

Impact study no. 10

**Romanian social insurance and the integration to
European Union**

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Acronyms used in the text

ANPC - National Agency for Child Protection

ANSV - National Sanitary Veterinary Agency

CEEC – Central and Eastern Europe Countries

CHIH – County Health Insurance House

DEILH - Department of European Integration and Legislative Harmonization

DRG – Diagnosis Related Groups

ECJ – European Court of Justice

EO – Government Emergency Ordinance

ESC – Economic and Social Council

EU – European Union

GD – Government Decision

GDP – Gross Domestic Product

GoR – Government of Romania

GP – general practitioners

IMF – International Monetary Fund

INN - international non-proprietary name

IRICPD - International Relations and International Cooperation Programs Direction

L. – Law

LASS – Law of Social Health Insurance

MAAF – Ministry of Agriculture, Alimentation and Forrest

MEI – Ministry of European Integration

MER – Ministry of Education and Research

MFA – Ministry of Foreign Affairs
MHF – Ministry of Health and Family
MI – Ministry of Interior
MIR – Ministry of Industry and Resources
MJ – Ministry of Justice
MLSS – Ministry of Labor and Social Solidarity
MPF – Ministry of Public Finance
MPWTH – Ministry of Public Works, Transport and Housing
MSMEC – Ministry for Small and Medium Size Enterprises and Cooperation
MTB – Mid-term Budget
NAE – National Employment Agency
NFC – National Frame Contract
NGO – Non-governmental organization
NHH – National Health Insurance House
NHPSIR – National House of Pensions for Social Insurance Rights -
NIS – National Institute for Statistics and Economic Studies
OG – Government Ordinance
OPC – Consumer Protection Bureau
PAYG – Pay-As-You-Go
PHARE – Poland and Hungary: Assistance with the Restructuring of their Economies
PNAR – Romanians National Programs for Accession to EU
PR – Public Relations
SEI – Service for European Integration
SME – Small and Medium Enterprises
SPC - Supplementary Protection Certificate
SSPH - State Secretariat for the Persons with Disabilities
TA – Technical Assistance
UNDP – Union Nations Development Programme
WB – World Bank
WHO – World Health Organisation

EXECUTIVE SUMMARY

Romania officially opened the Accession negotiations in February 2000. New challenges have to be surmounted, as Romania has to assume entirely the membership requirements. This relates above all to the adoption of the whole body of European law, known as the “acquis communautaire” and the administrative and institutional capacity to implement those legal provisions.

Social acquis, i.e. legally-binding norms in the social policy area, is closely intertwined with the free movement of workers and aims at insuring an adequate social protection, improving the living and working condition, promoting high level of employment, and developing human resources and social dialogue¹. In addition, a series of Council’s resolutions and recommendations, Commission’s communications, Green and White Paper are integrated into the acquis.

Romania is committed to adopt the acquis communautaire related to the free movement of workers and on social policy and employment without any transition period or derogation. Romania has unilaterally assumed the date of January 1, 2007 as a working hypothesis for concluding the preparation for accession to the European Union.

The Position Paper of the Romanian Government on “Social Policy and Employment” (Chapter 13) has been officially submitted to the European Commission in June 2001, and the negotiations lasted till April 2002 when the chapter was provisionally closed. Negotiations related to the second chapter of the acquis recently opened, under the Spanish Presidency of the European Union.

The policy report known as Study 10 will include an integrated overview and analysis of the Romanian Government strategy related to the social insurance reform according to the EU requirements. This policy report will hopefully represent an useful document for the Romanian decision makers, EU official, general public. The report will be focused on the specific EU requirements related to the Chapter 13 and Chapter 2 where social insurance component is included.

The present report is structured into three sections. The first section traces back the development of social dimension, particularly the development of the “soft acquis” within the European integration process in general. It then pinpoints the major steps in Central and Eastern Europe Countries (CEEC) accession process towards the European Union (EU), highlighting the social dimension of the process. Whereas in 1993, at Copenhagen European Council the predominant issues were democracy-related and economical in nature, a consensus is emerging at European level concerning the stringent necessity to ensure the social and economical cohesion with the accession countries. Finally, the section focus on the actual state of play for Romania in the social related field as presented by the Regular Report of European Commission.

The other two sections deal with pensions system (section 2), respectively the health care system (section 3). Each section outlines the legal acquis in the relevant social

¹ Article 136 (ex article 117) of Treaty of Rome, consolidated version

protection field and provide a detailed and updated overview of the reform process in these policy areas.

Our research on pension reform was not limited to the legislative side only; it took into consideration the relevant institutional framework in view to facilitate the successful implementation of the legal acquis. The required institutions are already set but, and they are in great need to strengthen/improve their capacities.

An overview of pension reform is presented, both the parametrical measures endorsed in the early 1990s and the major breakthrough that came with the adoption of Law 19/2000 on public pension system. An assessment of the latter measures after one year of implementation is carried out.

Also an administrative and institutional analysis concludes our study on the Romanian public pension system. The Romanian institutions responsible with the public pension administration – Ministry of Labor and Social Solidarity and the National House for Pensions and Other Social Insurance Rights – are faced with an enormous task in the context of accession. This section analysis briefly the challenges faced by these institutions to improve their administrative capacity.

Finally, the report brings into attention issues related to the supplementary pension since they too impact on the overall sustainability of public pension system.

The health section is organized on four chapters. The health background section briefly presents the history of health reform in Romania, and discusses the trends, both in terms of health status and of healthcare system performance. This section identifies as the main challenge facing the health system the introduction of hard budget constraints in hospitals. The governance failings of the Romanian health system, namely the delimitation of competencies between the Ministry of Health and Family and the National Health Insurance House, are also dealt with.

The section dealing with the presentation of the *acquis communautaire* identifies as the hard *acquis* the regulations 1408 / 71, and 574 / 72, on the compatibility of social insurance systems (in order to facilitate the free movement of people). However, the new perspectives brought by internal market based European Court of Justice (ECJ) rulings on access to health services are also analyzed.

The section dealing with the *acquis* implementation is the fundamental component of the study. It presents an institutional analysis of the two main state actors in the governance of the health system: Ministry of Health and Family (MHF), and The National Health Insurance House (NHIH), focusing on their respective bodies dealing with European integration. The section discusses the administrative capacity of implementing regulations 1408 / 71, and 574 / 72. However, a number of other *acquis* issues are raised, mainly dealing with the equality of treatment between domestic and international producers in respect to market access and public procurement.

The final section summarizes the arguments, and identifies the major issues, structured around four counts: the compatibility of the Romanian health system with the European model; the implementation of the relevant *acquis*; administrative capacity; and sustainability of the health system.

Unemployment benefits, though non-contributory benefits, are not subject of this report. Major changes are undertaken in this field: a new law on unemployment came into force in March 2002 and it is too soon to assess its impact and the new draft of Labour Code is will amend further the legal provisions in the field of unemployment.

Moreover, the acquis in this field is a complex one and the time constraint played a major role in our decision not to address the unemployment issue in this report.

It is our belief that a separate study dealing specifically with unemployment issues will give a more comprehensive and complete account of the social security reform in Romania.

Methodology:

To prepare the policy report an investigation was conducted in six Romanian public institutions with direct relevance for the research topic the compatibility between the Romanian social insurance system and EU norms. Our initial legislative analysis identified the following line ministries and agencies with specific attribution in the field of social protection: Ministry of Labour and Social Solidarity, Ministry of Health and Family, National House for Pension and Other Social Insurance Rights, National Health Insurance House, Ministry of Public Finance and Economic and Social Council.

To assess their activities related to the European Integration and the policy reform in depth interviews were conducted, both with high-ranking public functionaries within the above institutions and with Romanian experts working closely with international organizations in Romania such as World Bank. MPs that have participated in different phases of the reform were also interviewed. The core of the interviews was designed around social security system co-ordination and modernization issues.

Two “Interest group” meetings were held during the relevant period² in order to provide the necessary feedback. High-level public functionaries and elected officials were part of these groups. Their comments, observations were also taken into account in our final report.

Relevant official documents (strategies, programming documents) published by the Romanian Government present us with a road map of reform. European Commission documents (green paper, communication, reports) posted on the European Union website gave us an insight of recent developments in the field of pensions and health care and of future reforms envisaged.

Several sources were used for statistical data. General statistics were obtained from Statistical Yearbook published annually by the National Institute for Statistics. Ministries and agencies involved - Ministry of Labour and Social Solidarity and the Ministry of Health and Family, National House for Pension and Other Social Insurance Rights and National House for Health Insurance - made specific and detailed data available. International sources, such as the United Nations Development Programme, International Labour Organization, World Bank, and International Monetary Fund provided additional data for comparison.

Legislative analysis was also an important part of our methodology. Analysis of legally binding norms (European Union and Romania) was our primary focus. Secondly, we extended the analysis to what is known as the “soft acquis” since it is the accepted method in dealing with social policy at European level. Thirdly, we took into consideration several Romanian draft laws to put the entire reform process into perspective.

² October 2001 – May 2002

In addition to the comparative analysis between Romanian and EU legislation we have used judiciary practice examples in order to clarify elements related to the export of benefits between EU member states.

To facilitate the debate on different social insurance reform options we have designed a set of criteria aiming to indicate the core elements for an EU conform reform proposal. Those criteria are what we believe the basic criteria for assessing how the reform in social insurance field should be. Adhering to those criteria would help Romania to converge more in terms of social insurance system, and in general on social protection system, to the “European social protection space”. If comprehensive social insurance reform options are evaluated as indicated by the selected criteria we can have a good foundation for devising agreeable solutions, perhaps not in every detail, but as an overall reform package that will meet the most important of our objectives, the EU integration.

The criteria that we have used and we propose to policymakers to take into consideration when assessing different reform proposals are:

- Financial sustainability and how the reform proposal would affect economy and the social insurance budget.
- Conformity with EU norms and practices (*acquis communautaire*) in view of the co-ordination within the European social space.
- Feasibility of implementation and administration.

Chapter 1 - EU Social Dimension and Enlargement

1.1 Social Aspects of Enlargement

The enlargement is a process without precedent in terms of scope and diversity³. Did the number of candidate countries grew to the large number of 13, but the scope of the enlargement is no longer focused on democratic⁴ and economical issues, it encompasses also social dimension.

The present enlargement is a dynamic process. The European Union (EU) itself is reforming, developing new dimension of European integration, namely in the social field, especially in matters of employment and social protection systems where a supranational and intergovernmental approach has been launched. Issues related to employment and social protection system were exclusively dealt with at national level and the principle of subsidiarity applied heavily. Only limited and well-established issues (such as equal pay for equal work) were handled at Community level by means of regulations and directives. By acting collectively in these fields, the Member States have agreed to the common objectives to be attained by all, to the principle of action set out in different European acts. Thus, traditionally approach of social issues through legally binding norms is coupled with a “negotiated process”⁵.

Meanwhile, the candidate countries are facing new challenges as they too reform their system and are in search for a new model. The influence of international organization such as World Bank and the models they advocate – especially in pension and health care system reforms - cannot be overlooked. All these internal reforms cross at some point the integration process and they have to meet the requirements of membership, mainly catching-up with the Member States developments.

Membership requirements refer above all to the adoption of the whole body of European law, known as the “acquis communautaire” (hence *acquis*) and to the capacity to assume membership obligations⁶. The *acquis* may be limited if one deals only with the legally binding Community acts (“hard *acquis*”), but may be extended to principles, guiding rules, common objectives that encompasses the “soft” *acquis*. Both facets of the *acquis* are now compulsory for the candidate counties.

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Traditionally, all the social legislation developed since 1957 is intertwined with the free movement of workers. Secondary legislation⁷ developed around the equal pay and equal opportunities, health and safety at work, coordination of social security schemes and extended to social dialogue and labour law in the '80.

³ “Statistical Yearbook on Central European Countries” (1999), Eurostat, Statistical Office of European Commission, pp 6

⁴ On the previous enlargement one prerequisite for opening negotiations was the existence of functionally democratic institutions and the respect of human rights;

⁵ Commissioner Diamantopoulou speech; CES Executive Committee, Brussels, 3 December 1999;

⁶ other accession criteria set up by the Copenhagen European Council in 1993 are presented in details below;

⁷ secondary legislation in the EU law refers mainly to the Regulations and Directives;

Regulation 1408/71 and Regulation 574/72 regulates the coordination of social security systems. It ensure that the workers/self-employed moving within the Community enjoy the some social rights as the citizens of the Member State they reside in. Apart from detailed coordination rules which are not the subject of this study, the Regulation lay dawn four principle that govern the systems' coordination:

- only one legislation is applicable. It ensures that active persons moving within the Community are insured only once and their contributions paid under the laws of one Member State are recognized throughout the Community;
- equality of treatment implies that the migrant workers and their families enjoy the some rights and obligation as the residents of the Member State;
- retaining the rights to benefits by transferring the amount of contribution to other Member States;
- aggregation of all periods a persons has contributed to social security regardless the national laws applicable. Entitlement for social security benefits may be conditioned by a minimum stage, and the periods one person contributed to different national systems are taken into account.

Box 1: Hard Acquis

Legal acquis (in the field of coordination of social security system) consist of:

- I. European Economic Community Treaty provisions:
 - article 39 to 48 (ex article 48-58) on free movement of persons and the right of establishment
 - article 136 to 148 9 (ex article 117-125) dealing with social policy related issues and the European Social Fund
- II. Secondary legislation
 - Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within Community
 - Regulation (EEC) 574/72 of the Council of 21 March 1972 fixing the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons and their families moving within Community
 - European Court of Justice (ECJ) rulings⁸

This legally binding part of the *acquis communautaire*, covering a wide range of area⁹ constitutes the traditionally approach of European integration through directives and regulations and it dominated the European integration till 1989 when a major breakthrough is registered: the adoption of the Charter of Fundamental Social Rights. With the Charter the role of Commission as an actor in the social field has been established¹⁰.

Faced with the Member States reluctance to deepen the social integration, the EU developed an alternative approach axed on active social partners' participation and

⁸ some important case law are provided in Annex 12

⁹ area covered are: labour law and industrial relations; equal opportunities for women and men; heath and safety in the workplace; social dialogue; coordination of social security systems; European Social Fund activities;

¹⁰ Caroline de la Porte, "Is there an emerging consensus on social protection? (1999), pp 8 (article published in European Trade Union's Yearbook, also available on Internet: www.ose.be/fr/default.htm)

new policy framework on the European level. Common objectives negotiated at European level, specific timeframe, they are all part of the new approach¹¹.

Box 2: Soft Acquis

Soft acquis comprises:

- Community Charter of Fundamental Social Rights;
- Council's Recommendations (92/441 and 92/442) on the convergence of objectives and policies in the social field and on common criteria to be set up in order to insure sufficient resources and social assistance;
- Green Paper on European Social Policy (1993);
- White paper on European Social Policy (1994);
- Commission Communication "The Future of Social Protection: a Framework for a European Debate" (1995);
- Commission Communication "Modernizing and Improving Social Protection in the EU" (1997) developed the mainstream approach, an horizontal integration of the social protection policy into all Community policies, especially the Employment Strategy;
- The Employment Title in the Amsterdam Treaty states the coordination method as the guiding principle for the Member States actions through annually Employment Guidelines and National Action Plan for Employment;
- European Social Agenda adopted at Nice European Council in December 2000
- Commission Communication "A Concerted Strategy for Modernizing Social Protection Systems" in 1999 that focuses on four prioritized areas: pensions, health care, employment and social inclusion.

Historically, the Community actions evolved around three themes: social dialogue, employment and social protection systems in different degree. Social dialogue was the first one to be activated at European level. The Maastricht and Amsterdam Treaty empowered the social partners¹² to negotiate and conclude at Community level framework agreements that are to be implemented nationally or became part and parcel of European law by Council enactment. The level of involvement is exceeded by the mandatory consultative procedure with the social partners before any Commission's proposal in the social matters. Also, an impetus is given to strengthen the social dialogue at enterprise level through European Work Councils and the provision of information to employees.

Employment-related issues found their place on the European agenda in 1994 when the first European employment strategy is adopted at Essen European Council and a 5-point¹³ action programme is established. Subsequent implementation and experience gained peaked in 1997 when a new title of Employment is included in the Amsterdam Treaty. The novelty refers to the coordinated policy approach based on yearly employment guidelines and National Action Plan for Employment. Essen

¹¹ The European Council of Lisbon will designate this method as "open method of coordination" and it encompasses an integrated aspect.

¹² The main social partners at European level are the European Trade Union Confederation (ETUC), the Union of Industrial and Employers' Confederation of Europe (UNICE) and European Center for Enterprise with Public Participation (CEEP)

¹³ the key priorities refer to the effectiveness of labour market measures, reducing non-labour cost, especially on low skills workers,

priorities are reshaped and supplemented by the four-pillar design of the strategy – employability, entrepreneurship, adaptability and equal opportunities.

Recent years have witnessed the emergence of social protection-related matters on the European agenda¹⁴. The joint actions of European Commission and Finnish presidency (late 1999) have activated the social protection strategy at European level which tackles the issues of employability, providing revenue for the retired people and health care, and finally inclusion of the disadvantages and groups.

As concerns the pensions, the Commission establishes as objectives:

- the complementarity between employment policy and retirement, especially the early retirement;
- promoting the principle of “active aging”. It implies an extension of the active life and discourage at the same time the early retirement. It targets specifically the population above 45 that has at European level low rates of participation in labour market
- the impact of this approach should not be limited to the old generation, it should take into account the younger generation too.

Different European actors – ECOFIN, Economic Policy Committee, and European Central Bank - have contributed to the debate on pension systems. However, due to their “marginal” position, the discourse focuses on the financial aspects of pension systems. Lisbon European Council (March 2000) will set up a High level Group on Social Protection as a counterpart of the economical dominant actors.

The European Union has developed a social dimension of the integration process in the past years, comprising not only the “hard” legislation, but also the “soft” one. And it is the emergence of a consensus between Member States on a broad area of social issues that is the trademark of this process.

The cornerstone of the European Union – Central and Eastern Europe Countries (CEEC relations was set at Copenhagen in 1993 when the European Council adopted what was to be known as the “Copenhagen criteria”. In addition to the adoption of *acquis communautaire*, political and economical criteria have to be fulfilled by the candidate countries, namely the proper functioning of democratic institutions and the national economies capacities to withstand the competition forces from within the Community. Due to the piecemeal feature that is common to this enlargement, new criteria were formulated along the years. For instance, the importance of strengthened administrative structures capable to effectively implement the *acquis* was highlighted on numerous occasions.

The enlargement is a dynamic process that encompasses also the recent developments in the field of European Social Policy. The dominant economical issues have made place for social facets. And a consensus is emerging at European level concerning the stringent necessity for the CEEC to adopt not merely the legally binding *acquis*, but also to integrate the so-called “soft” *acquis*. It implies, at the same point, the need for the CEEC to catch-up with the other Member States in terms of development of social

¹⁴ the emergence of social protection on public agenda was triggered by the 1999 European Commission’s Communication “A Concerted Strategy for Modernizing Social Protection” COM (99) 346

dialogue, employment and modernizing social protection systems, while internally, they are reshaping their country welfare profile.

Candidate countries did set up social dialogue structures, but based on a tripartite structure and they witness structural weakness (i.e. regional or sectoral) due to weak representation at intermediate levels, low rate of union membership, and slow progress in institution building.

Overall assessment of the candidate countries points out to the weak impetus of the social partners in the decision making process, and also emphasizes the sectoral feebleness of trade union and employers' organization. Progress has been reported on the development of mutual relation between social partners on both sides¹⁵.

The year 2001 registered the participation of all CEEC¹⁶ to the European Employment Strategy, namely the National Action Plan for Employment were drawn according to the four-pillar design. The impact of this model in the CEEC remains to be assess since it is not yet clear how compatible is the European model of employment with the labour market institutions in the applicant countries. It has been argued that the Employment Strategy has developed in a different environmental context, EU's, and does not apply well to the reality of CEEC. Despite the structural incompatibilities reported, the practical aspects cannot be denied. It is an useful exercise for the candidate countries in evaluating and prioritizing their actions in the labour field.

As regard social protection systems, the Commission envisages in the near future the implication on the applicant countries in an exercise similar to the employment peer review through "Joint Inclusion Memorandum"¹⁷.

The process of integration of CEEC in the European Union crosses the internal reforms that are under way in most candidate countries. This raises new challenges since not only the EU may shape the future policy in the social field, but also other international organizations may advocate successfully their models.

What is characteristic for the early years of reforming social protection systems in CEEC is the absence of a model to follow. At first hand, the Member States provide for a model varying from the minimalist Anglo-Saxon model to the more universalistic Swedish model¹⁸. However, given the strong conditionality of financial assistance from other international organization such as World Bank, it is the liberal model it advocates that prevails in CEEC, especially when it comes to healthcare and pension reforms. Most of the candidate countries have implemented a system base on the three-pillar strategy advocated by the World Bank.

¹⁵ for instance "The Conference of Social Partners on Enlargement", Warsaw, 1999; and other sectoral related conference which brought together social partners from both EU and the candidate countries;

¹⁶ the first country to join the European Employment Strategy was the Czech Republic; Romania signed a similar agreement in February 2001

¹⁷ a proposal submitted by Director O. Quintin in a speech at high level meeting, Brussels, 13 February 2002

¹⁸ Caroline de la Porte, "Enjeux et perspectives de la dimension sociale de l'elargissement", pp 2-3, article published in "Revue belge de Securite Sociale", vol 43, 2000

1.2 Monitoring Romania

Each November, the European Commission publishes its annually reports on progress toward accession. The reports follow the progress achieved by candidate countries on an annually basis, usually from September to September next year and takes into account not only the legislative side (transposition of the *acquis*), but also the administrative capacity to implement and enforce the legislation. It monitors the legislative initiatives that are enacted in the reference period and assess their compatibility with the European Union's laws.

It should be recalled that, except for the first wave candidate countries¹⁹, the first reports were based on the "White Paper" (1995)²⁰ that committed the applicant countries to the approximation of laws, while the last two ones took into account the whole body of European law in force that has to be transpose into internal legislation.

The 1995 White Paper established the priority legislative measure to be addressed by applicant countries to fully participate to internal market. The legal *acquis* in the filed of social policy centre on

- labour law and working conditions, with a special emphasis on social dialogue;
- equal opportunities for women and men;
- health and safety at work;
- social security coordination, and
- tobacco products.

The first four key areas part and parcel of the legal *acquis* that has to be transpose into the national law (as part of Romanian commitment), and add to other areas of social and employment policy:

- fight against discrimination;
- employment;
- social security, aged people, exclusion;
- disabled people.

The table below synthesizes the main achievements and critics as lay down by the European Commission Report:

¹⁹ Hungary, Poland, Czech Republic, Estonia, Slovenia and Malta

²⁰ "White Paper" – preparation of the associated countries of Central and Eastern Europe for integration into internal market of the European Union"

Table 1: Romania progress toward accession as reflected in the Regular Reports of European Commission

Field	Year	
Labour law	1997	The absence of some European Directive is harshly criticized. Provisions such as the safeguarding of employees rights in case if insolvency or transfer of enterprises, in the event of collective redundancies are absent form domestic labour law.
	1998	Notes the partially transpose European norms on collective redundancies and protection of employees in case of insolvency of their employers.
	1999	There are still a lot of European Directives who have to be transposed into domestic law, especially the European Working Council Directive. Notes the coming into force of the law of Labour Inspectorate and the modifications to the severance payments regime
	2000	While some laws are amended, the adoption of a new Labour Code is pending
	2001	The postponement of adoption of a new Labour Law is cause for concern
Social dialogue	1997	Developing of social dialogue in Romania is acknowledged, but it emphasizes the institutional feebleness of social partners.
	1998	Though a new law established a new social dialogue structure in Romania, Economic and Social Council, institutional weakness remains a problem.
	1999	More emphasizes should be given to the bilateral agreements
	2000	-
	2001	Though a social pact was sign with the social partners, and a Secretary of State responsible with the relations with social partners were appointed din each ministry, the issues of bilateral agreements and workers' participation at enterprise level are still pending
Equal opportunities between man and women and fight against discrimination	1997	-
	1998	Except the enactment of law on parental leave, no progress is registered in the area in the reference period
	1999	As of this year, the report concludes that basic legislation on equal opportunities is being transposed, but Directive on access to employment, burden of proof, and health and safety of pregnant workers needs to be harmonized. Efforts to increased the administrative capacity are requested

	2000	The only development reported refers to the creation of a Consultative Inter ministerial Commission on equality of treatment between men and women. The enactment of a law on preventing all forms of discrimination is a welcome development
	2001	The adoption of a National Action Plan on Equal Opportunities is seen as a real progress, but its major setback is the absence of real implementation action
Health and safety at work	1997	The adoption of a new occupational health and safety act is considered in line with EU requirements, though legislation concerning labour inspection standards is numbered.
	1998	Though several other European Directives in the area were transposed, the administrative capacity is low, especially in the case of Labour Inspection whose creation is being postponed
	1999	Some concerns are expressed with regard to implementation of specific legislation
	2000	Though the Labour Inspectorate is finally set up, the operational capacity of this body is low
	2001	New legislative initiative are reported: criteria for defining “special conditions job”
Social security systems’ coordination	1997	The social security system faces serious financial problems due to low level of contributions collection. Main critics express refers to the low share of GDP spent on social security with repercussion on the level of benefits provided under the scheme, and also to the significant inequalities that are fostered by the current system. The administrative capacity to apply the detailed coordination rules of Regulations 1408/71 and 572/72 is question.
	1998	-
	1999	Despite measures taken to tackle difficulties in contributions collections, the recovery rates are still low.
	2000	Comments on the partially transfer of benefits and rights accumulated in Romania to the social security system of another countries due to the enactment and coming into force of the new law on pension. It also stresses the effects needed to strengthen the administrative capacity of institutions involved.
	2001	Needs to develop the necessary administrative structures and to have trained staff are highlighted. Romania is encouraged to continue the negotiation process and to conclude social security bilateral agreements with Member States.
Health system	1997	-

	1998	Lists the transitional legislative measure adopted by the Government to cope with the coming into force of new health insurance law
	1999	The impact of the new Social Health Insurance System cannot be fully assessed due to short period of time since its inception.
	2000	Both the practice of tripartite agreements and the absence of social dialogue structures in private enterprises (especially new SME's) are criticized.
	2001	-

Sources: "Opinion on Romania's Application for Membership of the EU", July 1997;
"Regular Report from the Commission on Romania's Progress toward Accession", 1998-2001

Chapter 2 – Romanian Pension System

2.1 STEPS IN REFORMING THE ROMANIAN PENSION SYSTEM. LEGAL AND INSTITUTIONAL FRAMEWORK

2.1.1 Pay-As-You-Go Framework

Public pension system in Romania is a traditionally PAYG scheme with today workers paying for present pensioners, while their own pensions will be covered by the next generation. The public scheme covered age-related benefits, and also survival and invalidity benefits.

The Law 3/1977 regulated the organization and functioning of the Romanian public pension and supplementary pension schemes and was repeatedly amended after 1990 in order to cope with the growing changes of a transition period. Also early retirement and some aspects of social assistance were regulated by Law 3/1977.

The public system was mandatory only for full time employee. Similar measures were provided for lawyers, military and police personnel, and non-orthodox clergy. Despite subsequent amendments to Law 3/1977 numerous categories – self-employed, civil contracts employees, temporary and part time employees, and unemployed persons - were left outside from the benefits' payment.

One was entitled for full pension upon fulfilment of age and years of employment related conditions. The statutory retirement age was 57 for women and 62 for men, only to be reduced in case of early retirement to 52 for women and 55 for men so that prior to 2000, the average age for retirement was 56 for men and 51 for women²¹. This was doubled by the mandatory employment period of 25 years for women and 30 years for men.

Eligible for early retirement was every person who has had at least 25 years (women) or 30 years (men) of employment. Initially, under the Law3/1977 provisions, all employers with full employment period could retire at least two years earlier, but in 1995 the Law on early retirement²² enhanced the period to 5 years. Another special provision referred to the unemployed person who benefited from an early retirement after the severance period expired. People working in arduous conditions enjoyed mostly of these provisions since for each year worked under these conditions, an additional period of 3-6 month was summed up to the total contribution period.

Occupational pension and supplementary schemes doubled the public scheme. Lawyers, farmers, military and police force, artists, writers and composers, officially recognized religious cults had such schemes. They were to be integrated in the state public scheme in the reform proceedings, starting with 1992²³.

Supplementary pension scheme was mandatory for all employees and their contribution financed entirely the Supplementary Pensions Fund. The minimum

²¹ Gerry Mangan, "Romanian Pension System and Reform", paper presented at "Learning from Partners", a Joint World Bank/IIASA Conference in collaboration with EC/Austrian Government/LBI, Vienna, April 2001

²² Law 2/1995

²³ Military personnel and lawyers are the exceptions (see below for details)

period for entitlement to a supplementary pension was 5 years, and upon retirement the contributors benefited of an increase of maximum 12% to the total amount payable.

Benefits calculation formula used the gross wage along with some permanent bonuses as the reference income for determining the amount payable to pensioners, averaged over 5 consecutive years of the last 10.

The publicly managed scheme was entirely financed from employers' contributions, and only a small percentage (2%) of employees' wage was transferred to the supplementary pension schemes. State subsidies were added as additional financial resource by the time annually deficits were registered. They were registered since with the lowest value of 0.023 of GDP registered in 1997 and the highest one in 1998, of 0.87 of GDP²⁴.

All pension contribution were saved in the State Treasury and used to pay the current obligations of the system. The only savings that generated some income were the contributions for supplementary scheme that under the law were deposited into an individual account at a state credit institution – CEC -, and payable at the time of retirement.

Ministry of Labour and Social Solidarity was responsible for the administration of the public scheme and the Supplementary Pension Fund. One structure within the Ministry – Central Office for Pensions Payments - handled the payment of benefits, while the territorial structures – judets'²⁵ pensions offices – dealt with daily routine of administration, processing workers request for pension and complains. Overall the system was highly centralized and inefficient in terms of costs and data collection.

2.1.2 Critical Points

Romania has entered the transition period with a balanced public pension system. Not only the ratio pensioners/employed persons was above 1, but also high levels of labour force participation were reported. Consequently for the first 5 years of transition the state social insurance budget registered surpluses and a high replacement rate for pension. Several factors caused the system to become unsustainable, such as such as dependency ratio dynamics, labour market conditions (such as raise in unemployment), and economic situation to impact on the pension expenditure. Table 2 synthesizes the evolution of these factors over the 90's.

Table 2

Year	Exp/GDP	60+/(15-59) Dependency ratio	POP(EMP)/(15-60) Labour force participation	AVE PEN/ AVE WAGE Replacement rate
1990	6.5	25.76	N/A	44.69
1991	6.0	26.21	N/A	45.05
1992	6.4	27.16	81.4	43.64

²⁴ authors' own calculations; data used to calculate was gathered form the execution of social insurance budget (source Romanian Yearbook, 1990-2001)

²⁵ these offices are located in all 41 judets, which are the Romanian administrative units

1993	6.5	27.51	78.1	45.20
1994	6.5	27.81	77.7	43.27
1995	6.9	28.14	71.9	40.78
1996	6.9	28.44	68.1	38.60
1997	6.4	28.85	67.0	40.33
1998	7.1	29.30	66.4	39.13
1999	7.4	29.55	N/A	35.00
2000	7.1	29.82	N/A	38.93

Sources: NIS, UNDP, and IMF

Exp/GDP – Pension Expenditure as share of GDP

N/A – not available

POP (EMP) – population employed

AVE PEN – average pension

AVE WAGE – average wage

The share of pension expenditure in the GDP in Romania is closely related to the labour force participation. Registered low levels of pensions expenditure are explained not by the decrease in the absolute number of pensioners, but rather by penury in public resources, as the contributors base continues to shrink despite high values in the labour force participation.

Dependency ratios in Romania were (and still are) lower than in other countries (such as Hungary), but it steadily increased in the 90's, reaching 30%. Increased dependency ratios didn't put additional pressure over the system, as the proportion of population over 65 is still under 15%.

Thus, demographic trends do not constitute a major reason for reform, but on the long run it will generate pressures over the public system. Data show a decline in the younger population as the natural growth rate is negative, and projections made by specialists indicate a rise of the population over 65 years. By the 2020 the share population over 65 years in working population will exceed a threshold of 20% as shown in table 3.

Table 3: Dependency Ratios Trends and Tendencies

	(0-14&60+)/(15-64)	65+/(15-64)	65+/(0-14)
1999	47%	19%	70%
2010	42%	20%	91%
2020	43%	22%	110%

Source: NIS

The worsening of the situation is due to the dramatic changes in the pensioners/contributors ratio. In a ten years period the ratio has more than halved, from 3.43 in 1990 to 1.2 in 2000, as seen in table 4. Moreover, the number of pensioners practically doubled itself, while the contribution payers halved in the same time bracket. In 1990, approximately 2,380 million pensioners were sustained by 8,156 millions full-time employed persons, while in 2000 4,246 millions pensions were financed by 4,458 millions employees' contributions²⁶. Main causes relate to the loosen conditions of early retirement and for invalidity pensions retirement.

²⁶ National Statistical Institute, Romania Yearbook, 1990-2001

Table 4 Dependency Ratio Dynamics

Contributors /pensioners	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
	3.43	2.69	2.17	2.10	1.91	1.75	1.63	1.48	1.32	1.16	1.05

Source: NIS

Low values in the replacement rate over the 90's were due to pension formula, to partially indexation of pensions, and to high inflation ratio that was part of Romanian life since 1990. The pension formula took into account only the earnings of the best 5 consecutive years out of 10. The reference value for determining the amount of pension was the average base earnings obtained from the multiplying the non-indexed wage with 60 (months/equivalence of 5 years). Hyperinflation eroded the real value of income and the most affected were the pensioners as their purchasing power decreased as shown in Table 5.

Table 5 Absolute impoverishment measured by average real pension value

Average real pension (%)	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
	100	77.5	63.7	56.5	55.3	61.2	62.8	49.7	48.5	50.4	46.9

Source: NIS

The above trends have impacted on the structure of expenditure of Social Insurance Budget and the financial situation of the state social insurance budget is presented in Table 6. As highlighted above the budget registered subsequent deficits and pension expenditure as share of GDP has fallen drastically. However the raise of revenues noted since 1998 is due mainly to improved collection capacities, and not to a raise in the absolute number of contributors. Relatively low level of total pension expenditure impacted heavily on the pensioners' purchasing power²⁷ and the Government endorsed quarterly indexation measures to offset these effects.

Table 6 Financial Situation of the Pension Fund

	Revenues (% GDP)	Deficit (% GDP)	Revenues (mil ROL 1990)	Expenditure (mil ROL 1990)
1991	7.44	+0.41	607.23	573.90
1992	7.77	+1.06	558.50	482.05
1993	6.59	+0.70	440.28	393.28
1994	5.65	+0.10	397.62	390.37
1995	5.44	-0.23	419.67	437.32
1996	5.43	-0.17	455.21	469.59
1997	5.26	-0.02	397.99	399.73
1998	6.81	-1.01	438.16	503.42
1999	7.35	-0.25	492.56	508.75

Source: NIS

²⁷ see for details table 2 above and table 5 below

2.1.3 Parametrical reform

Over years successive governments adopted parametrical measures to address these imbalances, but mostly they regard some financial arrangements. Mandatory contribution rates were raised successively, both for the employers and for employees. The original rate of contribution of 15% was gradually increased over years as a result of recurrent deficits and of contributor's base shrinkage. Also, due to the proliferation of jobs included into special working conditions classes, the rate of contribution was differentiated by work category²⁸. Thus the rate of employer's contribution raised to 25% for normal condition, 30% for group II and 35% for group I in 1992²⁹ (an average of 30%), and to 30% for normal condition, 35% for group II and 40% for group I in 1999³⁰ (an average of 35%).

In addition, the 3/1977 Law on Pensions stipulated that the employees contributed with an amount of 2%³¹ of monthly earnings to a form of mandatory pension scheme – supplementary pension. By 1999, the rate reached the threshold of 5%³².

To maintain the real value of pension in face of a high inflation, an adjustment mechanism was put in place. The Government opted for indexation to the inflation rate. In practice, full adjustment to the inflation rate never accomplished and the ratio between average social security pension and national average wage decreased to 30% in July 2000 (from a value of 60.2 in 1990). Table 5 shows in details the evolution of pensions' value, with 1990 as the reference period.

The mechanism was meant to offset the effects of pension calculation formula. Successive pensions indexation partially correlated to the inflation rate, generous benefit formulae generated significant inequality between different generations of pensioners. In the aftermath of the reform a new program of pension adjustment (so called "pension's re-correlation") was put in place.

Table 7: Re-correlation Plans 1996 - 2001

Decree	Implementation	Percent Increases
<i>State Pensions</i>		
1996	1996	19.7%
1998	1998	5.0%
1999	1999	0.1%
2000	2000	21.5%
2001	2002 – 2004	
<i>Farmers Pensions</i>		
2000	2000	47.2%
2002	2002 - 2004	

Source: World Bank, "Pension System in Review" (from national sources)

²⁸ There are three work categories under the 1977 Law on Pensions; thus group I comprises most arduous occupations such as mining; group II consists of occupations such as transport and industry and the third group (normal working conditions) which includes the majority of workers.

²⁹ Law 49/1992

³⁰ Emergency Ordinance 2/1999

³¹ since 1986 the rate was 3%

³² the rate was available from 1999 to April 2001

Finally, some expenses covered by the state social insurance budget were transferred toward other institutions: since 1995 the payment of social assistance allowances is managed by the local governments; some medical expenditure – drug reimbursement, medical devices for people with disabilities – are covered by Health Insurance Fund since 1998. Presently, the state social insurance budget covers basically pensions, sickness (loss of working capacity), disability and survivors. Main contingencies covered by the state social security budget are presented in Table 8.

Table 8 Main contingencies covered by the state social insurance budget

Contingency	Coverage
Old age pensions Invalidity pensions Survivors benefits Maternity leaves Children care allowance ³³	entirely covered by social security fund
Temporally loss of working capacity	shared-coverage between employers and social security budget

A set of measure related to the need to improve the public scheme in terms of coverage, equilibrium. The self-employed and the temporary workers contributed only on a voluntary basis to the state pension scheme since 1995 by means of contracting. In order to keep under control the growing number of pensioners by establishing higher contribution rates for I and II working group, but these remained without effect.

Simplification of the administration of pension system constitute another objective and various occupational pension schemes that existed were gradually integrated in the social security system starting from 1993 to 1998.

2.1.4 Reformed Pay-As-You-Go: First Steps

A new law on pension was passed in 2000 that reformed the public PAYG pension scheme and paved the way to the introduction of a multi-pillar system. The model envisaged by the Romanian Governments³⁴ was the three-pillar model advocated by the World Bank and other international financial institution.

Romania developed a reform strategy based on alternative financing sources framework. The first component of the newly pension system focuses on ameliorated version of the old “PAYG” pension scheme and is implemented under the Law 19/2000 on Pension and its subsequent amendments. The two pillars will be administered by private sector, but different in nature. Whereas the second pillar is mandatory, the third one is based on voluntary/ individual pension plans.

Main features of the new public pension scheme were designed to deal with previous deficiencies. Thus, better coverage, stricter access to benefits, redefining the compulsory contribution and benefits as well as a new benefit formula were regulated.

³³ Periodical payments granted to any persons who bears the responsibility of raising a child or taking care of a sick/disabled child

³⁴ Romanian Governing Programme 2001 – 2004 issued by Isarescu cabinet and by current cabinet

- a) stricter access to benefits by
 - an increase in retirement age from 57 to 62 for women and from 62 to 65 for men³⁵
 - compulsory contribution period raised from 25 to 30 for women and from 30 to 35 years for men,
 - tighter conditions for invalidity pensions' entitlement
- b) new methodology in pension formula (German system of points). The new formula takes into account annually contributions paid throughout the active life so that the total amount of pension equals approximate 45% of national average wage. Quarterly indexation is mandatory in order to avoid depreciation due to inflation.
- c) better coverage and benefits definitions. The public system
 - decreases the number of persons working in special conditions by classifying on different basis the "special conditions" category.
- e) administration of public pension scheme entrusted to an autonomous institutions:
 - National House of Pensions and Other Social Insurance Rights has a tripartite structure. The law stipulated that the decision on the effective creation of the House should be made in 60 days time for its enactment. However, administrative and political quarrels have postponed making the decision and consequently precious time for building the administrative capacity of the House was lost.

Coming into force of 2000³⁵ Law on Pensions and other Social Rights (Law 19/2000) marked the beginning of the reformation of PAYG system.

The previous pension system recognized only the employed persons³⁶ as beneficiaries. This situation was changed with in the Law 19/2000 on pension which lists the main categories of beneficiaries:

- permanently employed persons
- elected officials and those appointed in the executive, legislative and judicial authorities
- members of cooperatives and family associations
- registered unemployed persons
- self-employed
- farmers
- temporary workers
- Romanian citizens employed in other countries and by international organizations operating in Romania

The new law on pension, which came into force in 2001, requires an employer-employee shared contribution of an average value of 40%. The rate of employer's contribution represents 2/3 according to work category³⁷; thus employers contributed

³⁵ the law came into force in April 1st 2001; since its endorsement on March 2000, several provisions were early applies (e.g. obligation to be insured extended to all employed persons regardless their employment status – workers, self-employed, unemployed)

³⁶ Reminiscence of the communism who did not acknowledge the existence of unemployment

³⁷ New work categories are introduced in 2000 according to work conditions; the law distinguishes between special condition jobs ("locuri de muncă în condiții speciale") and particular conditions jobs ("locuri de muncă în condiții deosebite") and normal work conditions. As a distinguished feature, the new law limits the number of occupations included in the special conditions category to mining, nuclear and artistic activities, civil aviation, as defined by the annexes. Also, restrictive conditions are imposed in order to qualify for the particular conditions jobs.

to the social security fund by 23.33% for normal conditions, 28.33% for particular working conditions and 33.33% for special working conditions (an average of 28.33%). While the employer's contribution ranges according to work categories, the employee's is fixed – 11.67% (1/3 of total value).

The relation between contribution and final benefits is clearly highlighted in the 2000 Law on pension. The amount of the pension is dependent of previous contribution paid throughout the active life. A new pension formula based on a point system is now applicable. Each month the contributions paid are converted into points that are sum up to an annually score which is multiplied with the number of contributive years to obtain an average score. The amount payable to the beneficiaries represents the average score multiplied with the value of a pension point.

The Law envisages though a few limitations. Firstly the maximum annually score is 3 points and secondly, the value of a point cannot exceed 45% of national average wage.

The Romanian Government should develop a framework for the other two components of the system, in line with the economic programme (macroeconomic stabilization). The second pillar implies the involvement of public sector in administering pension funds and of individual contributions transferred from the public system (by creating individual accounts). The third pillar is optional in nature and refers to flexible pension schemes managed by private insurance and pension fund companies.

At the time of writing, a new draft law³⁸ for the other two pillars – Draft Law on Universal and Voluntary Pension Funds - is under preparation at the Ministry of Labour and Social Solidarity.

2.1.5 Reformed Pay-As-You-Go: One Year of Experience

At the time of writing this rapport, Romania has already 1 year since the coming into force of the new law on pension and subsequent amendments to the law were adopted³⁹. These acts modified the status of the institutions responsible with the management of the public system – Ministry of Labour and Social Solidarity, National House for Pensions and Other Social Insurance Rights -, and clarified the conditions for entitlement to benefits.

³⁸ The ongoing Isarescu Cabinet adopted an Emergency Ordonance on Universal Pension Fund, but it was revoke by the newly elected Cabinet in 2001.

³⁹ see Table 9 for details

Table 9 Chronological table of legislative changes of pension system design

Legislative acts	Subject	Main Provisions
L 19/17.03. 2000	Pensions	<p>Main legislative act that regulates the organization of public pension system in Romania. There are three types of old-age benefits awarded under the current legislation:</p> <ul style="list-style-type: none"> - old age pension, - invalidity pension, - survival pension. <p>The current statutory contribution period for full old-age pension is 30 years for women and 35 for men, and the legal retirement age is 60 for women and 65 for men. However, these values will be reached after a 13 years transition period. Under specific condition one is entitled to early retirement without penalties (exceed by a minimum 10 years the maximum contribution period). The minimum statutory contribution period relates to the insured age. Thus, for a person under 25 years the required stage is 5 years, while for a 55 years person the required stage is 25 years. These conditions do not apply if the invalidity is due to work injury.</p> <p>Survival pensions are awarded to the wife/husband or children. For the latter, the payments of benefits is granted till the age of 16 or till he/she graduates.</p> <p>It entrusted the management of the public pension scheme to an autonomous body – the National House for Pension and Other Social Insurance Rights – that will be set up before the coming into force envisaged for 1 April 2001.</p>
EO 41/27.04.2000	Pensions	Establishes new limits to the value of a pension point. Thus, the value cannot exceed the threshold of 45% of national medium wage and depends on the financial resources available.
GD 1065/9.11.2000	NHPSIR	<p>Gives the National House of Pensions and Other Social Insurance Rights the status of an autonomous institution, responsible with daily administration and management of public pension scheme.</p> <p>Its Board has a tripartite structure, with equal representatives of Government, employer's organizations and insured persons (trade unions and pensioners' organizations).</p>
EO 294/30.12.2000	Pensions	<p>Changes mainly the organizational chart of National House of Pensions:</p> <ul style="list-style-type: none"> - the President of the House is at the same time Secretary of State in the MLSS

		<ul style="list-style-type: none"> - the mandate for the Board members is limited at 4 years (from originally 5 years) - the members of Board are 5 Government representatives, 6 employers representatives and 8 beneficiaries representatives (employees and pensioners)
GD 4/4.01.2001	MLSS	<ul style="list-style-type: none"> - all the functions of the MLSS are clearly set out (strategy, regulation, synthesis, management of funds and budgets, representation, and state authority); - the Ministry is the primary credit (ordonator principal de credite) that delegates this function to the executive director of National House for Pensions and Other Social Insurance Rights; - the National House for Pensions and Other Social Insurance Rights is no longer coordinated by MLSS, but under its supervision - as concern the General Directorate of Social Insurance, it is under direct supervision of General Secretary in the MLSS and has three units (directii) – Pensions, Other Social Insurance Rights and Budget Unit
GD 297/22.02.2001	MLSS	Establishes the rights of MLSS to control the state social insurance budget execution done by the National House for Pensions and Other Social Insurance Rights.
GD 258/22.02.2001	NHPSIR	<p>It concerns the statute of the NHPSIR. According to the law, the NHPSIR is the public institution responsible for the administration of public pension system, and implementation of policies and programmes in the field.</p> <p>The NHPSIR main functions:</p> <ul style="list-style-type: none"> - pays the benefits - keeps a record of all contributors - manages the state social insurance budget and is accountable for its execution to the MLSS; - collects the legal contributions due by employers and employees; - supervision of payments of contributions.
EO 49/29.03.2001	Pensions	<p>Among the changes it has brought there are worth mentioning:</p> <ul style="list-style-type: none"> - the contributions paid for the unemployed persons are equivalent to the national medium wage; - new category for the special conditions jobs – marine platforms;

		<ul style="list-style-type: none"> - for people receiving severance payments (plati compensatorii), the contributions due are paid from the Unemployment Fund; - the contribution period taken into account for early retirement doesn't comprise the periods one has received invalidity benefits
EO 107/27.06.2001	Pensions	<p>The most important provision relates to the case of non-payment of legal contribution by the employers. The insured person is no longer sanctioned for this situation and enjoys all legal social rights under the Law of Pensions except the provisions on early retirement.</p> <p>Another change refers to the allowance accorded for loss of working capacity that is covered both by the employers and the social insurance budget and the period covered by the employer is increased to the first 7 days (from the first 4 days).</p>
GD 1317/27.12.2001	MLSS	<p>The function of supervision of contributions due to the state social insurance system is entrusted to the MLSS (the National House for Pensions and other Social Insurance Rights was formerly entrusted with it). As a result, a new General Directorate is set up within the MLSS in order to coordinate the activity of territorial structures in charge (directiile generale de munca si solidaritate sociala judetene si a Municipiului Bucuresti).</p> <p>Some changes are noted in the organizational chart of MLSS with a second new General Directorate – Budgeting General Directorate (Directia generala pentru Fundamentarea Bugetelor) directly under the Ministry.</p>
GD 1319/27.12.2001	NHPSIR	Adopted in order to avoid legislative confusion and its provisions are correlated to those in the GD 1317/27.12.2001

MLSS – Ministry of Labour and Social Solidarity

NHPSIR – National House for Pensions and Other Insurance Rights

L - Law

GD – Government Decision

EO – Emergency Ordinance

2.1.6 Administrative and institutional analysis

General administrative issues

The administrative performance is important if we want to insure the success of the overall economic and social reform. The role of the administration is crucial when we talk about the implementation of the reform plans and strategies. Beside the legal aspects related to the administrative reform we have to consider also the managerial aspects of the administrative reform. As a consequence of that, when we refer to the social security reform and compliance with the EU norms we have to keep in mind the importance of the administrative framework for the success of the integration project.

General administrative reform is not covered by *acquis communautaire* and there is no European model recommended. Each country has to insure the best administrative approach in order to make the system work. We cannot find something as “an European model for administrative reform”. But good performance in administration reform is a very important aspect of the EU integration success. A good argument for this assumption resides in the fact that often in regular reports and negotiation sector reports “general public administration problems” are indicated as causing problems for “the applicant countries capacity to meet EU accession requirements”

The new law on public pensions 19/2000 has changed aspects related to the administration of the public pension fund.

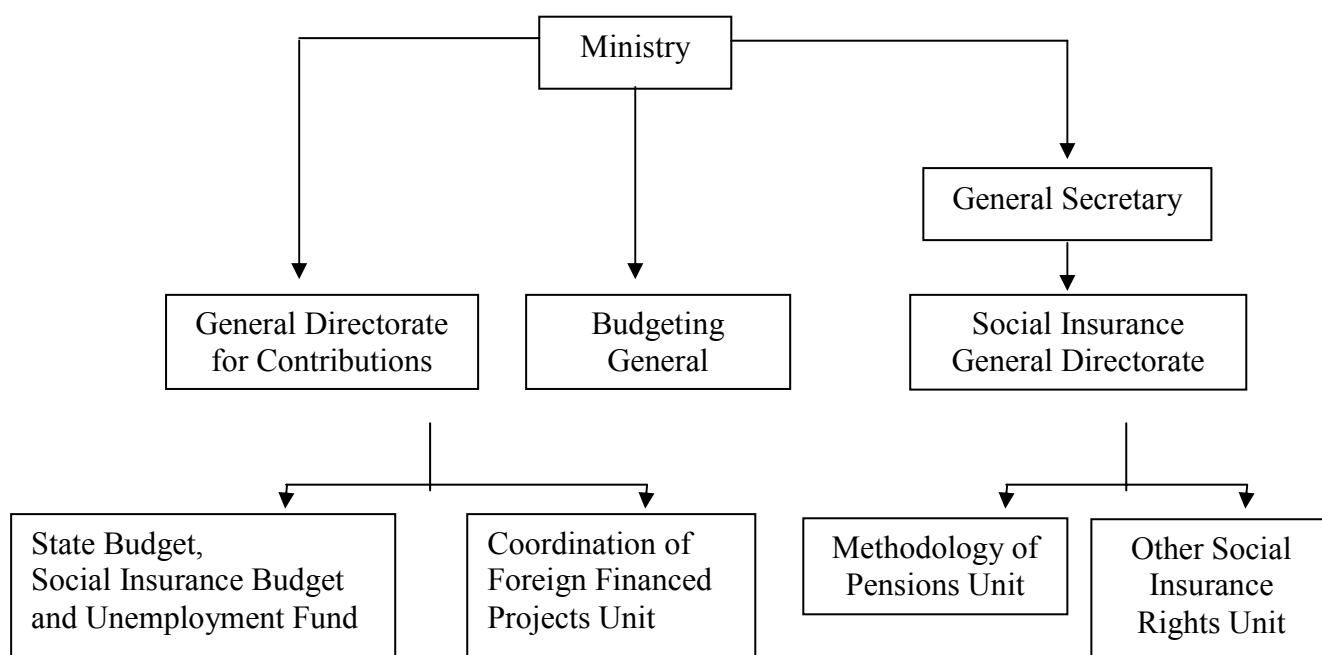
Ministry of Labour and Social Solidarity remains the institution responsible for policy design, but gradually the law extended its attribution to financial management and supervision, and placed under its direct supervision the National House for Pensions and Other Social Insurance Rights. Though the ministry is primarily accountable (*ordonator principal de credit*) for the Social Insurance Fund, he delegates it to the executive director of the National House for Pensions and Other Social Insurance Rights⁴⁰.

Government Decision 1317/2001 concerning the functioning of the Ministry of Labour and Social Solidarity has through its territorial structures (*directoratele judetene de munca si solidaritate sociala si a Municipiului Bucuresti*) the right to control the payment of contribution due by the employers, impose sanctions and penalties, or start the procedures for forced payment.

In order to cope with the new attributions, the organizational chart of the Ministry of Labour and Social Solidarity was modified accordingly. New structures (general directorates) are set up –General Directorate for Contribution Control -, while others are reorganized – Social Insurance General Directorate and State Social Insurance Budgeting General Directorate -. Chart 1 shows the new general directorates with responsibilities in the field.

⁴⁰ GD 4/2001

Chart 1 Structures responsible for public pension pillar management within the Ministry of Labour and Social Solidarity



Source: GD 1317/2001

The first important aspect is related to the collection and payment of benefits. Before enacting the law 19/2000 the above-mentioned administrative functions were hosted (related) to the Ministry of Labor and Social Protection. There was no proper database of the contributors (contributions were recorded by the employer in a workbook) and the contributions were collected on the basis of the total wage bill of the enterprise. In this way in was very difficult to see the individual contribution effort per worker.

The benefits were calculated at the moment of retirement and the calculation was based on the only existing information on contribution, the individual workbook.

Other deficiencies were present at the level of auditing and control.

The new public pension law 19/2000 established a new administrative formula, separating the politics of pension by the policy of pensions. The policy authority established under the new law is the **National House of Pensions and Other Social Insurance Rights** (NHPSIR).

The National House for Pensions and Other Social Insurance Rights was entrusted with the administration of the public pension system. Originally designed as an autonomous body, that was to be created from the nucleus within the Ministry (Central Office for Pensions Payments) and gradually to have its administrative capacities increased, it is now functioning as a public institution under the supervision of Ministry of Labour and Social Solidarity. Its main responsibilities ranges from funds collections to benefits payments, it also relates to the design and the management of relevant databases (contributors databases), methodological coordination on pensions.

For the first time, the employer, employee and pensioner representatives are co-opted in the National House for Pension and other Social Insurance Rights' Board. 5 representatives of employers and 8 representatives of employee and pensioners are appointed in the Board together with 5 Government representatives. They are appointed by the Prime Minister for a mandate of 4 years.

Under the management of NHPSIR and with the TA and financial assistance of the World Bank the development of an IT system started. The role of the IT system is to support the new collection methodology. During our institutional assessment we did not have access to the new database (registry on contribution) because of the delays in implementing the system. As mentioned in the World Bank report⁴¹ "The NHPSIR needs to focus more attention on the overall reengineering of key business processes, not only on the acquisition of supporting IT system".

Another critical element noted by the World Bank in the report is the low capacity of NHPSIR to attract good professionals in highly technical positions because of the "salary constraints"⁴². Overall the World Bank report notice shortcomings in management and "slow progress achieved within NHPSIR".

The general institutional framework for collecting social security contributions is assessed as being "fragmented and highly inefficient"⁴³. The report mentions the existence of a separate department for collecting unemployment insurance established under MLSS, duplicating the NHPSIR in collection, audit and enforcement arrangements. Another social security institution, National Health Insurance House (NHIH) has its own collection department.

Between all those social security collection institutions (departments) the communication is very limited and fragmented. In order to solve the specific problem related to the fragmentation of contribution collection, the Government is committed to centralize system in a unique social security contribution collection authority. The new institution will be set up in the near future as a response to the need for financial discipline in tax collection.

EU integration process related administrative issues

Romania, faced with the complexity of negotiating the chapters of the acquis has developed mechanisms and institutional arrangements to cope with the task of coordination. An entire **ministerial structure** – Ministry of European Integration - was entrusted with the preparation and conduct of negotiations and co-ordinates the Negotiation Delegation's activity. The Minister of European Integration is the head of the Romania Delegation to inter ministerial Accession Conference and represents Romania at EU-Romania Accession Committee.

National Delegation comprises the members of all sectoral delegations and is headed by a high ranking official in the Ministry of European Integration appointed by the Prime Minister. The Chief-Negotiator is also member of Government and he submits the drafts of position papers for approval to the Romanian Government.

Sectoral Delegations equal the number of chapters of acquis and one ministry with relevant task coordinates their activity. High-ranking civil servants are appointed to

⁴¹ World Bank, "Romania – Pension System in Review", pp 8

⁴² World Bank, "Romania – Pension System in Review", pp 8

⁴³ World Bank, "Romania – Pension System in Review", pp 9

participate at proceedings and their task is to draft the position paper of Romania on various chapters.

Working groups consisting of experts working as civil servants were set up in each ministry to back up the work of delegations.

The preparation of negotiations and of position paper are considered a strictly governmental matter, and only Member of relevant Parliamentary Commissions are informed on the preparation of position papers. Social partners are also involved in this process via Economic and Social Committee. The latter endorsed the social dialogue subchapter in Chapter 13.

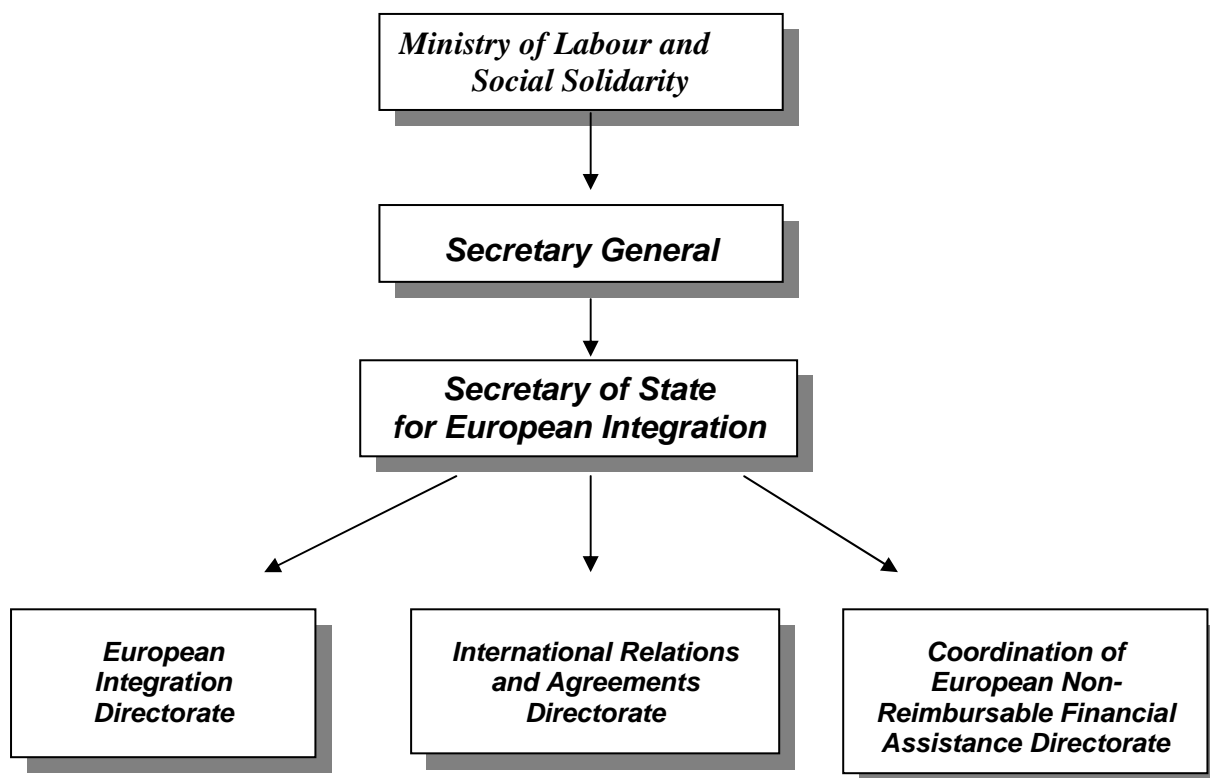
Upon submitting a position paper to government approval, the document is considered public issue and all the adopted position papers are posted on the web page of Ministry of European Integration. As concerns the Chapter 13, only the main document is public⁴⁴, the complementary document submitted to European Commission in March 2002 is treated as confidential.

In order to successfully integrate the *acquis communautaire* into the Romanian legislation and Romanian administrative practice the Ministry of Labor and Social Solidarity and The National House of Pensions and Other Social Rights have specific attributions and played a major role in designing the specific parts of the Position document - Chapter 13 “Social Protection and Employment”

The following two charts presents the structure and specific functions related to the EU integration process for the Ministry of Labor and Social Solidarity and The National House of Pensions and Other Social Insurance Rights.

⁴⁴ Romania’s Position Paper on Chapter 13 was submitted to Brussels in June 2001

Chart 2: Ministry of Labour and Social Solidarity^{*45}

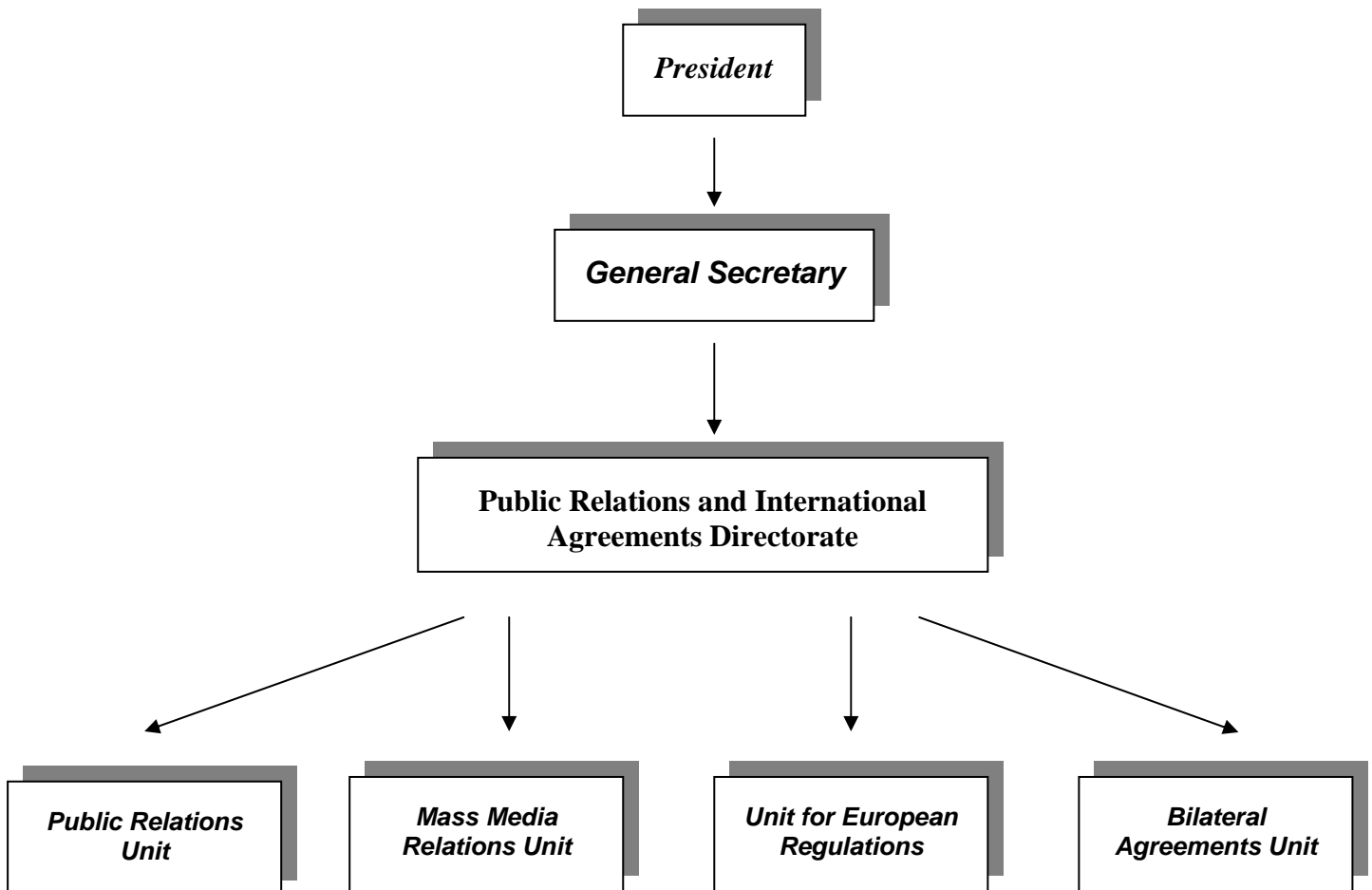


FUNCTIONS:

- coordinates the activity of position paper drafting on the relevant chapter of negotiations (chapter 13 “Social Policy and Employment” and 2 “Free Movement of Workers”)
- coordinates the Ministry’s participation at different sectorial delegation
- enforces the specific provisions from the European Agreement
- updates annually Romania’s “National Programme for Accession to European Union” (PNAR) and the “Report on the progress in preparing the accession to the European Union” (drafted by the Romanian Government)
- monitors the progress made in the preparation of the negotiations, namely the implementation of measures specified in the PNAR.
- prepares the EU – Romania Association Committee’s and Subcommittees’ reunions in the labor and social security related field

⁴⁵ the structure of the working groups and the presentation of the institution of the rest of the institutions involved in the process will be presented as Annex 1

Chart 3: National House of Pension and Other Social Insurance Rights



FUNCTIONS:

- gathers information about social security systems of other countries
- updates annually Romania's National Plan for Accession to the EU in social securities related fields
- participates at the completion of backup files (dosare de fundamentare)
- takes part in working groups session concerning the Chapters 13 and 2 of the Acquis communautaire
- carries out other functions related to international relation

Beside the specific tasks related to the preparation of accession documents, mainly the Position Papers, updates to the "Report on the progress in preparing the accession to the European Union", and to "The National Programme for Accession to the EU" (with specific emphasis on social security related fields), the Romanian social

administration has also to deal with the design and development of new administrative functions. As a consequence of the European Union accession process, the Romanian institutions have to develop a proper institutional framework and practices to be effective when the time of the integration will come. The preparation for accession of the Romanian social institutions is not limited to the transposition of the *acquis*. The “legal *acquis*” is only a part of the process. The “institutional *acquis*” (norm, practices, methodologies) is equally important in a successful integration process.

As we can see from the institutional Charts 2 and 3, the Ministry of Labor and Social Solidarity and the National House of Pensions and other Social Rights have specific departments dealing with European Integration. These departments are dealing mainly with the transposition of the *acquis* but also with present and future methodologies related to the bilateral agreements on export of benefits. Until now the Ministry of Labor and Social Solidarity is the institution practicing transfer of benefits between Romania and other counterpart countries. Romania has signed so far 9 bilateral agreements⁴⁶. So, the practice of exports of benefits with EU Member States is limited. In this unique case with Germany several methodological problems occurred and as a result the agreement was “frozen” in 2001. It is a warning signal that we have to consider and analyze it carefully.

As we mentioned before in the report the accession process is not limited to the transposition of the *acquis* into Romanian legislation. The institutions have also to be prepared and be modernized in order to cope with the new tasks and requirements related to the coordination of social security schemes.

As assumed in the Position Paper document Romania has to be ready at the moment of accession to coordinate social security schemes with other Member States and to insure a simple and coherent administrative structure fully adapted to the new migration patterns due to enjoyment of the right on free movement of workers and other persons.

The Romanian social administration in charge with the coordination of social security schemes have done a tremendous work in transferring the Regulations (EEC) 1408/71 and 574/72 into Romanian legislation. Still the preparation of institutional takeover of the administrative requirements related to the above-mentioned regulations has to be speed up. The Romanian social administration is aware about the existence of specific protocols and standardized forms⁴⁷ of exchange of information's between competent Member States social security bodies, as it is conscious about its practical experience.

Export of social benefits is subject to bilateral agreements signed by Romania to date. Once a member state, Romanian institutions will have to comply with rules of coordination set out by Regulation 140/71 and Regulation 472/72 regarding the application of social security schemes to employed persons, to self employed persons, to self-employed persons and to their families moving within the Community.

The above-mentioned Regulations states special rules as regards the calculation of old-age pensions for any person that worked during its lifetime in more than one Member State. For each persons entitle for old-age pension the competent national

⁴⁶ Romania has signed bilateral agreements with Switzerland, Portugal, Luxembourg, Netherlands, Germany (3 agreements), and Hungary (2 agreements).

⁴⁷ The form E 111 prepared for the use of Member States by the Administrative Commission on Social Security is the most well known.

authority/institutions make several calculus: the national pension, the theoretical amount and the pro-rata pension.

The national pension is the one computed after national regulations taking into account solely the period the migrant worker had been insured under the national regime.

A theoretical amount is then calculated in order to determine the pro-rate pension and that accounts for the whole period spent abroad as if it was under the national law. This calculus is a necessary step in establishing the amount for the pro-rate pension and the insured worker cannot claim it.

The pro-rate pension is obtained by “multiplying the theoretical amount by a fraction whose numerator represents the duration of the periods of work in the country and denominator all the periods taken into account in determining the theoretical amount⁴⁸”.

Once the two pensions calculated and compared, the most favorable one is granted to the worker. Moreover, the pension shall be paid wherever the pensioner stays or resides within the borders of European Union.

What is important for Romania at this point of accession relates to the clear identification of relevant national institutions and authorities with responsibilities in the area, of type of benefits covered by Regulations and clear definitions of beneficiaries. These issues were addressed by inter ministerial working group⁴⁹ that recently close its workings.

Increasing the cooperation and exchange of information with similar institutions from Member States can easily solve the above lack of knowledge on practices and procedures related to the exchange of social security benefits. It will also be useful to develop along with the other candidate countries cooperation and exchange of information related activities. Moreover, it was obvious from the interviews taken to representatives (public functionaries) of the National House of Pension and Other Social Security Rights and the Ministry of Labor and Social Solidarity that no budgetary provision exists for this type of activities.

Phare programs play an important role in increasing candidate countries capacities for successful integration. But, if we look at the Phare Social Programs list for Romania⁵⁰ we can see that there is no specific program component related to institution-building aspect of the acquis on export of benefits, specifically on the export of pension rights.

Only recently the Ministry of Labor and Social Solidarity prepared a specific program proposal entitled “Program for a friendly working environment” and submitted it for approval to the EU Delegation, right now in an advanced stage of processing. Within this program we can find a defined component on social security - “Social Security for migrant workers” aiming at creating a “functionable Romanian social system for migrant workers”⁵¹. This program, when implemented, will increase the Romanian social administration to better cope with EU requirements in the field of social

⁴⁸ Source: http://www.europa.eu.int/comm/employment_social/soc-prot/schemes/index_en.htm

⁴⁹ see Romania’s Position on Chapter 2

⁵⁰ Annex 3 provides a detailed description on PHARE implemented and ongoing programmes in Romania

⁵¹ Project description “Phare 2002”, MLSS

security coordination. Training of key personnel within the relevant institutions⁵² is envisaged, as well as the setting up of an Information and Documentation Center for Migrant Workers.

In assessing institutional capacity for social administration the World Bank report on Romanian pension system⁵³ has mentioned as a serious shortcoming the in what is related to IT and data collection methodology and technical support, the lack of high quality IT specialist because of the level of salaries.

To this lack of specific expertise we have to mention another critical aspect related to the lack of lawyers specifically trained to deal with social security issues and without solid knowledge of the EU legislation in the field of social security coordination. Two aspects have to be mentioned here. The fact that we found no staff with legislative training working in social administration department, it is heavily related to the inexistence of any Romanian lawyer specially trained for this type of activity that to lack of incentive in terms of salary. There is no academic specialization, no on-job training related to that.

Considering the strong legally binding character of the integration process in general and the existence of a solid jurisprudence⁵⁴ in the field of exports of social security benefits this situation needs serious consideration. A first step can be the recruitment of lawyers for the specialized department, on-job training in coordination with EU experts and the development of specific academic curricula in major Law Schools in Romania.

⁵² National Employment Agency, National House of Pensions and Other Social Insurance Rights and National House for Health Insurance

⁵³ see pp 28, footnote 40

⁵⁴ an account of major ruling can be found in Annex 12

2.1.7 Supplementary Pensions. Increased sustainability and modernization of pension system

There is a growing interest about modernizing the public pension systems both in the European Union's Member States and in the candidate countries. There is a recognized need to review the national pension schemes and design viable formulas "for securing the long-term sustainability of pension systems"⁵⁵. In this context, European Commission's Communication "Supporting national strategies for safe and sustainable pension through an integrated approach" sets out common guiding principles and objectives for Member States to follow in their reforming process:

- adequacy of pension systems – pensions systems should allow individuals to maintain reasonable living standard after retirement and should prevent poverty and social exclusion,
- financial sustainability – pension scheme should develop alternative sources and control expenditures to counteract the financial pressure of systems resulting from ageing,
- adaptation of pension system to a changing society – a reformed system should take into account the new pattern in employment (female participation on labour markets, flexibility and security).

However, it should be stressed out the strong conditionality between the stringent need to reform PAYG systems and general economical situations, demographic trend and labour market conditions. Ageing population, new patterns in employment, budgetary constraints under the EMU (Economic and Monetary Union) constitutes new challenges that need to be addressed too.

The European Commission strategy aims at: (methods envisaged)

- continuing efforts to coordinate the pension reforms in Member States by agreeing on a set of common guidelines for future developments.
- promoting exchanges between states on best practices, innovative approach through exchange of experience, policy discussion, monitoring ongoing political developments.
- involving the social partners and other European institution in this process.

Moreover, EU's documents point out to the complexity and challenges of reforming public pension schemes and advocate the development of an integrated approach, encompassing different policy areas. The table below synthesizes the efforts undertaken by the EU in reforming the pension systems, in relation with other Community policies.

⁵⁵ European Commission's Communication "Supporting National Strategies for Safe and Sustainable Pensions through an Integrated Approach COM (2001) 362 final, pp 3

Table 10 Triangle of policy in reforming pension systems⁵⁶

Policy area	
Employment	Ensure that pension systems more employment-friendly. In this regard, supporting the employability of older workers, reducing disincentives for working longer and encouraging an active participation are taken under consideration. High employment rates will help improve and maintain the sustainability of pension systems.
Social Protection	Ensure an adequate level of income for future pensioners so that poverty and social exclusion of old people should be alleviate.
Economic	Secure the financial balance of pension systems. Identifying alternative sources of revenue for future financing of pensions and containing the rise in pensions cost should be doubled by macroeconomic policy inducing growth and higher employment.

The reforms of pension systems are an essential element of the European strategy on modernizing social protection. European social protection systems were design on assumptions that changed considerably over the last decades and impacted on the sustainability (in terms of coverage and revenues) of the public systems⁵⁷. In this context, Member States should organize efficient and coherent frameworks for 2nd and 3rd pillars in order to supplement the PAYG scheme.

It is obvious, especially since 1994 when the World Bank⁵⁸ published its assessment on present pension system and its proposed multipilar strategy, and in line with the process of accession, that candidate countries need to modernize their social protection systems too. Several countries from Central and Eastern Europe (CEEC) are already making the necessary steps to reform their public schemes. Table below presents the state of reform in selected candidate countries at July 2001.

World Bank strategy on pension reform targeted at CEEC countries support the implementation of a three-pillar system. As shown in the table, the majority of candidate countries have developed reform strategies that aim at establishing a threefold pension framework.

It is for the candidate states to decide how they design their pension systems. They should however take into account the EU requirements in this area. EU social policy focuses primarily on the legally binding *acquis* (“hard *acquis*”)⁵⁹ and then takes on a broader sense with the “soft *acquis*”. In this respect, it should be recall the invitation made at Gothenburg European Council: “candidate countries are invited to translate the Union’s (...) social (...) objectives into their national policies”⁶⁰.

⁵⁶ compile after “Supporting National Strategies for Safe and Sustainable Pensions through an Integrated Approach COM(2001) 362 final and “Future Evolution of Social Protection from a Long-Term Point of View: Safe and Sustainable Pensions”, COM (2000) 622 final

⁵⁷ “Adequate and Sustainable Pensions”, Report of Social Protection Committee on the future evolution of social protection

⁵⁸ Adverting Old Age Crisis, World Bank, 1994

⁵⁹ In the pension area, two Regulations constitute the legally binding obligations that the candidate countries need to abide by for membership.

⁶⁰ Presidency Conclusions – Göteborg, 15 and 16 June 2001, point 11

Table 11: State of Pension Reform in Selected Candidate Countries

Candidate Country	System Design (Pillars 1, 2, and 3)
Bulgaria	<ol style="list-style-type: none"> 1. reformed PAYG system 2. mandatory participation in occupational and universal pension funds 3. voluntary private schemes under the insurance law
Czech Republic	<ol style="list-style-type: none"> 1. state pension scheme 2. voluntary supplementary pension scheme, mainly company-based pension fund
Estonia	<ol style="list-style-type: none"> 1. publicly managed compulsory PAYG (1999/2000) 2. privately managed quasi-compulsory funded (2002) since there is an opting out for individual already on labour market, 3. privately managed voluntary funded (1998) from pensions funds (defined contributions) or pensions insurance (defined contributions or defined benefits)based on individual pension plans
Hungary	<ol style="list-style-type: none"> 1. social security pension financed on PAYG basis based on defined benefits 2. mandatory fully funded pensions funds set up by employers 3. voluntary pension scheme based on individual pension plans
Latvia	<ol style="list-style-type: none"> 1. earning related scheme (reformed PAYG) 2. (state) funded pension schemes managed by private assets managers (licensed investment companies and State Treasury) 3. private pension funds (voluntary savings)
Lithuania	<ol style="list-style-type: none"> 1. state pension system based on social insurance principle 2. mandatory accumulative pension funds, under the Law on Pension Funds, effective in January 2000, but no pension insurance company registered till 2001 (unfavorable conditions) 3. voluntary pension scheme from life insurance companies
Poland	<ol style="list-style-type: none"> 1. defined contributions pension scheme based on individual accounts (notional defined contribution) manages by ZUS (Social Insurance Institution) 2. mandatory funded scheme based on individual accounts (financial defined contributions) managed by private firms 3. various individual and group scheme (employee pension fund, contract with an investment fund, group life

	assurance policy with an insurance company, contract with a mutual insurance society)
Romania	<ol style="list-style-type: none"> 1. defined contributions pension scheme 2. planned 3. Personal pension plans available from life-insurance companies acting under the insurance law
Slovak Republic	<ol style="list-style-type: none"> 1. PAYG with virtual accounts 2. funded pension scheme based on individual accounts (not yet approved by Government) 3. supplementary pensions available from pension funds
Slovenia	<ol style="list-style-type: none"> 1. reformed PYAG public scheme 2. compulsory funded pension systems, mandatory especially for those working in heavy and hazardous conditions 3. voluntary supplementary funded pension plans available from mutual pension funds, pension companies and insurance companies

Source: various papers presented at OECD/Bulgarian Ministry of Labour and Social Policy Conference on “Private Pensions”, Sofia, 2001

Romania still lags behind as concern the reform process. Lack of discipline in the process, the multitude of changes, and frequent delays ⁶¹ may account for this situation.

Considering all features of Romanian public pension system together with the demographic perspectives and economic trends it is clear that a deepen process of modernization is needed. The reformed pay-as-you-go modernizing strategy is not enough to insure the sustainability of the public pension scheme.

Romania has reformed to date only the public pillar by enacting a new law on pension in 2000⁶². At the same time, the Government made a first attempt to introduce a multi-pillar pension system in Romania.

Romanian Government endorsed the provision on universal pension fund through the Emergency Ordinance 230/2000. It offered the workers less than 47 years old the choice between the public schemes or the multi-pillar schemes (public PAYG doubled with mandatory private schemes). New entrants on the labour market and those under 37 years old automatically joined the mixed system.

Workers that decided to switch to the mixed system would have a share between 5 and 10% of their contributions channelled to the second pillar, depending on their employment status⁶³.

The mandatory contributions to the second pillar were placed in pension funds that were privately managed by private companies legally constituted under the Romanian company law and subject to an authorization procedure.

The law offered the companies to set up pension funds for their employees provided they have paid the mandatory 5% contribution rates to a pension fund company (article 67, paragraph a2).

Some internal safeguards were introduced in the management of the funds by private companies:

- a private company could administer only one pension fund and was restrained from participating to the social capital/shares of another pension company
- all transactions with shares were strictly controlled by the Supervisory Authority – National Commission for Pension Supervision
- incompatibilities clearly stated for the members of the Board
- requirement for holding assets in commercial banks (custodian bank)
- assets can not be used to guarantee for loans
- mandatory liquidity reserves that amounted to 2 millions euro
- investments portfolio restricted to few financial instruments.

There was a state guarantee of contributors. Since a pension fund could not become insolvent, a special fund - Guarantee Fund - for covering losses was regulated.

The newly elected Government canceled the Emergency Ordinance 230/2000 regarding the universal pension funds immediately after its adoption. One of the major reasons for this annulment was related to the FNI (National Investment Fund)

⁶¹ interview with World Bank expert in Romania

⁶² law 19/2000 that come into force in 2001

⁶³ Workers employed under the labour law (who would have contributed with 5%), unemployed, self-employed and workers employed under contract law (whose contributions rates would have amounted to 10% of their income)

scandal, the most “famous” bankruptcy case of a financial investment fund. Thousands of people were affected by this financial scandal and the new Government considered that social and political environment is not yet suitable for launching the second pension system pillar.

The new Government⁶⁴ placed the modernization of the pension system on his political agenda too and adopted a strategy on this line in December 2001⁶⁵. This political commitment includes the continuation of the pension system reform by introducing the second and third pillars.

In a nutshell, the Cabinet is planning⁶⁶ to introduce a funded pillar to be privately managed and to regulate the functioning voluntary individual pension plans by the end of 2002. The mandatory funded pillar will bring positive perspectives to the general effort to insure the sustainability of the pension system, to secure the future benefits, will increase the sense of ownership and the confidence of the population in the future of their pension system.

The World Bank prepared multi-pillar scenarios for the Romanian Government. The projections indicated that replacement rates for workers that switch to the funded system will be 53 (60) percent according to the contribution rate of 5 percent, respectively 8 percent⁶⁷.

Currently, the Ministry of Labour and Social Solidarity is preparing a new draft law on universal pension fund and voluntary pension scheme. Main feature of new provisions:

- a integrated regulatory framework for funded pension schemes and voluntary individual plans
- more emphasis on occupational schemes
- gradual coming into force: voluntary schemes will be operational 14 month after the law’s enactment, while the occupational schemes will be effective in two years time.

These provisions are still in incipient phase – the working group still debates - and any further comments at this stage will be inappropriate.

At the time of writing, the Ministry of Labour and Social Solidarity is still working to finalize the draft law. It will be submitted to Government and later to the Parliament for approval.

2.1.8 EU and the development of supplementary pensions schemes in Romania

The provision of pensions is very important for Romanian citizens as well for any other European citizen. State pensions represent the bulk of pension payouts but other sources of supplementary retirement provisions could offer viable alternatives to insure secure and decent income levels. All the Member States as well as the candidate countries are faced with pension policy decisions and in conformity with

⁶⁴ general election were held in Romania in November 2000 and a new Government was appointed in December the same year

⁶⁵ Ministry of Labour and Social Solidarity sectoral strategy, adopted by the Government in December 6, 2001

⁶⁶ see also Romania’s National Programme for Accession to European Union

⁶⁷ World Bank, “Romania – The Pension System in Review”, for details on projection see Annex 2

the subsidiary principle is up to each country to decide how they will organize the pension system and how they will design the balance between different pension schemes.

Within the European Union a large debate is opened on the supplementary pensions and their role in the Single Market. The debate was opened by a specific document agreed by the European Commission on June 10, 1997, a Green Paper on Supplementary Pensions.

The Green Paper was presented in the framework of the Single Market Action Plan and builds upon the Commission Communication on modernizing and improving social protection in the European Union (document issued on March 12, 1997). The main topics opened by the Green Paper are the need for funded supplementary pension schemes to be able to grow in the context of the Single Market and the freedom of movement of workers. Specific issues addressed in the Green Paper are:

- The importance of rate of return on pension fund investments. As showed in the Green Paper improved returns on pension fund investments are in the interest not only of workers contributing to various pension schemes, but also to the employers who also contribute. A good rate of return can directly contribute to economic growth.
- The flexibility of fund managers in investment choice versus the essential need to protect workers who belong pension schemes. The Green Paper notes that many Member States currently impose restrictions on pension fund investment on prudential grounds, investing as a result mainly in government bonds.
- The importance of appropriate prudential rules for Member States' supervision of pensions and life insurance funds and fund managers in order to ensure high level of protection of workers and their families against the effects of volatility in the market. Each Member State is free to establish its own rules as long they don't violate EC Treaty rules on the free movement of capital. The Green Paper launched the discussion around the idea of coordinating prudential rules at EU level.
- Rules and tax provisions applying to pension schemes affect the ways in witch the workers who wants to move to other Member State to work. The Green Paper identifies obstacles to mobility related to supplementary social security schemes: qualifying conditions for supplementary schemes, the difficulties of transferring accrued rights to another Member State, tax difficulties where rights are acquired in more then one Member State; the case of those seeking to work for a short period of time in another Member State.

The Green Paper launched a debate on how to overcome the above mentioned obstacles and also launched propositions for future Directives as for instance in the case of preservation of accrued rights and the particular problem that apply to workers seconded to another State Member.

It could be very interesting for the Romanian policy makers to pay attention to the discussions around supplementary pensions schemes in EU Member States. It is obvious that the interest for developing better regulations in the field is high and the lessons resulting from the debate are interesting for a candidate country.

Considering the specific of Romanian social and economic context, the expanded mistrust in investing funds after the National Investment Fund (FNI) scandal maybe the most important aspect to consider for the policy makers is related to the prudential laws.

The Green Paper stressed clearly ” pensions and life insurance funds and the managers of these funds must be subject to prudential supervision. Consumers (i.e. future pensioners) must be protected in an area where they have little knowledge.”⁶⁸.

Even if they are not same regulatory procedures in all Member States, we can extract some basic rules necessary to be applied when a State is organizing pillar 2 and/or 3:

- The pension fund must be authorized or approved by a competent authority;
- Set of criteria to be established in order to decide the authorization or approval, such as the suitability and approval of managers of pensions fund and custodians/depositaries/trustees of the funds’ or the legal form of the fund;
- Establishment of a prudential supervision of the fund, including regular reporting rules and powers of intervention by the supervisory authority;
- Minimum prudential rules on the investment of members’ contributions, in particular requiring that they be invested prudently⁶⁹.

The continuation of the pension reform and the creation of funded pillars privately managed will have a positive effect on the development of the financial market but also can lead to potential problems if not properly managed and legally framed.

In building successful new supplementary pension scheme and to protect the consumer is highly recommended to keep the capital market transparent and to educate the public.

The Romanian policy makers should look not only to successful cases of regulation and management of private pension funds, but also to learn from failures (from their own country, EU countries or U.S.) The recent Enron scandal make clearer the fact that even in sophisticated economies problems can happen if we don’t pay enough attention to the regulation environment. In order to have a success in implementing private pension funds we need to insure first proper financial, accounting and legal infrastructure. Is clear that we still have a lot to improve in Romania, at least in matters related to accounting standards and quality auditor’s training.

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An overview of Romanian pension system reveals that there are no obstacles hindering the implementation of social acquis from a legal/judicial standpoint.

⁶⁸ Green Paper “Supplementary Pensions in the Single Market” COM (97) 283 of June 1997

⁶⁹ see in Annex 4 Summary of National Regulations on Pension Funds Portfolios - pillar 2 and life assurance companies -pillar 3

However, there are sustainability issues that indirectly may impact on the successful implementation of European legislation and need to be address by the Government:

- critical deficits of public pension fund
- financing the transition to fully funded pillar
- law enforcement – supervision authority and its status
- collection – one agency to collect all social insurance contributions or fragmented collection units
- transparency – simplicity of provisions, stable legislative environment.

The EU membership is a national objective in Romania as it is stressed in all governmental documents. As a reflex of that, tremendous effort was and it is done in order to cope with EU requirements and to close as fast as possible the remaining negotiation chapters. The policy makers are more active then ever trying to compensate delays in the implementation of reform and catch up on terms and deadlines failed in the past. Special instruments for monitoring the reform and adoption of the *acquis* were put in place (the NPAA, the AP and the Regular Reports) and represent useful instruments to assess the progresses made.

In the specific area of social security reform the performance in adopting the *acquis* is quite complex because it encompasses the narrow legally binding *acquis* and the broader “soft *acquis*”.

Going back to our proposed criteria for assessing the Romanian reforming process, in ensuring the financial sustainability of the public pension system, first steps taken so far, though late, are encouraging. The PAYG has undergone a process of reform and plans are made to implement the pillars necessary to ensure safety and sustainability of pension systems.

In terms of EU conformity, the legal *acquis* is transpose in the internal judicial system and no obstacle to the free movement of workers can be notice. However, the successful co-ordination of social security systems will depend heavily on the existence of appropriate and functional institutions and much work needs to be done in this area.

The Romanian approach on European Integration focuses mainly on transposing the legal *acquis*, with issues related to the institution building and implementation lagging behind. Relevant institutions are in place, but they need a better definition of their functions in order to ease the transfer of European practices and methodologies. No doubt, this is the most challenging part of European integration as far as Romania is concerned.

Significant progress has been made, especially in legal transposition of the *acquis*, but there is still work to do as concern the “soft *acquis*”, aspects related to the institutional building and the strengthening of administrative capacity.

The EU membership cannot be separated from a general vision on how the social security system in Romania should be. The positive influence of the EU accession process has impacted on the Romanian social policy capacity in terms of coherence and maturity.

Chapter 3 - Romanian Healthcare System

3.1 HEALTH BACKGROUND

3.1.1 Health Status

On average, Central and Eastern Europe Countries (CEEC) had better health statistics than their GDP would have predicted. Romania is the exception from this point of view. Over the transition period, Romanian health expenditure stayed at about 3% of GDP, thus lower than in its neighbours. Life expectancy was also lower and infant mortality higher. Due to the natalist policies of the Ceausescu regime, abortions were all but illegal, what had resulted in horrific mother mortality rates. The liberalisation of abortions after 1989 has lead to a dramatic increase in the number of abortions in the first years, but also to a decrease in infant mortality rate (IMR). Based on anecdotal evidence, in the late 1980s malnutrition cases were reappearing. Morbidity of communicable diseases was and still is also higher - especially hepatitis (A and B) and tuberculosis. The main AIDS population are children, as result of infections through the medical act (but the number of new cases peaked in early 1990s). However, cardiovascular diseases and cancer represent the main mortality cause, similarly with Western Europe, but in difference their rates continue to grow. The most worrisome health status statistics are presented in tables below.

Table 12: Mortality rate 1981 – 2000

1,000 inhabitants																				
Year	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Rate	10,0	10,0	10,4	10,4	10,9	10,7	11,3	11,0	10,6	10,7	10,9	11,7	11,7	11,7	12,0	12,7	12,4	12,0	11,8	11,4

Source: Centre for Medical Calculations and Statistics, Ministry of Health and Family

Table 13: Mortality according to the most important causes 1989 – 2000.
Selected data

Deaths per 100,000 inhabitants												
Condition	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Tuberculosis	5.6	6.9	7.3	8.6	10.2	10.5	11.3	11.4	11.8	10.5	9.6	9.5
Tumours	141.6	142.1	144.7	153.0	158.9	162.2	165.5	170.3	173.6	174.6	176.7	184.0
Heart and circulatory conditions	617.6	627.0	658.2	707.8	712.3	709.9	736.1	785.9	761.5	738.6	737.0	701.8

Source: Centre for Medical Calculations and Statistics, Ministry of Health and Family

Table 14: Specific incidence of selected conditions.

New cases per 100,000 inhabitants.												
Types of conditions	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Infectious and parazytary	3183.3	2839.7	2717.3	2870.6	3172.9	3713.0	3728.6	3038.9	3163.6	3403.6	3005.1	3330.0

conditions												
Endocrine, nutritional and metabolic conditions	479.5	353.3	314.9	386.8	483.4	488.3	536.2	521.6	518.3	560.7	570.9	937.4
Respiratory conditions	31436.1	28866.3	27388.4	30275.2	31593.1	32207.1	32797.1	35652.5	31756.3	30719.6	29318.3	30083.3
Genito-urinary conditions	2675.6	2563.9	2574.9	2791.5	2913.6	2925.5	3201.9	3088.0	2989.7	3043.1	2768.8	3394.4

Source: Centre for Medical Calculations and Statistics, Ministry of Health and Family

Table 15: Main infectious and parazytary conditions in Romania.

		New cases per 100,000 inhabitants											
Condition		1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Tuberculosis		58,3	64,6	61,6	73,4	82,5	87,3	95,0	98,6	95,8	101,2	104,1	105.5
Syphilis		19,8	23,2	25,9	26,0	26,5	29,1	35,0	32,2	34,2	34,5	36,9	45.17
Viral Hepatitis type A	-	307,0	283,4	182,6	87,4	65,5	84,8	106,8	81,3	68,3	52,1	78,0	97.8
Cerebrospinal meningitis		2,5	1,2	1,1	1,2	0,97	0,88	0,58	1,01	1,19	1,25	1,76	1.2

Source: Centre for Medical Calculations and Statistics, Ministry of Health and Family

3.1.2 Health reform

First steps

Changes in the health sector advanced in Romania at a much slower path than in other CEEC. The first major change has been the privatisation. This progressed further in dentistry that was largely privatised. The pharmaceutical sector has also changed hands, at all levels: retailing is completely private, wholesale has been mostly privatised, and private capital made in-roads in manufacturing too.

The most important reform was a pilot project started in 1994 and that eventually covered eight (out of forty-one) counties (*judet*). The experiment consisted in developing primary care, with *family doctors* paid by a weighted points combination of capitation adjusted for patient age (60%) and fee for service (40%). The value of the point was variable, e.g. decreased with the number of patients registered with an individual doctor. The family doctors have the role of gatekeepers. The scheme was dropped after the change in government following the 1996 parliamentary and presidential elections. However, the social insurance reforms continue most of the elements of this pilot project.

Following the pilot scheme, patient and doctor satisfaction increased, and the system went some way to achieve its targets. The number of polyclinic and hospital referrals decreased by a quarter and respectively a half. However hospital admissions and emergency departments attendance rates remained constant, and prescription

increased 30%. In addition, general practitioners complained of the large amount of paper work that in absence of computers was difficult to handle.

Social insurance

After a lengthy passage through the bi-cameral parliament, the Law of Social Health Insurance (LASS) was promulgated by the president in July 1997 and came into effect on the 1st of January 1998. The system created by the new law was implemented over a transition period, and came fully in place by 1st January 1999. Separate laws for the re-organisation of the hospital sector, public health services, and the regulation of the medical profession have been passed by Parliament at a later date.

LASS instituted the health social insurance, financed by compulsory payroll based contributions. The system is administered by a decentralised network of regional health insurance funds, which contract the providers in the limits set by a national frame contract. The law gives the right for establishment of supplementary, volunteer private insurance, which was one of the priorities established by the new government in 2001. LASS guarantees the right of the patient to choose the provider at all levels and the insurer fund, but the general practitioner has the role of gatekeeper. The yearly national frame contract specifies the basic package of services that has to be provided by each health fund.

Governance

The health system is decentralised. The payer became the county health insurance houses (CHIH), which collect the social contributions from members. There are 42 regional insurance houses (one for each of the 41 administrative counties, plus the insurance house of Bucharest, the capital, that accounts for 10% of the population). In addition to the regional health funds, there is the National Health Insurance House (NHIH) that administers the solidarity (i.e. redistribution) fund to which the county houses have to contribute. The administration boards of the county health insurance house and of the National Health Insurance House are nominated by the social partners (trade unions and pensioners, employer associations, and county, respective national government). Recent changes have reduced the power of the administration boards to a consultative role, in favour of the appointed CHIH general manager.

In addition to the NHIH / CHIH system, there are two Special Health Funds, relics of the former socialist parallel health systems: the Transport Health Fund (covering public transportation workers, especially railways), and the Law and Order Health Fund (covering the employees of the defence, police and justice systems). These separate funds, comprising some of the best paid and disciplined tax payers, discharge the same functions like an ordinary CHIH, contribute to the redistribution fund, but their relationship with NHIH is a contentious unresolved issue.

The National Health Insurance House and the National College of Physicians negotiate the frame contract, with the agreement of the Ministry of Health and Family (MHF). The frame contract is then enacted as a Government Ordinance. The frame contract provides the basic package of services provided and the reimbursement of providers. Within the limits set by the frame contract, regional health funds will contract the local providers (general practitioners, hospitals etc.). NHIH and the MHF decide annually the list of reimbursed drugs, with the agreement of the College of

Physicians and after consultation with the College of Pharmacists. A national commission created by NHIH, MHF and the College of Physicians approves the big equipment purchases. NHIH and the College of Physicians are in charge with controlling the quality of medical services, and the accreditation of medical personnel, and, together with others, in designing the preventive programmes. The same two institutions create a paritary Commission of Arbitration, whose decisions are executory. The area of responsibility is summarised in table 16.

Table 16: Responsibilities of institutions

Tasks	Ministry of Health	National Insurance House	College of Physicians
Framework Contract	X	X	X
Drug List	X	X	X
Approval of High Tech Medical Equipment	X	X	X
Health Care Programmes	X	X	X
Commissions of Arbitrage		X	X
Quality of Services			
Surveillance			
Accreditation			
Medical and dentistry services		X	X

X = Responsibility

Source: Institute for Health Services Management, 1997

Funding

The sources of financing health services are payroll social insurance, the state budget and co-payments. The payroll contributions amount to 7% of the gross wage paid by the insured and a matching of 7% of the total wage bill paid by the employer. The social contribution was deducted from the income, respective profit tax. Pensioners and the recipients of unemployment benefit pay the 7% contribution from their benefits. The contribution for the recipients of social aid is paid by the budget of social insurance (N.B. social insurance is separate from health social insurance). Some particular categories of expenses, the most important being capital investments, are paid by the Ministry of Health and Family, from the national budget. Local government may pay for maintenance costs. Co-payments apply mainly to drugs, but the government plans to expand their role.

The social contributions are collected to the regional health insurance fund, and 25% of their monthly revenues are transferred to the National Health Insurance House to form the solidarity fund. The regional health funds apply for these funds to the national one.

The health funds have succeeded a relatively good collection performance. Each year the amounts collected have surpassed the initial projections. While this has to do with

higher than projected inflation rates (that increase nominal wages, and therefore the nominal value of the collected funds), other factors have played a role, too. The relative low value of the health contribution (14% of wage) made compliance more tempting for economic agents (in comparison with the 35% pension and other social benefits contribution). The presence of the social partners (especially of trade union representatives) in the managing boards of the regional funds has also improved the collection from large state companies (the main debtors to the pension fund).

The main challenge on the revenue side have been the constraints imposed by the Ministry of Public Finance, which regularly forbade the health funds to spend the whole amounts collected. Another risk that is worth mentioning here is the failure so far to connect the access to services with the payment of the contribution. In spite of the implications of the law, the access to health services remains practically unrestricted, what discourages compliance. The government stated in 2002 it is going to tackle this situation, but results are still awaited.

Primary Care

Through the reforms initiated, general practitioners (GPs), called family doctors, receive the role of gate-keeper, controlling through referrals the access to more advance care: hospitals (in-patient care) and specialists (out-patient departments). They are contracted by the county health fund of the territory where they have the cabinet. In order to be eligible for contracting they have to be legally accredited and to be members of the College of Physicians. General practice receives a higher emphasis in the medical education, being up-graded to a speciality status - before the general practitioners were the non-specialist medical doctors.

The patient has the right to choose the family doctor and to change this choice after three months. Primary care is free at the point of delivery, and co-payments apply only to pharmaceutical products.

There are about 11,800 GPs, most of them in private practice. The payment system employed is a combination point system of weighted capitation (children and elderly 'valuing' more), together with fee for service for a group of prophylactic measures, and a lump sum medical practice budget. Local authorities have the possibility to offer special inducements for medical personnel in under-served areas. A family doctor has up to 1500 patients, above this threshold the per capita fee is decreasing.

The main problem in the primary care sector is the lack of trained personnel for preventive activities and home aid. In addition, there is not a uniform coverage of the territory with GPs, with villages suffering heavily. One alternative is to waive the disincentive to GPs to have more than 1500 patients in the under-served areas. As we shall further, the role of GPs as gatekeepers is rather lax, and many patients still bypass them. This situation is not helped by the GPs lacking equipment and many times training, what sends to the patient the message that the family doctor is only an intermediary of little use.

Secondary and tertiary care

Specialist care is provided in outpatient and diagnostic centres, mostly publicly owned. One of the aims of the Romanian reforms is to shift the emphasis from the secondary to the primary care. In order to achieve this, access to secondary care is, at

least theoretically, restricted to referrals by GPs. Patients have however the right to chose the specialist whose advice they are seeking. The payment method is fee for service, and co-payments are envisaged.

Hospital care has been consuming most of the resources of Romanian healthcare. There are estimates that as much as 20% of admissions might be social rather than medical cases. The over-use of hospital services is stimulated by the payment system. Currently, hospitals are financed from CHIH by budgets. These are built according to a set of utilisation criteria (number of admissions, average cost/day hospitalisation, average duration of hospitalisation) on historical basis, are inflexible (the management is not allowed to shift money between departments), all the amount must be spent till the end of the respective financial year, and in order to conserve the level of the budget for next year, a 75% occupancy rate is required. In addition, maintenance costs are covered by the local government, and capital investments (e.g. equipment purchase) by the MHF. The new government draft law on hospitals would allow hospitals restricted access to loans or the use of CHIH receipts to cover capital expenses.

The staff is paid by fixed salaries, but could make additional income for overtime and night shifts. However, on anecdotal basis, the largest share of doctors' income comes from patient payments.

There are wide differences in occupancy ratios across the sector, territory-wise and according to the type of medical department. The structure of the hospital sector is presented in table 17. Most hospitals are still publicly owned (by local or national government) and managed. Many hospitals currently provide private (i.e. fee based) hotel facilities. The government intends to allow the privatisation of proper medical clinics too. Key hospitals will stay in state hands - they are defined as university hospitals and high performance clinical centres.

In order to control the number of admissions strict referrals (from GPs and specialists) should be used for non-emergency services, but this policy failed to be implemented so far. The most important change affecting the hospital sector is the trial introduction of the DRG payment system in 23 hospitals starting January 2002.

Table 17: Hospitals in Romania

<i>Types of hospital</i>	<i>Number</i>
Rural	90
Urban (town and city)	245
District	30
Specialized clinics	97
recuperatory spa	22
Total	484

Source: NHIH, 2001

Pharmaceuticals

There are a few elements worth noting about the pharmaceutical sector. First, it is the sector where privatisation went furthest. Both the wholesale and retail sectors are practically entirely private. The largest domestic manufacturers have been or are soon

expected to be privatised. This higher proportion of private capital in the sector means that it is more sensible to market forces, and therefore the state has less scope for administrative decisions and more for using economic incentives.

Second, Romania used to hold the record (together with the Czech Republic) as the highest spender on drugs in CEEC (calculated as a percentage of total health expenditure). This situation has however changed over the last years. However, the high proportion dedicated to the pharmaceutical expenditure, and the fact that much of it pays for imports, make this area of the health budget a priority target for cost-containment.

Finally, the availability of reimbursed drugs is also a key political issue. The lack of public funds leads to serious delays in reimbursing the pharmacist from the health budget for the price of 'compensated' drugs, what in turn results in many pharmacies refusing to dispense drugs under the reimbursement scheme, and patients being forced to buy the drugs at the full price. The government has intervened by restricting the number of pharmacists allowed to dispense compensated drugs.

In the hospital sector, the access to drugs is, again at least theoretically, free for the patient. The drugs are acquired by the hospital, through tender processes, and paid for with money from CHIH. There is under consideration the creation of a nation-wide drug-purchasing programme.

In the outpatient sector, different sets of rules apply. There is a positive list of drugs for 26 serious conditions, for which the access is free for the patient, and the funding is provided by the national health programmes (see below). For the other conditions, there is a list of 256 INN (international non-proprietary name) for which the reference price system (variant 1) applies. Here CHIH reimburses 70% of the reference price, the difference to the full price being paid by the patient. For all the other drugs, the payment is out of pocket.

There is a positive list of prescription drugs. The testing of drugs is performed by the National Drug Agency. Pricing of drugs is subject to approval by the Ministry of Health and Family. Another cost-containment measure is the monthly prescription budget for GPs. In addition, recently the government has allowed generic substitution by pharmacists.

Role of the Ministry of Health

By the creation of the National Health Insurance Fund, the Ministry of Health and Family has lost most of its management functions. It retains however the important regulatory function. In addition, it manages the 'National Health Programmes', representing about 20% of the public health expenditure. National Health Programmes are somewhat connected to the World Health Organisation (WHO) championed Health Targets concept, but are more priority setting rather than establishing measurable objectives to meet. Below I list the current national health programmes.

National Programmes financed by the Ministry of Health and Family in the year 2001

NO. Name of health programme

1. Supervising and control of infectious diseases programme.
2. Immunizations programme.
3. Supervising and control of tuberculosis programme.
4. Supervising and control of HIV / AIDS infection programme.
5. Prevention and control of sexual transmitted diseases programme.
6. Prevention and control of nosocomial infections programme.
7. Blood transfusion and transfusion haematology programme.
8. Prevention and control of drug addiction and induced pathology
9. The action programme related to environment and health (impact of environmental risk factors).
10. Supervising health status of children and teenagers collectivities programme.
11. Supervising the risk factors from the workplace and professional risk programme.
12. Family planning and protection of mother and child health programme.
13. Mental health and prevention in psychosocial and psychiatry pathology programme.
14. Elderly protection and prevention programme.
15. Prevention and control for cardiovascular diseases programme.
16. Prevention in renal pathology and dialysis.
17. Prevention and control in cancer pathology programme.
18. Prevention haemophilia and talasemie program.
19. Prevention and control diabetes and diabetic control programme.
20. Prevention and orthopaedic and trauma recovery for adults and children.
21. Prevention in endocrine pathology programme.
22. Prevention dental programme.
23. Rehabilitation of national reference centres for laboratories programme.
24. Standard health services in public health programme.
25. Promotion of health status and education for health programme.
26. Evaluating the public health status and demographic supervising.
27. Continuous training and human resources strategy programme.
28. Early diagnosis and prevention in neurological diseases programme.
29. Rehabilitation of pre-hospital emergency services programme.
30. Validate public health units and national interest services programme.
31. Prevention and spa-physic-climate recovery programme.
32. Abroad medical treatment programme.
33. Organ transplant, tissues and spinal transplant programme.
34. MHF reserve for special situations programme.
35. Baby protection programme.
36. Administration and other institutions and activities spending programme.

3.1.3 Impact of reforms

Romania used to spend for health between 2-3% of GDP. This was one of the lowest shares of GDP devoted to health among CEEC– even if, according to the World Bank,

consistent with the development level of the country. The health status of the Romanian population also looked worse than in neighbouring countries. In this context, policy makers considered the level of spending insufficient, and the social insurance was introduced to mitigate this situation.

Table 18 shows that since its introduction in 1998, social insurance has reached this goal. Public expenditure on health increased to 4% of GDP. When private expenditure is added, the total amounts to almost 5%. While this is still low by European Union practices, and even by the statistics of other CEEC, it is a considerable increase in relative terms over the early 1990s.

Table 18: Evolution of health expenditure – relative terms

Funding sources	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total public health expenditure (billion ROL, actual prices)	24	62	185	592	1544	2213	3228	7064	11600	20969	28817
Total public health expenditure out of GDP (%)	2,7	2,8	3,1	3,0	3,1	3,1	3	2,8	3,2	4,0	4,0
Private health expenditure (billion ROL, actual prices)	7,5	16,5	-	-	-	-	767	1782	3120	4673	-
Total health expenditure out of GDP (%)	3,5	3,5					3,7	3,5	4,1	4,9	-

Even in absolute terms, the increase in resources is substantial. Table 19 presents the evolution of health expenditure calculated in US dollars. The absolute expenditure declined with the start of transition – the share of GDP remained constant, but GDP contracted. The introduction of social insurance resulted in an absolute increase of about 25% over 1990, and over 30% over 1997 (the last year before the introduction of social insurance funding).

Table 19: Evolution of health expenditure – absolute terms

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total Public Health Expenditure (million USD)	1090	816	601	779	933	1088	1047	985	1307	1368	1340

Social insurance has now become the main source of funding for the health sector, by far. Table 20 presents the evolution of sources of funding. Currently, social insurance accounts for over 80% of health finance.

Table 20: Main public funding sources for the health sector

Funding source (%)	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Taxes	100	100	100	100	100	100	100	100	36,2	21,6	19,9
- national	100	100	82,7	61,7	64,6	62,5	64,5	64,3	31,6	18,7	16,5
- local	-	-	-	17,1	17,0	18,2	19,1	18,8	0,6	0,5	0,5
- health tax	-	-	17,3	21,3	18,3	19,2	16,4	16,9	4,0	2,4	2,9
Social insurance	-	-	-	-	-	-	-	-	63,8	78,4	80,1

Hospital sector

Romania entered the reforms with an over-bloated hospital sector – not unlike most EU and CEEC however. The main indicators used to assess the efficiency of the hospital sectors are:

- number of beds,
- occupancy rate
- number of admissions, and
- length of stay

On the last data available, Romania figures at the higher end, but within the expected range, on all these indicators. The rate of admissions (about 20 / 100 people), and the length of stay (about 10 days) are in the higher numbers in WHO Europe region as a whole, and average for CEEC. The occupancy rate (about 75%) is in the lower half, while the number of beds (over 7 / 1000 population) is in the higher one.

In assessing this performance we have to take into account that all the countries we benchmark with have a dire situation in the hospital sector: they all attempt to reduce the number of beds, admissions and length of stay, and to increase the occupancy rate. A situation that is slightly worse than their average is still problematic.

However, it is important that over the 1990s these indicators moved in the right direction. The number of beds declined sharply by about 20%, while the admission rate stayed practically the same. This boosted the occupancy rate. The length of stay declined by about 15%.

The most important conclusion from the point of view of funding is that the utilisation indicators have not worsened. This shows that the pressure for increased spending does not come from a larger number of cases.

Hospital funding

In table 21 are listed again the expectations of the artisans of the reforms concerning the allocation of resources inside the health sector. We can clearly see the intended shift of resources away from the hospital sector, and into primary care.

Table 21 Wishful thinking: 1997 pre-reform strategy.

Kind of health care	Current (1997*) financial allocation of resources	Estimated financial allocation of resources
1. Hospitals	50%	35%
2. Secondary care	30%	30%
3. Primary health care	20%	35%

Source: BASYS, 1997

* our remark

Table 22 presents the actual break down of resource allocation inside the health sector. In parallel with the actual expenses, are presented the provisions of the frame contract (drafted at the start of the year), and of the summer budget – the mid-term correction of the budget.

Table 22: Health expenditure: comparison between actual expenses and amounts provided by the National Frame Contract (NFC), and revised mid-term budget (MTB)

Service type	1998 Actual (%)	1999 NFC (%)	1999 MTB (%)	1999 Actual (%)	2000 NFC (%)	2000 MTB (%)	2000 Actual (%)	CoCa 2001 (%)
Primary care	9,01	15,5	9,48	9,05	14,5-15	9,78	9,51	14,5-15
Out-patient (specialists)	5,85	11,75	6,62	6,11	8,75	7,85	7,23	8,75
Hospitals	67,25	40,00	61,24	64,18	59-61	63,99	65,48	50-53
Subsidised drugs	6,81	20,0	9,32	8,03	10-11	12,83	12,41	10
Dentistry	2,66	4,25	2,76	2,36	2,5-3	1,58	1,43	3
Rehabilitation services	0,82	1,00	1,17	1,11	1	0,63	0,65	1-1,2
Prothesis	3,23	3,00	0,62	0,28	1	0,33	0,28	1
Ambulance services	4,32	4,50	3,80	3,67	3-4	3,00	3,00	3
Health programmes	0,06	0	4,99	5,20	0,1-1	0,00	0,00	8
Total	100	100	100	100	100	100	100	100

In each year the shares of hospitals increased in the summer budget is still over-shot by the actual expenditure. The reverse is true for primary care and drug expenditure. These data show the inability of the hospital sector to respect budget constrains. We have to bear in mind that, as table 23 proves, the resources actually collected have always been fewer than the estimates: the actual income has been lower in each year compared with the amount in the summer budget. This resulted in lower than expected expenditure. In consequence, a higher than expected share for hospital expenditure means lower than expected real resources for primary care and medicines.

Table 23: Income and expenses of the Health Funds 1998-2000

Billion ROL	1998			1999			2000	
	Budget law	Mid-term budget correction	Actual	Budget law	Mid-term budget correction	Actual	Budget law	Mid-term budget correction
Income	10296	9541	8372	11967	20443	18386	26725	29002
Total expenses	7626	7584	7403	11368	16997	15958	23907	25261
Reserve fund	-	-	-	598	962	806	1336	1450
Balance	2669	1957	969	0	2484	1622	2292	2292

To put things into context, in table 24 is presented the breakdown of resources by sector in healthcare for the OECD countries.

Table 24: Public health expenditure break down by sector in OECD countries

Public expenditure by health care sector out of total public health expenditure (%)	Median	Average	Maximum	Minimum
Hospitals	52	54	78	30
Drugs	12	13	27	6
Out-patient services	20	21	40	8

The critical fact is that Romania spends, in relative terms, more on hospitals, and less on primary care, and drugs than most OECD countries. In addition, we have to bear in mind that this break down is based on the expenditure of health funds. Were the rest of about 20% of public expenditure to be taken into consideration, the share of hospital expenditure would be even higher.

This is even more surprising if we take into account that in the early 1990s Romania was, together with the Czech Republic, the champion on drug spending. The expectation for a country like Romania is to spend a higher percentage on drugs than western countries, because the price of tradable goods like drugs varies less among countries than the price of labour. Therefore the labour intensive sectors should take a lower share from overall resources in Romania compared with Western Europe.

3.1.4 Institutional problems

There are two major institutional design problems affecting the Romanian health system. The first concerns the non-competitive nature of the health funds, which are regional monopolies, further restricted by national regulation (i.e. national frame contract). This results in a lack of incentives for regional funds behaving like selective purchasers. This argument and possible mitigating solutions are developed in the next session.

The second unresolved matter is the division of labour between the system of health funds and the government, represented mainly by the Ministry of Health and Family. The current situation practically puts the National Health Insurance House on equal

footing with the Ministry – at least in protocol terms the President of NHIH ranks as a full Secretary of State. However, NHIH lacks the right to initiate legislation, and the MoH jealously guards its prerogative of sole responsible for health policy, even if much of this policy has to be implemented by the health providers under contract with the health funds.

Actually, the initial version of LASS was going in effect to create a ‘local health government’, with the boards of the health funds being directly elected on a corporatist basis, and independent finance through the 7 + 7 % health tax.

The direct elections have been ‘temporarily’ replaced by nomination of board members by the social partners. The government faces now the decision whether to allow the initial election mechanism to go through, or to make the temporary nomination mechanism permanent. Moreover, repeated changes to the law have consolidated the role of the NHIH versus the county ones, and have eroded the power of the boards in favour of the appointed general managers. The role of redistribution has increased – initially only 7%, instead of the current 25%, of the revenues at the county level were supposed to be transferred to the National House. In addition, the Ministry of Public Finance has encroached on the financial independence of the health funds by restricting the amount of their revenues they can actually spend. We are in the rather strange situation where there is unspent revenue of the health funds, while the debts in the health system are piling up. Finally, the Ministry of Labour and Social Solidarity is considering the unification of the health and pension funds.

The current situation is a stand-off between the NHIH and the government. It is not conducive to good policy outputs, and is unlikely to resist. Anecdotic evidence suggests the relationship between the staff of the NHIH and the MHF is rather uncooperative. This lack of cooperation hinders the development of health policy, as we discovered in the case of EU integration efforts.

The House would like more autonomy, and direct accountability to Parliament instead of to the Government. The Ministry would rather subordinate the House, much on the model of the National House for Pensions and Other Social Insurance Rights which has been re-integrated in the Ministry of Labour and Social Solidarity. It is worth reminding that the Romanian LASS was closely modelled from the Hungarian law. The Hungarian system evolved towards increased centralisation: the elections for the boards have been replaced by nominations, and the supposedly independent National Health Fund was integrated in the Ministry of Public Finance, and then subordinated to the Prime Minister Office.

3.1.5 Current developments

Incentive misalignments

The root of the problem springs from the lack of adequate institutional incentives for cost-containment at the hospital level. The hospital sector is very powerful politically, as it comprises the elite of the medical profession. The matter is made worse by the fact that members of these elite form the decision-makers at all levels of the health system: health managers, Ministry of Health and Family, health funds, medical college, and most of the politicians dealing with health.

The lack of competition between health funds (which are regional monopolies, and therefore do not have to compete for clients) creates an institutional set-up where there is no incentive for the health fund to take on these powerful interest groups and enforce hard budget constraints upon hospitals. The dominant strategy is an alliance of the purchaser with the provider to pass the costs to the budget.

In addition, the autonomy of hospital managers is limited, what precludes even the restructuring measures intended by the public-spirited managers. Moreover, the only instrument for motivating managers is the rather gross firing threat, while no incentive plans are available.

Reform plans of the government

The leadership in the MHF has identified the reform of the hospital sector as a priority. It is less clear however whether the decision-makers understand the mechanisms that led to the current predicament, and if yes how are the policies that have been announced going to mitigate the situation.

The main initiatives consist of changing the funding system to DRG (diagnosis groups), and partial privatisation. Theoretically, basing the funding on the case-mix rather than on actual costs would encourage hospitals to be more efficient. The problem is that DRG per se could lead to more efficient interventions, but not necessarily result in overall cost reduction. More important, the full implementation of DRG is a very complicated process, which is going to take years. That is proven by the experience in Hungary, the first country in the area to use this method. Therefore whatever benefits it will bring, DRG is not going to be a solution in the short term. These matters are going to be settled soon, as starting this year the DRG system has been introduced experimentally in a number of hospitals.

Privatisation is a trickier matter. Whether this means outsourcing of some services, or even privatisation of 'hotel' services, it will improve efficiency. Partial privatisation of hotel facilities however bears the risk of part of the costs of these private facilities being passed to the public section of the hospital. A much better alternative would be outright privatisation of whole hospitals (or creating new private hospitals out of scratch).

While both policies have things to be commended for, they fail to address the cost containment of hospital expenditure and the looming crises in the primary care and pharmaceuticals.

A new hospital bill

The current hospital bill is more remarkable through the matters it fails to settle than for any consistent reform. As a sign of the perceived urgency of the hospital sector crisis, the Parliament is faced with two new drafts of the hospital bill. One is coming from the Ministry of Health and Family, and the other is put forward by the College of Physicians (the professional body). The two drafts have many similarities. The main innovation brought by the government is to increase the financial autonomy of the hospital, by allowing it to borrow up to 15% of the contracted income, with the condition that the overall debt level is no larger than 20% of the yearly budget. The College of Physicians goes a step further by allowing depreciation to be counted as a cost.

However, both drafts fail to address some fundamental issues:

- *hospital ownership*

The alternatives are to transfer them to local government, or even better to grant them the status of autonomous not-for-profit organisations

- *financial autonomy*

In spite of the welcome permission to borrow, the hospital management will continue to be construed, and more important to lack incentives for full financial accountability. The drafts would preserve the situation where the management has no incentive to economise on non-operational costs, which are provided on discretionary basis by the national or local government (equipment purchase, and building development are funded from the central budget, while maintenance costs could be provided by the local government). This contrasts with the situation of the operational costs covered by the County Health Insurance House, according to the National Framework Contract, and which bears some relationship with performance (i.e. utilization) indicators.

The effects of the envisaged strengthened control over the management ability to accumulate back-payments are unlikely to have much effect unless the incentive structure is changed.

3.1.6 Conclusions

The hospital expenditure is out of control, and is squeezing out the resources for pharmaceutical products and for primary care. In spite of improved overall funding for health and no increase in utilization rates, hospitals consume an even larger share of health resources. Romania, despite its low wages, is in the paradoxical situation of allocating to hospitals a larger share of public health resources than OECD countries. This situation presents obvious social and political risks. In addition, it undermines the role of primary care as the champion of reform.

The initiatives of the government concerning the hospital sector fail to address the cost-containment problem. While the shift to case mix funding and privatisation are commendable in their own right, their effects will not be seen for years to come. Partial privatisation (as opposed to full privatisation) might even worsen the situation.

The new drafts for the hospital bill increase the financial flexibility of the management. The inclusion of depreciation costs in the balance sheet, proposed by the College of Physicians, is especially welcome. However, they do not go far enough:

- the ability to fund investments is constrained by the limits on borrowing
- no motivation factors for managers are introduced; in contrast, exclusive reliance is placed on administrative controls;
- in addition, the ownership issue is not solved.

The non-competitive nature of the Romanian social health insurance funds is always going to create incentive problems. They can be however partly mitigated by:

- clarifying the ownership of hospitals, by transferring them to the local government, or better by establishing them as independent charities

- creating the incentive for managers to allocate efficient all expenses, by funding capital and operational expenses according to the same mechanism (e.g. from the Health Insurance Fund)
- devising incentive plans for hospitals managers that reward good performance.

3.2 ACQUIS - LEGAL AND INSTITUTIONAL FRAMEWORK

3.2.1 Introduction

As regards the social policy, whereas the Treaty did only deal with the freedom of circulation of workers (articles 39 to 42 of the Treaty, old articles 48 to 51) and with the freedom of establishment (articles 43 to 48), the Single European Act gave a new impulse, in particular as regards health, safety at the place of work and the dialogue between the two sides of industry.

Currently, the social policy is laid down by the chapter 1, Title XI of the Treaty (articles 136 to 145). Thus, the article 136 recalls that the social policy falls within the competence of the Union and its Member States. The aims of this policy, according to the principles of the European Social Charter and the Community Charter of Fundamental Social Rights, cover the promotion of employment, the improvement of living and working conditions, an adequate social protection, the social dialogue, and the development of human resources, providing a higher level of employment and the fight against exclusion.

It is advisable however to put into perspective the reach of competence of the Union concerning the social security. In this field, the Council decisions must be adopted unanimously or, in some cases, with a qualified majority. On the other hand, the Commission can, in its field of competence, adopt decisions which are mandatory. It is however revealing to note that the European Union web site, when dealing with the field of social security, treats only about the regulations 1408/71 and 574/72 relating to the application of the social security systems to workers or self-employed and to their families which move within the Community.

This means that each Member State remains basically free in what concerns the choice of its social security system. It must however allow to all workers – employees or self-employed - to carry on their professional activity on its territory and to have access, in the same terms as the nationals, to the existing social security system.

Within the framework of its field of competence, the European Union adopted specific provisions concerning social security:

- disease and maternity benefits;
- invalidity benefits ;
- old age and survivor pensions ;
- industrial accidents and occupational diseases ;
- unemployment benefit;
- services and family benefits.

In this study, we limit, of course, our analysis to aspects related to social security: other fields dealt with by the chapters 2) and 13) are included in other studies, and are not relevant for the field covered by the current study.

Limits and perspectives of the European social policy concerning health – The subsidiary principle.

The Treaty contains the basis of a political community concerning social protection. However, its setting in is paralysed by the maintenance of an unanimously vote within the Council of Ministers. Moreover, the Member States call upon the principle of subsidiary, defined in the article 5 of the Treaty, to keep on exercising a sovereign competence in the field of health and social protection.

“The Community acts within the limits of competences which are conferred and the objectives which are assigned by this treaty. In the fields which do not concern its exclusive competence, the Community intervenes, in accordance with the principle of subsidiary, only that insofar as the objectives of the action considered cannot be carried out adequately by the Member States and thus can, because of the dimensions or the effects of the action considered, be better realized at the community level. The action of the Community does not exceed what is necessary for achieving the goals of this treaty”.

The principle of subsidiary does not have the function of dividing competences between the community level and the national level. It only intervenes when there are concurrent competences between the Union and the Member States. In this case, the principle of subsidiary allows the evaluation of the Community legislator right to intervene.

In other words, while subject to the principle of subsidiary, the competence (shared) of the Union European in the matter of social protection and health is recognized. It remains however to determine, whether the Community legislator is more justified to intervene than the national legislators.

3.2.2 Towards a European policy of social protection?

It is within a framework of subsidiary that the Community policy has been built. Presently it is limited to support and coordinate the action of the Member States. It is an emanation of what is named “the soft law” – ie non-constraining measures such as communications or recommendations, missions of coordination or promotion of co-operation between the Member States.

The Recommendation of the European Council, concerning the convergence of the political objectives of social protection constitutes a good example. The Member States are asked in the field of health:

- a) *“under the conditions determined by each Member State, to provide to the people, residing legally on the territory of the Member State, the access to the healthcare necessary for prevention of diseases ;*
- b) *to take care of the maintenance and, if necessary, of the development of a system of quality care, adapted to the evolution of population needs, and in particular to those which rise from the dependency of old people, to the evolution of pathologies and of therapeutic means, as well as of the necessary intensification of prevention measures;*

- c) *to organize, if necessary, the readjustment of the convalescents, in particular after a serious illness or an accident, and their later professional reintegration.”.*

Under the impetus of the European Commission, the Community policy of social protection gradually acquired concrete contents. The communication *“To modernize and to improve social protection in the UE”* (1997) puts forward the need for modernizing the social protection systems, so that it continues to play an essential role in the reinforcement of social cohesion and the intensification of prevention against exclusion.

In order to undertake this reform and to produce concrete commitments from the Member States, the Commission, in a more recent communication *“A concerted strategy to modernize social protection”* (1999) puts forward a strategy of reinforced co-operation between Member States. It rests on four objectives among which *the guarantee of a high and durable level of health protection.*

Adopted by the European Council in Helsinki in December 1999, this strategy was ratified by the Council of Lisbon in March 2000. The latter generalized the method of reinforced co-operation, in particular because of the need to fight against social exclusion through an exchange of good practices and the convergence of the policies followed by the Member States.

Lately, the European Council of Nice (December 7-8 2000) fixed a multi-annual framework for the adoption of social measures based on an agenda of social policy worked out by the Commission.

3.2.3 A new strategy of health policy?

The Community policy of health seems to follow the same evolution. A greater co-operation between Member States is set up. The Treaty of Maastricht (1993) created the legal base which allows EU to deploy Community actions in the field of health protection. The former article 129 of the Treaty allotted to the Community a role of promotion of co-operation between the Member States in the prevention field. It allowed the development of action programs focussed on the large plagues - cancer, AIDS, drug-addiction, etc - of which several existed even before the reform of the Treaty of Maastricht.

The crisis of the mad cow disease supported the extension of community competences concerning public health. The Treaty of Amsterdam (1997) reformulates the content of the former article 129 as the article 152. This one allots a complementary role to the Community in *the public health amelioration, as well as in the prevention of diseases, human affections and the causes of danger for human health* (Article 152, 1, 2).

However, in spite of this reinforcement of the Community role, one of the principal aspects of the health policy remains at first sight left apart: the organisation of the care system. Indeed, in the section 5 of above mentioned article 152 it is clearly stipulated:

The action of the Community in the field of the public health fully respects the responsibilities of the Member States in the matter of the organisation and supply of medical care and health services. In particular, the measurements cited in paragraph 4 a), do not impede upon the national provisions relating to organ and blood donations, or to their use for medical purposes.

This provision is not unanimously interpreted as a total relegation of the Community level out of the field of the health care, but rather like a clarification of its complementary role. It is from this optics, that one has to read the new Community strategy defined by the Commission in a recent Communication.

In this text, the systems of health care represent an important issue. Their development is regarded as a determining factor of the situation of public health. Consequently, the Commission proposes to set up a system of information on the systems of health, their financing, the method of resources allocation, the role of the public and private insurers etc. The accent is thus put on the amelioration of the practices through the exchange and the promotion of activities in the field of *evidence based medicine*, of the quality of care, of *managed care* and of the evaluation of medical technologies.

According to the Commission, the European citizens will be able to take advantage of a critical comparison between the systems of care of the Member States and of a greater transparency on the level of access to care.

The article 152, 1 still accentuates the essential function that the policy of health in EU must fill: *A high level of protection of human health is ensured in the definition and the setting of all the policies and actions of the Community.*

Therefore, the Union, at the time of elaboration of other policies, is bound to take account of the consequences in respect to public health. This new instrument is much more significant than the indirect impact of the Community policy in the sector of health (in particular through the accentuation of mobility and the realization of the internal market), and it exceeds the direct influence on European social and health policy, which is still under construction. The recent cases Kohll and Decker are convincing examples.

3.2.4 The access to health care in another country - the Kohll and Decker decisions

With the cases Kohll and Decker a breach was introduced by the European Court of Justice, in what concerns the system of regulation of the access to care in another EU Member State. However, in the beginning these cases did not seem to include anything spectacular.

Misters Kohll and Decker, both of Luxembourg nationality and affiliated to the system of Luxembourg social security, saw themselves denied the refunding of health services delivered in another Member State: the purchase buying, in Belgium, of glasses prescribed by a Luxembourg ophthalmologist and an orthodontic treatment in Germany, respectively.

The refusal of refunding transmitted to Mr. Decker by his health insurer was justified by the preliminary absence of an authorisation required by the Luxembourg legislation in reference to the article 22.c of the EC Regulation 1408/71. As for the request of Mr. Kohll to consult a German orthodontist for his daughter, it had been rejected because the treatment was not considered to be urgent and consequently it could have been provided in Luxembourg.

Mr. Decker and Mr. Kohll launched an appeal against these decisions to the qualified Luxembourg jurisdictions. They claimed that the condition of the preliminary authorisation was against the principles of freedom of movement of the goods and services (old article 30 and 36 for M. Decker and 59 and 60 for M. Kohll). Indeed, this condition which was only required for medical benefits consumed abroad turns out to be dissuasive for the patients who wish to call upon foreign providers for receiving benefits. The smallest obstacle to freedom of movement, direct or indirect, real or potential, is enough to contravene to the principle of freedom of movement.

Because we were confronted with an interpretation of the Treaty establishing the European Community, the Supreme Court of Appeal from Luxembourg sent this case to the Court of Justice of the European Communities (ECJ).

In front of this jurisdiction, the Luxembourg authorities, supported by several Member States (Greece, the United Kingdom, Germany, France, Austria, Belgium, the Netherlands and Spain), justified their refusal of refunding and the Luxembourg regulation on which this refusal rested on several arguments.

The first debate related to the question whether the Community legislation applies to the social security, knowing that this matter comes under the responsibility of each Member State.

The C.J.C.E. considered that the Member States enjoy the freedom to organize their social security systems. European legislation authorizes each Member State to organize in an autonomous way its social protection system and to define the conditions that gives right to the refunding of the medical care within the framework of disease insurance.

However, the Court concluded that this capacity cannot be used to contravene to Community legislation. No sector can withdraw from the application of the Community principles of non-discrimination and freedom of movement. Like the attorney general explains in its conclusions: *The logical conclusion of the Court according to which the Community legislation does not impede the capacities of Member States in the organisation of their systems of social security does not suggest however that the sector of social security constitutes a small island within the Community legislation protection and that consequently all the national rules relating to social security do not enter in its field of application.*

Secondly, the Luxembourg authorities claimed that even if the principles of freedom of movement apply to medical benefits delivered within the framework of the social security, under legitimate reasons they could invoke one exception. They asserted that the Community legislation authorizes the Member States to restrict the freedom of

movement when the general interest or public safety appear to be put in danger. According to the Luxembourg government, a preliminary condition of the authorisation was necessary in order to:

- preserve the financial balance of the social security system: the absence of limitations regarding the flow of patients out of their country would involve serious financial consequences for the Luxembourg social security;
- protect the public health: without an instrument of preliminary authorisation, Luxembourg would be constrained to refund services provided abroad, without being able to guarantee their quality ;
- maintain on the Luxembourg territory medical departments and hospitals accessible to all: the financing, the viability and the medical quality of services in Luxembourg would be endangered if the people of Luxembourg would massively choose to look after themselves in a foreign country.

However, CJEC rejected these justifications:

- It considered that the request for refunding initiated by Misters Kohll and Decker was a neutral transaction from the financial point of view, because they proposed to be refunded on the basis of the Luxembourg tariff. In other terms, the expenditure of health insurance would have been identical for services delivered in Luxembourg and could not put in danger the financial balance of the system.
- With regard to the argument relating to the quality of care, the Court of Justice rejected this justification. It has called upon the application of the principle of mutual recognition of qualifications, as well as on the efforts carried out during the 1970s to harmonize the requirements concerning the training of health professionals. It considered that this would be a sufficient base on which to suppose an equivalent level of quality of care in the various Member States.
- Finally, the protection by a State of its medical infrastructure are justified only when the public health is actually threatened. However, these two cases could not be considered such a threat.

Consequently, the Court considered, in the two cases, that the preliminary authorisation required by the Luxembourg legislation constituted an unjustifiable restriction of the free movement of goods and services. This condition concerning the refunding of care in another Member State discouraged the Luxembourg nationals in their attempt to call upon medical products and services provided in another Member State, without a legitimate justification for such discouragement. However, the Court does not exclude that, in other cases, other reasons could justify a restriction of the freedom of movement.

The European legislative framework concerning the access to care and its use

In their defence, the Luxembourg authorities asserted that the accused national provision, which subjected the preliminary refunding of care in another country to the accord of the health insurance organization, was in accordance with the Community provision of the coordination of social security systems of migrant workers. This process was initiated at the beginning of the process of the European integration by the

predecessors of Regulations 1408/71 and 574/72 in order to promote the freedom of movement of people (first for workers, later for quasi all the European citizens).

In the field of health care, this system of coordination has as a principal objective to assure to the migrant workers and the members of their families the access to health care in the Member State where they reside, at the expense of the Member State to which they are affiliated.

The access to the care in a foreign State remains subject to conditions. Let us examine the two principal reasons to resort to this provision of care:

- In the event of a temporary stay in another Member State, the right to refunding of the care is primarily limited to the services immediately necessary, taking into account the state of health of the beneficiary (except for the pensioners). The form E111 proves the affiliation to the social security scheme of the country of origin of the patient.
- When someone wishes to receive care in another Member State using its system of social security, he / she must obtain beforehand an authorization from the institution of affiliation. This authorization is attested by the E112 form. It results that the discretionary power of the Member States determine the criteria on basis of which such an authorisation will be granted. However, this authorization cannot be refused when the treatment cannot be provided in time by the proper system of care of the patient (Article 22, 2, 2 of payment 1408/71).

AIM (European association of Health Insurance Organizations) devoted already ten years ago a study on the cross-border mobility of patients within the framework of the Community system of co-ordination. This study showed that the Member States carried out, in general, a very restrictive policy of authorisation.

Thus, the United Kingdom hardly delivers more than 600 E112 forms per annum, France 400, Sweden 20. Proportionally, Belgium and the Grand Duchy show themselves less restrictive with respectively on average 2000 and 7000 cases per year.

It is undoubtedly one of the reasons which limit the financial impact of cross-border care for the Member States - hardly 2 € per inhabitant and per annum or less then 0,5% of the public expenditure of health. The Grand Duchy of Luxembourg, made however exception, by adding up an average cost of 116 € per inhabitant, that is to say 9% of his public expenditure of health. This relatively liberal policy of authorisation is explained mainly by the reduced capacity of the healthcare infrastructure of the Grand Duchy, taking into account the small size of its population.

The patients tend to resort initially to the dispensation of care near their residence. For the primary health services, factors like language, distance, lack of information regarding care in other states and administrative hurdles are objective obstacles to cross border care. Among the categories of population having free access to two systems of care of health, one notes that the movements of patients are very limited and this has been going on for many years.

Among the main conclusions of the 1990 study of AIM was the need for a less difficult access to cross border in the frontier areas and in the segment of the highly

specialized medical care. During last years, there was a proliferation of pilot projects of co-operation between the insurance organisations from the different areas of UE, mainly within the framework of INTERREG projects, in order to elaborate practical solutions for the recipients of social policy benefits living in these border areas.

A dual system of accession to cross border care in the European Union?

The ECJ supports the opinion, in the Kroll and Decker decisions, that the regulation 1408/71 does not cover all the forms of access to care in another Member State. The traditional procedures of this Regulation do not exclude other *types of regulation*, in particular does not preclude the refunding for care delivered without preliminary authorization on the basis of the tariffs applicable in the country of affiliation.

The Court did not desire to express its support for one or another of the procedures. However, it created a double system of social security covering care delivered away from the state of residence. It, however, underlined the specificity of each of the two procedures and their complementarity. Making abstraction of the condition of preliminary authorisation, the E112 procedure follows a different path from the procedure created by ECJ in the Kroll and Decker decisions.

- On the one hand, the procedure governed by the article 22, 1, C of the regulation 1408/71 integrates the patient of country A in the social protection system of the country of stay B, where he/she receives the medical service. This implies that the patient is treated in the same manner as a social policy beneficiary of country B, since he/she is affiliated there; he/she pays identical fees, must observe the same conditions (e.g. benefit recipients have to be present for certain procedures; if required, to obtain first a reference from a general practitioner before visiting a specialist, etc). The social security system of country B will deal with the expenses of the benefit and will clear them with the social security system of country A, on the basis of tariffs of country B.
- On the other hand, there is the situation when a resident of country A desires to receives healthcare from a foreign provider (country B). That implies that he/she will behave to some extent like a private patient: need not comply with the rules imposed by the social security of the country of stay - B (e.g. does not need a “reference” in country B in order to be examined by a specialist). The principle of equivalent processing does not refer to the social policy procedure of country B, but rather to the social policy procedure of country A, the country of residence of the patient. The payment of the expenses is not conducted between Member States but between the social insurance beneficiary from country A and his/her institution of insurance, just as if he/she had obtained the care in his/her home country, and thus confirms to the tariffs and rules of refunding applicable in country A (e.g. reference, authorization, people entitled to public or officially agreed benefits etc). Accordingly, the Court makes the point that the procedure E112 allows the holder of social insurance, who obtained the authorisation of a qualified institution, to receive suitable care in another Member State without having to undergo additional expenses, while procedure Kroll and Decker rather guarantees a free access to the foreign services under the same conditions as in the home country.

In fact, this dual situation poses problems. Not only does it emphasize one inefficiency of the administrative management of refunding of care in another country, but it is especially likely to confuse the patient, the person receiving benefits of care, and the insuring body and, consequently, to question the legal security in this matter.

This confusion and insecurity is accentuated by different interpretations which were made on the judgements. On the one hand, there were positive reactions, especially in the press which read them as significant steps in the accomplishment of a Europe for patients. On the other hand, they are regarded as a threat for the social protection systems, especially by the Member States which rang the alarm bell.

3.2.5 Reactions of the Member States

The analysis of the reactions of the Member States, after the judgments delivered by ECJ, underlines a political scission between one part of the countries equipped with a system of care refunding where the insured can generally choose freely the physician, and the other countries equipped with a system where the social security remunerates physicians directly, either on the basis of contracts or wages.

Among the countries with a system of refunding, Luxembourg and Belgium set up administrative procedures authorizing the unconditional refunding of services and ambulatory medical goods purchased in other Member States. France nevertheless refuses any modification of its procedures with regard to cross border care.

The other Member States, which lay out a system of social insurance organized according to the delivery of services in kind or a national service of health, generally considered that the judgments did not target them because they do not have a medical reimbursement of expenses advanced by the patients. In these countries, one usually does not lay out a nomenclature on the basis of which a refunding of services delivered in another country could be carried out.

Nevertheless, some exceptions stand out even in these situations:

- The most clear exception is that of Austria. Before the delivery of the judgments, this country had already provided its social policy beneficiaries with the possibility of being placed in the care of a person, without official permission, both in Austria, and in a foreign state. The Austrian health fund refunds the invoice of the care to the amount of 80% of the amount paid to an officially agreed person receiving similar benefits.
- The second interesting exception is that of Denmark. An interdepartmental working group concluded that certain ambulatory services are likely to be subject to the principles of free movement of goods and services. It is for this reason that a bill was adopted to authorize the unconditional refunding of services of kinesitherapy, dental care and some other services in a Member State.
- As for Finland and Greece, they recognized a partial application, but however limited, of these judicial decisions on their system of care.

The countries which rejected in a categorical way any implication of the judgments for their health system, displayed, semi-officially, a less radical position. Thus, Great

Britain and Germany, two of the countries among the most enthusiastic opponents of a generalized mobility of patients, refunded the whole of the exempted services when someone was in a similar case to those presented to the ECJ, without preliminary authorization, when the patients challenged them, only to avoid litigation in the court.

The various positions of the Member States and their determination to lead a restrictive policy of authorisation of care in a foreign State do not help clarify the real impact of the judgement on the various social protection systems. From the poll carried out with regard to the national governments, within the framework of the recent study of the AIM, it appears that the Member States fear above all the repercussions freedom of movement of patients could imply for their system of health, than a hypothetical massive escape of patients in a foreign State.

Actually, the national authorities which are concerned over this matter share the following questions:

- Up to what point could waiting lists be reabsorbed?
- Would fear that generalization of access to care in another State ruin national measures aiming at ensuring the efficacy and the quality of the care, since care delivered by foreign providers could escape any control?
- Will one still be able to define priorities and to decide in an autonomous way the area its healthcare system will cover (restore the autonomy of health care)?
- Will one have to refund the services received by patients who did not have an official permission for seeking the treatment? Considering the strong political sensitivity of the area, the European Commission abstained so far from making any comment or interpretation regarding the judgments. Consequently, in the short run, one hardly should await more clarity in this matter, till new related cases will reach the Court.

3.2.6 In search of a clarification on the impact of freedom of movement in the field of healthcare. Unanswered questions and new cases

The ECJ examined only the specific situations which were subjected to its ruling. To date, many questions remain unanswered. But, since the decisions Kohll and Decker, five new requests for preliminary hearing were introduced. They refer explicitly to the decision of the Court. Their interest consists in bringing answers to the questions unsolved by the judicial decision.

The first question relates to the possibility of free choice of the procedure by social insurance beneficiaries. In the case of Vanbraekel, the Labour Court of Mons (Belgium) estimated on basis of an expert's report that the insurance organisation of the plaintiff unduly refused to authorize refunding for an orthopaedic intervention in a Parisian hospital, and raised a prejudicial question with the ECJ about the applicable tariffs. Belgium prefers refunding on the basis of the French tariff as prescribed by the article 22.1.c of the regulation 1408/71, whereas the heirs of the patient claim the

application of the Belgian tariffs (higher), referring explicitly to the cases Kohll and Decker.

A second series of questions relates to the discretion available to Member States to regulate the access to care of certain groups (e.g. age, etc.) and by certain methods (e.g. periods of waiting etc.).

In the Smits and Peerbooms cases, there is – in both cases – the question of a Dutch social policy beneficiary to whom an experimental procedure was performed in another country, without preliminary authorization. Mrs. Geraerts - Smits, a patient suffering from the Parkinson disease received a specific and multidisciplinary treatment in a hospital from Kassel (Germany), which is not available in the Netherlands. Mr. Peerbooms, fallen into a coma after an accident, was transferred to the university hospital of Innsbruck (Austria) where he received - successfully – a special therapy for intensive neuro-stimulation.

In the Netherlands, this therapy is covered by the disease insurance only with a experimental title and in two Dutch hospital complexes, to which Peerbooms could not have had access taking into account his age (accesses reserved to patients 25 years old or younger).

In the two cases, the Dutch insurance agency refused to refund the expenses of these operations asserting the absence of medical reason justifying treatment in another State. It considered that the two patients were able to receive a treatment, adequate and sufficient, in the Netherlands. Moreover, the treatments, in these cases, are not regarded as customary by the Dutch medical profession, and are not included in the coverage of the mandatory health insurance.

In this register of situations, the question of the waiting lists is probably even more delicate than that of the experimental procedure. In the Van Riet case, a social-policy beneficiary Dutchwoman is checked into a Belgian hospital to undergo, without waiting, an arthroscopy so as to avoid waiting for three months to undergo this intervention in a hospital in Amsterdam. The Dutch insurance refuses the refunding of the expenses for the same reasons as in the Smits and Peerbooms case: absence of medical need to go to Belgium since adequate care could be supplied in the Netherlands, by an officially agreed provider.

Finally, several relevant questions will find, undoubtedly, answers in the examination of the pending cases. They relate to the application of the court decisions to services, both in kind and hospital care. The Müller-Fauré case concerns a Dutchwoman policy-holder who deliberately decided to undergo a dental intervention during her holidays in Germany, on the claim she was not satisfied with the services provided by the Dutch dentists.

When she transmitted the invoice of this care to her insurance organisation, the refunding was turned down on the grounds that the intervention was neither urgent nor medically necessary.

In all Dutch cases, the government recalls that the provision of out-patient care is based on volunteer individual contracts between insurers and beneficiaries – since

1992, the obligation for the insurance organisation to contract all the people has been abolished. Today, the Dutch citizen who wishes to be examined by a provider who is not officially recognized by the insurance organisation, must obtain preliminary authorization. The question is whether this defence is applicable in the case of hospital care.

The General Attorney, in the cases Kohll and Decker, admitted, in his conclusions, that in the issue of hospital care obstacles to the principle of freedom of movement could be justified taking into account the existence of a necessary programming and of the importance of the financial implications. The European Court of Justice is not marked on the matter since the K&D cases referred to ambulatory services.

In the Vanbraekel and Smits – Peerbooms cases, the General Attorneys concluded that the medical benefits under consideration do not enter in the field of the application of free provision of services. This unanimous position is particularly interesting because it relates – in the Belgian system - to refunding while, in the Dutch case, they refer to a system of in-kind services. To elaborate this thesis, the General Attorneys relied on the article 50 of the Treaty which defined the services as *services provided normally against remuneration*.

They estimated that the medical departments which form an integral part of a public system of health and which are financed by public incomes do not fall under this criterion. They refer, for this purpose, to a previous decision, that pronounced in the case Humbel, where the European Court of Justice ruled that public education is not fixed with the Community principle of free provision of services because the service provided is not remunerated.

If the Court of Justice follows this thesis, the incidences of the cases Kohll and Decker would be limited primarily only to the ambulatory services in three Member States, in particular the Grand Duchy of Luxembourg, Belgium and France. But it does not necessarily follow that the ECJ will follow this reasoning.

Some critical remarks can be made on the conclusion arguments and the comparison with public education. In the “Humbel” décision, three criteria were defined to determine if a service is not a remunerated service:

- the service is provided an agent of the State ;
- the service is primarily financed by public means ;
- the price is not pre-established.

In the case of cross border care, as in the Kohll case, we can rightly doubt the status of the foreign person providing the benefits (in this case, a German orthodontist) is an emanation of the State which refunds the expenses (*in casu*, The Grand Duchy). On the other hand, it is plausible to suppose that it could be a remunerated service if the person providing the benefits is an autonomous agent whose services consist of selling more or less freely. It is the case of the private care provided for in the framework of the social security. This affirmation could be identical if the service were remunerated within the framework of social security. The question relating to the fact that remuneration be carried out directly, as is the case in a system of in-kind services and a system of third payer, or indirectly in a system of refunding, is of no importance to decide whether we are dealing with a remunerated service.

Moreover, the general attorney, in the case Humbel, confirmed that by ruling that the way in which the State financed the public education, either directly by the school, or indirectly by granting a subsidy to pupils did not define the nature of the service as a remunerated service.

It is more the mode of individual contract rather than the mode of remuneration of the service (refunding or in-kind) which seems the key factor of appreciation of health services in the cases of freedom of movement of the goods and services. Although contracts with the patients receiving benefits (collective as in Belgium or individual / selective as in the Netherlands) fall within the competence of each Member State, the decisions Kohll and Decker suggest that the people receiving benefits and the providers of medical goods and services cannot be discriminated without legitimate justification. As the Luxembourg social security automatically integrates all people receiving care services in a national convention and refunds the services, it practises a discrimination against people receiving benefits in other Member States which do not enjoy this privilege.

The Kohll and Decker decisions relate to the systems of in-kind services. Even if within the framework of social protection each Member State may decide upon the delivery of medical services to a restricted group of officially agreed people, foreign providers must enjoy the same access to obtaining a contract with officially agreed beneficiaries. The Court of Justice already declared that the Community rules on internal market were applicable to the services of disease insurance.

Finally, the principle of non-discrimination would also be applied to the not-officially approved interventions. When the system of social security refunds the services without requesting official pre-approval, like in Belgium, foreign suppliers who practice on the territory of the European Union should enjoy equivalent conditions, unless reasons of public health or general interest can justify an inequality of treatment.

3.2.7 Future prospects

Taking into consideration this analysis, the Kohll and Decker cases seem to give precedence to treating discriminations between people receiving benefits and providers, rather than the freedom of movement of patients. It would not be, moreover, surprising that ECJ leans, in future, on cases emanating from providers (rather than from patients), injured by the conventional system of a Member State or the conventional policy of an insurer.

This prospect for European cross border contracts throws a new light on the future of the application of the principle of freedom of movement in the sector of health and the development of a European market in healthcare. Against the most pessimistic scenarios, based on the deregulation generated by the freedom of movement of patients, the conclusion of cross-border conventions would insure the possibility of foreigners receiving benefits of guaranteed quality, and at the same costs as the nationals. This prospect should stimulate the Member States to adopt a more flexible position with regard to the recourse to the cross border care, in particular where it addresses a real need.

It is particularly the case:

- in the border areas where the regional offer of care could be improved by adding complementary services;
- for specific medical interventions, requiring know-how and sophisticated technologies which would be delivered in establishments of care defined as *centre of excellence of international vocation* ;
- in tourist zones or in exceptional and seasonal concentration of people having certain characteristics (linguistic or different) ;
- for certain types of care which, for lack of personnel or other resources, cannot be provided immediately and require waiting lists.

However, the propensity of the patient to resort to care in another State does not rise only from personal reasons. More and more frequently, other actors (doctors, hospitals, insurer organizations) concerned with the European market of health, influence the patient in these choices. They will intensify, probably, the recourse to cross border care in future.

The cross border convention is not science fiction. It is practised by certain organizations of health insurance in the frontier areas. These are, in addition, in the search of viable partners in non-bordering Member States. Also, the conclusion of strategic alliances between regional or national insurers gains in importance.

However, if we want European integration in the field of the care of health and the cross border conventions to become a social and realistic option, a structure of European reference is necessary. This should make it possible to establish points of comparison with regard to standards of quality, accreditation of providers, equivalence of medical practices, etc. If, moreover, one wants to ensure that economic integration does not create social inequalities in the matter of access to care, it is essential to attach fundamental and restrictive conditions to this process. The Community level seems the only level ready to undertake this task in an effective way. Fresh impulse given to the Community strategy with regard to social protection and health could offer the instruments necessary for such prospects.

3.3 IMPLEMENTATION OF THE ACQUIS

As was previously mentioned, the acquis relevant for the health sector is represented mainly by Chapter 13 –Social Policy and Employment, and Chapter 23 – Consumer and Health Protection. However, these chapters deal with public health and safety at work measures that have little bearing on social security arrangements, the topic of this study. The health relevant legislative tables of Chapters 13 and 23 are annexed. The only chapter that deals directly with health social security issues is chapter 2 – free movement of people. Again the relevant components of the legislative timetable are annexed.

There are a number of other issues that bear relation to the provision of health services. It is the case of internal market regulations (i.e. competition regulation) concerning non-discrimination between domestic and community companies in public procurement – relevant for preferential treatment for domestic producers in the case of registration of, and tenders for pharmaceutical products (i.e. Romanian manufacturers are not required the GMP standard). Also patent protection is not fully harmonized with EU rules (in what concerns the supplementary protection certificate - SPC).

Further on I shall discuss only the implementation of the regulations 1408 / 71, and 574 / 72 that provide for the compatibility of social security schemes in order to facilitate the free movement of people – the hard core of the acquis on health social insurance.

The main actors that have to deal with the implementation of the health aspects of regulations 1408 / 71 and 574 / 72 are the National Health Insurance House (NHIH) and the Ministry of Health and Family (MHF). In order to evaluate the administrative capacity problems that might hinder the implementation of the acquis I present an overview of the two institutions, focused on their respective structures dealing with European integration issues.

3.3.1 European integration and the National Health Insurance House

Legal base, resources and organizational structure

The activity of NHIH is based on the Health Insurance Law 145/1997, successively amended by the Emergency Ordinances 30/1998, 72/1998, 170/1999, 180/2000, on the Hospitals Law 146/1999 and the National Frame Contract of each year. The document that settles the organization and the functioning of NHIH is the Statute of NHIH, elaborated in 2001. More information is provided in the annexes. At local level, each NHIH elaborates its own statutes, according to the national legislation and the provisions of NHIH.

At central level, the main decisional structure is the board of NHIH, and the main executives responsibilities belong to the president of NHIH, who is also the president of the board (for further details, see the Statute of NHIH, chapter 3).

The National Health Insurance House does not have the right to legislative initiative. All its legislative suggestions are sent to the Ministry of Health and Family (MHF).

MHF evaluates these projects and submits them to the discussion of the Cabinet, which decides whether to enact them directly (as Government Ordinance) or through the Parliament.

The funding of NHIH and CHIH is ensured from the Social Health Insurance Fund, part of the State Social and Health Insurance Budget, which is separate from the State Budget, both of them being sent for parliamentary approval by the Government.

There has been no evaluation of the needs of NHIH related to the process of European integration, and no budgeting of these needs. This fact makes it difficult, if not impossible, to schedule actions like training programmes for employees or building a database on EU integration related documents – e.g. an EU legislative library, a collection of studies of impact, and assessments of needs and costs of European integration in the health insurance field.

There are two structures in charge with the foreign relations of National Health Insurance House (NHIH): the Service for European Integration (SEI) and the International Relations and International Cooperation Programs Direction (IRICPD). According to the organizational chart presented in annexes, the structure of NHIH at central level presents two particularities, which question the efficiency of the organization of the institution.

a. A clear separations of the two departments. If SEI reports directly to the president of NHIH, the IRICPD is accountable, together with, for instance, the PR and Marketing Direction, to the Logistics General Deputy Director – a more marginal position.

b. The difference in stature. As it might be noticed from their names, the two structures have different importance – the first is only a *service*, which result in a scheme of personnel of only five persons, while the second, being *direction*, has 13 persons, including a director. That leads to different budgets for the two structures. The funding for each of the structures is made accordingly to the personnel scheme, with no others supplementary funds. It can be inferred there is a real difference between the two structures in terms of power and responsibilities.

The orientation of the NHIH to the outside, the priority that is given to foreign relations seems to be, judging from the organizational scheme, rather low. Moreover, while Romania is expected to join EU within the next ten years, and accordingly the relations with EU are going to become the main focus of its international activity, the importance given to SEI is not commensurate.

The health social insurance system is relatively decentralized, with the District Health Insurance Houses (CHIH) discharging important functions. CNAS establishes and manages the policy and the general strategy within the social insurance system however.

It is therefore surprising there is no direct connection established between SEI and CHIH. SEI has no counterparts in the counties, no formal direction or service is within the organizational chart of CHIH. We have to bear in mind that SEI is a service – therefore with limited administration power and resources.

The Service for European Integration

The Service for European Integration is directly subordinate to the president of NHIH. SEI has a double role:

- consulting and analyses, upon request, on integration issues relevant for NHIH;
- drafting and monitoring the implementation of the undertakings of NHIH in the negotiating chapters in which the House is involved (SEI was responsible for the elaboration of point 7 from the *Position paper for Chapter 2 of negotiations of accession of Romania to the European Union – Coordination of social security schemes*).

The reduced prerogatives of SIE mean that the general or sector policies of NHIH which might contravene to EU requirements in this field cannot be identified timely. SEI is making part both of an internal working group (which includes representatives of Judicial Direction, IRICPD, and Evaluation, Incomes and Costs Direction), and of the inter-ministerial working group for chapter 2 of negotiations.

The inter-ministerial working group was set up by government decision in 2001, and the coordinating ministries are Ministry of European Integration and the Ministry of Labour and Social Solidarity. Participants in the group are the representatives of the ministries and governmental agencies of Labour (MLSS), European Integration (MEI), Health (MHF), Education (MER), Justice (MJ), Finance (MPF), Foreign Affairs (MFA), Home Affairs (MI), Small and Medium Size Enterprises (MSMEC), Industry (MIR), State Secretariat for the Persons with Disabilities (SSPH), National House of Pension and Other Social Insurance Rights (NHPSIR), Agriculture (MAAP), National Sanitary Veterinary Agency (ANSV), Public Works (MPWTH), Economic and Social Council (ESC), National Agency for Child Protection (ANPC) and National Agency for Employment (NAE). The group had as main task drafting the position papers for second chapter of negotiations. Within the group functioned different sub-groups, one for each section of the position papers. The elaboration of section 7 was made by the representatives of CHIH, MLSS, MHF, MER, NAE, MJ and NHPSIR. This particular group had weekly meetings. The main out-put was the substantiation file for each section of the position paper. The most important problem for this file was the absence of a financial evaluation for the monetary needs, evaluation that was the task of the Ministry of Public Finance⁷⁰.

The activity of the entire group has ceased at the end of 2001, and for the moment they are in stand-by (waiting for the reactions from Brussels regarding the position paper).

SEI was created in April 2001 (the structure is still “young” – the oldest employee has only two years in office, not surprisingly if one takes into consideration that the entire NHIH was created in 1999). SEI has 5 employees, 4 of them full-time. Three of them

⁷⁰ From MLSS, SEI received:

- The substantiation sheet card
- The concordance table
- The Budgetary sheet card (financial needs). No guidance was provided for filling in the budgetary requirements, either from Labour or Finance ministries, and no cost-evaluation was performed by any of these organizations. The problem was dealt with similarly in the case of the National House of Pension and Other Social Insurance Rights.

have an economic education, including the head of SEI. The fourth is a medical doctor. SEI does not have any legal expert.

The personnel training on integration issues is not the strongest point of SEI, only the head of SEI participating at two training programs - one in Sofia, Bulgaria, through a personal connection with an NGO, and one organized by the Coordination Unit for Continues Training, within the CONSENSUS III project, „Development of institutional capacity at NHIH and CHIH level”. Currently, for the entire NHIH, there are no training programmes regarding the European integration.

As it was already mentioned, SEI has a consulting and analyzing role. SEI is also drawing up reports for both MLSS and MHF. MLSS is permanently informed (as the lead institution for the chapter) over the evolutions of commitments taken in the position paper for chapter 2 (the part concerning NHIH activity).

Co-operation with governmental and non-governmental partners

The communication problems of SEI with MHF and particularly with the equivalent department within MHF causes failures in the daily activity. A solution could be to shorten the communication channel for requests made by other partner government institutions to SEI, by directly addressing the requests to SEI, not through MHF, as done in the present.

Another discontent is linked to the fact the NHIH is reduced to an execution role for punctual requests. What people are missing is the big picture. The solution could be to the full integration of NHIH in the respective process.

On the bright side, there are good relations with MLSS, MEI, and the Delegation of the European Commission. SIE has good relations with the Institute of Health Services Management, the Romanian Foundation for Democracy, USAID, World Bank, World University Service Romania (with the latest they have discussed a partnership for training).

The consulting in pre-accession program CONSENSUS III is the only twinning project that is under way with Phare funding. CONSENSUS is a twinning program with Germany – pilot-project on institutional development for NHIH and CHIH from seven departments (Bucharest, Argeş, Sibiu, Constanţa, initially Braşov and then Olt, Suceava and Iaşi). The emphasis is on communication inside NHIH. The programme is due to end in December 2002.

New developments

Legal base for NHIH activity on EU health insurance market – the new law on expenses clearance (which will include the service package) is its final stages in Parliament. It will regulate the export of benefits and non-contributive-benefits⁷¹. This new law is expected to clarify who and how will pay the care of the Romanians

⁷¹ The EU forms for benefiting health services within another member state are:

- E 111 – filled in by the employer; it gives the right to benefit of health services in another member state, paid accordingly to rules of the residence state (at the same value paid by the insurer or the insurance system as if the care was provided in the state of origin)
- E 112 – filled in by the doctor; it gives the right to treatment in another member state when there are no equivalent services in the residence state of patient; in this case the insurer of the patient integrally pays the costs.

abroad and the care of foreigners in Romania – but till the law is issued, these matters are dealt with other mechanism⁷².

Because there are no legal provisions, NHIH does not have the right to make external payments (the bills for the benefits consumed by the Romanian citizens outside the country are paid by MLSS from the State Budget and not by NHIH from the budget for healthcare).

In this case, there are no impact studies over the different problems that can appear after the law is adopted (nobody knows who will cover the cost differences of health services or what is the solution for the differences between the way drugs are reimbursed in EU and in Romania, especially when we are dealing with different drugs). On the other hands, based on the experience of the current member states the amounts involved are moderate.

3.3.2 European integration and the Ministry of Health and Family

Legal base, resources and organizational structure

Within the structure of the Ministry of Health there is a Secretary of State in charge with the coordination of:

- Department of European Integration and Legislative Harmonization (DEILH),
- Department for privatization and relations with foreign and local investors and
- Department for external relations.

The organisational chart of MHF is annexed.

The projects of the Ministry concerning European integration have been allocated the sum of 0.8 million Euros, representing a meager 0.16% of the 487 Million Euros budget of MHF.

The Department of European Integration

The Department for European Integration was created in 1994. The personnel consist of seven persons plus collaborators from other departments. The personnel are not specialized in the field of integration (training took place practically on the job) - training is needed, and there is a suggestion that training should be provided for short periods, and in Romania. The professional background of the staff is economic and medical; there are no lawyers in the department.

DEILH has as main task granting consultative opinions in the field of drafting medical legislation, certifying whether a draft is formulated in accordance with the European legislation. Nevertheless, the responsibilities of DEILH do not include initiating legislative drafts itself. The drafts arrive to DEILH for consultation from the specialized departments which have proposed them. More specifically, a draft law has to cover the following route inside of the ministry:

- Specialized departments produce the draft law;
- This is sent to the DEILH (and other departments) for consultation;

⁷² Currently it is the Labour Ministry that pays for the health services received by the Romanian nationals in other states, which have concluded a convention with Romania. The list of bilateral conventions concluded by Romania is annexed.

- After giving its opinion, DEILH sends the draft law to The Department for legislation and judicial review;
- The Department for legislation and judicial review sends the draft law to the Minister of Health and Family

DIEAL has a rather passive role in that it advises on new legislation, but it does not scrutinize existing legislation. DIEAL is able to involve through consultations other departments and services in the process of legislative harmonization. The consultation consists of analyses of draft laws according to community provisions, on a certain policy chapter, depending on the special expertise of the respective department.

The Ministry of Health and Family takes part in the following negotiation chapters with the European Union: 1-The free movement of goods; 2- The free movement of people; 3- The free movement of services; 5 – Commercial Law; 7 – Agriculture; 13 – Social policies and employment; 19 – Telecommunications and information technology; 22 – environmental protection; 23 – Health and consumer protection, 24 – justice and internal affairs; 25 – custom unification

Co-operation with governmental and non-governmental partners

Cooperation between DIEAL and the other departments within the Ministry of Health and Family, as well as with the other public institutions depends greatly on the personal relations. The department cooperates with the other ministries involved in the negotiation chapters. Cooperation with nongovernmental partners is difficult, mainly because MHF is only a co-funder and has little leverage on the recipients compared with EU institutional donors.

DIEAL has the coordinating role within MHF in implementing the Phare projects. The Phare projects the department is involved in are:

- Phare Project 2001 – improving the network of epidemiology (4.8 millions Euro)
- Phare Project 2002 – four projects (20 million Euros) on Public Health, Occupational Health, and Environmental Protection.

The department of European Integration and Legislative Harmonization is involved in the implementation phase of the World Bank II project. The budget of this project rises to approximately 65 million dollars.

In what concerns the tricky issue of the relationship with the National House of Health Insurance (NHH), from the point of view of the Ministry of Health and Family (MHF), between the Ministry and the House there is a clear delimitation of responsibilities:

- NHH does not have a political role, and therefore there is no reason for its becoming involved in drafting health policies
- NHH only plays the role of implementing the health policies drafted by the Ministry of Health and Family

3.3.3 Conclusion

The challenges facing SEI and DEILH come both from internal failures of their respective institutions (NHIH, and MHF), and from poor institutional rapports of these with other governmental actors (and especially one with another).

Internally, SEI has a good connection to the top management of NHIH. However the international relations department (IRICPD) is placed far apart in the organizational framework of NHIH, what does not facilitate the co-operation between the two related structures. The situation appears better in MHF, where both the Department of International Relations and DEILH report to the same junior minister.

Both structures lack sufficient resources (both in quantity and in skills). Systematic training is badly needed, and the absence of lawyers specialized in European Law is particularly worrying. The administrative procedures are not very developed either. In both institutions there is no formalized in-house or external evaluation mechanism. For the matter at hand, i.e. the implementation of the two regulations, there has been no institutional analysis for the entire process, no feasibility studies were made. In addition, because the Ministry of Public Finance (MPF) was almost always absent from the discussions for chapter 2 of negotiations, the funding needs were not discussed.

Externally, beyond explanations based on personal chemistry that can carry us so far, the lack of co-operation between NHIH and MHF is to be expected, as I have detailed in the section on the institutional analysis of the healthcare system. On the positive side, the co-operation with the Labour Ministry appears to work better (especially in the case of SEI). However, the relations with the Ministry of Public Finance are rather weak, what prevents the transfer of important budgeting skills, and does not guarantee resources for whatever international undertakings and implementation plans SEI and DEILH might have.

3.4 MAJOR ISSUES AND RECOMMENDATIONS

We shall resume the argument of the study, structuring them on four counts:

- the compatibility of the Romanian health system with the European regulation and practice in the field
- the approximation of legislation
- administrative capacity
- sustainability of the Romanian health system

Finally, we shall formulate short recommendations.

Compatibility with the European social model

This is a question that appears often in Romania. Fortunately, as is the case with most social policies, there is little that the *acquis* positively precludes. As was mentioned in the chapter presenting the *acquis*, healthcare is still a national prerogative. The European practice is that there are both health systems based on social insurance (as Romania is building now), but also national, tax-based systems, similar to the one Romania has got rid off. As far as the European social model is concerned, Romania may very well not have reformed its health system. The matter where there is a substantial difference in the Romanian and European practice is the overall resources allocated to healthcare. While most European states spend around 9-10% of GDP for health (with UK the laggard at 7% but with an upwards trend), and even the other CEEC spend over 6% of GDP, global health expenditure in Romania reaches only 4% of GDP. It is conceivable that the concern for social rights at the European level will translate in pressure to increase public expenditure on health. Moreover, as we have discussed in the *acquis* implementation section, European citizens are entitled to receiving health services abroad if they are not available in the country of residence. This might force a certain increase in health expenditure by back door.

Acquis approximation

The hard *acquis* on health social insurance is limited to regulations 1408 / 71, and 574 / 72. Romania is in advanced state of translating these regulations into domestic legislation. What is lacking is the preparation for implementation, issue that will be dealt with in the next section (administrative capacity).

Apart from the two regulations on the compatibility of social security systems, there are a number of other problems concerning the internal market regulations, relevant for the healthcare sector. More details presented in the *acquis* implementation section. Some are specific to the health sector, but most concern general free movement of goods and services provisions, like non-discrimination of foreign versus domestic manufacturers in access to market and rules of public procurement.

Emerging threats.

In the *acquis* section we have described at length the new legal trends introduced by rulings of the European Court of Justice. They support the conclusion that quasi market arrangements (as is the case with social security arrangements) are open to legal scrutiny under internal market regulations (i.e. free movement, and competition).

Administrative capacity

There are a number of factors contributing to the low capacity of implementing acquis related regulation. On one hand, there are internal institutional design flaws: the weak institutional position of the European integration departments – i.e. their marginal position in the decision making process, the separate reporting from the international relations departments (in the case of NHIH). These design flaws are compounded by the weakness of the department themselves: poor access to resources, lack of adequate personnel (i.e. lawyers), and lack of training. A role plays here the poor knowledge of decision makers about European integration issues, what both does not allow them to compensate the failures of the European integration departments themselves, and also to recognize the importance of these departments, and therefore allocate them appropriate resources.

The second set of factors is the inter-institutional design problems. Here comes the poor communication between different government agencies, especially with the Ministry of Public Finance (MPF). Specific for the health sector is the rivalry between the Ministry of Health and Family (MHF) and the National Health Insurance House (NHIH), born out from ill-defined competencies. A consequence is the fact that NHIH is still unable to engage in international transactions, and health benefits consumed abroad by Romanian nationals are paid from the budget of the Ministry of Labour and Social Solidarity. This matter is to be resolved soon, however it symbolizes the deficiencies of the system: NHIH had a pressing problem that required legislation, however it was precluded to initiate legislation itself, and was unable to move the Ministry of Health and Family to initiate it in its place.

These two types of administrative failure (inter-institutional co-operation and intra-institutional organization) have resulted in the lack of preparation for the administrative implementation of regulations 1408 / 71, and 574 / 72: the costs are practically unspecified (both administrative implementation costs, and service costs), proper budgeting was therefore impossible, and no training was provided to the staff that is supposed to administer the new legislation, even if on this last count plans are being put in place.

Sustainability

The sustainability of the Romanian healthcare system requires first of all adequate budget control mechanisms at the hospital level. The hospital profligacy sucks in resources destined for primary care and medicines consumption. The incentive misalignment that results in the current serious funding crisis has been analyzed in the healthcare background section.

A second type of concerns for the sustainability of the healthcare system springs from its ill-conceived institutional structure, as presented above. We have argued in the health background section, that the current status quo is untenable, and it should evolve either towards greater autonomy of NHIH from the Ministry of Health and Family, or, conversely, towards the integration of the House in the Ministry - somehow similar to the situation of the National House of Pension and Other Social Insurance Rights, and along the path the Hungarian health system (a major influence on the Romanian health social insurance legislation) has evolved.

Finally, resource allocation is another reason for concern. Even if Romania has increased the public expenditure on health since the introduction of social insurance, it continues to under-spend when compared both with EU member states, and even

with its CEE neighbours. In this context, the Ministry of Finance systematic denial NHIH the permission to use all the funds collected for health is unjustifiable.

On the positive side, the rate of collection of the health contribution has been robust. The recently aired proposal of the Ministry of Labour and Social Solidarity of unifying the health fund with the (poorly collected, heavily in deficit) pension fund raises serious concerns for the sustainability of the Romanian healthcare system, but this is just a tentative development, that should be addressed in another study when more details emerged.

Recommendations

On the short term:

- With assistance from the Ministry of Public Finance, a full cost-evaluation of the implementation of regulations 1408 / 71, and 574 / 72 should be realized; based on this evaluation, budgetary resources should be allocated
- The role of the European Integration Departments should be bolstered:
 - their positions in their respective institution should be improved – e.g. by:
 - increasing their status – i.e. upgrade SEI from NHIH to full department status
 - better relating them to the International Relations Departments, especially in the case of NHIH
 - the resource allocation should be increased
 - lawyers specialised in European Law should be included in their structure
 - a large training programme should be devised
- As the main funder in the health system, the operational autonomy of NHIH should be increased – e.g. by:
 - Finalising granting it the ability to engage in international transactions
 - Granting it the right to initiate legislation
 - Including NHIH in all inter-ministerial committees dealing with health matters
- In order to safeguard the sustainability of the health system:
 - hard budget constraints should be introduced for hospitals
 - NHIH should be allowed to use, under proper financial supervision, all funds collected from the health tax

On the medium term:

- The roles of MHF and NHIH should be clarified
- The Romanian government should confirm to internal market regulations, and preclude all discriminatory treatments between international and domestic manufacturers of health products (e.g. pharmaceutical products)
- The Romanian government should be prepared to increase the resources allocated to health
- The health governing authorities should keep an eye on ECJ for rulings concerning social insurance based healthcare

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