

**Assessment of sexual, reproductive, maternal, newborn, child and adolescent health in the context of universal health coverage in Romania**



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# Abstract

Achieving universal health coverage (UHC) – meaning that everyone, everywhere can access essential high-quality health services without facing financial hardship – is a key target of the Sustainable Development Goals. Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services that WHO uses as indicators of the level and equity of coverage in countries. In this context, WHO undertook an assessment of SRMNCAH in Romania. This report examines which SRMNCAH services are included in policies concerning UHC in the specific country context; assesses the extent to which the services are available to the people for whom they are intended, and at what cost; identifies potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens; and identifies priority areas for action. A set of policy recommendations provides the basis for policy changes and implementation arrangements for better SRMNCAH services and outcomes in the context of UHC.

## Keywords

SEXUAL AND REPRODUCTIVE HEALTH  
MATERNAL AND NEWBORN HEALTH  
CHILD AND ADOLESCENT HEALTH  
UNIVERSAL HEALTH COVERAGE  
HEALTH CARE SYSTEM  
QUALITY OF HEALTH CARE  
DETERMINANTS OF HEALTH  
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The authors’ views expressed in this report do not necessarily reflect the views of the World Health Organization or the Ministry of Health of Romania.

# Abbreviations

BCG	bacille Calmette–Guerin [vaccine]
EU	European Union
FP	family planning
GDP	gross domestic product
HPV	human papillomavirus
HTA	health technology assessment
IMCI	Integrated management of childhood illnesses [WHO strategy]
NGO	nongovernmental organization
NHIF	National Health Insurance Fund
NHIH	National Health Insurance House
OECD	Organisation for Economic Co-operation and Development
SHI	social health insurance
SMURD	Serviciul Mobil de Urgență, Reanimare și Descarcerare
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
STI	sexually transmitted infection
TB	tuberculosis
UHC	universal health coverage
UNICEF	United Nations Children’s Fund

# Executive summary

An assessment of sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) in the context of universal health coverage (UHC) was conducted in Romania on 21–25 January 2019. It included document reviews; interviews with policy-makers, health facility managers, service providers and clients; and visits to health facilities. Six SRMNCAH “tracer” interventions were investigated in greater depth, identifying barriers to access and utilization of services along the essential pillars of UHC.

The assessment found that Romania has given high priority to health care for mothers and children, adopting a national health programme for women and children for 2014–2020. This is also evident through the government’s health coverage of specific population groups, such as pregnant women and children, as well as multiple national protocols for the care of these groups. However, a comprehensive sexual and reproductive health strategy is lacking. Despite well intended policies, not all SRMNCAH services included in the health benefits package are provided free of charge, with adequate quality at the relevant level or reaching the most vulnerable population groups. Analysis of several tracers reveals significant deficits – for example, in provision of adolescent-friendly sexual and reproductive health services, fragmentation of SRMNCAH services and lack of providers skills at the primary care level, perverse financial incentives, among others. Beside the overall low spending on health, Romania suffers from system deficiencies and inefficient spending of the moderate resources available. Further, there are inequalities between urban and rural populations in access to health care services, in terms of both availability and quality.

The challenge is that the policy and management levels of the health system have not fully operationalized the key elements committed to in the health strategy.

Given the overall resource limitations in Romania, finding savings and efficiency gains in service organization, delivery and financing are crucial to ensure greater coverage of SRMNCAH while maintaining the quality of services provided. The assessment identified number of areas where improvements could be made without necessarily increasing the total budget. A set of policy recommendations intends to provide the basis for policy changes and strengthen implementation arrangements for better SRMNCAH services and outcomes and contribute to the efforts in accelerating progress towards universal health coverage.

# Introduction

Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition of UHC embodies three related objectives:

- equity in access, meaning that everyone who needs health services should get them, not only those who can pay for them;
- health services of good enough quality to improve the health of those receiving services; and
- protection against financial risk, ensuring that the cost of using services does not put people at risk of financial harm.

Achieving UHC is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015.

Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services in four categories that WHO uses as indicators of the level and equity of coverage in countries. Essential SRMNCAH services used as indicators for UHC are:

- family planning
- antenatal and delivery care
- full child immunization
- health-seeking behaviour for pneumonia.

An assessment of SRMNCAH in the context of UHC in Romania was conducted on 21–25 January 2019. Its specific objectives were to:

- delineate which SRMNCAH services are included in policies concerning UHC in the specific country context;
- assess the extent to which the services are available to the people for whom they are intended, and at what cost;
- identify potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens;
- highlight good practices and innovations in the health system, with evidence of their impact on SRMNCAH services;
- identify priority areas for action and develop policy recommendations jointly with the country to address health system barriers to the provision of SRMNCAH services.

The assessment was carried out on behalf of the WHO Regional Office for Europe and it is intended that similar assessments will be conducted in other countries in the WHO European Region.



# Methodology

A methodological approach was developed prior to the assessment and underwent several revisions. The visit to Romania was the fourth visit in a series, the first taking place in the Republic of Moldova in September 2018. The steps in the assessment included:

- a preliminary document review, including health policy and strategy documents, sexual and reproductive health and child and adolescent health strategy documents, UHC guiding documents, service package descriptions and similar;
- a country visit, including:
  - interviews with policy-makers from the Ministry of Health, health facility managers (primary health care and hospital), service providers (doctors, nurses and others) and beneficiaries (patients and clients);
  - visits to health care facilities at primary, secondary and tertiary levels;
- a presentation and discussion of findings and recommendations with key stakeholders at the end of the visit.

Semi-structured questionnaires were developed to conduct interviews with key informants such as, including:

- representatives of the Ministry of Health;
- health facility managers (hospital and primary health care);
- health workers including nurses, doctors and midwives, where applicable;
- patients and clients, including adolescents;
- partners and stakeholders, including representatives of the United Nations Children's Fund (UNICEF).

## Tracer interventions

Since the amount of resources and time available for the assessment were limited, six tracer interventions were identified and analysed in depth to assess the extent to which services are available to the people for whom they are intended and at what cost. These were:

- transport of sick neonates
- immunization
- case management of common childhood conditions
- antenatal care (including pre-eclampsia detection and management)
- adolescent-friendly health services (sexual and reproductive health)
- sexually transmitted infections (STIs) (excluding HIV).

The findings are analysed and reported according to WHO's six building blocks of UHC (Fig. 1).

**Fig. 1. The building blocks of UHC**



Source: Universal health coverage [website]. Geneva: World Health Organization; 2019 ([http://www.who.int/universal\\_health\\_coverage/en/](http://www.who.int/universal_health_coverage/en/), accessed 23 April 2019).

## Limitations

The methodology aims to triangulate information through document reviews, visits to health facilities and interviews with policy-makers, health managers, providers and clients. The depth of the assessment depends on the completeness of documents provided by the Ministry of Health and partners, as well as the extent to which the health facilities visited and key informants interviewed are representative and reflect the national context and situation. The appraisal of tracer interventions and health system barriers and challenges represents the judgement of the assessment team, based on the information obtained.

## Country context

Romania is a country located at the crossroads of central, eastern and south-eastern Europe. With a total surface area of 238 397 square kilometres, it is the twelfth largest country in the European Union (EU). It is also the seventh most populous EU country, with almost 20 million inhabitants, but the population has decreased since the 1990s owing to declining fertility and birth rates, relatively high death rates and outward migration. Approximately half of the population live in rural areas, where availability of services is more limited than in urban centres.

Romania has been a member of the United Nations since 1955, part of the North Atlantic Treaty Organization since 2004 and an EU Member State since 1 January 2007. The majority of the population are native speakers of Romanian and identify as Eastern Orthodox Christians. Romania is an upper-middle-income country. Its most important economic sectors in 2016 were industry (25.7%), wholesale and retail trade, transport, accommodation and food services (20.2%) and public administration, defence, education, human health and social work activities (11.7%).

# Health system organization and governance

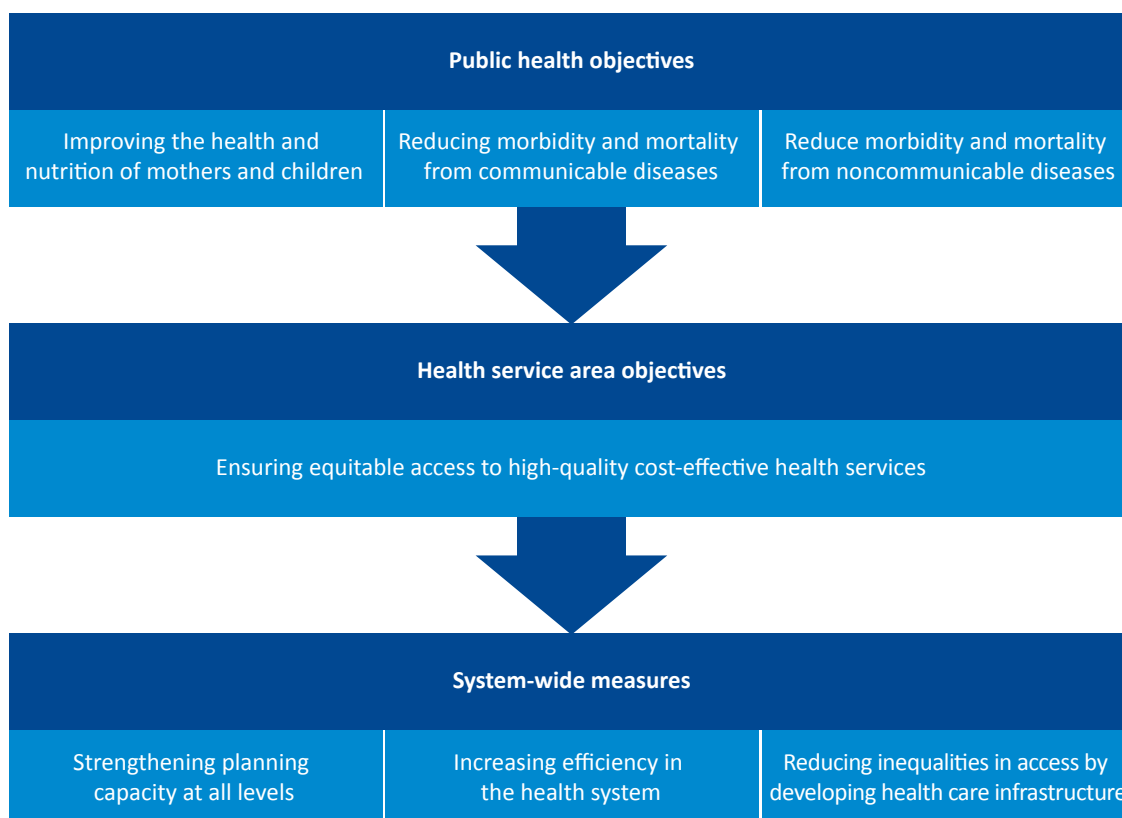
The health system in Romania remains highly centralized. The Ministry of Health is responsible for stewardship of the system and its regulatory framework, and is represented at the district level by district public health authorities. Another key player at the national level is the National Health Insurance House (NHIH), which administers and regulates the social health insurance system. The NHIH also has representation at district level via district health insurance houses.

Five main professional organizations at the national level (College of Physicians, College of Dentists, College of Pharmacists, Order of Nurses and Midwives, Order of Biochemists, Biologists and Chemists) actively participate in the process of defining the NHIH's benefits package. They are responsible for regulating their respective professions, monitoring health care professionals' practice and staff training and accreditation.

The approach to planning in Romania has changed somewhat since the 1980s. The planning functions are still highly centralized, reflecting the overall centralization of the health system. The main institutions involved in planning at the central level are the Ministry of Health, the NHIH and the Ministry of Public Finances. The district public health agencies and district health insurance houses are involved in planning at the local level, usually via submitting requests. The link between planning decisions at the central level and population health needs is not strong. The existing information systems do not facilitate identification of health priorities and rapid evaluation of needs, or providing feedback to decision-makers.

The key medium-term planning tool for the health sector is the National Health Strategy. The current strategy came into force in 2014 and covers 2014–2020. It covers three areas: public health, health services and system-wide health issues (Fig. 2).

**Fig. 2. Main objectives of the National Health Strategy 2014–2020**



Source: Strategia Nationala de Sanatate 2014–2020. Sănătate pentru prosperitate [National Health Strategy 2014–2020. Health for wealth]. Bucharest: Ministry of Health of Romania; 2014 ( <http://www.ms.ro/wp-content/uploads/2016/10/Anexa-1-Strategia-Nationala-de-Sanatate-2014-2020.pdf>, accessed 21 October 2019).

Romania has no sexual and reproductive health strategy, so it is difficult to judge whether sexual and reproductive health is a priority. It should be noted, however, that the country has a national health programme for women and children and a national strategy for gender equality for 2018–21, according to a draft report on gender perspectives on sexual and reproductive health and rights in Romania seen during the assessment visit.

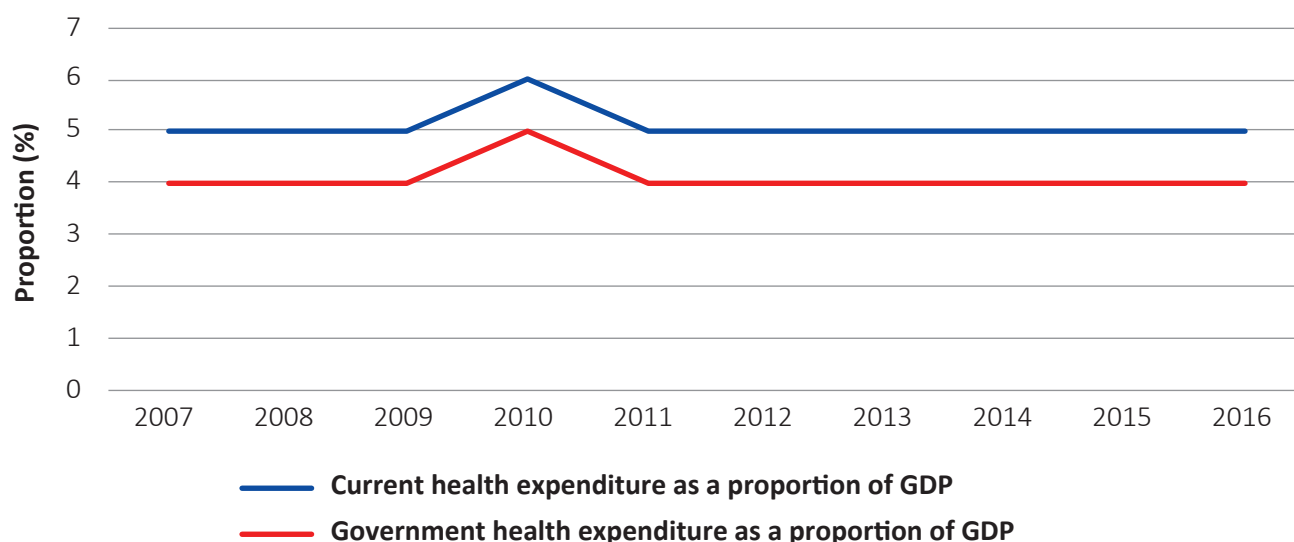
The key legal act governing the Romanian health system is Law 95/2006 on Health Care Reform. An accompanying comprehensive framework document brought together almost all main health care legislative acts and created the *acquis communautaire*. This consists of 19 topics, including health system financing, organization, governance and service provision (public health, primary care, emergency care, specialized outpatient care, hospital care and pharmaceuticals, human resources for health). The Law came into force in 2006; since then, over 1300 amendments been introduced.

The government's health reforms include strengthening the role of primary care and reducing the number of hospital beds, but health care provision remains characterized by underprovision of primary and community care and inappropriate use of inpatient and specialized outpatient care, including care in hospital emergency departments. The numbers of physicians and nurses are relatively low in Romania compared to EU averages. Other reforms have focused on introducing cost-saving measures, including shifting some health care costs to drug manufacturers (through claw-backs) and to the population (through co-payments), and on improving health care expenditure monitoring.<sup>1</sup>

## Health system financing for UHC of SRMNCAH

Romania spends around 5% of its gross domestic product (GDP) on health (Fig. 3). The government share of health expenditure as a proportion of GDP is around 4%, which is almost half the EU average.

**Fig. 3. Current health expenditure and government health expenditure as a proportion of GDP**

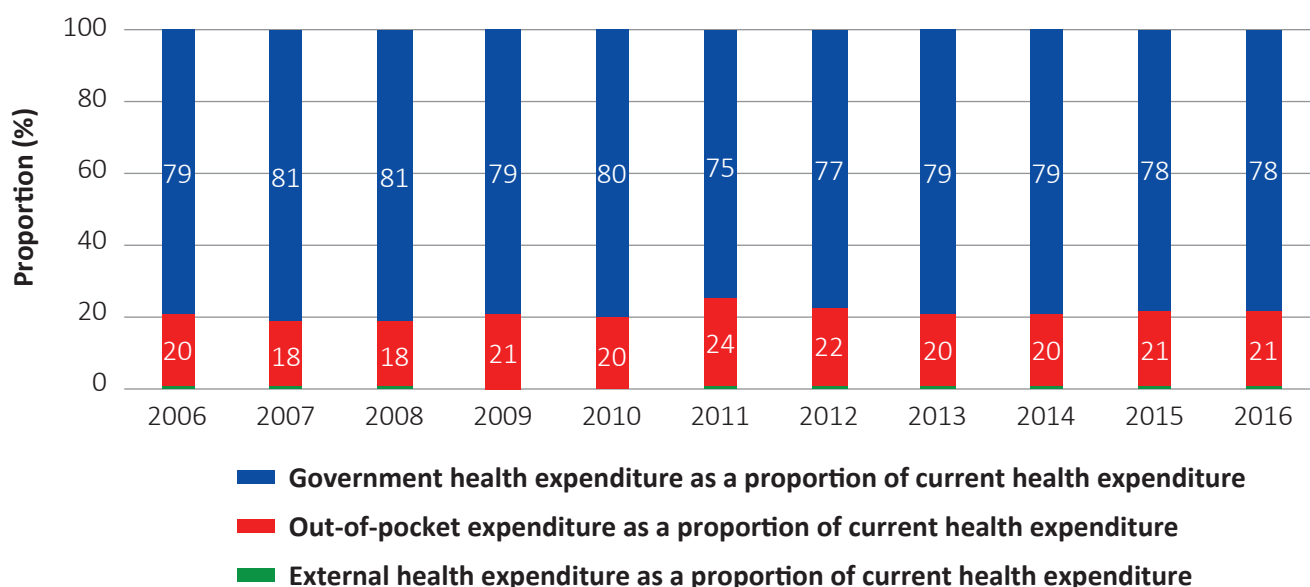


Source: WHO Global Health Expenditure Database. Geneva: World Health Organization; 2018 (<http://apps.who.int/nha/database/ViewData/Indicators/en>, accessed 14 October 2019).

<sup>1</sup> Vlădescu C, Scîntee SG, Olsavszky V, Hernández-Quevedo C, Sagan A. Romania: health system review. Health Systems in Transition. 2016;18(4):1–170 (<http://www.euro.who.int/en/countries/romania/publications/romania-hit-2016>); Strategia Națională de Sănătate 2014–2020. Sănătate pentru prosperitate [National Health Strategy 2014–2020. Health for wealth]. Bucharest: Ministry of Health; 2014 (<http://www.ms.ro/strategia-nationala-de-sanatate-2014-2020/>, accessed 14 October 2019); Romania. In: European Union [website]. Brussels: European Union; 2019 ([https://europa.eu/european-union/about-eu/countries/member-countries/romania\\_en](https://europa.eu/european-union/about-eu/countries/member-countries/romania_en)), all accessed 14 October 2019.

Although the country's total health expenditure is low compared to the EU average, the government share is high (Fig. 4). This may be a result of underestimations due to informal payments.<sup>2</sup> The largest share of public funding (64%) comes from the National Health Insurance Fund (NHIF); 16% comes from the state budget through national health programmes; 21% from out-of-pocket payments; and 1% mainly from private insurance.<sup>3</sup> No detailed information is available, but some studies suggest that this information may be inaccurate because of high informal payments, particularly in public hospital settings.<sup>4</sup>

**Fig. 4. Current health expenditure by source**



Source: WHO Global Health Expenditure Database. Geneva: World Health Organization; 2018 (<http://apps.who.int/nha/database/ViewData/Indicators/en>, accessed 14 October 2019).

## Social health insurance

According to the provisions of Law 95/2006 on Health Care Reform, social health insurance (SHI) is compulsory for all citizens and for foreign residents of Romania. According to the Organisation for Economic Co-operation and Development (OECD) and EU, SHI covers 86% of the population, with higher coverage in urban (94.9%) than rural settings (75.8%).<sup>5</sup> The scheme is mainly financed through income-related health insurance contributions through payroll, which amount to 10.7%: 5.2% paid by the employer and 5.5% by the employee. Self-employed people also pay 5.5% of their earnings. The main criteria for entitlement are proof of contribution payments or confirmation that the person is exempt from contributions.

Population groups exempted from contribution payments, or whose contributions are paid by other sources on their behalf, are:

- children and young people aged up to 26 years if they are enrolled in any form of education or are leaving a child protection institution and have no income;

<sup>2</sup> Health Systems in Transition (HiT) profile of Romania. In: The Health Systems and Policy Monitor [website]. Copenhagen: European Observatory on Health Systems and Policies (<https://www.hspm.org/countries/romania23092016/livinghit.aspx?Section=2.2%20Historical%20background&-Type=Section>, accessed 14 October 2019).

<sup>3</sup> OECD, EU. Health at a Glance: Europe 2016 – State of Health in the EU Cycle. Paris: OECD Publications; 2016 ([https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2016\\_9789264265592-en](https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2016_9789264265592-en), accessed 14 October 2019).

<sup>4</sup> Tambor M, Pavlova M, Rechel B, Golinowska S, Sowada C, Groot W. Willingness to pay for publicly financed health care services in central and eastern Europe: evidence from six countries based on a contingent valuation method. Soc Sci Med. 2014;116:193–201.

<sup>5</sup> OECD, European Observatory on Health Systems and Policies. Romania: Country Health Profile 2017 – State of Health in the EU. Paris: OECD Publishing; 2017 (<https://www.oecd.org/countries/romania/romania-country-health-profile-2017-9789264283534-en.htm>, accessed 14 October 2019).

- war veterans and their widows;
- victims of political repression during 1945–1989;
- people with disabilities;
- chronically ill patients covered under national health programmes;
- pregnant women.

In the case of unemployed people, insurance is covered by the unemployment insurance budget of the Ministry of Labour, Family, Social Protection and Elderly. The state budget covers people in penitentiaries, those on maternity leave of up to two years (three years in the case of children with disabilities), pensioners with an income of less than 740 lei (around US\$ 164) and refugees.

Insured citizens are entitled to a comprehensive benefits package, which is described in the framework document accompanying Law 95/2006. The basic benefits package is standard for all insured people and includes health care services, pharmaceuticals and medical devices.

The minimum package for uninsured people is set on basis of three main criteria: life-threatening emergencies, epidemic-prone/infectious diseases and childbirth. It is important to note that all services for pregnant women, delivery and postpartum/postnatal care for women and children is included in both packages.

For pharmaceuticals a positive list is produced by the National Agency for Medicines and Medical Devices, with input from the newly established Health Technology Assessment (HTA) Department.

## National health programmes

Another source of public funding for health care in Romania is a range of preventive national health programmes, regulated by Government Decision 155/2017 and the technical norms of the Ministry of Health. The programmes cover preventive actions and treatment for specific diseases that have a major impact on public health (Table 1). Funds are provided from the state budget through the Ministry of Health and district health authorities. The programmes have dedicated coordination units, and hospitals and other providers are selected for them based on qualifications and capacity criteria.

Preventive services (see Annex 1) are reimbursed from a dedicated budget according to activity levels such as information/education campaigns, case detection through active or passive testing, epidemiological surveys, preventive treatment (prophylaxis), treatment initiation for detected cases and medical supplies, as well as the volume of these activities (number of leaflets, tests, expected cases, treatments and so on).

Curative national health programmes (see Annex 2) are financed from the NHIF budget via NHIH Order 245/2017 and regulated by Government Decision 155/2017 and the technical norms of the NHIH. They cover treatment of specific diseases with a major impact on public health. The funds are contracted and provided from the NHIF through district health insurance houses, and cover the costs of medication, medical supplies, prostheses, medical devices and certain diagnostic procedures for selected cases, as inpatient or outpatient care. Hospitals and other providers are selected based on technical and capacity criteria.

**Table 1. Services included and funded by national health programmes and the NHIF**

Benefits covered	Primary health care	Specialized ambulatory care	Hospital
Antenatal care <sup>a</sup>	Eight visits	Three visits	Yes
Micronutrient supplements <sup>b</sup>	Yes	No	No

**Table 1. (contd)**

Benefits covered	Primary health care	Specialized ambulatory care	Hospital
Vaginal delivery/caesarean section <sup>b</sup>	–	–	Yes
Home visits for postpartum/postnatal care <sup>a</sup>	Yes	No	No
Family planning counselling <sup>b</sup>	Yes	Yes	Yes
Contraceptives, including emergency contraception	No	No	No
Abortion <sup>b</sup>	No	No	Yes
STI diagnosis <sup>b</sup>	Yes	Yes	Yes
STI treatment <sup>b</sup>	No	Yes	Yes
Human papillomavirus (HPV) immunization	No	No	No
Cervical cancer screening <sup>a</sup>	No	Yes	Yes
Cervical cancer treatment <sup>a</sup>	No	Yes	Yes
In vitro fertilization <sup>a</sup>	No	No	Yes

Notes: <sup>a</sup> covered by national health programmes; <sup>b</sup> covered by the NHIF.

The data on SHI coverage may not be accurate, since almost 4 million Romanians who live and work abroad are counted as still being in the country. Further, the Roma population do not have identity cards, which are required to access SHI, and some other population groups do not contribute to the fund (people working in agriculture, people “unofficially” employed in the private sector, self-employed people and unemployed who are not registered for benefits) and are consequently not covered by SHI. Finally, it should be noted that cost-sharing is applied for certain goods and services included in the basic benefits package.

- For pharmaceuticals provided during ambulatory care, patients have to pay 10% of the reference price for generic prescription drugs and 50% for branded or innovative prescription drugs.
- For expensive prescription drugs, with prices higher than the reference price, the patient’s contribution can be as high as 80%.

In general, affordability of care is reported to be the main reason for perceived unmet health care needs in Romania, at 13.2% in 2013.<sup>6</sup> Unequal distribution of health facilities and workers, and availability of services also create barriers to access for the population, especially in rural areas. Since 2013, hospitals have also charged a small co-payment for admissions: less than €2.50 (around 12 lei) has to be paid during discharge, but this was not assumed to be a barrier by either providers or clients.

Health care financing is characterized by some inefficiencies. For example, there are no clear criteria for inclusion of services in the benefit package, especially for insured people. If some services are not included in the SHI package, they may be funded from national health programmes, but this might include very high-cost services and interventions. For instance, curative programmes cover the costs of organ transplantation and in vitro fertilization. This is a generous decision by the government, but it is important that low-cost, high-impact

<sup>6</sup> Eurostat health database. Luxembourg: Eurostat; 2019 (<https://ec.europa.eu/eurostat/web/health/data/database>, accessed 21 October 2019).

public health interventions across the continuum of care are also covered. However, state funding covers neither HPV immunization nor contraceptives, for example.

A number of reports assessing gender equality and access of the population to sexual and reproductive health services also state that structural discrimination, cultural prejudices, school abandonment, unemployment, social class, ethnicity and place of residence heavily influence access.<sup>7</sup> In addition, women continue to be the focus of the limited sexual and reproductive services provided in Romania; men are not considered full users of the services, aside from their role in supporting the health of their partners. Information on responses to different sexual orientation and gender identity is also lacking.

## Provider payment mechanisms

Provider payment mechanisms are complicated and are linked to performance only in terms of quantity and complexity, using the diagnosis-related group system. Table 2 provides a summary of payment mechanisms for different facilities and services.

**Table 2. Provider payment mechanisms in Romania**

Provider	Ministry of Health	District health insurance house	Cost share	Direct payments
Family medicine physicians	–	50% capitation 50% fee for services	–	Fee for services
Ambulatory specialists	–	Fee for services	–	Fee for services
Hospitals	–	–	–	–
Acute hospital care	–	Diagnosis–related group	Co–payment	Fee for services
Emergency care	–	State budget	–	–
Hospital outpatient	–	Fee for services	–	Fee for services
Day care	–	Case payment Fee for services	–	–
National curative programmes	–	State budget	–	–
National preventive programmes	State budget	–	–	–
Long-term care	–	Day tariffs		Day tariffs
Pharmaceuticals	–	Cost–volume contracts	Co–payments	Cost–volume contracts

Table 3 sets out a summary of the assessment’s findings on health system financing.

<sup>7</sup> Concluding observations on the combined seventh and eighth periodic reports of Romania. Geneva: Committee on the Elimination of Discrimination against Women; 2017 (No. CEDAW/C/ROU/CO/7-8; [https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/ROU/CO/7-8&Lang=En](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW/C/ROU/CO/7-8&Lang=En)); Gender Equality Index 2017: Romania. Vilnius: European Institute for Gender Equality; 2018 (<https://eige.europa.eu/publications/gender-equality-index-2017-romania>), both accessed 14 October 2019.



**Table 3. Summary of findings on health system financing**

Policy	Rating	Criteria for rating
Coverage with mandatory health insurance	Some need for improvement	<p>Coverage with SHI is estimated at 86%, with higher coverage in urban (94.9%) than rural (75.8%) settings. An explicit policy describes the principles of SHI and defines vulnerable groups entitled to government-subsidized insurance. Despite the clarity in detailing beneficiary groups, equity is a challenge. Financial and geographical access is not equal. Young people, self-employed people and agriculture workers have higher odds of being uninsured. Even for insured citizens, the scheme requires co-payments for pharmaceuticals from the positive list.</p> <p>The SHI scheme only covers family planning counselling and does not provide any method of contraception free of charge.</p>
Financing mechanisms for primary health care	Considerable need for improvement	<p>Primary health care facilities are paid by a mix of age-weighted capitation and fee for service, with a current split set at 50/50. Family physicians are supposed to serve as gatekeepers, referring patients to specialists and hospitals, but Romania has the lowest rate of primary health care utilization in the EU, with an average of 2.7 consultations per year compared to 4.8 on average in EU countries. According to the NHIF's 2014 report, only 11.3% of its funding is allocated to services provided in primary care. The largest share is on inpatient care. This is confirmed by OECD data: in 2012 Romania spent the smallest share of funding on outpatient care among 23 EU Member States. Underutilization may be caused by unavailability of services that can be provided at primary health care level, and that are currently only provided either in hospitals or specialized ambulatory clinics, which are mainly located in urban settings.</p>
Financing mechanisms for hospital care	Some need for improvement	<p>Hospitals are funded based on a mix of diagnosis-related groups, case payments, day tariffs, lump sums and FFS. No detailed data are available, but some sources state that informal payments are frequent in hospitals. The majority of the population assumes that payment is needed to get high-quality care in hospital. This might prevent people, especially single mothers or low income or Roma communities, seeking care.</p>

# Essential medicines and health products for SRM-NCAH

All insured people are entitled to pharmaceuticals included in the positive list developed using HTA. The list is comprehensive and is organized according to the share of the co-payment contribution required (Fig. 5). It was not updated between 2008 and 2015, however, meaning that beneficiaries may not have had access to modern treatment schemes.<sup>8</sup> The government updated the list in 2018 and 2019 to include innovative medicines. For pharmaceuticals prescribed within ambulatory care, users must pay 10% of the price for generics and 50% for branded or innovative drugs.

Inclusion in or exclusion from the list depends on several parameters, including therapeutic benefit, reimbursement status (for example, whether it is reimbursed in another EU Member State), treatment cycle (if several treatment rounds are needed as opposed to one), patient accessibility, treatment cost and cost in relation to GDP per capita (compared to treatment costs in other countries). It remains unclear how drugs to be covered by insurance are prioritized, however.

**Fig. 5. Positive list of pharmaceuticals**

- List A – Drugs for **ambulatory** treatment, reimbursed at **90%** of the reference price for insured people
- List B – Drugs for **ambulatory** treatment, reimbursed at **50%** of the reference price for insured people
- List C – Drugs reimbursed at **100%** of the reference price for insured people:
  - C1 – for **certain diseases, ambulatory** treatment
  - C2 – for **national health programmes, hospital and ambulatory** treatment
  - C3 – for **children aged up to 18 years, for young people aged 18 to 26 if they are students and do not have an income and for pregnant and postpartum women, ambulatory** treatment
- List D – Drugs for **ambulatory** treatment, reimbursed at **20%** of the reference price for insured people

The list does not include contraceptives. Provision of free contraceptives was supposed to be part of the national health programme for women and children (subprogramme for women's health), but the government has not allocated state budget resources to this for the last couple of years. The reason given to the assessment team is that the HTA process delays registration of the contraceptives, leaving no opportunity to procure them using the state budget. HTA has a relatively short institutional history in Romania. So far the process has been limited to HTA appraisal of evaluation of submissions from manufacturers. The existing process has been evaluated as fragmented, without formal links to pricing, clinical guideline development, evaluating priorities for public health programmes or optimizing the basic benefits package.<sup>9</sup> Recommendations provided must be implemented as soon as possible to avoid further problems in the process.

All other drugs related to SRMNCAH services are covered by the positive list.

<sup>8</sup> OECD, European Observatory on Health Systems and Policies. Romania: Country Health Profile 2017 – State of Health in the EU. Paris: OECD Publishing; 2017 (<https://www.oecd.org/countries/romania/romania-country-health-profile-2017-9789264283534-en.htm>, accessed 14 October 2019).

<sup>9</sup> Technical assistance for institution building of health technology assessment structure, including training for the National Agency for Medicines & Medical Devices. Oxford: Oxford Policy Management, Imperial College London; 2017 ([http://www.ms.ro/wp-content/uploads/2017/12/HTA\\_Deliverable-2.pdf](http://www.ms.ro/wp-content/uploads/2017/12/HTA_Deliverable-2.pdf), accessed 15 October 2019).

*Romania: Country Health Profile 2017*, a joint annual publication of OECD, European Observatory on Health Systems and Policies and European Commission, states that anecdotal information exists that the cost of pharmaceuticals is an obstacle to access to some modern treatments. The assessment team was not able to identify any specific studies on the perceived affordability of drugs, so it is difficult to judge the overall situation in the country. This issue requires further research.

A related issue that deserves attention is data concerning health expenditure. The National Health Accounts of Romania<sup>10</sup> show a low share of out-of-pocket expenditure in total health expenditure. It can therefore be assumed that the population is not heavily affected by prices of pharmaceuticals, but the statement in OECD report seems to contradict this.

A defined pharmaceutical policy with clear and agreed objectives is lacking; regulation of the pharmaceutical market has so far been reactive and ad hoc, rather than part of an overarching long-term policy. Regulation has focused on containing costs and curbing increased demand, while health objectives and other system goals have played a marginal role, if any. The Ministry of Health and NHIH continue to try to improve price-setting procedures, drug reimbursement and use of HTA through individual projects and technical assistance, to get better value for money. A system of cost–volume and cost–volume outcome agreements was proposed in 2014 and partly implemented in 2015.

## Service delivery and safety for SRMNCAH

Service provision in Romania requires further attention – particularly fragmentation of services. This is caused in part by different funding flows. One example of service fragmentation is treatment of STIs. Family practitioners can diagnose and treat STIs, but patients are usually referred to specialists.

Interviewees mentioned problems with quality of care and confidentiality of patient information. Those concerns are confirmed by the Euro Health Consumer Index, according the 2018 report, as for the second consecutive year the Romanian health system was ranked last (34th).<sup>11</sup> The country received the lowest scores for indicators such as patients' rights and information, accessibility (waiting times for treatment), treatment outcomes, range and scope of services offered, prevention and pharmaceuticals.

## Health workforce for SRMNCAH

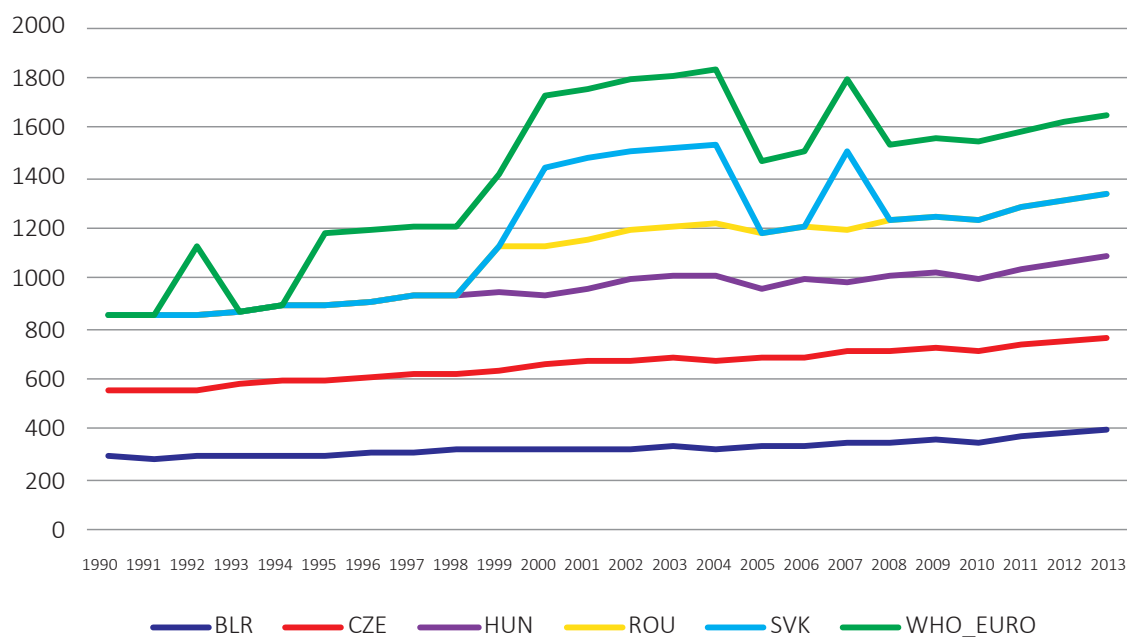
Romania has relatively low numbers of physicians and nurses, compared to the EU average and compared to other countries in central and south-eastern Europe, at 248 physicians and 581 nurses per 100 000 population in 2013 (Fig. 6). This is despite a steady increase since 2000 of about 20% among physicians and just under 10% among nurses.

<sup>10</sup> WHO Global Health Expenditure Database. Geneva: World Health Organization; 2018 (<http://apps.who.int/nha/database/ViewData/Indicators/en>, accessed 14 October 2019).

<sup>11</sup> Björnberg A, Phang AY. Euro Health Consumer Index 2018. Marseillan: Health Consumer Powerhouse; 2019 (<https://healthpowerhouse.com/publications/#200118>, accessed 15 October 2019).

**Fig. 6. Numbers of nurses and physicians per 100 000 population in Romania and selected countries, 1990–2013**

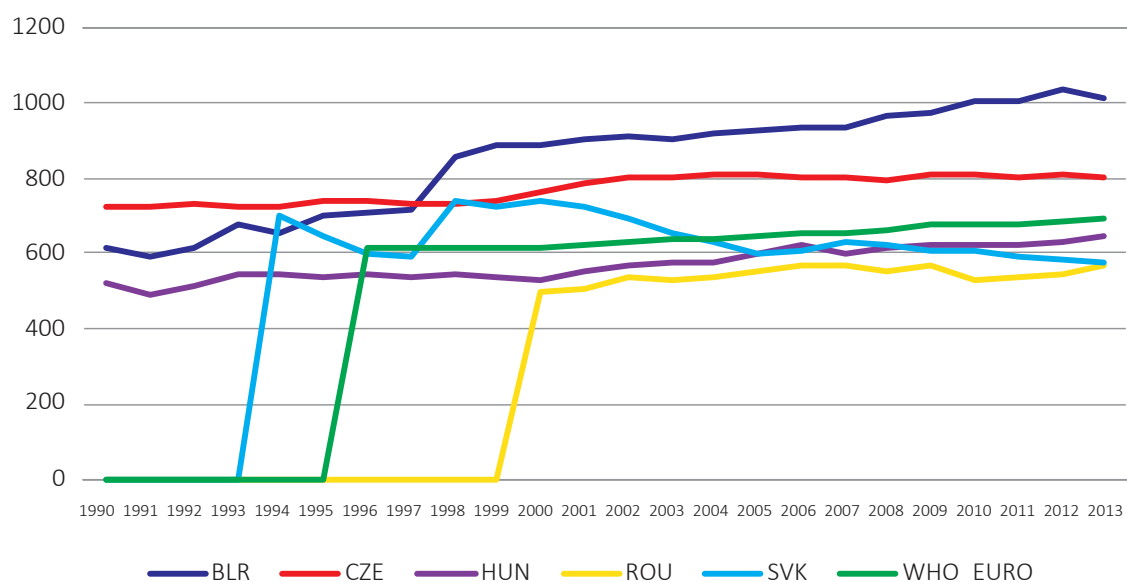
#### Physicians



Source: European Health Information Gateway: [https://gateway.euro.who.int/en/indicators/hlthres\\_193-practising-physicians-per-100-000/visualizations/#id=28409](https://gateway.euro.who.int/en/indicators/hlthres_193-practising-physicians-per-100-000/visualizations/#id=28409).

Note: BLR - Bulgaria, CZE - Czechia, HUN - Hungary, ROU - Romania, SVK - Slovakia, WHO EURO - WHO Regional Office for Europe

#### Nurses



Source: European Health Information Gateway: [https://gateway.euro.who.int/en/indicators/cah\\_17-practicing-nurses-per-100-000-population/](https://gateway.euro.who.int/en/indicators/cah_17-practicing-nurses-per-100-000-population/)

Note: BLR - Bulgaria, CZE - Czechia, HUN - Hungary, ROU - Romania, SVK - Slovakia, WHO EURO - WHO Regional Office for Europe

Since 1997, all doctors have been required to undertake specialist training. In 2013, 23.5% of physicians working in the health system were family medicine physicians. This is somewhat lower than in 2010, when family medicine physicians accounted for 29% of all practising physicians.<sup>12</sup> Key informants stressed the issue of lack of

<sup>12</sup> Vlădescu C, Scîntee SG, Olsavszky V, Hernández-Quevedo C, Sagan A. Romania: health system review. Health Systems in Transition. 2016;18(4):1–170 (<http://www.euro.who.int/en/countries/romania/publications/romania-hit-2016>), accessed on 20 August 2019.

knowledge and skills of family doctors regarding family planning, as well as communication skills required to provide services and information to adolescents.

Because of low salaries for health professionals, especially in public hospitals before 2018, doctors and nurses were migrating to other EU countries. Some hospitals (especially in rural settings) still have shortages of medical staff. This situation affects population access to health care services and creates inequities between rural and urban settings.

The shortage of human resources can have a serious impact on the quality and safety of health services, sometimes even causing tragedies. For example, a fire broke out in the intensive care unit of a maternity hospital in Bucharest in 2010. In the absence of the only nurse, who was out of the room, it claimed the lives of six neonates and injured another five.

In December 2017, following pressure from health professionals and communities, the government issued an emergency ordinance to amend Law 153/2017 on the salaries of staff paid from public funds, which instituted a gradual increase in salaries until 2022. The increase of staff salaries in clinical settings was in line with the Programme for Government 2017–2022, where “a motivating salary package for the health professionals to stop physician exodus” was included as part of the government vision. The law was amended in December 2017, raising the salaries of physicians, nurses and other health workers to the level established for 2022, starting on 1 March 2018.

Following this amendment, government data show that the net salary of a junior doctor increased by 162% (from about €344 (1636 lei) to €902 (4290 lei)) and the net salary of a senior physician increased by 131% (from €913 (4342 lei) to €2112 (10 045 lei)). Only staff working in hospitals benefited from this income increase, however. Income of health care workers in primary care (family physicians and nurses) remained the same because the law referred to publicly funded staff and primary care is private (under direct contract with the NHIH). It is early to assess evidence on the effectiveness of the current policy.

## Health statistics and information systems for SRMNCAH

The main health information system, which is the oldest of the various parallel systems, is managed by the Ministry of Health through the National Centre of Statistics and Informatics in Public Health at the National Institute of Public Health. It collects a very large volume of data, mainly on health services and utilization and on morbidity. Data are published annually in statistical reports and in specific bulletins, which are only available to health care units, but can be shared on request (this includes surveillance data on STIs). The main problems with the existing system relate to the quality and completeness of data collected, which are aggregated at the district level to reflect various levels of care and population groups. Access to disaggregated or individual data is limited; moreover, there is no feedback mechanism to health care providers supplying the data, so providers cannot easily compare their information with that of other providers or make decisions based on these data.

The NHIH manages the integrated unique informatics system, which collects information on over 26 000 health service providers that have contracts with the district health insurance houses and on all insured people. Data include medical information on patients, such as health care services received, economic information on providers and on the administration of the NHIF (such as running costs of the district health insurance houses). Data are collected and analysed by the district health insurance houses and aggregated and administered at the central level. Data are published on the websites of the National School of Public Health, Management and Professional Development and on the websites of the NHIH and district health insurance houses. On 1 May 2015, an electronic national health insurance card was introduced as part of this information system. It is

expected that, on full implementation, electronic health records will improve monitoring and control of the health services provided by the NHIH.

Numerous smaller information databases exist alongside these systems. These relate to the national health programmes or different clinical activities and are independent of one another.

There is no coherent policy in the field of health information and, despite significant investments in modern information and communication technologies, there is a high degree of data fragmentation and duplication of data collection. Since different information systems use different software, formats, definitions and standards, communication between and within the systems is minimal and data collected are not comparable. In addition, frequent changes of software complicate data storage and processing. It has been noted that the reporting burden on providers is considerable, as the same data must be reported to various systems but in different formats.

Not much analysis is done of the collected data and no dissemination policy is in place. As a result, the use of information in planning and decision-making is inadequate. There are plans to integrate information systems run by the NHIH and Ministry of Health, but public information on these plans is lacking.

## Findings on tracer interventions

### Neonatal transport

The strengths of the neonatal transport programme are set out in Box 1.

#### Box 1. Strengths of neonatal transport for SRMNCAH

- Perinatal care is regionalized.
- The neonatal transport system has been effective in Romania since 2005.
- Regular training is given in neonatal resuscitation (six-monthly) for all health staff.

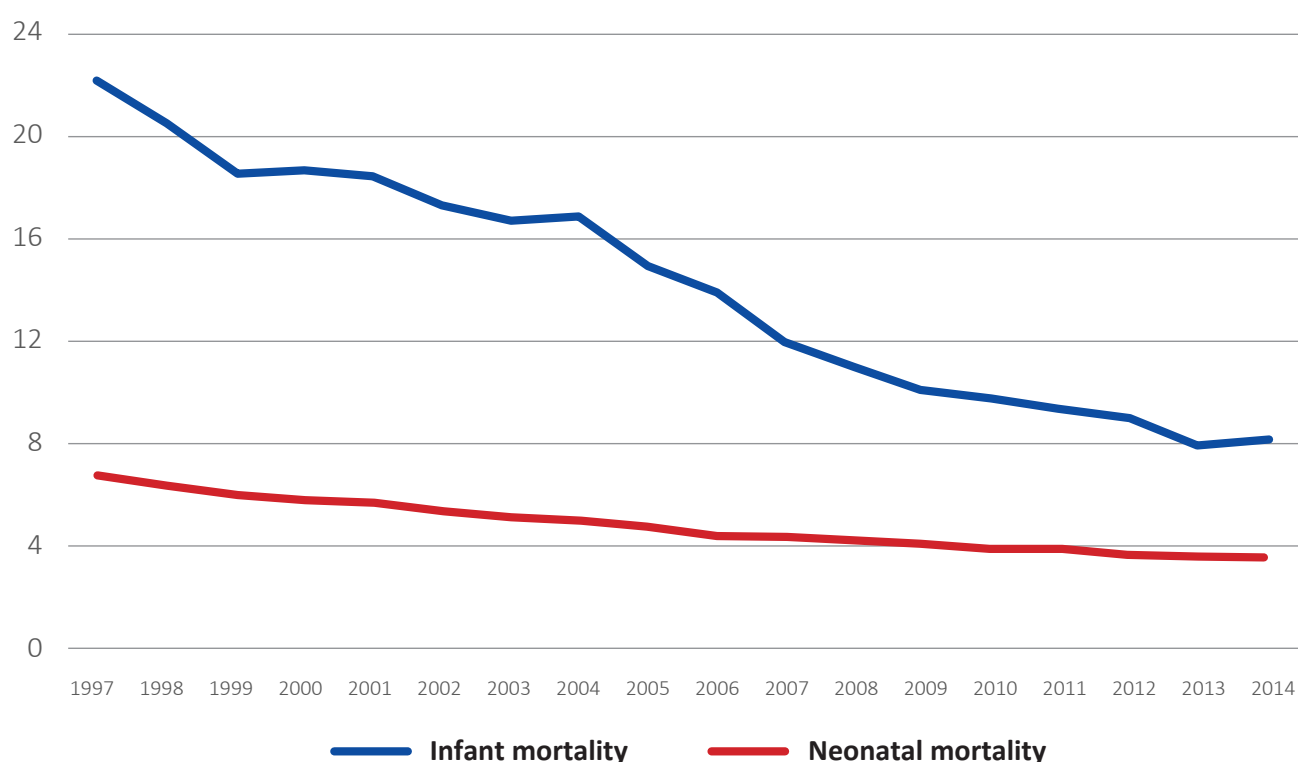
In 2017 the United Nations Inter-agency Group for Child Mortality Estimation reported the 2015 infant mortality rate as 7/1000 live births and the neonatal mortality rate as 4/1000 live births. Infant mortality in Romania is high among countries in the EU, at approximately twice the average (Fig. 7).<sup>13</sup> The most frequent causes of infant death in 2016 were perinatal conditions (34%), respiratory diseases (29%) and congenital pathologies (25%).<sup>14</sup>

Regionalization of perinatal care was introduced in 2005. According to current regulations, neonates born at 37 weeks' gestation and above should be cared for in level-1 facilities, those born at 34–37 weeks in level-2 facilities and those born at less than 34 weeks in level-3 facilities. There are six level-3 facilities in Bucharest and 22 in the rest of the country: two in each large town and one regional centre for about two counties.

<sup>13</sup> Levels and trends in child mortality report 2017. New York: United Nations Children's Fund; 2017 ([https://www.unicef.org/publications/index\\_101071.html](https://www.unicef.org/publications/index_101071.html), accessed 15 October 2019).

<sup>14</sup> Ministry of Health of Romania, The National Institute of Public Health, The National Center for Health Evaluation and Promotion, National Report on the Health of Children and Youth in Romania 2017.

**Fig. 7. Trends in infant mortality, Romania and EU, 1997–2014**



Source: WHO European Health for All database (HFA-DB). Geneva: World Health Organization; 2019 (<https://gateway.euro.who.int/en/datasets/european-health-for-all-database/#health-care-utilization-and-expenditure>, accessed 21 October 2019).

Neonatal transport is addressed by Ministerial Order 1232/2011 on stabilizing of newborns for transport and neonatal transport. A neonate requiring referral to another unit after birth is conducted by one of two medical services.

- Neonates with stable vital functions are transported with the crews of the county ambulance service, equipped with transport incubators that can provide thermal comfort and possibly oxygen delivery. The crew consists of a driver and physician or nurse trained to provide basic care.
- Critical neonates are transported by specialized ambulances and trained staff with fully equipped neonatal transport units with intensive therapy, mechanical ventilation equipment and monitoring. These ambulances operate within the Serviciul Mobil de Urgență, Reanimare și Descarcerare (SMURD), organized in cooperation with emergency departments through the fire brigade (under the remit of the Ministry of Internal Affairs). The crews include ambulance and paramedic staff provided by fire departments and medical crew of a physician and nurse from the SMURD structure or provided by regional maternity units.

The first specialized neonatal transport unit was established in 2005 alongside regionalization of perinatal care. The SMURD transport units operate regionally, with 6–8 regional centres providing transportation for neonates. Transport of neonates in critical condition is done using SMURD helicopters, with the same medical crews that ensure land transport. Neonates are transferred from level-1 or level-2 to level-3 maternity units or specialized centres for certain diseases (such as malformations or surgical conditions).

Interviewees reported that all necessary drugs, supplies and equipment, including surfactant, were available in the fully equipped neonatal transport units. In-utero transfers are generally done by ambulance unless the woman has a serious medical condition. Tocolytics to arrest preterm labour and antenatal corticosteroids can be administered by the transport team.

The national health programme for women and children (subprogramme for child nutrition and health) includes several activities relevant to neonates, including neonatal screening for phenylketonuria, congenital hypothyroidism and hearing deficiencies. Relevant activities are:

- prophylaxis of dystrophy in children aged 0–12 months who do not receive breast milk by administering milk powder;
- neonatal screening, confirmation of diagnosis of phenylketonuria and monitoring of disease progression;
- prevention of hearing deficiencies through auditory screening in neonates;
- prevention of retinopathy of prematurity and its complications by neonatal screening, laser therapy and monitoring the evolution of the disease;
- prophylaxis of rhesus isoimmunization syndrome through administration of specific anti-D immunoglobulin.

Key informants reported that clinical guidelines are in place for specific neonatal conditions, developed through consensus by a neonatal expert group commissioned by the Ministry of Health. These include Ministerial Order 1232/2011<sup>15</sup> and Ministerial Order 51/2017 (Phenylketonuria). Both Orders state that these guidelines should be applied in every public hospital, but the hospital may adapt them to the local context.

Other interviewees reported that no rigorous internationally accepted process is followed for clinical guideline development in Romania. It is unclear whether peer-reviewed updated evidence is used in clinical guideline development or what the validation process involves. Further, clinical guidelines that have been introduced are not implemented or monitored at the health facility level.

According to representatives at different levels of service provision, the neonatal transport system generally works well because of the regionalization of perinatal care and clear guidance on which neonates can be managed at what level. Problems arise because the assigned levels of care may not reflect what can in reality be done for that baby in the particular health facility, resulting in transfer elsewhere. Beds in Bucharest for sick neonates requiring level-3 support are limited, and staff at level-2 hospitals reported a time-consuming process where they were required to arrange a bed for a neonate requiring transfer before liaising with transport system. At times no bed is available, and level-2 hospitals need to work outside the legislated framework for perinatal care owing to a lack of central neonatal beds. This includes mechanical ventilation and provision of surfactant at some county hospitals. Sometimes there are delays at the village level in getting the baby to a health facility for retrieval. This may be circumvented by the family's own transport or helicopter transport.

Neurodevelopmental follow-up of preterm infants is only available in Bucharest and in some regional maternity units in the university centres; it is not reimbursed by the NHIF.

Visits to level-3 and level-2 facilities showed that infrastructure for neonatal care was in place, conditions were of good quality and babies were appropriately monitored. The visits showed, however, that the mother and baby were separated. Interviews with mothers revealed that they only saw their babies in intensive care for approximately 30 minutes, three times per day. Mothers reported that they wanted to see their babies more frequently, but nursing staff told them that there were hygiene concerns associated with mothers spending more time in the neonatal unit. Separation of mothers and babies was also evident in level-1 and level-2 maternity facilities, with violations of breastfeeding policies – such as early initiation, exclusive breastfeeding and promotion of infant-feeding formula in the facilities.

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<sup>15</sup> The Order covers the following categories: 1. determining the age of gestation of the neonate; 2. healthy normal-term neonate nutrition; 3. prophylaxis of respiratory syncytial virus; 4. diagnosis and treatment of neonatal convulsions; 5. neonatal resuscitation; 6. stabilizing of newborns for transport and neonatal transport; 7. management of respiratory distress syndrome by surfactant deficiency; 8. oxygen therapy in the neonate; 9. enteral nutrition of the normal-term sick neonate; 10. parenteral nutrition of the normal-term sick neonate; 11. maintaining body temperature in the neonate; 12. hand-washing; 13. follow-up of neonates at risk of neurological and developmental sequelae; 14. diagnosis and treatment of neonatal hypoglycaemia; 15. enteral nutrition of the premature neonate.



All staff caring for neonates – including midwives, nurses, obstetricians/gynaecologists and paediatricians – must undertake neonatal resuscitation training updates every six months; this is organized by the medical colleges.

Table 4 sets out a summary of the assessment's findings on neonatal transport.

**Table 4. Summary of findings on neonatal transport**

Attributes	Rating	Criteria for rating
Protocols and legislation	Some need for improvement	Clinical protocols for preterm and sick neonates were not readily accessed and it was unclear whether they were evidence-based.
Scope of services	Some need for improvement	The neonatal transport service is functional. Challenges exist around inconsistent facility capacity for neonatal care, despite assigned levels of care. Availability of level-3 beds in Bucharest is limited.
Population coverage	Some need for improvement	Perinatal care with level-3 services outside Bucharest is regionalized, but challenges surround capacity for neonatal care, despite assigned levels of care.
Quality of services	Some need for improvement	Not all practices are evidence-based or best practice-based (such as separation of mothers and babies and inadequate implementation of breastfeeding policies).

## Immunization

The strengths of the immunization programme are set out in Box 2.

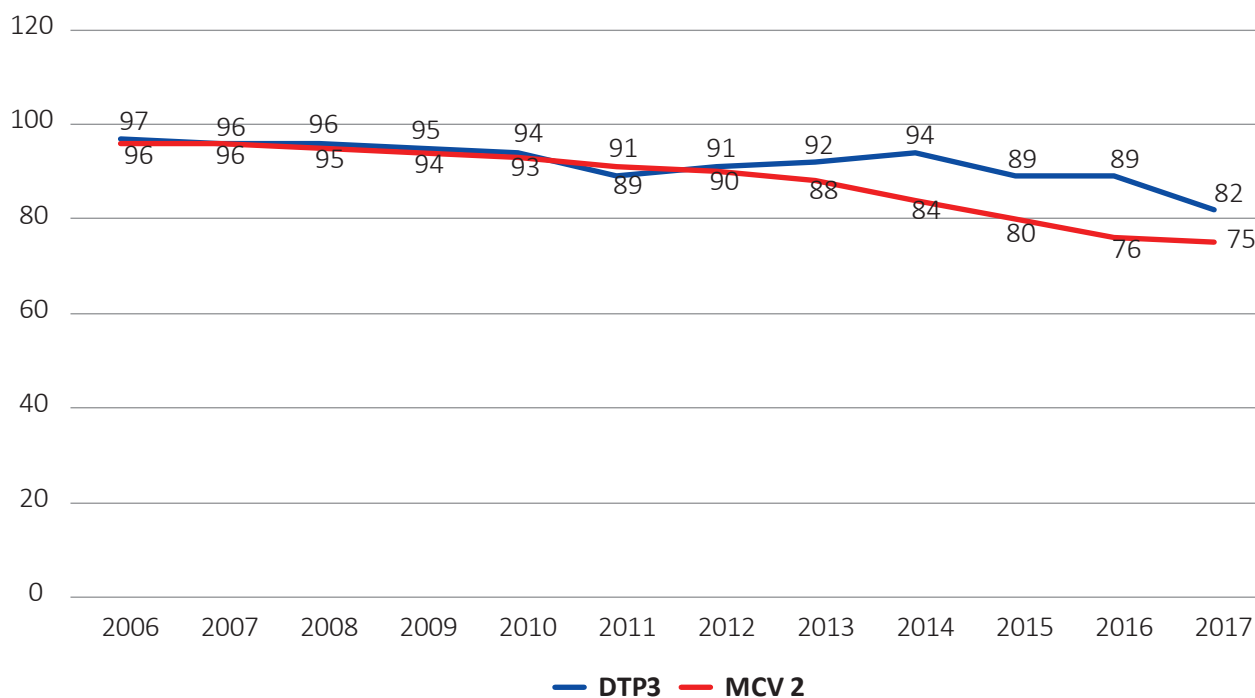
### Box 2. Strengths of immunization for SRMNCAH

- The assessment team found no concerns regarding vaccine safety.
- Family doctors provide immunization at the primary care level.
- A national electronic vaccination registry is in place, with patient lists and recalls.
- The schedule has included pneumococcal vaccine since 2017.
- HPV vaccine is to be purchased by the Ministry of Health in 2019 (supplied free for girls aged 11–14 years).

The WHO and UNICEF estimates of immunization coverage for Romania in 2017 reported bacille Calmette–Guerin at 97%; diphtheria, tetanus and pertussis at 82%; polio at 82%; measles at 75%; hepatitis B at 92%; and *Haemophilus influenzae* type B at 82%. Immunization coverage has decreased over the past 10 years, except for (Fig. 8).



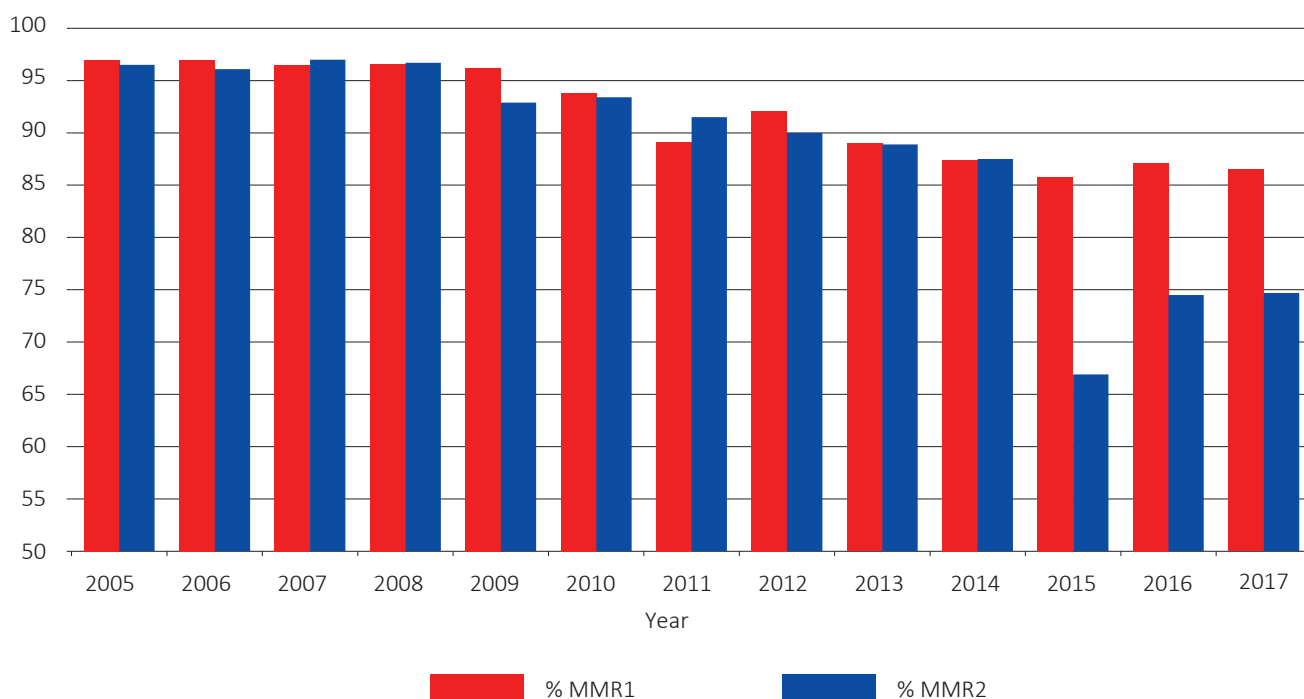
**Fig. 8. WHO and UNICEF estimates of immunization coverage: 2017 revision**



Source: WHO European Health for All database (HFA-DB). Geneva: World Health Organization; 2019 (<https://gateway.euro.who.int/en/datasets/european-health-for-all-database/#health-care-utilization-and-expenditure>, accessed 21 October 2019).

Data on measles vaccination coverage from the National Institute for Public Health are shown in Fig. 9.

**Fig. 9. Vaccine coverage in Romania, 2005–2017**



Source: Romanian National Centre for the Surveillance and Control of Communicable Diseases (CNSCBT) The Analysis of the Evolution of Communicable Diseases Under Surveillance, Annual Report for 2016. (2017). Available online at: <http://www.cnscbt.ro/index.php/rapoarte-anuale/779-analiza-evolutiei-bolilor-transmisibile-aflate-in-supraveghere-raport-pentru-anul-2016/file>, accessed 18 July 2019).

Note: MMR 1 - first vaccination against measles, mumps and rubella; MMR 2 - re-vaccination against measles, mumps and rubella

The national vaccination programme (established by Government Decision 155/2017, approving Ministry of Health Order 377/2017 on national health programmes) is coordinated by the Ministry of Health through the National Institute for Public Health in Bucharest, which works with all county public health directorates (decentralized bodies of the Ministry of Health). The directorates coordinate vaccination in maternity units and family doctor practices. The programme is financed by the Ministry of Health with funds from the state budget through county public health directorates. All immunizations should be recorded in the national electronic vaccination registry.

The schedule consists of all WHO-recommended vaccines including BCG, diphtheria, tetanus, acellular pertussis, inactivated polio, hepatitis B, *haemophilus influenzae* type B, pneumococcus (introduced in 2017) and measles, mumps and rubella. Pregnant women are provided with combined diphtheria/tetanus vaccine, and influenza vaccine is offered to people at risk.

HPV vaccine was first introduced in Romania in 2008 but uptake was limited due to insufficient knowledge and acceptance among service providers and the population. No HPV vaccines were purchased after 2008. It is planned that in 2019 HPV vaccine will be made available free of charge for girls aged 11–14 years, but at the time of assessment it was still not available. Education on HPV vaccine is to be provided to service providers through continuous professional development activities. Other vaccines, including rotavirus, have not been considered for introduction owing to cost.

Vaccines are centrally procured and distributed to the county level. Interviewees reported delays in vaccine delivery of 2–3 months due to procurement problems and poor planning in forecasting vaccine requirements. No problems with vaccine safety were reported at any level.

Family doctors provide immunization at the primary health care level through contracts with the county public health directorates. The family doctor has two contracts: one for receiving the vaccine supplies to be



administered and one for giving the vaccine. Family doctors report to the directorates on the number of vaccines administered through the electronic immunization register. They receive 27 lei (around 6.3US\$) for the first vaccine dose administered, and further payments for additional vaccines.

Parents register children with a family doctor after birth so that they are listed in the electronic immunization system and patient lists, and recalls are generated. Key informants reported that if a child is not registered with a family doctor then immunization will be missed. Each month the family practice collects the monthly amount of vaccines from the county public health directorate and children are called for vaccination. The health facilities have vaccine fridges and the cold chain is maintained. The family doctor assesses the child for contraindications to vaccination and a nurse administers the vaccine. Vaccination may be postponed for non-evidence-based reasons, including if the child has a viral illness. Families are advised to inform the health facility if there are problems and seek a review if required.

Immunization refusals, hesitancy and postponement are a significant problem, as elsewhere in the world. This is mainly due to a very strong anti-vaccine lobby presenting negative aspects of vaccination in both mainstream and social media. Further, religious groups that have concerns regarding vaccine components may refuse vaccination, and population groups including Roma communities that have difficulty accessing services may not be vaccinated. Interviewees also stated that the reasons for low vaccination uptake were more complex, with major vaccine procurement and primary health care service provision issues.

A measles outbreak began in Romania in 2015. The total number of cases confirmed by 4 January 2019 was 15 600, among which there were 59 deaths. According to key informants from the National Institute for Public Health, between 24 December 2018 and 4 January 2019 alone there were 13 new confirmed cases in two counties. In early 2018 a study was conducted to assess the measles outbreak and identify the factors behind low vaccination uptake. It identified that not everybody was fully aware or convinced that vaccines are provided free of charge; many did not know or were not informed when the child was due for the next vaccination; and the vaccines were said not to be available at health facilities. Family doctors were identified as the most used source of information and vaccine refusers were influenced by peer perception.

The Ministry of Health, with partners, is tackling immunization challenges with hard-to-reach populations by strengthening registration for immunization with door-to-door campaigns offering immediate vaccination. It is also developing health personnel capacity and offering education on immunization.

Table 5 sets out a summary of the assessment's findings on immunization.

**Table 5. Summary of findings on immunization**

Attributes	Rating	Criteria for rating
Protocols and legislation	Good practice/ little need for improvement	The national immunization schedule is consistent with WHO's Expanded Programme on Immunization schedule.
Scope of services	Some need for improvement	At the time of the assessment, HPV was not included in the list of vaccinations provided, but the plan was to introduce it by the end of 2019.

**Table 5. (contd)**

Attributes	Rating	Criteria for rating
Population coverage	Some need for improvement	Immunization coverage should be improved by reducing vaccine refusals, hesitancy and postponement in a number of population groups. This should include hard-to-reach communities and parent groups with concerns about vaccine safety that are not supported by evidence-based vaccine research.
Quality of services	Some need for improvement	Vaccines are of good quality. Issues exist with vaccine supply, procurement and functional distribution problems. Vaccinations maybe postponed by paediatricians for non-evidence-based reasons.

## Case management of common childhood conditions (cough and pneumonia)

The strengths of case management of common childhood conditions are set out in Box 3.

### Box 3. Strengths of case management of common childhood conditions for SRMNCAH

- Essential antibiotics, oxygen and radiology are readily available at all levels and free of charge for children.
- The immunization schedule covers major causes of bacterial childhood pneumonia.
- Children are followed up after discharge by family doctors at the primary care level.

The under-5 mortality rate in Romania was reported by the United Nations Inter-agency Group for Child Mortality Estimation as 8/1000 live births in 2015.<sup>16</sup> It has declined since 1990, when it was reported as 35/1000 by the National Institute of Public Health. Data on the proportion of children under 5 years with acute respiratory infection taken to a health facility were not available.

Children (0–18 years old) are insured by law and benefit from all the medical services provided in the insurance system. Those with respiratory, digestive and other acute diseases are fully covered by the NHIF, including:

- initial consultation, investigations and medications;
- referral by a family doctor to a specialist doctor, if required;
- direct referral to hospital if required;
- access to a specialist without a family doctor referral for children aged less than 1 year with acute or chronic pathology;
- use of ambulance services for emergencies or direct emergency department presentation.

Clinical guidelines for paediatric conditions are developed through consensus by paediatric expert groups commissioned by the Ministry of Health. These guidelines must be supported by the College of Physicians and are then directed to the Ministry of Health for automatic final approval. A ministerial order states that every hospital must have the guidelines available and apply them. For hospital accreditation, the focus is on procedural elements including patient flow and length of consultation rather than clinical care. As with the neonatal

<sup>16</sup> Levels and trends in child mortality report 2017. New York: United Nations Children's Fund; 2017 ([https://www.unicef.org/publications/index\\_101071.html](https://www.unicef.org/publications/index_101071.html), accessed 15 October 2019).

guidelines discussed above, no rigorous internationally accepted process is followed for clinical guideline development.

Family doctor interviewees reported that standard treatment guidelines for assessing and managing respiratory conditions in children were not available and not required, as they knew how to manage the conditions. Several key informants were not aware of any clinical guidelines for children for common conditions including cough, diarrhoea and fever. The assessment team also was told by professionals that Integrated management of childhood illnesses (IMCI)<sup>17</sup> – the WHO strategy to reduce under-5 mortality – has not been introduced in Romania as family doctors stated that it was too simple. Instead, an expert committee took some IMCI elements, including diagnoses and follow-up, and included them in paediatric training for family doctors at the primary health care level. The WHO Pocket book of hospital care for children<sup>18</sup> has also never been introduced.

Interviewees reported that bronchiolitis, pneumonia and gastroenteritis were the most common reasons for paediatric hospital admissions. Children with pneumonia were generally managed in hospital with third-generation cephalosporins (ceftriaxone). Oxygen was usually available from a central source. Chest X-rays could be accessed 24 hours a day, 7 days a week. There was no shortage of antibiotics or other medications for management of childhood pneumonia. Hospital representatives reported that parents demand antibiotics for their children even if an infection is clearly viral, and that these are prescribed by paediatricians.

Hospital visits showed that most of the children admitted with respiratory conditions could be managed at home. In one county hospital where 22 children aged 0–3 years and 34 children aged 3–18 years were admitted, none were on oxygen; none were being monitored and most were playing and looked well. Polypharmacy for management of respiratory conditions was observed. One child with a viral chest infection was being treated with two types of cough medicine, two non-steroidal anti-inflammatory drugs and injectable cefuroxime. Another child with laryngitis and no stridor on the second day of admission was receiving adrenaline nebulizers and inhaled fluticasone (steroid). Two children who were not clinically dehydrated were receiving intravenous fluids with inappropriate fluid (5% dextrose).

Interviews with parents revealed that they were happy with the care. They did not have to pay anything for the child's assessment, treatment or admission but only 10 lei (around 2US\$) per day for the parent to remain in hospital with a child older than 3 years.

Paediatrician and parent key informants reported that parents often bypassed the family doctor or only attended the family doctor to request a specialist referral for their child. Reasons given to the assessment team were that parents did not trust the family doctor to know what to do. Children observed waiting in outpatient settings had simple viral illnesses, and paediatricians at the hospital level complained that 40% of cases presented should be managed by a family doctor. While family doctors are often reluctant to initiate some medications for childhood respiratory conditions, including asthma, no regulations or guidelines prohibit initiation of treatment by a family doctor for current respiratory pathology. After a child has been seen by a specialist, the family doctor can provide repeat prescriptions for up to six months. The current payment system for family doctors provides incentives for referral to hospital and specialist care. Children are followed up after discharge at the primary health care level by family doctors.

There are an increasing number of private paediatric hospitals in Bucharest and other large towns in Romania. Key informants at one reported that children are generally referred by the family doctor, but parents can present directly to the hospital. If a child requires admission, the district health insurance house will cover part of the admission, including the medical consultation, investigations and treatment. More middle-income families are

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<sup>17</sup> Integrated Management of Childhood Illness: chart booklet. Geneva: World Health Organization; 2014 ([https://www.who.int/maternal\\_child\\_adolescent/documents/IMCI\\_chartbooklet/en/](https://www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet/en/), accessed 7 October 2019).

<sup>18</sup> Pocket book of hospital care for children: guidelines for the management of common childhood illnesses, second edition. Geneva: World Health Organization; 2013 ([https://www.who.int/maternal\\_child\\_adolescent/documents/child\\_hospital\\_care/en/](https://www.who.int/maternal_child_adolescent/documents/child_hospital_care/en/), accessed 7 October 2019).

now seeking private paediatric health care. The private facilities are more comfortable for clients and the results of tests are available more quickly than in public facilities. A range of paediatric medical and surgical cases are managed at private hospitals, but cases are less complicated than those seen at public university hospitals and the average length of stay is two days. Neonates requiring prolonged ventilation or surgery are transferred to the large maternity hospitals for management.

The basic package of medical services in primary care (for insured people and for all children, regardless of whether their parents are insured) includes preventive consultation and laboratory tests for all children, including those under 2 years old, but with different frequencies. In the first year of life the insurance settles about six preventive consultations and children aged between 2 years and 18 years receive annual clinical investigations. Laboratory tests are based on the referral slip issued by the family doctor.

Table 6 sets out a summary of the assessment's findings on case management of common childhood conditions.

**Table 6. Summary of findings on case management of common childhood conditions**

Attributes	Rating	Criteria for rating
Protocols and legislation	Considerable need for improvement	IMCI has not been introduced. Evidence-based protocols for common childhood illness are unavailable at the primary care level. Protocols at the hospital level are not standardized. No system is in place for internationally accepted protocol development and adaptation.
Scope of services	Some need for improvement	The basic package of medical services in primary care (for insured people and for all children, regardless of whether their parents are insured) includes preventive consultation and laboratory tests. Hospital visits showed that most of the children admitted with respiratory conditions could be managed at home: children were being managed in specialist facilities for common conditions.
Population coverage	Good practice/ little need for improvement	Services are available at all levels.
Quality of services	Considerable need for improvement	Antibiotics are overused and polypharmacy is in evidence. Hospitalization of cases that could be safely managed as outpatient occurs as a result of both health provider practice and parental expectation.

The maternal mortality rate (deaths per 100 000 live births) in Romania was 13.4 in 2015, 8.9 in 2016 and 12.5 in 2017. This figure is two times higher than EU average for the same year (6 per 100 000 live births). The most common causes reported by the National Institute of Statistics were postpartum infections, obstetric haemorrhage and eclampsia during pregnancy.



## Antenatal care

The strengths of the antenatal care programme are set out in Box 4.

### Box 4. Strengths of antenatal care for SRMNCAH

- Antenatal care protocols are in place, as are components of the basic package of medical services in primary care.
- The pre-eclampsia guideline has been updated.
- Consultations and investigations are free of charge in theory for all pregnant women (insured and uninsured).





The minimum package of medical services in primary care includes consultations to monitor the pregnancy and postnatal period:

- first trimester;
- surveillance, monthly, from the third to the seventh month;
- surveillance, twice a month, from the seventh to the ninth month;
- postpartum follow-up at discharge from maternity – at home;
- postpartum follow-up four weeks after birth;
- testing for HIV, hepatitis B and C and syphilis, as well as the usual analyses, such as a complete blood count, glucose, vaginal smear and urine culture.

The national health programme for women and children (subprogramme for women's health) includes:

- prevention of maternal morbidity and mortality by increasing access to, quality and efficiency of specific medical services for pregnancy and the lactation period;
- prevention of genetic diseases by pre- and postnatal diagnosis;
- prophylaxis of rhesus isoimmunization syndrome.

According to the National Institute for Public Health, out of 1360 infant deaths in 2017, the number of prenatal visits were: 1 to 4 (21.0%) 5 to 10 (19.6%) and more than 11 visits (9.5%). About 26.3% did not receive antenatal care at all and in 23.6% it was not possible to get the information about Antenatal care visits received<sup>19</sup>. The relatively high number of women who did not receive ANC or had only few visits is of concern as identification of pregnancy complications at early stages of pregnancy, timely referral and right management can improve both maternal and infant health outcomes. It has to be mentioned, that during the visits in facilities and interviews with staff, pre-eclampsia and/or eclampsia were not mentioned as one of the frequent complications identified during the ANC, despite preeclampsia/eclampsia being one of the main causes of maternal deaths.

Key informants reported that obstetric guidelines are developed through consensus by a group of specialists based on specialist expert opinion. These are presented at national conferences and then directed to the Ministry of Health for approval (as with Order 1982/2008 of the Minister of Health for the adoption of the Protocol on the Methodology for Prenatal Consultation and Postnatal Consultation, the Pregnancy Notebook and the Annex for the Medical Surveillance of the Pregnant and the Pregnancy). Currently, 23 guidelines are approved by Ministerial Orders 1524/2009 and 1347/2013. The last eclampsia/pre-eclampsia guideline was developed in 2010 and an updated draft is in progress.

The NHIF supports eight visits to a family doctor and three to obstetricians/gynaecologists, with three free ultrasound scans. Key informants including obstetricians/gynaecologists and patients reported that women often bypass the primary care level and receive all antenatal care for a normal pregnancy from obstetricians/gynaecologists at a public hospital. Women are provided with a pregnancy report card, where information from all consultations is collected so that they can present it to any facility for consultation.

Informal payments for health services are an issue in Romania. This was confirmed during interviews with women patients, both insured and uninsured, who reported that they had been asked to pay for blood tests and obstetric ultrasound scans at public hospitals during a normal pregnancy. Because they were not informed beforehand how much needed to be paid, and for what, they said that they would prefer to go to a private clinic

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<sup>19</sup> National Institute for Public Health, Infant Mortality 2017 (page 23). <https://www.insp.gov.ro/>

for pregnancy and delivery care, including for normal delivery, as the quality of care was better and it was clear what services needed to be paid for.

This was not the opinion of all women interviewed by the assessment team, however. An insulin diabetic postpartum woman from a rural village with a pregnancy complicated by pre-eclampsia and the need for an emergency caesarean section at 33 weeks' gestation at the county hospital reported that all her care and the care of her baby – who required respiratory support – was free of charge. She was happy with the quality of care at the county hospital. She stated that, based on her discussions with peers, good care very much depended on the individual doctor.

Availability and quality of services vary considerably; in particular, an urban–rural divide is clearly visible. The issue of informal payments, although not applied universally, deserves attention, as it may be a reason for not accessing health care facilities in time.

Table 7 sets out a summary of the assessment's findings on antenatal care.

**Table 7. Summary of findings on antenatal care**

Attributes	Rating	Criteria for rating
Protocols and legislation	Some need for improvement	Evidence-based protocols for antenatal care are available at the primary care level. Protocols at the hospital level are not standardized. No system for internationally accepted protocol development is in place.
Scope of services	Some need for improvement	All WHO-recommended antenatal care interventions are included in the protocol and the NHIF reimbursement scheme or provided through national health programmes.
Population coverage	Some need for improvement	The proportion of women receiving antenatal care has decreased considerably over recent years, from 93.5% in 2004 to 76.3% in 2016. The available evidence indicates insufficient antenatal care at the primary care level, especially for vulnerable women.
Quality of services	Some need for improvement	Providers at the primary care level, particularly in suburban and rural areas, need to update and improve skills for routine care of normal pregnancies and timely identification of pregnancy complications.

## Adolescent-friendly health services (sexual and reproductive health)

The strength of the adolescent-friendly health services programme is set out in Box 5.

### Box 5. Strength of adolescent-friendly health services for SRMNCAH

- A legislative framework in place for health, education, social assistance and rights.

The adolescent fertility rate (births to adolescent women per 1000 women aged 15-19 years) in Romania is reported 36/1000, which is high compared to the average 10/1000 in the European Union.<sup>20</sup> Demand satisfied

<sup>20</sup> The World Bank. World Bank Open Data, 2017. (<https://data.worldbank.org/indicator/SP.ADO.TFRT?locations=RO>, accessed 10 September 2019).







with modern methods among women aged 15–49 years who are married or in a union was 46.5% (World Bank 2004). A subnational World Vision survey (2010) of new mothers among women of reproductive age in rural areas showed that 54.6% used modern contraception. A recent reproductive health survey with updated statistics has been conducted, but the final report was not yet available during the assessment visit.

Romania has the highest incidence of cervical cancer and the highest associated mortality in the EU (34.9/100 000 for incidence and 14.2 for mortality against 11.3/100 000 and 3.7 in the EU in 2012).<sup>21</sup> Eurostat data documented that in 2014 the proportion of women aged 20–69 years reporting a pap smear test in the past three years was 27% (EU average 68.5%).<sup>22</sup>

Government Decision 1113/2014 approving the National Strategy for the Protection and Promotion of Children's Rights (2014–2020) and the operational plan for its implementation includes an objective “promoting a healthy lifestyle among adolescents” through health education, adequate family planning (FP) coverage for teenagers and stimulating health education in schools. Government Decision 383/2015 approving the National Strategy on Social Inclusion and Poverty Reduction for 2015–2020 and its strategic action plan also highlights improving coverage and quality of services for teenage mothers through education, early detection of pregnancy, FP and health counselling, and establishing protocols for immediate referral of young people to social services.

The minimum package of medical services in primary care includes FP consultations, with counselling and indication of a contraceptive method. The national health programme for women and children (subprogramme for women's health) includes:

- preventing unwanted pregnancies by increasing access to FP services;
- completing the processing and analysis of data from the reproduction health study, printing and dissemination of the results;
- acquiring and giving free contraceptives and medical devices.

In Romania, the right of a woman to decide whether to have a child is codified in Article 28 of Law 46/2003 on Patients' Rights. Abortion on request is legally permitted in the first 14 weeks of pregnancy and over 14 weeks as an exception, in cases when abortion is necessary for therapeutic reasons.

The Ministry of National Education, in collaboration with the Ministry of Health, plans to introduce a strategy on health education for health and nutrition in the framework curriculum for the 2020–2021 school year.

Family doctors are supposed to provide FP to all clients including adolescents, but interviewees complained that this is not happening. FP clinics have greatly reduced in number (unofficially by 50%) since withdrawal of funding, and only exist within the public hospital structure as an outpatient activity. Further, since free contraception is no longer available at FP clinics, services are limited to consultation and advice on FP methods. A previously well functioning programme with good client relationships has been undermined by the absence of free contraceptives, with loss of credibility for the service.

To obtain contraceptives, FP clients are provided with a prescription and must purchase the contraceptives (including oral and injectable contraceptives, intrauterine devices, caps and condoms) from a pharmacy. Interviewees reported that emergency contraception within 72 hours and oral contraception may be purchased from a pharmacy without a prescription, at the discretion of the pharmacist. Condoms may be available at some FP clinics if they have old stock remaining.

<sup>21</sup> WHO Evaluation Office. Country Office Evaluation: Romania. Volume 1. Report. December 2018. ([https://www.who.int/about/evaluation/romania\\_country\\_office\\_evaluation\\_report.pdf?ua=1](https://www.who.int/about/evaluation/romania_country_office_evaluation_report.pdf?ua=1), accessed 14 August 2019).

<sup>22</sup> Health interventions: health services indicators – cervical cancer screening. In: ECHI Data Tool [website]. Luxembourg: Eurostat; 2014 (<http://ec.europa.eu/health/dyna/echi/datatool/index.cfm?indlist=59>, accessed 28 January 2019).

Academic representatives reported that FP was included in the National Health Strategy 2014–20 with a well designed action plan, but was not implemented. No contraceptives are currently available and there has been loss of the FP network in terms of service provision and training roles. The lack of access to contraception and to accurate information can be presumed to have led to the high rate of teenage pregnancy in the country. Family doctors do not perform FP consultations or provide related services: they reported that they do not receive reimbursement for providing FP services, but this is contrary to information in the reimbursement mechanisms from the NHIH. Reporting of FP consultations and contraceptive needs has also greatly reduced, and the national logistics management information system put in place some years ago is not functioning.

Representatives of health facilities and county public health directorates reported that abortion services are offered at public hospitals, and clients presenting to family doctors are referred. Surgical abortions are available after the client has received counselling from the family doctor or obstetrician/gynaecologist. Key informants from nongovernmental organizations (NGOs) working on human rights reported that while abortion on request is legally permitted in the first 14 weeks, women's access to safe and legal abortion is obstructed by the practice of conscientious objection among individual health professionals and even entire hospitals.<sup>23</sup> During a roundtable meeting, NGO representatives also highlighted discrimination against women living with HIV/AIDS in access to reproductive health services, including pregnancy care.

Although legislation is in place for health, education, social assistance and rights of adolescents, it is inadequate for obligations to ensure that intended beneficiaries have access to services to enjoy these rights. Interviewees reported that, despite the content of the child protection law, sexuality education in the school curriculum is optional. Health promotion in schools has decreased, as now legal consent is required from the National Federation for the Parental Committee and parents are reluctant for their children to receive sexuality education. A 2013 UNICEF-supported publication<sup>24</sup> reported that adolescents were reluctant to access services, reporting issues including cost of transport to facilities located far away, barriers due to poor quality of care because of lack of staff knowledge and problems with patient confidentiality.

A county public health directorate reported that health education was provided in schools related to national awareness campaigns for various health topics, including tuberculosis, diabetes, immunization and cardiovascular disease, but not sexuality education. FP clinics also had a role in providing sexual and reproductive health education in schools, but this has almost ceased as schools have their own doctors.

Adolescents aged less than 18 years should be able to obtain contraception without parental approval according to the law, but this is dependent on the doctor's discretion. NGO representatives reported that FP clinic providers were better suited than family doctors for provision of services to young people as they can maintain a degree of patient autonomy and confidentiality and have been specifically trained to work with adolescents and young people.

Adolescents aged less than 18 years seeking abortions are referred to public hospital counselling services with a psychologist and social worker, and their parents and social services are informed. Based on key informants, medical abortion is not offered.

Table 8 sets out a summary of the assessment's findings on adolescent-friendly sexual and reproductive health.

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<sup>23</sup> Vdovii L, Bird M. Over 30 percent of hospitals in Romania are refusing legal abortions. The Black Sea; 11 July 2019 (<https://theblacksea.eu/stories/quarter-hospitals-romania-are-refusing-legal-abortions/>, accessed 15 October 2019).

<sup>24</sup> Final report: state of adolescents in Romania. Bucharest: UNICEF Romania; 2013 ([http://www.youthpolicy.org/national/Romania\\_2013\\_UNICEF\\_Study\\_State\\_of\\_adolescents.pdf](http://www.youthpolicy.org/national/Romania_2013_UNICEF_Study_State_of_adolescents.pdf), accessed 15 October 2019).

**Table 8. Summary of findings on adolescent-friendly sexual and reproductive health**

Attributes	Rating	Criteria for rating
Protocols and legislation	Considerable need for improvement	A legislative framework is in place for health, education, social assistance and rights to access health care services. No adolescent-friendly health service guidelines have been developed in accordance with WHO recommendations.
Scope of services	Considerable need for improvement	Adolescent-friendly health services, including sexual and reproductive health, are not available. Sexuality education is not provided in schools. Contraceptives are not available for adolescents and young people.
Population coverage	Considerable need for improvement	Adolescent-friendly health services, including sexual and reproductive health, are not available. Significant barriers exist to adolescents' access to sexual and reproductive health services.
Quality of services	Considerable need for improvement	Adolescent-friendly health services, including sexual and reproductive health, are not available. Staff are not trained in adolescent-friendly health service standards. Confidentiality issues exist.

## STIs (excluding HIV)

The strengths of the STI programme are set out in Box 6.

### Box 6. Strengths of STI programme for SRMNCAH

- Consultations and investigations are free of charge.
- Medications for STIs are available and reimbursable by the NHIF if on the approved drug list.
- Some staff in FP clinics can diagnose and provide treatment for STIs.

The National Institute for Public Health communicable diseases surveillance report<sup>25</sup> shows a reduction in reported cases of syphilis and gonorrhoea (Fig. 10).

The national health programmes for communicable disease surveillance and control and for health assessment, promotion and education for health are involved in STI activities.

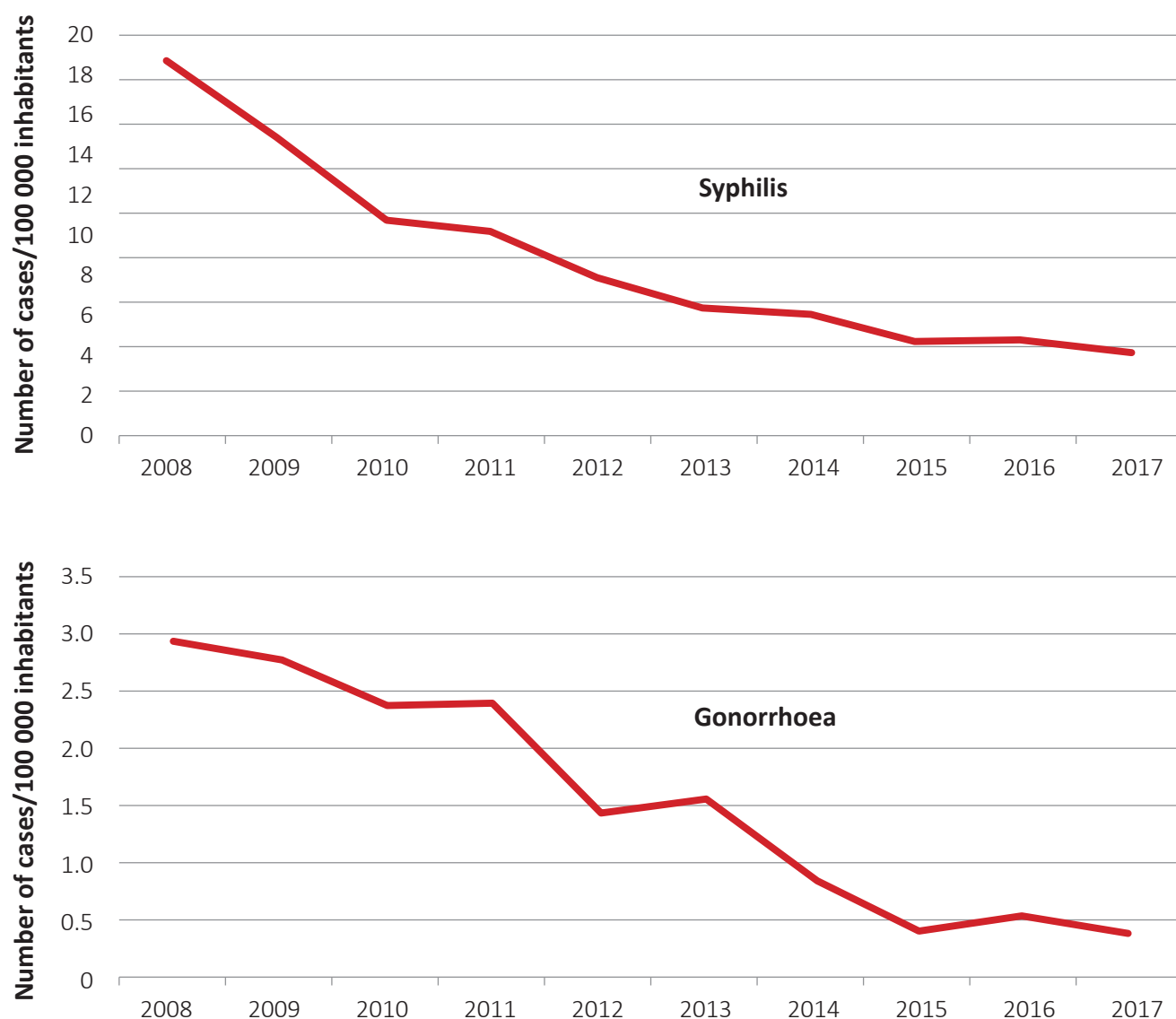
Ministerial Order 1342/2013 approving the methodology for surveillance of STIs includes detection and mandatory reporting of syphilis, chlamydia trachomatis and gonorrhoea. Article 4 states that family doctors can provide syndromic diagnosis and treatment for patients in rural areas with limited access to diagnosis if they inform a dermatologist/venereologist. Article 5 provides a guideline for diagnosis and treatment of STIs.<sup>26</sup> The

<sup>25</sup> Romanian National Centre for the Surveillance and Control of Communicable Diseases (CNSCBT) The Analysis of the Evolution of Communicable Diseases Under Surveillance, Annual Report for 2016. (2017). Available online at: <http://www.cnscbt.ro/index.php/rapoarte-anuale/779-analiza-evolutiei-bolilor-transmisibile-aflate-in-supraveghere-raport-pentru-anul-2016/file>, accessed 18 July 2019).

<sup>26</sup> STIs included are: 1. syphilis; 2. gonorrhoea; 3. genital infection with chlamydia trachomatis; 4. haemophilus ducreyi; 5. inguinal granuloma; 6. genital herpes; 7. HPV conditions – human papillomaviruses; 8. trichomonas vaginalis; 9. bacterial vaginosis; 10. genital candidiasis; 11. scabies; 12. pediculosis pubis.

Order also sets out the responsibilities of health units and health personnel in prevention and control of STIs and surveillance activities.

**Fig. 10. Reported cases of syphilis and gonorrhoea in Romania (2008–17)**



Source: Romanian National Centre for the Surveillance and Control of Communicable Diseases (CNSCBT) The Analysis of the Evolution of Communicable Diseases Under Surveillance, Annual Report for 2016. (2017). Available online at: <http://www.cnscbt.ro/index.php/rapoarte-anuale/779-analiza-evolutiei-bolilor-transmisibile-aflate-in-supraveghere-raport-pentru-anul-2016/file>, accessed 18 July 2019).

Key informants reported that patients with STI symptoms, especially from villages, usually bypass the family doctor and present directly to specialists (dermatologists/venereologists), as family doctors do not arrange investigations and provide treatment for STIs. Specialist consultations, investigations and obtaining results are free for insured patients but reimbursement of drug costs for treatment depends on the medication prescribed. Health providers at some FP clinics can diagnose, arrange investigations and provide treatment for STIs, but generally patients are referred for specialist consultation. Pap smears for cervical cancer screening can be done at some FP clinics but not all steps of the process are reimbursed by the NHIF, including transport of samples to the laboratory. In general, women visit obstetricians/gynaecologists at public hospitals or private clinics for a pap smear, where all the steps for cervical cancer screening can be completed.

The Ministry of Health initiated a free cervical screening programme for all women (both insured and uninsured). Women can request a pap smear at public hospitals in counties or through participating family doctors who have been trained. Further, mobile units are available to access women in hard-to-reach areas. Interviewees at the county level reported that the programme is not functioning well, and women continue to be referred to public facilities in urban areas for pap smears.

Table 9 sets out a summary of the assessment's findings on STIs.

**Table 9. Summary of findings on STIs**

Attributes	Rating	Criteria for rating
Protocols and legislation	Some need for improvement	Detailed treatment protocols are not available. The general protocol is part of Ministerial Order 1342/2013.
Scope of services	Some need for improvement	Services are available but only at the specialist level.
Population coverage	Some need for improvement	Services are fragmented. Family doctors refer symptomatic patients to specialists. A cervical screening programme has been initiated but is not functioning at the primary care level.
Quality of services	Considerable need for improvement	Stigma seems to limit the availability of data and services. Treatment where it is available in primary health care seems to be inconsistent; (self-)referral to specialists and/or hospital is common.

## Policy recommendations for SRMNCAH

Romania has policies and strategy documents in place, but gaps remain. Beside overall low spending on health, the health system experiences systemic deficiencies and inefficient spending of the moderate resources available. Inequalities exist between urban and rural populations in access to health care services, in terms of both availability and quality.

Rights-based approaches to health, achieving equity and “leaving no one behind” should become an explicit objective for all SRMNCAH policies, and there is a clear opportunity to refocus efforts through system-wide support for protection of rights and cross-sectoral collaboration. This would include:

- involving a broad range of partners within and outside government, including representatives of the populations concerned, in the formulation of strategies and action plans to provide services to population groups with specific needs;
- setting policy targets for closing equity gaps – for example, between geographical areas and population groups – and presenting all SRMNCAH data disaggregated for sex, age, geographical location, ethnicity and wealth, monitoring the data over time to ascertain that equity gaps are closing;
- targeting SRMNCAH services for population groups with specific needs, including people with lower socioeconomic status and other vulnerable, disadvantaged and hard-to-reach groups, and ensuring that services are provided free of charge and made accessible.



Despite several waves of reforms, the country still needs to reorganize the health system, establish more effective funding mechanisms and introduce measures to improve quality of care.

## **Strengthening governance for SRMNCAH**

In the light of slow progress in reducing the adolescent birth rate, cervical cancer, high maternal mortality rate in comparison with the EU average and the gaps in access to sexual and reproductive health services that disproportionately affect marginalized groups, clear vision and stronger political commitment – in particular for sexual and reproductive health at the national level – is required. Harmonization of national legislation on gender-based violence with the Istanbul Convention is an achievement, however, implementing legislation and addressing barriers for free access to medical and psychosocial support for victims of violence against women and girls is of concern. The refusals by health professionals and entire hospitals to perform medical abortion will require strong governance and regulation from the state that guarantees access to legal safe abortion. While permitting conscientious objections, clarity on which grounds it is permissible for health professionals to raise such objections, providing ready access by mandating referral or establishing direct entry through contracting services are the required elements of the regulation.

The country lacks a rigorous internationally accepted process for clinical guideline development for SRMNCAH. The guidelines approved by the Ministry of Health can be modified by health facility standardization of management of common conditions.

Finally, without strong accountability mechanisms to track universal access to SRMNCAH and commitments made to human rights in sexual and reproductive health, progress in closing inequity gaps will be unclear.

The assessment team recommends the following.

- Sexual and reproductive health services should be prioritized for adolescents and young people, Roma communities, women with disabilities, rural and other hard-to-reach populations to reduce existing inequities. A major effort should be made to improve availability of these services, including contraceptive services and commodities, emergency contraception, legal safe abortion and post-abortion care, prevention and management of STIs and HPV immunization, without social and financial barriers.
- Multisectoral collaboration in the area of SRMNCAH should be analysed, with the aim of identifying and optimizing the most important entry points for action, such as sexuality education and prevention of and response to gender-based violence. Work should be undertaken with the educational sector to strengthen mandatory, age-appropriate school-based sexuality education programmes and use other health literacy opportunities aimed at promoting healthy sexual development, sexual education, safe sex, contraception, prevention of STIs and other topics related to sexual health.
- The evidence-based clinical guideline and protocol development process should be reinforced, as should implementation and monitoring of their use at all levels of health facility.
- Implementation of evidence-based maternal and neonatal care practices should be promoted and functional system for regularly analysing and addressing causes of preventable maternal mortality and morbidity both at facility and national level developed.

## **Strengthening human resources to provide high-quality SRMNCAH services**

The government has introduced several policy changes to reduce outflow of medical personnel from the country and make the profession attractive again for younger generations. Several actions remain to be implemented, however.

- A review of the role of family doctors in providing essential SRMNCAH services should be conducted to determine whether the current model is the most appropriate approach, including assessment of:

- knowledge and skills, including communication skills to provide interventions;
- authority to perform basic functions.

Capacity-building of family doctors to provide essential SRMNCAH services should be continued, including antenatal and postpartum care, management of common childhood illnesses, comprehensive maternal, sexual and reproductive health services such as FP, management of STIs, HPV immunization, cervical cancer prevention and early detection and working with adolescents and young people.

- Updating nurses' technical skills to deliver evidence-based preventive, promotive and supportive services should be considered.

## Reviewing and strengthening the service delivery model

Making SRMNCAH services integral to primary health care and reducing fragmentation of service provision need to be prioritized. Service fragmentation can prevent clients from accessing services fully, so the country needs to streamline services to ensure a “one-stop-shop” approach and provision of high-quality care and better access. Romania is having difficulties in ANC service utilization. Even though state policy for ANC package is comprehensive and in accordance with WHO recommendations, informal payments and fragmentation of services are making antenatal care ineffective, resulting in inadequate maternal and perinatal health outcomes.

Adolescent-friendly health services are lacking, and even though Law 95/2006 on Health Care Reform defines the age of consent as 16 years, doctors still act according to their personal opinions, so services are not accessible for young people. In the absence of sexual and reproductive health education in schools, adolescents are at risk of STIs, unwanted pregnancies and similar.

The assessment team recommends the following.

- Fragmentation of services should be avoided by ensuring that complete care is available at the primary health care level via family doctors. For example, the system for STI diagnosis and treatment should be reviewed in the light of advances in rapid tests moving towards point-of-care testing and treatment, with the aim of avoiding multiple referrals and fragmentation.
- Preconception, antenatal and postnatal care – which are critical opportunities for primary health care to deliver care and support – should be strengthened and give information to women to ensure their and their children's health and well-being.
- Clear referral pathways and referral criteria to specialist care for SRMNCAH should be established and patients and providers oriented along patient pathways.
- Capability of nurses to work with the local community should be developed, particularly to access hard-to-reach population groups, to educate pregnant women and new mothers about infant and child nutrition; to support lactating women and promote exclusive breastfeeding; and to provide information about prevention of unwanted pregnancies, FP methods and adoption of healthy lifestyles.
- Adolescent-friendly health services, including sexual and reproductive services, should be introduced according to globally accepted quality standards. Adolescents should be allowed formalized legal access to more defined, confidential, non-judgemental and appropriate health services.
- A communication strategy for parents regarding common childhood illnesses should be developed that includes home care, care-seeking from health professionals and unnecessary use of antibiotics, intravenous fluids and other medications.
- Use of ambulances and hospital emergency rooms for non-urgent cases should be discouraged by exploring patient access to health services and providing incentives for appropriate use of the health system.

## **Orienting health financing to improve support for SRMNCAH**

Romania spends around 5% of its GDP on health, and the government share of health expenditure as a proportion of GDP is around 4%, which is almost half the EU average. Coverage with SHI is estimated at 86%, with higher coverage in urban (94.9%) than rural (75.8%) settings. No accurate data are available, but studies suggest that insurance coverage may not be accurate, since almost 4 million Romanians who live and work abroad are counted as still being in the country. Experts also doubt the low reported numbers of out-of-pocket payments, which are most likely to occur through underestimation of informal payments.

An explicit policy describes the principles of SHI and defines vulnerable groups entitled to government-subsidized insurance. Despite the clarity in detailing beneficiary groups, equity is a challenge. Financial and geographical access is not equal. Young and self-employed people and agriculture workers have higher odds of being uninsured. Even for insured citizens, the scheme requires co-payments for certain services and for pharmaceuticals from the positive list.

Another problem with financing the health sector, including SRMNCAH services, is provider payment mechanisms, which are complex, mixed and not linked to performance. The complexity of payment mechanisms causes inefficient spending of scarce resources and puts the NHIH in a position where it is not able to cover all the commitments declared by the government.

The assessment team recommends the following.

- Funding for the health sector should be increased, depending on resource availability.
- A strategy to increase the coverage of the health insurance scheme should be developed, to reduce inequalities between urban and rural settings.
- Provider payment mechanisms should be simplified and linked to performance.
- Financial flows should be simplified to reduce fragmentation of services and avoid duplications with national health programmes.
- Coverage of SRMNCAH services should be expanded, specifically to include contraceptives in the positive list.

## **Expanding community engagement for SRMNCAH**

The assessment showed that the vaccination programme overall is functional, but vaccine refusal is a concern. This may be attributed to various reasons, but the country needs to act quickly in an attempt to decrease the number of unvaccinated children. To achieve this, government structures will need to collaborate closely and gain support from society, including religious leaders.

The assessment team recommends the following.

- The recommendations of the WHO/UNICEF report on suboptimal vaccination uptake should be reviewed and implemented, including:
  - increasing provision of information for parents on vaccination to resolve misconceptions and improve access;
  - building capacity of family doctors to provide accurate and appropriate information on vaccination;
  - developing a stakeholder strategy for immunization, forming partnerships with trusted opinion leaders to strengthen community and peer support for vaccination;
  - working with the media to ensure dissemination of evidence-based information;
  - targeting initiatives to specific groups of vaccine refusers;
  - addressing vaccine supply issues.

## Expanding and strengthening the health information system

The health information system is fragmented, leading to problems related to quality of data collected and linkages among the different systems operating in the country. All this results in a shortage of high-quality data for analysis and use in decision-making processes. Lack of availability and poor quality of data create problems when the NHIH attempts to estimate accurate coverage with health insurance, to forecast and plan adequate budgets and to optimize the basic benefits package.

The last reproductive health survey in Romania was conducted in 2016, but the report was not yet available during the assessment visit. Thus, no accurate information has been collated regarding sexual and reproductive health indicators for almost 12 years; this is an important gap for assessing the situation and adequate planning.

The assessment team recommends the following.

- A comprehensive health information system that will provide accurate, disaggregated data on SRMNCAH indicators should be developed.
- Full access of all interested parties to available surveillance bulletins should be ensured.
- Training should be conducted for relevant staff on the use of available data in decision-making processes.

## Essential medicines and health products

All insured people are entitled to pharmaceuticals included in the positive list developed using HTA. The list is comprehensive and is organized according the share of the co-payment contribution required.

This list does not include contraceptives; these are supposed to be covered by the national health programme for women and children (subprogramme for women's health), but since 2015 the government has not allocated funds for their procurement. The reason given to the assessment team is the HTA process, without which government money cannot be spent on drugs. The team was not able to establish the details of the problem, but it is obvious that this issue needs to be studied closely.

The assessment revealed that all other drugs used for management of SRMNCAH issues are included in the positive list, but the level of co-payment depends on the type of drug prescribed.

The assessment team recommends the following.

- Free contraceptives, including condoms, oral contraceptives, intrauterine devices and injectable contraceptives should be made available as a priority, addressing procurement and planning issues.
- The problem related to the HTA process for contraceptives should be evaluated to speed up the process of inclusion in the positive list.
- A comprehensive pharmaceutical policy should be developed to avoid reactive ad hoc decisions that could hamper the process inclusion of contraceptives in the positive list.
- A strategy to promote prescription and use of generics should be developed.

Another general recommendation would be to conduct a pharmaceutical affordability and availability survey using WHO's standard methodology, to gain a clear understanding of the prices and geographical distribution of drugs in country.

# Annex 1. Structure of the national preventive health programmes

- National programmes for communicable diseases
- National programme for vaccination
- National programme for transmissible diseases surveillance and control
- National programme for prevention, supervision and control of HIV/AIDS
- National programme for prevention, monitoring and control of tuberculosis
- National programme for surveillance and limitation of infections associated with medical care and microbial resistance, as well as monitoring the use of antibiotics
- National programme for monitoring the determinants of living and working environments
- National programme for transfusion
- National programmes for noncommunicable diseases
- National programme for early cancer screening
- Subprogramme for early detection of cervical cancer
- Subprogramme for early detection of colorectal cancer
- Subprogramme for early detection of breast cancer
- National programme for mental health and prevention of psychiatric pathology
- National programme for transplantation of organs, tissues and cells of human origins
- Subprogramme for organ transplantation, tissues and cells of human origin
- Subprogramme for transplant of haematopoietic stem cells
- Subprogramme for in vitro fertilization and embryo transfer
- National programme for endocrine diseases (thyroid diseases)
- National programme for diet treatment of rare diseases
- National programme for the management of national registers
- National programme for health assessment and promotion and education for health
- Subprogramme for health assessment and promotion and education for health
- Subprogramme for tobacco prevention and control
- National programme for women and children
- Subprogramme for child nutrition and health
- Subprogramme for women's health

## Annex 2. Structure of the national curative health programmes

- National programme for cardiovascular diseases (interventional cardiology and cardiovascular surgery)
- National programme for oncology
- Subprogramme for treatment of patients with oncological diseases
- Subprogramme for monitoring disease progression in patients with oncological diseases by positron emission tomography–computed tomography scan
- Subprogramme for breast reconstruction after oncological diseases by endoprosthesis
- Subprogramme for the diagnosis and monitoring of minimal residual illness of patients with acute leukaemia
- Subprogramme for radiotherapy of patients with oncological diseases
- Subprogramme for genetic diagnostic of solid malignant tumours
- National programme for the treatment of deafness by implantable auditory prostheses
- National programme for diabetes
- National programme for the treatment of neurological diseases (multiple sclerosis)
- National programme for treatment of haemophilia and thalassemia
- National programme for treatment for rare diseases
- National programme for mental health (drug addiction)
- National programme for endocrine diseases
- National programme for orthopaedics
- National programme for transplantation of organs, tissues and cells of human origin
- National programme for renal replacement for patients with chronic renal failure
- National programme for hepatic intensive therapy
- National programme for diagnostics and treatment using high performance equipment
- Subprogramme for interventional radiology
- Subprogramme for diagnosis and treatment of epilepsy resistant to drug treatment
- Subprogramme for treatment of congenital or acquired child hydrocephalus
- Subprogramme for neuropathic pain treatment by implant of medullary neuro-stimulators



## The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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