision of long-term care services. Besides revisiting long-term care legislation, there are plans to increase continuing education programmes for health care practitioners to better meet the needs of older people, to develop standards of operation, practice guidelines and patient pathways and to develop mechanisms to foster the integration of rehabilitative care for older people (7).

Highlights

The current approach to governance in the health and social services sectors is not conducive to integration. Funding of long-term care is heavily fragmented between sources of funding, types of services, type of providers, geographical location and duration along the continuum of care. Proper staffing remains a major challenge; a multi-pronged approach will be required to enhance working conditions and increase the retention of health workers.

Policy pointers

The following conclusions are pointers to address needs, coordinate providers and align system components towards integrated delivery of health and social services.

Improving the understanding of the health needs of older people, their families and unpaid caregivers

The starting-point for realigning the provision of services towards integration is obtaining comprehensive understanding of the health needs of older people, their families and their unpaid caregivers. Romania already has the infrastructure needed to advance the collection and analysis of patient-reported outcomes and data on the needs and satisfaction of beneficiaries and unpaid caregivers. The National Institute of Statistics website presents a wealth of demographic and epidemiological data (43), and its reach could be expanded to collect additional information. The people who need long-term care services, those receiving care in different settings and the number of unpaid caregivers providing care need to be accurately counted. Additional data collection efforts could focus on beneficiaries' satisfaction with long-term care services, settings and practitioners; user experience navigating the long-term care system to obtain coverage; uncovered needs such as medical devices, diagnostic care and rehabilitative services; and the unmet needs of unpaid caregivers.

The current policy initiatives, including the National Strategy for Promoting the Active Ageing and the Protection of Older People 2015–2020, the National Health Strategy 2014–2020, the Strategic Action Plan 2015–2020 and the Strategy for Social Inclusion of People with Disabilities 2014–2020, could be aligned to prioritise activities to prevent, slow or reverse declines in intrinsic capacity, and if these declines are unavoidable, to help older individuals to compensate in ways that maximize their functional ability by reducing geographical disparities and improving the efficiency of allocating resources. These policies could also intensify efforts to combat the stigma associated with ageing and give priority to disease prevention programmes to reduce the burden of morbidity and declines in functional ability.

The recently developed Rights of Older People Index can serve as backdrop to guide the development of policy and legislation that ensure the fulfilment of human rights when applied to older people with care and support needs (49). This Index has 35 indicators related to access and affordability of care, legal protection of older people's rights, social inclusion and standards of health. Implementing this Index will ensure that the newly designed policies are in accordance with the latest available evidence and consensus on the measures needed to uphold the rights of older people (49).

Addressing inequalities in care among population groups and geographical areas

There are gender inequalities in health status and access to services that place women at a disadvantage compared to men. Women report lower life expectancy in good self-perceived health, higher rates of self-reported pain and other sensory and functional limitations. They are also more affected by poverty and by a higher burden for taking care of older people as unpaid caregivers. Men on the other hand report higher engagement in lifestyle-related risk factors, such as smoking and alcohol consumption.

The long-term care framework does not yet acknowledge a need to address these differences; instead focus is placed on addressing issues of underfinancing and staff shortages. It is important to further efforts to collect data on health outcomes disaggregated by sex, but also information on long-term access, utilization and satisfaction of quality care among women and men. Additionally, the needs of women should be considered from a system perspective when designing and implementing long-term care policy.

The health needs of older Roma people need to be investigated and addressed. Obstacles to care that can be undertaken include improving the provision of identity documents to facilitate access to entitlements, addressing low expectations of and satisfaction with health services because of discrimination as reported in qualitative studies and improving knowledge of the health services system (31). Strengthening the Roma mediation programme would be important, with measures such as expanding the training of health mediators, improving salaries and working conditions and ensuring the continuity and retention of mediators (31).

Disparities in provider capacity across regions persist, and national averages of various indicators mask inequalities between urban and rural areas. The current efforts to attract health care practitioners who have emigrated need to include incentives for relocating in rural, less populated areas. The coverage and capacity of long-term care facilities in these areas should be given priority as well as providing primary care services, out-of-hours coverage and remote assistance via call centres for urgent and non-urgent needs and counselling.

Enacting needs assessments and entitlements for unpaid caregivers

Ensuring the well-being of unpaid caregivers and of the quality of care they provide can contain costs and prevent burnout among unpaid caregivers and the consequent need for more extensive formal care for beneficiaries (36). It will also increase user satisfaction associated with both care and with being cared for at home.

It is key to integrate family members and unpaid caregivers into the care continuum and improve their skills and status through training, counselling and respite services. First, needs assessment for caregivers should be integrated as part of treatment plans for beneficiaries. These needs could be assessed by using information and communication technology already accessible across settings and providers. Needs assessment can then inform the development of comprehensive training aimed to improve the quality of care and prevent abuse and neglect of older people. The existing network of nongovernmental and civil society organizations that are already involved in providing long-term care can be responsible for developing

and administering this training. Current cash benefits could also be increased in amount and entitlements to include pension credits and health insurance coverage, while support services such as counselling and respite care can be expanded.

Fostering the deinstitutionalization of care

Shifting care from hospitals to less-expensive settings can reduce the average length of hospitalization and increase system efficiency by fostering care in less expensive settings, such as ambulatory and primary care. There is a need to continue efforts to invest more funding in strengthening outpatient and primary health care services provision, including out-of-hours care and call centres operating around the clock, both of which could prevent avoidable hospitalizations. In addition, day surgery can be encouraged, including cataract surgery, tonsillectomy, inguinal hernia repair and laparoscopic cholecystectomy. Special attention should be given to avoiding potential geographical differences when designing these measures.

The country should consider investing in programmes that foster health literacy among older people. The existing infrastructure of non-profit organizations can be further involved in providing education on healthy lifestyles. There can also be programmes on self-management, which can rely on the participation of patient associations and other health organizations. Overall, beneficiaries should also be better informed about the available services, facilities and health providers and the pathways for receiving entitlements.

Efforts to increase workforce in these settings, i.e. salary improvements and expanding capacity in ambulatory and intermediate care settings, should also be prioritised. Funding schemes focused on reimbursing hospitals based on predetermined estimates for different conditions and fees for services can dissuade bed blocking and using acute care beds for long-term care.

Establishing clearly defined pathways and promoting integration of care

The transition between hospital and other service providers, such as primary care and nursing homes, needs to be better coordinated. This requires implementing hospital discharge protocols that are planned in advance and further enacting

Box 4. Stakeholders' perspective: conclusions from a 2018 round-table on the organizational, financial, workforce and judicial conditions for a sustainable system for long-term care services in Romania

Short-term proposals (six months to one year)

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|---|--|
| <ul style="list-style-type: none"> - Eliminate the need for contracting a family doctor by home care teams. - Regulate the distinction between acute post-hospital home care (as currently foreseen in the framework contract) and home care for dependent older people (long-term care) as regulated at the EU and WHO levels. - Elaborate county plans and programmes for developing and diversifying long-term care services based on proactively identified needs at | <ul style="list-style-type: none"> the local level, monitoring and reporting their implementation of local public social assistance services. - Defining county plans and programmes for integrated (social and health) services for long-term care to be funded through local budgets, according to the number of beneficiaries identified at the local level. - Carry out a cost analysis per case according to the dependency levels of the elderly. |
|---|--|

Medium- and long-term proposals (two to seven years)

The current plans to revamp long-term care legislation under the National Strategy for Promoting Active Ageing and the Protection of Older People 2015–2020, the National Health Strategy 2014–2020 and the Strategic Action Plan 2015–2020 could consider:

- Adopt integrated health and social services provision in long-term care in accordance with European and international norms.
- Organize integrated long-term care services under one institution by establishing an interinstitutional body as a legal entity to regulate, accredit, supervise and monitor long-term care services, defined according to European and international norms.
- Carry out cost-benefit research to highlight the costs to society in relation to the opportunity to implement firm measures for providing long-term care services.
- Ensure funding according to the identified beneficiaries based on standardized instruments and the increasing institutional capacity of service providers for providing integrated long-term care services.
- Create a distinct budget line for the integrated funding of long-term care services, including gradually creating 9000 stable jobs in long-term care with appealing working conditions.

pay-for-performance and pay-for-coordination schemes for hospitals. The role of primary care should be strengthened not only as gatekeepers but also as the focal point for information exchange among providers. Primary care can also serve as a space to support self-management and to implement measures to foster the engagement of beneficiaries. Current mandates of local authorities to establish multidisciplinary teams of general practitioners, nurses and social workers and health mediators for Roma populations can be expanded and strengthened (50). The importance of improving data collection and exchange via information and communication technology among providers and of making information available on entitlements and provider performance cannot be overstated.

Measures that are feasible with the currently available resources and that would adhere to recommendations from ICOPE (51,52) and from a recent review of reviews on integrated care approaches for older people (53) include (1) establishing a comprehensive assessment and care plan shared with all providers; (2) defining care pathways and discharge management, referral and transition procedures shared between health and social services; (3) strengthening the role of case management rooted in the primary care setting; and (4) promoting multidisciplinary work. In addition, the ICOPE recommendations include a scorecard that enables assessing the level of implementation of integrated care for older people across services and systems. This scorecard can serve as a blueprint and guidance in designing care pathways and to strengthen governance (51).

Reducing fragmentation in entitlements, governance and funding

The fragmentation of health and social services needs to be addressed from a multi-pronged perspective. As long-term care policy is developed, governance could be fostered by joint administration of health and social services under a single ministry at the country level. It is also important to allow enough flexibility in the form of decentralization of competencies at the regional and municipal levels while remaining vigilant about the potential of regional inequalities. Along this line, it would be important to promote multisectoral plans, cross-sectoral collaboration and joint resource planning between providers of health and social services at the local level.

Beneficiaries, their representatives and the workforce should be a part of the long-term care decision process, including designing policies for long-term care, planning of services, needs assessment and care pathways. Establishing associations of these stakeholders could be a good starting-point.

Addressing the financial stability of long-term care services provision

Increasing funds for long-term care and coordinating the funding of long-term health and social services currently functioning at the national level (different departments and ministries) and the local level (counties and municipalities) are fitting starting points to address the financial stability of long-term care provision. Decentralizing the delivery of social services has resulted in unstable and vulnerable funding of these services (54). County councils and especially municipalities are not able to fund all services for which they are responsible, transferring the financial burden to beneficiaries. If international agencies or grants fund programmes, the provision of services is often discontinued permanently when funding ceases.

Long-term care funding needs to be expanded and optimized to increase coverage of residential and non-residential services, to improve staffing and workforce conditions and to increase the quality of the services provided.

Implementing electronic medical records and fostering interoperability among databases

The country has implemented electronic prescription for medications covered by the public system, but electronic medical records have not yet been rolled out. Once developed, the interoperability of electronic medical records across facilities and with the electronic national health insurance card system should be given priority. In addition, current data collection efforts can be consolidated to avoid the duplication of data collection and fragmentation across databases. The use given to this information can be expanded from the current quality assurance measures. This information should also be easily accessible to beneficiaries and their families to facilitate informed choice and selection of providers.

Reducing out-of-pocket expenditure and further addressing the issue of informal payments

Even minor out-of-pocket expenditure can create financial hardship for families and represent a barrier to care. This in turn may exacerbate inequalities, affecting disproportionately low-income households, older people and people with chronic conditions (39). Overall out-of-pocket expenditure is higher than the EU as a whole, a problem aggravated by the high prevalence of informal payments. Efforts to reduce out-of-pocket payments can therefore be aimed at increasing the share of the population covered by the national health insurance system, the range of services covered and the proportion of costs covered. Implementation of the Good Governance in the Health System project needs to be given priority, with an emphasis on encouraging beneficiaries to report informal payment requests and on using the data collected to inform measures for discouraging health care providers from requesting informal payments.

Promoting responsible use of medicines and medicine expenditure

Measures to reduce expenditure on medication as a percentage of total health expenditure, which is much higher than the EU average, may include strengthening the information and communication technology in place, specifically the electronic prescribing programme but also electronic medical records. The development or adaptation of clinical practice guidelines with recommendations on prescribing can aid physicians in choosing medications in accordance with the latest available evidence on effectiveness and cost. Strengthening the emerging health technology assessment programme could inform the development and adaptation of clinical practice guidelines and further ensure value for money when deciding which medication can be covered. Hospital medication waste can be reduced if manufacturers provide medication in a variety of packs and sizes to better tailor dosage without having to waste leftovers and basing reimbursement on dosage, i.e. not funding leftover medications (39).

Improving medication adherence is a key aspect that can both control expenditure and improve patient outcomes. Among people with diabetes, hypertension and hyperlipidaemia who fill their first prescription, only an estimated 50–70% take their medication regularly (39). Adherence can be improved via patient education programmes and avoiding inappropriate repeat prescription or dispensing.

Equipping long-term care with adequate human resources and information systems

Addressing workforce shortages through measures to reduce workforce migration, enticing health workers who have left the country to return and improving working conditions and remuneration are importance measures to improve long-term care workforce. The Ministry of Health and Ministry of Labour, Family and Social Justice are already implementing measures to work on this direction. In addition, workforce competencies in long-term care can be improved by adding training curricula to include gerontology, geriatrics, healthy ageing, multimorbidity, polypharmacy, frailty and health conditions associated with ageing. Multidisciplinary teams can be encouraged, including coordinated efforts by nurses, social workers, psychologists, occupational therapists and physiotherapists.

Developing new quality assurance activities

Measures to improve quality management and assurance in the long term may include actions that can be applied at four levels: the system level, the organizational level, the health professional level and the user level (55). At the system level, strengthening the legal framework to regulate the provision of health and social services is important, including regularly inspecting facilities and implementing standards and guidelines for practice. At the organizational level, measuring performance indicators tied to outcomes that can be monitored and compared across sectors and providers can be emphasized. At the health professional level, new roles can be created to address the specific requirements of long-term care provision, such as case and discharge managers and redefining the role of nursing personnel in primary care. At the user level, as previously mentioned, efforts are needed to collect data on the satisfaction of beneficiaries and unpaid caregivers.

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