

**Romania Health Program for Results  
(P169927)**

**ENVIRONMENTAL AND SOCIAL SYSTEM ASSESSMENT**

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## ABBREVIATIONS

BJR	County Office for Roma
CHPS	Centre for Health Policies and Services
CME	Continuous Medical Education
DHIH	District Health Insurance House
DPHA	District Public Health Authority
DLI	Disbursement Link Indicator
EA	Environmental Assessment
EC	European Commission
ECA	Europe and Central Asia
EGO	Emergency Governmental Ordinance
EIA	Environmental Impact Assessment
EMP	Environmental Management Plan
EP	Environmental Permit
EPA	Environmental Protection Agency
ER	Environmental Report
ESIA	Environmental Social Impact Assessment
ESSA	Environmental and Social System Assessment
EU	European Union
EUMIDIS	European Union Minorities and Discrimination Survey
E&S	Environmental and Social
FP	Family Physician
GD	Governmental Decision
GDP	Gross Domestic Product
GLL	Local Working Group
GO	Governmental Ordinance
GoR	Government of Romania
GP	General Practitioner
GRS	Grievance Redress Service
HPV	Human papillomavirus
HTA	Health Technology Assessment

ICR	Implementation Completion Report
IGSU	General Inspectorate for Emergency Situations
IT	Information Technology
LEPA	Local Environmental Protection Agency
MDIS	Minorities and Discrimination Survey
MDRAP	Ministry of Development and Public Administration
MO	Minister Order
MoE	Ministry of Environment
MoNEd	Ministry of National Education
MoH	Ministry of Health
MoLSJ	Ministry of Labor and Social Justice
MoPF	Ministry of Public Finance
MoWF	Ministry of Waters and Forests
NAGPE	National Association of Practice Owners
NAM	National Administration for Meteorology
NAR	National Agency for Roma
NCD	Non-communicable diseases
NCSFM	National Centre for Family Medicine Studies
NEAP	National Environmental Action Plan
NEG	National Environmental Guard
NGO	Non-governmental Organization
NHIF	National Health Insurance Fund
NHIH	National Health Insurance House
NIPH	National Institute of Public Health
NRIS	Strategy of the Government of Romania for the Inclusion of Romanian Citizens belonging to Roma Minority 2015-2020
NSPH-MPD	National School of Public Health, Management & Professional Development
NSFM	National Society for Family Medicine
ONAC	National Office for Centralized Procurement
OJ	Official Journal of Romania
OP	Operational Policy

PAP	Program Action Plan
PforR	Program for Results
PIU	Project Implementation Unit
PHC	Primary Health Care
POM	Project Operation Manual
PP	Program or Plan
RAS	Reimbursable Advisory Services
RHM	Roma Health Mediator
SEA	Strategic Environmental Assessment
SQM	Square meters
SPAS	Social Assistance Service
TOR	Terms of reference
USD	United States Dollars
WB	World Bank
WHO	World Health Organization

## EXECUTIVE SUMMARY

The ESSA findings confirm that the Government of Romania's (GoR) current system to manage social aspects of the Romania Health Program for Results has several strengths: a strong legal framework for improving equitable and inclusive access to PHC services; institutional mechanisms for various stakeholders to relay their perspectives regarding the Program's design, including national and local level complaint procedures; and a Roma Health Mediator program that has high potential for scale-up.

This Program is expected to generate substantial social benefits, particularly through its efforts to improve primary healthcare coverage (PHC) for underserved populations including the uninsured and the poor and people living in local authorities that lack a family physician or in rural local authorities with a low density of family physicians. At the same time, its overall social risk is **substantial** due to potential bottlenecks that could hinder the access of underserved populations to PHC. Firstly, many vulnerable groups, including but not limited to Roma, may not be able to use family physicians since they do not have ID cards and/or birth certificates and thus are not able to register themselves for family care. Secondly, they have a disincentive to seek PHC services due to alleged perceptions of disrespect, cultural insensitivity etc. on the part of service providers. Thirdly, access to family physicians may become even more constrained for elderly/ disabled people, particularly in remote and rural areas, as the workload of family physicians significantly increases because of the Program. Fourthly, many of the currently underserved population, especially those who are illiterate or based in remote rural areas, may remain unaware of the improved coverage and scope of basic benefits now available to them and may not seek PHC services as a result. They may also remain unaware of existing feedback/grievance mechanisms that they can use to report whether their access to PHC services has improved or not.

The Program is designed to mitigate several of these risks. The Program's expansion of community health care and strengthening its collaboration with PHC will be helpful to improve access to community health services (CHC) and PHC services for underserved groups. The MoH will hire community health nurses and Roma health mediators and deploy them to communities to provide community-based interventions. Protocols and guidelines will be developed to guide their daily work and collaboration with family physicians, and trainings will be provided to ensure their compliance with the protocols. These measures will make CHC more accessible and/or attractive to vulnerable groups, including Roma by: i) increasing the ratio of community health nurses and Roma health mediators to community members so that they can provide community health care more readily and regularly and ii) improving the quality and effectiveness of the work performed by community healthcare workers since they would now be based on formalized standards and protocols. As part of its effort to improve collaboration between CHC and PHC and to facilitate access to PHC, targeted communities will receive health education and support from community nurses and Roma health mediators in navigating the health system, particularly PHC.

To help allay some of the disincentives to seek PHC services due to alleged perceptions of disrespect, cultural insensitivity etc., primary care providers and community nurses will be trained in working effectively with different cultures and ethnic minorities, as needed. Strategic planning to close supply-side barriers to PHC access that are informed by community needs assessments, combined with the mobilization of additional community health personnel will also help to abate any potential instances of constrained access to PHC for elderly/disabled people in remote or hard to reach locations due to the increased workload of family physicians. Finally, to increase awareness regarding expanded insurance coverage and PHC services that are available to them the Program will include public outreach efforts and monitor the level of awareness of the population in this regard.

To maximize the Program's benefits, the ESSA recommends that 1) public outreach efforts are tailored to meet the information and communication needs of target audiences to increase awareness among the



population regarding the benefits to which they are entitled, and about the feedback mechanisms that they can use; 2) Information regarding the primary healthcare sector is made available in accessible formats to increase awareness of the insurance coverage and scope of services included in the basic healthcare package on an ongoing basis beyond the initial thrust of public outreach efforts; 3) instituting periodic monitoring of the uptake of PHC services and the perceptions of beneficiaries to identify changes in the number of beneficiaries registered with their primary healthcare providers, as well as any other challenges with regard to their accessibility to PHC services; and 4) monitor the number of potential patients that social workers have helped to acquire IDs for their registration with family physicians is monitored so that it can serve as an incentive for social workers to help persons who are contending with this issue.

The ESSA confirms that the Government of Romania's (GoR) current system to manage environmental aspects of the Romania Health Program for Results is appropriate in terms of legal framework for medical waste management system. The ESSA findings identified a general satisfactory implementation and enforcement level for the the current norms for medical waste management, including at the PHC level.

The Program's environmental risk is considered to be "moderate" because the extension of PHC services will not generate significant additional quantities of medical waste as in the existing situation:

#### *Management of Medical Waste*

The increased number of PHC facilities within the present Program, in rural and remote areas might not generate significant associated negative impacts if these PHC services will have proper and regular access to the existing medical waste management infrastructure system. The country has in place a regulatory framework as described in the technical norm regarding the management of the medical waste resulted from medical services, issued by the MoH on 12/3/2012, published in the Official Journal on 01/17/2013. This norm refers to the management of waste resulting from medical activities for all medical services and regulate the way in which separate collection by category, packaging, temporary storage, transport, treatment and disposal of medical waste is carried out, paying particular attention to hazardous waste to prevent environmental contamination and damage to health. The medical waste producer is responsible for the management of the medical waste resulting from his activity. The PHC units performing medical activities generate in average less than 300 kg of hazardous waste per year, which represent a reduced negative potential impact to environment, and this is fully manageable under the existing normative framework.

It is a moderate risk also because in the country is in place an integrated waste management system and it is mandatory for all the providers of medical services to have contracts with licensed sanitary operators for each category of wastes. The average quantity of medical waste, per day/month will not be significantly increased within the context of this Program, and there are not expected major changes in the existing contracts for medical waste management.

However, for the new created PHC facilities under this Program in rural/remote areas it should be confirmed the existence of medical waste collection contracts with specialized sanitary operators.

One of the priorities in terms of environmental sensitivity in the health sector, including the primary and community care is related to the concrete and constant implementation of the regulations for the management of medical waste. The risk in the case of this Program is mainly related to insufficient implementation of the related regulatory frame in place, as described in the Annex to this ESSA, with focus on the above-mentioned technical norms issued by the MoH. In view of an appropriate compliance with the regulations in the field of the medical waste management, there are a few areas to be further addressed:

- The need to increase the level of knowledge on prevention and/or mitigation in relation to the generation of medical waste at the level of the primary and community health care;
- Develop medical wastes management at the PHC level in the rural areas which are largely targeted by the Program ,with the aim to mitigate the potential risks related to inappropriate disposal of hazardous and non-hazardous waste;
- Update the contracts with authorized sanitary operators for collection and appropriate disposal of each category of medical wastes at the level of the PHC in the rural areas which are largely considered by the Program.

In the rural and remote areas largely addressed under this Program the PHC services need to consider the continuous implementation of the mandatory legal regulations for medical waste management, in order to avoid potential risks of inappropriate disposal in non-authorized landfill.

#### *Adaptation of the Health System to Climate Change and Extreme Weather Events*

Romania is exposed to climate change effects and an increased incident of extreme natural events (heat waves, droughts, floods, storms etc.) and the levels of awareness, basic education and protective measures provided by the PHC services are still insufficient and inefficient. Threats arising from extreme events can affect and aggravate health problems. The healthcare system needs to be prepared to explain the potential consequences for each group of sensitive and/or vulnerable groups. This is an aspect to be considered also in the isolated zone, rural and remote areas. A proactive approach will create to the population the ability to prevent and respond in such situations.

The Program will increase Romania population's access to health services, which is important in case of climate change-induced natural disasters or epidemics of diseases exacerbated by extreme weather events. This will contribute supporting resilience to climate change trends for the overall population, which will have better access to adequate information and care, including climate-related conditions.

Although Romania has well established public policies to promote human health, it is still not sufficiently prepared to deal with the range of problems associated to the consequences of climate change. Climate change and the increased incidents of extreme weather events (heat waves, droughts, floods, storms etc.) request a clear determination to adapt systems, in this case human health in general and vulnerable groups in particular. Despite a significant risk of exposure to such natural events for the vulnerable groups mainly, but also to the affected communities, the levels of awareness, basic education and protective measures provided by the PHC services are still insufficient. Key issues identified by the Environmental System Assessment, including risk mitigation and capacity building could be addressed through the implementation of environmental as defined in the PAP and/or through some of the DLIs.

One of the common objectives in terms of health and environment, under the National Strategy on Climate Change and Economic Growth Based on Low-carbon Economy for the period 2016 – 2020 (GD 739/2016) is to protect citizens' health against the impacts of extreme weather events. In line with this provision, preventive actions have been proposed to strengthen the capacity to react in the case such weather events – development at national level of detection, surveillance and response systems for all events and risks related to the public health, including strategic stocks of critical supplies, trained personnel and a mechanism of institutional coordination and partnerships between the public and private sectors.

# 1 BACKGROUND

## 1.1 Context

### Country Context

**Romania is an upper-middle income country with a Gross National Income per capita of US\$ 9,970 and a population of approximately 19.7 million in 2017.** The population has been declining at an average annual rate of 0.6 percent since 1990 due to low fertility and high premature mortality, as well as high levels of migration. This has resulted in a relatively older demographic structure of the population. The old age dependency ratio – or the number of people aged 65 years and over as a share of the working age population – is 27 percent.

**Romania's membership to the European Union (EU) has triggered important positive socio-economic and political transformation in the country.** Since Romania joined the EU in 2007, the country has benefitted substantially from the free movement of capital and labor and from access to grants associated with membership. Entry into the EU opened the door for fundamental societal changes and has enabled modernization linked to the EU economic markets and institutions. The EU has become an anchor for Romania's prosperity and has spurred the process of income convergence with the other members. The country's gross domestic product (GDP) per capita (at purchasing power standard) increased from 30 percent of the EU-28 average in 1995 to around 61 percent in 2017. Over 70 percent of Romanian exports go to the EU, which is also the main source of investment into the country. Social and political progress has accompanied these gains.

**Despite its economic progress, Romania continues to face large social and spatial disparities in inclusion, presenting a significant development challenge.** Romania's economy grew by 7 percent in 2017 and 4.1 percent in 2018, driven by consumption, investment and exports, and poverty declined in rural and urban areas since 2014. At the same time, in 2016 poverty rates in rural areas remained six times higher than in cities and just over twice as high as in towns and suburbs. The urban-rural gap in mean equivalized net income is the second-highest in the EU, with mean urban income almost 50 percent higher than mean rural income. Poverty rates also vary significantly across regions, with poverty in some counties in the North-East region being more than ten times higher than that of Bucharest.

### Sector Context

#### *Outcomes*

**Despite significant progress since joining the EU, Romania lags behind its peers on health outcomes.** While health outcomes have improved over the past two decades, they remain below the EU average, with significant geographic disparities. Life expectancies in Romania at 57.9 years for women and 58.6 years for men are lower than the EU average of 61.5 years and 61.4 years, respectively. Furthermore, national averages hide significant gaps in health outcomes: for instance, the mortality rate in rural areas is 15.4 deaths per 1,000 population compared to 11.7 deaths per 1,000 population in urban

areas.<sup>1</sup> The rate of amenable mortality in Romania is the highest in the EU for women and the third highest for men, signaling opportunities for improving health outcomes through the provision of essential services and public health interventions. In 2014 Romania's maternal mortality rate was one of the highest among EU member states at 31 per 100,000 live births. Maternal mortality is over 15 times higher among Roma women than non-Roma.<sup>2</sup> Vaccination rates have declined and are significantly below EU averages. In 2017, 87 percent of children in Romania received at least one dose of the measles vaccines before age one compared to the EU average of 94 percent.

Moreover, a 2010 survey based on a representative sample found that more than half of Roma adults aged 45 and over suffer from disabilities or chronic illnesses; more than 60% of adult men and women have cavities; and about half of the adults are either overweight or obese<sup>3</sup>.

Romanian women face a high risk of cervical cancer. The country has the highest incidence and mortality of cervical cancer in the EU, exacting a severe toll on women's health. In 2012, incidence and mortality rates of the cancer reached 34.9 percent and 14.2 percent, respectively, compared to the EU's rates of 11.3 percent and 3.7 percent (European Cancer Observatory 2012). Cervical cancer ranks as the leading cause of cancer deaths in women between the ages of 15 and 44 years in Romania. Reasons for these high rates include late diagnosis due to factors such as limited screening opportunities, and low vaccination rates. In 2014, about half of Romanian women between the ages of 20 and 69 in cities reported never having had a smear test. This share was even higher among women living in towns and suburbs (62.5 percent) and rural areas (73.3 percent). In 2008, the government introduced an HPV vaccine campaign targeting girls between the ages of 10 and 11, but only 2.5 percent of the 110,000 eligible girls were vaccinated. Reasons for the low up-take include fear of risks associated with the vaccine and mothers' negative perceptions of it<sup>4</sup>.

Minority women and women from low socio-economic backgrounds in rural areas are particularly vulnerable to cervical cancer. A qualitative study found that Roma women's participation in the national screening program for cervical cancer in 2012 was lower in rural than in urban areas (Andreassen et al. 2017)<sup>5</sup>. The study also argued that the main barrier was the screening system itself, which they said was not tailored to the targeted audience, and highlighted doubts among Roma women about whether they were meant to be included, misconceptions that insurance was necessary to participate, and expectations of discrimination and rejection. Another study on the national screening program found significant differences between women in rural and urban areas in terms of knowledge and acceptance of the Pap smear (Grigore et al. 2017). The main reason that urban women gave for not participating in it was lack of time (38.1 percent), while in rural areas, the main reason was lack of financial resources (49.2 percent)<sup>6</sup>.

### *Access*

Romania allocates less than 5 percent of GDP to health care compared to an average of about 10 percent in the rest of the EU. Government spending is the main source of funding, representing 78 percent of current health spending and consisting largely of social health insurance contributions and general government transfers. While government health expenditures grew between 2013 and 2017 in Romania,

<sup>1</sup>National Institute of Statistics. Romania. 2015.

<sup>2</sup>Romania Gender Assessment. 2018. World Bank Group

<sup>3</sup>Roma health mediation in Romania'. Case study. Copenhagen, WHO Regional Office for Europe, 2013. Roma Health Case Study Series, No. 1.

<sup>4</sup>Romania Gender Assessment. 2018. World Bank Group

<sup>5</sup> Andreassen et al. 2017. Controversies about cervical cancer screening: A qualitative study of Roma women's (non) participation in cervical cancer screening in Romania'. *Social Science & Medicine* 183 48e55.

<sup>6</sup>Romania Gender Assessment. 2018. World Bank Group

per capita spending, at EUR 983, was far below the EU28 average of EUR 2,773 in 2017, and five times less than the weighted health spending per capita in the EU15 countries<sup>7</sup>. The practice of informal payments, particularly for hospital-related care, is widespread and adds to the financial burden on patients<sup>8</sup>.

Although insurance is compulsory, in principle, only about 86 percent of the population is covered, approximately 14 percent of the population do not have health insurance. Notably excluded are vulnerable groups, particularly those who lack identity cards which prevents them from formally enrolling with a general practitioner<sup>9</sup>, such as agricultural workers<sup>10</sup>, the Roma and informally employed, unemployed or self-employed who are not registered for unemployment or social security benefits. Disparities in access to health care services are high. In 2016, only 66 percent of rural population was insured compared to 86 percent in urban areas. In addition, the EU's Minorities and Discrimination Survey (MIDIS) II 2016 survey showed that only 54 percent of Roma are covered by the national basic health insurance scheme or other insurance. This percentage had not improved since the previous survey in 2011<sup>11</sup>. Finally, 13.2 percent of the adult population in the bottom income quintile reported having unmet health care needs, compared with only 4.8 percent in the top quintile<sup>12</sup>.

There are two types of issues that contribute towards the disparities in access to healthcare: 1) the limited number of family physicians and 2) sociocultural barriers to accessing and navigating health services.

Underpopulated and rural areas have a significantly lower supply of family physicians than urban areas, contributing to geographic disparities in access to care. Two hundred and eleven<sup>13</sup> local public administration authorities, over 90 percent of which are rural, lack a family physician.

The accounts of Roma in particular attest to a series of obstacles to access health care services, including informal payments, family doctors' leeway to accept or deny patient enrolment and the existence of discriminatory practices in the medical system, such as segregation in maternity wards; redirection of patients to other medical practitioners; separate time slots to receive Roma patients, usually towards the end of the work schedule; and use of derogatory language<sup>14</sup>.

Apart from access per se, Roma have mentioned discontent with the quality of visits to family doctors due to limited physical contact during medical examination, no involvement of patients in deciding treatment; use of aggressive medical procedures; insufficient provision of information regarding the prescribed treatment and having to wait much longer than non-Roma to receive services, sometimes for up to a day.

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<sup>7</sup>EU15 are the 15-member countries in the EU prior to the accession of ten candidate countries on May 1, 2004; the EU13 are the countries that have acceded to the EU since 2004; and the EU28 are all member states of the EU.

<sup>8</sup> State of Health in the EU. Romania Country Health Profile 2017.

<sup>9</sup>According to a survey carried by the National Contact Point for Roma in 2016, at the level of Prefectures in Romania, over 5600 persons do not possess a birth certificate and almost 160,000 persons do not possess an ID card, acting as a barrier to accessing social services, including health. See [www.fonduri-ue.ro/pncr/1804-anunt-23-03-2016](http://www.fonduri-ue.ro/pncr/1804-anunt-23-03-2016), accessed April 15, 2019

<sup>10</sup> These include self-employed agricultural workers and daily workers, that are employed on a daily basis, without any health insurance attached to their payment.

<sup>11</sup>Romania Gender Assessment. 2018. World Bank Group

<sup>12</sup> Emergency care tends to be ineffective when people use it as an alternative for primary care since they often don't receive a full examination, advice on prevention and promotion, neither a follow-up after a visit.

<sup>13</sup> At least 90% of the authorities that lack a family physician are rural – the absolute number of authorities without a physician may be anywhere from below 211 to 300

<sup>14</sup>'Roma health mediation in Romania'. Case study. Copenhagen, WHO Regional Office for Europe, 2013. Roma Health Case Study Series, No. 1.

The perceived low quality of the interaction with medical practitioners represents a major deterrent from seeking medical help, particularly for minor health issues<sup>15</sup>.

Finally, the findings of a 2014 survey of general practitioners (GPs) revealed that only 20 percent of family doctors dedicate health education and health promotion activities that are geared towards persons 70 years and older. Only 5.5 percent of GPs see patients in senior residential centers during a normal working week<sup>16</sup>.

## 1.2 Description of Romania Health Program for Results

To facilitate economic and social convergence with the EU, Romania has committed to structural and institutional reforms needed to achieve a healthier, inclusive, productive and resilient country. These recommendations identified key actions to address institutional barriers to universal health coverage, including overall low funding, inefficient use of health resources in the health sector, hospital-centric service delivery and socio-economic obstacles for vulnerable groups (including Roma) to gain access to primary healthcare<sup>17</sup>.

**The National Health Strategy 2014-2020 has seven General Objectives (GOs), each of which identify priority actions.** The first three GOs focus on population health initiatives to improve maternal and child health, reduce the burden of communicable diseases, and reduce the burden of non-communicable diseases. The fourth GO is focused on ensuring access to quality and effective health services, including among underserved populations. The last three GOs involve cross-cutting measures for a sustainable health system, including pharmaceutical policy, eHealth solutions, and development of health infrastructure (Table 2).

**The boundary for the PforR within the government program has three dimensions.** First, the PforR will focus on PHC within health services and on pharmaceutical policy and data-driven decision-making within the cross-cutting measures. Focusing the Program resources on these areas will contribute to the expansion of coverage of PHC and increasing efficiency of the health system – which are critical to reducing amenable mortality in Romania. Secondly, the PforR will have national coverage in line with the government program. However, efforts under the PforR to PHC coverage will be intensified among underserved populations given the barriers they face to health care use. Finally, in line with the stated commitment to continue implementation of the government program until 2023, the PforR will support the next four years of implementation of the National Health Strategy.

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<sup>15</sup>'Roma health mediation in Romania'. Case study. Copenhagen, WHO Regional Office for Europe, 2013. Roma Health Case Study Series, No. 1.

<sup>16</sup>Evaluation of structure and provision of primary care in Romania'.2012. WHO Regional Office for Europe

<sup>17</sup> European Commission. Council recommendation on the 2018 National Reform Programme of Romania and delivering a Council opinion on the 2018 Convergence Programme of Romania. 2018.

The engagement of community health nurses has contributed towards addressing these obstacles, by providing more accurate advice and guidance at the level of local communities. The Roma health mediation program is also designed to address these socio-cultural obstacles.

**Table 1: Boundary for PforR within the government program (highlighted in grey)**

<b>Population Health Initiatives</b>	GO 1: Improving maternal and child health
	GO 2: Reducing morbidity and mortality due to communicable diseases
	GO 3: Reducing morbidity and mortality due to non-communicable diseases
<b>Health Services</b>	GO 4: Ensuring equal access to quality health services, especially for underserved populations, including primary and community care
<b>Cross-cutting Measures</b>	GO 5: Increasing sustainability and predictability in the health system, including through pharmaceutical policy
	GO 6: Accelerating the use of modern information and communication technology or eHealth
	GO 7: Development of health infrastructure, including hospital networks

**Based on the National Health Strategy (2014-2020), the proposed Program focuses on the following three areas where the Government requested the Bank's support and the Bank's engagement is likely to make a significant impact:** (i) improving PHC coverage for underserved populations; (ii) rebalancing the hospital-centric system towards effective PHC; and (iii) improving fiscal efficiency by addressing critical cost drivers.

### **Results area 1: Improving PHC coverage for underserved populations**

This results area aims to improve PHC coverage for underserved people by addressing the physical, financial, and social barriers they face.

- To address physical barriers hindering access to PHC, the Program will expand community health care and strengthen its collaboration with PHC. The National Health Strategy has identified community health care as a cost-effective means of providing access to essential services in rural areas and for underserved populations. The MoH will hire community health nurses and Roma health mediators and deploy them to communities to provide community-based interventions. Protocols and guidelines will be developed to guide their daily work and collaboration with family physicians, and trainings will be provided to ensure their compliance with the protocols. To improve the governance of community health care and PHC, the MoH will institute a unit to ensure the strategic planning at the institutional level for primary and community health care services and to improve the supervision of implementation, in partnership with local authorities.
- To address social barriers faced by vulnerable groups, the targeted communities (including marginalized communities) will receive health education and support in navigating the health system, particularly PHC. As part of the communities, community health nurses and Roma health mediators will map out specific social barriers and help address them. As needed, primary care providers and community nurses in these communities will also be trained in working effectively with different cultures and ethnic minorities. Guidelines for such trainings will be prepared as needed, as part of the development of health promotion protocols for community healthcare and guidelines for collaboration with PHC and local authorities.
- To address financial barriers to PHC, the Government recently announced an initiative to provide the basic package of PHC to the uninsured in Romania. This will entail amending the health law to extend this benefit to the uninsured. In addition, state budgets and the NHIH's framework

contract<sup>18</sup> with family physicians will be revised to reflect the cost of providing this benefit. Furthermore, public outreach will be conducted to make the population aware of the benefit to which they are entitled. Their awareness of the new benefit will be monitored, and grievance mechanisms will be strengthened to facilitate people's access to PHC services.

These measures will enable the community healthcare system to have a more effective role in facilitating access of vulnerable groups to PHC and will also serve to strengthen and make the community healthcare system more accessible to vulnerable groups such as the Roma by: i) increasing the ratio of community health nurses and Roma health mediators to community members so that they can provide community health care more readily and regularly and ii) improving the quality and effectiveness of the work performed by community healthcare workers since they would now be based on formalized standards and protocols.

## **Results area 2: Rebalancing the hospital-centric system toward effective PHC**

This results area aims to rebalance the hospital-centric system toward effective PHC by addressing the underlying institutional constraints: chronic underinvestment in PHC, the misalignment of incentives that is embedded in NHIH's provider payment mechanisms, and regulatory restrictions on the scope of PHC services. The Government plans a set of initiatives to make PHC comprehensive, widely accessible, and effective.

One initiative will revise the package of services in PHC to expand the number of services, including prescriptions for exams and medications to control the most prevalent noncommunicable diseases (NCDs) and increase the supply of preventive services for adults and children such as regular check-ups. In consultation with physician associations, the MoH will modify clinical guidelines to expand the scope of services in PHC to include initiation and coordination of care for diabetes mellitus, asthma, chronic obstructive pulmonary diseases, psychiatric conditions, and chronic pain, including prescription of related medication and the required diagnostic tests. These normative changes will be translated into the basic package of PHC that will be available for both the insured and uninsured.

To increase the supply of PHC, the NHIH also aims to revise provider payment mechanisms, incentivizing family physicians to improve the quality of services. Specifically, NHIH will reimburse family physicians to provide services—for example, initiation of treatment of Diabetes Mellitus. It will also use a combination of mechanisms such as capitation (adjusted by age and gender), fee-for-service, and performance-based payment (payment made when pre-agreed performance criteria are achieved), and will adjust specific payment terms (e.g., rate of capitation, threshold for fee-for-service volume) to reflect global experiences and country context.

Chronic underinvestment in PHC will be addressed through a two-pronged approach. First, the allocation of NHIH budget to PHC will be substantially increased during the next four years as the expanded scope of and access to PHC increase its use. This will greatly improve the funds inflow for family medicine practices. Second, a state aid scheme will be established to provide grants to facilitate the establishment of family medicine practices in areas where no PHC is available. It will also provide interest-free loans for practices to improve the quality of care, such as acquiring necessary equipment, training, or transportation

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<sup>18</sup> Framework contract is government by Health Reform Law 95/2006 and defines types of services covered by the insurance and provider payment mechanisms that apply to different providers for a given group of beneficiaries. Introduction of new groups of beneficiaries (e.g., basic package of PHC for the uninsured) will require change in the law. However, changes to the specific contents of services and specific parameters of provider payment mechanisms (e.g., fee level and caps on volume of claims reimbursed) can take place through its annual updating process. Framework contract is updated and signed annually.



and conducting minor refurbishment. The state aid scheme will be first piloted and then expanded to about 20 percent of family medicine practices.

### **Results area 3: Improving health expenditure efficiency by addressing critical cost drivers**

This results area aims to increase the efficiency of health expenditure by addressing critical cost drivers, including high spending on pharmaceuticals, devices and supplies and inefficient spending that can be detected through effective use of information.

To better control spending on pharmaceuticals and supplies, the Program will focus on more effective implementation of centralized procurement and pharmaceutical policies. This will entail refining the current policies (set out in Emergency Ordinance no. 71/2012, which notes that other European countries that implemented centralized procurement realized price reductions of 10-30 percent) and strengthening institutional capacity to implement them. Other proposed actions include modifying costing methodologies, setting health services prices by category of service providers, increasing the transparency of public spending using annual reports prepared by the NHIH and MoH, using risk-sharing mechanisms and cost-volume regulations for all new high-cost drugs, and revising the positive drug lists to ensure cost-effectiveness.

Under the Program, improvements in health information management are envisioned to ensure standardization, and interoperability of the existing subsystems, to facilitate access to information and enable evidence-based decision-making, including commitment controls. The application of state-of-the-art data analytics will help identify and prevent inefficient spending in many areas—for example, unnecessary care (referrals, visits, laboratory tests, etc.), failure to adhere to best practices, duplication of services, non-optimized drug prescriptions (e.g., less use of generics than expected), non-optimal use of infrastructure and medical equipment, low workforce productivity, detectable high-cost centers (e.g., population with high number of readmissions, over-prescribing centers), errors (e.g., coding, claimed services not connectable to medical conditions), and frauds.

The budget for the Government program over the next four years is estimated at US\$4.8 billion, of which IBRD financing would be US\$570 million, or 11.9 percent of the program budget. The specific expenditure categories included in the Program are goods and services, the wage bill, capital expenditures. The activities under the Program will be funded from the budgets of the NHIH, MoH, and MoPF. In the case of the NHIH, the Program will pertain to expenditures for family medicine services and NHIH administration. In the case of MoH, the Program will relate to expenditure items dealing with community care, PHC, and administration of respective activities. In addition, the Program will include the portion of the MoPF budget related to ONAC.

#### **1.2.1 Key Implementing Agencies and Partners**

Program implementation will be supervised at the national level using existing institutions and supervision practices. At the national level, the MoH will provide overall oversight of the Program, facilitate strategic decision-making, and ensure cross-agency coordination during Program implementation. The MoPF, MoH, and NHIH will be jointly responsible for the national-level day-to-day supervision, technical guidance, and actual implementation of the Program. Moreover, to promote Program ownership by the MoH, Technical Working Groups (TWGs) will be established to provide support on technical matters.

At the subnational level, the Local Public Administration Authorities, under the coordination of the Ministry of Regional Development and Public Administration, and the DPHAs, under the coordination of the Ministry of Health, will be involved in the implementation of community health care and of the state

aid scheme. Under the framework of Emergency Ordinance 18/2017, the DPHAs will supervise the implementation of community health care at the local level, including collaboration with family physicians.

### **1.2.2 Description of Borrower’s Past Experience with the World Bank in the Health Sector**

Since 1991, the World Bank has been a key partner in Romania to provide support for its health sector reforms. Its investment project financing support for the health sector has included: the Health Services Rehabilitation Project (1991); the Health Sector Reform Project (2000) and the Second Health Sector Reform Project (2004); and the Health Sector Reform - Improving the Health System Quality and Efficiency Project (2014). As a result, between 2007 and 2013 the Government of Romania (GoR) has updated maternity services and successfully implemented a critical reform of the health emergency services. This reform included the development of hospital emergency departments, implementation of telemedicine in emergency services, and the development of the Mobile Emergency Service for Resuscitation and Extrication. The GoR also developed a hospital rationalization plan and an interim HTA tool to implement evidence-based access to essential technologies was implemented. Since 2014, the GoR has relied on its collaboration with the World Bank for hospital network rationalization; ambulatory care strengthening; and health sector governance and stewardship improvement<sup>19</sup>.

The World Bank has also engaged in continuous policy dialogue on health sector reforms in Romania through the 2012 Development Policy Lending, Deferred Drawdown Option (DPL-DDO) which included significant health related measures. It was also actively involved in health policy dialogues with the GoR as part of the International Monetary Fund and European Commission programs. These dialogues have focused on areas such as: the scope of the basic package of medical services, revision of reimbursable drugs lists, implementation of Health Technology Assessments, introduction of supplementary private health insurance, and improved revenue collection for the public health insurance system<sup>20</sup>.

The Project Management Unit of the Ministry of Health (MoH) has had experience with implementing activities financed by World Bank investment project financing. The Implementation Completion Report (ICR) for the Second Health Sector Reform Project attests that the project had a substantial institutional development impact, at both local and national levels. The project significantly increased the capacity of MoH to plan and manage the health system. Specific attention was focused on the rationalization of health services and building HTA capacity. Moreover, the project strengthened national capacity to manage two of the main areas of the health system: Emergency and Maternal and Child Services, i.e., obstetrics and neonatology. Several fundamental documents also were written and/or adopted by the GoR, including the PHC strategy that was approved within the framework of the Health Sector Reform Strategy for the EU financing exercise 2014-2020. The ICR also indicates that the project strengthened local government capacity to implement health reforms<sup>21</sup>.

## **1.3 Overview of the Environmental and Social Systems Assessment and its Findings**

### **1.3.1 Overview**

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<sup>19</sup> Romania HEALTH SECTOR REFORM – IMPROVING HEALTH SYSTEM QUALITY AND EFFICIENCY PROJECT (P145174). Project Appraisal Document. 2014. World Bank

<sup>20</sup> PROJECT PERFORMANCE ASSESSMENT REPORT. Romania DEVELOPMENT POLICY LOAN WITH A DEFERRED DRAWDOWN OPTION (IBRD-81760) June 20, 2017. Independent Evaluation Group.

<sup>21</sup> IMPLEMENTATION COMPLETION AND RESULTS REPORT. HEALTH SECTOR REFORM PROJECT IN SUPPORT OF THE SECOND PHASE OF THE HEALTH SECTOR REFORM PROGRAM. June 19, 2014. World Bank

This Environmental and Social Systems Assessment (ESSA) Report has been prepared for Romania's Health Program for Results (PforR)<sup>22</sup>. It is a comprehensive assessment of: 1) the systems that Romania has in place for managing environmental and social effects (defined as benefits, impacts and risks) that are associated with the Romania Health PforR; and 2) the government's institutional capacity to plan, monitor and report on environmental and social management measures under the Program.

Its findings are intended to ensure that programs supported by PforR financing are implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes or mitigates adverse environmental and social impacts and risks. They inform the preparation of the Program Action Plan (PAP) that the government is expected to use to bridge any significant gaps in existing environmental and social management systems in line with the sustainability principles of the PforR (see Box 1).

#### Box 1. Core Principles for ESSA

**Core Principle 1: General Principle of Environmental and Social Management.** This core principle aims to promote environmental and social sustainability in Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program's environmental and social impacts.

**Core Principle 2: Natural Habitats and Physical Cultural Resources.** This core principle aims to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program.

**Core Principle 3: Public and Worker Safety.** This core principles aims to protect public and worker safety against the potential risks associated with: (i) construction and/or operation of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

**Core Principle 4: Land Acquisition.** This core principle aims to manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist affected people in improving, or at the minimum restoring, their livelihoods and living standards.

**Core Principle 5: Indigenous Peoples and Vulnerable Groups.** This core principle aims to give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.

**Core Principle 6: Social Conflict.** This core principle aims to avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

the needs of health care, social assistance, social inclusion of vulnerable groups and environment. It also focused on reports produced by national and local institutions and European and international bodies, informing on the advancements of pasts reforms, shortfalls and actions to improve the existing framework in which the Program is being implemented.

<sup>22</sup>PforR is one of the World Bank's financing instruments. Its unique features include: 1) linking disbursement of funds to the achievement of specific program results, 2) supporting clients in enhancing the effectiveness and efficiency of their development programs to achieve tangible and sustainable results, 3) strengthening the institutional capacity and the processes and procedures needed for programs to achieve their desired results, and 4) assuring that World Bank financing is used appropriately and that the Program's environmental and social aspects are addressed.

The *legal* analysis included a wide range of acts in the field of waste management, climate change, Disaster Risk Management, health and safety, public health, grievance mechanisms, gender equality, anti-discrimination, social policies, etc. For the *institutional* analysis, roles and responsibilities for respective institutions were identified based on a review of the current legal acts and strategic documents that have proposed the development of inter-institutional cooperation<sup>23</sup>. Reports from relevant public institutions, the European Commission, international financial organizations, and other organizations also informed the team on the performance of the current institutional set-up for managing social and environmental effects of the Program. Finally, the desk review also covered reports drafted by public institutions that focused on the implementation of strategic documents and other actions relevant for the Program<sup>24</sup>, as well as independent reviews by national, European and international organizations and institutions.

**B. Consultations and Disclosure.** Extensive consultations were carried with the main Program implementing agencies, the Ministry of Health, the Ministry of Finance and the National Health Insurance House. Other institutions that were consulted during the process included: the National Institute for Public Health, The National School for Public Health at Babes Bolyai University, the National School for Public Health, Management and Training in Healthcare, Ministry of Social Justice, College of Physicians in Romania, National Society for Family Physicians, County Public Health Directorates, the National Association for the Protection of Patients, the Coalition of Associations working with Chronic Disease Patients (19 NGOs), the Renasterea Foundation for Women's Health, the E-Romja Association for Roma women rights and other Roma NGOs. Municipalities, family physician practices, community health nurses and health mediators were also consulted during site visits in the following rural and urban communities in disadvantaged and underserved areas in the south-east of Romania: Tandarei, Barbulesti, Ceamurila, Jurilovca, Kogalniceanu, Crisan, Mila 23, Caraorman, Sfantu Gheorghe. The ESSA team also convened a consultation with the Roma Sounding Board on March 28, 2019 (9 Roma organizations were present at the meeting: Roma Educational Fund, Danrom, CRIS, Roma Centre for Health Policies - Sastipen, Resource Centre for Roma Communities, Romani CRISS, NevoParudimos, Botosani Roma Marginalized Association) in relation to the Program's outcomes.

### 1.3.2 Social Risks and Considerations Associated with the Program

This section provides an overview of the social risks associated with this Program, that are underpinned by ESSA core principle 1 on General Principle of Environmental and Social Management and core principle 5 on Indigenous Peoples and Vulnerable Groups. The former aims to promote environmental and social sustainability in Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program's environmental and social impacts. The latter aims to give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups. Core Principle 4, Land Acquisition, is not relevant because the Program will only support minor refurbishment of existing facilities, including small repairs of existing facilities such as painting, flooring, sealing windows, fixing doors, and no impact on private assets or livelihoods is therefore expected. The proposed small-scale interior construction works for renovation/repairs of existing PHC spaces and the associated environmental impacts would be limited and typically include: dust, noise, on-site safety and waste management.

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<sup>23</sup>These include: National Health Strategy 2014-2020, Strategy on Social Inclusion and Poverty Reduction 2015-2020, Strategy on Inclusion of Romanian Citizens of Roma Ethnicity.

<sup>24</sup>such as the *Implementation Report on the National Health Strategy 2015*, *Report of activity of the National Health Insurance House 2017*, *Report of Activity of the Ministry of Health 2017*, *Report of activity of the Ministry of Labor and Social Justice*,

The ESSA findings confirm that the Government of Romania's (GoR) current system to manage social aspects of the Romania Health Program for Results has several strengths: a strong legal framework for improving equitable and inclusive access to PHC services; institutional mechanisms for various stakeholders to relay their perspectives regarding the Program's design, including national and local level complaint procedures; and a Roma Health Mediator program that has high potential for scale-up.

This Program is expected to generate substantial social benefits, particularly through its efforts to improve primary healthcare coverage (PHC) for underserved populations including the uninsured and the poor and people living in local authorities that lack a family physician or in rural local authorities with a low density of family physicians. To address physical barriers hindering access to PHC, the Program will expand community health care and strengthen its collaboration with PHC. The National Health Strategy has identified community health care as a cost-effective means of providing access to essential services in rural areas and for underserved populations. To address social barriers faced by vulnerable groups, the targeted communities (including marginalized communities) will receive health education and support in navigating the health system, particularly PHC. As part of the communities, community health nurses and Roma health mediators will map out specific social barriers and help address them. To address financial barriers to PHC, the Government recently announced an initiative to provide the basic package of PHC to the uninsured in Romania. This will entail amending the health law to extend this benefit to the uninsured. In addition, state budgets and the NHIH framework contract with family physicians will be revised to reflect the cost of providing this benefit.

At the same time, its overall social risk is **substantial** due to potential bottlenecks that could hinder the access of underserved populations to PHC. Firstly, many vulnerable groups, including but not limited to Roma, may not be able to use family physicians since they do not have ID cards and/or birth certificates and thus are not able to register themselves for family care. Secondly, they have a disincentive to seek PHC services that could stem from: i) concepts, beliefs and attitudes of the Roma towards health, health behavior and disease. E.g. some values, like notions of purity and impurity, are widespread among the Roma, and may explain the avoidance of contact with particular materials or individuals and ii) discriminatory practices on the part of doctors and other medical practitioners towards Roma, including having to wait much longer than non-Roma to receive services and getting less information about treatment, are reported as a major deterrent from seeking medical help, particularly for minor health issues<sup>25</sup>. Thirdly, access to family physicians may become even more constrained for elderly/ disabled people, particularly in remote and rural areas, as the workload of family physicians significantly increases because of the Program. Fourthly, many of the currently under-served population, especially those who are illiterate or based in remote rural areas, may remain unaware of the improved coverage and scope of basic benefits now available to them and may not seek PHC services as a result. They may also remain unaware of existing feedback/grievance mechanisms that they can use to report whether their access to PHC services has improved or not.

The Program is designed to mitigate several of these risks. The Program's expansion of community health care and strengthening its collaboration with PHC will be helpful to improve access to community health services (CHC) and PHC services for underserved groups. The MoH will hire community health nurses and Roma health mediators and deploy them to communities to provide community-based interventions. Protocols and guidelines will be developed to guide their daily work and collaboration with family physicians, and trainings will be provided to ensure their compliance with the protocols. These measures will make CHC more accessible and/or attractive to vulnerable groups, including Roma by: i) increasing the ratio of community health nurses and Roma health mediators to community members so that they can

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<sup>25</sup> Graaf et al, 2016 drive this point home by highlighting the lack of acceptability and respect as a supply side barrier in the discussion of their research findings for primary care for the Roma in Europe.

provide community health care more readily and regularly and ii) improving the quality and effectiveness of the work performed by community healthcare workers since they would now be based on formalized standards and protocols. As part of its effort to improve collaboration between CHC and PHC and to facilitate access to PHC, targeted communities will receive health education and support from community nurses and Roma health mediators in navigating the health system, particularly PHC.

To help allay some of the disincentives to seek PHC services due to alleged perceptions of disrespect, cultural insensitivity etc., primary care providers and community nurses will be trained in working effectively with different cultures and ethnic minorities, as needed. Guidelines for such trainings will be prepared as needed, as part of the development of health promotion protocols for community healthcare and guidelines for collaboration with PHC and local authorities. Strategic planning to close supply-side barriers to PHC access that are informed by community needs assessments, combined with the mobilization of additional community health personnel will also help to abate any potential instances of constrained access to PHC for elderly/disabled people in remote or hard to reach locations due to the increased workload of family physicians. Finally, to increase awareness regarding expanded insurance coverage and PHC services that are available to them the Program will include public outreach efforts and monitor the level of awareness of the population in this regard.

### 1.3.3 Environmental Risks and Considerations Associated with the Program

**The Program itself does not have explicit environmental management objectives.** The ESSA finds the existing legal and regulatory frameworks for environmental management relevant to the activities supported under the Program and consistent with the World Bank's PforR Policy and Directive. The Program is likely to have positive environmental impacts to the health sector. Benefits include improved overall access to quality and efficient PHC services, including in underserved areas. However, there might be potential negative impacts associated with the Program due to an increase in medical waste generation and point source pollution due to the potential increase in the number of PHC facilities delivering primary care services.

Romania has a comprehensive legislation on environmental protection, which is fully aligned with the EU legislation and, therefore, the Borrower's systems can handle the activities proposed under the first two Program result areas. The results areas identified under the Program and the corresponding DLIs do not recommend activities/actions that will have significant adverse impacts on the environment that are sensitive, diverse or unprecedented. As the Program will only support minor refurbishment of existing PHC infrastructure, including small repairs such as painting, flooring, sealing windows, fixing doors, the assessment considers that no impact on private assets or livelihoods is therefore expected.

The proposed small-scale interior construction works for the refurbishing of existing PHC facilities and the associated environmental impacts would be limited and typically include: dust, noise, on-site safety and waste management. Mainly waste from replacement (e.g. windows, flooring) and or demolition will be generated as a result of refurbishment of PHC facilities. At this stage, the expected amounts of generated wastes cannot be estimated as the state aid scheme will be a demand-driven funding mechanism, but considering the very small scale of such interventions the expected quantities of refurbishing-related waste can be properly managed in accordance with the actual practices and norms. Wastes containing asbestos, if any, will be managed in accordance with the REACH<sup>26</sup> (European

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<sup>26</sup>Regulation 1907/2006 of the European Parliament and of the Council from December 18, 2006 on the Registration, Evaluation, Restriction and Authorization of Chemicals (REACH) is an EU regulation designed to ensure a high level of protection

Community Regulation on Chemicals and their Safe Use) norms for prevention and reduction of environmental pollution by asbestos.

All the above impacts are to be successfully mitigated through the application of good engineering and construction practices, and with mitigation and monitoring measures to be specified in the works contracts prepared by the beneficiaries.

The project will not support construction of new buildings, but only interventions to the existing ones under the same foot print.

Contracts and bill of quantities will include clauses for appropriate disposal of debris, including hazardous materials that may be encountered. In addition, the municipal administration should determine sites for their subsequent transport and treatment, as well as define a route for transport. Existing regulations require, and procurement documents will specify, that no environmentally unacceptable materials can be used (e.g. only latex-based, acrylic, water-based epoxy, and water-based urethane paint would be eligible). The actual legislation in force foresees that all wastes generated from refurbishment of facilities shall be managed by licensed waste operators and recovered or disposed of in an environmentally friendly manner and that such wastes be disposed at appropriate licensed landfill sites.

Regulations concerning air quality, proper waste management and preventing noise pollution of the environment, legislation related to health and safety at work should also be followed. All these activities may be subject to control by the municipal administration, environmental authorities, or other authorities with attributions in the field of health and safety.

Considering the geographical coverage and nature of the Program activities, OP 7.50 on International Waterways or OP 7.60 on Disputed Territories are not triggered.

The general adequacy of the environment systems, of institutional and legal framework for medical waste management at the PHC level, as well as the role of PHC in preparing for and responding to climate change related threats to human health was confirmed during the assessment. The medical waste categorization system, medical waste management plans, and ad-hoc training programs are practiced within the health sector in Romania, and there is periodic revision of state competent authorities (environmental, health, Court of Accounts, etc.) on the effectiveness and performance of internal waste management system. However, with the increased number of PHC facilities generated by the Program in rural and remote areas there might be associated negative impacts if these PHC services will not have proper and regular access to the existing medical waste management systems.

- Although Romania has well established public policies to promote human health, it is still not sufficiently prepared to deal with the range of problems associated to the consequences of climate change. Climate change and the increased incidents of extreme events (heat waves, droughts, floods, storms etc.) request a clear determination to adapt systems, in this case human health in general, and vulnerable groups particularly. Despite a significant risk of exposure to such natural events for the vulnerable groups mainly, but also to the affected communities, the levels of awareness, basic education and protective measures provided by the PHC services are still insufficient and inefficient. Through DLI 1, DLI 2, DLI 3, and DLI 6, the Program will increase Romania population's access to health services, which is critical in case of climate change-induced natural disasters or epidemics of diseases exacerbated by climate change. This will

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of human health and the environment, to manage and control the potential risk to human health and the environment from the use of chemicals in the European Union, given the free movement of substances as such, in mixtures or in articles.

particularly benefit vulnerable groups in communities such as elderly, disabled, children, women, ethnic minorities, and those on low incomes: DLI 1 will provide incentive to reach 100 percent coverage of PHC services in all communities and improve effectiveness in PHC service delivery, increase preparedness to extreme weather conditions and prevent harmful impact by preventing deaths due to heat waves and the aggravation of chronic conditions (such as cardiovascular disease and respiratory diseases). Consequently, it will strengthen resilience through community access to PHC services and increase utilization of health care.

- DLI 2 will further increase access to PHC services, particularly to underserved communities, by expanding the scope of services, including integrated services. By supporting this integrated form of care, community health workers will educate the population on climate issues. Furthermore, the Program will make first-aid readily available to the population in case of climate-related extreme events (such as flooding and earthquake) in underserved areas. In addition, community health nurses and family medicine physicians will reach out to vulnerable groups who cannot seek care in facilities during climate-related extreme events.
- DLI 3 will expand scope and services for PHC by increasing its budget. This will contribute to supporting resilience to climate change events to the overall population, which will have greater access to adequate information and care, including climate-related conditions.
- DLI 6 will support the establishment of an inter-operable data system that connects data from all types of providers (community nurses, family medicine physicians, hospitals), public health institutes, and MoH. This will provide the possibility for the country to perform epidemiological studies on the influence of climate change effects on health and develop methodologies to forecast major health problems related to climate change effects.

Through DLI 4 and 7, the Program will support mitigation measures to create environment resilient to climate change events:

- DLI 4 will provide incentive to Romanian family physicians to improve climate smart infrastructures and integrate energy efficiency measures in the refurbishing of health facilities. This incentive will support expenditures on facility rehabilitation and equipment in accordance with the EU standards in respect of the Paris Agreement of 2015 and requirements for health facilities and services, particularly in relation to the energy efficiency updates and appropriate waste management. Consequently, the Program will help reduce carbon dioxide (CO<sub>2</sub>) emission caused by the sector and improve energy efficiency, which is in line with the strategy of the European Climate Change Program.
- DLI 7 will support centralized procurement of medical supplies and devices using climate smart approach towards reducing embedded carbon footprint in manufacturing processes.

Key issues identified by the Environmental System Assessment, including risk mitigation/capacity building, may be addressed through the implementation of environmental actions as defined in the PAP.

### *Overview of Medical Waste Effects*

The main environmental sensitivity in the health sector, and in particular the fields of primary and community health care is related to the management of medical waste. Risks associated with this section include:

- Actual limited level of knowledge on prevention and/or mitigation in relation to the generation of medical waste at the level of the primary and community health care;
- The current implementation of the regulations in the field of medical wastes management at the PHC level in the rural areas is not fully effective;



- The potential risks related to inappropriate disposal of hazardous and non-hazardous waste in non-authorized places, especially in rural, remote areas;

About 20,000 tons of medical waste are generated by state and private hospital units every year, or about 3% of all hazardous waste collected in Romania<sup>27</sup>. Out of these, the PHC units performing medical activities generate in average less than 300 kg of hazardous waste per year. Medical waste is defined under the Romanian legislation (MoH Order no.1226 from December 3, 2012), as all hazardous and non-hazardous waste that is generated by medical activities. Special norms are in force for dangerous medical wastes to prevent the contamination of the environment and the people' health. The segregation of waste is mandatory in all health care facilities units (big, medium and small) and the monitoring procedures are already developed.

The hazardous medical waste is classified as follows:

- anatomopathological waste –includes human tissue, human pieces resulted from autopsy laboratories, dead bodies, fetus and placenta;
- infectious waste –includes all waste which contains or was in contact with blood or viruses (syringes, needles, scalpel blades, razor blades, gloves, lines)
- sharpening-cutting waste –includes hypodermic needles and syringes, scalpel blades, razor blades etc;
- chemical and pharmaceutical waste –includes the expired vaccines, drugs, used substances resulted from laboratories, packaging from dangerous chemical substances, medicines, etc,
- radiation sources which are periodically changed

The non-dangerous waste is the waste assimilated to domestic waste.

Selective collection, specialized transport and treatment and neutralization complex systems are in place and functional. The Program risks on dealing with medical waste management are reasonably covered by the existing systems but will require efforts to address additional challenges emerging from the expansion of PHC services. The increase in the number of primary care units, community care integrated centers and community workers, as well as additional procedures that are being proposed under the current Program, can increase the quantity of medical waste produced at the level of these units. Community nurses perform limited medical procedures and thus generate limited amounts of medical waste. However, there is currently no service specifically dedicated to community health care, with the medical waste from nurses being fed into the collection systems of family physician practices.

Risks of inappropriate disposal may arise in cases where no FP practices are available at the level of the community where the nurse performs her work (over 200 administrative units are currently not covered by FP practices, according to the MoH) or where the relationship between the FP and community nurses is not functional.

The selective collection of the medical wastes is mandatory and is under the responsibility of each sanitary unit. This collection is standardized and includes dedicated containers that are labeled with the specific medical waste that is being handled. The transport of medical waste is carried out by an authorized transport company under strict safety and packaging requirements imposed by the Regulations on the Transport of Dangerous Wastes on Public Roads, in accordance with the A.D.R. (European Agreement concerning the International Carriage of Dangerous Goods by Road). The removal from the medical premises needs to be done periodically by special authorized sanitary operators. The collection of

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<sup>27</sup>NIPH, 2015, mentioned on the <http://www.ecologic.rec.ro/articol/read/reciclare-recuperare/15057/>

medical wastes needs to have a periodicity shorter than in present. The preventive measures need to be enforced.

The treatment of health care wastes with chemical disinfectants can result in the release of chemical substances into the environment if those substances are not handled, stored and disposed in an environmentally sound manner. Methods of disposal of medical waste should ensure rapid and complete destruction of factors with potentially harmful environmental and health impacts. According to the law, treatment for the disposal of waste is done by two procedures: incineration and sterilization. Incineration of waste has been widely practiced, but inadequate incineration or the incineration of unsuitable materials results in the release of pollutants into the air and in the generation of ash residue. Incinerated materials containing or treated with chlorine can generate dioxins and furans, which are human carcinogens and have been associated with a range of adverse health effects. Incineration of heavy metals or materials with high metal content (in particular lead, mercury and cadmium) can lead to the spread of toxic metals in the environment. Measures to ensure the safe and environmentally sound management of health care wastes can prevent adverse health and environmental impacts from such waste including the unintended release of chemical or biological hazards, including drug-resistant microorganisms, into the environment thus protecting the health of patients, health workers, and the general public.

However, the institutional setup has the potential to develop required capacity to deal with these potential environmental risks and challenges.

#### *Adaptation of the Health System to Climate Change and Extreme Weather Events*

Although Romania has well established public policies to promote human health, it is still not sufficiently prepared to deal with the range of problems associated to the consequences of climate change. Climate change and the increased incidents of extreme weather events (heat waves, droughts, floods, storms etc.) request a clear determination to adapt systems, in this case human health in general and vulnerable groups in particular. Despite a significant risk of exposure to such natural events for the vulnerable groups mainly, but also to the affected communities, the levels of awareness, basic education and protective measures provided by the PHC services are still insufficient. Key issues identified by the Environmental System Assessment, including risk mitigation and capacity building could be addressed through the implementation of environmental as defined in the PAP and/or through some of the DLIs.

One of the common objectives in terms of health and environment, under the National Strategy on Climate Change and Economic Growth Based on Low-carbon Economy for the period 2016 – 2020 (GD 739/2016) is to protect citizens' health against the impacts of extreme weather events. In line with this provision, preventive actions have been proposed to strengthen the capacity to react in the case such weather events– development at national level of detection, surveillance and response systems for all events and risks related to the public health, including strategic stocks of critical supplies, trained personnel and a mechanism of institutional coordination and partnerships between the public and private sectors. Extreme weather events, such as floods, storms, heat waves and drought can lead to severe consequences for the population, and in particular for the most vulnerable groups that are far more exposed due to poor housing and limited engagement with alert systems. In addition, threats arising from extreme events can be aggravated by the healthcare system, which may have weaknesses not only in terms of early warning and alertness, but also in its ability to respond. The consequences of disasters require a rapid and well-coordinated response to protect the health of affected communities.

Romanian and English versions of this draft ESSA report were disclosed on the websites of the World Bank on June ----, 2019. This draft will be finalized upon consideration of the feedback provided during the public consultation scheduled for June --, 2019 and will be redisclosed on the websites of the Ministry of Health and the World Bank.

The structure of the remainder of this report is as follows: Chapter 2 outlines relevant stakeholders in the health sector and others that readers should be cognizant of vis-à-vis the Program's environmental and social aspects; Chapters 4 and 5 describe the Program's respective social and environment management systems. Chapter 6 delves into the Program's social and environmental capacity and performance assessments. Chapter 7 provides an assessment of the Program system, Chapter 8 lists recommendations and inputs for the Program Action Plan and Chapter 9 refers to the Program's Environmental and Social Risk Ratings.

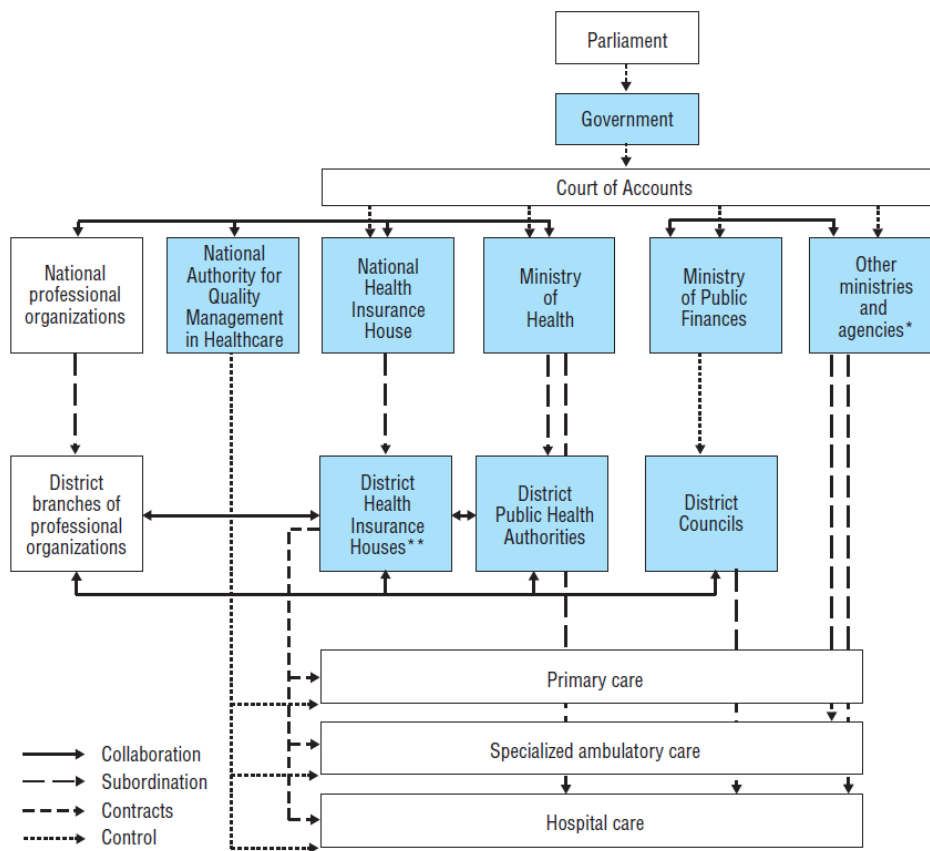
## 2 STAKEHOLDER MAPPING

Relevant stakeholders for the Romania Health PforR include entities that are associated with Romania’s health system, mainstreaming of social inclusion (women and Roma), and oversight and management of environmental issues.

### 3.1 Health System Stakeholders

The Romanian health system is organized at two levels: national and county level (*judet*). The national level is responsible for setting and achieving general objectives and ensuring the fundamental principles of the government health policy. The district level is responsible for ensuring service provision according to the rules set by the central level (see figure 1).

Figure 1. Organization of Romania’s Health System



Source: Romania: Health System Review 2016

### 3.1.1 National Entities

The main institutions at the national level are: the Ministry of Health, the National Health Insurance House (NHIH), the National Institute for Public Health and professional organizations. The parliament has a key position in the policy process, representing the legislative power and controlling the activities of the government. The Ministry of Public Finances oversees the financial resources raised for and spent on health care and plays a key role in decisions on health sector reforms when they involve changes in public finances. The Court of Accounts controls the formation, administration and utilization of state financial resources in the public sector. The Ministry of Transport, the Ministry of National Defense, the Ministry of Internal Affairs, and the Ministry of Justice and the Romanian Intelligence Agency also play a role in the health system by operating their own parallel health systems as well as through inter-sectorial cooperation.

*Ministry of Health.* The Ministry of Health is the central administrative authority in the health sector. It is responsible for the stewardship of the system and for its regulatory framework, including regulation of the pharmaceutical sector as well as public health policies and services, sanitary inspection and the Framework Contract, which regulates the purchasing of health services. It is also in charge of monitoring and evaluation of population health, provision of public health education and health promotion, human resources policy and certain infrastructure investments. Since 2010, local authorities have taken over some functions and competencies in health from the Ministry of Health (see below)<sup>28</sup>.

*National Health Insurance House.* The NHIH is an autonomous public institution that administrates and regulates the social health insurance system. Established in 1999, it decides on resource allocation from the NHIF to the DHIH; sets out annual objectives for its own activities and for the activities of the DHIHs; supervises and coordinates the activity of the DHIHs (it has the power to issue implementing regulations mandatory to all DHIHs); and decides on the resource allocation between different types of care. Jointly with MOH, it also elaborates the Framework Contract, which together with the accompanying norms, defines the benefits package to which the insured are entitled as well as the provider payment mechanisms.

*National Authority for Quality Management in Health Care.* The National Authority for Quality Management in Health Care was created in 2015. Its tasks include: elaborating, in collaboration with the Ministry of Health, the National Strategy for Quality Assurance in Health; drafting legislative proposals to ensure harmonization with international regulations; elaborating accreditation standards, methods and procedures for health care providers; accrediting training and technical consultancy providers in the field of health quality management; evaluating, re-evaluating and accrediting health providers; monitoring that appropriate quality standards are in place in health care facilities at all levels of care; and performing research activities in the area of health services quality.

*National Institute for Public Health.* The National Institute for Public Health has the mandate for:<sup>29</sup> prevention, surveillance and control of communicable and non-communicable diseases; monitoring health status; health promotion and health education; conducting occupational health assessments; health monitoring in relation to the environment; development of public health regulations; public health management; and the development of specific public health services<sup>30</sup>.

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<sup>28</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.

<sup>29</sup>[https://www.insp.gov.ro/organizare\\_insp/hg1414.pdf](https://www.insp.gov.ro/organizare_insp/hg1414.pdf)

<sup>30</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.

### 3.1.2 National Professional Associations

The *College of Physicians* has an important role in the obligatory registration of physicians and a consultative role in health policy. The College is in charge of licensing physicians, continuous medical education (CME) programs and quality of care (mainly via malpractice complaints).

The *National Society for Family Medicine (NSFM)* is the national professional association of FPs, with branches in almost all districts of the country. It is involved in professional development projects and is the main primary care advocate organization. It works in close cooperation with the National Association of Employers in Family Medicine and the College of Physicians in negotiating contracts for primary care doctors.

The *National Federation of FP Employers/Entrepreneurs (NAGPE), reuniting the Family Medicine Employers' Associations in Romania*, aims to develop family medicine services, to support training in managing the practice and to represent the profession in relation to authorities, unions and international organizations.

The *Order of Nurses and Midwives* has a similar role with the Physician College in Romania. By law, nurses and midwives are obliged to register with the order to be allowed to practice their profession. The Order has two main roles: monitoring the way nursing and midwifery are practiced and contributing to policy development regarding these two professions. The order is also representative for community health nurses.

The *National Centre for Family Medicine Studies (NCSFM)* was established in 2001 as relatively small organization (54 FP trainers) aiming at cultivating primary care professionalism. It became involved in professional matters since FPs/GPs felt that professional development in family medicine was insufficiently dealt with by other bodies, usually dominated by physicians with other backgrounds. Working in close cooperation with other international organizations, the NCSFM Foundation provided FPs/GPs with a coherent vision and pilot projects contributing to improving the quality of care and strengthening the status of primary care and family medicine<sup>31</sup>.

### 3.1.3 District Entities

The representatives of the central health care authorities at the district level are: the district public health authorities (DPHAs), DHIHs, district councils and district branches of the professional associations.

*District public health authorities.* There are 42 DPHAs, with one in each of the 41 districts plus one in the municipality of Bucharest. These are mainly responsible for carrying out the functions of the Ministry of Health related to population health at the local level, including: monitoring the health status of the population; developing, implementing and evaluating public health programs; organizing health promotion and health prevention activities; as well as controlling and evaluating health care provision and the functioning and organization of health care providers<sup>32</sup>. The DPHAs provide technical and methodological guidance to community health workers at the local level and provide support for local administrations to plan community health services and promote public health campaigns.

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<sup>31</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.

<sup>32</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.

*District health insurance houses.* There are 43 DHIHs, including the Bucharest Health Insurance House and one insurance house for the employees of the Ministries of National Defense, Internal Affairs and Justice and the agencies related to national security. The DHIHs are mainly responsible for concluding contracts with health service providers at the local level and monitoring these contracts and certain quality aspects of service provision.

*District councils.* The district councils are the elected bodies of the local government. Since 2010, the local authorities (local government and district councils) have taken on some responsibilities in the health area from the Ministry of Health, including the management and administration of the majority of public hospitals, as well as regulatory functions in areas that have an impact on health, such as sanitation and waste management<sup>33</sup>.

The *National Institute for Public Health* implements its activities through four national centers<sup>34</sup> and six regional public health centers<sup>35</sup>. The institute is a specialized agency of the Ministry of Health, providing scientific, technical and methodological support to health policy-making. It develops and conducts public health studies, elaborates norms and methodologies, produces reports and coordinates various public health programmes.

### 3.1.4 Primary Care

Overall, primary care in Romania is focused on family medicine (family physicians and practice nurses).

*FDs/GPs.* As a general condition to practice, all primary care providers in Romania must be organized in one of the following four legal structures: an individual practice, a group practice, an associated medical office or a commercial medical society with limited responsibility (Ordinance Nr.124 /1998 published in *Monitorul Oficial* Nr. 568; August 2002).

The official norm recommended in the framework contract for the number of patients per FD/GP is 1800 (as of April 2010). However, in some areas the practice list can be higher if no new FDs/GPs open a practice. As mentioned above, the minimum number of patients for FDs/GPs contracted with the NHIH is 1000 (although temporarily it may be lower and may also be lower in rural and remote areas where different limits are set). Having more than 2200 registered patients has been discouraged by the application of regressive points above that number. Norms for other primary care workers were not available.

With the exception of emergencies, patients are formally required first to visit their FD/GP before they can be treated by a medical specialist or any physician working in the public system. Patients can visit physicians in the private sector without referral and paid out-of-pocket. The gate keeping role of the FD/GP was strengthened in 1999 with the introduction of out-of-pocket payments for hospital admission

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<sup>33</sup> 'Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

<sup>34</sup> These are: a) the National Center for Transmissible Diseases Control and Control (CNSCBT); b) The National Center for Monitoring of Risks in the Community Environment (CNMRMC); c) National Center for Evaluation and Promotion of Health (CNEPSS). d) National Center for Statistics and Informatics in Public Health (CNSISP)

<sup>35</sup> These are: a) Regional Center for Public Health Bucharest (CRSPB); b) The Regional Public Health Center of Cluj (CRSPC); c) Regional Center for Public Health Iasi (CRSPI); d) The Regional Center of Public Health Timisoara (CRSPT); e) Targu Mures Regional Public Health Center (CRSPM); f) Regional Center of Public Health Sibiu (CRSPS).



without a FD/GP referral. Physicians in both inpatient and outpatient settings are formally obliged to send the FD/ GP who referred the patient a summary of the medical procedures, the diagnosis and treatment recommendations (called a “medical letter”)<sup>36</sup>.

*Community Health Nurses.* Community nurses have been historically present in the Romanian medical system since the inter-war period. During socialist times, their main focus was on the health of mother and child. Following reforms in the transition period, the network was abolished and then brought back in 2002, when a program of the MoH, intended to target the most vulnerable groups and ensure access to basic health care. Community nurses provide preventive and curative medical services at the individual, vulnerable, insured or uninsured, as well as community health services. The existing network of 1556 nurses are trained as general nurses, and work under the Social Assistance units within urban and rural public administrations. Their works involves coordination with social workers, health mediators (where Roma communities are present) and family physicians at local level. Among the tasks associated with the job, the most important include:

- perform the cartography of the population at local community level in terms of health determinants and identify households with vulnerable and / or community-based medical-social risk, priority being given to children, pregnant women;
- identify the non-registered persons on the lists of family doctors and support their inclusion on the lists of family doctors;
- report to the family doctor physically and socially vulnerable persons who require access to preventive or curative health services
- participate in the implementation of national, county and local health programs and actions within the local community, addressing especially the vulnerable persons from a medical, social or economic point of view;
- provide preventive health services and promote health-friendly behaviors of children, pregnant women and mothers, such as measuring blood pressure, blood sugar levels and weight;
- provide primary, secondary and tertiary prophylactic services to community members that include guidance on hygiene, diet and vaccinations.
- inform, educate and raise awareness among members of the local community about maintaining a healthy lifestyle
- administer medical care within the limits of professional competencies such as guiding patients on their medical regimen as prescribed by the family physician or specialist physician.

### 3.1.5 Community Care

Community care is comprised of community nurses, Roma health mediators and midwives.

*Community Nurses.* Community nurses have the same training as a practice (general) nurse<sup>37</sup>. There is no separate specialization for community nursing in the sanitary educational system.

*Health Mediators.* Hired specifically as part of the Roma Health Mediation program, the role of health mediators includes:

- serving as a liaison between Roma communities and health care practitioners;
- collecting data on the health situation in the community;
- increasing Roma access to health care;
- providing health education; and

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<sup>36</sup>Evaluation of structure and provision of primary care in Romania'.2012. WHO Regional Office for Europe

<sup>37</sup> Community nurses are trained as general nurses and can then opt to become a general nurse in a hospital, in a private praxis or under the community health care program.



- participating in public health interventions.

As liaisons, mediators are responsible for increasing mutual trust and improving communication between members of the community and medical personnel. Mediators also collect data on pregnant and recently confined women, the infant population of the community and immunization and check-ups of children aged 0 to 7 years. To increase access to health care services, they help to enroll newborns with family doctors and explain the advantages of being medically insured and the procedures for obtaining insurance coverage. Mediators are charged with raising awareness on family planning, child health care, nutrition, breastfeeding and hygiene. They also contribute to public health interventions, by mobilizing community members to take part in health campaigns (on vaccination or chronic diseases for example), identifying cases of tuberculosis and transmittable diseases and informing medical practitioners about the occurrence of particular problems within the community, such as transmittable disease foci and intoxications<sup>38</sup>. Qualitative evidence suggests that the engagement of health mediators has had a positive impact on the access of vulnerable groups (including Roma) to healthcare. However quantitative evidence to support this claim is not available in the absence of statistics in this area.

*Midwives.* The evolution of midwifery in Romania has seen a considerable decline from 50.5 midwives per 100.000 persons in 1990 to only 16.3 in 2013. Midwives are employed in the medical system as nurses under the gynecology and obstetrics departments. Romania has three faculties providing education to midwives and starting with 2014, midwives can open their independent practice. In community care, during the early stages when the focus was on the health of the mother and child, former midwives became the first community nurses. Today, there is usually one midwife employed in the national network of community health workers (nurses, mediators and midwives)<sup>39</sup>.

Table 2 outlines the key stakeholders who are engaged in the organization of community care, including: the Ministry of Health's Social Inclusion Unit, the Ministry of Labour and Social Justice (MoLSJ) and the Ministry of Education (MoEd) and District Public Health Authorities and Local Public Administrations (LPA).

**Table 2. Stakeholders Involved in Coordination of Community Care**

Administrative Level	Main authorities	Main responsibilities in Social Management
Central	Ministry of Health – Social Inclusion Unit	<ul style="list-style-type: none"> <li>- - Regulates the field of activity for community health care;</li> <li>- Ensures the technical and methodological coordination, monitoring and evaluation of the network;</li> <li>- Establishes the strategic objectives at national level and gradual expansion of the network</li> <li>- Consults and establishes the training needs for community health care;</li> <li>- Elaborates cost standards for the sector, together with the Ministry of Development and Public Administration, MoLSJ and MoE;</li> <li>- elaborates guidelines and standards of practice in the field of community health care</li> </ul>

<sup>38</sup>'Roma health mediation in Romania'. Case study. Copenhagen, WHO Regional Office for Europe, 2013. Roma Health Case Study Series, No. 1.

<sup>39</sup> [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/317240/Hit-Romania.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0017/317240/Hit-Romania.pdf?ua=1), Romania Health System Review, WHO, 2016, accessed 8 May 2019

		<ul style="list-style-type: none"> <li>- develop tools for the planning, monitoring, reporting and evaluation of community health care</li> <li>- endorses the establishment of integrated community centers [these refer to community level health/education/social services co-located as specified in emergency ordinance 18/2017]</li> <li>- participates in the elaboration of inter-institutional mechanisms and procedures for the provision of integrated medical-socio-educational services</li> <li>- collaboration with other institutions and NGOs implementing projects in the area of community care;</li> <li>- support the use of data collected at local level to inform decision making on social risks in relation to health care, associated with accessibility of vulnerable persons;</li> </ul>
	Ministry of Labor and Social Justice	<ul style="list-style-type: none"> <li>- mapping of existing providers of community services (social, medical, educational and employment);</li> <li>- participation in a working group establishing the institutional set-up for integrated community services, together with the MoH and the Ministry for Education;</li> <li>- drafting of sustainable models for integrated community services;</li> <li>- training plan for social workers in order to prepare integrated delivery of services;</li> <li>- regulating the role of social workers within the integrated teams;</li> <li>- developing and coordinating national plan for staffing local authorities with social workers;</li> </ul>
	Ministry of Education	<ul style="list-style-type: none"> <li>- participation in working group establishing the institutional set-up for integrated community services, together with the MoH and the MoLSJ;</li> <li>- supporting the development of educational councilors and educational Roma mediators at national level;</li> <li>- assuring the methodological coordination, training, monitoring and evaluation of educational staff in the integrated teams;</li> </ul>
District	District Public Health Authorities	<ul style="list-style-type: none"> <li>- Provides technical and methodological guidance of community health providers at county level</li> <li>- Provide technical support (e.g. needs assessment, prioritization, etc.)</li> <li>- Supports local administrations in planning community health services</li> <li>- Promotes campaigns for public health in relation to vulnerable groups;</li> </ul>
Local	Local Public administrations	<ul style="list-style-type: none"> <li>- Plan the activity of community health at local level, including needs assessment, integration with social services, employment of nurses and mediators</li> <li>- identifies the medical and social problems of the community members, especially of those in vulnerable groups</li> <li>- monitor and evaluate the work of community health providers</li> <li>- facilitate the collaboration between community health care staff and social service staff, mental health centers, family physicians, hospitals, CDPH</li> <li>- provides logistic support to community health care services (offices, equipment, transportation, internet access, PCs, telephone);</li> <li>- supports transport needs of beneficiaries of community health care;</li> <li>- concludes a framework agreement with family physicians in their administrative unit</li> </ul>

Other stakeholders that could be engaged in the process of developing, coordinating and evaluating the services of community health workers include the National School for Public Health (e.g. development of guidelines, trainings, monitoring tools, definition of result indicators, etc), the National Institute for

Public Health (e.g. data collection at community level), professional associations and Roma organizations.

### 3.1.6 NGOs and Patient Organizations

*NGOs* usually focus on delivering specific health and social services, for instance in areas like health promotion, reproductive health, family planning, HIV/AIDS and community care. A number of NGOs are involved in home care and palliative care under contracts with the DHIHs. The Centre of Roma on Health Policies focuses on the promotion of health policies and actions in Roma communities across the country.

*Patient associations* also have influence, via their official right to attend meetings of Ministry of Health special consultative committees. Furthermore, the Ministry has consultations with major patient umbrella organizations like The Patients College, The Association for Protecting Patients, The National Union of Organizations of HIV Affected People (UNOPA), the Federation of Cancer Associations, the Federation of Diabetes Associations and the National Alliance of Associations for Rare Diseases. In 2015, the Community of Patients Associations<sup>40</sup> was established, currently enrolling 235 organizations from Romania. Protocols for monitoring the implementation of Framework Contracts between the NHIH and health providers, by Patient Organizations, are being under development.

*Patient representation* in decision-making processes occurs via NHIH and DHIH administrative councils. Patients are represented in the NHIF Administrative Council by representatives from trade unions, employers' associations and the National Council of Elderly Persons. However, given that only 33 percent of employees in Romania are unionized<sup>41</sup>, and this applies mostly to employees in the public sector, the representation does not necessarily reflect an even distribution across all employees in Romania, not to mention those who are unemployed.

## 3.2 Stakeholders for Roma Inclusion

### 3.2.1 Government Entities

The main institutions responsible for implementing the National Roma Inclusion Strategy at the central level are: the Ministry of European Funds, the Ministry of National Education, the Ministry of Labour and Social Justice, the Ministry of Health, the Ministry of Regional Development, the Ministry of Culture, the Ministry of Public Finance, the General Secretariat of the Government, the National Agency for Roma, the Department for Interethnic Relations, and the National Council for Combating Discrimination. At the local level the responsible institutions are: Prefectures through County Offices for Roma, the local public authorities, and decentralized public services.

Among these institutions, the Ministry of Health, Ministry of Labour and Social Justice, the National Agency for Roma, prefectures through county offices for Roma, local public authorities and decentralized public services are or could be relevant for this Program.

*Ministry of Labour and Social Justice.* This ministry coordinates, monitors and evaluates the implementation of social policies dealing with children's rights, family issues, people with disabilities, the elderly, victims of domestic violence, vulnerable groups, people at risk of poverty and social exclusion. At local level, county and municipal authorities have shared and individual responsibilities in

<sup>40</sup><http://caspa.ro/home/>, visited on 5 April 2019

<sup>41</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.

relation to different categories of vulnerable groups and in providing primary and specialized social assistance.

*National Agency for Roma.* This Agency has the mandate for oversight of the GoR's policy and strategy for the protection of Roma minority rights. In addition to its other functions, the National Agency for Roma (NAR) collaborates with other public administration bodies, Roma NGOs and representatives of the Roma minority to assess the needs of Roma communities and coordinate the implementation of their support programs; implements activities for information sharing, capacity building and engagement that are accessible to the Roma community, and evaluates the impact of externally funded projects intended to promote Roma inclusion<sup>42</sup>.

### 3.2.2 NGOs and Working Groups

Some of the more prominent NGO coalitions include: 1) The Roma Democratic Federation (Federatia Democrată a Romilor), which consists of five of the most active Roma NGOs (Impreuna Agency, Romano Butiq, Sastipen, Roma Party Pro Europe, Amare Romentza) and 2) the Advisory Council (Consiliul Consultativ) of the National Agency for Roma, consisting of several Roma and pro-Roma NGOs that are active at national level; 3) the Non-discrimination Coalition – an informal non-governmental structure for lobby and advocacy including 10 organizations active in human rights in Romania; and 4) the NGO Structural Funds Coalition.

Working groups representing Roma interests include groups that have been established within ministries, for example the Desegregation Working Group and the Romanian Presidency working groups (for example, Educated Romania)<sup>43</sup>.

## 3.3 Stakeholders for Gender Mainstreaming

### 3.3.1 Government Entities

In Romania gender equality falls under the responsibility of two main institutions: the Directorate for Equal Opportunities between Women and Men within the Ministry of Labour, Family, Social Protection and Senior Citizens, and the National Anti-discrimination Council. The Department for Equal Opportunities between Men and Women is 'responsible for drawing up, coordinating and applying government strategies and policy in the field of equal opportunities between men and women, and exercising state competencies in strategy and regulation in this area.

### 3.3.2 NGOs

Certain health conditions specific to women have resulted in the creation of specialized associations focusing on the promotion of women's health, in areas related to breast, ovarian and cervical cancers. Their work involves educational and promotional campaigns, as well as representation of women patients in consultations with health authorities in Romania. Some examples of these NGOs include:

- The Renasterea Foundation for Women's Health<sup>44</sup> – working on awareness campaigns, health education and partnerships for health promotion; the foundation has been credited with the public

<sup>42</sup><http://www.anr.gov.ro/>

<sup>43</sup>, Civil Society Monitoring Report on Implementation of the National Roma Integration Strategy in Romania'. 2018. Directorate-General for Directorate-General for Justice and Consumers

<sup>44</sup><http://fundatiarenasterea.ro>, accessed 15 April, 2019

utility title by the Parliament, and has been actively involved in campaigning for breast cancer prevention;

- The Coalition for Women's Health<sup>45</sup>, initiated by the Renasterea Foundation, reunites 10 patient organizations and works on promoting national screening programs and supporting media campaigns for women's health educational purposes;
- Donna Association for Women's Health<sup>46</sup>, promotes prevention actions related to breast cancer;
- Primul Pas Association<sup>47</sup> - works on delivering services to pregnant, single mothers, or post-abortion counseling.

Other organizations, such as the Roma Centre for Health Policies – Sastipen, have also developed specific projects aiming the health of Roma women.

### 3.4 Environmental Stakeholders

This section provides an overview of the stakeholders who are involved in environmental management in Romania and that are relevant for the two environmental dimensions of this Program: medical waste management and adaptation to climate change.

*The Ministry of Health* designs specific strategies, policies, plans and regulations in response to the environmental needs (e.g.: in response to the health indicator in the National Plan for Waste Management, or Article 52 of the Law no.211 / 2011 on the waste regime). MoH coordinates the activities under his health responsibilities, including those in the field environment and relative priorities, such: medical wastes, quality drinking water, adaptation measures in response to extreme natural events, etc. The Ministry of Health ensures the technical and methodological coordination in terms of monitoring, reporting and evaluation for environmental collected information. MoH cooperates with the professional associations and NGOs for a transparent implementation in its inter-institutional common responsibilities for health and environment, such as: medical wastes, quality drinking water, adaptation measures in response to extreme natural events, etc.

*The Ministry of Environment* designs and promotes regulations dealing with waste management, including those relevant for health sector, such as the medical wastes; this is stipulated in the environmental regulations, where are set specific further actions for the MoH. It designs and promotes regulations dealing with waste management, including the medical wastes, for which measures are defined under the responsibility of the MoH and other ministries and central institutions. It also prepares the Waste Management National Strategies, as well as the Waste Management National Plans and is also primarily involved in drafting legislation concerning waste management for all the sectors. Regional Waste Management Plans are drafted by the LEPAs, in cooperation with local authorities of each of the 41 counties and Bucharest.

Moreover, MoE is responsible for coordination of waste management at the national level, while enforcement is assured at local level by the Local Environmental Protection Agencies (LEPAs), in cooperation with local authorities, local directorates for public health and sanitary operators. The National Environmental Guard of Romania (NEG) and the National Environmental Protection Agency (NEPA) assume responsibility for ensuring that waste management is performed in compliance with the norms concerning environmental protection.

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<sup>45</sup><https://www.coalitiapentrusanatateafemeii.ro>, accessed 15 April, 2019

<sup>46</sup><http://www.asociatiadonna.ro/>, accessed 15 April, 2019

<sup>47</sup> <http://www.primulpas.org/>

The MoE and the LEPAs are in charge of regulating environmental permits, endorsements and supervision of waste management, as well as registration and collection of information and data. At the local level, the environmental permits for all the activities generating waste and for all operators providing municipal waste services are issued by the LEPAs.

Based on this framework, other authorities are drafting and promoting their own related legislation for health and environment. For such regulations, the respective body seeks for endorsement of the Ministry of Environment and/or its territorial subordinates. The MoE also ensures the technical and methodological coordination in terms of monitoring, reporting and evaluation, and reports on a yearly basis to the Romanian Government on the status of waste management and its compliance with applicable European and national regulations on waste management.

*The Ministry of Waters and Forests* coordinates the activity of integrating the requirements for strategic planning, water management, and hydrology, hydrogeology into other sectoral policies, in line with European and international requirements and standards. The main directions of activities relevant for the goal of this analysis are: flood risk management, safety of the dams, safety of the dikes and river basin planning.

*The National Environmental Protection Agency (NEPA)* is planning, monitoring, and authorizing from environmental point of view the activities in all the sectors. This Agency is implementing its strategies, policies and regulations at the national, regional and local level. At the local level the activity is performed with the local Agencies for Environment Protection (EPAs) which are providing assistance and conducting the legal procedures in terms of environmental permitting, including for waste management at the level of medical services and facilities.

*National Institute for Public Health (NIPH)* is in charge with the monitoring and surveillance of the state of health related to environmental pollutants need more enforcement and also the need of considering the characterization of risks and the ways to communicate to the population the potential environmental risks. This is a responsibility under the area of responsibilities of the National Institute of Public Health, in a close collaboration with the central and local authorities responsible for health and the state of environment at the national and sub-national levels. It is a need to increase the preventive approach, preparedness and responsiveness to environmental issues and threats, including those associated with emerging climate change, in view to respond adequately to the identified needs.

The regional public health centers, which ensure the Institute's regional coordination and professional execution, are: a) Regional Center for Public Health Bucharest (CRSPB); b) The Regional Public Health Center of Cluj (CRSPC); c) Regional Center for Public Health Iasi (CRSPI); d) The Regional Center of Public Health Timisoara (CRSPT); e) TarguMures Regional Public Health Center (CRSPM); f) Regional Center of Public Health Sibiu (CRSPS).

*National Environmental Guard (NEG)* and its subordinated territorial inspectorates represents the specialized body of the central public administration, with legal personality, financed entirely from the state budget, subordinated to the Ministry of Environment and in charge with control the compliance of the units with their regulatory permits and also with accidental pollutions. The National Environmental Guard is control bodies that can take measures to sanction, suspend or close any activity if a pollution and/or damage are occur for environment point of view. This body and its territorial inspectorates are responsible for ensuring control of the professional, uniform and integrated implementation of the Government's policy of applying the national legislation harmonized with the Community legislation in the field of environmental protection.

*The National Health Insurance House (NHIH)* and its territorial Health Insurance Houses is the main

funding system for health care Citizens' welfare that provides access to a basic service package, being mandatory and is functioning as a unitary system. NHIH participates in establishing the objectives of public health programs in collaboration with the Ministry of Public Health, the Romanian College of Physicians, representatives of the policyholders, hospitals and university clinics, research units, non-governmental organizations, trade unions and employers' organizations, ministries and central institutions with their own sanitary network. NHIH elaborates methodological norms for the implementation of the framework contract, with consultation of the Romanian College of Physicians, College of Pharmacies in Romania, College of Dental Practitioners in Romania, the Medical Assistants' Order, Biochemistry Order, Biologists and Chemists in Romania, as well as a representative organizations and employers' organizations in the medical field, up to 15 December of the current year for the following year, which is approved by MO. NHIH performs forecasts, strategies, studies and analyzes on the development, operation, efficiency and performance of the Health Insurance System of Romania in Romania in view of improving it.

*County Directorates for Public Health (CDPH)* are mainly providing technical and methodological guidance of community health providers at local level. These directorates also provide technical support (e.g. needs assessment, prioritization, etc.) for local administrations in planning community health services and conducting campaigns for public health in relation to vulnerable groups.

At the regional and local level, all mentioned central bodies have representatives, such as the local EPAs, for providing assistance and conduct procedures related to the environmental permitting, including for waste management at the level of medical services or practices for family physicians (FP). Prior the elaboration of ESSA site visits took place in two settlements in the south region of Romania, Barbulesti and Tandarei. During this site analysis, consistent concrete information was obtained in relation with the connection between environmental responsibilities and health. On waste management, the interviews underlined that the contracts with sanitary operators are in place, but the periodicity of the selective collection of the different types of medical wastes from the facilities where the FP are providing medical services is quite relative and sometimes at large intervals (five-six months).

Based on the Government institutional structure, there are special committees and commissions, as set by the legislation which are operational in case such natural disasters, extreme events or adverse phenomena occur. One example is the National Emergency Situation Management System which is functioning based on the Ministerial Order 1422/192 from May 16, 2012 for the approval of the Regulation for the management of the emergency situations generated by floods, dangerous meteorological phenomena, hydraulic engineering accidents, accidental pollution on water courses and marine pollution in the coastal zones.

*Local Public Administration* is dealing with concrete responsibilities in terms of environment and health, planning activities in terms of emergency situations related to environmental extreme events, for increasing awareness to the adaptation measures as result of the climate changes, etc. Dealing with activities for the community health at local level, including needs assessment, integration with social services, employment of nurses and mediators, identifying the medical and social problems of the community members, especially of those in vulnerable groups, monitor and evaluate the work of community health providers, facilitate the collaboration between community health care staff and social service staff, mental health centers, family physicians, hospitals, etc.

*National Emergency Special Committees* were established under a common MO No. 1422 / 192/2012 for the approval of the Regulation regarding the management of flood emergency situations, dangerous meteorological phenomena, hydrotechnical accident and accidental pollution on the watercourses and marine pollution in the coastal zone. The Annex contains the "Regulations on the management of flood emergency situations, meteorological phenomena hazardous, hydrotechnical accident, accidental

pollution on watercourses and pollution marine in the coastal area”.

The *National Meteorological Administration* is the national authority in the meteorological field in Romania, with a continuous service since 1884. Romania is a founding member of the International Meteorological Organization and starting with 1947-member of the Convention setting up the World Meteorological Organization. The main responsibilities of NMA are meteorological protection of life and property, sustainable development and improvement of life quality, and areas including meteorology, fundamental research, systematic and complete weather monitoring, international data exchange and integration in the World Meteorological Monitoring. Romania has a vast experience in extreme events monitoring and control at national level, with a history of 120 years of observations, forecasts and case studies performed by National Meteorological Service. The scientists from National Meteorological Administration are actively involved in prevention and mitigation of all the natural risks affecting the environment and the agriculture, as well as disseminating specialized forecasts and advisories to decision-making factors and other end-users (farmer, citizens).<sup>48</sup> As an overall objective is to develop a warning system and tools for the assessment of extreme events (floods and droughts) in order to improve water resources management and disaster risk prevention.

Another important role is attributed to the *Ministry of Internal Affairs*, with its Department for Emergency Situations which is in charge of national coordination of emergency prevention and management actions, the provision and coordination of human, material, financial and other resources needed to restore normality, including specialist first aid and emergency medical care in Emergency Care Units and Centers. The DES coordinates the General Inspectorate for Emergency Situations (GIES) and the General Inspectorate of Aviation (with respect to medical missions); it also performs the operational coordination for ambulance services in counties and in Bucharest, for UPU/CPU, and for public mountain rescue services.

Overall, a common and convergent approach between the ministries and other central governmental authorities is in place in relation to the health and environmental sectors, starting with the strategies and policies developed by each of the Ministries of the Government of Romania. Currently, the Ministry of Environment is leading the preparation of the environmental regulations in the sector and is considering allocation of specific responsibilities to the other authorities. In the current Governmental framework, the Ministry of Waters and Forests has its role and responsibilities in relation the management of water streams. This creates a framework between the MoH and the two ministries in terms of roles and inter-cooperation, covering also the local entities.

The relevant Non-Governmental Organizations (NGOs) for the Program could be selected based on their already carried out programs in the field of environment and health<sup>49</sup>.

The *Chronically Patients Alliance in Romania*<sup>50</sup>; The immediate mission of the Alliance of Chronic Patients in Romania is to determine the authorities to constantly consult patients in real terms about the changes they intend to make in the healthcare system and to make patient rights known and respected in Romania. The following organizations are among the members of this Alliance<sup>51</sup>: Federation of Cancer Associations, Association of Patients with Hepatic Diseases in Romania, Association of patients with autoimmune diseases in Romania, National Association of Hemophiliacs in Romania, etc.

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<sup>48</sup><http://www.inmh.ro/>

<sup>49</sup>[http://www.cdep.ro/informatii\\_publice/ong2015.pe\\_com](http://www.cdep.ro/informatii_publice/ong2015.pe_com)

<sup>50</sup><https://aliantapacientilor.ro/>

<sup>51</sup><https://aliantapacientilor.ro/organizatii/>



The *Environmental Protection Organization*<sup>52</sup> is a platform for social mobilization and volunteering for environmental protection. It is a tool for communication with both authorities and stakeholders to find solutions to the environmental issues. The development of this platform is considering three main directions: (i) facilitating communication between NGOs and volunteers by promoting local associations' actions, ideas and initiatives; (ii) organizing volunteers into action groups for the causes they support and (iii) promoting the environmental solutions found to become legislative measures.

## 4 DESCRIPTION OF THE PROGRAM'S SOCIAL MANAGEMENT SYSTEM

There is no overarching social framework or system that is specifically applicable to Romania's healthcare sector, which could be used to determine whether there is an adequate regulatory and institutional structure in place that can ensure equitable and socially inclusive delivery of primary healthcare. The description of the 'social management system' for this Program will therefore need to be based on an analysis of legislative and institutional arrangements for the health sector that is overlaid by the GoR's cross sectoral priority to improve the social inclusion of vulnerable groups.

### 4.1 Healthcare

#### 4.1.1 Legislative Framework

Key legislation that is relevant for the Program includes Law 46/2003 on Patients' Rights, the 2004 Personal Data Act, the Health Reform Act - Law 95/2006 and the Community Healthcare Emergency Ordinance 18/2017. A list of other legislation that is pertinent for healthcare in Romania is included in Annex 2.

#### *Key Legislation*

- The Social Health Insurance Act of 1997 instituted the framework contract defining the entitlements of the insured population and the conditions for all providers, including FDs/GPs, to deliver medical care under the social health insurance system as well as the payment and incentives system.
- The Patient's Rights Act of 2003 and the Personal Data Act of 2004. Both laws contain provisions obligating providers to display statements of patients' rights in the medical units and health authorities to issue annual compliance reports. Both laws establish the following patient rights.
  - The right to be informed. Patients have the right to be informed about available health services, the qualifications of health care providers and the regulations about the functioning of medical units. They should also be informed about their health status in a polite, non-technical manner.
  - The right to informed consent. Patients have the right to provide informed consent on the medical services they receive, and the consequences of treatment denial should be explained to them. Consent should also be obtained from the patient for involvement in medical teaching or research. If the patient doesn't have the capacity to be involved in the decision-making process, consent should be obtained from his or her legal representative.

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<sup>52</sup><https://www.protectiamediuului.org/>

- The right to confidentiality. Patients have the right to the protection of confidentiality of information regarding their health status, the treatment received and personal information. Patients also have the right to privacy concerning family or personal life, unless this interferes with treatment or puts their lives or those of others in danger.
- The right to health care. Patients have the right to health care, including palliative care. The services should be provided by accredited personnel or medical units, as close as possible to the patient's environment. Rationing of scarce resources should be done on medical criteria.

Table 3 outlines the types of information that should be made available to patients as per national legislation.

**Table 3. Types of Information Available to Patients<sup>53</sup>**

Type of information	Where is it provided?	What type of information is provided?	Is there a legal obligation to provide such information?
Information about statutory benefits	Websites of the NHIH and the DHIHs	Range of services covered including services provided abroad	Law 95/2006
Comparative information about the quality of individual providers (e.g. doctors)	Independent websites providing information on health services and providers (e.g. <a href="http://www.doctorbun.ro">www.doctorbun.ro</a> )	Range of services covered and contact information	No
	Independent websites dedicated to various health topics (e.g. <a href="http://www.desprecopii.ro">www.desprecopii.ro</a> ; <a href="http://www.kudika.ro">www.kudika.ro</a> )	Mainly subjective opinions of the patients	No
Comparative information about hospitals	n/a <sup>a</sup>	n/a	No
Comparative information about the quality of hospitals	n/a <sup>b</sup>	n/a	No
Information on hospital clinical outcomes	n/a	n/a	No
Information on hospital waiting times	n/a <sup>b</sup>	n/a	No
Patient access to own medical record	At provider level	Information on diagnosis, treatment and costs (upon request)	Law 95/2006; Law 46/2003 on Patients' Rights
Interactive web or 24/7 telephone information	Phoneline of the Coalition of Organizations of Patients with Chronic Diseases in Romania ( <a href="http://www.copac.ro">http://www.copac.ro</a> )	Patients' rights, importance of preventive checkups, patient problems relating to access to health services	No
Information on patient satisfaction collected (systematically or occasionally)	Questionnaires used by individual hospitals (no countrywide survey); online forms	Opinions on service quality; complaints	Ministry of Health Order 146/2015 on the implementation of patient feedback mechanisms
Information on medical errors	n/a <sup>c</sup>	n/a	Law 95/2006

Source: Romania Health System Review, 2016

The main development in patient rights in recent years has been the transposition of EU legislation, including Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border health care, to the national law. The rights outlined in the European Charter of Patients' Rights are also included in the national legislation, including: the right to preventive measures, free choice, respect for patients' time, observance of quality standards, safety, innovation, avoidance of unnecessary suffering and pain, personalized treatment, complaints and compensation.

<sup>53</sup> The telephone number on the COPAC webpage is +4 021 / 319.93.29

- Law 95/2006 on Health Reform. This law provides the roles, responsibilities and institutional set-up for PHC practices – the services they provide, the contracting and payment mechanisms with the NHIH and DHIHs, professional requirements for FPs, etc.
- Emergency Ordinance 18/2017 on Community Healthcare. This Ordinance provides detailed regulation of the community health care network, comprised of community nurses, Roma health mediators and midwives. It also sets the basis for community integrated centers, seeking to stimulate better integration of different medical and social providers at local level<sup>54</sup>. The act is also far more detailed in comparison to previous regulations on community care, and provides the basis for training, monitoring, guidelines, protocols of collaboration with FPs and other providers, etc.

### *Governance*

The Framework Contract is the main legislative tool that regulates the purchasing of health services. It is developed by the NHIH, in consultation with the representatives of service providers, patients and civil society. It is approved by the Ministry of Health and passed as a Government Decision. The Framework Contract contains a definition of the statutory benefits package and information on the terms under which patients can obtain services, provider payment mechanisms, the relationship between providers and the DHIHs, terms of contracts (e.g. quality criteria for providers), providers' rights and obligations, and transposition of EU regulations with relevance to health care provision.

The Framework Contract and its norms form the basis for concluding individual contracts between the DHIHs and health service providers. The contracts must take into account the following criteria: the number of residents registered with the family medicine physicians, number of hospital beds, average length of stay (ALOS), number of consultations, etc. These criteria are linked to the health needs of the local populations, but also to the existing infrastructure and health personnel. The DHIHs monitor the fulfilment of the contracts. All DHIH activity is monitored and controlled by the NHIH according to a control and monitoring plan.

### *Planning of Human Resources*

The key legal act regulating the organization and functioning of health care providers is the Law 95/2006. The Ministry of Health develops the secondary legislation on the technical norms required for issuing the authorizations for the establishment and functioning of health care providers, and, together with the NHIH, secondary legislation on service provision, including quality norms.

The Ministry of Health controls, both directly and indirectly, the number of health professionals in the system. Direct control is exerted by approving the number of posts and types of medical specialties within the publicly owned health care units. Indirect control is exerted by issuing regulations in cooperation with the professional associations in order to ensure better geographical distribution of human resources.

The Government of Romania has made successive efforts towards primary healthcare reform. A major step for family medicine was the passage of the Health Reform Act of 2006, which dealt specifically with family medicine and covered almost all fields in the health care sector and included all previous legislation adapted to the *Acquis Communautaire*. In that same year, the Presidential Commission for Romanian

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<sup>54</sup>[https://ec.europa.eu/health/sites/health/files/state/docs/chp\\_romania\\_english.pdf](https://ec.europa.eu/health/sites/health/files/state/docs/chp_romania_english.pdf)

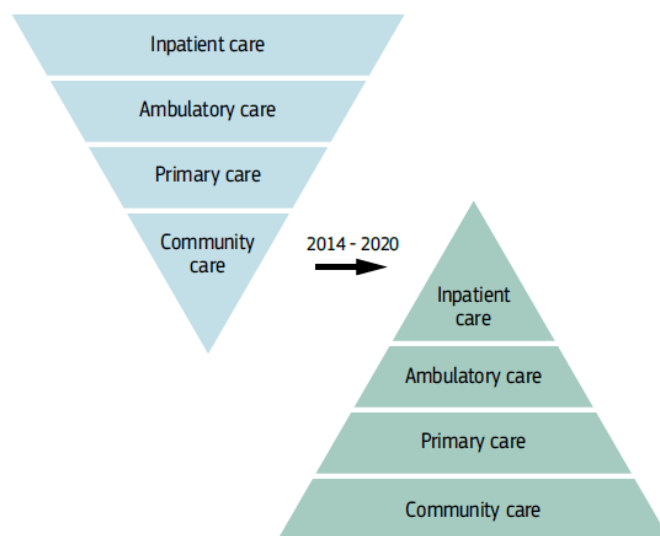
Public Health Policy Analysis and Development published *A health system focused on citizen' needs*, describing a vision of horizontal integration of health care providers with primary care as a key element<sup>55</sup>.

### 4.1.2 Strategy

**Figure 2 The vision of change in the Health Strategy 2014-2020**

In February 2012, the MoH developed and approved a comprehensive strategy for primary health care development in Romania<sup>56</sup> and a related action plan. This strategy was geared towards making primary health care comprehensive, widely accessible, and responsible for ensuring continuity of care with other providers. The more recent National Health Strategy 2014-2020 provides a national vision on health care services provision, which focuses on restructuring the currently inefficient pyramid of services and gradually ensure a wider coverage of the population health needs through health services that are provided at the foundation of the system (community care services, health care services provided by the family doctor and specialized ambulatory care).

As part of this Strategy's priority to ensure access to quality and cost-effective health services for vulnerable groups, integrated and comprehensive community health care is identified as a cost-effective means of providing access to basic medical services. This model of community care will involve integration with primary health care, specialized medical care, school care, and social services.



Source: Ministry of Health (2014).

### 4.1.3 Staffing

Despite increasing trends, in 2013 the numbers of physicians and nurses per 100 000 people were relatively low in Romania: 248 doctors per 100 000 compared to 347 in the EU, and 581 nurses per 100 000 compared to 850 in the EU. In 2013, 23.5 percent of physicians specialized in family medicine, which is lower than in 2010 (29 percent) and at odds with efforts to strengthen the role of primary care<sup>57</sup>.

The network of community health nurses and Roma health mediators varies considerably from one county to another. Although Roma health mediators are legally stipulated to serve a community of 500–750 persons, an independent evaluation commissioned by the MoH in 2012 indicated that the average number of clients for each Roma health mediator in the areas under scrutiny was as high as 1108<sup>58</sup>.

<sup>55</sup>'Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

<sup>56</sup> with support from the Health Sector Reform Project II (Loan IBRD 47600)

<sup>57</sup>'Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

<sup>58</sup>'Roma health mediation in Romania'. Case study. Copenhagen, WHO Regional Office for Europe, 2013. Roma Health Case Study Series, No. 1.

In a similar vein, a community nurse should serve 500 persons according to the current cost standard norms. However, the number of patients served by community nurses is unknown given that the by-laws are not approved yet, and since efforts to assess the health needs of the population and to monitor the performance of CHC providers are nascent. As their main focus is to serve vulnerable persons and persons with chronic diseases, prioritization of their work should be outlined on socio-medical data at local level. A pilot reporting system currently implemented by the MoH may establish the current workload and assist local authorities in the planning process, once the by-laws will be approved.

#### **4.1.4 Institutional Arrangements for Community Care**

Through the National Health Strategy 2014-2020, the Ministry of Health has defined a goal of developing integrated and comprehensive community health care services, mainly for rural populations and for vulnerable groups, including Roma. The community centers are expected to integrate medical, social and educational services at local level, by creating teams comprising of a community nurse, a social assistant, an educational mediator and a Roma health mediator (in communities with Roma ethnics). The main areas targeted by integrated centers are marginalized settlements as defined by urban and rural marginalization atlases<sup>59</sup>, with the purpose of addressing poverty reduction and social inclusion for the most vulnerable communities in Romania.

The concept of integrated community centers has been shaped by changes to the legal framework of community health care, national strategies in the sectors of health, social inclusion and poverty reduction and education and by the approval of the joined protocol<sup>60</sup> of the three ministries to develop and coordinate the implementation of these teams. The institutional set-up at the central level has not yet occurred, but a recent EU funded project, “The development and implementation of integrated community services for poverty reduction and social inclusion”<sup>61</sup>, carried in the period 2018-2022, will test the concept in 139 rural and small urban settlements (local public administrations that have a degree of marginalization above average and even severe).

Another recent project, “The Consolidation of the national network of Roma health mediators”<sup>62</sup>, implemented in the period 2014-2016, has resulted in the creation of 45 health community centers, comprising of community nurses and Roma health mediators in 45 rural settlements, focusing on the health of the mother and child, reproductive health, and multi-drug resistant tuberculosis.

#### **4.1.5 Qualifications and Training for Nurses and Health Mediators**

Nursing training takes three years in nursing schools (vocational schools) after completion of high school or four years in university colleges. Nurses can specialize in several disciplines: laboratory, public health and hygiene, balneo-physiotherapy, radiology, nutrition. Specialization takes one year. The continuing professional development of nurses is validated every five years through the accumulation of a sufficient number of continuous education points. If the minimum number of points has not been achieved, the nurse must pass revalidation exams<sup>63</sup>.

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59 The Atlas of Rural Marginalized Areas and of Local Human Development in Romania, World Bank, 2016 and Atlas of Urban Marginalized Areas, World Bank, 2014

<sup>60</sup>[http://www.mmuncii.ro/j33/images/Documente/Legislatie/Assistentia-sociala-2018/Ordin\\_393\\_2017\\_la\\_18-01-2018.pdf](http://www.mmuncii.ro/j33/images/Documente/Legislatie/Assistentia-sociala-2018/Ordin_393_2017_la_18-01-2018.pdf), accessed March 20, 2019

<sup>61</sup><http://www.ms.ro/2018/11/26/demararea-proiectului-pocu-122607-crearea-si-implementarea-serviciilor-comunitare-integrate-pentru-combaterea-saraciei-si-a-excluziunii-sociale/>, accessed April 10, 2019

<sup>62</sup> <https://insp.gov.ro/sites/2/>

<sup>63</sup> ‘Romania Health System Review 2016’. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

The majority of health mediators are women of Roma origin, and should be secondary school graduates. The health mediation training course includes two modules: 1) Theoretical training: The module “Notions of health mediation,” delivered by Romani CRISS trainers and 2) Practical and permanent training: The module “Education for Health,” delivered by the coordinator of health mediators from the Authority of Public Health. However, most health mediators do not benefit from continued training. Since no standards or protocols have been established for their functions, the trainings do not proffer specific knowledge and skills that are necessarily pertinent to their job or that pave the path towards attaining a specialization in primary healthcare. According to research conducted by Open Society Public Health Program, Roma health mediators would like additional training in reproductive health; newborn care; cancer; anti-discrimination legislation; and management topics, such as computer training or proposal development. Moreover, there is no system in place to maintain records of training curricula and trainings provided to respective mediators<sup>64</sup>.

#### 4.1.6 Benchmarking and Monitoring

The MoH routinely measures outcomes in mother and child health care by means of six indicators, derived from the National Health Programmes, namely the numbers of: pregnant women registered for follow-up, children receiving iron prophylaxis, children receiving vitamin D prophylaxis, pregnant women with malformation and genetic risk tested for anemia, pregnant women receiving informational support and vaccines administered<sup>65</sup>.

The NHIH gathers monthly data in electronic form on drug prescriptions, services provided and utilization of resources of each individual GP. Data about primary care drug consumption is discussed by the College of Physicians and pharmaceutical companies and is evaluated every year during the negotiations of the framework contract, and the data influence the level of drug reimbursements<sup>66</sup>.

Every two years the Romanian Centre for Health Policies and Services (CHPS) measures patient satisfaction and/or the physician opinions of the health care system. The results are usually debated in open meetings with stakeholder representatives like the College of Physicians, Ministry of Health, NHIH and patients’ associations<sup>67</sup>.

For community health mediation, monitoring and evaluation of the activities performed by health mediators are delegated to county health authorities, but the lack of protocols and guidelines in this regard suggest that this exercise is limited or intermittent.

It is uncommon for doctors and county health authority representatives to empirically verify the data provided by the mediators. Moreover, activity reports tend to be formal and quantitative in nature, using templates that do not allow for accurate recording of all the activities implemented within the community. The assessment of activities is not comparative and does not contribute to the standardization of monitoring practices. Usually no feedback is provided to the health mediators<sup>68</sup>.

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<sup>64</sup> Roma Health Project Open Society Public Health Program. 2011. Open Society Foundations

<sup>65</sup> ‘Evaluation of structure and provision of primary care in Romania’. 2012. WHO Regional Office for Europe

<sup>66</sup> ‘Evaluation of structure and provision of primary care in Romania’. 2012. WHO Regional Office for Europe

<sup>67</sup> ‘Evaluation of structure and provision of primary care in Romania’. 2012. WHO Regional Office for Europe

<sup>68</sup> ‘Roma health mediation in Romania’. Case study. Copenhagen, WHO Regional Office for Europe, 2013. Roma Health Case Study Series, No. 1.



#### 4.1.7 Information Management

The main and the oldest health information system is managed by the Ministry of Health through the National Centre of Statistics and Informatics in Public Health at the NIPH. It collects a very large volume of data, mainly on the health services and utilization (such as the number of medical consultations, inpatient days, average length of stay or bed occupancy) and data on morbidity. Data are published annually in statistical reports and in specific bulletins (e.g. there is a bulletin on the causes of deaths), which are restricted to health care units and not publicly available. However, they may be made available upon request. Data are aggregated at the district level and the aggregation reflects various levels of care and population groups.

Access to disaggregated or individual data is difficult at the national level; for instance, it is not possible to obtain data on the activity and costs of individual providers. Access to disaggregated data is also difficult at the district level as not all data are publicly available. Moreover, there is no feedback for health care providers supplying the data and as a result, providers cannot easily compare themselves to other providers or make decisions based on these data.

The NHIH manages the Integrated Unique Informatics System (SIUI). It collects information on over 26 000 health service providers that have contracts with the DHIHs and on 21 million insured persons. Data include medical information on patients, such as on health care services received, economic information on providers and on the administration of the NHIF (e.g. the running costs of the DHIHs). Data are collected and analyzed by the DHIHs and aggregated and administered at the central level. In addition, there are numerous smaller information databases. These are connected with the national health programs or with different clinical activities and are independent of one another; for example, the National School of Public Health, Management and Professional Development collects patient-level clinical data from hospitals. This information is used by the NHIH for hospital reimbursement.

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<sup>69</sup>.

#### 4.1.8 Transparency and Feedback Mechanisms

##### *Transparency*

The MoH has a dedicated section on their webpage<sup>70</sup> for informing the population on the rights they benefit from under the health system in Romania. The section includes information on the insurance system, drug policies, legislation, treatment in other countries, decisional transparency and other useful information.

##### *Complaint Procedures*

Although the Patients' Rights Act and Ministry of Health order 386 describe the right to treatment and information, they do not stipulate the procedural aspects of complaints. The key channels through which patients can assert their rights are the departments of public relations of the DHIHs and the Professional Jurisdiction Departments of the District Colleges of Physicians. The public relations departments of the

<sup>69</sup>'Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

<sup>70</sup><http://www.ms.ro/pacienti/>, accessed on 5 April, 2019



DHIHs follow up on patient complaints and communicate the outcomes to the patient. They issue monthly reports on both the information requests and the complaints.

The Professional Jurisdiction Department of the District College of Physicians analyzes complaints in accordance with the Deontology Code<sup>71</sup>. In 2016, the College of Physicians reported 684 complaints received in relation to the medical act. The complaints are dealt with at local level where an investigation is carried by the local branch, and more complex cases are administered by the Central Discipline Commission of the College. Out of the total complaints, 160 were submitted to the Central Discipline Commission and 23 sanctions were applied, including three cases of exclusion from the medical system. Surgery was the most common area in the complaints filed<sup>72</sup>.

Patients can also complain directly to the Ministry of Health or to their local DPHA, where special departments process the complaints. The focus is usually on whether administrative rules and procedures were adhered to. Finally, patients may also seek legal redress through civil courts (see Table 4)<sup>73</sup>.

**Table 4. Summary of complaints avenues and liability/compensation mechanisms**

Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	Not required but in most public health care institutions and in the DHIHs there are departments of public relations dealing with patients' rights and access to entitlements
Is there a health-specific Ombudsman responsible for investigating and resolving patient complaints about health services?	No
Is liability insurance required for doctors and/or other medical professionals?	Yes, mandatory for all providers (public and private) (according to Law 95/2006); compensation includes the cost of legal trial (see below), which is shared by the patient and provider
Can legal redress be sought through the courts in the case of medical error?	Yes (see section 2.8.2), but the process is cumbersome and this may discourage patients from using it; the upper limits for compensation are established by the NHIH in consultation with the representatives of the insurers' and health providers' professional associations; provider's fault is established by a commission for malpractice monitoring, which comprises representatives of the DPHAs, DHIHs, district branches of health providers' professional associations and a legal medical expert
Is there a basis for no-fault compensation (when a patient experiences a medical injury that was not caused by the doctor's fault)?	Yes, the court decides on the no-fault compensation
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	Yes, the court decides the value of the awards for both economic or non-economic losses
Can class action suits be taken against health care providers, pharmaceutical companies, etc.?	Yes

Source: Romania Health System Review, 2016

A petitioning system is established at the level of the Ministry, with an online platform that can be used to forward a petition and monitor its evolution. In 2017, 6,700 petitions were recorded at the level of the

<sup>71</sup> The Medical Deontological Code has been approved by the National Assembly of the Romanian College of Physicians on November 4 2016.

<sup>72</sup> <https://www.mediafax.ro/social/684-de-reclamatii-cu-privire-la-actul-medical-din-romania-colegiul-medicilor-a-decis-sa-dea-26-de-sanctiuni-ministerul-sanatatii-propune-modificarea-ordinului-de-feedback-al-pacientului-16215552>

<sup>73</sup> 'Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

Ministry<sup>74</sup>, with 4,854 being addressed within the institution, 1,572 forwarded to other competent bodies, and 274 recorded as non-compliant. Petitions include: complaints, requests and suggestions.

### *Surveys*

According to MoH order 146/2015, public hospitals should assess patient satisfaction with health care services<sup>75</sup>. Surveys applied at the level of the population are a mandatory feature at the level of each DHIH. Each year, DHIHs apply a survey<sup>76</sup> to a sample of the population to assess the level of satisfaction with medical service providers and to assess the level of knowledge of beneficiaries, in relation to their rights and services made available to them.

Unofficial interviews with hospital managers on the results of patient satisfaction questionnaires reveal that patients appear to be satisfied with the health care services provided but not with the attitudes of the nurses and other caregivers, or with the food and accommodation<sup>77</sup>.

#### **4.1.9A holistic and cross-sectoral approach to health**

A cross-sectoral approach to health is included in the key strategic documents: the National Development Plan 2014–2020, which indirectly addresses the most important health determinants including economic development, transport infrastructure, environment, social inclusion and living standards; and the National Sustainable Development Strategy 2013–2020–2030 (Government of Romania, 2008), which includes a range of activities seeking to reduce environmental hazards and to improve human health and well-being.

In practice, at the national level, the main mechanisms for addressing and integrating health across national policies are: the legal obligation on the government to conduct an impact assessment, including health impact assessments, of proposed legislation and to publish drafts of proposed legislation for public consultation; the use of inter-ministerial councils, commissions and expert working groups that work together on issues involving the remit of more than one ministry; and collaboration between the Ministry of Health and the NHIH and professional organizations.

Inter-ministerial councils ensure communication and coordination among ministries and coherent implementation of intersectoral policies. There are 13 permanent inter-ministerial councils (established by Government Decision 750/2005), including the Inter-ministerial Council for Health, Consumer Protection and Social Affairs. The councils can form inter-ministerial commissions and working groups, which may include representatives of other public institutions as members and may invite guest members, including from academia and civil society when specific expertise is needed.

At the district level, cross sector interventions are ensured through the collaboration of representatives of the Ministry of Health (i.e. the DPHAs) with the DHIHs, district councils, district branches of professional associations and district representatives of other ministries<sup>78</sup>.

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<sup>74</sup> Annual Report of Activity of the MoH, <http://www.ms.ro/wp-content/uploads/2018/08/Raport-de-activitate-MS-2017-.pdf>, accessed April 5, 2019

<sup>75</sup>'Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

<sup>76</sup>Several annual reports from different DHIHs were analyzed. Results are presented in terms of satisfaction with medical providers and the information on the services that are provided under the Framework Contract.

<sup>77</sup>'Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

## 4.2 Social Inclusion

### 4.2.1 Legislative Framework

Table 5 lists the laws and regulatory instruments that are related to various facets of social inclusion in Romania, and that are relevant to consider in the context of this Program.

**Table 5. Legislation related to Social Inclusion in Romania**

Law No. 202/2002 on Equal Opportunities of Women and Men	Provides the legal basis for promoting equal opportunities and treatment between men and women and removing all forms of discrimination based on gender in all spheres of public life in Romania.
Law No. 448/2006 on the protection and promotion of the rights of disabled persons (republished in 2008)	Regulates the rights and obligations of disabled persons granted for the purpose of their social integration and inclusion.
Law No. 292/2011 on Social Assistance is the main regulation	Establishes the social inclusion and protection system in Romania. It defines roles and responsibilities at central, county and local levels and establishes categories of vulnerable persons, monitoring mechanisms and the types of services to be provided.
GEO 18/2017 on community health care, approved by Law no 180/2017	Defines the legal and institutional framework for community health care, defines the vulnerable categories that are addressed by the Program, responsibilities for service providers (community health nurses, Roma health mediators, midwives), integrated community centers. The associated methodological norms for the application of this law were not in place at the time of conducting this assessment.
Emergency Ordinance no. 162/2008 on the transfer of the attributions and competences exercised by the Ministry of Health to the local public administration authorities, as subsequently amended and supplemented;	Defines the institutional involvement and responsibilities of local public authorities in relation to the provision of health services at local level. Community health care objectives fall under the responsibility of local authorities, with coordination from the Ministry of Health and the Country Public Health Directorates.
Order of the Minister of Health and Family no. 619/2002 for the approval of the functioning of the health mediator	Outlines the framework for community work performed by health mediators in Roma communities.

<sup>78</sup>Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

and of the Technical Norms regarding the organization, functioning and financing of the activity of the health mediators, as subsequently amended and supplemented.	
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## 4.2.2 Strategies

*The National Strategy on Social Inclusion and Poverty Reduction for 2015-2020.* This Strategy outlines a structured set of policy measures for achieving the Europe 2020 targets for Romania. It identifies the following as the main vulnerable groups: (1) Poor people, (2) Children and youth deprived of parental care and support, (3) Lone or dependent elderly, (4) Roma, (5) Persons with disabilities, (6) Other vulnerable groups<sup>79</sup>, (7) People living in marginalized communities.

This Strategy also identifies the main issues in relation to social inclusion:

- The high share of people whose income is low and insufficient for a decent living compared with the average of the other EU Member States, including a large number of working poor;
- Major gaps between rural and urban residents in terms of access to social services, employment, health care, education, and proper housing;
- Difficulties in achieving full social integration for certain social groups, due to their ethnicity, health, age, social or family background.

Its priorities in specific areas are summarized as follows:

**Health.** Prioritize increasing the coverage of basic healthcare service providers (family doctors, community nurses, and Roma mediators) at the local level countrywide, and instituting screening programs for the main pathologies (e.g. cancer, diabetes, HIV/AIDS, etc.).

**Social Services.** Highlight the development of integrated intervention community teams to provide social services (in education, employment, healthcare, social protection and other public services) and social intermediation and facilitation programs at local level, especially in the poor and marginalized areas, rural and urban, Roma and non-Roma, by: (i) developing clear methodologies, protocols, and work procedures for community-based workers, and (ii) developing, in the larger marginalized areas, multi-functional community centers to provide integrated services to (primarily though not exclusively) families in extreme poverty.

**Social Participation.** Ensure that open and responsive grievance and complaints mechanisms are built into the institutional set up of social services and promote evidence-based awareness-raising and advocacy campaigns about diversity (including various categories of marginalized or discriminated

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<sup>79</sup>As per Strategy on Social Inclusion and Poverty Reduction, other vulnerable groups include: persons suffering from addiction to alcohol, drugs, and other toxic substances, persons deprived of liberty or on probation, persons under the supervision of probation services, with non-custodial measures or sentences (persons granted postponement of punishment, suspension of sentence under supervision, release on parole – if the remaining sentence time is of minimum two years, and persons imposed the enforcement of a fine sentence by performing community service), minors under the supervision of probation services (sentenced to a non-custodial educational measure, granted the replacement of the custodial educational measure, or release from detention), homeless people, victims of domestic violence, victims of human trafficking, refugees and immigrants.

groups) as a complement to other actions, to address stigma and discrimination.

**Strengthening Capacity to Promote Poverty Reduction and Social Inclusion.** Establish functional inter-sector - MLSJ, Ministry of Regional Development and Public Administration (MDRAP), MoEd, MoH) coordination policies and enhance cooperation between central and local authorities, for fostering the integrated approach on antipoverty and promoting social inclusion policies.

*The Strategy of the Government of Romania for the Inclusion of Romanian Citizens belonging to Roma Minority for 2015-2020.*

This Strategy (NRIS) provides detailed directions for action in various areas to improve Roma inclusion, including health. Some of the directions that are more relevant in the context of this Program are as follows:

(1) Improving the access of the Roma population to integrated and quality, preventive and curative, basic healthcare services

- Developing the institutional capacity of healthcare service providers at community level through education and training, and development of work instruments in integrated system, guides and practice protocols.
- Hiring, with priority, a community nurse of Roma origin in rural communities with Romanian citizens belonging to that minority.
- Increasing the share of the Roma people in the health insurance system by: (i) Informing Romanian citizens belonging to the Roma minority on their right to the minimal health service package designed for persons not covered by the health insurance system; (ii) increasing the share of the Roma people receiving primary healthcare services; and (iii) monitoring access of the Roma people uninsured with the minimal healthcare service package.

(2) Increasing the institutional capacity of local public authorities within the process of identifying health needs, developing and implementing health programs/interventions designed for Roma communities, and their monitoring and evaluation:

- Identifying and mapping the medical and social needs of the population at risk both in the urban and rural areas.
- Developing standardized tools for analysis, data collection, planning and communication between the local and central public authorities involved in community healthcare provision.

(3) Preventing discrimination of Romanian citizens belonging to the Roma minority who access healthcare services through: (i) Educating in the spirit of non-discrimination of vulnerable groups within the medical schools at secondary, university and post-graduate levels and (ii) Setting up by the county council of a toll-free number for denouncing incidences of discrimination of Roma patients who access healthcare services<sup>80</sup>.

### 4.2.3 Institutional Arrangements

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<sup>80</sup> The Strategy was developed at the level of the Romanian Government, and pursuant to previous inclusion strategies and EC requirements. The implementation is distributed among several central and local authorities, with Ministerial Commissions for Roma being set-up at the level of each Ministry involved. The assessment and monitoring functions are associated with an inter-ministerial committee, and a Technical Secretariat, coordinated by the National Agency for Roma.

### *Social Services*

The MoLSJ is the specialized authority of the central public administration that carries out government policies in the field of social protection. Primary social assistance for persons with disabilities, protection of children and the elderly and for victims of domestic violence fall within the responsibility of local authorities. District level social authorities are organized to provide specialized assistance to all these groups.

Medical care and social assistance for the persons in need or for people with social problems is mainly organized under local authorities.

Social workers<sup>81</sup> are responsible with the identification of vulnerable communities or persons and the evaluation of social exclusion risks, followed by several steps taken to support the persons in need:

- Elaborates action plans, programs, measures and specialized services for support
- Establishes the means for accessing social aid support and specialized services for the persons in need
- Creates the basis for tolerance for persons in need at the level of the community.

Law 292/2011 on social assistance required every local government to establish public social assistance services (SPAS), but the implementation of this law has been delayed, especially in smaller rural municipalities. Although some progress has been made in recent years, the World Bank's census of SPAS carried out for this Strategy in May 2014 showed that over one-third (34 percent) of local governments in rural areas and 8 percent in very small cities had not set up the relevant services but has instead added to the responsibilities of existing staff.<sup>82</sup>

The development of primary social services has been hindered by a lack of financial resources at the local level, by the hiring freeze and wages limits in the public sector (as part of the austerity policies implemented in the 2008 to 2010 period), by a failure to use flexible forms of employment (part-time staff), and by a lack of effective training of staff.

Public social assistance services are severely understaffed in rural and small urban areas. In most rural communities there are just one or two staff members with social assistance duties (and very few professional social workers) to meet the needs of a population, usually spread over between 2 and 40 villages, often located many kilometers apart.

### *Mainstreaming of Roma Inclusion*

The NRIS has specified modalities to implement actions for Roma inclusion at the central, county and local levels. At the central level, each Ministry should have a Ministerial Commission for Roma, and their responsibilities include implementing the action plan, collecting data, and preparing the monitoring reports and evaluation reports about their own institutional activity.

Each county must have a plan of measures for Roma social inclusion. The County Office for Roma (*Biroul Județean pentru Romi, BJR*) must draft the plan, taking into consideration information at the local level, to harmonise the main needs of Roma communities with the measures provided by the NRIS. The BJR members “pay regular visits for assessing and monitoring the situation of the communities of

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<sup>81</sup>Social workers' professional role is defined by Law 466/2004

<sup>82</sup>National Strategy on Social Inclusion and Poverty Reduction 2014-2020

Romanian citizens belonging to the Roma minority, they obtain data and information from the local level, which they centralize at county level.

Each municipality must have one local action plan that should be drafted by the local working group (*Grupul de lucru local, GLL*). Members of the local working group GLL are responsible for implementing the measures corresponding to their specific area of activity, as included in the local action plan. In addition, they are responsible for monitoring the implementation of the measures set out in the local action plan and for drafting progress reports every half year on the implementation of the local action plan that will be submitted to the mayor, the BJR, and the NAR.

## **5 DESCRIPTION OF THE PROGRAM'S ENVIRONMENTAL MANAGEMENT SYSTEM**

The national environmental protection system is based on EU standards and Directives that have been transposed into national legislation by Romania, following accession to the EU in 2007. The system in Romania sets out the general principles of environmental policy: polluter-pays principle, integrated monitoring, sustainable development and public participation, international cooperation, and rehabilitation of degraded areas. It also outlines the general means for achieving the enforcement of these principles, such as: harmonization of environmental policies and development programs, correlation between social and environmental development, compulsory use of the environmental permitting procedure for certain economic and social activities with significant environmental impacts and the use of economic incentives.

### **5.1 Legislative and Regulatory Framework for Environmental Management**

An analysis of the current legal framework for environmental and social management inform partial readiness for program implementation. This section briefly describes the main existing environmental and social regulations and standards relevant to the Program and refers to local and national levels institutions that are responsible for issuing permits and licenses and enforcing compliance of environmental and social standards.

A number of strategic regulations and sectorial policies in the environmental sector have been analyzed for the purpose of this assessment, including mitigation and adaptation to climate change.

Waste management is based on the general principles and rules stipulated in Law no. 211/2011 mentioned in the previous chapter.

A complete list of legal acts on environmental management, relevant for the purpose of this document, can be found in Annex 1.

### **5.2 Institutional Responsibilities for Implementing Program Environmental Management**

The MoH is responsible for the management of this Program's environment aspects, with support from a number of central and local institutions and authorities. The most relevant supporting roles belong to the Ministry of Environment (MoE), Ministry of Waters and Forests (MoWF), National Environmental

Protection Agency (NEPA) and its local EPAs, local authorities and directorates for public health and other bodies and organizations as presented below.

### 5.3 Strategies

Responsibilities and roles for performing environmental management in relation with the Program, are defined under the national environmental and health strategies and other related policies and regulations in relation to the two sectors. The current assessment analyzes the institutional, regulatory and human resources capacities of the Ministry of Health to deal with the existing responsibilities for an appropriate enforcement of the environmental provisions, as stipulated in the environmental legislation and in the health sector regulatory frame.

The *National Strategy on Climate Change and Low-Carbon Economic Growth* gives a systemic approach for further actions in the health sector. It is considered the development of the capacity for better monitoring of various factors with potential impact on public health. The weather events and the calamities without significant consequences, which only hinder certain human activities as a result of climate change, can lead to public health events. As an example, intense precipitation, mainly in rural zones can lead to diseases or could increase susceptibility to diseases. This is a basis for strengthening disease surveillance activities and early warning systems, regardless of the origin of the disease, can also contribute to the benefit of the community.

The current National Emergency Situation Management System is appropriate and in a continuous development. It was implemented an integrated alert system of the population in major risk situations. There is hardware, software applications and related installation and commissioning services required for the implementation of the "RO-ALERT" system will be carried out by General Inspectorate for Emergency Situations (IGSU) in an emergency regime, according to the provisions of the Art.104 paragraph 1 letter c of the Law no. 98 from 2016 on public procurement, with subsequent amendments and completions.

The Strategy for Occupational Safety and Health for the period 2018 – 2020 was promoted in the GD No. 191 from April 4, 2018, under which the objectives set out in its Annex are financed for the implementation of the specific objectives for health and safety.

There are two main environmental areas relevant for this assessment and within the scope of the proposed Program: *(i) medical waste management, and (ii) public health and primary health care services in the context of adaptation to the climate change effects.*

### 5.4 Medical Waste Management

MoH promoted the MO No. 1226, from 03 December 2012 regarding the approval of the technical norms for the medical hazardous waste management and methodology for separate collection by category, packing, temporary storage, transportation, treatment and disposal of medical waste. In this act, a special attention is given to hazardous medical wastes and the need to prevent environmental contamination and the potential damage on the public health. In para.1 of its Chapter1, is stipulated: " These technical norms are applied by all the sanitary units, regardless of the form of organization in which medical activities are carried out, as a result of which waste is produced, hereinafter called medical waste". In para (2) of the same chapter is stipulated "The medical waste producer is responsible for the management of the medical waste resulting from his activity". Any medical waste generator "develops and applies plans, management strategies and medical procedures to prevent the production of hazardous medical waste or to reduce as much as possible the quantities produced." In its para. (4) Is presented the requested pre-marked form for the wastes: "The units shall draw up and apply their own waste management plan resulting from medical



activities, in accordance with the internal regulations and the procedure codes, based on the regulations in force and respecting the presented framework content in annex 4 of the MO".

According with the definitions contained in this MO, a *medical activity* is any activity of diagnosis, prevention, treatment, research as well as health monitoring and recovery, whether or not involving the use of instruments, equipment, substances or medical devices. The wastes generated from medical activities are hazardous waste as well as non-hazardous waste and are classified according to GD No. 856/2002 on waste management and waste management approval of the list of wastes, including hazardous waste, with further additions. The equipment for the thermal decontamination treatment of waste resulting from medical activity is any fixed equipment intended for thermal treatment at low temperatures (105 ° C to 177 ° C) of hazardous medical waste where it is the general action of removal by reduction of microorganisms (pathogenic or saprophytes) contained in the waste.

The waste management means the collection, temporary storage, transport, treatment, recovery and disposal of waste, including surveillance of these operations and the subsequent maintenance of the sites used. Producers of medical waste, as defined in the regulation have the following main responsibilities:

- a) Prevention or mitigating the production/generation of medical waste;
- b) Separate collection of different types of waste from the place of production/generation;
- c) Appropriate treatment and disposal of all types of medical waste products (contracts with authorized sanitary operators).

The management of the medical waste is integrated in the entire cycle of the waste management system at the local and national level. This holistic vision needs to be considered in a bottom up approach, which means integrating the local medical facilities and services provided for population, including the vulnerable and marginalized groups in the counties systems for waste management. It is necessary to clearly stipulate the responsibilities in terms of medical and municipal wastes in the frame contracts the private physicians sign for performing their medical services. These mentions need to refer to segregated collection and temporary disposal of the waste; to be mandatory signed contracts with specialized sanitary operators for each category of waste and a periodicity of waste collection not longer than one month for those collected in special containers and one week for other categories of wastes, including the municipal solid waste. Currently, during the site visits discussions was mentioned by the local physicians in rural areas a rather relative periodicity at sometimes six or even more months for the sanitary operators to collect the containers with medical wastes. Even it is mandatory to collect medical wastes in special labeled containers, as stipulated in technical norms, it is necessary to have in place contacts with licensed sanitary operators to ensure an appropriate frequency of the collection of the wastes from the locations where primary and community health care are providing their medical services. The PHC units performing medical activities generate in average less than 300 kg of hazardous waste per year, which represent a reduced negative potential impact to environment, and this is fully manageable under the existing normative framework.

## **5.5 Adaptation to CC and Extreme Weather Events**

One of the common objectives in terms of health and environment, under the National Strategy on Climate Change and Low-Carbon Economic Growth is to protect the health of citizens against the impacts of extreme weather events on human life. In line with this there are proposed preventive actions by strengthening the national emergency management system. The extreme weather events, such as floods, storms, heat waves and drought can lead to severe consequences for people's lives and the most vulnerable groups are the most sensitive. In addition, threats arising from extreme events can be

aggravated by healthcare systems, which may have weaknesses not only in terms of early warning and alertness but also in its ability to respond. The consequences of disasters require a rapid and well-coordinated response to protect the health of citizens. As presented above, Romania has in place a system to alert population and this can be activated in case of emergency situations, including extreme weather events. It will be a need for developing further this system in rural areas and among marginalized communities.

The extreme weather events were in a significant increase in the last years. For example, in September 2017, in Bucharest was a storm alert. Even the warning did not manifest at the originally projected scale, it was possible to note that the urban population is promptly and to a larger extent in compliance with the procedures, in comparison with the people living in rural or isolated areas, where they are not so reactive and not promptly informed. As a first assessment, communication between institutions responsible for responding at local level, in rural zones was more deficient than communicating from authorities to citizens through media channels, the internet or direct channels in urban areas. Thus, the practice of the day proved that citizens can be very quickly informed and ready to take the necessary measures for their protection, families and goods.

In line with this, one indicator common for environment and health might be the number of people who die or are severely affected by extreme weather events in one year. The decrease of this indicator from one year against the prior year could be considered as a barometer of how the education among citizens with regard to the preventive actions was successful.

The Program, a subset of the National Health Strategy, has areas where baseline data is available and monitoring tools are in place (e.g. number of FPs signing registering offices in underserved areas), but also actions that involve, at an initial phase, the collection of data to inform decision-making, and establish a baseline for monitoring purposes (health needs at the level of community care, given that the population served is larger than the calculated thresholds of 500 patients per community nurse).

The *environmental policy for the adaptation to climate change covers the reactive and preventive measures and actions*. In the last years, the preventive measures and preparedness for such type of events become a priority. There are two examples selected as representative and relevant for the Program: (i) *The National Emergency Special Committees*. (ii) *The RO-ALERT System*.

The *National Emergency Special Committees* were established in the MO No. 1422 / 192/2012 for the approval of the Regulation regarding the management of flood emergency situations, dangerous meteorological phenomena, hydro technical accident and accidental pollution on the watercourses and marine pollution in the coastal zone. The Annex to this MO contains the "Regulations on the management of flood emergency situations, meteorological phenomena hazardous, hydro technical accident, accidental pollution on watercourses and pollution marine in the coastal area".

The "*RO-ALERT*" System was tested in September 2018 and the population perception is good with regard to the need for rapid reaction in case of emergency situations. This system is managed by the General Inspectorate for Emergency Situations (IGSU) according to the provisions of the Art.104 paragraph 1 letter c of the Law no. 98 from 2016 on public procurement, with subsequent amendments and completions.

The "*RO-ALERT*" system has a number of advantages, including:

- Transmitting warning messages adapted to the imminent event through the networks of the mobile operators;
- Rapid transmission of messages to all users in the area threatened even under congested

- conditions by mobile operator networks;
- Instantly displaying messages on the mobile terminal screen without the need for user intervention;
- Cyclical repetition of alert messages at configurable intervals;
- Receiving alerts and roaming terminals;
- The accuracy of warning messages based solely on information provided by authorized sources.

## **5.6 PHC to the Climate Change Effects**

The climate change effects do not cause many new or unknown risks for public health, but they will enhance some interactions between the environment and human health, with effects more drastic in each year, which will need more adaptation measures to new situations and new needs.

These include heat stress related to heatwaves; injuries related to extreme weather events such as storms, fires and floods; infectious disease outbreaks due to changing patterns of mosquito borne and water borne diseases; poor nutrition from reduced food availability and affordability; the psychosocial impact of drought; and the displacement of communities. Primary health care has an important role in preparing for and responding to these climate change related threats to human health.

Infectious diseases form a group of health problems highly susceptible to the influences of climate. Adaptation to protect human population health from the changes in infectious disease epidemiology expected to occur as a consequence of climate change involve actions in the health systems as well as in other non-health sectors.

Measures in other sectors such as meteorology, civil defense and environmental sanitation will also contribute to a reduction in the risk of infection under climate change. Changes in baseline climatic conditions, such as average daily temperatures or seasonal precipitation, can affect the developmental biology of different infectious diseases.

Other extreme events such as droughts, which may have severe and lasting effects in poverty-stricken areas, often facilitate an increase in the incidence of infections due to poor hygiene standards resulting from water scarcity.

Although Romania has well established public policies to promote human health still is not sufficiently prepared to deal with the range of problems associated to the consequences of climate change.

The country still needs to improve the capacities to formulate and implement adaptive strategies for health protection. This would imply the reduction in many determinants of vulnerability to the impacts of climate, especially in poor/low income counties. The reduction in poverty and the improvement in the quality of education, the effective control of health vulnerability potentially caused by climate change and improved access to health care and sanitation services are essential. The adaptation measures will depend on local or regional characteristics such as the availability of resources, the profiles of vulnerability, the patterns of exposure to the hazards, on the capacity of decision makers to use the information available and the public perception of the problem.

Development of early warning systems for epidemics, especially after extreme hydro-meteorological events, such as storms and floods. Outbreaks of water-associated, water-borne and mosquito born infections are commonly reported after these events.

The EU 7th General Program for Environment by 2020, Environmental Action Plan (EAP) in its third thematic priority refers to the human health and well-being, considering the reduction of climate change

effects, of air and water pollution, of noise and toxic substances.

The MoH promoted the MO No.119 from February 2014 regarding the approval of the hygienic and public health norms for environment and population health, published in the Official Journal No.127 from 21 February 2014. This MO sets standards of hygiene and public health on the living environment of the population, for the underground water sources used for drinking water supply to localities and economic operators, the definitions for "severe sanitary protection area", "sanitary protection zone with restriction regime" and "hydro geological protection perimeter" are applied, according to Government Decisions 930/2005 on the approval of the Special Norms on the character and size of the sanitary and hydro geological protection areas and the MO No. 1278/2011 for the approval of the Instructions on the delimitation of the sanitary protection areas and the hydro geological protection perimeter. This MO sets also hygiene rules on living areas: Housing for dwellings should be made in safe areas on sanitary land to ensure: (i) Protection of the population against the occurrence of natural phenomena such as landslides, floods, avalanches; (ii) Reducing the release or infiltration of toxic, flammable or explosive substances resulting from environmental pollution; (iii) Drinking water supply system in accordance with the legal norms in force; (iv) Sewage system for collecting, removing and neutralizing domestic waste waters, meteoric waters; (v) Selective waste collection system; (vi) The population's health versus anthropogenic pollution with chemical compounds, radiation and/or biological contaminants.

To ensure communities and healthcare facilities are prepared for impacts of climate change, including natural disasters and flooding, nurses can work with local and state health departments and healthcare facilities to ensure that disaster preparedness plans and training are in place in the event of disruption in community infrastructure or health services. Nurses can further facilitate the development of climate adaptation plans and action plans for extreme temperature events to ensure that people have access to necessary care.

In order to convey the message of how climate change affects health and the urgency to act now to prevent worsening impacts, nurses should understand how to effectively communicate with patients, colleagues, policy makers, and the public.

## 6 PROGRAM CAPACITY AND PERFORMANCE ASSESSMENT

### 6.1 Social System Capacity and Performance Assessment

This section describes the findings of a SWOT (Strengths-Weaknesses-Opportunities-Threats) analysis of relevant aspects of the Program's social management system.

#### 6.1.1 Strengths and Opportunities

**Romania's legal and regulatory frameworks for healthcare are robust and bolster several aspects that are relevant to this Program.** These include stipulations for: responsibilities and institutional set-up for PHC practices (the Law on Health Reform); patient's choice and access to information regarding their health, available treatments and the range of available services (Law on Patient's Rights); and organization of community healthcare and integration with other health and social providers (Community Healthcare Emergency Ordinance).

**The overlaps in GoR's strategic approach to integrated primary healthcare and its plans for**

**mainstreaming social inclusion could serve as opportunities for collaboration with other government entities and NGOs.** For instance, one of the priorities of the *National Strategy on Social Inclusion and Poverty Reduction for 2015-2020* is to increase the coverage of basic healthcare service providers countrywide at the local level, and instituting screening programs for key pathologies. In the same vein, the *Strategy of the Government of Romania for the Inclusion of Romanian Citizens belonging to Roma Minority for 2015-2020* emphasizes increasing the share of the Roma people in the health insurance system.

**Efforts are underway to operationalize the current National Health Strategy.** The current National Health Strategy is the first to have an allocated budget. During 2016, eight regional plans were developed to reorganize the health system in accordance with the national strategic objectives, as well as the development of specific plans for the priorities of prevention, cancer, diabetes, cardiovascular disease and rare diseases<sup>83</sup>.

**The GoR is making concerted efforts to enhance health workforce capacity.** The GoR has taken steps in recent years to incentivize the delivery of more primary care services in rural settings, such as the revision of the benefits basket and the proportion of spending on primary care and ambulatory services (2014–15). Early efforts have included increasing the fee-for-service share of primary care providers' salary from 30% to 50% (2011) and reimbursing telemedicine in remote areas (2013). Moreover, a new National Centre for Human Resources has been established that will have a remit to assess human resource needs, coordinate training and guide career development. The MoH has also announced assistance for Romanian doctors who are currently practicing abroad and who wish to return to Romania if certain conditions change, including remuneration levels<sup>84</sup>.

**Romania's Roma Health Mediator (RHM) program has already demonstrated substantive successes and high potential for scale-up.** The RHM program is characterized by strong leadership from Romani Criss - a Roma NGO, with ongoing cooperation with the GoR that has enabled the institutionalization of the RHM program. Except for the past few years, the program has grown steadily with increasing numbers of trained and employed RHMs<sup>85</sup>.

**The precedent for administering periodic surveys in the health sector bodes well for the development of a standardized monitoring approach for integrated primary care.** For example, findings of the 2016 study on Quality and Costs of Primary Care in Europe study for Romania confirmed GPs' willingness to widen the scope of their activities and their readiness to improve the way in which they are contributing to the goals of the Romanian health care system<sup>86</sup>. In addition, surveys applied at the level of the population are a mandatory feature at the level of each DHIH. Each year, DHIHs apply a survey<sup>87</sup> to a sample of the population to assess the level of satisfaction with medical service providers and assess the level of knowledge of beneficiaries, in relation to their rights and services made available to them.

**There are existing legislative and institutional entry points to improve transparency and the accessibility of beneficiary feedback systems in the primary healthcare sector.** In this regard, the law

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<sup>83</sup>State of Health in the EU Romania Country Health Profile 2017 on Health Systems and Policies European a Partnership

<sup>84</sup> State of Health in the EU Romania Country Health Profile 2017 on Health Systems and Policies European a Partnership

<sup>85</sup>'Roma health mediation in Romania'. Case study. Copenhagen, WHO Regional Office for Europe, 2013. Roma Health Case Study Series, No. 1.

<sup>86</sup>Butu et. al. 2014. 'Are Romanian Family Doctors Ready for Health 2020?' *Management in Health* XVIII/2/2014; pp. 17-20.

<sup>87</sup>Several annual reports from different DHIHs were analyzed. Results are presented in terms of satisfaction with medical providers and the information on the services that are provided under the Framework Contract.

on Patient's Rights stipulates their right to information about the range of available services and certain information about the providers. There are also provisions for patients to report their feedback on health service provision to the MoH, DPHAs and DHIHs<sup>88</sup>.

### 6.1.2 Threats and Weaknesses

**Limited efforts to make information available to vulnerable and underserved groups in accessible formats (e.g. in the form of brochures or posters).** In the absence of such efforts, there may be challenges for persons who are unfamiliar with technical or legal terms to understand their rights and entitlements with regard to accessing PHC services, persons who may not have access to the internet in remote areas, or for blind persons who may wish to seek information on primary healthcare in braille. Moreover, the level of awareness of procedural aspects and value chains of various GRMs in the health sector appears to be limited, particularly among more remote communities and vulnerable groups.

**Non-monetary deterrents for underserved groups to register with family care physicians.** These include perceptions of discriminatory conduct (such as longer wait times) and limited appreciation by medical service providers of some of the cultural concepts, beliefs and attitudes that influence incentives to seek primary healthcare services.

**Lack of access to ID cards for some members of underserved and vulnerable communities.** In the absence of ID cards, even hitherto uninsured persons who have an interest in seeking PHC services would be unable to register with their family physicians and to gain access to PHC. 35. In specific rural and remote areas where there is already a shortage of family physicians, their increased workload may serve as a deterrent for accommodating field visits, which could have a debilitating impact on elderly/disabled patients with limited mobility and the ability to access the PHC facility.

## 6.2 Environmental System Capacity and Performance Assessment

### 6.2.1 Organization and Staffing

The Program structure and organization depend on the extension of its proposed activities/interventions. There are two areas of activities for which environmental approvals and permits are necessary to be requested. In the case of the promotion of a national program, this needs to be notified to the competent environmental authority (MoE) and if necessary a Strategic Environmental Assessment (SEA) procedure will be decided. In the situation of concrete interventions/rehabilitation works to medical facilities located in different zones, individual notifications will be submitted by each beneficiary of the works to the competent environmental authority (local EPA) and a procedure to be followed will be decided.

Program implementation from environmental point of view will be developed according with the relevant regulations and norms. The concrete works will be analyzed on a case by case by the competent local EPAs.

*Staffing and capacities at the level of the implementing agencies.* At the level of MoH there is still insufficient approach in managing the environmental activities in relation with the public health, and therefore proper functions and staffing of MoH dedicated to this area is representing a challenge.

During the discussions with the representatives of MoH, the environmental assessment identified the need for more staff to deal with the environmental aspects in connection with the public health programs. Presently, there is only one expert with responsibilities related to environmental aspects. In addition,

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<sup>88</sup>'Romania Health System Review 2016'. Health Systems in Transition. The European Observatory on Health Systems and Policies. Vol. 18 No. 4 2016

specific training on environment and public health related activities could be more systematically planned within the ministry's annual training programs.

*Inter-agency collaboration.* The inter-agency cooperation for environment and health is established at the central level in the strategies and national plans and is enforced at the local level in the cooperation between subordinates of the central authorities. The roles and responsibilities are set in the following main strategic documents: The National Strategy for Health 2014-2020<sup>89</sup>, National Strategy on Climate Change and Growth based on low carbon emissions<sup>90</sup>. National Waste Management Plan<sup>91</sup>.

*Grievance mechanism.* The legal and institutional framework in Romania concerning the submission of petitions/ grievances is clearly established at the level of each public authority, with the obligation to respond and follow up 30 days after recording the grievance. Records are kept with all grievances and reports are usually made public at the level of each institution.

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<sup>89</sup><http://www.ms.ro/strategia-nationala-de-sanatate-2014-2020/>

<sup>90</sup>[http://www.mmediu.ro/app/webroot/uploads/files/2015-12-04\\_Strategia\\_CRESC.pdf](http://www.mmediu.ro/app/webroot/uploads/files/2015-12-04_Strategia_CRESC.pdf)

<sup>91</sup><http://mmediu.ro/categorie/planul-national-de-gestionare-a-deseurilor-pngd/239>

## 7 ASSESSMENT OF PROGRAM SYSTEM IN MANAGING SOCIAL AND ENVIRONMENTAL IMPACTS

### 7.1 Assessment of Program System to Manage Social Impacts

Based on the desk review and detailed analysis of the social effects of the Program and preliminary discussions with stakeholders, the analysis presented here is focused on the six Core Principles for ESSAs (see box 1) and synthesizes the main findings using the SWOT (Strengths-Weaknesses-Opportunities-Threats) approach, which has been adapted to the context for this Program as follows:

- Strengths of the system and whether it is consistent with the core ESSA principles;
- Inconsistencies and gaps (“weaknesses”) between the principles and the system for managing social impacts;
- Actions (“opportunities”) to strengthen the existing system; and
- Risks (“threats”) to the proposed actions designed to strengthen the system.

**Core Principle 1: General Principle of Environmental and Social Management** Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in Program design; (b) avoid, minimize or mitigate against adverse impacts; and (c) promote informed decision-making relating to a program’s environmental and social effects

#### **Applicability**

Core Principle 1 is highly relevant to this Program given the importance of accessible primary healthcare, and its implications for the mortality, quality of life and human capital endowments for all population groups in Romania.

#### **Summary Findings**

The Program’s social management system has potential for ensuring that its interventions are based on informed decision making, i.e. there are avenues in place such as inter-ministerial committees, patient’s associations and legal and institutional set-up for complaint mechanisms at the national and local levels and active NGO engagement on health and other social inclusion issues to facilitate feedback from Program beneficiaries and other stakeholders that could inform decisions regarding the Program’s design. There is also a comprehensive legal and strategic framework in place that serves as the basis for accessible primary health services and social inclusion of vulnerable groups. However, since its social management system also has weaknesses vis-à-vis its planned interventions this could increase the risk of information asymmetry regarding access to PHC. These weaknesses include limited efforts to make information available to vulnerable and underserved groups in accessible formats on issues such as patient’s rights and entitlements, access to the PHC basic services package for hitherto uninsured groups, and the types of grievance redress and feedback mechanisms through which they can relay their concerns etc. Therefore, additional measures would need to



be undertaken to adopt communication tools that are sensitized to the information needs of underserved and vulnerable groups.

<p><b>Strengths:</b></p> <ul style="list-style-type: none"> <li>• There is a strong legal framework for improving equitable access to PHC services</li> <li>• There are institutional mechanisms to facilitate feedback from stakeholders regarding the Program’s design, including national and local level complaint procedures, inter-ministerial committees, active NGO engagement in the health sector etc</li> <li>• There are strong linkages between primary healthcare reform and the GoR’s vision for enhanced social inclusion</li> </ul>	<p><b>Weaknesses:</b></p> <ul style="list-style-type: none"> <li>• There are limited efforts to make information available to vulnerable and underserved groups in accessible formats, e.g. in the form of brochures or posters for persons who may not have access to the internet in remote areas, or in braille for blind persons who may wish to seek information on primary healthcare</li> <li>• The level of awareness of procedural aspects and value chains of various GRMs in the health sector appears to be limited, particularly among more remote communities and vulnerable groups</li> </ul>
<p><b>Actions and Opportunities:</b></p> <ul style="list-style-type: none"> <li>• Developing and implementing a public outreach and communications strategy that is sensitized to the needs of target audiences</li> <li>• TA for development of a Patient’s Rights Charter in various accessible formats (e.g. pictures, braille)</li> </ul>	<p><b>Risks:</b></p> <p>Members of vulnerable and underserved groups including Roma who are illiterate or based in remote rural areas may not be aware of the Program’s benefits and will therefore not register with their family physicians</p>

**Core Principle 5: Indigenous Peoples and Vulnerable Groups**

Undertakes free, prior, and informed consultations if Indigenous Peoples are potentially affected (positively or negatively) to determine whether there is broad community support for the program. This ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of their indigenous Peoples (ii) Gives attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.

**Applicability**

This principle is highly relevant to the Program’s objectives and planned interventions, particularly against the backdrop of challenges in access to healthcare for vulnerable and marginalized groups. For instance, survey evidence attests that in 2016, only 66% of rural population was insured compared to 86% in urban areas, and

that only 54% of Roma are covered by the national basic health insurance scheme or other insurance.	
<b>Summary Findings</b>	
From a strategic standpoint, the Program’s results are geared towards addressing existing inequities in access to PHC services. However, there are “supply side” challenges from the standpoint of PHC providers that are both operational and cultural. There are also “demand side” challenges to inform and incentivize beneficiaries to ensure that vulnerable groups can avail of the Program’s benefits, as well as the very tangible obstacle of not being in possession of a birth certificate or an ID card that restricts the access of about 160,000 Roma citizens to all services, including PHC.	
<b>Strengths:</b>	<b>Weaknesses:</b>
Romania’s Roma Health Mediator program has already demonstrated potential for scale-up	Members of underserved and vulnerable groups do not have access to ID cards that would enable them to register with family care physicians
<b>Actions and Opportunities:</b>	<b>Risks</b>
TA to incorporate nondiscrimination training and introduction to ethnic minority cultures into current educational modules for family physicians and nurses	<ul style="list-style-type: none"> <li>• Members of vulnerable groups, including Roma may be aware of the Program’s benefits but may not register with their family physicians since they do not have ID cards and/or birth certificates</li> <li>• Members of underserved and vulnerable groups, including Roma have a disincentive to seek PHC services due to prevalent perceptions of disrespect, cultural insensitivity etc. on the part of service providers</li> <li>• In specific rural and remote areas where there is already a shortage of family physicians, their increased workload may serve as a deterrent for accommodating field visits, which could have a debilitating impact on elderly/disabled patients with limited mobility and the ability to access the PHC facility</li> </ul>

## 7.2 Assessment of Program System to Manage Environmental Impacts

**Core Principle 1:** General Principle of Environmental and Social Management. This core principle aims to promote environmental and social sustainability in Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program’s environmental and social impacts.

The environmental sustainability in program design refers to avoid and mitigate adverse impact based on promoting preventive measures and addressing to vulnerability and adaptation of the health system to environmental sensitive aspects. This is considering the improvement of the medical waste management and the adaptability of the health system to climate change effects and to extreme weather events and

other natural emergency situations. The environment sustainability needs to be continuously taken into consideration in the decision-making processes of any further project or intervention proposed under this program. For any project, mitigation and reduction of the environmental sensitive aspects is a basic condition. Sustainability with regard to the medical waste management is ensured by an improved segregated collection of the different types of wastes, reducing the period for collection of the medical wastes from the facilities and ensuring more secure transport conditions. The legal frame for environment management in Romania aims to promote environmental and social sustainability under comprehensive legislation, regulations, guidelines and institutional arrangements. The decision making process in health sector needs to constantly consider the environmental sustainability. Over the last decades, the EIA and SEA procedures evolved into a comprehensive system, fully transposing the EU regulations and being in a continuous development from the implementing and enforcing point of view. The Program designs promote environmental sustainability and is avoiding, minimizing and mitigating adverse impacts. This core principle is respected and the Program promotes informed decision-making relating to the Program's environmental impacts.

**Core Principle 2:** Natural Habitats and Physical Cultural Resources. This core principle aims to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program.

The Program design takes into consideration and complies with legal environmental requirements to avoid, minimize, and mitigate adverse impacts on natural habitats and physical cultural resources. The further implementation of the Program will consider each location where the interventions will take place, and the necessary environmental permits will be requested accordingly.

**Core Principle 3:** Public and Worker Safety. This core principles aims to protect public and worker safety against the potential risks associated with: (i) construction and/or operation of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

This core principle applies to the construction phase, which needs to be considered from the beginning of the design of the Program. The Public and Worker Safety are domestically regulated and mandatory to be respected during the entire construction phase. For each intervention/construction works there are requested legal permits, in which the locations and type of works are determining the environment, public and worker safety procedures to be followed. A set of specific measures is issued together with the construction approval.

The Program interventions as related to the public and worker safety are small and does not entail a significant amount of labor as the Program aims only at refurbishing the existing PHC buildings only. The majority of labor will be locally hired.

## 8 INPUTS FOR THE PROGRAM ACTION PLAN

This chapter provides an overview of overall recommendations to mitigate the Program's environmental and social risks and to improve implementation effectiveness.

### 8.1 Recommendations to Mitigate Social Risks

#### a) Necessary Measures

- **Widespread public outreach and communication on the expanded coverage of the basic healthcare package and scope of services.** These outreach efforts would need to be tailored to

the information needs and channels of the marginalized groups that are being targeted. It will rely heavily on the achievements of community nurses and Roma health mediators in getting the word out but should also explore a range of other channels and methods of communication.

- **Increasing awareness of grievance redress and feedback mechanisms for the primary healthcare sector.** This could be part of the public outreach efforts to increase public awareness of grievance redress mechanisms.
- **Measure the number of persons that social workers have connected to services to acquire IDs,** that would make it possible for them to register with family physicians,<sup>92</sup>

#### *b) Useful Measures*

- **Instituting access to information in the primary healthcare sector in accessible formats by developing and displaying Patient's Rights Charters in PHC facilities and local healthcare authorities.** This would help to increase awareness of the insurance coverage and scope of services included in the basic healthcare package on an ongoing basis beyond the initial thrust of public outreach efforts. It would also be useful to adopt and institutionalize a more proactive approach towards disseminating information about patient's rights, the duties and responsibilities of family physicians, nurses and Roma health mediators, and standards and procedures for a complaint mechanism for the primary healthcare sector if it is instituted.
- **Instituting community needs assessments and monitoring of PHC service delivery.** Instituting periodic community needs assessments would help to identify gaps in PHC service delivery on an ongoing rather than an adhoc basis. It would facilitate resource allocation and planning for this activity, in part by establishing linkages with plans developed by local administrations and DPHAs. This approach will also be necessary to make provisions for the capacity building of local health authorities or other stakeholders in this regard. In the same vein, instituting periodic monitoring of the uptake of PHC services and the perceptions of beneficiaries would be useful to identify changes in the number of beneficiaries registered with their primary healthcare providers, as well as any other challenges with regard to their accessibility to PHC services.

## **8.2 Recommendations to Mitigate Environmental Risks**

#### *a) Necessary Measures*

- **Develop inter-agencies cooperation at the central and local level** to address the adaptation to climate change and the adjacent extreme weather events.
- **Develop reactive and preventive procedures and guidelines for PHC system** with regard to common and shared responsibilities for environment and public health, in relation with the two identified priorities: adaptation to climate change effects and medical waste management.
- **Continue and develop awareness and training programs on medical waste management** for medical and paramedical staff. Assessing the needs for additional training and develop on a continuous basis the Human Resource dealing with the responsibilities for environmental aspects, mainly for medical waste management and for preventing the risk on human health of the extreme weather events. **Revise and improve procedures for the sanitary services to report environmental indicators,** such as: quantity of medical waste collected from their activity, type

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<sup>92</sup> Civil society monitoring report on implementation of the national Roma integration strategy, Roma Civil Monitor, 2018

of wastes, periodicity of collecting, data concerning the status of sanitary operator (approved for the type of collected wastes).

*b) Useful Measures*

- **Increase in the number of employees dealing with environment at central and local level of the MoH structure** and allocate clear responsibilities according with the activities necessary to be carried out in terms of monitoring and reporting.
- **Increase the allocated budget for preventive measures**, such as: general education and special targeted to vulnerable groups (children in schools and old people, or people in isolated rural zones) health campaigns, with environmental component, programs for dissemination of information with regard to preventive actions for an increase in the quality of life and environment etc.

### 8.3 Inputs for Program Action Plan

Social Actions			
Action	Due Date	Responsible Agency	Completion Measurement
1. Develop and implement communication tools to increase public awareness of Program initiatives in consultation with the World Bank	Year two and year three of implementation	MoH, NIPH, CSO, other	<ul style="list-style-type: none"> <li>- Availability of Patient’s Rights Law and other legislation in accessible formats(e.g., services provided, amount of payment, right and responsibility)</li> <li>- Findings on the level of public awareness regarding access to basic services package for uninsured and their familiarity with existing feedback and grievance redress mechanisms from information compiled through data collection tool on beneficiary awareness and feedback</li> </ul>
2. Maintain records of and track the number of potential patients who social workers have helped to acquire IDs for their registration with family physicians	First year of Program implementation	NHIH, MoH, MoSPJ	Reporting by social workers on the number of potential patients who they have helped acquire an ID for their registration with family physicians
3. Monitoring of beneficiary awareness and feedback based on adjusted methodology	Adjustment of existing data collection methodology and data collection tool on community healthcare	MoH, National Institute for Public Health, National Authority for Quality Management in Health Care	<ul style="list-style-type: none"> <li>- Development of modified methodology and data collection tool [based on triangulation of direct observations and quantitative survey data] to measure awareness regarding: basic services package, the existence of complaint mechanisms and perceptions regarding PHC service delivery</li> </ul>

	provision in Year 1;  Rollout of modified data collection tool in year 2		<ul style="list-style-type: none"> <li>- Analysis of data collection results in report format</li> <li>- Convening of public hearings/meetings on findings of baseline and end line data collection efforts</li> </ul>
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#### Environmental Actions

Action	Due Date	Responsible Agency	Completion Measurement
1.Strengthening the enforcement of the existing regulations for medical waste management to handle, collect, record, store, decontaminate, transport and disposal of medical waste by developing / updating / revising internal procedures and guidelines at PHC level.	First 6 months – 1 year of implementation	MoH	<p>MoH internal revised regulations / norms for implementing the procedures for reactive and preventive identified priorities for medical waste management. Procedures and guidelines would cover: handling, collection, recording, storing, decontamination, transport and disposal of medical wastes at the PHC level.</p> <p>Specific sets of such procedures and guidelines will be produced for PHC facilities in rural/remote areas.</p>
2. Strengthening the capacity to adapt, prevent and react to climate change and extreme weather events by developing / updating / revising internal procedures and guidelines at PHC level.	First year of implementation	MoH	<p>MoH internal revised regulations / norms for implementing the procedures for reactive and preventive identified priorities for adaptation to climate change effects.</p>

## 9 ENVIRONMENTAL AND SOCIAL RISK RATINGS

### 9.1 Social Risk Rating

This Program's overall social risk is considered to be **substantial** due to potential bottlenecks that could hinder the access of underserved populations to PHC. One risk in this regard could be that of information asymmetry, i.e. that vulnerable and underserved groups will not seek PHC services if they are unaware that hitherto uninsured groups have access to the basic PHC package, or if there is confusion or misperception due to ineffective communication or lack of understanding. Another challenge in this regard could be limited awareness of complaint and feedback mechanisms for the primary healthcare sector in Romania, and therefore no utilization of these mechanisms by beneficiaries to relay their concerns or suggestions regarding the implementation and results of the proposed Program. The second risk is that the Program's social sustainability may be hindered by challenges related to incentivizing demand for PHC, which would depend on whether expanded health insurance coverage would be sufficient to reduce the non-monetary disincentives for vulnerable groups such as Roma to utilize PHC services (e.g. lack of access to IDs that would enable them to register with family care physicians).

### 9.2 Environmental Risk Rating

The environmental risk is rated **moderate** due to the two main environmental dimensions identified in the ESSA, as: medical waste management and adaptation of the health system to climate changes effects, considering also the extreme weather events.

There might be potential negative impacts associated with the Program due to an increase in medical waste generation and point source pollution as a result of increased number of PHC facilities delivering primary care services. The increased number of PHC facilities in rural and remote areas might generate associated negative impacts if these PHC services will not have proper and regular access to the existing medical waste management systems.

In addition, Romania is exposed to climate change effects and an increased incident of extreme natural events (heat waves, droughts, floods, storms etc.) for the vulnerable groups mainly, but also to the affected communities, and the levels of awareness, basic education and protective measures provided by the PHC services are still insufficient and inefficient. Threats arising from extreme events can be aggravated by the healthcare system, which may have weaknesses not only in terms of early warning and alertness, but also in its ability to respond.

However, the Program will increase Romania population's access to health services, which is critical in case of climate change-induced natural disasters or epidemics of diseases exacerbated by climate change. This will contribute to supporting resilience to climate change events to the overall population, which will have greater access to adequate information and care, including climate-related conditions.

#### *Medical Waste Management*

The increased number of PHC facilities within the present Program, in rural and remote areas might not generate significant associated negative impacts if these PHC services will have proper and regular access to the existing medical waste management infrastructure system. The country has in force a regulatory frame as described in the technical norm regarding the management of the medical waste resulted from



medical services, issued by the MoH on 12/3/2012, published in the Official Journal on 01/17/2013. This norm refers to the management of waste resulting from medical activities for all medical services and regulate the way in which separate collection by category, packaging, temporary storage, transport, treatment and disposal of medical waste is carried out, paying particular attention to hazardous waste to prevent environmental contamination and damage to health. The medical waste producer is responsible for the management of the medical waste resulting from his activity. The PHC units performing medical activities generate in average less than 300 kg of hazardous waste per year, which represent a reduced negative potential impact to environment, and this is fully manageable under the existing normative framework.

It is a moderate risk also because in the country is in place an integrated waste management system and it is mandatory for all the providers of medical services to have contracts with licensed sanitary operators for each category of wastes. The average quantity of medical waste, per day/month will not be significantly increased within the context of this Program, and there are not expected major changes in the existing contracts for medical waste management. However, for the new created PHC facilities under this Program in rural/remote areas it should be confirmed the existence of medical waste collection contracts with specialized sanitary operators.

Risks associated with the medical waste:

One of the priorities in terms of environmental sensitivity in the health sector, including the primary and community care is related to the concrete and constant implementation of the regulations for the management of medical waste. The risk in the case of this Program is mainly related to insufficient implementation of the related regulatory frame in place, with focus on the above-mentioned technical norms issued by the MoH. In addition, potential risks could be generated by:

- Actual limited level of knowledge on prevention and/or mitigation in relation to the generation of medical waste at the level of the primary and community health care;
- The current implementation of the regulations in the field of medical wastes management at the PHC level in the rural areas is not fully effective; and
- The potential risks related to inappropriate disposal of hazardous and non-hazardous waste in non-authorized places, especially in rural, remote areas.

### ***Adaptation of the health system to climate changes effects***

According with the information provided by the National Meteorological Administration, the average annual air temperature recorded in Romania in 2018 was 11.57 ° C, the third highest since 1901. The average air temperature recorded in 2018 exceeded by 1.35 ° C the climatologic actual norms (the multiannual average from 1981 to 2010). The climate change means not only increase in the temperature, but also increase in the incidence of the extreme events, such as heat wave in the summer and frozen rains in the winter or many others natural phenomena. These increase in extreme natural events request a clear determination to adapt systems, in this case the human health in general, and the vulnerable groups in special. At the same time, it is a need to a balanced between the needs of communities and the need to live on a healthy environment. This means implementing concrete measures and equal efforts in both directions: both reducing greenhouse gas emissions and adapting to the effects of climate change.

There are necessary to establish health surveillance indicators in relation with the environment in general, and with the adaptation to the effects of climate change in special. The indicators could be for air quality, drinking water quality, number of diseases caused by environment pollutants, etc. The indicators can be

positive and/or negative determinants for the health, with a view to identifying areas of intervention, prevention and evaluation of the results of specific policies and programs aimed at improving public health. Health incidents during periods of extreme temperature seem to be the most common manifestations of the effects of climate change on public health. The incidence of diseases cardiovascular and respiratory infections increased in the context of a warmer climate.

The MoH promoted the MO No.119 from din 4 February 2014 regarding the approval of the hygienic and public health norms for environment and population health, published in the Official Journal No.127 from 21 February 2014. ***This MO sets standards of hygiene and public health on the living environment of the population, for the underground water sources used for drinking water supply to localities and economic operators.*** This act applies definitions for "*severe sanitary protection area*", "*sanitary protection zone with restriction regime*" and "*hydro geological protection perimeter*" as defined in the GD No. 930/2005 on the approval of the Special Norms on the character and size of the sanitary and hydro geological protection areas and the MO No. 1278/2011 for the approval of the Instructions on the delimitation of the sanitary protection areas and the hydro geological protection perimeter. This MO 119 from 2014 sets also hygiene rules on living areas. In line with this, housing with dwellings should be made in safe areas on sanitary land to ensure: (i) Protection of the population against the occurrence of natural phenomena such as landslides, floods, avalanches; (ii) Reducing the release or infiltration of toxic, flammable or explosive substances resulting from environmental pollution; (iii) Drinking water supply system in accordance with the legal norms in force; (iv) Sewage system for collecting, removing and neutralizing domestic waste waters, meteoric waters; (v) Selective waste collection system; (vi) The population's health versus anthropogenic pollution with chemical compounds, radiation and/or biological contaminants.

***The environmental policy for the adaptation to climate change effects is covering reactive and preventive measures. National Emergency Special Committee*** is established in the MO No. 1422/192/2012 for the approval of the Regulation regarding the management of flood emergency situations, dangerous meteorological phenomena, hydro-technical accident and accidental pollution on the watercourses and marine pollution in the coastal zone. The Annex to MO No. 1422/192/2012 contains the "***Regulations on the management of flood emergency situations, meteorological phenomena hazardous, hydro-technical accident, accidental pollution on watercourses and pollution marine in the coastal area***". Emergency management of floods, dangerous meteorological phenomena, accidents to hydro-technical constructions and accidental pollution are achieved through preventive measures, operative intervention and rehabilitation, consisting of identification, recording and evaluation types of risk and their determinants, notification of stakeholders, warning, alerting, evacuating and sheltering the population and animals, limiting, removing or counteracting negative effects caused by the risk factors. The measures to limit, remove or combat the effects of the types of risk referred in the previous sentence is an obligation for the central and local public administration bodies with attributions in this field. In the case of water drought, when water flows cannot be provided to all authorized users, temporary restrictions on the use of water resources are applied on the basis of the restriction plans and the use of water in short periods. The state of defense generated by floods, dangerous meteorological phenomena, accidents at hydro-technical constructions and accidental pollution are triggered when they are found the occurrence of the dangerous phenomenon (overcoming the defense thresholds) or when the probability of occurrence is set by prognosis. The characteristic flood defenses are:

- a) zone warning zones, established at hydrometric stations and rain meter stations upstream of endangered targets, as appropriate, for precipitation, levels or flows;
- b) local defense sizes established near targets, in the form of levels or flows.

Hydrometer stations and warning rain meter stations are part of the national grid hydrology and meteorology and must be located at a sufficient distance from the warning, so that the necessary pre-

established measures can be taken through defense plans. In the case of floods, there are levels of defense, such as: for the first phase Yellow Code, the second defense phase Orange Code and the third phase of the defense the Red Code. In Annex 3 of the MO No. 1422/192/2012 is established the structure of the County Plan for flood defenses, dangerous meteorological phenomena, accidents at hydro-technical constructions and accidental pollution for the County Emergency Committee. In Annex 8 is presented the *Content of Operative Reports on the Effects of Dangerous Hydro-meteorological Phenomena* prepared and submitted during the phenomena are taking place.

**RO-ALERT System** was established to be used in those major situations, in which citizens' lives and health condition are endangered, such as extreme weather conditions, threatening floods, terrorist attacks and other situations that severely threaten communities.<sup>94</sup> This system is managed by the General Inspectorate for Emergency Situations (IGSU) according to the provisions of the Art.104 paragraph 1 letter c of the Law no. 98 from 2016 on public procurement, with subsequent amendments and completions. The "RO-ALERT" system has a number of advantages, including:

- Transmitting warning messages adapted to the imminent event through the networks of the mobile operators;
- Rapid transmission of messages to all users in the area threatened even under congested conditions by mobile operator networks;
- Instantly displaying messages on the mobile terminal screen without the need for user intervention;
- Cyclical repetition of alert messages at configurable intervals;
- Receiving alerts and roaming terminals;
- The accuracy of warning messages based solely on information provided by authorized sources.
- The "RO-ALERT" System was tested in September 2018 and the population perception is good with regard to the need for rapid reaction in case of emergency situations.

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<sup>94</sup><https://ro-alert.ro/en/about-ro-alert-2/>

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- Report on thematic evaluation on anti-corruption, MoH, 2017
- Annual Report of the Ministry of Social Justice and Labour, 2017
- Evaluation of activity carried by health service providers in 2016, NHIH
- Evaluation Report on decisional transparency in 2018, MoH
- Activity Reports from National School of Public Health, 2017
- Evaluation of satisfaction of insured persons in relation to the medical services under the social health insurance system, 2018
- Activity Reports from County Directorates for Public Health in Satu Mare, Cluj, Sibiu, National Institute for Public Health for 2017.
- Municipal Report on the activity of health Mediators in Timisoara, Municipality of Timisoara, 2009

#### *Strategies and National Plans*

- National Health Strategy 2014-2020
- Strategy on Social Inclusion and Poverty Reduction 2015-2020
- Strategy for inclusion of Romanian citizens of Roma ethnicity 2014-2020
- National Action Plan for Waste Management
- National Strategy for Adaptation at the Climate Change
- Strategy of Cluj-Napoca in the health sector, 2014

#### *Project Reports*

- POCU EU Integrated community care
- Community integrated health and social services Report, Swiss Romanian Cooperation Program, 2014
- Initiatives in Public Health, RO 19.03, Expansion of the Roma health mediators in Romania to increase the overall health condition of Roma population, Norway grants, National Institute for Public Health, 2014-2016
- Socio-Map – Research on Roma Mediators, Norway Grants, 2017
- Final Report on Initiatives in Public Health, RO 19.03, Expansion of the Roma health mediators in Romania to increase the overall health condition of Roma population, Norway grants, National Institute for Public Health, 2014-2016

#### *Other Reports*

- Final Report on Initiatives in Public Health, RO 19.03, Expansion of the Roma health mediators in Romania to increase the overall health condition of Roma population, Norway grants, National Institute for Public Health, 2014-2016
- Are Romanian Family Doctors Ready for Health 2020?, Butu et. al. 2014, Management in Health XVIII/2/2014

## Annex B. Environmental Legislation

Law	Purpose
<p>Law no.211 / 2011 on the waste regime, republished (responsibilities to the MoH in Art.52).</p>	<p>- <b>In Article 7 (b)</b> is referring to Commission Decision 2000/532 / EC of 3 May 2000 replacing Decision 94/3 / EC establishing a list of wastes pursuant to Article 1 1 lit. (a) of Council Directive 75/442 / EEC on waste and Council Directive 94/904 / EC establishing <b>a list of hazardous waste</b>;</p> <p>- <b>In Chapter 12 - Protection of the health of the population and the environment, Article 20:</b> "Waste management must be carried out without endangering human health and without harming the environment".</p> <p>- <b>In Chapter 32 "Record and keeping data"</b>, Article 49: (4). Reporting of waste management data and information shall be made to the territorial environmental protection authority by 31 March of the year following that of the reporting, both on paper and electronically. (5) The Environmental Protection Agency keeps, for statistical purposes, for at least 5 years, the records stipulated in paragraph (1).</p> <p><b>In Article 52 - The Ministry of Health</b> has the following tasks:</p> <p>(a) assess, through competent structures, the potential impact on population health caused by the operation of waste generators and / or waste treatment objectives; the (b), (c) ; (d); (e) (f); (g); (h) are describe in the body text</p>
<p>Law No. 249 of 28 October 2015 on the management of packaging and packaging waste.</p>	<p>In Article 1 stipulates:</p> <p>(1) This law regulates the management of packaging and packaging waste in order to prevent or reduce the environmental impact.</p> <p>(2) The provisions of this Law shall be applied in compliance with the specific quality requirements for packaging for safety, health and hygiene</p>
<p>GD No. 1061 of 10 September 2008 on the transport of hazardous and non-hazardous waste on the territory of Romania (only in terms of wastes transport).</p>	<p><b>In Chapter V: Transport of waste resulting from medical activity</b></p> <p><b>Article 24</b></p> <p>(1) Waste management resulting from medical activities shall be managed in accordance with the Technical Norms on the Management of Wastes Resulting from Medical Activities and Data Collection Methodology for the National Databank on Wastes Resulting from Medical Activities, approved by the Order of the Minister of Health and Family no. 219/2002, as subsequently amended and supplemented.</p> <p>(2) Waste packaging whose packaging is not labelled with the following information shall not be accepted: identification data of the sanitary unit, section / laboratory, quantity and date of filling.</p>
<p>GD No. 349 of 21 April 2005 on the storage of waste</p>	<p>In Article 5 - Waste that is not acceptable for storage in a warehouse is:</p> <p>Little c) - medical hazardous waste or other hazardous clinical waste from medical or veterinary establishments with the H9 property, as defined in</p>

	Annex no. I E and having the category referred to in A point 14 of annex no. I C to Government Emergency Ordinance no. 78/2000, approved with amendments and completions by Law no.426 / 2001;
GD No. 856 of 16 August 2002 on waste management records and the approval of the list of wastes, including hazardous wastes	Annex No. 2: List of waste, including hazardous waste  18 – Wastes resulting from the activities of <b>sanitary units</b> and veterinary activities and/or related research (excluding catering waste in restaurants or kitchens not directly related to health);  18 01 - waste resulting from prevention, diagnosis and treatment activities in sanitary facilities;
GD No. 942/20.12.2017 regarding the approval of the National Plan for Waste Management, published in Official Journal Part I, no. 11 bis.	In section VI.5 dedicated to monitoring indicators, Table VI.19 - Monitoring indicators to prevent generation of priority waste streams is a Part 6 dedicated to measures in Section VI.5 dedicated to monitoring indicators in Table VI.19 - Indicators for monitoring to prevent the generation of priority waste streams is a Part 6 dedicated to measures on the prevention of medical waste (
GD No. 1028 from 18 November 2014 regarding the approval of the National Strategy for Health 2014 - 2020 and the Action Plans for the 2014-2020 for the implementation of the NS, promoted by the Romanian Government, published in the Official Journal No. 891 from 8 December 2014;	The following principles are guiding the NS:  1. Access to health services is a right fundamental;  2. Population must have access to staff medical and trustworthy;  3. Human Resource Planning in Health (RuiS) must take into account the needs and applications recorded in the health and community system;  4. Equitable distribution of human resources to avoid or remedy imbalances between rural and rural areas urban area;  5. Effective management to maximize the potential of the labour force to provide services quality;  6. Provide adequate funding to support the successful implementation of the Multiannual Plan for the strategic development of human resources in health 2017-2020;  7. Motivation of medical staff from point of view financial, professional and educational view.
MO No. 1149 of 28 September 2017 for amending and completing the MO of the Minister of Health No. 1093/2004 regarding the licensing of toxicology laboratories for the performance of professional noxious measurements issued by the MoH, published the Official Journal No. 801 of 10 October 2017	In accordance with Art. 2 lit. d) and art. 3 lit. a) from the Government Decision no. 1.414 / 2009 regarding the establishment, organization and functioning of the National Institute of Public Health, as subsequently amended and supplemented, as well as in accordance with art. 29 lit. v) of the Order of the Minister of Health no. 261/2010 regarding the approval of the organizational chart and of the Regulation for the organization and functioning of the National Institute of Public Health Bucharest, with the subsequent modifications and completions, according to the provisions of art. 7 par. (4) of the Government Decision no. 144/2010 on the organization and functioning of the Ministry of Health, as amended and supplemented, the Minister of Health issues the following order: Article I MO of the Minister of Health no. 1.093 / 2004 regarding the licensing of the toxicology laboratories for carrying out the professional pollutants, published in the Official Gazette of Romania, Part I, no. 840 of 14 September 2004, as amended and supplemented, shall be amended and supplemented.

<p>MO No.1279 of December 14, 2012 of the Minister of Health regarding the approval of the Evaluation Criteria, the conditions of operation and monitoring of the thermal decontamination equipment for hazardous medical waste.</p>	<p>In Art.2 there are stipulated the categories of hazardous waste resulting from medical activity, according to the Order of the Minister of Health no. 1226 / 2012 and the list of wastes listed in Annex no. 2 to the Government Decision no. 856/2002 on the waste management record and the approval of the list of wastes, including hazardous wastes, with subsequent additions, which can be subjected to thermal decontamination treatment at low temperatures, are without exception only the following categories:</p> <ul style="list-style-type: none"> <li>a) infectious waste under code 18 01 03 *;</li> <li>b) Punch-cut waste according to code 18 01 01.</li> </ul>
<p>MO No. 1226 from 03 December 2012 regarding the approval of the technical norms for the medical hazardous wastes management and methodology for data collection, enforced 17 January 2013, published in Official Journal Part I No. 855 from 18 December 2012, modified until 05 July 2016.</p>	<p>This MO regulates how separate collection by category, packing, temporary storage, transportation, treatment and disposal of medical waste is carried out, paying special attention to hazardous waste to prevent environmental contamination and damage to health in Chapter 1, paragraph 1 . In Art. 2. (1) mentions that "These technical norms are applied by all the sanitary units, regardless of the form of organization in which medical activities are carried out, as a result of which waste is produced, hereinafter called medical waste" and in (2) "The medical waste producer is responsible for the management of the medical waste resulting from his activity".</p>
<p>MO No.119 from din 4 February 2014 regarding the approval of the hygienic and public health norms for environment and population health, published in the Official Journal No.127 from 21 February 2014.</p>	<p>MO sets standards of hygiene and public health on the living environment of the population, for the underground water sources used for drinking water supply to localities and economic operators, the definitions for "severe sanitary protection area", "sanitary protection zone with restriction regime" and "hydrogeological protection perimeter" are applied, according to Government Decisions 930/2005 on the approval of the Special Norms on the character and size of the sanitary and hydrogeological protection areas and the Order of the Minister of Environment and Forests. 1.278 / 2011 for the approval of the Instructions on the delimitation of the sanitary protection areas and the hydrogeological protection perimeter;</p> <p>MO sets also hygiene rules on living areas: Housing for dwellings should be made in safe areas on sanitary land to ensure:</p> <ul style="list-style-type: none"> <li>a) protection of the population against the occurrence of natural phenomena such as landslides, floods, avalanches;</li> <li>(b) Reducing the release or infiltration of toxic, flammable or explosive substances resulting from environmental pollution;</li> <li>c) drinking water supply system in accordance with the legal norms in force;</li> <li>d) Sewage system for collecting, removing and neutralizing domestic waste waters, meteoric waters;</li> <li>e) Selective waste collection system;</li> <li>f) The population's health versus anthropogenic pollution with chemical compounds, radiation and / or biological contaminants.</li> </ul> <p>(2) The functional zoning of localities shall be considered: separation of</p>



	<p>functions, interdependent relation of different functional areas, avoidance of functional incompatibilities in the areas for their living and their complementary functions.</p> <p>(3) The sanitary protection zones shall be ensured, according to the legal provisions in force, on the basis of the approvals corresponding to the technical-municipal facilities of the residential areas.</p> <p>(4) Zones with natural or anthropogenic risks shall be designated as areas with a ban on the construction of residential or socio-cultural buildings, based on geological studies by competent institutions, until the risk is removed.</p>
<p>MO No. 756 of 26 November 2004 for the approval of the Technical Standard on Waste Incineration</p>	<p>Thermal waste treatment processes are a feasible option after recovery (collection, sorting, recycling) and prior to controlled disposal.</p> <p>The overall purpose of waste incineration is:</p> <ul style="list-style-type: none"> <li>- minimizing the potential of risk and pollution;</li> <li>- reduction of the quantity and volume of waste;</li> <li>- the conversion of the remaining substances into a form which permits their recovery or storage;</li> <li>- transforming and capitalizing on the produced energy.</li> </ul> <p>In Annex no. 1 of the present normative, the integrated waste management system is presented in two ways:</p> <p>material balance - energy - pollution</p> <ul style="list-style-type: none"> <li>- inputs - waste, energy, etc .;</li> <li>- emissions into the atmosphere, water, recyclable inert materials;</li> <li>- final products - secondary materials, compost, reusable energy;</li> </ul> <p>costs and revenues.</p> <p>Oxidation at high temperatures transforms organic components into specific gaseous oxides, which are mainly carbon dioxide and water. Inorganic compounds are mineralized and converted to ash.</p>
<p>GD 242/2013 on minimum health and safety at work requirements for the prevention of wounds caused by sharp objects in hospital and health care activities.</p>	<p>This GD approved the technical norms for incinerators.</p>
<p>2003 Patients' Rights Act - Law No.46/2003 on patient's rights, published in the Official Journal no.51 of 29 January 2003.</p>	<p>The patient has the right to be informed of his or her state of health, proposed medical interventions, the potential risks of each procedure, of the alternatives to the proposed procedures, including non-treatment and non-compliance with medical recommendations, as well as data on diagnosis and prognosis (Art.6).</p> <p>The information is brought to the attention of the patient in a respectful, clear language, with the minimization of specialized terminology; if the patient does not know the Romanian language, the information is brought to his / her knowledge in the mother tongue or in the language he / she</p>

	knows or, if necessary, another form of communication will be sought (Art.8).
MO of the Minister of Health No. 1093/ 2004 regarding the licensing of the toxicology laboratories for carrying out the professional pollutants, published in the Official Journal of Romania, Part I, no. 840 of 14 September 2004.	This MO introduces provisions on the coordination of the determination of professional pollutants by experienced specialists, the need for periodic reassessment of the laboratory to allow verification the competence to determine the professional noxiousness and the possibility of solving it situations where changes occur in the activity of these laboratories.
Government Emergency Ordinance no. 1/2014 regarding certain measures in the field of management of emergency situations, as well as for the modification and completion of Government Emergency Ordinance no. 21/2004 on the National System for Emergency Situations Management	In Article 1, The Ministry of Internal Affairs is set up by the Department for Emergency Situations, hereinafter referred to as the Department, the operational structure without juridical personality, with coordinating powers, permanently, at national level, of the activities for prevention and management of emergency situations, the provision and coordination of the resources human, material, financial, and other necessary to restore normal, including first-aid and emergency care in emergency units and emergency compartments, hereinafter referred to as UPU, until hospital admission.
Government Decision 94/2014 on the organization, operation and composition of the National Emergency Special Committee	In its Article 2 stipulates: in (2) The National Committee shall ensure: <ul style="list-style-type: none"> <li>a) the fulfillment of the specific attributions regarding the achievement in Romania of the objectives of the European and international strategies for disaster reduction;</li> <li>b) adopting policies and strategies for knowledge, prevention and management of emergencies, as well as mitigation;</li> <li>c) co-ordination of the management of the emergency situations determined by the main types of risk set out in Annex no. 2;</li> <li>d) permanent monitoring and evaluation of risks, threats and vulnerabilities in the area of competence;</li> </ul>
Common MO No. 1422 / 192/2012 for the approval of the Regulation regarding the management of flood emergency situations, dangerous meteorological phenomena, hydrotechnical accident and accidental pollution on the watercourses and marine pollution in the coastal zone;	In its Article 2 stipulates: "Central and local government structures involved in managing emergencies floods, dangerous meteorological phenomena, hydraulic engineering accidents, pollution accidental water courses and marine pollution in the coastal zone will result in the provisions being met of this order. <p>The Annex contains the "REGULATIONS on the management of flood emergency situations, meteorological phenomena hazardous, hydrotechnical accident, accidental pollution on watercourses and pollution marine in the coastal area".</p> <p>Within this regulation there are defined the following types of emergency generating risk:</p> <ul style="list-style-type: none"> <li>a) floods as a result of natural outflows of watercourses caused by increased flows rainfall and / or sudden snow melting or blockage caused by inadequate dimensions of bridges and bridge drains, blockages</li> </ul>

	<p>produced by ices or floats (waste and timber), landslides, landslides and avalanches snow, as well as leakage from the slopes;</p> <p>b) floods caused by incidents, accidents or damages to hydrotechnical constructions;</p> <p>c) floods caused by the elevation of ground water table;</p> <p>d) Dangerous meteorological phenomena: torrential rains, heavy snowfalls, storms and blizzards, deposits of ice, chicory, plows, early or late frosts, heat, hail and drought;</p> <p>e) floods caused by sea storms;</p> <p>f) hydrological drought (water shortage at source due to prolonged drought);</p> <p>g) accidental pollution of watercourses and marine pollution in the coastal zone.</p>
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### Annex C: Legislation on Social Inclusion

Law	Purpose
Law no 95/2006 Health Reform Act	The reform establishes the role of community health care and primary health care in the overall delivery of public health services.
Social Assistance Law (292/2011)	The legal act sets defines the objectives, roles and responsibilities for providing social protection for vulnerable categories. It sets out the key social protection benefits and social services that are applicable to vulnerable groups in Romania.
GEO 18/2017 on community health care, approved by Law no 180/2017	Defines the legal and institutional framework for community health care, defines the vulnerable categories that are addressed by the Program, responsibilities for service providers (community health nurses, Roma health mediators, midwives), integrated community centers. The associated methodological norms for the application of this law were not in place at the time of conducting this assessment.
Emergency Ordinance no. 162/2008 on the transfer of the attributions and competences exercised by the Ministry of Health to the local public administration authorities, as subsequently amended and supplemented;	Also regarded as the decentralization reform in health services, the act defines the institutional involvement and responsibilities of local public authorities in relation to the provision of health services at local level. Community health care objectives fall under the responsibility of local authorities, with coordination from the Ministry of Health and the Country Public Health Directorates.
Order of the Minister of Health and Family no. 619/2002 for the approval of the functioning of the health mediator and of the Technical Norms regarding the organization, functioning and financing of the activity of the health mediators, as subsequently amended and supplemented.	The framework for community work performed by health mediators in Roma communities.
Law No. 53/2003 - Labor Code	The legal act regulates individual and collective employment relationships, the enforcement of the regulations regarding employment and the labor jurisdiction.
Law No. 319/2006 – Occupational Health and Safety	The law provides the general framework for health and safety at the workplace, roles and responsibilities, monitoring bodies.
Law No. 448/2006 regarding the protection and promotion of the rights of disabled persons (republished in 2008)	Regulates the rights and obligations of disabled persons granted for the purpose of their social integration and inclusion.

Law no. 202/2002 regarding the Equal Opportunities of Women and Men	Legal frame for promoting equal opportunities and treatment between men and women and removing all forms of discrimination based on gender in all spheres of public life in Romania.
Law no. 544/2001 regarding the free access to information of public interest	The law outlines the transparency principles for public administration, providing free and unrestricted access of citizens to information of public interest, defined as such by this law; it constitutes one of the fundamental principles of the relation between persons and public authorities, in accordance with the Constitution of Romania and with the international treaties ratified by the Romanian Parliament and Government.
Law no. 350/2001 regarding spatial planning and urbanization	The law defines the roles and responsibilities in relation to urban planning in Romania.
Law no. 287/2009 – The New Civil Code	The New Civil Code in Romania provides indication and regulation on access to neighboring properties, rights for compensations, principles of good-faith vicinity.
Law No. 263/2004 on permanent centers	The law governs the provision of health care through an additional institution (besides family medicine practices and hospitals), the permanent centres. The law governs the establishment, organization and operation of these centres.

## **Annex D: Main Vulnerable Groups in Romania**

The list below reflects the categories of vulnerable groups that were identified as part of the Social Inclusion and Poverty Reduction Strategy 2015-2020.

1. Poor people
  - Poor children, especially those living in families with many children or in single-parent families
  - In-work poor, especially under-skilled (mainly rural) workers; the self-employed in both agriculture and other fields
  - Young unemployed and NEETsb/ (not in education, employment or training)
  - People aged 50-64 years out of work and excluded from social assistance benefits schemes
  - Poor elderly, especially those living with dependent household members, and lone elderly
2. Children and youths deprived of parental care and support
  - Children abandoned in medical units
  - Children living in large or low-quality placement centers
  - Youths leaving residential care
  - Children and youths living on the streets
  - Children with parents working abroad, especially those with both parents abroad and those confronted with long-term separation from their parents
  - Children deprived of liberty
  - Teenage mothers
3. Lone or dependent elderly - Elderly living alone and/or are dependent and/ or are with complex dependency needs
4. Roma children and adults at risk of exclusion from households without a sustainable income
5. Persons with disabilities- children and adults with disabilities, including invalids, and with a focus on those with complex dependency needs
6. Other vulnerable groups
  - persons suffering from addiction to alcohol, drugs, and other toxic substances
  - Persons deprived of liberty or on probation
  - Persons under the supervision of probation services, with non-custodial measures or sentences (persons granted postponement of punishment, suspension of sentence under supervision, release on parole – if the remaining sentence time is of minimum two years, and persons imposed the enforcement of a fine sentence by performing community service)
  - Minors under the supervision of probation services (sentenced to a non-custodial educational measure, granted the replacement of the custodial educational measure, or release from detention)
  - Homeless people

- Victims of domestic violence
- Victims of human trafficking
- Refugees and immigrants

7. People living in marginalized communities

- Rural poor communities
- Urban marginalized communities
- Roma impoverished and marginalized communities

Note: a/ Some of the groups may overlap. For example, a child living in a single-parent family may experience poverty and/or multiple deprivations as well. b/ NEET stands for 'Not in Education, Employment or Training'.