Program Information Documents (PID)
BASIC INFORMATION

A. Basic Program Data

<table>
<thead>
<tr>
<th>Country</th>
<th>Project ID</th>
<th>Program Name</th>
<th>Parent Project ID (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romania</td>
<td>P169927</td>
<td>Romania Health Program for Results</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Appraisal Date</th>
<th>Estimated Board Date</th>
<th>Practice Area (Lead)</th>
</tr>
</thead>
</table>

Financing Instrument | Borrower(s) | Implementing Agency |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Program-for-Results Financing</td>
<td>Romania</td>
<td>Ministry of Health</td>
</tr>
</tbody>
</table>

Proposed Program Development Objective(s)

The Program Development Objective (PDO) is to increase the coverage of primary health care for underserved populations and improve the efficiency of health spending by addressing underlying institutional challenges.

COST & FINANCING

SUMMARY (USD Millions)

<table>
<thead>
<tr>
<th>Government program Cost</th>
<th>55,473.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Operation Cost</td>
<td>4,803.00</td>
</tr>
<tr>
<td>Total Program Cost</td>
<td>4,803.00</td>
</tr>
<tr>
<td>Total Financing</td>
<td>4,803.00</td>
</tr>
<tr>
<td>Financing Gap</td>
<td>0.00</td>
</tr>
</tbody>
</table>

FINANCING (USD Millions)

<table>
<thead>
<tr>
<th>Total World Bank Group Financing</th>
<th>570.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank Lending</td>
<td>570.00</td>
</tr>
<tr>
<td>Total Government Contribution</td>
<td>4,233.00</td>
</tr>
</tbody>
</table>
B. Introduction and Context

Country Context

1. **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 because of low fertility and high premature mortality, as well as high levels of migration. This has resulted in a population with a relatively old demographic structure. The old age dependency ratio – that is, the number of people aged 65 and over as a share of the working age population – is 27 percent.

2. **Romania’s membership in the European Union (EU) has triggered an important positive socioeconomic and political transformation in the country.** Since joining the EU in 2007, Romania 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, enabling 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.

3. **Following parliamentary elections in December 2016, Romania is governed by a coalition of the Social Democratic Party and the Liberal-Democratic Alliance.** In January 2018, the coalition appointed a Cabinet led by Prime Minister Viorica Dăncilă, the first woman to lead the Romanian Government. The Government’s priorities for 2017-2020 include investments in infrastructure, health care, education, agriculture, job creation, small and medium enterprise development, and tax and pension reforms. The first two years of the coalition have been marked by a high turnover of ministers – three prime ministers and over 70 ministers have taken office since the December 2016 elections – which has affected the predictability of policymaking and the investment climate.

4. **Despite political volatility, Romania enjoys high rates of economic growth, but with widening macroeconomic imbalances.** Romania’s economy grew by 7 percent in 2017 and 4.1 percent in 2018, driven by consumption, investment, and exports. The information and communication technology (ICT) sector is one of the most dynamic in Europe, but foreign direct investment inflows of around 2 percent of GDP per year remain below potential. High economic growth and external migration have triggered labor shortages for both skilled and unskilled jobs. In 2017 the Government promoted a series of procyclical fiscal measures, mainly tax cuts (value-added, income, profit) and pensions and public sector wage increases. These measures boosted private consumption, leading to a peak in inflation in May 2018, at 5.4 percent, and the widening of the current account deficit, which reached 4.7 percent of GDP by the end of 2018. Although recurrent public spending expanded by 16.5 percent in 2018, the fiscal deficit was contained at 2.9 percent of GDP, but at the expense of the investment budget. Public debt, at 42.1 percent of GDP as of November 2018, remains one of the lowest in the EU. A slowdown in Romania’s export markets in the EU, mainly Germany and Italy, could generate important adverse effects on domestic growth and investment, which could be exacerbated by the uncertainty in fiscal policy and the tightening labor market. The partial decoupling of real wage growth and productivity could also affect Romania’s competitiveness, adding upward pressures on the current account deficit.

---

1 Source: Ministry of Public Finance (MoPF).
5. **Economic growth has reduced poverty, although poverty rates remain higher in rural areas.** In line with robust economic growth, increased private consumption, and labor market improvements, the country’s poverty rate (using the poverty line of US$5.50/day, 2011 purchasing power parity), which peaked at nearly 32 percent in 2012, is estimated to have declined to 22.3 percent in 2018, from 25.6 percent in 2015. The incomes of the bottom 40 percent of the population were boosted by employment gains in sectors with a large share of low-skilled workers (Figure 1). The impact has been stronger for those in the bottom 80 percent of the income distribution, who have seen an increasing share of total income over this period. This has contributed to a reduction in inequality, reversing the rise in the Gini index that occurred between 2010 and 2016. Although poverty has declined in both rural and urban areas since 2014, in 2016 poverty rates in rural areas remained six times higher than those in cities and just over twice as high as those in towns and suburbs.

6. **Although Romania has made progress, its continuing large social and spatial disparities in inclusion present a significant development challenge.** The country’s incomplete structural transformation is associated with an uneven spatial distribution of opportunities: 45 percent of the population still resides in rural areas, where poverty is substantially higher. Disparities in living standards between urban and rural areas are striking: 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; in some counties in the North-East region, the poverty rate is more than 10 times higher than in Bucharest (see Figure 2).

![Figure 1. A large share of the bottom 40 percent has limited access to work or relies on subsistence agriculture](image1)

![Figure 2. Romania is characterized by wide disparities in income.](image2)

7. **This strong duality is a manifestation of unequal opportunities and unequal access to markets that has no parallel in any other EU country.** Disparities in endowments (notably human capital) and various factors that influence the returns to endowments combine to shape the high social and regional disparities, and fiscal policies have failed to counter high levels of inequality. Health insurance coverage

---

2 Source: 2016 Household Budget Survey.
for example, is 52 percent among the poor\(^3\) compared with 94 percent among the non-poor. Much lower among the poor. To counter the consequences of a population that is shrinking and aging—largely because of the external migration of working-age people—Romania urgently needs to enhance equality of opportunities, between groups and across regions, to foster broad-based improvements in living standards and allow those at the bottom to contribute more actively to economic growth, triggering a virtuous cycle of inclusive growth and development.

8. **The 2015-2020 Government Strategy on Social Inclusion and Poverty Reduction acknowledges the need for tailored social services targeting vulnerable groups.** The Government’s strategy defines vulnerable groups irrespective of poverty levels, as they face other barriers to social service access. The main categories of vulnerable groups it identifies are poor people, children, youth deprived of parental care and support, lone or dependent elderly people, Roma, persons with disabilities, people living in marginalized communities, and other vulnerable groups.\(^4\) In 2013, these categories covered an estimated 1.85 million Roma, 1.4 million poor children aged between 0 and 17 years, over 725,000 people aged above 80 years, 687,000 children and adults with disabilities living in households, 16,800 children and adults with disabilities living in institutions, 62,000 children living in placement centers or family-type care, and 1,500 children abandoned in medical units. The strategy noted that vulnerable groups require targeted interventions to increase their social and economic participation.

9. **Despite significant progress, Romania’s fundamental institutions remain weak and hinder progress in building an inclusive society, promoting growth, and strengthening human capital.** Disparities in economic opportunity, poverty, and access to essential services across the country are most pronounced between urban and rural areas. Lack of access to essential services for some segments of the population reinforces the notion of “two Romanias”—one urban, dynamic, and united with the EU; the other rural, poor, and isolated. While de jure Romania has adequate structures in place, de facto implementation of key governance functions and legislation is poor. Political instability and the frequent turnover of ministers results in limited continuity and implementation of policies, while weak coordination between government levels and agencies undermines the efficiency of public financing. Underfinancing of social sectors, such as health and education, results in poor quality and prevents Romania from achieving its human capital potential.

10. **To boost human capital—a central driver of sustainable growth and poverty reduction—Romania has made substantial progress in improving health outcomes and educational attainment over the last two decades, but challenges remain.** Between 1990 and 2016, life expectancy in Romania increased from 69.7 to 75.0 years, while under-five mortality declined from 31.1 to 8.5 deaths per 1,000 live births. Expected years of schooling were at 12.2 years in 2017, but because the quality of education

---

\(^3\) The poor is defined as those at-risk of poverty, with income below 60% of the median equivalized income.

\(^4\) This category includes persons suffering from addiction, persons deprived of freedom or on probation, homeless people, victims of domestic violence, victims of human trafficking, refugees, and immigrants.
is low, children receive only about 8.8 years of learning. This translates into Romania’s relatively low human capital index of 0.60, which is significantly below the predicted values for its income level and puts the country in 67th place out of 157 countries surveyed. This indicates that a child born in Romania today will only be 60 percent as productive as an adult as he/she would be with a complete education and full health.

**Sectoral and Institutional Context**

11. **Health services in Romania are delivered through a complex network of public and private providers.** Box 1 presents brief definitions of the types of care and related providers. Most health services (including Primary Health Care (PHC), specialist care, inpatient care and palliative care) are contracted by the National Health Insurance House (NHIH), while community health care and emergency care are financed through the Ministry of Health’s budget.

**Box 1. Brief definitions of different types of care**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community health care:</strong></td>
<td>At the community level, 1528 community health nurses and 484 Roma health mediators are employed by Local Public Administration Authorities, and are involved in health education, surveillance of infectious diseases, and follow-up of treatment initiated in primary or specialist health care. Community health care providers refer to both community health nurses and Roma health mediators.</td>
</tr>
<tr>
<td><strong>Primary health care:</strong></td>
<td>Primary health care and family medicine are used interchangeably in Romanian context. It involves basic, rather than specialized services, for most adult and childhood conditions, including diagnosis, treatment, and follow-up. There are 12,185 family physicians, who are primary health care providers and work in private family medicine practices (mostly solo practices).</td>
</tr>
<tr>
<td><strong>Specialist care:</strong></td>
<td>Care is provided within a specific area of medicine, in inpatient and ambulatory settings*, including 3125 outpatient providers and over 560 hospitals.</td>
</tr>
<tr>
<td><strong>Inpatient care:</strong></td>
<td>Medical treatment that is provided in a hospital or other facility and requires at least one overnight stay. There are 6.3 beds per 1,000 in Romania. About 96 percent of inpatient hospital beds belong to public hospitals, which are increasingly under the responsibility of the local public administration authorities.</td>
</tr>
</tbody>
</table>

* Ambulatory settings include medical centers, polyclinics, physician offices, centers for diagnosis and treatment, and hospital outpatient departments. Except for hospital outpatient departments, other ambulatory settings are mostly private.

12. **Despite significant progress since joining the EU, Romania lags on health outcomes and service utilization.** While health outcomes have improved over the past two decades, they remain below the EU average. Healthy life expectancies in Romania—57.9 years for women and 58.6 years for men—are lower than the EU averages of 61.5 years and 61.4 years for women and men, respectively. Furthermore,
national averages hide subnational disparities 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.\(^5\) 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. Diabetes Mellitus is a significant contributor to the burden of disease among adults. The number of years lived in disability, attributable to Diabetes, increased by 10.4 percent between 2007 and 2017, more than any other single disease in Romania.\(^6\) Romania’s rate of amenable mortality, that is mortality preventable through access to essential health services and public health interventions, is the highest in the EU for women and the third highest for men (Figure 3), signaling opportunities for improving health outcomes through higher access to health services. Moreover, early deaths from preventable diseases and their complications are concentrated in the poorest 40 percent of the population.

Figure 3. Amenable mortality rates in EU countries in 2015

Source: Eurostat.

Spending on Health

13. **Poor health outcomes and low service utilization are a function of low and inefficient health spending.** Despite a growing trend in the past, Romania spends less than 5 percent of GDP to health care, compared to an average of about 10 percent in the rest of the EU. Public spending constitutes 78 percent of current health expenditure, and 80 percent of it is pooled by the NHIH, the purchasing agency for health services. Only 0.3 percent of health spending is funded through voluntary private insurance.\(^7\) The Public Expenditure Review conducted in 2017 identified major sources of inefficiency in health spending. First, health spending is skewed toward hospitals rather than PHC, which is a cost-effective means of service provision in EU countries with lower rates of amenable mortality. The NHIH allocates 55 percent of expenditures to inpatient care, and only 6 percent of its health budget to PHC. Second, decentralized

---


\(^7\) Eurostat, 2015.
procurement of medicines and medical devices, and limited implementation of innovative pharmaceutical policies, represent missed opportunities for efficiency gains. Between 2006 and 2017, they accounted for 37.5 percent of health spending, more than double the EU average. In addition, the state budget transfers to the NHIH—which have averaged US$500 million annually over the past five years—are used predominantly to cover deficits in the NHIF, creating disincentives for the NHIH to operate efficiently.

14. **With a public funded health sector, the Government needs to introduce efficiency discipline in managing public expenditure so that health outcomes will be improved in a financially sustainable manner.** Acknowledging Romanian spending is at the low end among EU countries, global experiences prove that it is essential to put in place efficiency enhancement mechanisms first. If hospitals or health insurance funds are guaranteed to be bailed out when they have deficit, there will be no motivation to control cost and cut deficit. Consequently, this affects countries’ fiscal ability to cover the vulnerable groups as they should. With an efficient system that assures funds will not be wasted, it will improve the sector’s financial sustainability and facilitate increased share of the sector through reprioritization in the medium and long term. Health spending is normally driven up by an ageing population, increased prevalence of chronic diseases, rising prices of inputs and technology development; Total public health spending in Romania has increased from US$ 7.0 billion in 2015 to US$10.6 billion in 2018. Savings from efficiency improvement, therefore, often leads to a lower expenditure level than otherwise would have been (i.e., a slowdown in growth), but not an absolute reduction in health spending level.

15. **Significant gains in efficiency could be made by redirecting expenditures from hospitals toward PHC.** Family physicians have a gatekeeping role in Romania, but bypassing them is allowed for urgent or emergency conditions. However, because of both supply- and demand-side barriers (see Box 2 and Figure 4), PHC is underused; many patients delay seeking care or choose emergency services and specialists for care that could be provided in PHC settings. Furthermore, even for patients who have access to PHC, the effectiveness or quality of such services can be poor, so that health outcomes are suboptimal (Box 3). Bypassing PHC misses many other opportunities for prevention and cost-effective management. In 2013, the number of PHC contacts per person per year in Romania was 4.8, lower than the EU average of 6.9.8


The cost of these inefficiencies is high. In 2018, at least US$400 million of hospital spending could have been avoided through effective PHC. Hospital expenditure has been a major driver for the insurance fund’s deficit that demands the state’s bailout. By redirecting expenditures from hospitals toward PHC, growth in hospital expenditure is expected to slow down as preventable hospital admissions will be avoided, and hospital resources will focus on complex cases who truly need medical attention from hospitals.
Box 2. Barriers to access to PHC faced by underserved populations

Underserved populations refer generally to groups that face supply-side or demand-side barriers to health care use, including 1) the uninsured and the poor*; and 2) people living in local authorities that lack a family physician or in rural local authorities with a low density of family physicians. Vulnerable groups (defined in paragraph 8), such as Roma population, are overrepresented in both categories.

- **Supply side.** Residents in rural and remote areas are more likely to face physical barriers to health care access because there are few or no family physicians in these locations. Up to 90 percent of local authorities lacking a family physician are rural.

- **Demand side.** Financial barriers arise because of lack of health insurance, predominantly among informal workers, those who lack identity cards, and unemployed people who are not registered for social benefits. An estimated 2 million people do not have health insurance, hence access to basic package of PHC services. More than 60 percent of them are poor; 86 percent belong to the bottom 40 percent of the income distribution. However, even when insured, the poor may also face financial difficulty in accessing the care they need because of the copayments required for medication.

- **Demand side.** Vulnerable groups, including the Roma, also face social barriers to health care access, because their knowledge about benefits related to health services and their understanding of how to navigate the health system are limited.

- Among vulnerable groups, financial, physical, and social barriers often overlap. For example, 50 percent of Roma are not insured, and 9 percent are not registered with a family physician, compared to 14 percent and 4.5 percent in the general population.
Figure 4. Barriers to access to health services faced by underserved populations

- **Financial barriers**
  - Uninsured
  - Poor

- **Physical barriers**
  - Rural
  - Remote

- **Social barriers**
  - Roma
  - Other vulnerable groups
Box 3. Barriers to PHC effectiveness

Effectiveness of PHC services is compromised by the limited scope of care provided by family physicians and the way they are being paid, resulting in underuse of these services.

- **Scope of care.** Clinical guidelines do not allow family physicians to initiate care for several ambulatory care sensitive conditions, including diabetes, asthma, chronic obstructive pulmonary disease, psychiatric conditions, and chronic pain. The scope of PHC has been reduced over the past decades: between 1993 and 2012, the probability of a primary care physician referring minor technical procedures to a specialist increased by 20 percent.\(^1\) For example, Diabetes Mellitus can be appropriately diagnosed, treated, and followed-up at the PHC level, with referrals to relevant specialists for complications as needed, as is the norm in strong health systems in high-income countries\(^1\). However, the 2016 Country Profile for Romania revealed that PHC does not have basic medicines and technologies needed to manage Diabetes effectively, including prescriptions (for metformin, sulphonylurea, and insulin), HbA1c test, and urine strips for glucose and ketone measurement. As a result, family physicians are bypassed by patients seeking care directly from diabetologists or from emergency services for preventable complications at significantly higher costs to the system.

- **Provider payment methods.** Family physicians are paid on the basis of capitation (a fixed rate per capita) and fee-for-service (a price schedule for service activities). The best practice is to fully adjust capitation rate by disease risk, so that providers do not reject high risk group; at the same payment level, high risk group brings less income to providers due to their frequent use of care. However, capitation rate is adjusted for age only in Romania, and requires further adjustment for other determinants of disease risk such as gender and historical utilization patterns. Moreover, the volume of claims reimbursed on a fee-for-service basis, including preventive and case management services, is capped at 20 services per day, resulting in the undersupply and underreporting of these services. Performance-based payments for quality or service coverage targets have not been implemented.

16. **Decentralized procurement of drugs and medical devices by health care facilities presents a missed opportunity for economies of scale and efficiency gains.** Currently, over 350 public hospitals individually procure almost all medicines, medical supplies, and medical devices. This leads to a lack of standardization and multiplies the amount of administrative procurement activity. Information on the numerous procurement processes, including tendered prices, is not routinely shared through formal channels between hospitals or with the Ministry of Health (MoH) to inform procurement practice. Initial analyses point to substantial differences between unit prices of identical goods in individual hospitals, so that there are ample opportunities for savings. In 2017, EUR 1.3 billion expenditure on medical products could have benefited from centralized procurement. If all hospitals implement centralized procurement of medical products, it can lead to annual savings of US$ 300 million. The weak public procurement system prevents the Government from making the most effective use of public funds. Previous efforts to expand
centralized procurement (e.g., developing annual plans for centralized procurement in the MoH) were compromised by limited institutional capacity and faced sustainability challenges.

17. **Although innovative pharmaceutical policies have been adopted to improve the efficiency of the health system, their implementation is limited.** Romania has introduced some of the best global practices in pharmaceutical policy, including external reference pricing\(^9\), health technology assessment (HTA)\(^10\), clawback taxes\(^11\), and managed entry agreements (MEAs)\(^12\), but their design and implementation require substantial adjustments to ensure value for money. Price referencing is not regularly implemented, and the HTA does not consider the cost-effectiveness of medicines in the Romanian context. Moreover, it appears that the introduction of regulatory measures to control prices has disproportionately affected some of the old and very cheap generics, which the pharmaceutical companies have withdrawn from the market because they are no longer profitable. There are also concerns that the lower prices of some medicines in Romania compared to other EU countries may lead to parallel exports, jeopardizing access to certain innovative medicines. The number of medicines under MEAs, approximately 30 in 2018, is much lower than in other countries in the region. Strengthening and updating of the existing pharmaceutical policies would put Romania in line with the EU and neighboring countries and significantly strengthen efficiency in spending on medicines.

**Institutional Factors**

18. **In addition to the broader challenge of socioeconomic inclusion, institutional factors underlie the barriers to access and drivers of inefficiency in the health system:** fragmentation in institutional coordination, misalignment of incentives in public financing relative to the goals of access and efficiency, and limited implementation capacity in key institutions. A review of health care reform experiences\(^13\) in Europe reveals that other countries in the region with stronger health systems than Romania, invested in addressing structural problems in health service delivery\(^14\). These investments essentially address the

---

\(^9\) External reference pricing (ERP, is also known as international reference pricing) refers to the practice of using the price of a pharmaceutical product (generally ex-manufacturer price, or other common point within the distribution chain) in one or several countries to derive a benchmark or reference price for the purposes of setting or negotiating the price of the product in a given country. Reference may be made to single-source or multisource supply products.

\(^10\) Health Technology Assessment is the systematic evaluation of the properties and effects of a health technology, addressing the direct and intended effects of this technology, as well as its indirect and unintended consequences, and aimed mainly at informing decision making regarding health technologies.

\(^11\) Clawback Tax is the amount that pharmaceutical companies have to return to the state when public spending on drugs exceeds the amount budgeted for.

\(^12\) Managed Entry Agreements are contractual agreements between the marketing authorization holder (MAH) and health care payers that enable access to a health technology subject to specified conditions.


\(^14\) These investments include adopting policy instruments to shift care from hospitals to primary care (such as incentive-based physician payment systems and need-based planning), using management information systems to monitor and reward performance, and promoting efficiency.
institutional barriers that have been identified as constraints to expanding access and efficiency in Romania – miscoordination, misaligned incentives, and gaps in implementation capacity.

19. **Poor coordination among multiple agencies hinders the design and implementation of policies to improve access to care and efficiency in health spending.** At the national level, the MoH is responsible for defining the general objectives and regulatory framework of the health system, while the NHIH manages the National Health Insurance Fund (NHIF), through which health services are reimbursed. The MoH funds preventive programs, and the NHIH is responsible for curative care, but there is little coordination between the two entities. The Ministry of Public Finance (MoPF) oversees the management of health care financing. In practice, the state budget transfer to the MoH is mainly based on agreed line items (e.g., administrative wages, capital investment, ambulance services) and historical trends, without explicit links to sectoral priorities. Local authorities are responsible for providing PHC facility operating spaces, funding operating costs, and supplementing personnel costs for community health care, but are often excluded from national health strategy. Coordination challenges at the institutional level are also reflected at the service delivery level. The implementation of community health care requires coordination among the MoH, to pay personnel; the local authorities, to employ the personnel and provide for operating costs; district public health authorities (DPHAs), to supervise service delivery; and family physicians, who ensure continuity of care between PHC and community health care. While in principle, community health nurses and Roma health mediators, who provide community health care, should coordinate with family physicians, only 20 percent of family physicians report regular meetings with community health personnel. There are no official protocols for community health care, for coordination with family physicians, or for supervision by DPHAs.

20. **Fragmentation of information, low quality of data, and limited use of data for decision-making hinder the transparency and accountability of the health system.** Although large amounts of data are collected, they are not visible to all stakeholders in the health system, and health data analysis at the national level is incomplete and inefficient. The NHIH databases, although rich in information content, are mostly related to the core business of insurance and are not easily available to the MoH and other stakeholders. The quality of data collected from providers and institutions is low. Data are incomplete, fragmented, unreliable, unstructured, non-standardized, and non-electronic. As the National Health Strategy recognized, there is no systemic data governance framework in place to address data quality and efficient exchange between data producers and consumers. The MoH lacks the stewardship capacity to deal with the fragmentation of health information and to coordinate across agencies. No agency or MoH unit is responsible for improvements in data governance and management within the health system and with other sectors. The lack of central medical data exchange services and the limited coordination of provider information systems present significant institutional and technical barriers for the introduction of patient-centered health care models in which services are coordinated across providers and levels of care. Although most providers do have some sort of computerized information system, the lack of a data governance standardization platform prohibits the efficient introduction of performance indicators and quality assurance mechanisms, which are needed for performance-based payment methods.

21. **The public financing system creates incentives that are inconsistent with reducing inefficiencies and disparities in access to care.** Recognizing the inefficiency of a system of service delivery that is heavily skewed toward inpatient care, the Government of Romania (GoR) has identified PHC as a central component of the National Health Strategy 2014-2020. However, the allocation of NHIH budget to PHC has remained flat, around 6 percent, since 2012. NHIH mostly uses its annual state budget transfers to fill the deficit in NHIF, rather than to achieve service delivery results, so it has no incentive to operate

---

efficiently. As Box 3 explained, the effectiveness of PHC is limited by the way family physicians are paid by NHIH; family physicians have no obligations or financial incentives to improve service conditions, as local authorities own the PHC facilities and NHIH historically underfunds them. The status of family medicine practices as small private businesses also makes it difficult for them to access public funding for improving supply conditions. Finally, the fact that contracting mechanisms are tailored to budget classifications perpetuates fragmentation in service delivery and misses the opportunity to stimulate the coordination of services across the continuum of care.  

22. While some reforms have been introduced to improve the governance and accountability of public financing, the roles and responsibilities of implementing agencies are not clearly defined, and their capacities are limited. The delegation of some regulatory functions to newly established agencies is a step in the right direction, but its success will require substantial capacity building and clear delineation of functions. The National Authority for Quality Management in Health Care, established in 2015, cannot assess the quality of facilities in the absence of quality indicators. The National Agency for Medicines and Medical Devices relies on an ineffective HTA methodology that does not consider the cost-effectiveness of medicines in the Romanian context. Although a centralized procurement agency – the National Office for Centralized Procurement (ONAC) – was recently established, it does not yet have the mandate to procure goods and services for the health sector. The under-staffing of Government institutions, an indication of mismatching between stated government priority and resources allocation, continues to present significant challenges: for example, the Community Health Unit within the MoH that is tasked with the development of community health programs has only one staff.  

23. Efficiency gains and access to services by underserved groups can be achieved only by addressing the institutional barriers that hinder effective implementation of the country’s strategies and policies. The National Health Strategy aims to restructure the inefficient pyramid of services and to gradually ensure wider coverage of the population’s health needs through the provision of services at the foundation of the system (community health care services, health care services provided by family physicians, and specialized ambulatory care). In addition, the Strategy identifies cross-cutting solutions that would improve the sustainability and predictability of health financing to ensure access to quality care and financial protection for the population. The vision of enhanced PHC, however, has yet to materialize. Implementation of the Strategy is hindered by institutional constraints, such as poor coordination, lack of commitment to results and value for money, and limited institutional capacity. Concerted efforts are needed to achieve long-term policy goals.

---

16 The NHIH contracts providers separately for each type of service they provide, according to how they are structured in the budget classification. Thus, a hospital signs several contracts with the NHIH, instead of just one, as do family physicians and specialist physicians.
C. Proposed Program Development Objective(s)

24. The proposed Program Development Objective (PDO) is to increase the coverage of primary health care for underserved populations and improve the efficiency of health spending by addressing underlying institutional constraints.

25. **Four PDO indicators have been identified to measure progress in the three results areas:**

   - **PDO indicator 1:** Number of the uninsured in Romania who are registered with family physicians and entitled to receive the basic package of PHC services (Results area 1).
   - **PDO indicator 2:** Percentage of adults (40 years old and above) receiving regular check-ups from family physicians (Results area 2).
   - **PDO indicator 3:** Share of the National Health Insurance Fund annual budget allocated to primary health care (Results area 2).
   - **PDO indicator 4:** Proportion of the supplies and devices for emergency medical services (in value) procured under framework agreements by the National Office for Centralized Procurement (Results area 3).

D. Environmental and Social Effects

26. The Environmental and Social Systems Assessment (ESSA) for this Program was undertaken to: 1) assess Romania’s systems for managing environmental and social effects that are associated with the proposed set of investments related to this Program; and 2) the GoR’s institutional capacity to plan, monitor and report on environmental and social management measures as part of this Program’s implementation. The ESSA took into consideration the requirements of the Program-for-Results Financing Policy and Directive. Its findings are intended to ensure that this Program is implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes or mitigates adverse environmental and social impacts and risks. This assessment also informs the preparation of the Program Action Plan (PAP) that the GoR is expected to use to bridge any significant gaps in existing environmental and social management systems in line with the six core sustainability principles of the PforR.

*Environmental System*

27. **The Program itself does not have explicit environmental management objectives.** The ESSA finds the country’s existing legal and regulatory frameworks for environmental management to be relevant to the activities supported under the Program and consistent with the World Bank’s PforR Policy and Directive. 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. The average daily/monthly quantity of medical waste will not be significantly increased and the existing disposal infrastructure for medical waste has sufficient capacity to take these additional quantities.

28. Romania has comprehensive legislation on environmental protection that is fully aligned with the EU legislation, and the assessment confirmed the general adequacy of the environmental systems and of the institutional and legal framework for medical waste management at the PHC level. There is in place a medical waste management system, and a regular verification of the effectiveness and performance of internal medical waste management. As the Program will not support any new investments in construction or major rehabilitation works, this assessment does not include other environmental issues.
such as potential impacts of civil works, energy conservation, as well as environmental legacy in the case of closing any buildings.

29. The general adequacy of the environmental systems, of institutional and legal framework for medical waste management at the PHC level, was confirmed during the assessment. The medical waste system, medical waste management plans, and contracts of the family practices with authorized sanitary operators are practiced in all areas within the health sector in Romania. At the level of towns, the waste management systems are fully operational, but at the level of rural and remote areas there is a need for a better and more accessible waste management systems in all stages of the selective collection, specialized transport, treatment and neutralization. The Program risks are moderate and are dealing with the enforcement of medical waste management, which is reasonably covered by the existing national, regional and local levels.

30. Key issues identified by the Environmental System Assessment as potentially sensitive are not connected with any further capacity building and may be addressed through the continuous enforcement of the specific regulatory framework issued by the MoH. The relevant implementation of environmental actions is defined in the PAP.

Social System

31. The Program is expected to generate substantial social benefits, particularly through its efforts to improve PHC coverage 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.

32. The Program will achieve this by expanding community health care and strengthen its collaboration with PHC to address physical barriers hindering access to PHC, particularly since 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.

33. Gender. This Program has built on recently conducted country gender assessment and intends to contribute towards reducing the gender gap. Data for monitoring PDO 1 (Number of uninsured in Romania who are registered with family physicians and entitled to receive the basic package of PHC services) will be disaggregated by gender to ensure that the gender gap is minimized over time. Women in particular can avail of effective PHC services to benefit from this Program’s interventions. Roma females have the highest prevalence of non-users (10 percent) and under-users (51.4 percent) of prenatal care services and contend with reproductive risks health risks that are closely related to early marriage, with approximately 10 percent of girls giving birth when they are 12-15 years old and 48 percent at the age of 16-18 years. Therefore, the prospect of inclusive and effective collaboration between primary and community health care would be beneficial for female Roma patients in particular. One reason for this is that the Program intends to strengthen the collaboration between community health workers

---

(community nurses and Roma health mediators) and primary healthcare, and Roma females are heavily reliant on the support of community health workers for counseling and access to healthcare. Another reason is that since 70 percent of family physicians in Romania are female, it will be possible for Roma women to benefit from expanded access to the basic services package without concerns about routing traditional norms by seeking care from male family physicians.

34. **Citizen Engagement.** There are a range of existing citizen engagement mechanisms in the health sector. Some of these mechanisms include a complaint management system and avenues for consultations; the engagement of Patients Associations\(^\text{18}\) to monitor the implementation of framework contracts between the NHIH and health providers; and activities of NGOs related to areas such as increasing awareness of health initiatives and community health care. The Program will include a public awareness campaign, and will build upon and improve the accessibility and inclusivity of selected citizen engagement mechanisms at the community level.

35. From the social development standpoint, two core ESSA principles are relevant for this Program: (i) **Core Principle 1: General Principle of Environmental and Social Management**;\(^\text{19}\) and (ii) **Core Principle 5: Due consideration to be given to the needs or concerns of vulnerable groups**. Core Principle 4: Land Acquisition\(^\text{20}\) is not relevant in this case since there is no land acquisition and therefore no impact on

---

\(^{18}\) [http://caspa.ro/home/](http://caspa.ro/home/), visited on 5 April 2019

\(^{19}\) 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.

\(^{20}\) 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.

\(^{21}\) 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.
private assets or livelihoods is expected. This Program will only support minor refurbishment of existing facilities (e.g. small repairs of existing facilities such as painting, flooring, sealing windows, fixing doors). The ESSA findings confirm that the GoR current system to manage the 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.

36. At the same time, there are 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 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.

37. 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.

38. 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.

39. Consultation and disclosure of the ESSA Report. The ESSA report was prepared in consultation with several stakeholders including the implementing agencies and other public institutions, NGOs, municipal authorities, family physicians, community health nurses and health mediators. The World Bank team also convened a consultation with the Roma Sounding Board on March 28, 2019. The final draft of the ESSA
The report was presented in a workshop during the appraisal on June 21, 2019 with the participation of the MoH, NHIH, MoPF and representatives of other groups. Prior to organizing the workshop, English and Romanian versions of the draft ESSA report were posted on the website of the World Bank’s Country Office for Romania. The final English version of the ESSA report will also be disclosed on the World Bank’s website.

D. Climate co-benefits

Exposure

40. Romania is highly vulnerable to the impacts of climate change—droughts, high temperatures, heat waves, heavy precipitation, landslides, earthquakes, and floods. Droughts may become more frequent in some areas because of decreased river runoff and increased demand for and consumption of water due to economic development and population growth. The most common natural disasters—heavy rainstorms, mudslides, landslides, earthquakes, and extreme weather—have resulted in significant physical, social, and financial impacts over recent decades. Increases in the annual average temperature are expected to be in the range of 0.5-1.5°C by 2029, and 2.0-5.0°C by 2099.

41. Climate and disaster risk screening conducted for the Program has confirmed that the risk of exposure to climate change or geophysical hazards for this Program is Moderate. Program activities could be affected by river floods and earthquakes, causing destruction to health facilities and further disturbing the already limited access to health services.

Impact of climate change on health

42. The strong increase in the frequency of extremely high values for summer thermal stress since the mid-1980s indicates an increased risk to human health during the summer months in Romania. Heat waves lead to a short-term increase in the number of deaths or the aggravation of certain chronic conditions (especially the cardiovascular and respiratory ones). Longer summers lead to increases exposure to UV radiation, with direct effects on skin health (skin cancer), and the stress on agriculture may influence nutritional status, especially that of the poor population and children.

43. Although Romania has well-established public policies to promote public health, it is still not sufficiently prepared to deal with the range of problems stemming from climate change. It also lacks a climate-smart approach in the health sector. Health has been identified as one of the most vulnerable sectors in the country, and improved access to health care, particularly for vulnerable groups, is one of the adaptation measures to reduce vulnerability to climate change. The low overall enrollment with a PHC practice—particularly among vulnerable groups and in rural areas—and the limited access to technology make it more difficult to monitor disease outbreaks and warn vulnerable populations. In spite of the country’s significant risk of exposure to natural events, the levels of awareness, basic education, and protective measures provided by PHC services are still insufficient and inefficient.

Climate adaptation measures supported by the Program

44. Through DLI 1, DLI 2, DLI 3, and DLI 6, the Program will increase the Romanian 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 increased access will particularly benefit vulnerable groups such as the elderly, the disabled, children, women, ethnic minorities, and those on low incomes.

- By expanding access to PHC services to the entire population, DLI 1 (EUR 75 million) will increase
preparedness for extreme weather conditions and help prevent 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.

- As part of the community health care provided under DLI 2 (EUR 75 million), community health workers will educate the population on climate issues and will make first aid readily available to the population in case of extreme climate-related events (such as flooding and earthquake) in underserved areas. By promoting institutional coordination in the sector, the Program will help the Government’s response to climate events and enhance emergency preparedness.
- DLI 3 (EUR 75 million) 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.
- The establishment of an interoperable health data system under DLI 6 (EUR 50 million) will allow epidemiological surveillance, which can provide early detection of changes in incidence, mortality and geographic range of health outcomes associated with climate change and the development of methodologies to forecast major health problems related to climate change effects.

**Climate mitigation measures supported by the Program**

45. Through DLIs 4 and 7, the Program will support measures to mitigate climate change events.
46. **DLI 4** (EUR 75 million) will support expenditures on facility rehabilitation and equipment in accordance with the EU standards, encouraging Romanian family physicians to improve climate-smart infrastructures and integrate energy efficiency measures in refurbishing 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 EU Directive 2010/31/EU requirements for health facilities and services, particularly in relation to the energy efficiency updates and appropriate waste management, which has been translated into the Romanian Law 121/2014 that defines the energy efficiency requirements and requirements to withstand various climate change impacts. Abiding to the Directive is mandatory for all EU member states, including Romania. Adhering to defined norms and standards will be mandatory for all beneficiaries of grants/loans. Consequently, the Program will help reduce carbon dioxide (CO2) emission caused by the sector and improve energy efficiency, which is in line with the strategy of the European Climate Change Programme.
47. **DLI 7** (EUR 50 million) will support the centralized procurement of medical supplies and devices, using a climate-smart approach to reduce the carbon footprint of manufacturing processes by ensuring adherence to the EU Directive 2014/24/EU on the following conditions to be included within the procurement processes: a) environmental requirements to be included in technical specifications (Article 23(3)b); b) award decisions and specifications to be based on criteria required by eco-labels (Article 23(6)); c) social and environmental conditions to be included in performance of contracts (Article 26); d) bidders and their suppliers have to demonstrate compliance with environmental obligations (Article 27); e) bidders have to show that they can perform a contract in accordance with environmental management measures (Articles 48(2)f and 50), and f) environmental characteristics can be included in award criteria (Article 53). Furthermore, consolidating procurement of these goods from 300 hospitals will significantly

---

22 Climate change and adaptation of the health sector: The case of infectious diseases. Confalonieri, Menezes, and de Souza. [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4720270/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4720270/)
reduce carbon footprint by increasing efficiency of the procurement process.

E. Financing

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount (US$ million)</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counterpart funding</td>
<td>4,233</td>
<td>88.1</td>
</tr>
<tr>
<td>International Bank for Reconstruction and Development (IBRD)</td>
<td>570</td>
<td>11.9</td>
</tr>
<tr>
<td><strong>Total Program financing</strong></td>
<td><strong>4,803</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

CONTACT POINT

World Bank

Name : Huihui Wang  
Designation : Senior Economist  
Role : Team Leader (ADM Responsible)  
Telephone No : 5220+34193 /  
Email : hwang7@worldbank.org

Name : Ana Holt  
Designation : Health Specialist  
Role : Team Leader  
Telephone No : 5220+36076  
Email : aholt@worldbank.org

Borrower/Client/Recipient

Borrower : Romania

Implementing Agencies

Implementing Agency : Ministry of Health

Contact : Ana Ciobanu  
Title : State Secretary - Project Coordinator  
Telephone No : 40213072501  
Email : ana.ciobanu@ms.ro
FOR MORE INFORMATION CONTACT

The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 473-1000
Web: http://www.worldbank.org/projects