Case study no 4. Romania

I. THE HEALTH SYSTEM IN ROMANIA - GENERAL CONTEXT

SOCIO-DEMOGRAPHIC AND HEALTH INDICATORS

Romania is facing major demographic challenges, i.e. an aging population, low birth rates and massive migration. Romania's population in January 2020 was 19 328 836 people, a decrease of about 10% in the last fifteen years, a decline due to both natural growth and net migration (1). The impact of an aging population will have a major significance in the coming decades, given that the proportion of the elderly continues to increase. In 2017, the proportion of Romanian citizens of working age (20-64) residing in EU countries represents almost a fifth (19,4%) of the resident population of Romania, by far the largest national group among mobile citizens in the EU.(2)

Although life expectancy at birth has steadily increased over the past fifteen years, it remains lower by more than 5,7 years, and the difference in life expectancy at birth for women and men remains high, with women living at 7.6. years older than men (3). Due to the 2020 COVID-19 pandemic, life expectancy at birth has decreased in most EU member states (according to the latest available data from 2020). Romania has registered one of the higher decreases (1,4 years for both genders), according to the most recent published data.(4)

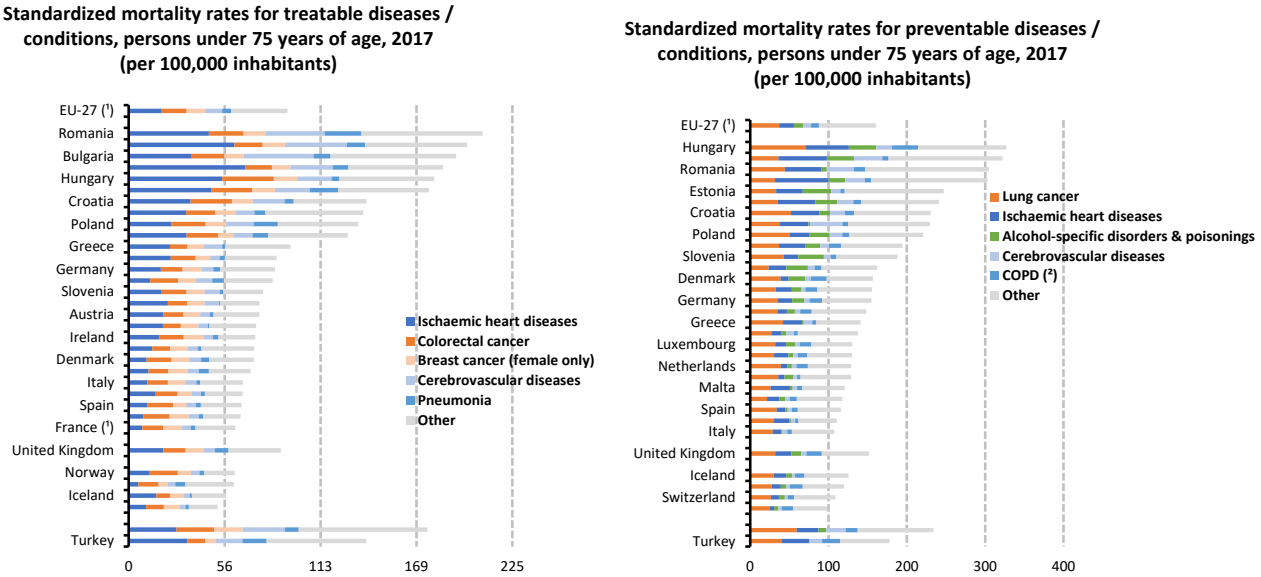
Infant and under-5 mortality rates have continued to fall, but remain high. Infant mortality was the highest in the EU in 2018 and the second highest in 2019, almost twice the EU28 average (Eurostat database). (5) The under-5 mortality rate has dropped to less than half in the last fifteen years (9 deaths per 1,000 live births).(6)

HEALTH AND BEHAVIORAL RISK FACTORS

The indicators of the health status of the Romanian population are weak, with the second highest proportion of preventable deaths at people under 75 registered in the EU (512.64 / 100,000 people). Dividing preventable deaths by the 2 categories, treatable and preventable diseases, Romania ranks first in treatable mortality in people under 75 among EU member states, with a standardized rate of 205.98 / 100,000 people, and in fourth place (after Hungary, Latvia and Lithuania) for preventable deaths. Ischemic heart disease remains the leading cause of death (7). (Figure 1). In cancer deaths, lung cancer is the most common cause of death, but mortality rates from other cancers have also risen in recent years, especially colorectal and breast cancer.(8)

More than half (62%) of deaths in Romania can be attributed to a set of behavioral risk factors, including poor nutrition, smoking, alcohol consumption and lack of physical activity, well above the EU average (44%). Alcohol consumption is a major public health problem in Romania, with a binge drinking rate of 35%, well above the EU average (20%). At men, the rate is over 50%.(8)

Figure 1 **Preventable and treatable mortality through the first 5 causes of death, European Union, 2017**

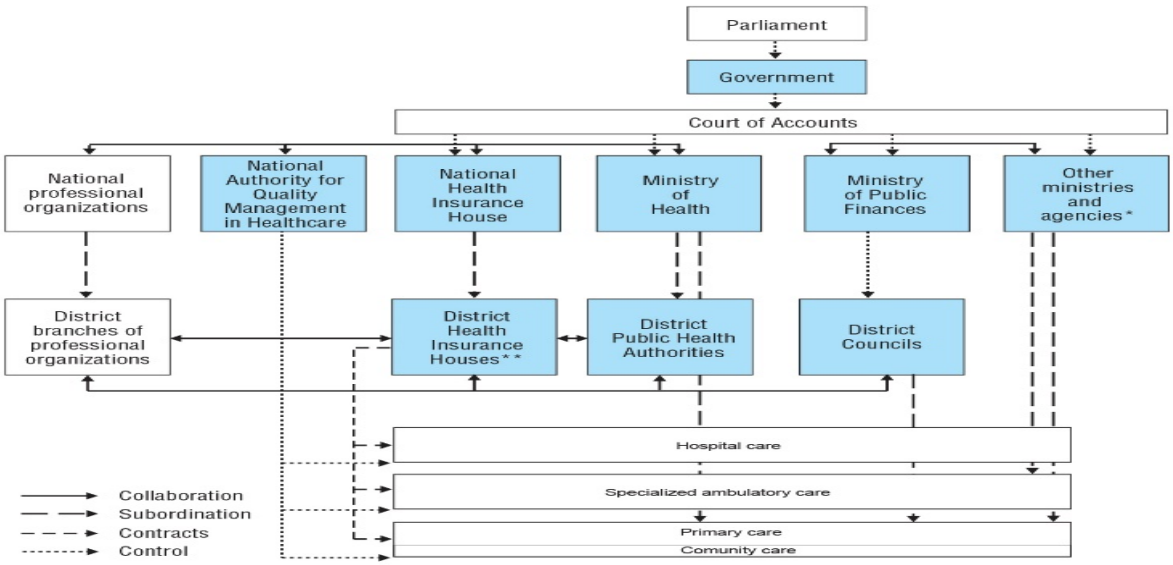


Source: Eurostat database, Treatable and preventable mortality of residents by cause and sex, online data code: [hlth_cd_apr]

STRUCTURE AND LEADERSHIP

Romania has a system of compulsory health insurance. The Health Law (Law 95/2006) establishes the functioning of the health system (organization, financing, provision of services and benefits, and public health). The system remains very centralized, the national level representing the administrative authority and the regulatory framework, while the county level is responsible for organizing and providing health services to the population (Figure 2).

Figure 2**: Romanian Health System**



Source: (adapted from Vlădescu C, Scintee SG, Olsavszky V, Hernández-Quevedo C, Sagan A. Romania: Health system review. Health Systems in Transition, 2016; 18(4):1–170

The Ministry of Health (MoH) is the central authority, responsible for policy formulation, initiates legislative proposals, planning, control and implementation of National Health Programs that address public health priorities and funding from the state budget. Through the decentralization process other important responsibilities of the MoH have been gradually transferred to local public authorities (ownership and administration of public hospitals, responsibility for providing several public health services at the local level, such as school medicine, providing community health care services provided by to community nurses and health mediators for Roma communities). The deconcentrated units of the Ministry of Health at county level are the County Public Health Directorates (DSP). The 41 county DSPs and Bucharest DSPs control the public health activity at the county level and coordinate the implementation of the National Health Programs financed by the Ministry of Health. In recent years, due to the decentralization process, the role of DSPs in the health system as well as their ability to coordinate public health activities have decreased (in terms of human resources, financial resources, influence).

The National Health Insurance House (NHIH), the main source of funding for the health care system, is a central government body. NHIH is a third-party payer of the system, it receives funds collected through the National Agency of Fiscal Administration which belongs to the Ministry of Finance. By governmental decision (Annual Framework Contract), agreed by the MoH and NHIH, in consultation with the College of Physicians, the College of Pharmacists and the Order of General Nurses, Midwives and Nurses in Romania, the health services contracted and reimbursed each year in the health insurance system are established. The Framework Contract also establishes the level of payments for both public and private providers (primary care, outpatient and hospital care, medicines).

The National Authority for Quality Management in Health Care was established in 2015 and it is in charge of hospital accreditation; recently, additional power was given by law to the Authority, which will be in charge of the development of quality standards for all outpatient health care providers.

Other important actors in the health system are: the College of Physicians (protects the interests of service providers), the College of Pharmacists and the Order of General Nurses of Midwives and Nurses in Romania. The three organizations are responsible for regulating the medical professions, membership is mandatory for practitioners, pharmacists and nurses.

FUNDING

Romania spends less money for health than any other member country of the European Union (EU), both in per capita expenditure and as a percentage of GDP. Although health spending has steadily increased in recent years (CNAS budget has increased 15 times in the last 10 years - EUR 8.89 billion in 2019) (9)[1], nonetheless, total health spending is the second lowest in the EU, at 5.56 % of GDP, with 1,212 EURO per capita (10), less than half of the EU average - EUR 3,078. (Eurostat database 2021, data for 2018). The second source of income are the out-of-the pocket direct payments which accounted for 20.5% of health expenditures in 2017. Informal payments are believed to be important but difficult to quantify.(8)

The allocation of resources in the system indicates a relatively constant pattern of allocation of financial resources, especially towards hospitals and reimbursed medicines; a small percentage goes to outpatient care (primary level, specialized outpatient settings, paraclinical investigations). The current payment system for family doctors encourages them to maximize the number of enlisted patients, but does not encourage them to provide a comprehensive package of primary and preventive care services. The payment system does not discourage referrals to the hospital or the prescription

[1] Year 2019 was considered to avoid health expenditure in the context of COVID19 pandemic; calculation is based on the National Health Insurance Fund data, available at: http://www.casan.ro//theme/cnas/js/ckeditor/filemanager/userfiles/BUGET_FNUASS/08.04.2021_Evolutia_anuala_FNUASS_1999-2021.pdf used exchange rate EUR/RON- 1:4.7

of expensive drugs. As a result, family physicians contribute to the excessive use of hospitals and over-prescribing of drugs *(11).*

HUMAN RESOURCES

Although the size of the health workforce has increased in the last 10 years, the health system in Romania still faces a shortage of medical staff (doctors and nurses). Thus, in 2018 there were 3 doctors / 1000 inhabitants, the third place among the last EU countries (EU average - 3.6), and 7.2 nurses / 1000 inhabitants (EU average - 8.5). The waves of external migration of medical staff have contributed to the lack of medical staff, with profound effects on the population's access to health care. The main factors that contributed to the migration of medical staff were better career development opportunities and better payment.

In response to this issue, in 2018 the government tried to adopt some retention mechanisms, granting substantial and rapid salary increases, which led to an increase of over 100% in the salaries of specialty-training doctors in public hospitals." (8) However, it should be noted that remuneration is not the only way to retain medical staff. Working conditions, living conditions, social and professional status, etc should also be mentioned here.

PROVISION OF HEALTH SERVICES

Health services are provided in outpatient settings (family physicians/primary care services, outpatient specialty services, pre-hospital emergency services) and inpatient care.

At the level of primary health care, family doctors are **independent/private providers** paid through a combination of capitation and pay per service (about 50% each). Also, at the primary level there are community health care services organized at the level of local public authorities, mainly in localities with vulnerable populations. Coverage with such services is not uniform. Rural and poor areas are poorly covered in terms of access to primary health care. In these areas, emergency medical services are mainly used as a way to have access to hospital care. However, the pandemic reshaped the way the vulnerable population used to access medical services, the admission rates for the main types of diseases being reduced to about half in 2020 compared to 2019. (data provided by the National Center for Statistics and Informatics, NCSI) .

Specialized ambulatory services are provided through a network of hospital outpatient departments and polyclinics, specialized medical centres, centres for diagnosis and treatment, and individual specialist physician practices under contract with the County Health Insurance Fund. Generally, ambulatory speciality physicians who divide their work0time between the public and private sectors.

The 42 county health insurance houses including Bucharest Municipality contract health services with all health care providers accredited at district level, **including hospitals public and private hospitals.** The inpatient care is financed per case (diagnosis related groups - DRG) for acute care and by hospitalization day for chronic care. Despite the increase in the number of services contracted in the specialized outpatient clinic, the service system still remains hospital-centred.

Other type of health care services, in particular those for the elderly, rehabilitation, terminal diseases, are underdeveloped or absent. Access to health promotion and disease prevention is sporadic, based on available funds and the interventions are not evaluated.

The coverage with health services is unequally distributed in Romania. The vulnerable population (below the poverty line, the rural population, including Roma, children and elderly people) are hard to reach populations. A significant proportion of farmers and Roma population are not covered by health insurance. At the level of family doctors, the insured population has access to a package of basic medical services (including a set of paraclinical services), while the uninsured population

has access to a minimum package of health services, including some preventive services, services for communicable diseases and emergency care. In outpatient care settings, uninsured persons cannot benefit from paraclinical investigations that can underlie a diagnosis, nor from medications recommended / prescribed by the family doctor. In addition to emergencies, services for pregnant women and some infectious diseases, the uninsured persons have to pay for the medical care out of their own pocket (except for diseases covered by the National Curative Programs financed from the state budget). Ensuring appropriate health care coverage for all social groups remains a challenge aiming at reducing health inequities. For the uninsured population, hospital services (diagnostic, investigations, treatment and care) are covered only for emergencies and for some diseases included in the National Health Programs (e.g. oncology, diabetes, cardiovascular diseases). The combination of poverty and the inability of the health care system to provide access to basic care for the entire population leads to high rates of ill health among the poor population.

HEALTH INFORMATION SYSTEMS

In 2019, an evaluation of the Romanian information system was made within a European JA InfAct project (https://www.inf-act.eu/) based on interviews with the main stakeholders which contribute to the functioning of the health information system. The evaluation methodology was based on an adapted evaluation tool developed by WHO. (12) The conclusions of this report were that Romania is in the process of improving the system of collecting and disseminating data from the health system. The introduction of E-health in the existing system is planned. This progress would be a good opportunity to improve communication with data providers, data holders and users, as well as to avoid duplication of data, which is currently happening. It would also contribute to better data accessibility.(13)

The most important recommendations and suggestions of this evaluation were:

- To integrate the progress made so far in the field of E-Health in a single integrated information system of CNAS, the electronic card to be insured, the electronic prescription and the electronic file of the patient, essential elements of the system in different stages of development.
- It was suggested to accelerate the adoption of e-Health solutions, including m-Health, in order to increase the efficiency of the system as a whole, finally aiming at increasing access to quality services and reducing inequities.
- It was suggested to increase the capacity of data collection, processing, analysis and reporting, within the existing information system; use of unitary classification and coding systems (e.g. for health units with beds, types of outpatient providers, medical laboratories, etc.).
- The MoH should adequately plan human and financial resources in subordinate institutions (e.g. NIPH) involved in the health information system.
- In the medium term, the responsible authorities (such as MoH, NHIH) should review the data flow so as to reduce data fragmentation and duplication.
- Also in the medium term, the Ministry of Health should support the development, maintenance and sustainability of disease registries and ensure their interoperability; the main actors (MoH, National Institute of Statistics, NIPH, Romanian College of Physicians, National School of Public Health, Management and Training) to collaborate to create a register of human resources in health and interoperability with the information system of NHIH.

REFORMS IN IMPLEMENTATION

Special measures during the pandemic

In order to ensure access to primary care services in 2020, the year marked by the COVID-19 pandemic, in which measures were taken to limit the transmission of SARS-CoV2 infection at the community level, a series of changes were undertaken:

- Providing remote medical consultations with the possibility of transmitting medical documents by electronic means, without the need to use the national health insurance card (in the patient's possession)
- Maintaining the validity of some medical documents beyond the expiration date (for referral tickets, medical recommendations for medical devices, technoclogs and assistive devices)

Intersectoral collaboration for strengthening the community health care network

The Ministry of Health is carrying out a project under the Human Capital Operational Program (POCU) between September 2018 and July 2022 called" Creating and implementing integrated community services to fight poverty and social exclusion", implemented in partnership with the Ministry of Labor and Social Justice and the Ministry of Education, thus laying the foundations for an intersectoral collaboration vital for the sustainability of this system of integrated services.

The project will contribute to increasing social inclusion and combating poverty by developing and piloting integrated community services in 139 rural communities with above average and severe marginalization, in 7 development regions (except for the Bucharest-Ilfov region). The integrated community teams consist of community nurse / health mediator (where applicable), social worker / social technician and school counselor / school mediator. For the Ministry of Health, the target group is represented by the team consisting of the community nurse and the health mediator.

Such an approach aims to increase the access of people belonging to vulnerable groups to medical-socio-educational services, as well as to assess the impact of the services provided, but especially the chances of getting out of the state of multiple vulnerabilities of this category of people.

Increase the number of integrated community centres

The construction/renovation and endowment of the integrated community centres are provided by the Regional Operational Program to be developed complementary for the 139 rural communities with marginalization above average and severe, included in the POCU project mentioned above. A number of 200 integrated community centres are also planned to be created through the National Recovery and Resilience Program.

The specialization program of the community nurse

The specialization program of the community nurse comes in the context of the need to train their abilities and skills to work effectively in the urban or rural community, as the case may be, by addressing the complex issue of community health care in collaboration with the staff in family physician's practices, the staff of the public social assistance service, the staff of the integrated community center and other providers of health, social and educational services, including non-governmental organizations providing specific services. The specialization curriculum of the medical staff from the community care team (community nurse, midwife) is under development.

II. FACILITATING FACTORS OF THE COMMUNITY Health care SYSTEM

LEGAL FRAMEWORK

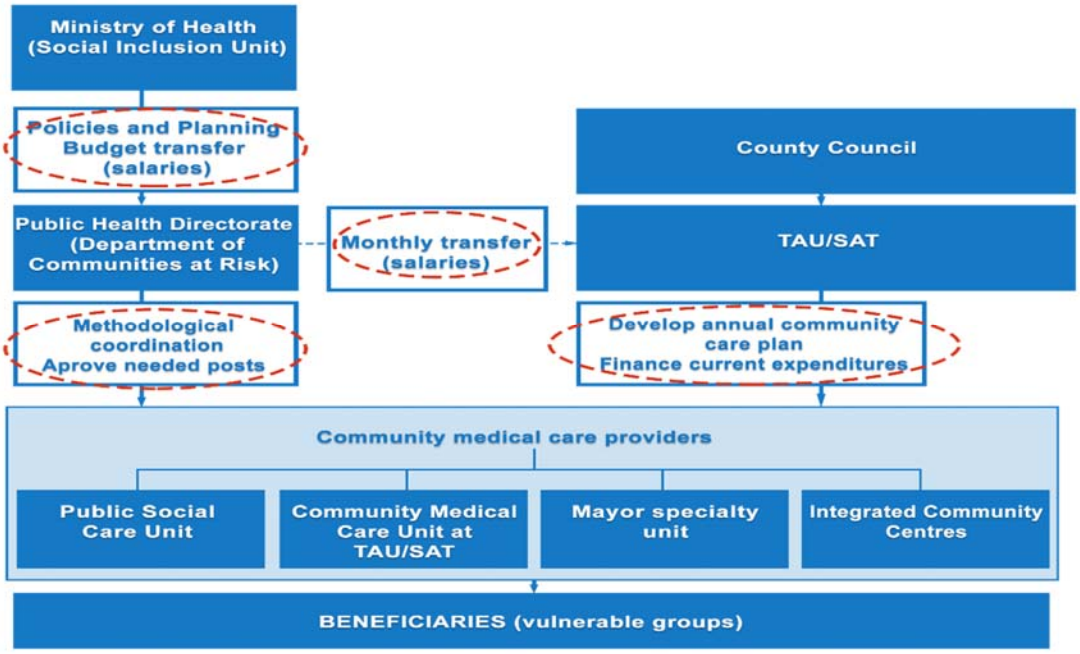
The legal framework governing the organization, operation and financing of the Community health care activity is represented by:

- Government Emergency Ordinance (GEO) no. 18/2017 on community health care approved by Law 180/2017 with subsequent amendments and completions;
- GD 324/2019 for the approval of the Methodological Norms regarding the organization, functioning and financing of the community health care activity;
- GD 459/2010 for the approval of the standard cost/year for services provided in the medical-social units and of some norms regarding the personnel from the medical-social assistance units and the personnel carrying out community medical assistance activities, with subsequent modifications and completions.

ORGANIZATION OF THE COMMUNITY Health care SYSTEM AT NATIONAL, COUNTY AND LOCAL LEVEL

According to GEO 18/2017 and GD 324/2019, community health care is organized in the structure of administrative-territorial units, and financed mainly from the state budget, through the Ministry of Health (Figure 3).

Figure 3 Organization, financing and operation of the Community health care system



Thus, at the level of the Ministry of Health there is the Social Inclusion Unit with a national coordinator of the community health care activity. At the level of the County Public Health Directorates there is a department of communities at risk that have appointed a county coordinator of community health care (however, it should be emphasized the undersizing of this department in terms of staff, in many counties working only one person who has and other attributions, or, there are county DSPs in which this compartment does not exist at all in the organizational structure). At the level of territorial administrative units / territorial administrative subdivision (ATU / SAT), the staff of the community health care (doctor,

community nurse, midwife and health mediator) is found in the organizational chart, as follows: (a) in the public social assistance service; (b) in the Community health care department of the local government authorities; (c) in integrated Community centres set up by decisions of the deliberative authorities of the local public administration; (d) in the specialized apparatus of the mayor.

According to the provisions of the legislation in force, there is also the possibility of contracting community health care services by private providers authorized, accredited or licensed according to the regulations in force.

SOURCES OF FUNDING OF THE COMMUNITY Health care SYSTEM

The funding of personnel expenses for community nurses and health mediators who carry out their activity according to the provisions of GEO 18/2017, as well as the expenses determined by the application of minimum endowment standards, is ensured from transfers from the state budget to local budgets, through the Ministry budget. Health, within the budget appropriations approved for this purpose and the staff regulations approved by GD 459/2010 for the approval of the cost/year standard for services provided in medical and social care units and regulations on staff in medical care units. social security and staff carrying out community health care activities, with subsequent amendments.

Where possible, at the level of territorial administrative units, the financing of human resources can be ensured from the local budget if the units/subdivisions of the territorial administration ensure from their own income the funding of new positions in community health care.

Also, the funding of human resources and emergency kits can be done from projects financed from non-reimbursable external funds and, as the case may be, other legally constituted funds to this end.

Currently, the funding of the 1791 community nurses comes from the following sources: for 1599 (338 urban, 1261 rural) from the state budget through the Ministry of Health, 118 (3 urban, 108 rural) from the POCU project "Creation and implementation of services integrated community programs to combat poverty and social exclusion ", 81 (18 urban, 63 rural) from local budgets, and 4 nurses are paid by UNICEF. Funding for the 463 health mediators comes from the following sources: for 447 (191 urban, 260 rural) from the state budget through the Ministry of Health, 9 (rural) from the POCU project "Developing and implementing integrated community services to combat poverty and social exclusion ", 7 (4 urban, 3 rural) from the local budgets.

III. PROVISION OF COMMUNITY HEALTH CARE SERVICES

TARGET GROUPS (BENEFICIARIES) AND NEEDS

The main beneficiaries of community health care services are vulnerable people in communities. According to the legislation in force (OUG180 / 2017 on community health care activity), vulnerable people are those who meet medical or social criteria, Roma people and especially the rural population.

GEO 18/2017 on community health care defines the categories of vulnerable persons as follows: a) with economic level below the poverty line; b) unemployed; c) with a low level of education; d) with disabilities; e) with chronic diseases; f) with terminally ill diseases, which require palliative treatments; g) pregnant women; h) the elderly; i) children and young people under 18 years of age; j) children who are part of single-parent families; k) persons at risk of social exclusion; l) other categories identified at the community level as being medically or socially vulnerable.

The beneficiaries of the community health care services are actively and continuously identified by registering the population of the local community and by updating it monthly in the online application AMCMSR.gov.ro.

An important proportion (4.7%) of the Romanian population reports unmet health care needs. Moreover, there are significant disparities in access at regional, ethnic or income level. People in rural areas, marginalized communities and low socioeconomic groups face greater barriers to accessing care. (8)

A research study conducted in 2019 by NPHI (14) shows that 31% of vulnerable people responded that they suffer from a chronic disease. The prevalence of self-reported chronic diseases in the vulnerable population is worrying because young age groups (with an average age of 38 years) predominated in the studied group. Moreover, if we compare the proportion of vulnerable people who report at least one chronic disease with that of the general population, there is a big difference, only 19.5% of the general population of Romania self-declaring a chronic disease in 2018. (15)

As in the study conducted in 2015 by INSP in the project RO 19.03 "Strengthening the National Network of Roma Mediators to Improve the Health of the Roma Population" (16), the proportion of Roma people who declare the need for health services that were not met it was great. Thus, 34% of vulnerable people say in 2019 that they needed medical services but did not go to the family doctor, compared to 23% of Roma. Comparing these data with the same ECHI indicator reported for the general population in Romania, it is found that in 2017 only 4.7% of Romanians consider that they needed unsatisfied health services. Only 62% of the vulnerable population has health insurance (14), a worrisome percentage if we compare it with the one declared by the National Health Insurance House for the insured in Romania, where the coverage level is about 90%. The main reason why vulnerable people did not go to the doctor is the financial one (32%). (14)

In order to bring health services closer to vulnerable communities with high health needs, the National Health Strategy 2014-2020 has set among its priority objectives the establishment of integrated community centres. The strategy proposed a systematic assessment of the needs of the vulnerable population for the creation of integrated service packages (social, health, educational, employment and housing).

SCOPE OF THE SERVICES

The legislation governing the organization, operation and financing of the community health care activity establishes as its purpose the reduction of the differences in the state of health at the level of communities and between communities. The specific objectives of Community health care services are: (a) to actively identify the medical and social problems of the community and individuals, with a focus on vulnerable individuals and families; (b) facilitating access, in particular for the vulnerable population, to health services; (c) promoting attitudes and behaviors that are conducive to a healthy lifestyle; and (d) the development of health programs and interventions tailored to the needs of the community.

COMMUNITY Health care PROVIDERS (WORKFORCE AND WORKING CONDITIONS)

The concept of community health care is not new in Romania. In rural communities, the "sister of protection" has existed since the interwar period, and during the communist period provided community care in a mixed team, along with the midwife, the general practitioner, the pediatrician and the school doctor, carrying out field work and providing mainly interventions. primary prophylaxis, health education, and mobilization of the population to preventive medical services. After 1990, primary care reform transferred responsibility for the health of community members to the new primary care provider (family doctor). Professions such as the pediatrician general practitioner, the school doctor, the midwife, the school nurse or the caregiver gradually disappeared. For a decade, urban-rural disparities in access to health services have intensified, health education and preventive services have been significantly reduced, becoming a public health problem, according to health indicators, in particular women's health and the child. With the technical and financial support of UNICEF and USAID, in the period 2002-2004, the Institute for Maternal and Child Care initiated the Community Health Care Program within the National Program for Health of the Mother, Child and Family of the Ministry of Health, with the

declared aim of increasing access of the population, especially the poor and vulnerable in rural areas, to basic health services. The professions of community nurse (with basic medical training) and health mediator for Roma communities (without medical training, but belonging to the community where they practice their profession and receiving training to provide health-friendly education and to facilitate access) have been regulated. Roma population in health services). The introduction of the social health insurance system has accentuated inequities in access to health services, especially among the rural population and vulnerable groups without health insurance. The Community Health Care Program has gradually proved its effectiveness and efficiency, at the end of 2008 there were 1228 community nurses and 498 health mediators at national level. In 2008-2009, with the decentralization of health services, community health care providers were taken over by local public administrations through a new legislative act (GEO 162/2008). Lack of understanding by local authorities of the importance of these qualified human resources for community health, sudden transfer of responsibility unaccompanied by funds for community health care (other than the salary still paid by the Ministry of Health through county public health directorates) and Adequate information, given that the communities with these staff were predominantly rural and among the poorest and most vulnerable, led in the next decade to a reduction in the number of community nurses and health mediators, or to the deprofessionalisation of some of them, gradually assigned to office, social protection. The need for community health care has gradually returned to the attention of the authorities, with the accentuation of rural-urban differences in the number of people living in poverty, with reduced access to basic public services. A new model was initiated by UNICEF in 2010 to provide integrated social, health, non-formal education and school dropout prevention at Community level. European, Norwegian and Swiss - funded programs have provided an opportunity for the Ministry of Health, the National Institute of Public Health and non-governmental organizations to respond to the health needs of vulnerable populations through community interventions.

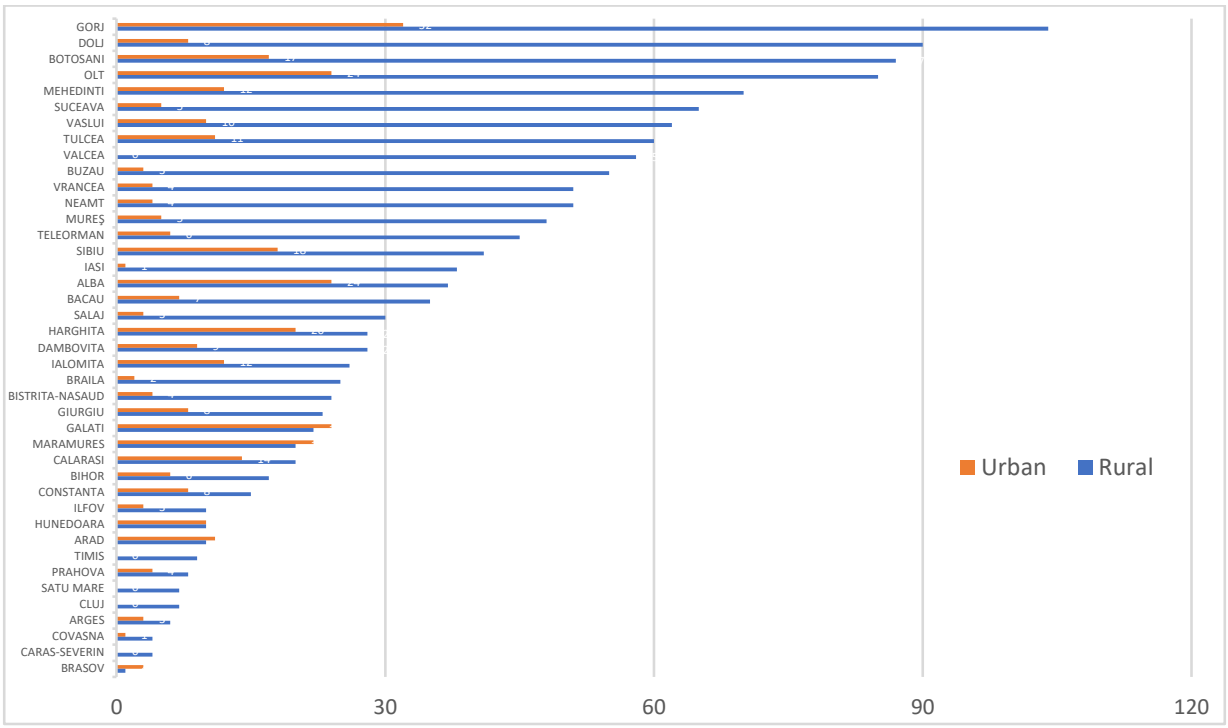
In February 2021, in the 3228 administrative-territorial units in Romania, out of which 2862 rural communities[2], community health care services were provided by 1791 community nurses, of which 1436 in rural communities and 355 in urban communities, and 463 health mediators, of which 268 in rural communities and 195 in urban communities. Although existing legislation includes the profession of midwife as part of community health care, there are currently only 2 midwives among these providers, although generally the access to risk-free pregnancy and maternity services are deeply deficient, particularly in rural areas and among people in the vulnerable groups. (17)

There are currently 1880 territorial administrative units in Romania without any community nurse, even if a number of 160 localities in rural areas do not have any family doctor. (18) Even in the communities where there are community nurses, their number is insufficient, compared to the legal provisions in force, both from the perspective of the activities they have to carry out in the community and the number of beneficiaries. The proportion of community nurses in the total number of nurses and midwives represents 0.83% (213 926 nurses and midwives registered in 2019 according to the Eurostat database). The standard provided by the regulations in force (GD 459/2010) sets for a community nurse a number of 500 people to be cared for, and currently only 14 localities have a number of beneficiaries less than 600 inhabitants served by a community nurse. Only 4 of these communities have a family doctor, and another 3 have a family doctor's office, so the presence of the community nurse is essential / critical. In the vast majority of cases, there is only one community nurse in each locality. A number of 15 cities and municipalities have over five community nurses, the record being held by Galați (20), Baia Mare (13), Giurgiu and Călărași (8). In rural localities, there are 8 communes with 4 community nurses (3 communes in Gorj, 2 in Mureș, 1 in Călărași and Mehedinți), 32 communes with 3 community nurses each, and 110 communes with 2 community nurses. With the exception of 7 localities, in rural or urban localities where the number of community nurses is at least two, the number of beneficiaries is higher than the legal standard in force.

[2] Including the six sectors of Bucharest Municipality (http://www.dpfbl.mdrap.ro/nr_uat-uri.html)

To the reduced number of community nurses is added the unequal geographical distribution at national level (Figure 3), the data of the Ministry of Health showing a variability from 4 community nurses in Brașov county, to 136 in Gorj county. Until 2021, there was only one community nurse in Brașov; the three positions created and budgeted in 2021 for the municipality of Brașov are from the European funding provided within the POCU project.

Figure 3 Distribution of the number of community nurses by counties and areas of residence



Source: MoH/UIS, February 2021

Community health care is extremely necessary for any locality, rural or urban, because there are poor communities and vulnerable populations everywhere. However, evidence-based planning and a set of objective criteria for the gradual expansion of community health care services at national level are important and necessary, in the context of the limited public budget and the existence of communities without any family doctor and/or at risk of great poverty and vulnerability. Currently, community health care providers do not necessarily focus on the counties with the most marginalized or vulnerable communities. The Atlas of Marginalized Rural Areas and Local Human Development in Romania (19) shows the existence of marginalized rural communities in all counties and regions of the country, but with considerable differences between counties. Vaslui County has a rural marginalization rate of 23%, about four times higher than the national average; eight other counties (Iași, Covasna, Brașov, Botoșani, Galați, Bacău, Sibiu and Mehedinți) have a rural marginalization rate between 9 and 15% of the total rural population. (19) The graphical representation of the distribution of community health care providers (Figure 3) shows that Gorj, Dolj and Botoșani counties are in the upper third, while Brașov, Caraș-Severin and Covasna counties have the lowest number of community nurses.

According to a nationally representative study published in 2021 by UNICEF Romania(20), most community nurses (88% - 1,201 people) are employed for an indefinite period by territorial administrative units, based on an employment contract. The same study shows that 68% of community nurses are based in the town hall, 8% in the family doctor's office, and only

4% in integrated community centers, while 8% say they do not have a permanent office. The rest of the respondents (12%) declare they have an office in various other locations, for example public social services. In terms of working conditions, the same UNICEF study shows great variability between counties in terms of local authorities' concern for the provision of non-medical and medical goods and equipment needed for community health care. The community nurses from Tulcea, Alba, Maramureș and Galați counties declare that they have support from the local authorities, at the opposite pole being Bucharest, Giurgiu, Cluj and Mehedinți. The most important problem reported by 9 out of 10 community nurses is access to a means of transportation. Deficiencies are also reported in medical and non-medical equipment, medical consumables necessary for daily activity.

The main location of community nurses, as well as their mentions regarding the working conditions, need to be carefully assessed by decision-makers from different perspectives: access to a means of transportation is extremely important, particularly in rural communities with villages spread over a large area, varied relief, poor transport infrastructure. The minimum endowment (non-medical goods and equipment) provided by the regulations in force (GD 324/2019) must be provided by the employing local administrative authority, and the emergency kit must be monitored/requested to the Ministry of Health through the Public Health Directorates. The lack of an office, but also an office inappropriate for the activity can question the quality of the services provided, the adequacy of these services to the health needs of the most vulnerable beneficiaries. The presence of community nurses in family doctors' practices must also be carefully analyzed: it may be the most suitable place to carry out the activity in the absence of an integrated community center. But, although the collaboration of community nurses with primary care providers (family doctors) is essential for increasing the access of vulnerable people to medical services, the relationship between the two professionals must remain very well defined, collaborative and not subordinate. The community nurse does not have to perform the activity for which the family doctor is responsible and reimbursed through the social health insurance system. And the part-time employment of community nurses by the family doctor can raise questions, from the possible reduction of the working time allocated specifically to uninsured/vulnerable people, to the possible double financing from public funds of the same services.

INTEGRATED COMMUNITY CENTERS

Community centers have been set up over the last eight years by local public authorities in some rural communities in response to the need for basic services for the vulnerable population. This approach has been made possible with the technical support of public institutions (e.g. NIPH), international organizations (UNICEF), or non-governmental organizations, with integrated community centers being regulated in the legislative context of social services and financially supported through externally funded programs. Capitalizing on the results obtained and to increase access to health services in poor and vulnerable communities, the Ministry of Health initiated the regulation of community health care (GEO 18/2017), two years later clarifying through methodological norms the organization, financing and operation of integrated community centers (GD 324/2019). The existence of the legislative framework is important, but the effective establishment of Integrated Community Centers (ICCs) remains a challenge in many ways.

The sole responsibility for the establishment and financing of integrated community centers, with or without legal personality, lies with local public authorities except for the provision of human resources from community health care provided from the state budget and medical personnel who will perform specialized services under contract with CNAS for which it is envisaged to amend the specific legislation in this regard. The poorer a community, the more difficult it is to ensure the long-term sustainability of a ICC, its operating costs, after the completion of projects that sometimes ensure the rehabilitation of space, the purchase of necessary goods and equipment, and staff.

Tailoring to local needs, the flexibility to set up ICCs according to the needs of the beneficiaries is a challenge. The establishment of an integrated community center is not easy, nor is the authorization and accreditation of services provided in an integrated system. The health, social and educational services provided in the community are located at the intersection of vertical systems (health, work and social protection, education), but under the responsibility of local authorities that also operate according to local public administration legislation.

Community health care legislation requires the existence of a minimum amount of space (six rooms), and of social staff with university education (social worker), in a context where at national level the number of social workers in rural areas is extremely low and social workers/officers from rural areas are/can be beneficiaries of competency trainings, in addition to the experience and good knowledge of the beneficiaries. And imposing a minimum number of spaces, although it can be considered beneficial from the perspective of integrating the services provided in the community, can bring difficulties in setting up a ICC, or, at the limit, can create legislative problems for community centers established before 2019 (e.g. those operating in modular system/container). For example, they are communes with an ageing population, where "room for school counselling/mediation/other educational activities, with separate entrance and separate toilets" included in the ICC minimum requirements is difficult to achieve, or are communities that do not they may / may not have a space with the minimum number of rooms required by regulations, but where the need for basic services is extremely necessary. Also the variety of health services may be limited by health system legislation. For example, for a remote rural community where medical services can be organized by deploying specialists to the community (an option that puts the patient at the center of care as a reality, not a statement) and can be effective for the health system, it is extremely difficult. The legislation for regulating the community health care foresees in the minimum requirements of a ICC " a space with minimum medical equipment in which consultations can be provided by the family doctor or by specialists who want to provide specialized medical services within a flexible system, including telemedicine and palliative services", but the financing of this type of service is not provided in the social health insurance system, the services cannot be reimbursed from public funds. The regulations regarding the authorization of medical offices are also restrictive for an ICC, requiring different rooms for medical and surgical specialties, and each room can be accredited maximum two specialties. In other words, in a ICC in which, for example, a neurologist and an obstetrician would come quarterly (in different weeks) to consult elderly and pregnant patients among the vulnerable population, according to health regulations that ICC must have at least two rooms with medical destination.

The collaboration of community health care providers with the family doctor and the provision in ICCs of consultations of specialist doctors for the examination of vulnerable patients close to home can directly contribute to reducing inequities in the access of the vulnerable population to health services. The option is one of health policy.

SERVICE MANAGEMENT AND PERFORMANCE MONITORING

The community health care is technically and methodologically coordinated by the Ministry of Health, through its deconcentrated structures in the territory, respectively the county and Bucharest Public Health Directorates (PHD). The ICCs together with the local public administration authorities are responsible for monitoring and evaluating the community health care activity.

The Ministry of Health monitors, analyzes and evaluates periodically and whenever necessary the services provided within community health care, through the PHD, to evaluate the efficiency and effectiveness of these services. The purpose of these evaluations is to adapt the community health care activity to the health needs of community members, especially those of vulnerable people, in order to improve access to health services and their health indicators.

The Ministry of Health controls the observance of the legislation specific to the organization, functioning and financing of the community health care activity.

The data regarding the activity of the community health care staff are reported in the functional application of the Ministry of Health AMCMSR.gov.ro, application that is currently in the process of restructuring, to improve the case management of the beneficiaries as well as the reporting functionalities, through the POCU project "Creating and implementing integrated community services to combat poverty and social exclusion".

By developing the functional online application, with the subdomain name AMCMSR.gov.ro, ensuring the protection of personal and medical data according to the legislation in force, the Ministry of Health has a standardized tool for data collection, analysis, planning, monitoring and evaluation of health care services. community health care at national level and real-time intervention in case of identification of high-risk medical and social situations. The application allows the analysis of indicators both on each locality, by county and at national level. Currently, reporting in the application of the ministry is mandatory as a result of the provisions of GD 324/2019. By analyzing the indicators calculated on the basis of the data collected and from the community diagnostic component of the application, it is possible to obtain the follow-up and timely implementation of monitoring, evaluation and control of community health care staff in order to improve health indicators of vulnerable groups. .

The population mapping (updated monthly) and the reporting of the activity of the community health care staff is done through the AMCMSR.gov.ro application.

COLLABORATION WITH OTHER ACTORS AT COMMUNITY LEVEL (FAMILY DOCTORS AND SOCIAL SERVICES)

According to the legislation in force, the community health care activity is carried out in an integrated system, by collaborating with family doctors' practices, social services and educational services, with other medical and social structures in the community and county, including non-governmental organizations. Staff providing Community health care activities:

a. works in collaboration with the staff of the family doctors' practices, with the staff of the public social care service, with the staff of the integrated community center and with other providers of health, social, educational services, including non-governmental organizations providing specialized services.

b. organizes and carries out joint actions with the social services from the mayor's office and staff from other structures at local or county level, in case of social issues that might affect the health status or access to medical services of the vulnerable person;

c. Collaborates with other institutions and organizations, including non-governmental organizations to implement medical and social programs, projects and actions that address medically, economically or socially vulnerable people or groups;

d. Performs integrated interventions with preventive measures and actions of social and educational assistance.

The case management, performed by the community nurse, is the mandatory working method used for the care of patients with rare diseases and represents the set of techniques, procedures and working tools that ensure the connection of the patient and their family with all specialists, experts, Centres of expertise in rare diseases and the medical, social and educational services they need, as well as the coordination of all care activities in the community, carried out in the interest of the patient. The working procedure is being developed and will be approved by order of the Minister.

EXAMPLES OF GOOD PRACTICE AND OPINIONS OF COMMUNITY NURSES

In large cities and municipalities, where community teams often have insufficient staff, the beneficiary population is large and distributed over large areas. The access of the vulnerable population to community health services suffers if the activity is not properly planned and prioritized according to needs.

Gorj county - Urban

Gorj County - the community health care team from Tg. Jiu, coordinated by PHD Gorj, organized and implemented in the municipality the national campaign "National Day of personal alcohol testing" in June 2019.

The AUDIT test was applied to 800 people and minimal advice was provided.

Neamt county - Rural

Neamt County, school health promotion activity

The health mediator organized a health education session with primary school children on the occasion of June 1.

The children were offered coloring books with health promotion messages and backpacks with school supplies.

Botosani county – home visits, care for the elderly

Botoșani County, activity for monitoring the health of the elderly

The Community nurse carries out home visits, in which monitoring of hypertension is a predominant activity, given the prevalence of this condition.

In April-May 2021, a series of interviews were conducted among community nurses from the 7 counties included in the project (Botoșani, Călărași, Dolj, Giurgiu, Gorj, Neamț and Suceava). We summarize below the opinions on special cases solved by the community nurses and proposals for the improvement of the community health care system.

Cases that community nurses proudly remember they managed to solve

"In July 2020, I was asked to take care of the wound of a 71-year-old man who had suffered a lower limb amputation. He lived with his mother. The old man told me disappointed that he had turned to a company that provides home care and that, after a month in which he had performed the wound dressing, he decided to give up the patient on the grounds that his leg would be amputated once again anyway. I encouraged him and decided to visit him daily and take care of the wound that had started to become infected. After about 4 months, the wound healed. I want to add that during all this time I went to the pharmacy every month to pick up his prescription, I helped him submit the file in order to benefit from a companion and sometimes also to make the groceries. " (community nurse, Călărași county)

"A minor from a disorganized family, physically and mentally abused by his mother and her concubine, he confessed to me during a home visit and asked me to help him go to an institutionalized center because the mother and concubine no longer want him to go to school. The child was dressed poor, dirty and hungry. I took him to the shops and bought him food and clothes. The maternal grandparents did not want to get involved either. I took the necessary steps to hospitalize him in an institutionalized center. Currently he is still in the center, he goes to school and comes on vacation to visit his mother. He always thanks me for everything I did for him. " (community nurse, Gorj county)

"A successful case in which I was directly involved was that of a family that asked me for help in obtaining identity documents for their little girl born in Spain. The mother left the maternity hospital in Spain without any proof of birth and the family immediately returned to Romania, crossing the border into the country with the child hidden in a bag. Together with the health mediator, I went to the Office of Population Evidence in Craiova, General Directorate of Social Care and Child Protection Dolj, Craiova Forensic Medicine service. In about 6 months I managed to get the birth certificate of the child. Currently, the child is enrolled in kindergarten and at the family doctor, she has all the vaccines provided in the National Immunization Program according to age. " (community nurse, Dolj County*)*

"A 38-year-old pregnant woman, mother of 9 children, was detected only in the third trimester of pregnancy. I registered her with a family doctor and accompanied her to a specialist for investigations and analyzes. The woman gave birth to a child with Down Syndrome. I contacted the neonatologist at the hospital and discussed the care of this child. The child was registered with the family doctor and I visited him daily for the first few weeks. The mother, although counseled about the child's illness, refused to accept the diagnosis. The family was supported to go to a hospital in Bucharest for a specialized consultation and the mother was accompanied to the General Directorate of Social Care and Child Protection for disability. Currently, the child is constantly monitored by me together with the family doctor and a specialist doctor and I can say that he develops according to his age and illness, he goes to kindergarten. " (community nurse, Giurgiu county)

Asked what should be improved, the community nurses mentioned the need for more intensive support from the authorities. Provision / disbursement of transportation, medical kit and consumables are considered *important by all community nurses.*

"I think that local public authorities should be more involved in community health care." (community nurse, Calarasi county)

"…. Tasks that we have to do, although they are not in our attributions but those of the mayor's office employees. And we also want a disbursement or provision of transportation in the filed. The City Hall sends us to the PHD to request the disbursement, and the PHD to the City Hall. We are sent from one side to the other and no one supports us." (community nurse, Suceava County).

"… We still need the support of local authorities, materials of various types (informative, various and quality medical materials) financial support regarding the transportation of CN in large communities and / or means of transportation, laptops, telephones and pre-paid cards or phone subscriptions, experience exchanges, trainings." (community nurse, Neamț County)

"We need more consumables" (community nurse, Dolj County)

"Equipment with medical kit according to HG324 / 2019, access to transportation or disbursement of transportation in the locality where we work, provision of disposable equipment, masks, gloves and raincoat, and access to communication infrastructure, telephone, laptop or PC and Internet. " (community nurse, Botoșani county)

IV. CHALLENGES AND NECESSARY REFORMS

COMMUNITY Health care SERVICES DURING THE SARS COV2 PANDEMIC

In the context of the pandemic caused by SARS-CoV2 virus, the Ministry of Health drafted and proposed for approval Ministerial Order 725 on establishing measures to support vulnerable people in isolation at home, as a result of measures to limit the spread of COVID-19.

Based on the provisions of GEO 18/2018, GD 324/2019 and WHO 725, community health care staff provided community health care services to the population at the level of the communities they serve, regardless of the status of medical or social vulnerability. During the emergency and alert states, they performed the epidemiological triage in the school units where there is no employee providing school health care services, both during the national exams and from the beginning of the 2020-2021 school year.

Community health care staff has provided and continues to provide the following community health care services in a pandemic context:

- field verification of compliance with the measures imposed on persons in isolation at home, by carrying out home visits;
- monitoring the health status of isolated people at home, especially those who are not registered with a family doctor;
- identification of persons with a history of international travel and immediate adoption of appropriate measures, in accordance with the legal provisions in force, and under the coordination of the epidemiologist within the county / Bucharest PHD;
- distribution of food to people in isolation at home and to those with medical and social problems;

- monitoring of persons over 65 years of age living alone;
- distribution of medicines for people in isolation at home, according to the doctor's indication;
- Home visits to beneficiaries discharged from the hospital in need of medical care;
- field verification, at the request of the county and Bucharest PHD, by making home visits to persons who have returned from abroad and who have not duly completed the declaration upon entering the country, obtaining the appropriate data and submitting them to the representatives of the county/Bucharest public health directorates;
- informing and raising awareness of members of the local community about the recommendations on responsible social behavior in order to prevent the spread of SARS-CoV-2 virus, as well as on the conduct to be followed by people in self-isolation, in accordance with the recommendations issued by specialists of the National Institute of Public Health;
- sending to the county/Bucharest PHD, using the electronic means of remote transmission, the declarations for the persons identified at community level.

According to the UNICEF study (20) mentioned above, community nurses reported a variety of activities in which they took part in 2020 in the context of the COVID 19 pandemic: identifying and monitoring people with COVID-19, people in self-isolation, those returning from abroad; information, education, counseling on epidemic prevention and control measures (e.g. the importance of wearing a mask, hand hygiene, maintaining the physical distance, the importance of self-isolation); procurement and distribution of food and medicines to the homes of the people isolated, quarantined or at high-risk; purchase and distribution of personal protection equipment (masks, gloves); conducting social surveys for isolated people at home for food distribution; regular reporting on people in solitary confinement and quarantine; participation in the evacuation of persons at risk, in order to stay in quarantine centers; activity in quarantine centers; measuring body temperature; participation in triage activities at border crossings; security activities in the mayor's office and community patrols; documentation on regulations ("study of the Official Gazette during the pandemic").

RECOMMENDATIONS - STRATEGIC DIRECTIONS FOR THE DEVELOPMENT OF COMMUNITY Health care

Community health care services are an integral part of public health services, and in communities without a family doctor they are an alternative to accessing health services, particularly for the vulnerable population. Integrated social and health services provided in the community, close to the vulnerable, contribute substantially to increasing social inclusion as well as maintaining health by promoting health-friendly behaviors, early detection of diseases and delaying their complications. And at the systemic level, the provision of primary, secondary and tertiary prevention services in the community can bring multiple benefits, from limiting the excessive use of specialized health services, to ensuring the medium and long term sustainability of the social health insurance system, burdened by a chronic shortage of doctors and the lowest public health expenditure among the Member States of the European Union.

The option is one of health policy. If the vision of integrated community centers and community health care is primarily to maintain health by promoting health-friendly behaviors and early detection of disease, then the regulatory framework exists. If the vision of integrated community centers is to contribute to a sustainable health system, focused on the needs of the population and universal health coverage, including the most vulnerable citizens and communities, then flexible regulations are needed, which favor structures flexible ICCs tailored to the specific needs of each community.

Collaboration of community health care providers with the family doctor, organizing screening programs and ensuring access to investigations and treatment, providing consultations of ICC specialists for the examination of vulnerable patients near their place of residence, well planned and systematically provided, can change the paradigm of the health system in a system in which the hospital is no longer the center of health services. In order to work, the new model must

also find solutions for the access of vulnerable people to investigations and compensated or free treatment outside the hospital.

Some recommendations for stakeholders:

Ministry of Health

- Further expand the national health care network at national level, with priority in poor rural communities and/or without a family doctor;
- To ensure the financial sustainability of the Community health care activity; poor communities are the first beneficiaries of community health care and they will not be able to ensure sustainability;
- Regularly evaluate the legislation (including sectoral legislation) governing Community health care, including integrated community centers, and initiate legislative changes, as appropriate, to ensure a flexible regulatory framework tailored to the specificities of each community. To use in this end the conclusions and recommendations resulting from the various projects being implemented, including this case study;
- Use a systematic way of assessing needs and setting priorities for intervention;
- Review the information system, which currently provides little relevant information on the access of vulnerable groups to health services, using the opportunity for restructuring. Include in the evaluation system of the Community health care activity the measurement of the level of satisfaction of the beneficiaries. Make this information system interoperable with other health and social information systems;
- Establish transparent and flexible rules for distance medical services (telemedicine);
- To regulate the professional relationship with the family doctor, with the other service providers (from the community team, from the community, with the specialized services);
- To develop and plan together with the National School of Public Health, Management and Improvement in the Health Sector the national specialization program in community health care, in a modular system, so as to: allow the participation of employed community nurses, to subsidize (totally or partially) tuition costs, to contain a methodology for ensuring the quality of the training process, in particular the practice component;
- Regulate and plan together with the competent authorities a framework program for continuing medical education, adapted to the specifics of the Community health care activity; to monitor and evaluate annually the implementation at county level of county EMC programs adapted to local needs, the quality of these programs;
- Ensure a predictable career plan for the community health care providers to ensure job stability and recognition of the professional role in the community, including planning in advance the retention of staff employed with external funds (projects) after the completion of projects;
- Plan systematic, results-based campaigns to promote community health work to increase understanding of its role and importance among all stakeholders (from policy makers to local authorities and the general public);
- To plan a national framework for systematic actions and interventions of health education, and of making people vulnerable people aware of the responsibility for their own health, as well as of community awareness (barriers to

access to health services also include attitudes, level of understanding, information , and education, of the general population, in particular of vulnerable persons / groups);

- To monitor the sending of data/information from the PHD provided in the legislation and to publish the annual report foreseen by the legal regulations in force. Develop a unitary community health care activity reporting structure to be used by the PHD;
- To strengthen the capacity of the Social Inclusion Unit within the MoH.

County Public Health Directorates / DSP

- To establish and / or strengthen the service of the community health care in the PHD, to improve the activity of technical and methodological coordination, regular monitoring and evaluation of the community health care activity, and of the quality of these services;
- To initiate a county program of regular meetings with the employers of community health care providers (standardization of working tools, analysis of activity according to job description, relationship with primary health care / existence or need to formalize the collaboration) improving working conditions for community nurses, needs of support from the PHD which is in their competence); the gradual extension of regular meetings to communities without community health care;
- Propose to the central authorities necessary changes to the regulatory framework based on locally identified issues;
- Identify with local authorities the priority health care needs for the vulnerable population, including those To plan annually with the professional authority (OAMMR) the assessment of the needs for professional development and continuing medical education and to develop the annual program of continuing medical education and training for community health care providers with an emphasis on the practical component training identified as most needed;
- To plan and implement each year county level campaigns, based on results, to promote the community health care activity in order to increase the understanding of its role and importance among all stakeholders (from local decision makers to local authorities and the general public);
- To effectively send data/information to the MoH provided in the legislation and to make the quarterly reports and the annual report provided by the legal regulations in force. To draw up these reports on the basis of a unitary structure for reporting on the Community health care activity developed by the MoH;
- Creating/strengthening the capacity of the at-risk community compartment within the PHD.

Local authorities and other employers of community health care providers

- Observe the activities in the job description of community health care providers; if necessary, to revise with the support of the PHD the job descriptions of the community nurses according to the attributions from GD 324/2019;
- To plan and ensure (gradually) decent working conditions, and facilities for the optimal development of the community health care activity, in particular means of transport/disbursement of transportation costs, as the case may be;

- To facilitate/mediate the relationship within the community team and in the relationship between community health care providers, with the family doctor and professionals or institutions at local and/or county level;
- To request support whenever needed from the county PHD and the Municipality of Bucharest, for the development of the community health care activity;
- Get involved in identifying and providing support for local human resource development that is involved in community care activities;
- To motivate community nurses and health mediators to work in the community, to provide incentives for the coordination of medical and social care and for good collaboration for the benefit of the patient.

Beneficiary population of community health care services

- Be regularly consulted on their own health needs and the inclusion of proposals in the local care plan;
- To express their opinion on health promotion campaigns, what would be the topics of interest to them and especially what educational materials would be useful to them;
- Contribute, together with the community nurses, to the care plan.

ACRONYMS

Communiy nurse - CN

National Health Insurance Fund - NHIF

Integrated Community Centres - ICC

Public Health Directorates – PHD

National Institute of Public Health – NIPH

Ministry of Health - MoH

Operational Program with Human Capital - POCU

Administratvive territorial subdivizion – SAT

European Union - EU

Administratvive territorial unit - UAT

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