LIVING LONG, STAYING ACTIVE AND STRONG:
Promotion of Active Ageing in Romania

Human Development Network
Europe and Central Asia Region

June 2014
Document of the World Bank
Acknowledgements

This report was written under the Advisory Service Agreement on preparation of a Draft National Strategy Regarding Elderly and Active Ageing between the Ministry of Labor, Family, Social Protection and Elderly Persons and International Bank for Reconstruction and Development.

The task team was led by Asta Zviniene (Sr. Social Protection Specialist, ECSH3). Introduction has been written by Miglena Abels (Consultant, ECSH3) with contributions from Asta Zviniene and Janssen E. N. Teixeira (Sr. Education Specialist, ECSH2). Chapter 2 has been prepared by Asta Zviniene, Miglena Abels, Claudia Rokx (Lead Health Specialist, ECSH1) and Richard Floresco (Sr. Operations Officer, ECSH3) with contributions from Gabriel I. Prada (Consultant, ECSH3), Cristina Petcu (Consultant, ECSH1), Irina Boeru (Consultant, ECSH3), and Sandu C. Moldovan (Consultant, ECSH3). Chapter 3 has been co-authored by Asta Zviniene and Miglena Abels with inputs from Janssen E. N. Teixeira, Irina Boeru, Norbert Petrovici (Consultant, ECSH3), Vlad A. Grigoras (Consultant, ECSH3), Tatyana Bogomolova (Sr. Social Protection Specialist, HDNSP), Eugenia Naghi (Consultant, ECSH3) and Stephen J. Cutler (Consultant, ECSH3). Chapter 4 has been composed by Stephen J. Cutler with contributions from Norbert Petrovici. Finally, Chapter 5 has been co-authored by Kai-Uwe E. Leichsenring and Claudia Rokx. The administrative and logistical support has been ably provided by Carmen F. Laurente (Sr. Program Assistant, ECSHD) and Camelia I. Gusescu (Program Assistant, ECCRO) and is greatly appreciated.

The report was prepared under the overall leadership and guidance of Andrew D. Mason (Sector Manager, ECSH3). The team also benefited greatly from the support and guidance of Mamta Murthi (Country Director, ECCU5), and Elisabetta Capannelli (Country Manager, ECCRO). The team would like to thank the staff at the Ministry of Labor, Family, Social Protection and Elderly Persons, especially Ms. Carmen Manu, Ms. Rodica Carausu and Ms. Alina Petric, as well as the counterparts from the Ministry of Public Health, Ministry of Finance, Ministry of Transport, Ministry of Regional Development and Public Administration, Ministry of Economy, National House of Pensions, National Agency for Payments and Social Inspection, National Institute for Medical Expertise and Labor Capacity Rehabilitation, National Employment Agency, National Council of Elderly People, and Local Council of Bucharest, Sector 1 and different Social Partners for their excellent collaboration and invaluable feedback throughout the preparation of this report, largely provided during two workshops in November 2013 and March 2014. The team also benefited from helpful comments from Cristian Bodewig (Sector Leader, ECSHD), Maria I. Fraile-Ordonez (Lead Operations Officer, ECCRO), Corina M. Grigore (Operations Analyst, ECCRO) and the peer reviewers, Phillip B. O’Keefe (Lead Economist, EASHD), Johannes Koettl-Brodmann (Sr. Economist, ECSH4), Carlos M. Bortman (Sr. Public Health Specialist, ECSH1), and Rafael P. Rofman (Lead Social Protection Specialist, LCSHS) as well as representatives of the European Commission Enrica Chiozza (DG REGIO), Fritz von Nordheim Nielsen (DG EMPL), Dana Verbal (DG EMPL), and Ettore Marchetti.
# Table of Contents

Acknowledgements ......................................................................................................................... 2  
List of Figures ................................................................................................................................ 5  
List of Tables ................................................................................................................................... 6  
EXECUTIVE SUMMARY ............................................................................................................ 7

Chapter 1 INTRODUCTION ........................................................................................................... 20
   A. Demographic and Macroeconomic Context in Romania ................................................... 20
   B. Active Ageing Agenda and EU Co-operation ................................................................. 22
   C. EU Level Statistical Tools and Policy Framework ............................................................ 25
   D. Development of the Strategy for Protection of the Elderly and Promotion of Active Ageing ................................................................. 30

   Chapter 1 Bibliography ............................................................................................................. 31

Chapter 2 HEALTHIER LIVES IN AN AGEING SOCIETY ..................................................... 32
   A. Ageing of Romania’s Population ....................................................................................... 32
   B. Geographic Patterns of Ageing .......................................................................................... 38
   C. Health Status of Romania’s Ageing Population ................................................................ 42
   D. Implications of ageing for health expenditures and the health system ...................... 47

   Chapter 2 Bibliography ............................................................................................................. 53

Chapter 3 WORK AT OLDER AGES........................................................................................ 55
   A. The Older Population - an Underused Resource of the Romanian Economy............... 55
   B. The Incomes of Older Population Will Need a Boost from Employment ......................... 60
   C. Removing Barriers to the Employment of the Older Population ....................................... 68

   Chapter 3 Bibliography ............................................................................................................. 84

Chapter 4 SOCIAL PARTICIPATION ...................................................................................... 86
   A. Social Participation, Its Types, and Its Benefits ................................................................. 86
   B. Comparisons to Other EU Countries ................................................................................. 90
   C. Barriers and Impediments to Social Participation ............................................................ 92
   D. Options to Encourage Growth in Social Participation .................................................... 101

   Chapter 4 Bibliography ............................................................................................................. 110
### Chapter 5 TOWARDS HIGHER INDEPENDENCE IN LONG TERM CARE

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Developing an Identity of Long-term Care System (LTC) in Romania</td>
<td>116</td>
</tr>
<tr>
<td>B. Policy and Governance</td>
<td>118</td>
</tr>
<tr>
<td>C. Organizational Structures</td>
<td>123</td>
</tr>
<tr>
<td>D. Pathways and Processes</td>
<td>130</td>
</tr>
<tr>
<td>E. Human Resources</td>
<td>133</td>
</tr>
<tr>
<td>F. Financing</td>
<td>137</td>
</tr>
</tbody>
</table>

### Chapter 5 Bibliography

---
List of Figures

Figure 2.1 Evolution of Life Expectancy in Romania ................................................................. 33
Figure 2.2 Evolution of Total Fertility Rate in Romania .......................................................... 33
Figure 2.3 Reduction in cohort size between 2002 and 2012 .................................................... 34
Figure 2.4 Number of people in different age brackets from 1960 to 2060 .............................. 34
Figure 2.5 Contrasting Population Pyramids: Roma and Overall Population in Romania ...... 35
Figure 2.6 Trends in Population Dependency Rate and Share of 65+ Population ...................... 37
Figure 2.7 Share of population aged 65 and over in total population ...................................... 39
Figure 2.8 Share of pensioners in total population .................................................................. 39
Figure 2.9 Proportion of older population by the degree of urbanization in population deciles .. 40
Figure 2.10 Social Insurance coverage of older population by the degree of urbanization in population deciles ................................................................................................................. 40
Figure 2.11 Old age-dependency rates by the degree of urbanization in population deciles ...... 41
Figure 2.12 Proportion of population aged over 75 and living alone by the degree of urbanization in population deciles .................................................................................................... 42
Figure 2.13 Life expectancy (LE) and Healthy life expectancy (HLE) at the age of 50 ............... 43
Figure 2.14 Proportion of population over the age of 65 with strong limitation in activities due to health problems for at least the last 6 months (2008) ................................................................. 46
Figure 3.1 Employment rates among prime and old age groups, 2013 .................................. 56
Figure 3.2 Socio-economic structure of population aged 50-64 ................................................ 56
Figure 3.3 Employment status of the 18-64 population not in school or training by degree of urbanization .............................................................................................................................. 56
Figure 3.4 Segments of 18-64 population not in school and not with labor contract as a proportion of the total 18-64 population ............................................................................................................ 59
Figure 3.5 Poverty rates for different population segments in 2012 ......................................... 62
Figure 3.6 Average pension (social insurance pensioners excluding farmers) as a percentage of average gross wage ..................................................................................................................................... 63
Figure 3.7 Projected system and old age dependency rates ....................................................... 64
Figure 3.8 Coverage and generosity of the PAYG system are projected to decline. A (left) and B (right) .................................................................................................................................................. 64
Figure 3.9 The public pension system is projected to remain in deficit ...................................... 65
Figure 3.10 Opinions: People should be able to continue working ......................................... 66
Figure 3.11 Opinions regarding retirement ............................................................................... 67
Figure 3.12 Evolution of retirement ages in Romania .............................................................. 71
Figure 3.13 Invalidity pensioners by category, as a percent of all old age and invalidity pensioners ............................................................................................................................................. 74
Figure 3.14 Leading causes for invalidity in 2013 ................................................................. 75
Figure 3.15 Average monthly pension amount by program, % average gross earnings .......... 76
Figure 3.16 Breakdown of Romania’s workforce by formal education level ............................. 80
Figure 3.17 Evidence from Latvia: ALMP Program evidence indicates that highly focused training can yield successful results.

Figure 4.1 Romania's ranking on social participation among EU28 countries.

Figure 4.2 Relationships between Age and Measures of Social Participation: Romania, 2011.

Figure 4.3 Relationships between Income and Measures of Social Participation: Romania, 2011.

Figure 4.4 Relationships between Education and Measures of Social Participation: Romania, 2011.

Figure 4.5 Relationships between Gender and Measures of Social Participation: Romania, 2011.

Figure 4.6 Relationships between Residence and Measures of Social Participation: Romania, 2011.

Figure 4.7 Relationships between Health and Measures of Social Participation: Romania, 2011.

Figure 4.8 Percentage of 60+ populations thinking that people 55+ contribute greatly as volunteers in (country).

Figure 4.9 Perception of People 55+ in Country: Among Population 60+.

Figure 4.10 Opinions: Tension between Old People and Young People in This Country: Mean Scores for All Persons 60+ (0=none, 1=some, 2=a lot).

Figure 4.11 Percentage of Population 60+ Experiencing or Witnessing Age Discrimination.

Figure 5.1 The aim of an integrated long-term care system.

List of Tables

Table 2.1 Composition of Active Ageing Index.

Table 3.1 Social protection expenditure by category and function.

Table 3.2 Occupational disease incidence rates by type of condition.

Table 3.3 Musculoskeletal diseases and their prevention in workplace environments.

Table 4.1 Mean Scores on Participation in Voluntary Activities by Age: Romania.

Table 5.1 Key-indicators of LTC demand and supply in Romania.

Table 5.2 Selected individual Active Ageing Index indicators for Romania.

Table 5.3 Number of residential care facilities by region and by type of provider (2012).

Table 5.4 Number of day care facilities by region and by type of provider (2012).

Table 5.5 Number of home care units and users by region and by type of provider (2012).

Table 5.6 Funding sources of residential care facilities, 2012.

Table 5.7 Funding structure of selected home care providers.

Table 5.8 Funding sources of home care services (2012).

Table 5.9 Public expenditures for cash benefits, 2011.
EXECUTIVE SUMMARY

Romania is undergoing a profound socio-economic transformation brought about by unprecedented demographic change. On one hand, the share of population aged 65 and over is expected to double from 15 percent to 30 percent by the year 2060, potentially putting enormous stress on pension, healthcare and long-term care costs. At the same time, Romania’s working age population, aged 20 to 64, is reversing its decades long growth and is heading for a decline of 30 percent by the year 2060, one of the deepest declines in the EU. Further stress is being created by the significant labor market exclusion of the Roma, one of Romania’s largest, youngest and most dynamically growing ethnic minority groups, as well as strong net emigration which over the last decade reduced the cohort currently aged between 25 and 30 by close to 20 percent. These trends are even more pronounced in the rural areas, where the number of elderly for each working age person can be up to 2.5 times higher than in urban areas. Consequently, the decline in the share of the population contributing to the economic output could result in lower growth in income per capita and dampen overall prospects for economic growth. The trend also creates a challenge in recruiting needed numbers of healthcare and eldercare workers, especially in more remote localities.

Therefore, the crucial question going forward is whether projected gains in life-expectancy for increasingly larger cohorts of older people will be accompanied by illness, disability, vulnerability and dependence, or whether growing life expectancy will mean additional healthy, active and productive years. The Active Ageing policy agenda aims to put Romania on the road to the latter scenario. It envisions a society where older people are encouraged and empowered to lead healthy, productive, participative and independent lives to the highest extent possible.

Anchored by the process of EU accession, Romania continues to converge with the other EU Member States in terms of income and living standards, even though the recent economic crisis has slowed down this process. In order to return to the path of higher economic growth, Romania set itself a target to achieve a 70 percent employment rate among its population aged 20-64 by 2020, compared to the current 64 percent. Another goal is to reduce the number of people at risk of poverty or exclusion by 580,000 in the same period.

These goals are set in Romania’s National Reform Program (NRP) and are supported by EU, which considers the Active Ageing concept to be an essential element of achieving strategic Europe 2020 goals. To increase coherence between policy commitments made in the context of Europe 2020 Strategy and investment on the ground, the EC adopted the Common Strategic Framework for cohesion policy for the 2014-2020 period, which, among other measures, makes the adoption of an Active Ageing Strategy one of the ex-ante conditionalities for the financial support from European Structural Investment Funds.
To further support national agendas in the area of Active Ageing, the European Commission also offers helpful statistical tools and an active ageing policy framework. The Active Ageing Index (AAI)\(^1\) has been created as a summary measure of the current situation in four domains of active ageing in each of the EU member countries, namely 1) employment, 2) participation in society, 3) independent, healthy and secure living, and 4) capacity and enabling environment for active ageing. The Special Eurobarometer survey #378 on Active Ageing is another useful tool developed to understand European citizens’ views and attitudes towards older people. In setting its Active Ageing agenda Romania can also benefit from the active ageing policy guidelines agreed by the Council of the European Union in 2012.

In this context Romania has set out to prepare a Strategy for Protection of the Elderly and Promotion of Active Ageing covering four policy areas: 1) prolonging lives and achieving healthy ageing; 2) promoting employment at older ages; 3) increasing social and political participation of older age groups, and 4) decreasing dependence of the elderly and improving long-term care. The preparation of the Strategy for Protection of the Elderly and Promotion of Active Ageing will be informed, among other sources, by socio-economic analysis presented in this document. The summary of the main findings and policy options is provided below, following the structure of the report.

**Healthier lives in the Ageing Society**

Population dependency rate, defined as the number of people aged 65 and over and those under age 20 for every 100 people aged 20 to 64, has been relatively stable and averaged around 75 between 1950 and 1990. Between 1990 and 2010 this ratio dropped to 55, due to the numerous cohorts born after 1960s joining the ranks of the working age population\(^2\). This development has created an important tailwind for Romanian economy. However, the trend in population dependency rate is reversing sharply and is expected to approach 100 by the year 2055, as shown in Figure 1 below. The phenomenon is caused by continuous fertility rate decline since the 1970s, which has accelerated in the 1990s; strong emigration flows in the last decade; and a decades long trend of increasing life expectancy.

While the overall working-age population in Romania is projected to fall, the share of Romania’s Roma minority among them is expected to grow: according to the estimates of the Roma population, already between 6% and 20% of today’s youth are Roma. This minority group faces

---

\(^{1}\) The Active Ageing Index (AAI) is a product of a joint project undertaken in 2012 by the European Commission Directorate General for Employment, Social Affairs and Inclusion together with the Population Unit of the UNECE and the European Centre for Social Welfare Policy and Research in Vienna.

\(^{2}\) The baby boom was caused by the banning of abortion and introduction of a set of pronatalist policies in 1966.
exclusion from the labor market which, if continued, would create even faster contraction of employed population than national demographic projections would suggest.

**Figure 1. Population dependency rate in Romania**

![Population dependency rate graph](image)

*Source: UN population statistics.*

National averages of fertility, life expectancy and migration are most likely concealing other considerable inequalities related to education and socio-economic status. Population ageing also has a pronounced regional and urban/rural dimension: while urban areas reap the benefits of internal migration of the young population, rural regions are left to bear increased burdens of social service provision for older people. Rural regions also struggle with complexity and lack of human resources in providing medico-social services to isolated older populations. Pension spending, at 7% of GDP, also mostly benefits urban families who tend to be better covered by pension system and are eligible for higher benefits, predominately stimulating urban regions. Given that high ageing burdens in rural settings are often a cost of internal migration and economic development in the cities, ageing costs should be more fairly shared between urban and rural communities.

The current epidemiological profile of Romania, with the exception of Roma population, to a large extent mirrors that of the other EU countries. It is characterized by low prevalence of communicable diseases and growing share of cardiovascular diseases (heart disease and stroke), cancer, and health conditions stemming from external causes including violence and injuries. As in most EU countries, the growing number of obese and overweight people is increasing the burden on disability and associated health and care costs, including Type 2 Diabetes, which is one of the most costly chronic diseases in the Western world. Generally, diseases generated by preventable lifestyle factors are also claiming an increasing share, including from tobacco consumption, alcohol abuse, and lifestyle related risk factors. The most common non-communicable diseases including cardiovascular, cancer, respiratory diseases and diabetes mellitus together account for 86% of total mortality in Romania. Weakening cognitive function
is also an increasingly prevalent condition in the ageing society. In fact, at least half of all cases of dementia among older persons are due to Alzheimer’s disease.

**Figure 2. Life expectancy (LE) and Healthy life expectancy (HLE) at the age of 50**

![Life expectancy chart](image)

*Source: Eurostat, 2011 data*

The Romanian Roma population, however, shows a different epidemiological profile and suffers worse health than the general population. In addition to having much lower life expectancy rates, they carry a higher burden of both infectious and chronic disease. Explanatory factors of lower health status include poor living conditions, high risk behaviors and ineffective use of the available health services.

Given these factors, population ageing is likely to contribute to increased pressures on health spending in Romania, which currently is not yet very high. To achieve longer healthy and productive lives Romania should invest in prevention, early detection and treatment of chronic disease as well as review its’ pharmaceutical policies with regards to prescription of generics and drug pricing. Especially strong attention should be paid to reducing tobacco and alcohol use, and promotion of healthy diet and exercise, including among the elderly, by better integrating these preventive measures into primary care and community life. Early detection and management of cardiovascular disease, diabetes and depression are likely to become more important as the population ages. The healthcare system will also need to become more focused on geriatric and family doctors, well equipped to manage multiple chronic diseases and cognitive decline in mainly ambulatory settings.
Work at Older Ages

The older population is an underused resource of Romania’s economy and it will be difficult, if not impossible, for the country to reach its 70 percent employment target without tapping into it. Romania’s employment rate of population aged between 25 and 54 is only 2 percent below the EU average, while that rate for the population aged 55 to 64 is 9 percent below even with significant upward bias. In urban areas, almost half of all people aged 18 to 64 and not in school, training or with the labor contract are in the 55 to 64 age range.

A marked reduction in the number of formally employed people begins as early as ages 50-54. Between those ages, 20 percent of women and 17 percent of men are already retired, mostly through the invalidity program, typically assuming a permanent full-time pensioner status. Despite the well-intentioned reforms of 2005 which tightened old age pension eligibility conditions, early retirement through the old age program also remains strong. Between the ages of 55 and 59, up to five years before statutory retirement age, there are already 2.5 women pensioners for every employed woman. Similarly, between the ages of 60 and 64, up to five years before statutory male retirement age, there are 4.5 male pensioners for every employed man. Importantly, the number of people without a pension or wage income does not rise just before statutory retirement ages, suggesting that early pension eligibility rules could be tightened further without creating unfairly heavy burdens on pre-retirement cohorts.

Furthermore, the transition from paid full-time employment into full-time retirement in Romania is very abrupt, without significant pathways through partial retirement, where lesser responsibilities, less strenuous work, fewer work hours, and volunteering work is combined with the first draws on retirement income. Given that poverty rate in Romania is lowest among population aged 50 and over, it could be argued that job opportunities are not desperately needed for people who are eligible for pensions. However, supplementing pension income through work should still be encouraged, as the outcomes can only be positive both for the individuals and for the economic growth. More numerous working pensioners would also help to develop societal norms of more active lives at older ages.

While most of the older people currently are recipients of a pension of some kind, pension system coverage is expected to decline among persons soon to retire and, especially, among middle aged cohorts. The situation is worst in rural areas, where new farmer’s pensions are no longer offered since 2000. Coverage, although higher, will also decline in urban areas due to reduced proportion of working age population making Social Security contributions in the last two decades. Furthermore, as the current pension formula closely links pensions to contributions,

---

3 Employment statistics include landowners and their families in the employed category, classifying many low intensity subsistence farmers as self-employed and unpaid family workers. This especially elevates employment rates at older ages, since higher proportion of Romania’s older population is rural. Same bias causes Active Ageing Index to rank Romania highly on the measure of employment at older ages.
with no significant minimum pension guarantee, attempting to improve pension system sustainability, pension incomes are expected to decline in relation to wages, especially for the big proportion of the population with low incomes and sporadic careers (see Figure 3).

The developing situation in rural areas will seriously jeopardize achieving Romania’s 2020 poverty targets and raises the question of how the risk of old age poverty will be addressed. In urban areas, reliance on the labor market to provide additional income at older ages will become increasingly important, given the decreasing future role of the pension system. Already increased interest in longer careers can be seen among women, well-educated people, and people with the difficulty in paying their bills.

**Figure 3. Coverage and generosity of the PAYG system are projected to decline**

![Projected coverage of pension system](chart1)

Source: Administrative data, World Bank pension modeling results with PROST software

To date, there was substantial progress in increasing effective retirement ages in Romania, but future plans for a continued increase are not very ambitious, with the statutory retirement age for women reaching 63 only in 2030. Further progress could be made by tightening early retirement options, more often used by men, and raising the statutory retirement age faster for women to fully equalize it with retirement age for men at 65. Better outcomes with respect to early retirement options could be achieved by tightening early retirement eligibility rules and properly pricing benefit reductions associated with early retirement, at the same time providing a better

---

4 Coverage rate here is defined as a proportion of population aged 65 projected in receipt of either old age or disability pension.
safety net and re-training opportunities, and increasing people’s ability to supplement a pension with a labor income\(^5\).

Furthermore, mandatory retirement age law should be abolished, and age sensitive human resource policies should be employed, including: monitoring of the age mix of workers and of those who are being fired; investing in health-promoting programs for workers; offering opportunities to update and develop skills; ensuring rotation of employees to foster their learning and adaptability; and offering more part-time work opportunities for older workers. The young workers would also benefit from working together with more experienced workers. Introducing mandatory counselling before retirement (including in groups for efficiency purposes) would be beneficial. The Government, as the largest employer in the country, should be leading this agenda and enforcing age anti-discrimination laws in the workplace and beyond. Reduction in social insurance rates paid by older workers and their employers might also be warranted.

Harmonizing the disability certification procedures for the disability allowance benefit and invalidity pension and unifying the institutional framework is one of the Government’s objectives, supported by the World Bank. The unification of the systems aims to significantly reduce duplication of services, reduce administrative costs, and improve the overall efficiency and equity of outcomes. However, even with better procedures, databases and monitoring, the system will continue to struggle in light of strong incentives to seek invalidity certification, especially by those who do not have a sufficient length of service to be eligible for an old age pension. Per a recent Constitutional Court decision invalidity pension can be relatively easily claimed, as required vesting period\(^6\) has been reduced to only one day. There should be pathways from invalidity back into work, including partial working opportunities for the disabled.

Ensuring healthy and age-friendly work environments, which not only prevent development of diseases but also promote and encourage healthy life choices, will become increasingly important as Romania’s workforce ages. Employers and policy makers should monitor employee health and intervene early with required counselling and adjustments, so that health can be restored and retirements postponed. It is also important to be conscious of workplace adjustments needed by older and disabled employees, as these adjustments are not only benefiting workers, but also increase firm productivity. Many of the useful changes in the workplace are not very expensive. Some of them could be piloted with the surplus of Work Accident and Injury Insurance Fund.

Life-long learning is another essential goalpost needed in order to achieve longer working lives. In Romania the lower skilled population starts losing their share of employment as early as ages 50 to 55. This phenomenon is not likely to change for at least another 15 years unless middle

---

\(^5\) Currently early retirees cannot combine wage and pension income.

\(^6\) Vesting period refers to a requirement that pension contributions have to be paid for a certain period of time, before a person is eligible for a benefit, in this case invalidity pension.
aged and older workers, and their employers, are convinced of the benefits of lifelong learning. A firm foundation for life-long learning should also be built for Romania’s youth, especially Roma and those living in rural areas, to ensure longer productive lives in the future. The Lifelong Learning Strategy of the Romanian government includes big investments in community learning centers, which are expected to provide education and training, disseminate information, and aid personal development of older population, among others. The centers will also provide jobs, often very suitable for older people. Ensuring that resources are used efficiently will be a challenge, necessitating careful monitoring of education and training outcomes.

**Social Participation**

For all its challenges, population ageing also presents Romanian society with an opportunity. Further improvements in health and education, and greater numbers of people with more discretionary time will provide Romania with a pool of retirees capable of making significant contributions to Romanian society via their social participation. Civic engagement, both through formal and informal social networks, has been linked to improvements in a variety of measures of well-being, including happiness, life satisfaction, self-esteem, sense of control, physical health, reduced risk of depression, and longevity. Social participation in the form of civic engagement and volunteering also contributes to the well-being of the recipients of these efforts; for example, children in educational activities greatly benefit. Civic engagement through unpaid social work also provides an enormous economic benefit to communities operating in a constrained budget environment with growing social needs. In Romania the economic value of older adults’ unpaid civic contributions, especially in child and elder care, are estimated to exceed 2 percent of GDP. Therefore, social participation may truly be considered a win-win proposition, stressing the importance of enacting reforms that would promote more opportunities for social participation among older adults.

The current degree of social participation among the older population in Romania, as compared to EU28 countries using Social Participation related components of Active Ageing Index, exposes substantial room for improvement. Romania ranks near the bottom of EU28 in terms of volunteering hours provided by the older population, signalling strong negative societal perceptions of volunteering in general (see Figure 4). Romania’s level of political participation places it in the bottom third of EU28 nations. The level of care to older adults and care to children and grandchildren places Romania higher, close to the bottom of the middle third of the countries, although the main reason for this higher ranking is most likely the effect of poorly developed formal care systems and not necessarily a sign of voluntary social participation. Only in terms of its overall level of social connectedness is Romania closer to the EU average.

These results can be explained by significant political, cultural and socio-demographic barriers to more frequent and extensive social participation. At present, Romanian culture does not support
volunteering and volunteering is not pervasive at the community level because communities neither welcome involvement nor do they offer opportunities to be involved. Encouragingly, the negative connotation of volunteering appears to be dissipating with younger cohorts who have not lived through the communist era. In addition to the enduring negative impact of communist legacy, there has been minimal legislative support for volunteering in recent years. Making matters even worse is the fact that the Romanian government itself does not appear to promote volunteering or draw upon the talents and expertise of older volunteers. Financial hardships, lower levels of education, and residence in rural areas have also been cited as key impediments to social participation among older adults. Poor health status and disability laws discouraging recovery from illness and even promoting refusal of treatment also work against social participation.

**Figure 4. Percentage of 60+ Population Thinking that People 55+ Contribute Greatly as Volunteers in (Country)**

![Percentage of 60+ Population Thinking that People 55+ Contribute Greatly as Volunteers in (Country)](chart)

*Source: Eurobarometer 76.2 (2011): Employment and Social Policy, Job Security, and Active Ageing*

Romania would benefit from introducing an Office of Community Service, charged with making volunteering more visible, rewarding, and attractive. Communication channels between the Government and the older population could be improved through better representation and increased range of discussion topics. Media and role models could be better employed to creatively promote the idea of active ageing. Companies must be encouraged to be more proactive in their support for employee participation in volunteering activities. In every way possible Romania should take a hard look at images of ageing, at respect accorded to the aged, and at the nature of relations between generations. Policies and practices that discriminate against older persons based solely on their chronological age should be examined carefully, and abolished where unnecessary. More options for formal child and elder care would also allow the older population to consider a wider array of options to participate in the society. Finally,
reducing income, health and infrastructure barriers for participation would doubtlessly lead to increased volunteering.

Determining whether progress is being made requires a data system for monitoring social and behavioral (as well as biomedical) aspects of ageing. Surveys should also be prepared and conducted, and analyses be carried out to document whether and how the health, economic, and social situations of older members of ethnic minorities differ from those of members of older Romanian majority groups.

**Higher Independence in Long-term Care**

The long-term care (LTC) system in Romania is quite young, with still underdeveloped identity requiring more public debate to form a clearer vision. Currently, the system is characterized by relatively less developed policies and practices, given the level of funding, the extent and quality of facilities and services as well as coverage and the regulatory framework. The level of formal supply of LTC services is low, and the system is fragmented across the health/social service divide, distinctions between disabled and older persons, as well as across jurisdictions with uneven access to services. A heavy burden of care provision is therefore falling on family members without any major support structure. Historic cultural norms of care provision by the family have more recently been stressed by strong emigration flows and a development of a negative image of an older person, representing frailty and communist past. Therefore, community involvement pioneered by NGOs in the LTC area is very welcome.

There is a need for better coordination in the provision of long-term care services in Romania between the Ministry of Public Health, Ministry of Labor, Family, Social Protection and Elderly, county and local councils, NGOs, private care providers, hospitals, GPs, pharmacists, informal caregivers and persons in need of care. Authorization and accreditation mechanisms, including quality assurance, have to be addressed, among other issues, and an emphasis on prevention and rehabilitation has to be strengthened. Successful examples from other countries offer ways to increase cooperation at the local community level, to structure formal integration between health care and social services, and to provide the incentives for fast placement of persons in need of care into the most appropriate setting.

The current infrastructure for the formal provision of long-term care consists of nursing and residential care homes, day care centers, and formal care services at home. While this infrastructure is often described as insufficient, nursing and residential care homes are characterized by both low capacity utilization and long waiting lists, and day care centers seem to be underutilized in many cases. Services of professional caregivers are in high demand, but not sufficiently funded and staffed, while the institution of “personal assistants”, as a form of formalized family caregivers, has been growing in importance since 2006. Integrating people with care needs into community life and creating an enabling environment so that they can live at
home as long as possible remains the main challenge and a goal of the long term care system. Examples from Denmark and Netherlands on developing social housing for older people, rehabilitation and prevention services, and integrated community health and social services offer useful options to consider.

Information flow and the seamless transition of a person through different care pathways is a complicated but crucial part of a long term care system. Currently care needs in Romania are determined based on an integrated ‘National Grid for Needs Assessment of Older People’, based on which eligibility for three different care levels is assigned. However, the assessment is geared towards assigning care rather than the promotion of self-care and rehabilitation. The communication between hospital and home care is also lacking. Good international examples of integrated home care and hospital discharge practices, use of technology for communication between providers, and establishment of single integrated service access points can be used to further the agenda in this area.

Romania also faces a big challenge in recruiting, training and retaining required numbers of staff with relevant skills and qualifications. Recently many NGOs have been instrumental in providing training for caregivers, but the system is coping with significant “leakages” of graduates to other EU countries with high demand for caregiving services at much higher wages. Currently, the number of nurses in Romania stands at only half the average number of nurses per 100,000 inhabitants in EU. Examples of more satisfying work conditions in small neighbourhood care teams, employment of self-assessment in quality management processes, and more convenient learning and certification options are useful ways implemented in other countries that could be helpful in coping with these challenges. A stronger reliance on younger pensioners working as part time caregivers may be another interesting option to explore.

Romania’s total public spending on long-term care stood at 0.69% of GDP in 2011. Residential facilities are funded from general taxes by county or local councils and by private funds, with great variation in funding between public and NGO run facilities. Post-acute home nursing care is fully funded by Health Insurance for the first 90 days, after which care might be provided by an NGO, financed through public subsidies and private funds. The ‘personal’ assistant” model that has been employed in Romania is fully funded from public funds and tends to be an expensive solution, although further analysis is needed to form stronger conclusions. Finally, cash benefits, which include attendance allowances and the complementary ‘personal budget’, involve small amounts for a relatively broad pool of beneficiaries, resulting in substantial costs for the social security budget. Going forward, decisions will have to be made on how to adjust the current funding mix, how to raise additional resources, and how to make the funding model compatible with preferred benefits levels, benefit eligibility rules, and proper incentives.
Conclusions

The collection of existing and new evidence collected for this report lead to the following conclusions:

- Activating older population and ensuring healthier, more productive, participatory and independent lives is of paramount importance both for the large cohorts reaching older ages, but also for the future macroeconomic development of the country.

- Healthier ageing is a prerequisite for longer active lives and requires urgent attention to preventive measures, early detection and treatment of chronic disease. Promoting healthy lifestyles is of particular importance as is increased focus of the health system towards geriatric and family care in ambulatory settings.

- Reaching Romania’s 2020 employment target will require substantially higher employment rates among older population. Employment opportunities at older ages will also become increasingly needed as the footprint of pension system slowly contracts both in terms of coverage and in terms of relative pension levels. To make progress, retirement eligibility conditions have to be tightened, invalidity certification procedures strengthened, and life-long learning promoted. Employers, including the Government, should ensure healthier working conditions and revise their human resource policies.

- Social participation benefits both suppliers and recipients of volunteering efforts. Economic value of older adults’ civil contributions in Romania is estimated to exceed 2% of GDP. However, societal perceptions of volunteering are still quite negative, requiring concerted efforts by the Government, organisations of older people, media, and employers to make it more visible, rewarding and attractive.

- Long-term care system in Romania is quite young and still has not developed its own identity. It is important to ensure that it grows in the direction of integrating people with care needs into community life and creating an enabling environment for them to live at home as long as possible. Prevention and rehabilitation should be made important goals of the modern long-term care system.

- Finally, active aging policies can only be successful when implemented with a cross-sectoral systemic approach: needed investments in health might be expensive if resulting healthy life years are not turned into productive years; tightening retirement eligibility conditions can be unproductive if age discrimination in labor market persists; building skills in rural areas would not work without a good road and transportation system and increased productivity of agriculture; increased social participation and independent living will be hard to achieve without making public environment more accessible; providing adequate long-term care may necessitate rethinking of the structure of public finances; and failed improvements in education might lead to contracting tax base and decreased affordability of social programs needed in the aging society. While all these interlinked sectors require important investments, careful choices and long term vision beyond 2020 will be needed to make investment priorities for the 2014-2020 period in the environment of constrained fiscal resources.
The evidence presented in this report should help to provide the foundation for the public debate around active aging policies and to set the priorities based on which the Strategy for Protection of the Elderly and Promotion of Active Ageing could be developed.
Chapter 1 INTRODUCTION

*The Active Ageing* concept envisions a society where older people are encouraged and empowered to lead healthy, productive, participative and independent lives to the highest extent possible. Policies developed to implement this concept aim to reduce premature physical ageing, encourage the older population to work longer, to continue contributing to the society through civic and political activities long after retirement, and lead independent lives even in advanced old age. Active ageing can reduce age-sensitive public spending, produce higher current and future incomes for the older population, increase economic growth, and create a more inclusive society where people of all ages have a role and an opportunity to make an economic and social contribution.

A. Demographic and Macroeconomic Context in Romania

Romania is undergoing a profound socio-economic transformation brought about by unprecedented demographic change. The process of population ageing has been the result of steady improvements in life expectancy and declining fertility rates during the last four decades. These two combined demographic trends are rapidly changing the age composition of Romanian society. United Nations Population projections show that over the coming decades, the numbers of older people aged over 65 are expected to increase significantly while the working-age population, defined as those aged between 20 to 64, after the prolonged period of growth is heading for a steep decline from 2014. The process of demographic ageing in Romania is further accelerated by a more recent dramatic increase in net emigration among younger aged groups.

Romania is projected to experience one of the sharpest drops in working-age population in the European Union, a trend that will likely impose a heavy burden on the economy. According to Eurostat population projections, Romania’s working age population, aged 20 to 64, is projected to decline by 30 percent by the year 2060. The old age dependency ratio, i.e. the ratio between the number of older people (65 and over) and the number of working-age people (20 to 64) is projected to more than double by 2060: in 2010, there were roughly 25 people over the age of 65 for every 100 people of working age, which is projected to increase to 60 people over the age of 65 for every 100 people of working age by 2060. Consequently, the decline in the share of the population contributing to the economic output could result in lower growth in income per capita and dampen overall prospects for economic growth.

Demographic change will also put pressure on the fiscal situation of the country as the rapidly growing numbers of older people impose increased fiscal pressure on public pension,
health and long-term care systems against the backdrop of declining labor tax revenues. The number of elderly is projected to increase both in absolute numbers and as a share of the total population, resulting in increased demand for health and long-term care services, raising difficult questions on how to meet the growing needs. In the absence of reform, demographic ageing may therefore lead to higher rates of poverty, social exclusion and dependence among the elderly. (European Commission 2012 Aging Report, 2012)

At the same time, anchored by the process of EU accession, Romania continues to converge with the other EU Member States, in terms of income and living standards. From 2001 to 2008, the Romanian economy expanded by an average of 5-6 percent per year, representing one of the fastest growth rates in the EU. The process of convergence was slowed somewhat in 2008 by the arrival of the global economic crisis, but it is still observed. In 2011, Romania’s income per capita reached 48 percent of the EU 27 average, up from a trough of 26 percent a decade earlier. This growth has already led to significant gains in poverty reduction and improvements in social and economic indicators and, if sustained, will help to defray some of the costs brought about by population ageing.

The roots of the more recent slowdown in economic growth stem from the late 2000s when the economy started to overheat. Government spending was also on the rise. Between 2004 and 2008, public spending increased by around 6 percent of GDP, of which 80 percent was current spending, mainly public sector wages and pensions. In fact, the public sector wage bill expanded by around 60 percent in real terms in the same period. At the same time, budget revenues remained stationary, at around 32-34 percent of GDP, putting substantial pressure on the fiscal deficit, which reached 7.3 percent of GDP in 2009.

Widening imbalances exposed Romania to the global economic crisis, depressing growth, endangering macroeconomic stability, and forcing the Government of Romania (GoR) to adopt fiscal adjustment measures. The implementation of these measures and prudent macroeconomic management gradually began to yield results. In 2011, the economy started to recover, albeit at a modest pace. Real GDP grew by 2.5 percent in 2011, aided by strong performance in agriculture and exports. The worsening economic conditions in the Eurozone, which re-entered recession, and a severe drought affecting agricultural output depressed growth again in 2012, although it still remained positive, at an estimated 0.7 percent.

In order for Romania to return to the path of higher economic growth it is imperative to increase its persistently low employment rate among the population aged 20-64, which at 64 percent was amongst the lowest in the EU10 in 2013. Low labor market participation means that out-of-the-labor force working age people do not generate added value and, therefore, do not contribute to output growth. Increasing employment rates is even more important in the context of a shrinking labor force and an ageing population. The age cohort of 55-64 has the highest potential to increase the number of workers by as much as 10%.
To maintain macroeconomic stability it is also important to put old age related spending on a sustainable path and encourage older individuals to contribute as much as possible to building healthier, happier, and more socially active and independent lives for themselves and their communities. Every attempt should be made to help and empower older population to improve their health, increase independence, and find opportunities to raise their incomes and participate in their communities. Efforts should also be made to encourage the younger population to be aware of ageing related issues, to improve their own ageing experiences in the future, and not to hinder the efforts of older cohorts in achieving these goals.

B. Active Ageing Agenda and EU Co-operation

Over a decade ago, the World Health Organization introduced the concept of Active Ageing as a necessary condition for confronting the negative macro-fiscal and social effects of population ageing. To help inform the formulation of action plans that promote healthy and active ageing, the WHO’s Ageing and Life Course Programme developed a Policy Framework as a contribution to the Second United Nations World Assembly on Ageing, held in April 2002, in Madrid, Spain (WHO 2002).

In recognition of and as a response to population ageing, the European Union has adopted the goal of promoting active ageing: encouraging older people to remain active by working longer and retiring later, by engaging in volunteer work after retirement, and by leading healthy and autonomous lives. As defined by the World Health Organization, active ageing is the process of optimizing opportunities for health, participation, and security in order to enhance quality of life as people age both within the labor force through delaying retirement and within society through participation in a range of social, economic, civic or cultural activities (European Commission, 2012, p. 8).

In June 2010, the European Council approved the Europe 2020 Strategy which commits to achieving smart, sustainable, and inclusive growth in the European Union through investments in education, research and innovation, a low-carbon economy, and job creation and poverty reduction measures. The Europe 2020 Strategy coordinates policy actions aimed at this objective at the EU level and sets five ambitious goals in the areas of employment, innovation, education, poverty reduction and climate change. To measure the progress in meeting these goals, five headline targets have been agreed to at the EU level as a whole, with corresponding national targets. Two of the five EU 2020 targets most closely related to the Active Ageing concept are an employment rate of 75 percent for the 20-64 year-old population (70 percent for Romania) and at least 20 million fewer people in or at risk of poverty and social exclusion ($80 thousand fewer for Romania).
The Active Ageing concept is considered an essential element of achieving the Europe 2020 Strategy goals. It has been repeatedly recognized as the most natural, sensible and promising solution to mitigating the effects of demographic change. In 2011, the European Council launched the "European Innovation Partnership on Active and Healthy Ageing" and proposed to declare 2012 as the European Year of Active Ageing and Solidarity between Generations, further bolstering the Union’s dedication to the issue. Consequently, the Council Declaration of the European Year for Active Ageing and Solidarity between Generations (2012): The Way Forward invited all relevant actors (policy-makers, civil society, private sector employers) at the national level to adopt the Guiding Principles for Active Ageing and Solidarity between Generations elaborated by the Social Protection and Employment Committees.

To increase coherence between policy commitments made in the context of the Europe 2020 Strategy and investment on the ground, the EC adopted the Common Strategic Framework (CSF) for cohesion policy 2014-2020, which is EU's principal investment tool for delivering the Europe 2020 goals. To ensure that the CSF Funds deliver long-lasting economic and social impacts, the Commission adopted a new approach for the use of the Funds in this programming period. Strong alignment with policy priorities of the Europe 2020 agenda, macroeconomic and ex-ante conditionalities, thematic concentration and performance incentives are expected to result in more effective spending. The adoption of an Active Ageing Strategy is one of the ex-ante conditionalities that needs to be fulfilled in order to access ESIF support in the 2014-2020 programming period.

With respect to thematic concentration, the CSF outlines eleven thematic objectives, each with a range of key investment priorities. Active and Healthy Ageing is directly identified as an investment priority #6 under thematic objective #8 Promoting Employment and Supporting Labor Mobility. Other thematic objectives relevant to the Active Ageing concept include, but are not necessarily limited to, objective #9 Promoting Social Inclusion and Combating Poverty and Objective #10 Investing in Education, Skills and Lifelong Learning by Developing Education and Training Infrastructure. In the Europe 2020 Strategy, these three objectives are positioned together under the heading People and Society Development Challenge.

Partnership agreements between the European Commission and individual EU countries set out the national authorities' plans on how to use funding from the ESIF for 2014-2020. They outline each country's strategic goals and investment priorities, linking them to the overall aims of the Europe 2020 strategy for smart, sustainable and inclusive growth. Based on the lessons learned during the 2007-2013 programming period and the Commission's legislative proposals for 2014-2020, the Commission prepared a position paper on the development of Partnership Agreement and programs for the period 2014-2020 for each Member State. The position papers inform the Member States of the Commission's views on the main challenges and funding priorities. They also establish a framework for dialogue between the Commission and each Member State on the preparation of the partnership agreement and programs which will form the basis for the use of the EU Structural and Investment Funds. The position papers were
presented to the Member State authorities as the Commission's views based on the Commission's legislative proposals, without prejudice to the final outcome of the negotiations on the legislative package.

**Romania’s commitment to Active Ageing concept and the broader Europe 2020 Strategy is revealed in its National Reform Program**\(^7\) **2011-2013 (NRP) and its Partnership Agreement (PA)** for the 2014-2020 programming period. According this agreement, **People and Society Development Challenge** objectives will be synchronized with thematic objectives \(^1\) and \(^3\). A commitment to develop the Draft Strategy for the Protection of the Elderly and Active Ageing further underscores the government’s resolve to transform Romania into an age-friendly society that is prepared to effectively confront the macro-fiscal and social implications of demographic change in the coming decades.

**For the 2014-2020 period, Romania will be able to complement domestic financing with additional allocations from the European Structural and Investment Funds (ESIF) under all thematic objectives**, including **People and Society Development Challenge** objectives, most relevant to the Active Ageing agenda. The European Social Fund (ESF) is the primary financing instrument in the area of **Active Ageing**, supporting the following priority areas: employment, with special emphasis on the employment of disadvantaged groups and the young, skills and lifelong learning, labor market reforms to promote employment at older ages and promotion of social inclusion.

In addition, various other large-scale investments through the Cohesion Fund and European Regional Development Fund (CF and ERDF), in particular to improve the environment, transport infrastructure, energy and broadband connections, can also have a direct impact on growth, jobs, and accessibility of services and living environments, thus contributing to Active Ageing policies as well. In addition, the ERDF also provides valuable support for entrepreneurship, investment in enterprises, innovation and research, and ICT for business, potentially providing indirect support to the Active Ageing agenda.

**Not all above listed resources are directly available for Active Ageing policies**, as other priorities identified by Romania’s Strategies in other fields are competing for the same European Structural and Investment funds. Therefore, coordination between these different strategies is

\(^7\) All Member States have committed to the Europe 2020 strategy. However, each country has different economic circumstances and translates the overall EU objectives into national targets in its National Reform Program – a document which presents the country's policies and measures to sustain growth and jobs and to reach the Europe 2020 targets. The National Reform Program is presented in parallel with its Stability/Convergence Program, which sets out the country's budgetary plans for the coming three or four years.

\(^8\) Objective 1 - strengthening research, technological development and innovation. Objective 3 - enhancing the competitiveness of small and medium-sized enterprises, the agricultural sector (for the EAFDR) and the fisheries and aquaculture sector (for the EMFF).
important and will be aided by channeling all these funds through the single Ministry of European Funds.

C. EU Level Statistical Tools and Policy Framework

Two statistical tools have been developed at the EU level with specific purpose of informing the Active Ageing Agenda. The first, the Active Ageing Index\textsuperscript{9,10} (AAI), aims to measure the current situation in four areas related to active ageing. The index was developed by the European Commission and the United Nations Economic Commission for Europe (UNECE). It attempts to measure the extent to which older people can realize their full potential in terms of employment, participation in social and cultural life, and independent living. It also tries to assess if the living environment enables older population to lead an active life.

The composition of the Index is presented in Table 1.1, together with Romania’s ranking in each of the subcategories. Romania ranks #20 overall, with the strongest showing in the category of employment of older workers. While the Index presents a rare opportunity to compare countries, it has important limitations in terms of comparability and reliability of the underlying data. For example, Romania’s strong position in the Employment category is dependent on the unconventional statistical definition of an employed person used in Romania, which considers all land owners and their family members as self-employed and non-wage workers, respectively.

The Special Eurobarometer survey on Active Ageing\textsuperscript{11} is another useful tool developed to understand European citizens’ views and attitudes towards older people. The survey has been commissioned by the European Commission's Directorate General for Employment and Social Affairs. It takes stock of people’s readiness and willingness to adapt to the changing demographics and accept reforms that would promote active ageing.

Survey results reveal divergence between Romania and the rest of EU27 in perceptions of age and older people. For example, almost twice as many respondents in Romania indicated a negative perception towards people aged 55 and over as in the EU27 average. In Romania, one is considered “old” at 61.3 years of age compared to the EU27 average of 64. Romanians also indicate that they would need to retire from their current occupation on average four years before their EU27 counterparts (EU27-61.7 vs. RO-57.7). According to survey results, slightly fewer people in Romania would like to continue working after reaching the pension age compared to

\textsuperscript{9} The AAI is a product of a joint project undertaken in 2012 by the European Commission Directorate General for Employment, Social Affairs and Inclusion together with the Population Unit of the UNECE and the European Centre for Social Welfare Policy and Research in Vienna.
\textsuperscript{10} http://www.euro.centre.org/data/1356002554_9393.pdf
\textsuperscript{11} Special Eurobarometer survey #378
EU27 average (EU27-33% vs. RO-27%). Almost twice as many Romanian respondents totally disagree with the need for the retirement age to increase by the year 2030 as in the EU27 average (EU27-36 vs. RO-69).

**Table 1.1 Composition of Active Ageing Index**

<table>
<thead>
<tr>
<th>Component of the AAI</th>
<th>Romania’s rank among 27 EU members</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Employment</td>
<td></td>
</tr>
<tr>
<td>a. Employment rate for ages 55-59</td>
<td>#9</td>
</tr>
<tr>
<td>b. Employment rate for ages 60-64</td>
<td></td>
</tr>
<tr>
<td>c. Employment rate for ages 65-69</td>
<td></td>
</tr>
<tr>
<td>d. Employment rate for ages 70-74</td>
<td></td>
</tr>
<tr>
<td>(2) Social participation in society</td>
<td>#25</td>
</tr>
<tr>
<td>a. Voluntary activities</td>
<td></td>
</tr>
<tr>
<td>b. Care to children and grandchildren</td>
<td></td>
</tr>
<tr>
<td>c. Care to older adults</td>
<td></td>
</tr>
<tr>
<td>d. Political participation</td>
<td></td>
</tr>
<tr>
<td>(3) Independent, healthy and secure living</td>
<td>#16</td>
</tr>
<tr>
<td>a. Physical exercise</td>
<td></td>
</tr>
<tr>
<td>b. Access to health services</td>
<td></td>
</tr>
<tr>
<td>c. Independent living</td>
<td></td>
</tr>
<tr>
<td>d. Financial security (three indicators)</td>
<td></td>
</tr>
<tr>
<td>e. Physical safety</td>
<td></td>
</tr>
<tr>
<td>f. Life-long learning</td>
<td></td>
</tr>
<tr>
<td>(4) Capacity and enabling environment for active ageing</td>
<td>#27</td>
</tr>
<tr>
<td>a. Remaining life expectancy at age 55</td>
<td></td>
</tr>
<tr>
<td>b. Share of healthy life expectancy at age 55</td>
<td></td>
</tr>
<tr>
<td>c. Mental well-being</td>
<td></td>
</tr>
<tr>
<td>d. Use of ICT</td>
<td></td>
</tr>
<tr>
<td>e. Social connectedness</td>
<td></td>
</tr>
<tr>
<td>f. Educational attainment</td>
<td></td>
</tr>
</tbody>
</table>

**Overall Rank for Romania**

#20

*Source: (European Commission, 2013)*

The survey also presents the responses to the question about useful things the government could do to help people who care for elderly family members, with the most frequent responses being: (1) receiving financial remuneration for the care they provide; (2) receiving pension credits for their care time; (3) being allowed to work part-time; (4) being allowed to work flexible hours; and (5) being allowed to temporarily leave their job with the right to return afterwards.

**Romanians on average feel that their local area is less age-friendly than their EU27 counterparts** (EU27-65% vs. RO-47%). The most needed improvements to make their local
environment more age friendly were perceived to be: (1) more facilities for older people to stay fit and healthy; (2) better public transport; (3) improved roads and road safety; and (4) more public areas such as parks.

**While survey results are valuable in assessing attitudes of people, it is also important to note their limitations.** Most importantly, people’s attitudes and views are strongly shaped by the policies currently in place, which over time tend to become internalized as normal and acceptable. For example, people will commonly state that they expect to be able to work until the age that happens to be legally legislated retirement age in their country and the age at which most of their peers currently tend to retire.

**Therefore, the Active Ageing agenda should not only attempt to follow implied preferences of the population, but should also aim to shape those preferences** so that an active ageing way of life becomes a widely accepted social norm. In fact, changing attitudes and opinions towards age and ageing should be considered one of the most important components of the Active Ageing Strategy.

**Policies consciously promoting Active Ageing in an integral manner are still a relatively new phenomenon.** Therefore, new policies often have to be developed in the absence of good data and with a limited array of tried-and-true examples from other countries. Nevertheless, a set of commonly recognized areas for action in Health, Employment, Social Participation and Independent Living domains are starting to be formed at the EU level (Council of the European Union, 2012). Not all of the recommended policy areas are equally relevant for Romania given divergences in current health outcomes, income levels, lifestyle habits, prevailing occupations of older workers, and geographical distribution of the older population between urban and rural areas between Romania and the rest of Europe. As such, this document will place the main focus on the following themes that were deemed most appropriate and pertinent to Romania in each of the four Active Ageing agenda domains.

**Prolonging Life and Achieving Healthy Ageing**

A **target to add 2 years of healthy life to all people in Europe until 2020 has been set** in the context of "European Innovation Partnership on Active and Healthy Ageing". This task is further complicated in Romania by extremely sharp projected population ageing, which is bound to create fiscal pressure on healthcare systems through increased utilization. At the same time, a rapidly shrinking working age population poses questions about whether raising additional financing is feasible, and whether the needed healthcare and eldercare workforce can be mobilized in light of strong emigration flows. An uneven geographical distribution of ageing is also an extremely important feature of the Romanian context, where half of the population lives in much more rapidly ageing rural areas.
Therefore, to pre-emptively reduce future pressures on Romania’s healthcare system, it is especially important for Romania to:

- Achieve reduction in behavioural risk-factors, including alcohol and tobacco use, and development of obesity, as well as promote healthy lifestyles through improved diet and exercise;
- Strengthen policies regarding prevention, early detection and treatment of chronic diseases, including cardiovascular disease, diabetes and depression, which are likely to become more common as population ages;
- Refocus Romania’s healthcare workforce with an emphasis on geriatric and family doctors, well equipped to manage multiple chronic diseases and cognitive decline in mainly ambulatory settings.

**Increasing Employment Rates among the Older Population**

To achieve its national target of 70 percent employment rate for the population aged 20 to 64 by the year 2020, Romania needs to substantially increase the employment rate of its older working-age population. Romanians tend to retire early, which especially strongly applies to women, and the transition from full time employment to full time retirement tends to be very abrupt. At the same time, the Romanian pension system is set on the path of taking a smaller role in providing income to Romania’s older population, both in terms of population coverage and pension levels, which creates the need for additional income from employment for the older population.

To address these needs Romania should consider policy questions in the following areas:

- Review of eligibility criteria for retirement, with the focus on achieving higher effective retirement ages;
- improved human resource policies concerning older people;
- modernization of invalidity and disability benefit programs;
- promotion of health-friendly work environments; and
- Improvements in life-long learning.

**Increasing Social and Political Participation of the Older Population**

The idea of social and political participation is new in Romania. In the context of the Active Ageing Index, the concept includes volunteering activities, care to children and grandchildren, care to older adults, political participation, and social connectedness. In Romania the level of volunteering activities is particularly low, while, on the other hand, Romania’s older population provides a lot of care to their grandchildren and to the elderly. On average, social connectedness also seems to be quite strong among older Romanians.
Given beneficial effects of social and political participation for all concerned, and a projected increase of the older population, Romania would be advised to introduce a comprehensive program for promotion of social participation among elderly. The main areas where actions are needed include:

- Establishment of a steering body for the social participation program;
- Improved communication channels between the Government and older population;
- Employment of media and role models to promote idea of social participation, especially at older ages;
- Provision of more options for formal child and elder care, allowing older population to consider a wider array of options to participate in the society;
- Reducing poverty, health and infrastructure barriers for participation.

Promoting employment and social participation among older population can also contribute to Romania’s goal to reduce the number of people at risk of poverty or exclusion by 580,000 people by 2020, set in its National Reform Program (NRP) and also a national target in the context of the EU 2020 growth strategy. This would be achieved as longer careers translate into higher accrued pension rights under current pension law.

**Reducing Dependence among Elderly and Providing Long-term Care**

The long-term care system in Romania is still very young and, as in most EU Member States, faces challenges in planning, funding, governance, organization and monitoring of service delivery in the area of long-term care. In the coming decades the Romanian long-term care system is expected to be strongly pressured as Romanians live longer, and quite likely experience more chronic disease accompanied by disabilities. The system is also already pressured by the lack of care professionals, which is expected to worsen in coming decades.

Unless appropriate measures are taken, population ageing will also increase health care costs and put pressure on the demand for long term care. The key approach for Romania therefore has to be on keeping people as healthy as possible and at home as long as possible, with an emphasis on activation and self-help measures. To prepare the long-term care system to cope with these challenges, policy makers should consider the following actions:

- Initiating a public dialog about the identity and goals of the long-term care system;
- Setting up clear governance structures and policies for the integrated system;
- Deciding on which organizational structures will be emphasized;
- Establishing seamless pathways and processes for clients;
- Finding ways to attract, train and retain care professionals;
- Securing needed finances for long-term care provision.
D. Development of the Strategy for Protection of the Elderly and Promotion of Active Ageing

In the context described in this section, Romania has set out to prepare a Strategy for Protection of the Elderly and Promotion of Active Ageing which, based on the current situation, commits to policy measures in order to:

- Prolong lives and achieve healthy ageing
- Promote longer employment
- Increase the social and political participation of older age groups, and
- Decrease dependence of the elderly and provide long-term care

The preparation of the Strategy for Protection of the Elderly and Promotion of Active Ageing will be informed, among other sources, by socio-economic analysis presented in this document. The Document in turn takes into account analyses performed by the Ministry of Labor, Family, Social Protection and Elderly (MoLFSPE), national strategies and policies regarding the protection of the elderly and promotion of active ageing, as well as parallel strategies, some still under preparation, in the areas of disability, health, employment and life-long learning. The document also benefits from an analysis of best practices around the world, including the EU, and guidance provided by the EC and other relevant organizations.

The analytical document aims to provide a comprehensive analysis of the core active ageing principles in the context of Romania development goals and the EU2020 vision for growth. Its structure is organized around each of the building elements of the active ageing concept, where every leading theme is covered in a separate chapter.
Chapter 1 Bibliography


Steering Group (the SG) of the European Innovation Partnership on Active and Healthy Ageing (the EIP on AHA). (2001). *Strategic Implementation Plan for the European Union Innovation Partnership on Active and Healthy Aging*. Brussels.

Chapter 2 HEALTHIER LIVES IN AN AGEING SOCIETY

A. Ageing of Romania’s Population

Population ageing is driven by three separate phenomena, namely improvements in life expectancy, declining fertility rates, and emigration, which for Romania are depicted in Figure 2.1, Figure 2.2, and Figure 2.3. In Romania, average life spans increased substantially in the last 60 years, with life expectancy at birth rising by about 14 years for females and 10 years for males. At the same time, the total fertility rate dropped from 2.9 in late 1960s\textsuperscript{12} to 1.3 children per woman by late 2000s. In addition to longer life spans and fewer births, the age composition of Romanian population has been further transformed by pronounced emigration, especially over the last decade. Figure 2.3 shows the percentage reduction in cohort sizes between 2002 and 2011, underscoring the obvious trend in emigration among the population under 30 years of age. For example, only 80% of the population aged 15 to 19 in 2002 still appeared in 2011 census.

By 2035, it is expected that there will be more people over the age of 65 than people under the age of 20 in Romania (Figure 2.4). So far the rise in population aged 65 and above has been an outcome of increasing life expectancy and larger cohorts of people reaching that age. The declining rate of fertility is clearly reflected in the reduced number of children since 1980 and the projected declining size of the working age population since 2010. It is important to keep in mind that population projections may not be extremely accurate as any of the three demographic factors may start diverging from their trends. For example, migration is famously unpredictable. Fertility rates might also change, although the changes would only start influencing the outcomes in a few decades. The trend of lengthening life expectancy is already well entrenched and surprises, if any, should be expected on the upside.

\textsuperscript{12} Romania has experienced a dramatic but short-lived baby boom in 1967 and 1968 (and to a lesser extent in the years after that until 1989). For about a decade -- from the late 1950's to the mid-1960 -- the principal means of family planning in Romania was abortion, with most estimates placing the proportion of conceptions ending in abortion at 80 percent. In October 1966, effective November 1, 1966, in response to declining birth rates, the Government has issued the Decree No. 770 essentially banning most if not all abortions, making it difficult to obtain other means of birth control, and incorporating several pronatalist provisions. As a consequence, there were about twice as many babies born in 1967 and 1968 as in 1966. These two cohorts -- known in Romania as the "decree babies" or "decree cohorts" -- will be reaching old age in a little less than two decades from now, adding to the urgency of dealing with population ageing.
Figure 2.1 Evolution of Life Expectancy in Romania

Source: UN population statistics

Figure 2.2 Evolution of Total Fertility Rate in Romania

Source: UN population statistics
In contrast with these national demographic trends, one of the largest ethnic minorities of Romania, the Roma population, is a comparatively young and dynamically growing group. About 613,000 Romanians, approximately 3.3% of the population, have declared Roma ethnicity in the 2011 Census, which makes them the second-largest ethnic minority in Romania, after Hungarians. However, there are concerns that this estimate is inaccurate due to significant
underreporting. Expert estimates place the number of Roma much higher: according to Council of Europe data, the Romanian Roma population in 2010 was estimated at between 1.2 million and 2.5 million, or 6.5 to 13.5 percent of the total population. Children and youth aged 0–14 years - the new generation of labor market entrants - make up almost 40 percent of the total Roma population, compared to 15 percent among the general population. The youth of the Roma thus stands in stark contrast to the fast-ageing profile of Romania’s general population (Figure 2.5). Life expectancy among the Roma ethnic minority is considerably lower than among the general population in Romania: some estimates point to a gap of 6 years, while others find a 16-year difference in the average age of death of Roma and the general population in Romania (World Bank, 2014).

Figure 2.5 Contrasting Population Pyramids: Roma and Overall Population in Romania


---

13 Given the likelihood that Roma substantially underreport their ethnicity on the national census, an alternative set of expert estimates is commonly reported. According to the Strategy of the Government of Romania for the Inclusion of the Romanian Citizens Belonging to Roma Minority 2012–2020, estimates range from 535,140 (National Census in 2002), to 730,000–970,000 (Romanian government/World Bank survey, “The Roma Communities Social Map,” 2005), to 1,850,000 (European Commission, An EU Framework for National Roma Integration Strategies up to 2020, based on data from the Council of Europe).
Romania is projected to experience one of the sharpest drops in the working-age population in the European Union, a trend that will likely impose a heavy burden on the economy. United Nations Population projections show that over the coming decades, the numbers of the older population (aged over 65) are expected to increase significantly while the working-age population (defined as 20 to 64), after a prolonged period of growth, heads for a steep decline from 2014. Consequently, the decline in the share of the population contributing to economic output could result in lower growth in income per capita and dampen overall prospects for economic growth. The population dependency ratio –defined as the ratio of people younger than 20 and older than 64 to working-age population, those aged 20 to 64 – has been rapidly declining in the last 20 years, creating a strong tailwind for the economy and reaching a “sweet spot” of its lowest dependency rate of 0.55 in 2010. However, the dependency rate is projected to double in the next 50 years, also at a very rapid pace (see the graph on the left in Figure 2.6). This demographic development is partly driven by a sharp increase in the number of people over the age of 65 as a share of total population, as shown on the right of the Figure 2.6.

It is important to note that, as the overall working-age population in Romania is projected to fall, the share of Romania’s Roma minority among them is expected to grow: depending on the aforementioned estimates of the Roma population, already between 6% and 20% of today’s youth are Roma. This minority group faces exclusion from the labor market which, if continued, would create even faster contraction of employed population than national demographic projections would suggest. The scope to increase the employment rates and earnings among Roma translates into a considerable economic benefit potential, ranging between €887 million and €2.9 billion annually, and additional fiscal benefits ranging between €202 million and €675 million annually. (The World Bank, 2014).

The projected demographic transition will likely impose increased fiscal pressures on public budgets. The increasing numbers of elderly will result in increased spending on pensions and long-term care services. As growth and income tax revenues decline – a likely outcome of a shrinking working-age population – Romania will need to find low-cost solutions to meeting the growing needs of an expanding older population. A crucial question is whether projected gains in life-expectancy will be accompanied by increases in illness, disability, vulnerability and accompanying higher use of social services. Research findings are at times conflicting, and it is not entirely straightforward to predict rising costs due to ageing (Lancet, 2013). Much depends on the prevailing scenario: (i) compression of morbidity, as suggested by Fries in 1980, whereby medical improvements would delay morbidity but not mortality, resulting in more healthy life-years but not much longer lives; (ii) expansion of morbidity, as argued by Gruenberg and Kramer who believe that medical progress would increase survival instead and lead to an expansion of unhealthy life-years or (iii) the dynamic equilibrium proposed by Manton, in which increased survival is offset by better control of chronic disease, keeping the proportion of life lived in good health more or less constant. The next section of this chapter offers more discussion on how likely these scenarios are in the Romanian context, and what are the possible
implications for health expenditures as a result. (Gruenberg, 1977) (Fries, 1989) (Kramer, 1980) (Manton, 1982)

Another difficult challenge in meeting the needs of older people is likely to be the declining pool of potential healthcare and eldercare workers. Romania is already reporting shortages in healthcare professionals, mainly the result of pronounced emigration to other ageing EU countries that can afford to pay higher wages for these highly labor intensive and, in many cases, physically demanding occupations. Human resources account for up to 60–80% of total recurrent expenditure in health systems, not including the costs of education and training, and 8% of all jobs in the EU-28. The European Commission has estimated that two million new jobs in health and long term care will be created in the EU alone between 2010 and 2020 (European Commission 2012) and many younger Romanians might be tempted to take them in richer EU member states.

**Figure 2.6 Trends in Population Dependency Rate and Share of 65+ Population**

<table>
<thead>
<tr>
<th>Population dependency rate</th>
<th>Share of 65+ in total population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>30%</td>
</tr>
<tr>
<td>0.80</td>
<td>25%</td>
</tr>
<tr>
<td>0.60</td>
<td>20%</td>
</tr>
<tr>
<td>0.40</td>
<td>15%</td>
</tr>
<tr>
<td>0.20</td>
<td>10%</td>
</tr>
<tr>
<td>0.00</td>
<td>5%</td>
</tr>
</tbody>
</table>

Source: UN population statistics.

To summarize, Romania is at the cusp of a very significant demographic change. The rapidly decreasing dependency rate, which created strong tailwinds for the economy until 2010, is sharply reversing course. A crucial question going forward is whether projected gains in life-expectancy will be accompanied by increases in illness, disability, vulnerability and accompanying higher use of social services, or whether, instead, growing life expectancy will mean additional healthy and active years for future cohorts of Romania’s older population. Strong emigration trends among younger cohorts is another important demographic factor which could potentially be destabilizing for the Romanian economy and social service provision in particular, by reducing the pool of potential health and eldercare personnel.
B. Geographic Patterns of Ageing

Population ageing in Romania has a pronounced regional dimension, evidenced by the uneven distribution of the older population across the country, as shown in Figure 2.7. Interestingly, the uneven ageing does not necessarily translate into a commensurate regional reduction in the number of taxpayers or increased old-age related spending. For example, the areas of high “pensioner density” shown in Figure 2.8\textsuperscript{14} are not always found where the share of population aged 65 and over is the highest. While in the southern provinces the two maps show concentration of both elderly and pensioners, the west and central Romania have significantly more pensioners than the number of elderly would suggest, while the reverse is true in the north east.

Further analysis of the geographical distribution of older population highlights stark divergences in the age composition of population by the degree of urbanization. To approximate the degree of urbanization, the population of Romania has been grouped into deciles by the size of municipality they live in (see Figure 2.9). The leftmost column represents the population of Bucharest, while the rightmost column represents the 10% of Romania’s population living in the smallest rural municipalities with an average of 1700 inhabitants. Figure 2.9 shows that if 12% to 15% of the urban population is aged over 65, this proportion reaches 23% in the smallest communities. At the same time, close to 25% of the urban population are in receipt of a social insurance pension, compared to only 18%-20% in rural areas. While the latter statistic is biased lower due to exclusion of recipients of the farmer’s pension benefit, closed to new beneficiaries since 2000, it properly represents the future trend of the pension system without a farmer’s scheme.

The divergent geographical distribution of ageing and social insurance coverage also creates important implications for regional development. As shown in Figure 2.10, social insurance coverage among the urban population over the age of 65 exceeds 95 percent. On the other hand, the older rural population is faced with declining pension coverage\textsuperscript{15}. Therefore, even if ageing is most pronounced in rural areas, most of the old age related government spending is likely to reach urban regions. Taking into account that overall pension spending exceeds 7 percent of GDP, regional distribution of this spending does matter, due to its ability to stimulate regional economies.

\textsuperscript{14} Recipients of “farmers pension” benefit, which is no longer assigned since 2000, but continues to be paid if assigned prior to 2000, are excluded from this analysis.

\textsuperscript{15} While most of the rural population aged 65+ and not covered by general social insurance scheme are eligible for the farmer’s pension benefit, this is no longer true about younger rural cohorts.
Figure 2.7 Share of population aged 65 and over in total population

Figure 2.8 Share of pensioners in total population

Source: Census data
Figure 2.9 Proportion of older population by the degree of urbanization in population deciles

Source: 2011 Census data
Note: recipients of “farmers pension” benefit, which is no longer assigned since 2000, but continues to be paid if assigned prior to 2000, are excluded from this analysis.

Figure 2.10 Social Insurance coverage of older population by the degree of urbanization in population deciles

Source: Census data
Note: Recipients of “farmers pension” benefit, which is no longer assigned since 2000, but continues to be paid if assigned prior to 2000, are excluded from this analysis.

The uneven geographical distribution of ageing in Romania poses an added complexity of providing medico-social services to an isolated older population. Figure 2.11 highlights the uneven ageing of Romania even more starkly. It shows that the old-age dependency rate, the ratio of the 65+ population to the working age population, can be as much as 2.5 times higher in
the smallest municipalities, if compared to urban settings. This large difference is bound to stretch not only municipal budgets, but also the availability of the local workforce to provide a sufficient pool of recruits for the eldercare and healthcare professions in small localities. The degree of population density is typically low in these areas, imposing added difficulty, cost and need for human resources in providing medico-social services to this population.

The magnitude of the challenge of providing medico-social services to rural older population is even larger if one looks at the geographical distribution of the oldest old. Despite a lower life expectancy in poorer rural areas, the highest proportion of oldest old – aged 75 and over – still live in rural regions. Figure 2.12 shows that up to 11% of the populations in the smallest municipalities are in this age bracket and more than a third of them live alone. This population is extremely vulnerable to poverty, exclusion and lack of access to health and long-term care.

**Figure 2.11 Old age-dependency rates by the degree of urbanization in population deciles**

Source: Census data

The large differences in old-age dependency rates between urban and rural communities are mostly caused by emigration, a big part of which reflects internal migration due to urbanization. It is important for policy makers to realize that emigration, especially internal migration to urban areas, is a natural product of development, mostly benefiting urban areas. The phenomenon is often encouraged in the name of increased productivity and employment opportunities of the young population and might be beneficial for other reasons. However, high old-age dependency rates in rural settings are often a cost of such economic development, the burden of which should be shared between urban and rural communities.
To summarize, population ageing in Romania has a pronounced regional and urban/rural dimension, creating important implications for regional development and social service provision. For example, most of the 7% of GDP which the government spends on pensions is paid to urban pensioners and stimulates mostly urban economies. Urban areas also reap the benefits of internal migration of the young population, leaving rural regions to bear increased burdens of social service provision for older people. Rural regions also struggle with complexity and lack of human resources in providing medico-social services to isolated older population. Therefore, policy makers should take into account that the high old-age dependency rate in rural settings is often a cost of internal migration and economic development, the burden of which should be shared between urban and rural communities.

C. Health Status of Romania’s Ageing Population

To better gauge the health status of Romania’s population and compare it to other countries, it is important to clarify the meaning of the various statistical measures used in defining population ageing. A typical approach is to look at changes in average life expectancy as an indication of ageing. However, mortality is only one aspect of ageing. Longer life spans do not provide any indication regarding the health condition of a person during the added years. Additional years may be plagued with illness, disability, frailty and dependence on others. On the other hand, if the added years are spent in good health, a growing older population should only be celebrated and regarded as a valuable social and economic resource. Healthier ageing would not only help offset the projected decline in working-age population by allowing more older workers to stay in the labor force for longer, but it would also contribute to containing
rising healthcare expenditures. One useful measure in this regard is healthy life expectancy (HALE), also called "disability-adjusted years", representing the average number of years that a person can expect to live in full health\textsuperscript{16}. Figure 2.13 shows healthy life expectancies for men and women at the age of 50 for all EU and some other selected countries compared to unadjusted life expectancies, and the gender gap between them. The gap between life expectancy and healthy life expectancy can be interpreted as the average number of life years lived in poor health\textsuperscript{17}.

As was shown in Figure 1, Romanians are living longer, but these gains are lower than in the rest of the EU, with many years lived with disability (Figure 2.13). At the age of 50, men can expect to live for another 25 years, only 13.1 of which would be spent in good health. At the same age, women can look forward to a life expectancy of 30.4 years, 12.1 of which are estimated as healthy years. Thus, women can expect to live 5.1 years longer than men, but with much higher proportion of remaining life lived with disability (18.3 years versus 11.9 years for men). By comparison, years lived with disability in Norway amount to only 8.8 for women and 5.6 for men.

**Figure 2.13** Life expectancy (LE) and Healthy life expectancy (HLE) at the age of 50

\[\text{Source: Eurostat, 2011 data}\]

\textsuperscript{16} In comparison to average life expectancy – which treats all years as equal - the healthy life expectancy (HLE) indicator assigns different weights to different years depending on their relative healthiness. Years spent in an unhealthy state are deducted from the total and adjusted for the severity of the unhealthy state in question (as judged by large population surveys). One year of healthy life expectancy therefore indicates one full extra year of life lived in perfect health, free from disability or illnesses. In effect, the statistic measures the number of years that a person at a given age can expect to live in good health taking into account age-specific mortality, morbidity, and health status.

\textsuperscript{17} Variability of healthy life expectancy estimates is large. Institute of Health Metrics and Evaluation estimates reports much higher values for most countries presented in Figure 2.13.
A large part of improvements in life expectancy and healthy life expectancy in the last decades were no longer driven by the reduction in common infections, as in the past, but by medical improvements, higher levels of education, and increased socio-economic levels (Rechel et al 2009). These gains are expected to continue and, if Romania catches up with the rest of the EU, the process might even accelerate. This begs the question of whether further life expectancy gains will be accompanied by increases in illness, disability and vulnerability, resulting in heavy burdens on health and LTC services. Achievements of Nordic countries, which have reached a low number of years with disability even in the context of high life expectancy offer hope for Romania, at least in the catch-up period. Going forward, as mentioned in the earlier discussion of this Chapter, there are different scenarios and theories about the extent to which increases in life expectancy go together with increases in healthy life years, or how do declines in mortality and morbidity correlate. A recent OECD study on 12 countries shows a mixed picture, concluding that much depends on the country, its policies, rates of risk-factors (smoking, physical activity, diet) and past attention to preventing chronic disease.

The incidence of severe disability varies a lot between countries as they age, but mild and moderate disability tends to increase more uniformly with longer lives. Austria, The Netherlands and UK are among the countries showing only moderate reductions in severe disability with the increased life expectancy, while Germany, France and Japan have experienced much greater declines. One study even found an increase in severe disability coinciding with increased life expectancy in Canada and Australia. The findings are clearer regarding mild and moderate disability, which are expected to grow as life expectancy increases with greater certainty. The trends for mild and moderate disability have even stronger implications for future care and health expenditures, since they affect larger numbers of people.

Most EU countries and OECD country studies show increases in mild and moderate disabilities which may be attributed to improvements in treatment, early detection and prevention of co-morbidities and their severity. In Romania, the data on disability related to ageing are very limited and no trend data are available to estimate future disability rates. Based on the European Union Statistics on Income and Living Conditions (EU-SILC) data analysis, a total of 20% of Romanians over the age of 65 report having strong limitations due to health problems (see Figure 2.14). It may be assumed that this population would require some form of long-term care with medical interventions. The demand for these services is likely to grow given the current high rates of risk factors (see next sections of this Chapter).

In most EU countries the growing number of obese and overweight people is increasing the burden on disability and associated health and care costs. Type 2 Diabetes, which is closely related to obesity, is one of the most costly chronic diseases in the Western world. It also is the biggest contributor to severe disability due to complications (amputations and cardio-vascular incidents). Hypertension is the next most costly risk-factor to cardio-vascular disease. In Romania, the prevalence of obesity among adults is currently at about half of the EU average (7.9% as compared to 16.6%), but it is increasing with very little public education about the
associated risks and prevention measures. Being overweight and obese has risen rapidly in younger generations in Romania and, although prevalence of diabetes in 2013 is still lower than in most EU countries, the risk factor is high and is likely to get higher if no preventive measures are taken. Type 2 diabetes, hypertension and obesity prevalence all increase in advanced age, as does the risk of co-morbidities, while most of the prevention (life-style) is needed in earlier adult life\textsuperscript{18}.

\textbf{Romania to a large extent mirrors the epidemiological profile of the other EU countries, except with regards to its Roma population.} It is characterized by low prevalence of communicable diseases and growing share of cardiovascular diseases (heart disease and stroke), cancer and health conditions stemming from external causes including violence and injuries. Diseases generated by preventable lifestyle factors are also claiming an increasing share, including from tobacco consumption, alcohol abuse, and lifestyle related risk factors (Country cooperation at a glance - 2013). The most common non-communicable diseases including cardiovascular, cancer, respiratory diseases and diabetes mellitus together account for 86% of total mortality. (The diabetes epidemic and its impact on Europe - 2012)

\textbf{The Romanian Roma population, however, shows a different epidemiological profile and suffers worse health than the general population.} In addition to having much lower life expectancy rates, recent survey data on the health status of Roma point to a higher burden of both infectious and chronic disease. Explanatory factors of lower health status include poor living conditions which contribute to infectious disease, diarrhea and respiratory disease, especially among children. High burden of chronic disease is also consistent with high risk behaviors such as poor diet, low levels of physical activity and smoking, both for men and women: for example, recent analysis shows that almost half of Roma adults smoke regularly and Roma women smoke 2.2 times as much as Romanian women nationally. Poor health outcomes can also be caused by ineffective use of the available health services: approximately 42 percent of Romanian Roma do not seek health care when they actually need it. Over 80\% of those that do not seek needed care cite financial constraints, even though a number of medical services are free of charge. Lack of insurance and uncertainty about out-of-pocket costs are major concerns (World Bank, 2014). Given the importance of the Roma population as a growing minority, more attention is needed to their specific needs\textsuperscript{19}.

\textsuperscript{19} The recently produced Roma report “ Diagnostics and Policy Advice for Supporting Roma Inclusion in Romania World Bank 2014” provides more specific needs oriented policy recommendations for Roma,
Weakening cognitive function at older ages is a major cause of disability and dependence; however, data and trends are less well studied (WB, Regional report 2014). The current population in the Europe and Central Asia (ECA) region are likely to have accumulated risk factors over the course of their life - evidence from the Survey of Health, Ageing and Retirement in Europe (SHARE) shows that economic recessions during early and middle age are associated with worse cognitive function at ages 5—74 (Leist, Hessel et al, 2014). Dementia, most commonly manifesting itself in the form of Alzheimer’s disease, leads to brain degeneration that affects memory, thinking, behaviour, and ability to conduct activities of daily living. Dementia is not a normal part of ageing. However, it is increasingly common with age, and its prevalence is rising in ECA (WHO, 2012b). In 2009, there were an estimated 6.8 million people aged 60 years and over suffering from dementia in EU member states, accounting for around 6 percent of the population in that age group, according to estimates by Wimo et al. (2010). In Romania the prevalence rate of dementia in this age group was lower, at 4.7 percent.

Depression is also a concern in an ageing population and especially so in Romania’s rural areas where many elderly live alone. Loneliness is a strong determinant of depression, in particular among women. Prevalence of depression in older age is estimated at about 10% of the population for those living independently worldwide, rising to about 25% of the older population who have concurrent chronic diseases, and even higher for those in institutional care (McDougall et al, 2007). Rates of self-reported depression are higher in ECA than in EU15 populations (Smith and Nguyen, 2013). Managing depression could have significant health benefits in ECA (Jenkins, Klein and Parker 2005, World Bank 2007).
In brief, given the limited data available, only broad conclusions are possible. The life expectancy of Romanians is increasing (with the exception of the Roma minority), and people are likely to live the extra years without a substantial increase in severe disabilities. Under current trends and policies they will however suffer more from moderate and mild disabilities, based on the prevalence of risk factors and the current level of self-reported illness, in particular taking vulnerable groups (the poor in rural areas, Roma) into account. A more detailed analysis of the trends of chronic disease and disability among the ageing population as well as strengthening of the health information systems would improve future analysis and evidence-based policy making. In addition, national averages may conceal considerable inequalities, as well as differences in education and socio-economic status. Gender considerations are important as well as women tend to live longer, but with more years in poor health. Women worldwide are also more prone to depression which needs heightened attention in the ageing society (Ritsatakis 2008 and Jette 1981).

D. Implications of ageing for health expenditures and the health system

Population ageing potentially creates fiscal pressure on health care expenditures through increased utilization. It is very difficult to estimate how much, and even whether, health expenditures would increase due to ageing as much depends on how successful Romania will be in mitigating the effects that can be prevented. As older people typically account for about half of hospital workload (McKee 2002), it is logical to assume that an increased number of elderly would translate into increased hospital utilization and bed days and thus costs. In Romania half of the total health budget is spent on hospital care. However, most studies show that it is not ageing or even utilization that drives up health costs. Technological developments instead are the main cost driver. In France for example, between 1992 and 2000, health expenditures were reduced by 8.6%, but these gains were cancelled out by new costs related to technological progress; for comparison, ageing increased health expenditure only by 3.2% (Dormont 2005).

It is likely that ageing in Romania will affect health expenditures and this may even be considerable, as current spending is low and there is large unmet need, especially with regards to chronic disease management. The current health system is underperforming, especially for the poor, and is underfunded (Health Sector Functional Review, 2013, WB). Although Romania’s health system has done well in the last decade reducing infant mortality and maternal mortality, and has increased life expectancy, there are serious problems with access to services. This is especially so for the poor and vulnerable, who do not seek care when in need. This gap is particularly large in the treatment of chronic disease with 42% of the poor not receiving treatment for lack of infrastructure, availability of medical personnel, and financial access as many still pay out of pocket for health services and drugs (WB 2013).
Early detection and treatment of chronic disease and better management of risk factors and prevention can reduce future health expenditures\textsuperscript{20} and accelerate the increase in life-expectancy. In 2012, less than 30\% of surveyed adults in Romania reported having had a heart check-up and less than 50\% had their blood-pressure measured over the last 12 months (Getting Better, WB 2013). These are important screening measures which would help detect chronic disease early and avoid development of severe and costly conditions. Even among those adults who are aware of having hypertension (50\%) and were being treated (45\%), less than 10\% had it under control, meaning the drug regimen was not appropriate.

Risk factors such as smoking and alcohol use remain very high in Romania, healthy diet guidelines are sparsely communicated, and early screening needs more promotion (see Boxes 1 and 2). The life-expectancy gap between Romania and the EU-12 countries can be largely explained by the so-called ‘cardio-vascular’ revolution that took place over the past decade in Western Europe due to (1) control of risk-factors; (2) early detection and treatment; and (3) technological advances leading to reduced fatalities in the acute phase of chronic disease. In Romania, the prevalence of daily smoking among the adult population was 20.5\%, slightly lower than the European Union average of 23\%, with smoking rates significantly higher for men (33\%) than for women (9\%). However, there is a recent tendency of an increase in the number of women smoking daily. As in the rest of Europe, in Romania there is a strong evidence of socioeconomic differences in smoking and mortality: people of lower socio-economic status have a greater prevalence and intensity of smoking, a higher all-cause mortality rate and lower rates of cancer survival. Alcohol consumption is higher in Romania (12.7 liters per capita) as compared to the European Union average (10.7 liters per capita), with a 17\% increase during the last 30 years.

National public health programs which focus on awareness creation about risk-factors, prevention and promotion of early screening are very limited in Romania (WB 2013). Initially these programs focused on communicable disease such as TB and HIV/AIDS, lately also including hypertension. However, the financing and delivery arrangements of these programs tend to be vertical and have limited reach, as they are not sufficiently integrated into primary care and more broadly at the community level. They also tend to veer towards curative interventions instead of prevention. For example, the Diabetes program funds insulin pump treatment, but does very little about population education and screening of blood glucose levels. Very little information can be found about physical activity and attention to the elderly.

\textsuperscript{20} Prevention and early detection by themselves will not necessarily reduce future health expenditures. Much has been written about whether or not preventive actions in fact reduce later life health expenditures. On an individual basis this is without doubt the case, a person in need of heart surgery due to a arterosclerosis might have prevented these costs if proper early treatment and lifestyle changes had been advised and applied. However, from a population basis, if everyone would take frequent testing and screening and early treatment, the benefit of a life saved would not weigh up to the increased costs of preventions and early treatment. Adding into the calculation the benefits of health life years saved, it would come closer and may even outweigh costs. For a more comprehensive review see: New England Journal of Medicine, February 14, 2008.
Box 1. Tobacco control policies

Tobacco

Effective tobacco control policies cover a range of areas, aligned with the best evidence on what works to help people stop smoking (WHO 2013):

Policy Lever 1: Increase taxation on tobacco. In ECA countries, two thirds of people make smoking choices based on costs. Research demonstrates that a 10% increase in the cost of cigarettes reduces overall consumption by about 2.5-5% in high income countries, with a likely greater impact in lower and middle income countries and on the young (Chaloupka et al, 2010, Cawley and Ruhm, 2012); taxation is the single most effective and cost effective intervention to reduce cigarette smoking (Laxminarayan et al, 2006), and in ECA have demonstrably driven smoking cessation in Poland, Russia and Ukraine (Ross et al 2014). Yet cigarette taxes in many countries of the region fall below 50%, and even in the Balkan states, where taxation is particularly well imposed, do not reach 75% of retail price.

Policy Lever 2: Implement smoking bans in public places to reduce passive smoking and nudge smokers to quit or reduce the amount of cigarettes they smoke. Since its introduction in Ireland in 2004, the smoking ban in public places has been an effective and well-received measure to reduce smoking across Europe and beyond (EPHA, 2012; Spinney, 2007). Research shows that smoke-free legislation leads to a significant reduction in smoking-related cardiovascular and respiratory disease within a few months, with more comprehensive laws associated with greater risk reduction (Tan and Glantz 2012).

Policy Lever 3: Restrict the advertisement, promotion and sponsorship of cigarettes. Advertisement is the driver of one third of young people’s experimentation with smoking (WHO 2013), and banning advertising saves lives. Tobacco companies are targeting low and middle income countries with country-specific marketing that falsely emphasizes youth, glamour and sex appeal to increase smoking prevalence. Partial bans and voluntary restrictions on such advertising have been found to be ineffective, while comprehensive bans reduce consumption in all countries where they have been implemented (WHO 2013). Bans should forbid direct, indirect (sponsorship and promotions), and point-of-sale advertising, and corporate social responsibility activities by tobacco companies, with monitoring and enforcement.

Policy Lever 4: Incorporate health warning information on cigarette packets, and restrict sales of cigarettes to young people. Health warning labels on cigarette packets have been found to be effective, cost-effective, and publicly supported. Turkey is the only ECA country currently meeting international guidelines for these warnings. Restricting the age at which cigarettes can be purchased creates a disincentive and a barrier for smoking by young people.

Policy Lever 5: Provide information about the dangers of smoking and access to support to quit smoking, including nicotine replacement therapy. Public information campaigns can play a key role in preventing smoking, and research shows they are effective in countries of all income levels (WHO 2013). Each country’s health system should take responsibility for leadership and coordinating delivery of a national tobacco control program, including the provision of free access to smoking cessation programs.

Source: ECA Regional Flagship on Ageing, Forthcoming
Box 2. Policies to reduce alcohol consumption

**Alcohol**

Excessive alcohol consumption is a particular hazard to health and a risk to life expectancy in ECA countries, both as a risk factor for cardiovascular disease and for external causes of death, such as injuries. Eastern and Western Europe lead the world in per capita consumption of alcohol (WHO 2011). Alcohol-related deaths have been shown to contribute heavily to the overall gap in mortality between groups with different education levels in EU Member States (European Union 2013). This risk to health is mainly attributed to ‘binge’ drinking, that is drinking five or more drinks at one sitting (WHO 2012). Binge drinking is more common in ECA than in EU15, particularly where it forms part of cultural ceremonies.

The majority of people in ECA, and particularly women, support better policies to reduce risky alcohol consumption. Indeed, support for alcohol reduction policies have more public support in ECA than in neighboring EU-15. There is a good precedent for this from a set of anti-alcohol policies introduced during the 1980s (including taxation, sale and production restrictions, and health and education programs around alcohol), with wide ranging health benefits across the Soviet Union (Sidorenko 2013). When the Soviet Union dissolved, so too did these policies, resulting in a rise in alcohol availability and consumption that is considered responsible for up to half of the increase in mortality seen at that time (Bhattacharaya J, Gathmann C, Miller G 2011). These changes happened at a time when much of the rest of the world was implementing policies to improve morbidity and mortality from alcohol. By strengthening alcohol policy, significant gains could be made in healthy life expectancy in ECA.

**Policy Lever 1:** Deter use of alcohol by implementing health awareness campaigns, raising the cost of alcohol through increased taxation, limiting advertising, marketing and sponsorship, and using prominent health warning labels on all alcohol purchases. There is extensive evidence showing strong price responsiveness to alcohol, similar to tobacco.

**Policy Lever 2:** Reduce risk of harm from alcohol by enforcing laws that prevent drinking and driving, and providing advice and treatment for excessive alcohol use through primary care. Most ECA countries have more restrictive laws on blood alcohol content when driving than the EU-15, however enforcement is key.

**Policy Lever 3:** Limit availability of alcohol by restricting age, hours and location of purchase. Sales to youth are restricted nearly everywhere in ECA; however further restrictions on locations and hours of purchase (e.g. banning sales from vending machines) could be beneficial.

*Source: ECA Regional Flagship on Ageing, Forthcoming*
A healthy diet and staying physically active are among the key determinants of healthy ageing, and should be heavily promoted among all population groups to postpone physical ageing (social participation also has been proven to contribute to health outcomes; for more discussion see Chapter 4). More narrowly, creating opportunities for the elderly to walk and be active can help prevent and reduce development and severity of chronic disease substantially. Although the risk of injuries and falls increases with activity, this does not weigh against promoting physical exercise, but should be accompanied by creation of appropriate recreational areas. There are many innovative interventional experiences that can provide lessons (Japan, Netherlands, Denmark). A healthy diet may be a challenge for the elderly, especially since they have less ability to shop for fresh foods, cooking a meal is more challenging, and dental issues may impede eating fresh foods. More attention and awareness creation in this area is urgently needed in Romania.

Romania spends less than 5% of its GDP on health, which is low compared to the European average of 6.5% and EU-average of 8.7% (WB 2013). There is much room for improvement and the recent health sector functional review recommends developing a long term strategy, addressing efficiency improvements, fiscal space and sustainability as well as considering private financing. Ageing and related cost expansion as well as investments in early detection and treatment of chronic disease should be a big part of this strategy. A review of the pharmaceutical policy with regards to generic drugs and the prices of hypertension and cholesterol reducing drugs may provide important insights how to contain these costs. The implications for long term care are also very important and will be discussed in a separate chapter. Specific options for the health sector to consider in contributing to the goal of healthy ageing in Romania are suggested below.

- **The health system has a crucial role to play not only in the provision of medical care to the elderly, but also to provide early screening, awareness creation and preventive programs.** Romania’s health system has not paid adequate attention to this role in general, and especially not for the older population. With a growing elderly population and the ongoing development of a new long term strategy it is an opportune moment to pay more attention.

- **Many chronic conditions can be prevented through healthier lifestyle choices.** Adopting a healthier diet or undergoing regular health screenings can be a challenge, and many adult Romanians may not even be aware of the benefits of these actions. Therefore, policy makers should develop an integrated care approach which provides pathways for both preventative care and curative medicine in a more holistic and personalized fashion which can meet multi-dimensional health needs. The basic principles of this approach are based on the concept of integration of hospital, community, home and self-care:
  (1) Improving effectiveness of clinical outcomes through increased health literacy, patient empowerment, ethics and adherence programs;
  (2) Realizing innovation in personal health management through validated programs and good practices for early diagnosis and preventive measures;
(3) Implementing integrated programs for prevention, early-diagnosis and management of functional decline, both physical and cognitive, among the older population;
(4) review of the pharmaceutical policies with regards to prescription of generics and drug pricing.

- **As in any ECA country, in order to meet the needs of an ageing pool of patients in a fiscally sustainable manner, Romania will need to expand its geriatric health workforce.**
  The next generation of health workers will need to better understand the specific health needs of elderly patients. This includes managing multiple chronic diseases and cognitive decline in mainly ambulatory settings. In the context of a shrinking health workforce and constrained fiscal resources, Romania will need to introduce a shift from hospital-based care to strengthened primary care and prevention. In fact, as the population ages, care will increasingly need to be provided at the community level. Several countries in Europe and Central Asia, such as Turkey and Georgia, have been very successful in introducing a family medicine model despite a historical focus on hospital care (Smith and Nguyen 2013). Sustained increments in the ratio between family and specialist doctors will be needed to manage the disease burden of an ageing population. (ECA Ageing Study 2014).

- **Addressing healthy ageing in a fiscally sustainable manner: efficiently and with a focus on prevention:**
  (i) disseminating and implementing, as appropriate, protocols, education and training programs for health professionals, care personnel and informal/family caregivers with special attention to emerging roles and comprehensive case management, for example on frailty, multi-morbidity and remote monitoring;
  (ii) Piloting and establishing multi-morbidity case management, with new models of care for a range of chronic conditions, including protocols and individualized care plans;
  (iii) Reducing avoidable/unnecessary hospitalization of older people with chronic conditions, through the effective implementation of integrated care programs and chronic disease management models that should ultimately contribute to the improved efficiency of health systems.

**To conclude, population ageing is likely to contribute to increased pressures on health spending in Romania, which currently is not very high. To pre-emptively reduce these pressures Romania should invest in prevention, early detection and treatment of chronic disease. Especially strong attention should be paid to reducing tobacco and alcohol use, and promotion of healthy diet and exercise, including among the elderly, by better integrating these preventive measures into primary care and community life. Early detection and management of cardiovascular disease, diabetes and depression are likely to become more important as the population ages. The health system will also need a much larger geriatric health force who is well equipped to manage multiple chronic diseases and cognitive decline in mainly ambulatory settings.**
Chapter 2 Bibliography


Chapter 3 WORK AT OLDER AGES

A. The Older Population - an Underused Resource of the Romanian Economy

Romania’s national target to reach a 70 percent employment rate for the population aged 20 to 64 by the year 2020 is extremely ambitious. So far the progress has been slow. According to Eurostat data, the employment rate has consistently registered around 63 - 64 percent between 2003 and 2012. To reach its target Romania has to make concerted efforts to raise employment rates among all segments of the unemployed population, especially in the most vulnerable areas, such as those predominately populated by Roma, whose employment rate in 2011 stood at only 30 percent compared to their non-Roma neighbors, 44 percent of whom were employed (World Bank, 2014). However, the older working age cohorts currently represent the largest potential for increasing the labor force, especially in urban areas, as will be shown below. The labor force participation rate of the female population aged 50-64 is particularly low, and was standing at only 43% in 2012.

Romania’s progress towards its national target to reduce the number of people in poverty by 580 thousand people would also be much easier to reach if higher employment rates could boost incomes of the older working age population. This would further translate into higher future pensions, amplifying the positive impact on the incomes of the elderly.

Currently employment rates of the older working age population in Romania are quite low by EU standards notwithstanding an important upward bias in measurement which will be discussed below (see Figure 3.1). According to the statistics, the employment rate of the 55 to 64 year-old population stands 9 percentage points below the EU27 average, whereas the employment rate of 25 to 54 year olds is only 2 percentage points below. Just based on this one statistic, older cohorts seem to be an obvious big pool of potential additional workers, which cannot be ignored in setting policies to achieve the ambitious employment target that Romania has set to itself.

Administrative data on employment and pensions, shown in Figure 3.2, shed more light on the employment status of the older population. The figure indicates that a marked reduction in the proportion of formally employed people begins as early as age 50 - 54. Between those ages, 20 percent of women and 17 percent of men are already retired, mostly through the invalidity program, typically assuming a permanent full-time pensioner status. Despite the well-intentioned reforms of 2005 which tightened old age pension eligibility conditions, early retirement through the old age program also remains strong. Between the ages of 55 and 59, up to five years before statutory retirement age, there are already 2.5 women pensioners for every employed woman.
Similarly, between the ages of 60 and 64, up to five years before statutory male retirement age, there are 4.5 male pensioners for every employed man.

**Figure 3.1 Employment rates among prime and old age groups, 2013**

![Employment rates among prime and old age groups, 2013](source: Eurostat)

**Figure 3.2 Socio-economic structure of population aged 50-64**

![Socio-economic structure of population aged 50-64](source: Government of Romania administrative data, 2011 Census data)

*Note: Self-employed workers, mostly in agriculture and recipients of farmer’s pensions are included in the white area of the graph.*
Importantly, current retirement rules and the labor market environment do not seem to create a significant segment of population without a wage or a pension income at older working ages. In fact, the data in Figure 3.2 suggest that the proportion of the female population without such income decreases from ages 50-54 to ages 55-59, from 39 percent to only 9 percent. A similar observation can be made about men transitioning from the 55-59 to the 60-64 age group. These trends strongly suggest that early pension eligibility rules could be tightened further without creating unfairly heavy burdens on the population a few years away from statutory retirement age.

A very slim sliver of part time workers in Figure 3.2 also reveals that the transition from paid full-time employment into full-time retirement is very abrupt, without significant pathways through partial retirement, where lesser responsibilities, less strenuous work, fewer work hours, and volunteering work is combined with the first draws on retirement income.

As can be seen from Figure 3.2, only 23 percent of female and 34% of male population aged 50 to 64 are holding either full time or part time labor contracts. The overall employment statistic for this age group stands at 51 percent, much more in line with the employment statistic presented for Romania in Figure 3.1. The large difference is due to the inclusion in the employment statistic of a sizable group of small landowners and their family members, classified as self-employed and unpaid family workers, most of whom are engaged in low intensity subsistence farming, partially reflected by the large white area in Figure 3.2.

Inclusion of land-owners and their family members in the employment statistic in a country with a large older rural population, like Romania, strongly elevates the overall employment rate of older people and masks part of the gap between employment rates of younger and older population. The approach can also be partially blamed for the stubbornly stable overall employment rate. Under this measurement approach, increasing formal employment rates among small landowners and their family members does not show up in the improved overall measure of employment.

Romania’s high ranking in the Employment component of EU Active Ageing Index is similarly biased upwards. The index ranks Romania at 9th place in the Employment domain (out of 27 countries), which considers employment rates of persons aged 55-59, 60-64, 65-69, and 70-74, and where someone is considered “employed” if he or she performed any work, even for just one hour a week, for pay, profit or family gain as an employee or a self-employed person during the reference week. In Romania, around half of the population referenced by these statistics lives in rural areas, and most of them can report having worked on their land at least one hour a week, elevating the overall employment statistic mainly through the virtue of living in rural area and owning a land plot. This explanation is further substantiated by the fact that Romania’s high ranking in the Employment domain is mostly influenced by the employment rate among the very old cohorts, particularly among the population aged 70 to 74. (European Commission, 2013) (European Commission, 2013)
Figure 3.3 sheds additional light on the geographical distribution of employment in Romania and on the importance of relying on relevant definitions when considering potential interventions. The figure presents the employment status of the population aged 18 to 64 not in education or training. The population has been subdivided into deciles by the size of municipality in which they live, which strongly correlates with the degree of the urbanization. As is clearly shown in the figure, self-employment in Romania is almost exclusively a rural phenomenon that starts to be pronounced only in the localities with 8 thousand inhabitants or less. In urban areas, the majority of the working-age population that is not in education or training is formally employed or retired. Figure 3.3 indicates that in Bucharest, which is represented by the leftmost column in the graph, 72.3 percent of the population is formally employed, with another 1.5 percent self-employed. It also shows that 16% of the population aged between 16 and 64 and not in education or training has already retired, leaving only 10% of this group of people without formal work or a pension. This statistic is quite low even by developed country standards. As a result, in urban areas early retirees comprise the single largest group that has a potential to significantly increase overall employment rates.

**Figure 3.3 Employment status of the 18-64 population not in school or training by degree of urbanization**

![Graph showing employment status by degree of urbanization](image)

Source: 2011 Census

Figure 3.4 also negates the idea that employment and social insurance coverage can be substantially expanded by “formalizing” informally employed and self-employed workers. While under-declaring the level of income might still be an important phenomenon in Romania, most of the urban population is already “registered” as contributors in the Social Insurance system, while many rural “self-employed” may be mainly outside of the cash economy and cannot be expected to make tax payments or social security contributions even based on the minimum wage. Therefore, the long road to increased employment and broader social security
coverage in rural areas goes through improved education, general economic development of remote regions, and gradual urbanization.

As can be seen from Figure 3.4, in the urban setting the number of 55-64 year olds without a job almost equals the size of the whole jobless population aged 18-54, when the population that is in education or training is excluded. Contrary to the younger jobless, many of whom may have never held a job or have been jobless for a long time, most of the jobless urban 55-64 year olds have long work histories and could be retained more easily as part of the workforce with important improvements to life-long learning, labor and social insurance policies. Reaching the ambitious 70% employment target by 2020 without heavily prioritizing employment oriented programs for this crucial age group, representing half of the urban jobless population, would be very difficult, if not impossible. To maintain and further raise employment target beyond 2020, education prospects of youth, especially Roma and others living in rural areas, should be urgently improved.

Figure 3.4 Segments of 18-64 population not in school and not with labor contract as a proportion of the total 18-64 population

Due to the shrinking of the size of the working age population, Romania is positioned to undergo a 12 percent contraction in employment by 2030 and a 32 percent contraction by 2050, if current employment patterns remain stable. Failing to raise employment rates of Roma population would contract the labor force significantly further. To stem the decline, increased labor force participation among all segments of society should be strongly promoted. However, the potential of the older age groups to contribute to the Romania’s workforce, already very strong, will only grow in the future as the proportion of the older population increases and becomes more urban.

Source: Government of Romania administrative data
The policies to increase employment at older ages should be directed at five distinct groups: 1) raising employment rates of *urban better skilled older workers* could be the fastest and cheapest way of increasing overall employment in the economy in the short term, especially if separation of this group from the labor market could be delayed; 2) a harder to reach, but much more numerous segment of population with the potential to significantly increase employment is the *urban less skilled older workforce*, a large proportion of which may still be employed but is about to reach pension eligibility requirements through different retirement programs; 3) efforts should be made to raise employment rates among the *younger pensioners*, especially through part-time work; 4) general economic development of rural regions should also yield results in improving employment prospects of *older rural population*; and 5) expectation of much longer working lives should be created among the *younger workers*, with important implications for taking care of one’s health and skills.

B. The Incomes of Older Population Will Need a Boost from Employment

As was discussed in Chapter 2, 96% of the urban population aged 65 and over are in receipt of at least a minimum wage or minimum pension. In rural areas, 93% are covered between the Social Insurance System and the Farmer’s Pension Scheme. The remaining uncovered population remains dependent on their families or on Social Assistance programs.

However, pension coverage is likely to deteriorate significantly going forward, especially in the rural areas, due to the closing of the farmer’s pension scheme to new entrants as part of the pension reform of 2000. Since there are no new entrants, the number of beneficiaries in the farmer’s scheme is declining by more than 9 percent per year due to deaths. The reform made participation in the national pension system voluntary for farmers, since most of them cannot afford to pay contributions. As a consequence, in rural areas only 45% of 55 to 64 year olds and 35% of the 45 to 49 year olds are currently either contributing to the Social Insurance program or are already in receipt of pension.

The developing situation in rural areas will seriously jeopardize achieving Romania’s 2020 poverty targets and raises the question of how the risk of old age poverty in rural areas will be addressed by policy makers in the medium to long run. The changes will especially affect women, 32% of whom currently depend on a farmer’s pension after reaching the age of 65 (only 13% of men in this age group are currently in receipt of the farmer’s pension). Universal old age pensions, re-established farmer’s pensions, or greatly expanded Social Assistance programs for rural areas seem to be the only viable options.

Pension coverage is expected to decrease somewhat in urban areas as well. Only 80% of urban 45-54 year olds are actively contributing to the social insurance scheme or receiving pensions at this time. While a small portion of the remaining 20% might already have accrued
pension rights for at least a minimum pension, the majority is likely to become dependent on family and social assistance programs once they are no longer able to work.

People, especially women, who have had sporadic careers and paid their social security contributions based on a low wage, may also be in need of an income boost in old age. Women are more vulnerable in this regard because of the career gaps due to child and elder care obligations, lower wages and younger retirement ages. Minimum pension, on which most of such people currently rely, now stands at about half of the minimum wage, but is expected to decline in relation to wages being indexed only to inflation.

In urban areas, gradually increasing statutory retirement ages will also start exposing some people in the 55 to 64 age range to the risk of unemployment and temporary hardship before they become eligible for pensions. As has been shown in Figure 3.5, this risk has not yet materialized in a significant fashion and, given the large social gains from policies to increase the age at retirement, can be tolerated. In fact, the absence of pronounced stress in this population segment could even be viewed as a call for accelerated retirement age increase. However, close monitoring of the situation and readiness of labor market activation and social assistance programs to provide the safety net to those who lose their jobs prematurely is paramount. Increasing of the retirement age is also likely to put strong pressure on the invalidity program, given its lenient contribution requirements discussed below.

Overall poverty rates for older population are currently low, lower than for children and younger population (see Figure 3.5). Older people have weathered the economic crisis relatively well, given that social protection spending grew by more than 3 percentage points of GDP between 2007 and 2011, with the most pronounced growth in old age pension spending, as shown in Table 3.1. Moreover, in the years before the financial crisis, Romania observed a dramatic increase in pension levels of more than 10 percentage points of average employment earnings (see Figure 3.6), and the higher pension to wage ratio was preserved since 2009.

As revenues declined sharply in response to the economic crisis, Romania was not able to reverse pension increases granted in the boom years to match its new fiscal reality. This inflexibility is a typical characteristic of pension spending and pension increases of 2005-2009 will have a long-lasting effect on pension system expenditures. Since 2011, spending on pensions as a percent of GDP has stabilized, settling at 7.3% of GDP in 2013. Despite a modest decline in spending, the Pay-As-You-Go (PAYG) pension system still registered a deficit equal to 2.4% of GDP in 2013.

Given poverty and income data it could therefore be argued that job opportunities are not desperately needed for older people. However, supplementing pension income through work should still be encouraged, as the outcomes can only be positive both for the individuals and for the economic growth. Willing grandparents can also be encouraged to take more formal childcare responsibilities freeing mothers of young children to return to work earlier (for
example, childcare benefit could be made more flexible, so that it can also be paid to grandparents, if a mother returns to work earlier). More numerous working pensioners would help to develop a societal norm of more active lives at older ages.

**Figure 3.5 Poverty rates for different population segments in 2012**

![Graph showing poverty rates for different population segments in 2012](image)

*Source: 2011 census*

**Table 3.1 Social protection expenditure by category and function**

<table>
<thead>
<tr>
<th>Category</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>Increase between 2007 and 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Protection Total</td>
<td>13.6%</td>
<td>14.3%</td>
<td>17.1%</td>
<td>17.6%</td>
<td>16.3%</td>
<td>20%</td>
</tr>
<tr>
<td>Sickness/Health care</td>
<td>3.5%</td>
<td>3.5%</td>
<td>4.1%</td>
<td>4.4%</td>
<td>4.0%</td>
<td>14%</td>
</tr>
<tr>
<td>Disability</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.6%</td>
<td>1.6%</td>
<td>1.5%</td>
<td>15%</td>
</tr>
<tr>
<td>Old age</td>
<td>5.5%</td>
<td>6.5%</td>
<td>8.0%</td>
<td>8.0%</td>
<td>7.9%</td>
<td>44%</td>
</tr>
<tr>
<td>Survivor</td>
<td>0.5%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.7%</td>
<td>40%</td>
</tr>
<tr>
<td>Family/ Children</td>
<td>1.7%</td>
<td>1.5%</td>
<td>1.7%</td>
<td>1.7%</td>
<td>1.4%</td>
<td>-18%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Source: National Institute of Statistics, Romania*
In the future, average real pension income is expected to continue rising, but will slowly decline in relation to wages. The pension reform of 2000 has strengthened the link between the contributions paid and pensions received, providing some incentives to work longer. However, the reform has also aimed to address projected fiscal imbalances that were developing with rapidly rising population dependency rates (see Figure 3.7). Policy makers should be credited for realizing early that demographic developments require a reduced rate of pension rights accrual. This, of course, means that replacement rates will decline unless contribution periods are significantly prolonged. Even with projected gradual increase in retirement ages, the replacement rates are still expected to decrease over time, as shown in Figure 3.8B. It is likely that people affected by this change will prefer to work longer in order to soften the relative decline in their pension incomes.

Figure 3.6 Average pension (social insurance pensioners excluding farmers) as a percentage of average gross wage

![Graph showing average pension as a percentage of average gross wage from 2005 to 2013.]

Source: National Institute of Statistics, Romania

Unfortunately, the pension system will not be able to afford increased generosity for the vulnerable older population groups discussed above, so job opportunities and continued employability of the older population will be increasingly important. Figure 3.8 and 3.9 demonstrate that even with lower projected benefits and significantly reduced coverage, which will effectively shrink the role of the pension system in providing old age income, the pension system will remain in fiscal deficit for the foreseeable future. Already based on current projections, in the next 15 years the deficit of the pension system alone will exceed 3 percent of GDP threshold which all EU countries have agreed to observe under the Maastricht criteria, requiring contraction in other areas of public spending or necessitating additional pension system restrictions.
Figure 3.7 Projected system and old age dependency rates

Source: Administrative data, World Bank pension modeling results with PROST software
Note: The projected nominal system dependency ratio accounts for legislated increases to the standard retirement age. Source: Romania House of Pensions.

Figure 3.8 Coverage and generosity of the PAYG system are projected to decline. A (left) and B (right)

Source: Administrative data, World Bank pension modeling results with PROST software

---

21 The pension system dependency ratio is defined as the number of pension system contributors relative to the number of pension system beneficiaries. The nominal system dependency rate counts all registered contributors in deriving the ratio. In reality, the number of contributors actually paying contributions, also referred to as “effective contributors”, is typically lower than the number of nominal contributors. For example, a contributor on maternity leave continues to accrue pension rights – and is thus counted as a contributor without paying contributions. As a result, the already very high system dependency rate in Figure 3.7 is likely even higher if only effective contributors are considered.
The general awareness of the need to work longer in the future is still lacking both in Romania and in the EU as a whole. The majority of EU citizens (59 percent) think they will continue working until they are in their 60s, on average up to the age of 61.7. However, the expected retirement age differs markedly by the current age of respondents, with those aged 55 and over expecting to work until 66 years while those aged 15-24 years only expecting to work until the age 56.7.

Figure 3.9 The public pension system is projected to remain in deficit

![Graph showing the public pension system deficit as a percentage of GDP from 2014 to 2079.]

Source: Administrative data, World Bank pension modeling results with PROST software

Comment: In the coming decades, a growing number of elderly will not have rights to a contributory pension – the result of short careers or work in the informal economy. The above calculation assumes a minimum pension provision to those falling outside the pension system, allowing for a more realistic projection of future financing needs.

In Romania, the current policies regarding early retirement and compulsory retirement have contributed to forming societal opinions, but differences of views exist. Figure 3.10 shows that in general, there is substantial support for current policies with only 31% of people believing that people should continue working after reaching pension eligibility and only 21% of respondents disagreeing with compulsory retirement policies. However, there is substantial diversity of opinion when education and age of respondents is taken into account. The population aged 50 to 74 believes much more strongly in continued work and rejects the idea of compulsory retirement, with the well-educated older population being the strongest opponents of current policies.

People’s own willingness to work at older ages also dramatically differs by personal characteristics, as shown in Figure 3.11 women aged 45 to 64 are more willing to work after pension retirement is reached, and are especially interested in partial retirement; more than half of the women aged 55 to 64 would like to continue working; 2) about half of the well-educated
people of all ages would like to work past their eligibility for pension, although their interest in part-time work is less pronounced; interestingly, 60% of the least educated 45 to 54 year olds would also like to continue working which morphs into heightened interest in part-time work between the ages of 55 to 64; 3) the breakdown of the respondent population by difficulty in paying bills further reveals that, among the population aged 45 to 64, people in more difficult financial circumstances are more interested in continued work and part-time work.

**Figure 3.10 Opinions: People should be able to continue working**

![Graph showing percentage of positive responses for the ability to continue working and retirement not compulsory by age and education level.](source: 2011-2012 EQLS)

Interestingly, the two sets of data presented in Figures 3.10 and 3.11 seem contradictory. On the one hand, when thinking about the economy in general, around 70% to 80% of the population supports a compulsory retirement age and disapproves of continued work, as can be seen from Figure 3.10. However, when asked to think about their own circumstances, 40% to 50% of the population would like to work longer, with especially strong support for the idea coming from older women, well-educated people and people with the difficulty paying their bills. The discrepancy of the opinions may be attributable to the entrenched societal norms regarding the value that older workers can bring to the economy, and an unfounded fear that older people maybe be displacing younger workers in the labor market.
Figure 3.11 Opinions regarding retirement

Source: 2011-2012 EQLS
The societal perception of a trade-off between employment of younger and older workers is universally known as the lump-of-labor fallacy. The idea that older workers prevent youth from finding jobs is not supported by empirical observations. A comparison of employment rates of older individuals (aged 55–64) and unemployment rates of young people (aged 20–24) across countries yields a statistically significant negative relationship. In fact, evidence strongly suggests that having a larger labor force of any age group, including older workers, creates more employment opportunities in the growing sectors of the economy for workers of all ages, including youth. Analysis by Gruber and Wise (2010) clearly refutes the claim of a fixed number of jobs in the economy and the existence of a trade-off between older workers’ and youth employment.

To summarize, given decreasing future role of the pension system in providing income at older ages, interest in working longer should increase in all segments of population. Already increased interest in longer careers is seen among women, well-educated people, and people with difficulty in paying their bills. An increasingly large segment of the older population without pension coverage, which is expected to emerge in the coming years, will also inevitably be dependent on however meager job opportunities as well as on social assistance programs, especially in rural areas.

C. Removing Barriers to the Employment of the Older Population

As was shown previously in this Chapter, increasing the employment rates of the older population is both necessary for the Romanian economy and sorely needed by large segments of the Romanian population, especially in the medium and longer term. The relatively large gap in employment rates between the prime and the older working age population in Romania can be attributed to a host of factors in the national policy environment as well as social perceptions towards the older population and their role in society. Promoting increased employment among the older population will therefore require a change in societal and employer attitudes, review of the current labor market laws and regulations, and a re-assessment of the social protection and life-long learning frameworks.

Old Age Retirement Options

Standard retirement ages in Romania are gradually rising to 65 for men and 63 for women from 64.8 and 59.8, where they stood in 2013; the length of service requirement is also increasing to 35 years for both genders. These tighter pension eligibility conditions in the old age program are a reflection of longer and healthier lives, expected decline in the contribution paying workforce, and the need for longer careers in the face of slower pension right accrual. They are,
therefore, necessary steps on the road of needed adjustments in the social security system, even though being implemented relatively slowly, to reach the targets only by 2030.

**However, a number of sectors, industries, and occupations within the Romanian economy are exempt from the normal rules** and continue to benefit from much more lenient eligibility conditions within the old age program. These industries and occupations enjoy a reduced standard retirement age and shorter length of service requirement at the expense of other industries and occupations which do not offer such privileges. Although pension contribution rates are higher for people working under special conditions by up to 10% of the wage, even this higher rate is far from sufficient to cover the costs of financing these programs.

**Expecting equally long careers for office workers and workers employed under special working conditions would be unreasonable** for some occupations, for example those that require agility or heavy lifting, like in the case of acrobats. However, it would be preferable to create new employment opportunities for the affected older people rather than offer across-the-board early pensions to anyone who has ever worked in such circumstances. For example, when an employee reaches an age where he or she can no longer work under special conditions, he or she - after learning a new skill, preferably in advance - could assume a different responsibility with the same employer. Alternatively, with adequate re-training and support, a person could change professions and continue working under normal working conditions on a full or part-time basis. Higher social contribution rates that are collected from special industries could be better used to finance retraining programs or provide income supplements to those who experience the loss in their earning capacity due to the change in occupation.

**The list of special occupations has been substantially shortened in 2005**, but pre-2005 work in the occupations that were part of the old list still qualify workers for significant early retirement privileges and there are renewed discussions about lengthening the list again. These grandfathered rights are extremely costly to the pension system, and in many cases are hard to justify. Eliminating these privileges would be the preferred solution, as was done in quite a few countries. However, softer options of offering partial credits for these years also exist. For example, the extra length of service points could still be claimed for higher pension, but only at the regular retirement age. Alternatively, the workers could be offered a government subsidy of a certain proportion of the worker’s wage (partial pension), if the employer agrees to continue employing the worker with a proportional reduction in working hours and wages (such a program functions in Austria and is known as Old Age Part Time Benefit - Altersteilzeitgeld).

**Romania’s social protection system also includes two additional early retirement pathways** – a full early retirement and a partial early retirement schemes for workers with long careers. The early retirement pension can be claimed 5 years before the standard retirement age as long as the claimant has at least 8 years of contribution in excess of the full contribution period. The partial early retirement pension, with deduction, can be claimed 5 years before the
standard retirement age with the full standard contribution period. Women who have raised three or more children also qualify for earlier retirement.

**Crucially, the early retirement and partial early retirement pensions cannot be supplemented with earnings from work.** Although these types of programs can serve as a much needed safety net for workers who become unemployed at an older age and have slim chances of finding a new job, they can also be an impediment to extending the working lives, especially if pensions cannot be supplemented with earnings from work. This well-intentioned provision, designed to encourage workers to delay retirement, might in fact be contributing to low labor market participation among older age groups. Experience from Latvia, where after the introduction of a similar policy more than 50 percent of working pensioners dropped out of the labor force, illustrates the potentially negative labor market effects of such laws.

The partial early retirement pension is also poorly designed: this type of pension is reduced by 9% for each year of anticipation, or a 45% reduction for 5 years of early retirement with full contribution period. However, the reduction is only applied until the pensioner reaches standard retirement age. While the initial heavy reduction is appropriate, full restoration of the original pension is not. To be actuarially fair, the payments made during early retirement years should be recouped through smaller reductions in pensions applied after reaching the statutory retirement age. A pensioner would still be eligible for a pension increase after reaching the standard retirement age, but not by as much as under current rules.

While there was substantial progress in increasing effective retirement ages in Romania so far (see Figure 3.12), future plans for continued increase in retirement ages are not very ambitious. Numerous surveys have shown that the most frequent reason for retirement is the eligibility for a pension. As has been shown in the beginning of this chapter, the population cohort a few years away from the standard retirement age does not experience undue stress between losing their last jobs and not being able to qualify for a pension or finding new employment opportunities, justifying a more ambitious reform agenda. **Further progress could be made by tightening early retirement options, more often used by men, and raising the statutory retirement age faster for women.** Eventual equalization of retirement ages for both genders is also necessary. Better outcomes with respect to early retirement options could be achieved by tightening early retirement eligibility rules and properly pricing the benefit reduction associated with early retirement, at the same time providing a better safety net and re-training opportunities, and increasing people’s ability to supplement pensions with labor income.
Current legislation requires employers to terminate employment contracts of individuals who have met conditions for a pension. This often happens even before the standard retirement age, if the eligibility for a full early pension is reached at the younger age. As a result, reaching retirement age, at least in the public sector, is almost perfectly equated with immediate, absolute, and permanent withdrawal from the labor force. The only possibility for older workers to continue working for the public employer beyond the retirement age is to be re-hired on a contractual agent agreement for a maximum duration of 2 years, renewable up to 4 times. In reality, the incidence of such employment arrangements is extremely low.

The mandatory retirement policy in the public sector is extremely counterproductive. The public sector employs a significant share of Romania’s workers and a much larger proportion of the skilled ones. Therefore, the government itself is substantially contributing to the problem of early retirement prevalence in Romania, especially among the skilled workers who often have both the capacity and the willingness to work longer. Such policies are sometimes justified by Human Resource planners by the need to “free the positions at the top” for younger workers. While this might be true in some cases, the across-the-board policy of mandatory retirement at such relatively young ages seems to be an overly drastic solution for a relatively small problem. For example, the problem could be easily solved by a requirement to reapply for a managerial position after reaching a certain age or after having held the position for a certain number of years. Another softer alternative could be legislating the mandatory retirement age to be, say, 5
years older than regular retirement age. However, the best approach would be to eliminate the mandatory retirement policy altogether, as is done in a majority of countries.

More generally, the Government, as the largest employer of the country, should be pioneering age sensitive human resource policies, fostering by example the idea of longer working lives. It should pay attention to the age mix of its employees as a whole and at the department and team level, making sure that older workers are not discriminated against and younger workers can benefit from the experience of older workers. The Government should also invest in health promoting programs for its workers, offer opportunities to update and develop new skills for middle aged staff, ensure rotation of its employees to further foster their learning and adaptability, and offer more part time work opportunities for older workers.

In the private sector the inflexible labor market and labor regulations make firing difficult, concentrating any required workforce adjustment on older workers who are eligible for some pension. This is partially due to the fact that workers lose all employment protections after reaching eligibility for retirement, which exposes them to the age based discrimination with little room for legal recourse. Other times, the employer is simply attempting to choose between firing a younger worker, who is assumed to have limited re-employment options, and firing an older one, who “at least” has an option to apply for a pension. While such practices might be considered normal and “humane” by many people, they are in fact discriminatory, as these employer choices are made not on a basis of worker’s merit but on his or her age. In many such cases an older worker, having lost his or her job and facing low chance of finding a new one, is forced to take a partial discounted pension or attempt to seek an invalidity pension, neither of which might have been his or her preferred options. To make firing practices fairer, the law could require that mass firings from larger enterprises reflect the age mix of company’s employees, including those who are eligible for a pension. Anti-discrimination rules in the labor market should also be more vigilantly enforced.

It is also important to promote continued work after eligibility for pension is reached, as retirement and a right to receive a pension do not have to coincide. Surveys indicate that people often find retirement less satisfactory than they have originally thought, but returning to an old job or taking up a new one might be much more difficult after the interruption in one’s career. Studies also show that most instances of retirement in many countries happen “by default” once eligibility for a pension is reached, without prior conversation between an employer and an employee about options for continued work. Therefore, older workers should be provided more information about their legal protections against involuntary separation from the job, about what to expect at retirement, and about options for continued work, before they take the crucial decision to retire completely. It would be beneficial to require such counseling to be mandatory (see Box 3). More information, and possibly financial incentives, also needs to be provided to employers regarding ways to integrate older workers into the workforce, and the legal basis for revising labor contracts for reduced responsibilities or reduced working hours.
Box 3. Examples of Programs to Promote Pre-retirement Counseling

**Senior Career** - Active Ageing & Pre-retirement Counselling is a program funded by the European Union through the Lifelong-Learning Program Grundtvig, to promote the idea of compulsory pre-retirement counselling across Europe for people over 55 or those who are going to retire in the near future. Organizations from Denmark, Italy, Poland, Germany and Greece were represented in the project. The partnership was formed on the basis of ensuring a wide geographical representation as all five partners are from north, south, west, and east Europe. Main objectives included: sharing observations and the latest research results concerning the main problems senior employees meet when retiring; sharing experiences and know-how on counselling and guidance to senior employees before they make decisions on when and how they intend to leave the labour force; exchanging experiences on how to improve and develop counselling for senior employees for the benefit of senior-employees, their companies; and their communities; promoting the idea of compulsory pre-retirement counselling for senior employees in EU. (Kryniska & Szukalski, 2013) see also: http://europa.eu/ey2012/ey2012main.jsp?catId=975&langId=en&mode=initDetail&initiativeId =317&initLangId=en.

**Young Elders from Nancy (France)** is a program in which a group of retirees is invited to visit companies of the region in order to talk with older employees about their impending retirement. Experiences are exchanged and ideas are given on how to structure the new phase of life, for example through voluntary commitment. Cited in Stula (2012), p. 79.

**A reduction in social insurance rates paid by older workers and their employers might be warranted.** The overall tax wedge in Romania ranks at the higher end of the EU spectrum, but across-the-board decreases in social insurance contribution rates to stimulate employment would be hard to justify in the presence of a significant social insurance fund deficit. However, given the multiple barriers to longer careers, a lower tax wedge at older ages might be desirable. For example, social insurance contribution rates could be lowered for working pensioners and workers who reach pension eligibility conditions by eliminating maternity, unemployment and disability components from social insurance contribution rates that workers and their employers pay.

**To summarize, mandatory retirement laws should be abolished, and age sensitive human resource policies should be employed, including: monitoring of the age mix of workers and of those who are being fired; investing in health-promoting programs for workers; offering opportunities to update and develop skills; ensuring rotation of employees to foster their learning and adaptability; and offering more part-time work opportunities for older workers. All this would also benefit younger workers who would be exposed to the experience of the older ones. Mandatory counseling before retirement (including in groups for efficiency purposes) would be beneficial. The Government, as the largest employer in the country, should be leading this agenda and enforcing age discrimination laws in the workplace and beyond.**
Invalidity and Disability Benefit Programs

As was discussed in Chapter 2, there is a continuum of disabling conditions that tend to creep up with the advancement of age, and drawing a line between being and not being able to work for health reasons is, in many cases, a very subjective assessment. For invalidity benefit programs, which are meant to ensure an individual against the loss of income due to a disabling condition, the focus of any such assessment needs to be on evaluation of remaining work capacity (including for another job), rather than on the medical diagnosis. Many serious chronic medical conditions are not debilitating if properly managed: for example, prescribing antidepressants to control a mental illness, or blood pressure lowering medicines for a cardiovascular disease.

Demographic ageing and slowly tightening pension eligibility conditions in the old age program will lead to more people seeking to retire through the invalidity program in the future, and the trend is already visible (see Figure 3.13). While the total number of invalidity cases has seemingly decreased since 2009, III degree invalidity cases (the least severe ones) continued to increase. The more recent trend of declining number of total invalidity cases may also be more influenced by the new policy of diligently re-registering all disability pensioners who reach old age eligibility as old age pensioners, than a significantly decreased flow of new invalidity claims.

Figure 3.13 Invalidity pensioners by category, as a percent of all old age and invalidity pensioners

![Invalidity Pensioners Chart]

Source: National Institute of Statistics of Romania
Therefore, good governance structure, monitoring and rule enforcement will only become more important going forward. A review of invalidity certification procedures to mitigate a potential upsurge in fraudulent and border-line cases is also required. In 2013 the invalidity application rejection rate stood at 11 percent, but this number was not regularly monitored over time or by jurisdiction. The system also does not have sufficient capacity to re-evaluate complicated to diagnose cases by a second medical professional. For example, the number of applications based on mental illnesses is on the rise in Romania, and, being hard to diagnose, many such cases might benefit from a second opinion. The breakdown of all claims by diagnosis is presented in Figure 3.14.

Figure 3.14 Leading causes for invalidity in 2013

Pressure on the invalidity program is further amplified by a recent Constitutional Court ruling, slashing the contribution requirement needed to qualify for an invalidity pension to only 1 day. It is likely that the high number of new invalidity applications with less than 30 days of contributions, which amounted to 17,225 in October of 2013 alone, is attributable to this decision (at this monthly rate, in a year applications with under 30 days of insurance would amount to 26% of the total number of disability pensions currently in payment).

The invalidity program offers a far more generous benefit than the disability allowance program, creating an incentive for potential beneficiaries to try gaining eligibility, especially since the current legislation permits accumulation of these two benefits (see Figure 3.15). As of 2010, about 50% of the disability allowance beneficiaries were also receiving a pension, and 20% were in receipt of an invalidity pension.

Harmonizing the disability certification for receipt of a disability allowance benefit or an invalidity pension and unifying the institutional framework is one of the Government’s objectives, supported by the World Bank. The unification of the systems aims to significantly
reduce duplication of services, reduce administrative costs, and improve the overall efficiency and equity of outcomes. However, even with better procedures, databases and monitoring, the system will continue to struggle in light of strong incentives to seek invalidity certification, especially by those who do not have sufficient length of service to be eligible for an old age pension but can relatively easily claim an invalidity pension per Constitutional Court decision. There should be pathways from invalidity back into work, including partial working opportunities for the disabled.

Figure 3.15 Average monthly pension amount by program, % average gross earnings

Source: House of Pensions, Romania

Health-friendly and age-friendly work environments

Another set of measures that are particularly important in reducing the number of invalidity claims and prolonging working lives relate to improving workplace environments. While the increased incidence of early retirement due to health reasons is inevitable at older ages, employers, policy makers and individuals should combine forces in reducing such occurrences.

The Department of Labor Security and Health Service of the Ministry of Labor is charged with enforcing healthy workplace standards in Romania. Enterprises also pay premiums to the Work Accidents and Occupational Diseases Insurance Fund. In 2012 the fund has posted a surplus amounting to 0.04% of GDP, with costs accounting for only 30% of the revenue. The number of claims compensated by the fund is presented in Table 3.2. The table indicates the downward trend in most claim categories with total number of claims down by 32 percent from
2003 to 2012. The trend is most likely associated with improving health conditions and declining importance of accident prone industries in Romania.

However, Table 3.2 also shows a sharp rise in musculoskeletal disorders (MSDs) over the last decade, which could be stemmed with the right interventions (see Table 3.3). Between 2003 and 2012, the incidence of musculoskeletal disorders increased from 33 to 258 cases, peaking in 2009 at 300 cases. The general rise is mostly due to MSDs only starting to be recognized as an occupational disease, and many cases are still likely to be unreported. However, ageing of the labor force will inevitably further contribute to the increased risk of MSDs going forward. The higher prevalence of desk jobs requiring intensive use of computer will also likely add to the increased number of claims. Improved workplace safety regulations, employer self-interest, and possible financing for preventive measures from the Work Accidents and Occupational Diseases Fund surplus could combine to lower the risk of MSDs going forward.

**Table 3.2 Occupational disease incidence rates by type of condition**

<table>
<thead>
<tr>
<th>Disease/Year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cases</td>
<td>1376</td>
<td>990</td>
<td>1002</td>
<td>910</td>
<td>1353</td>
<td>1286</td>
<td>1366</td>
<td>1065</td>
<td>929</td>
<td>879</td>
</tr>
<tr>
<td>Diseases caused by specific work activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Larynx</td>
<td>41</td>
<td>27</td>
<td>46</td>
<td>49</td>
<td>133</td>
<td>218</td>
<td>394</td>
<td>308</td>
<td>301</td>
<td>263</td>
</tr>
<tr>
<td>Muscular-skeletal disorders</td>
<td>33</td>
<td>24</td>
<td>34</td>
<td>47</td>
<td>117</td>
<td>197</td>
<td>384</td>
<td>300</td>
<td>296</td>
<td>258</td>
</tr>
<tr>
<td>Visual</td>
<td>8</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Silicosis</td>
<td>428</td>
<td>269</td>
<td>209</td>
<td>268</td>
<td>268</td>
<td>308</td>
<td>282</td>
<td>305</td>
<td>237</td>
<td>203</td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>44</td>
<td>26</td>
<td>71</td>
<td>62</td>
<td>152</td>
<td>193</td>
<td>174</td>
<td>64</td>
<td>23</td>
<td>29</td>
</tr>
<tr>
<td>Occupational asthma</td>
<td>108</td>
<td>89</td>
<td>98</td>
<td>105</td>
<td>119</td>
<td>90</td>
<td>149</td>
<td>43</td>
<td>32</td>
<td>26</td>
</tr>
<tr>
<td>Hearing impairment caused by noise</td>
<td>292</td>
<td>258</td>
<td>213</td>
<td>153</td>
<td>302</td>
<td>178</td>
<td>145</td>
<td>90</td>
<td>67</td>
<td>44</td>
</tr>
<tr>
<td>Occupational diseases</td>
<td>503</td>
<td>365</td>
<td>408</td>
<td>347</td>
<td>446</td>
<td>357</td>
<td>324</td>
<td>213</td>
<td>184</td>
<td>136</td>
</tr>
<tr>
<td>Asbestosis</td>
<td>24</td>
<td>7</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>8</td>
<td>24</td>
<td>37</td>
<td>109</td>
<td>173</td>
</tr>
<tr>
<td>Infectious or parasitic diseases</td>
<td>35</td>
<td>36</td>
<td>42</td>
<td>20</td>
<td>42</td>
<td>23</td>
<td>22</td>
<td>46</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td>Ulcer, Perforation of nasal septum (Chromium)</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>


Age conscious team composition and adjustments of the workplace to the changing needs of older workers is a promising area of intervention. For example, BMW, the German luxury automaker, successfully implemented a number of interventions to accommodate its ageing workforce. Some of the measures included hoists to spare ageing backs, adjustable-height workbenches, and wooden floors instead of rubber to help hips swivel during repetitive tasks. In the course of one year, through a series of 70 interventions, the productivity level of older workers in the study increased by 7 percent, bringing it up to par with the plant’s average. Quality defects quickly decreased to expected levels and, later on, decreased even further. Absenteeism due to sick leave and rehabilitation dropped from an above-average 7 percent to 2 percent, well below average. Such interventions are not only useful for the older population but are also helpful for younger people with disabilities, pregnant women, etc. Overall risk of injuries among general worker population is also likely to fall. (For more on productivity of older workers see Skirbekk, 2008 and Bloom & Sousa-Poza, 2013)

Table 3.3 Musculoskeletal diseases and their prevention in workplace environments

| Musculoskeletal disorders (MSDs) are injuries or disorders of the muscles, nerves, tendons, joints, cartilage, and spinal discs. MSDs are associated with high costs to employers such as absenteeism, lost productivity, and increased health care, disability, and worker’s compensation costs. An important category of workers exposed to the risk of MSDs are computer users in office work environments. Back injury and back pain are among the top MSD conditions. There are numerous studies on the risk factors of MSDs in the occupational health and safety literature. Data from scientific studies of primary and secondary interventions in the United States indicate that low back pain can be reduced by: |

<table>
<thead>
<tr>
<th>Engineering controls (e.g., ergonomic workplace redesign)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Changing the way materials, parts, and products are transported. For example, using mechanical assist devices to relieve heavy load lifting and carrying tasks or using handles or slotted hand holes in packages requiring manual handling</td>
</tr>
<tr>
<td>▪ Changing workstation layout, which might include using height-adjustable workbenches or locating tools and materials within short reaching distances</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative controls (specifically, adjusting work schedules and workloads)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Reducing shift length or limiting the amount of overtime</td>
</tr>
<tr>
<td>▪ Changes in job rules and procedures such as scheduling more breaks to allow for rest and recovery</td>
</tr>
<tr>
<td>▪ Rotating workers through jobs that are physically tiring</td>
</tr>
<tr>
<td>▪ Training in the recognition of risk factors for WMSDs and instructions in work practices and techniques that can ease the task demands or burden (e.g., stress and strain)</td>
</tr>
</tbody>
</table>

Programs designed to modify individual factors, such as employee exercise

Combinations of these approaches
Yet another example of a program focused on preventing early retirement due to health reasons has been successfully implemented in Austria. Fit2work program is overseen by the steering committee headed by the Ministry of Welfare and aims to preserve or enhance the working capacity of people with health impairments, reduce sickness absence, promote sustainable integration of people into health-adequate jobs, prevent premature exits from the labor force (and hence, unemployment or retirement for health reasons), and offer opportunities for re-integration of people in the workplace after long periods of sick leaves (see Box 5).

Box 4. Experience from Austria: fit2work program

| The target groups | include employed and self-employed persons with long sick leaves or health problems, companies and employees, especially with an above-average number of days of sick leave and unemployed people with health impairments. |
| The program is based upon the following **basic principles:** |
| ▪ Building on existing structures |
| ▪ Avoiding redundancies and over-capacities |
| ▪ Voluntary, free of charge, confidential |
| ▪ Early intervention |
| ▪ Sustainable assistance |
| ▪ Tailored to the individual |
| ▪ Gender- and diversity-sensitive |
| ▪ Supporting responsibility of the individual |

**Organizational framework:**

*Steering Group headed by the Social Ministry*
  – Members: Ministries (Social, Health, Economy, Finance), PES, Social Insurance Institutions (Pensions, Health, Accident)
  – Support team: Federal Social Office

*Advisory Council*
  – Members: Social Partners, National Council of Disabled Persons, Labour Inspectorates

**Co-financed by** Public Employment Service, Pension, Health and Accident Insurance Institutions, and Federal Social Office

40 regional contact points all over Austria

Ensuring healthy work environments which not only prevent the development of diseases, but also promote and encourage healthy life choices will become increasingly important as Romania’s workforce ages. **Employers and policy makers should monitor employee health and intervene early with required counseling and adjustments, so that the health can be restored and retirements postponed. It is also important to be conscious of workplace adjustments needed by older and disabled employees, as they not only benefit workers, but also increase firm productivity. Many of these suggested changes are not very expensive. Some of them could be piloted with the surplus of the Work Accident and Injury Insurance Fund.**
**Life-long learning**

The breakdown of Romania’s workforce by education level is presented in Figure 3.16. The graph demonstrates that around the ages of 50 - 55, the population with lower formal education skills start losing their share among the employed population. This can be attributable to many factors, for example to the earlier achieved pension eligibility rights due to earlier start of careers and more prevalent credits for working under special conditions, both of which apply more strongly to less educated population. However, it is also quite likely that less educated workers have lower skills that are relevant to today’s economy. Unfortunately, this problem is not going to disappear quickly, as education levels of today’s 40-year-old employees in Romania are very similar to those who are aged 55, as can be seen from the graph. Therefore, Romania cannot afford to wait for a problem to solve itself, but should attempt to stimulate lifelong learning, especially among the middle-aged and older population. A better foundation for life-long learning also has to be built for Romania’s youth, especially Roma and young rural population, to reach desirable outcomes longer term.

Survey data on attitudes indicate that older workers are often viewed as poor candidates for education or re-training. Unfortunately, such expectations are often self-fulfilling, reducing the motivation to learn and leading to poor outcomes. In fact, older workers tend to learn differently, with better outcomes reached with on-the-job training that is built on already acquired experience, rather than in still prevalent classroom settings. Therefore, changing attitudes towards learning at older ages among employers and among older workers themselves should be at the top of the active ageing agenda as unwarranted stereotypes can impede the success of all other interventions in active ageing agenda.

**Figure 3.16 Breakdown of Romania’s workforce by formal education level**

*Source: 2011 Census data, own analysis*
Lifelong learning in its fullest sense encompasses all forms of learning: formal education, non-formal education and informal learning. This concept includes a notion of learning always and everywhere (uninterrupted learning) and a favorable attitude towards learning. Several factors contribute to the growing importance of lifelong learning over the 21st century, across all European Union countries and beyond. These include, on the economic front, a growing global competition, an increased demand for a better skilled workforce and accelerating technological changes. On the social front, these factors include the need for constantly renewed social integration and the capacity to participate in democratic society. These factors operate in a context of shifting demographic profiles and increased mobility across frontiers. Romania, like other Member States, is facing these simultaneous challenges, which call for a strategic expansion of lifelong learning.

In 2009, the European Commission (EC) drew up the Strategic Framework for European Cooperation in Education and Training (ET 2020). This strategic document highlights the decisive role of education and training policies for high productivity and sustained growth. The ET 2020 recognizes high-quality pre-primary, primary, secondary, higher and vocational education and training as fundamental to Europe's success. The long-term strategic objectives of EU education and training policies are: (1) to make lifelong learning and mobility a reality; (2) to improve the quality and efficiency of education and training; (3) to promote equity, social cohesion and active citizenship; and (4) to enhance creativity and innovation, including entrepreneurship, at all levels of education and training.

A Lifelong Learning (LLL) strategy is being prepared by the Government of Romania to increase the participation in lifelong learning and to improve the relevance of the education and vocational training systems for the labor market. The LLL goal for Romania is to increase the participation rate of adults (ages 25-64) to 10 percent by 2020. Between 2007 and 2013, Romania did not make significant gains in this area, as participation has only increased from 1.3 percent to 1.8 percent. This is significantly below the EU27 average, which stood at 8.9 percent in 2011 and is targeted to increase to 15 percent by the year 2020. The proposed pillars of the LLL Strategy in Romania are: access and incentives for participation; quality and relevance; and partnerships for better information. To implement this Strategy, the Government will have to play a key role in coordinating, financing and regulating stakeholders’ activities.

The existing education legal framework includes requirements for the establishment of Community Permanent Learning Centers (CPLC) to implement LLL initiatives. These centers should be established by local authorities in partnership with education and training providers. The centers should be key LLL providers for local communities and are expected to have a great impact on increased participation from currently underrepresented groups, including the older population. The main functions proposed for the centers are: providing education and training, disseminating of information, and aiding personal development. The activities in such centers would include second chance programs and certification of competencies and skills acquired through non-formal and informal education.
The LLL strategy covers measures to support the implementation of the CPLC, which will also require the provision of human and financial resources. The participation of the older population in the activities to be carried out in these centers could play a double role of promoting LLL and engaging this population in community initiatives. At present, the lack of human resources is a key constraint for the proper functioning of the centers. The involvement of older persons could help the Government to face this constraint under either a voluntary-based arrangement or a partially funded approach.

Awareness raising campaigns targeted to the middle-aged and older population could promote a culture of learning during the entire life cycle. These campaigns could be a part of a broader initiative of developing a common space for learning, promoting intergenerational responsibilities, and increasing awareness of cultural diversity based on common values. The campaigns could also be useful in encouraging older people to remain active as long as possible and promoting a more positive image of an older person to combat stereotypes.

Public funding is justified in some cases to address market failures in the area of education and training in order to provide incentives for the participation of underrepresented groups, including the older population. Financing incentives for older workers could be made available for retraining in the form of demand-side instruments, like vouchers for training, especially vocational and on-the-job training with employer commitment to hire at least a portion of the trainees. The vouchers initiative should be combined with profiling and counselling of prospective trainees to help them make good choices and to ensure efficient use of resources. Another interesting idea, successfully implemented in Austria, is a temporary government financed placement of unemployed older workers to work in social economy enterprises, which provide on-the-job training, coaching and social support, and helping re-integration of beneficiaries into the labor market.

Learning should be promoted among older people, so that they could see the value of learning continuously, including for everyday life, and become motivated to take part in learning activities. The focus of this type of intervention should cover both employment related aspects, such as reskilling (for older workers), as well as aspects related to everyday life, such as health, elder care, financial and legal planning for retirement and inheritance management, and benefits of technology to enhance social connectedness. To reach a broad set of beneficiaries, counselling and training should be provided at the community level. In the area of re-skilling, targeted Active Labor Market programs (ALMP) – highly focused training targeting older population – can boost employment prospects of older population, as is shown in Figure 3.17 for the case of Latvia.

Finally, life-long learning policies, and active aging policies more generally, can only be successful in combination with supporting policies from other sectors. For example, learning to drive seems to have helped to increase employment prospects of females aged 50 and older, but for such policies to have positive outcomes in rural areas improved roads might be necessary.
Similarly, positive training outcomes that are seen in Figure 3.17 for Latvia might also depend on very restrictive retirement and disability eligibility criteria, increasing motivation of older people to lean and to seek employment in that country.

To conclude, lifelong learning is an essential goalpost in order to achieve longer working lives. In Romania the lower skilled population starts losing their share of employment as early as age 50 - 55. This phenomenon is not likely to change for at least another 15 years unless middle aged and older workers and their employers are convinced of the benefits of lifelong learning. The Lifelong Learning Strategy of the Romanian government includes big investments in community learning centers, which are expected to provide education and training, disseminate information, and aid personal development to the older population, among others. The centers will also provide jobs, often very suitable for older people. Ensuring that resources are used efficiently will be a challenge, and therefore careful monitoring of education and training outcomes will be key.

Figure 3.17 Evidence from Latvia: ALMP Program evidence indicates that highly focused training can yield successful results

![Diagram](image)

Source: ECA Regional Flagship on Ageing, Forthcoming
Chapter 3 Bibliography


For all its challenges, population ageing also presents Romanian society with an opportunity. In coming years, there will be a larger number of older persons, most of whom will likely no longer be employed. Further improvements in life expectancy, and especially in healthy life expectancy, will lead to a longer post-employment interval with greater amounts of available discretionary time. Subsequent cohorts of Romanian pensioners will also have higher levels of educational attainment than current cohorts of elders.\textsuperscript{22} Intergenerational responsibilities for child care will be fewer and less time consuming with the low birth rates that are currently prevalent and with more childcare options. And if improvements in the economic situation of elders materialize, the combination of more time, better health, more education, fewer child care obligations, and better financial circumstances will provide a pool of retirees capable of making significant contributions to Romanian society via their social participation. As noted more generally by the European Economic and Social Committee (2013, p. 7):

Older people contribute to society from a social and economic point of view. From the social perspective, the role of older people could be described as "social glue", due to their contribution to family and communities through volunteering and participation in democratic institutions. From the economic perspective, the increase in older people should be considered as an opportunity, the so-called "silver economy".

This chapter focuses on the forms that social participation can take, research findings about the variety of benefits that follow from social participation, comparisons of Romania with other countries in its overall levels of participation, examination of barriers and impediments to participation, and steps that might be taken to promote and encourage social participation in Romania, especially among older cohorts.

A. Social Participation, Its Types, and Its Benefits

“Social participation,” in this chapter refers to the activities in which people engage via their formal or informal social networks. Generally, these activities are informal as, for example, in social interaction with friends and neighbors. On the other hand, some forms of social participation may be of a more formal nature, or they may occur in a more formal setting.

\textsuperscript{22} Data from the 2011-2012 European Quality of Life Survey show that 25.2% of Romanians 30-44 years of age, 15.8% of those 45-59 years of age, and 7.9% of those 60 years of age and older age have completed their education through the tertiary level.
Holding an office in a voluntary association would be an illustration of the former while volunteering with children in an elementary school would be an illustration of the latter. For some types of activities, participation may be entirely optional (as in corresponding with a Facebook friend), while other types may assume a more obligatory character (such as providing day care to a young grandchild so that one or both of the grandchild’s parents may work).

**Whatever the particular form it may take, countless studies in the field of ageing have pointed to a variety of benefits to individuals engaged in social participation.** For the older persons themselves, the activities in which they engage via social participation have been shown to promote physical and psychological well-being (see, for example, GHK, 2010; Paganini-Hill, Kawas, & Corrada, 2011; Huxhold, Miche, & Schüz, 2014; Katja, Timo, Rantanen, & Tiina-Mariet, 2014; Corporation for National and Community Service, 2012). Relationships between civic engagement, for example, and physical and psychological well-being have been examined using multiple waves of the Americans’ Changing Lives study, the Assets and Health Dynamics among the Oldest Old Study, the National Survey of Families and Households, the Wisconsin Longitudinal Study, and the Longitudinal Study of Ageing II (see Cutler, Hendricks, & O’Neill, 2011 for specific references). Collectively, these studies lead to the conclusion that civic engagement, as measured by volunteering and net of confounding variables, enhances a variety of measures of well-being: happiness, life satisfaction, self-esteem, sense of control, physical health (including both self-rated health and functional dependency), depression, and longevity. Similar overall relationships between volunteer activity and well-being are found in studies of elders in Germany (Huxhold, Miche, & Schüz, 2014), Taiwan (Li, Chen, & Chen, 2013), Japan, Australia, and Israel (Corporation for National and Community Service, 2012; Cutler, Hendricks, & O’Neill, 2011).

**Social participation in the form of civic engagement and volunteering also contributes to the well-being of the recipients of these efforts, to the communities in which the providers and recipients reside, and to society at large.** For example, older adults make vital economic and social contributions to their communities and families through unpaid caregiving roles. Recipients of older volunteers’ services also benefit from older adults’ engagement with them. Children in educational activities especially benefit. Furthermore, older adults’ volunteer activities help governments and nonprofit organizations meet the growing demand for social services, as these activities, even while unpaid and often unreimbursed, may certainly be viewed as “productive” (Kryńska & Szukalski, 2013).

---

23 Earlier studies on well-being outcomes typically relied on cross-sectional samples, making it impossible to separate selection effects from causation effects. The increasing availability of longitudinal data, together with the results of cross-sectional studies (e.g., Morrow-Howell, Hong, & Tang, 2009), have now created a consistent picture of the salutary effects of social participation. In other words, it is true that good health promotes social participation among elders, but carefully designed longitudinal research has also pointed to clear causal links in the direction of social participation fostering and sustaining good health.
As budget constraints curtail social programs, nonprofit and volunteer sectors gain in importance in meeting social needs. Harnessing the immense social capital in an ageing population via public/private volunteer partnerships can help meet the[se] growing social needs… (MacArthur Foundation, Network on an Ageing Society, 2012, p. 3).

The economic value of older adults’ unpaid civic contributions in Romania is estimated to exceed 2 percent of GDP, partially compensating for declining public and private expenditures for social needs. In the European Quality of Life Survey (EQLS), 22.9% of persons aged 60 years and older reported spending an average of 23 hours weekly on providing care to children or grandchildren outside of paid work, and 9.6% reported spending an average of 22 hours per week providing care to elderly or disabled relatives. Extrapolating these figures to the size of the 60+ population yields a total annual estimate of 1.03 billion hours of informal care to children and grandchildren and 494.2 million hours of care to elderly or disabled relatives, valued at 8.24 billion RON and 3.95 billion RON respectively. The special Eurobarometer survey on Active Ageing asks for the number of hours per month respondents volunteer for 15 types of organizations, allowing us to make economic value estimates for other volunteering activities. It is calculated that 8.7% of Romanians 60 years of age and older volunteered an average of 29.1 hours per month yielding a total of 140 million hours per year valued at 1.1 billion RON.

Therefore, social participation may truly be considered a win-win proposition, a win for the older individuals who may have a greater amount of discretionary time at their disposal – as will most certainly be the case for Romanian elders in coming years – and a win for those who are the recipients of the contributions of elders. The government also wins as volunteerism and social participation have demonstrable effects on the economy and potentially reduce government costs for health care given the salutary effect of participation on physical and mental health.

For the remainder of this chapter social participation will be viewed in the manner adopted by the Active Ageing Index (European Centre Vienna, 2013) and as measured through the 2011-2012 European Quality of Life Survey (EQLS). That is, social participation will be considered to be comprised of four individual dimensions and also as a summary index (see European Centre Vienna, 2013 for the specific items used to measure each dimension):

1. **Voluntary activities**: providing unpaid voluntary work through organizations;
2. **Care to children, grandchildren**: providing care to children and/or grandchildren (at least once a week, outside of work);
3. **Care to older adults**: providing care to elderly or disabled relatives (at least once a week, outside of work);

---

24 Calculations use an estimated hourly wage of 8 RON per hour, based on the 2012 gross monthly income of 1265 RON of workers in the “other service activities” category (NIS, 2014, Table 5.8).
4. **Political participation**: taking part in the activities of a trade union, a political party, or political action group;

5. **Participation in society**: a composite indicator based on the four previous indicators.

In addition, and to be conceptually consistent with the Active Ageing Index effort, an indicator of connectedness to various social networks based on the data from the 2011-2012 EQLS\(^25\) is also examined:

6. **Social connectedness**: having face to face contact outside the household with children, parents, siblings or other relatives, friends or neighbors and having contact outside the household by phone, the Internet, or by post with children, parents, siblings or other relatives, and friends or neighbors.

**Finally, for analyses using the EQLS, three cohorts are examined:** (1) those 45-59 years of age, the cohort whose members will soon be entering older ages; (2) those 60-74, the “young-old” or the cohort whose members have mostly reached pension age; and (3) those 75 years of age and older, the “old-old,” or the cohort whose members have reached the more advanced stages of old age.

**To summarize, countless studies have shown a variety of benefits – both physical and psychological – to individuals engaged in social participation.** Civic engagement, both through formal and informal social networks, has been linked to improvements in a variety of measures of well-being, including happiness, life satisfaction, self-esteem, sense of control, physical health, depression, and longevity. Social participation in the form of civic engagement and volunteering also contributes to the well-being of the recipients of these efforts; for example children in educational activities especially benefit. Civic engagement through unpaid social work also provides an enormous economic benefit to communities operating in a constrained budget environment with growing social needs. Therefore, social participation may truly be considered a win-win proposition, stressing the importance of enacting reforms that would promote more opportunities for social participation and among older adults.

---

\(^{25}\) Social connectedness in the original Active Ageing Index is measured by an item from the European Social Survey asking respondents “[h]ow often [they] socially meet with friends, relatives or colleagues?” Instead, we elected to base the social connectedness index examined in this report on two items from the 2011-2012 EQLS. The choice of the EQLS items rested on three reasons: (1) the conceptual similarity in the dimensions of participation being tapped by the respective sets of items; (2) the broader set of ways in which social connectedness can occur in the EQLS items; and (3) the advantage of basing analyses and comparisons on the same set of data and the same sample.
B. Comparisons to Other EU Countries

The data in Figure 4.1 compare Romanians with persons from other EU countries on both the individual component measures of social participation as well as the summary measure. Data are presented first for all persons 45 years of age and older and then for each of the three cohorts identified above: persons 45-59 years of age, 60-74 years of age, and 75 years of age and older. The data give Romania’s rank among the 28 member nations of the EU. Given the way that these data have been presented, the higher Romania’s number, the “lower” its rank. Thus, looking at Figure 4.1, persons 75 years of age and older are ranked 27th on voluntary participation activities compared to persons of the same age in the remaining EU28 nations (only Hungary has a lower level). In contrast, Romanians 45-59 years of age rank 8th – or quite high – on social connectedness compared with persons from the same cohort in the other EU28 countries.

Figure 4.1 Romania's ranking on social participation among EU28 countries

The concept of social participation is composed of different types of activities, adding considerable complexity to cross-country comparisons. The data in Figure 4.1 tell many stories. First, not all forms of social participation are alike. For some types of participation, Romania in 2011 ranks quite low. For instance, among all persons 45 years of age and older, Romania ranks 26th out of the EU28 member states in terms of voluntary activities. And for persons 75 years of age and older, Romania has the second lowest level of participation in...
voluntary activities among the 28 nations. On other measures, however, Romania ranks nearer to the middle. Romania’s scores on the social connectedness index place it in 15th position overall among the 28 countries and in 8th position among persons in the 45-59 years old cohort. On still other indicators, however, being closer to the top of the rankings may provide a misleading picture of the situation in regard to an indicator. For example, persons 60-74 years of age rank 11th among the 28 EU nations in terms of providing care to older adults, but this is likely a reflection of poorly developed formal systems of support for elders (see more discussion in Chapter 5). Thus, the data support our earlier contention that social participation is composed of a variety of different types of activities. These activities may be aggregated for convenience, but it is also important to examine differences among them, to disclose varying antecedents and consequences.

Second, there are interesting cohort differences on some of the measures but minimal differences on others. In terms of participation in voluntary activities, all three of the cohorts are near the bottom compared with their age peers in the other EU28 countries. Romanians 60-74 years of age rank in the upper half (albeit toward the lower end of the upper half) in terms of providing care to children, grandchildren, and to disabled and elderly relatives. Also, the cohort 45-59 years of age stands out when compared to its age peers in other countries in terms of its social connectedness or gregariousness.

And, finally, of the five individual component measures, Romania ranks just two steps up from the bottom in terms of overall participation in voluntary activities. Only Bulgaria and Latvia have lower scores on participation in voluntary activities. Romania’s level of political participation places it in the bottom third of EU28 nations. It is likely that the combination of these two measures accounts for Romania’s low position – 22nd out of 28 EU nations – on the composite measure of participation in society. Romania’s level of care to older adults and care to children and grandchildren place it close to the bottom of the middle third of the countries. Only in terms of its overall level of social connectedness is Romania closer to the middle in terms of its placement vis-à-vis other EU28 countries.

To summarize, the current degree of social participation among the older population in Romania, as compared to EU28 countries, exposes substantial room for improvement in performance of all four individual dimensions of social participation – as defined by the Active Ageing Index (European Centre Vienna, 2013). Although carrying out cross-country

---

26 Comparable results are found in a 2008 Eurobarometer survey in which retirees in Romania were 4th from the bottom of the EU27 countries in the percentage that already have participated in community work or volunteering (European Commission, 2008, p. 41).

27 The relative placement of the 60-74 year old Romanian cohort on these two measures suggests that they may be particularly susceptible to strains created by being part of what is referred to as the “sandwich generation” (Brody, 2006) – that is, providing simultaneous or sequential care to persons in the younger and older generations.
comparisons relying solely on the index is a complex task, results provide for an informative peek into generational and cultural dynamics of Romanian society. Romania ranks near the bottom in terms of voluntary activities, signaling strong negative societal perceptions of volunteering in general. On the other hand, Romania ranks closer to the top with respect to providing care to older adults, albeit most likely the effect of poorly developed formal systems for support for elders and not necessarily a sign of voluntary social participation. As a result, referring to the Index could be a useful contribution in constructing policies aimed at boosting all forms of social participation in Romania.

C. Barriers and Impediments to Social Participation

This section draws upon interviews conducted in Bucharest, Romania in March, 2014 as well as data from the 2011-2012 European Quality of Life Survey. Given the known benefits of social participation, the intent is to identify a range of factors that stand in the way of older Romanians engaging in more frequent and extensive social participation (Voicu & Voicu, 2003).

Political and Cultural Factors

Historical and cultural elements, typically related to the Soviet past, impede Romania’s ability to advance social participation of older population. Two factors were consistently noted as cultural and political barriers to the social participation of older Romanians. First, the respondents pointed to the legacy of the communist era prior to the 1989 Revolution. During the decades of the Ceaușescu regime, life in Romania was dominated by structure and organization. “Voluntarism”, to the extent it existed, was mandatory. Because persons were forced to “volunteer,” volunteering came to have negative connotations. Thus, “the low levels of volunteering and negative prejudices associated with it stem from the communist period in Romania, during which ‘voluntary work’ meant unpaid and mandatory activities, imposed by the communist public administration on its citizens” (GHK, 2010, p. 1). As a result, it is alleged that volunteers are not trusted, that present-day Romanian culture does not support voluntarism, that voluntarism is not pervasive at the community level because communities neither welcome involvement nor do they offer opportunities to be involved, and that in general Romania is best viewed as having a weak civil society.

Empirical evidence for the enduring impact of the communist legacy on civic engagement has been sought by a number of investigators. For example, Pop-Eleches and Tucker (2013; see also Wallace, Pichler, & Haerpfer, 2012) conclude that:
Most importantly, we have fleshed out our understanding of what it means to “live through communism” in terms of the civic participation deficit: the socio-demographic landscape left behind by communism, living more years under communism, and socialization in the post-totalitarian phases of communist regimes seem to be important drivers of the civic participation deficit. Furthermore, we show that the post-communist economic—although not political—environment also seems to play a non-negligible role (p. 64).

Additional evidence for the connection between the communist legacy and volunteering is found in the 2011 EQLS data on Romania. Assuming that persons in the youngest age groups would be least affected by having lived through the communist era, we would expect to see that the highest levels of volunteering are among those born after or at the very end of the communist era in Romania. The data in Table 4.1 provide clear support for this conclusion. The level of participation in voluntary activities of those in the youngest age group – 18-29 years of age in 2011 – was considerably higher than those in the next oldest age groups and considerably higher than those in the remaining two age groups.28

<table>
<thead>
<tr>
<th>Age</th>
<th>Mean Voluntary Activity Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>7.46</td>
</tr>
<tr>
<td>30-44</td>
<td>3.85</td>
</tr>
<tr>
<td>45-59</td>
<td>3.49</td>
</tr>
<tr>
<td>60-74</td>
<td>2.11</td>
</tr>
<tr>
<td>75+</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Source: 2011-2012 EQLS

Ironically, legislative “support” for volunteering was also cited as an impediment to social participation. On the one hand, volunteering does have some legislative backing in laws passed in 2001 (“The Law in Volunteering” [no. 95/2001]) and modified in 2006. “The law covers: the definition of volunteering; the basic principles related to volunteers; the volunteer agreement or contract, rights and obligations; the termination of a contract; the reimbursement of expenses; and the social protection of volunteers and foreign volunteers in Romania” (GHK, 2010, p. 14). Despite the existence of this legislation, however, its particulars have been noted as being counter-productive, especially the provision in the earlier legislation mandating a contract. The

28 Those in the youngest age group differ in other ways from persons in other cohorts. Notably, they are in better health and more highly educated - two factors that are related to voluntaristic behavior. Still, even controlling for education and health, the mean voluntary activity score of the youngest age group is statistically significantly higher than the scores of the remaining groups.
need to sign a contract was seen as working against short-term and spontaneous volunteering. Having made the contract optional in the more recent legislation represents a valuable revision, although whether a contract needs to be signed and the availability of medical insurance now are left to the discretion of the voluntary organization. The more recent legislation also does not contain provisions to encourage employers to have their employees volunteer.²⁹

Moreover, the Romanian government itself does not appear to draw upon the talents and expertise of older volunteers. Interviewed Romanian government officials could not cite any examples of volunteers being utilized in a systematic manner by their ministries. Then, too, the relative absence of publicly supported day care facilities for childcare may cause elders to devote their energies to providing care to their grandchildren rather than to volunteering in other ways.³⁰ Care allowances that are sometimes paid to family members for assisting in the care of a frail family member (see Chapter 5 of this report) may also work against participating in volunteer activities.

Socio-demographic Factors

For all indicators, there are clear and statistically significant relationships between cohort and the specific measures of social participation. Looking at the data in Figure 4.2, the younger cohort has a higher level of participation than the middle cohort in each of the areas, while the middle cohort in turn has higher levels of participation than the oldest cohort.³¹ Unclear from these data, as with any cross-sectional results, is whether these findings can be attributed to age effects or to cohort effects. If the former – that is, the effects are due solely to ageing or ageing-related sequelae – then declining levels of participation among the two younger cohorts should be expected as those cohorts age. If, however, the results are due to cohort differences, continuation of the higher rates of participation should be expected as the two younger cohorts progress through the age structure. In all likelihood, these differences are due to some combination of the two effects, and thus future cohorts of older persons are likely to have

²⁹ For greater detail on the legislative backdrop of volunteering in Romania, see Rebeleanu & Nicoară, 2011 and Luca & Girleanu-Şoitu, 2012.

³⁰ Some support for this contention is found in each of the two older cohorts where the relationships between caring for children and grandchildren and volunteering are negative (though statistically non-significant).

³¹ As will be shown later in this chapter, and as the results of numerous studies in the gerontological literature have shown (see, e.g., Cutler, Hendricks, & O’Neill, 2011), some portion of these cohort effects may be attributable to the effects of compositional factors that vary between cohorts and that also are associated with social participation. Two of these compositional factors are education and health. Younger cohorts have higher levels of educational attainment and they are in better health, and these are two factors that are consistently related to social participation as will be shown below. To look at the effects of cohort membership net of the effects of such compositional variables, a series of multivariate analyses were performed looking at the relationships between cohort and the measures of social participation controlling for health and education. The results of these analyses showed that cohort membership exerted a statistically significant negative effect on each of the social participation indicators, net of the compositional factors.
somewhat higher levels of participation than current cohorts of elders. A more precise determination of the relative weight of age and cohort effects and their implications for future levels of social participation among older persons in Romania would require the availability of some form of longitudinal, panel data such as the Survey of Health, Ageing, and Retirement in Europe (SHARE), but to our knowledge such data do not exist for Romania.32

Figure 4.2 Relationships between Age and Measures of Social Participation: Romania, 2011

Financial impoverishment was consistently cited as a major factor affecting the social participation of Romanian elders. As one informant put it, if persons spend a considerable portion of their day seeking the least expensive price of food and other necessities, there will be little energy left to participate in voluntary and other social activities. But in terms of specific components of participation, income operates in a variety of more complicated ways as suggested by the data in Figure 4.3. Participation in voluntary activities shows a significant J-shaped relationship: at the three higher income levels, the greater the household income, the greater the participation in this form of activity, but there is a departure from linearity between the levels of participation of persons in the two bottom quartiles. Political participation and social connectedness also show significant J-shaped relationships: participation and connectedness increase as household income increases, except for those in the lowest income quartile whose levels of participation are higher than those of persons in the 2nd quartile. Providing care to children and grandchildren exhibits an oscillatory but non-significant relationship to income: highest in the lowest income quartile and second highest in the second highest quartile. Providing care to older adults shows a reverse J-shaped distribution, although statistically non-significant, with decreasing participation as household income increases through

32 See this chapter’s section on recommendations for further discussion of data infrastructural issues.
the second highest quartile, but with an increase at the highest quartile. These differing patterns produce a U-shaped but non-significant distribution on the overall measure of participation in society, with higher participation scores at the extremes of the income quartiles and lower scores in the middle quartiles.33

Figure 4.3 Relationships between Income and Measures of Social Participation: Romania, 2011

As presented by the data in Figure 4.4, participation increases with the level of educational attainment among persons 45 years of age and older, including participation in voluntary activities, in political participation, in social connectedness, and in the overall index of participation in society. Participation in intergenerational care to children and grandchildren shows a marginally significant relationship with education (p=.078) and is at its lowest level among persons whose education is at the primary level, although this form of participation is more nearly equal at the secondary and tertiary levels. The lowest level of providing care to

33 Of the six measures, only social connectedness shows significant relationships with income within each of the three age groups and these relationships are generally linear: the higher the income, the higher the social connectedness. Income is a significant predictor of voluntary activities only among the young (in which case the overall J-shaped relationship is evident) and of political participation only among the middle cohort (where the relationship is linear). And among the oldest age group, income is nearly a significant predictor of voluntary activities (p=.058), but only persons with incomes in the highest quartile have higher levels of voluntary activities.
disabled and older adults is also seen at the lowest educational level, but the overall relationship is statistically non-significant.34

Figure 4.4 Relationships between Education and Measures of Social Participation: Romania, 2011

Gender differences disclose a variety of patterns, as shown in Figure 4.5, although on only two of the measures are the gender differences statistically significant: care to older adults and the composite measure of social participation. For all Romanians 45 years of age and older, the gender difference in voluntary activities is small and non-significant. Women are more likely to provide child care and men to participate in political activities and be socially connected, but again the differences are non-significant. On the other hand, women are much more likely to provide care to older adults — a difference that is consistent with much of the gerontological literature on gender differences in caregiving (e.g., Brody, 2006)35 — and it is probable that the strength of that difference is the major contributor to the significant overall gender difference in participation in society.36

34 Within the three age groups, the only statistically significant relationships are those between education and voluntary activities and between education and social connectedness (although the latter is marginally significant among the oldest cohort \[p=0.073\]). Functionally, these relationships are all linear: as level of educational attainment increases, so too do participation in voluntary activities and social connectedness.
35 This gender difference is a reflection of both cultural norms about gender roles in caregiving and traditional norms governing age differences between spouses that result in gender differences in morbidity and life expectancy.
36 By age, gender differences are significant only in the youngest cohort. Women are significantly more likely to provide care to children and grandchildren and to older and frail relatives. These significant differences probably
Many comments were directed at the difficulties for social participation posed by residence in rural areas. It was mentioned, for example, that most NGOs are found in urban areas and that there are very few in rural settings. Rural areas were also said to have fewer communal facilities for meetings and community events. Allegedly community events have disappeared and community traditions have been destroyed. It was also suggested that it is more difficult to recruit volunteers in rural areas and that the emigration of the middle generation from rural areas left the older generation in the position of having to take care of grandchildren, further creating inroads on the time available to participate in other forms of social activities.

Despite the appeal of these hypotheses, the data from the EQLS provide very limited support. Among all Romanians 45 years of age and older, there are significant differences on providing care to children and grandchildren among persons living in different residential settings but it is those living in the most urban areas – cities and their suburbs – who have the highest scores on providing care to children and grandchildren (see Figure 4.6). By age, residence differences in caring for children and grandchildren are significant only among the oldest cohort with the highest level of care provided in the larger urban areas.

Social connectedness also varies by residential setting, with the larger urban areas again having significantly higher scores among all Romanians 45 years of age and older and among Romanians 45-59 years of age and 60-74 years of age. Significant differences appear among the account for women in the youngest cohort having significantly higher scores than men on the overall measure of participation.
oldest cohort also, but in this case the highest level of social connectedness is found among persons living in the medium to large towns.

For the remaining measures, none of the differences are statistically significant and there are no significant differences by residence on any of the participation measures within the three cohorts. The small differences indicate that participation in voluntary activities is at its lowest levels in the countryside, care to older adults and overall participation are at their lowest levels in the most rural of settings, and political participation is at its lowest level in the most urban of areas.

Figure 4.6 Relationships between Residence and Measures of Social Participation: Romania, 2011

Health was mentioned as a factor precluding social participation. An additional implication was that governmental policy worked against social participation, in that disability laws discouraged recovery from illness and promoted refusal of treatment. Self-reported or subjective health status was used to test these hypotheses.37 For all respondent groups, health

37 Long ago, the sociologist W. I. Thomas noted that if persons perceive a situation as real, it is real in its consequences (Thomas & Thomas, 1928). Subsequent research has provided ample support for Thomas’ observation about one’s definition of the situation and about the importance of subjective versus objective assessments. In regard to health, for example, studies have shown that self-reported health status may be an even more effective predictor of various health-related outcomes than objective measures of health (e.g., Ferraro & Farmer, 1999). In addition to broad-gauged measures of health, we would note that further research also should examine the role of sensory impairments that become more prevalent with age and serve as obstacles to social participation (see, e.g., Viljanen, Törmäkangas, Vestergaard, & Andersen-Ranberg, 2014).
had expected effects on most of the participation variables (see Figure 4.7). Better health was associated with higher levels of participation in voluntary activities, care to children and grandchildren, political participation, social connectedness, and overall participation in society. For care to older adults, the relationship is actually in the opposite direction: the better the health, the lower the level of care to older adults. Nevertheless, among all six of the relationships between health and the participation variables for the total population of Romanians 45 years of age and older, only voluntary activities and social connectedness exhibit statistically significant differences.38

**Figure 4.7 Relationships between Health and Measures of Social Participation: Romania, 2011**

![Bar chart showing relationships between health and measures of social participation](image)

Source: 2011-2012 EQLS

To summarize, older Romanians face significant political, cultural and socio-demographic barriers to more frequent and extensive social participation. At present, Romanian culture does not support voluntarism and voluntarism is not pervasive at the community level because communities neither welcome involvement nor do they offer opportunities to be involved. **Encouragingly, the negative connotation of volunteering appears to be dissipating with younger cohorts who have not lived through the communist era.** In addition to the enduring negative

---

38 Within each of the three cohorts, social connectedness is significantly associated with self-reported health, but as age increases, the form of the relationship shifts from linear to curvilinear with the highest levels of social connectedness being found among persons 75 years of age and older whose health is “fair.” Among the youngest cohort, a significant relationship is seen between health and voluntary activities and a marginally significant relationship between health and care provided to frail and older relatives (p=.062). Both relationships are linear, but positive for voluntary activities and negative for providing care to frail and older relatives. Among persons 60-74 years of age, there is a significant relationship between health and voluntary activities, with nearly equivalent higher levels of voluntary activities for those in good and fair health. Among the oldest cohort, other than the relationship between health and social connectedness, none of the other relationships is significant.
impact of the communist legacy, there has been minimal legislative support for volunteering in recent years. Making matters even worse is the fact that the Romanian government itself does not appear to draw upon the talents and expertise of older volunteers. Financial hardships, lower levels of education, and residence in rural areas have also been cited as key impediments to social participation among older adults. Poor health status and disability laws discouraging recovery from illness and promoting refusal of treatment have also proven to work against social participation.

D. Options to Encourage Growth in Social Participation

This chapter has maintained that social participation yields a variety of benefits to the individual participants, to the communities in which they live, and to the nation as a whole (Sirven & Debrand, 2008). With the continuation of population ageing that Romania will experience – resulting in an older population that will be more numerous, in better health, more highly educated, and perhaps of better financial status – the talents and expertise of the older population can and should be utilized much more so than is currently the case. The social capital represented by Romanian elders, in other words, should be drawn upon both for their own benefit and for the benefit of the nation as a whole.

It was consistently noted throughout this chapter that Romanian culture assigns a low priority to voluntaristic activities. Additional evidence supporting this conclusion is found in data on active ageing collected in 2011 as part of the Eurobarometer series of surveys. Figure 4.8 presents data on perceptions of the contributions made by persons 55 years of age and older as volunteers. For each of the EU28 countries, the data give the percentages of persons 60 years of age and older who reported that the older population (55+) contributes “greatly” as volunteers. Of the 28 countries, Romania ranks fourth from the bottom. Only Croatia, Poland, and Hungary have lower percentages of those 60+ indicating that people aged 55 and over contribute greatly as volunteers to their country. As a major study of volunteering in Romania notes, “…there is no main public body currently responsible for the monitoring and regulation of voluntary activities and institutions in Romania,” and there is a “…lack of specific national programmes designed to stimulate volunteering in Romania” (GHK, 2010, p. 10 and p. 12; see also Angermann & Sittermann, 2011).
Voluntarism, therefore, must be made more visible, rewarding, and attractive. The Government might, therefore, consider the following measures:

- **Establish an Office of Community Service** in the Ministry of Labour, Family, Social Protection and Elderly with principle responsibilities:
  - To assess and minimize barriers to participation among Romanians and especially older Romanians;
  - To take a proactive role in encouraging community participation through publicity and through recognition of volunteers and volunteer programs;
  - To emphasize, publicize, and support Romania’s annual National Volunteer Week;
  - To identify prominent and visible Romanians who could endorse volunteering activity and “get out the message” by serving as role models;
  - To work with other Ministries in encouraging the use of volunteers throughout the system of government supported activities: for example, to work with the Ministry of Culture to promote the use of volunteer docents throughout Romania’s system of government supported museums; or with the Ministry of Education to establish voluntarism and community service as integral parts of the educational curriculum by imbuing children from kindergarten on with the importance of voluntarism and by encouraging teachers and schools and entire school systems to foster voluntarism;
  - To work with municipalities to identify physical and spatial barriers that act as impediments to social participation, to remove or otherwise minimize the effects of
these barriers as impediments to social participation, and to increase access to and encourage the use of local libraries, educational facilities, and other public properties and spaces for social activities; these changes would also improve social participation, mobility and independence of disabled population, pregnant women, and adults with small children.

- To work with components of the Romanian system of higher education (e.g., medical schools, social work programs, etc.) to foster more extensive opportunities for civic involvement via internships and service learning;
- And, finally, to act as a clearinghouse for information on volunteering opportunities.

Some of the participatory activities suggested for possible involvement of older persons and/or their representatives during the interviews were:

- **Support the participation of elders in physical activities** (for instance, Senior Olympics: see [http://www.nsga.com/](http://www.nsga.com/) or [http://www.evaa.ch/](http://www.evaa.ch/) or [http://www.seniorgames.net/]), as currently the funds are earmarked exclusively or primarily to support sporting activities in which the young are the major participants.

- **Ensure that voices of older persons are heard.** Perhaps the most visible and institutionalized linkage between the Romanian government and older persons is the National Council of Elderly Persons (NCEP; Bucur, 2012). NCEP was established in 2000 as a result of the enactment of Law No. 16/2000 and is funded through the Ministry of Labour, Family, Social Protection, and Elderly. NCEP’s primary purpose is to regularize discourse between the Romanian government and elderly persons, principally through monthly meetings between the leadership of NCEP and representatives of the Romanian government. Although the mandate of NCEP is broad-gauged, its focus and emphasis to date has been on economic issues and pension adequacy. “Pensioners’ groups have lobbied the government on pensions, but to date have not engaged with wider social and healthcare issues for older people” (HelpAge International, 2001, p. 29). This emphasis is important and understandable given the economic circumstances of older Romanians, but organizations such as NCEP representing older Romanians need to (a) ensure that their leadership is representative of all segments of Romanian society (women, the rural aged, the poor, and ethnic minorities), and (b) encourage their membership to be concerned with and to participate in a broader range of activities – promoting healthy lifestyles among the older population, combating outdated stereotypes regarding the elderly, organizing ecological and cultural events and programs (e.g., festivals), arts and crafts, teaching and mentoring, promoting lifelong learning and “seniors universities,” and supporting family and intergenerational involvement in voluntarism.

- **The mass media must be mobilized to disseminate information about the value of participation and to foster awareness of models and best practices** - whether through the government or through the private sector or through NGOs, or some combination of these sectors. Consistent with an earlier recommendation, charismatic leaders should be identified who would be able, by virtue of their own involvement, to transmit the message via the mass media about the importance of various types of social participation.
• To the extent that the Romanian government is able to encourage and support the development of a widespread system of child daycare and elder daycare, the energies of older caregivers might be freed for a greater range of options for social participation. It has been shown in this chapter that Romania is very low in its level of participation in volunteering activities. Among the several factors that were identified to account for this phenomenon are competing obligations that are in some measure necessary because of the absence of formal support systems. Thus, the absence of inexpensive, high quality systems of day care for children thrusts grandparents into the role of caregivers for their grandchildren in order that the middle generation – the parents of the children – might be freed for labor force involvement. Similarly, the absence of high quality, low cost day care options and other support systems for frail elders likewise thrusts older people into the role of caregivers. In both circumstances, the contributions of older persons may be viewed as “productive,” but sometimes may be overly taxing, also obliging the older generation to participate in caregiving activities at the expense of other productive endeavors. (See Box 6 for examples of volunteer programs designed to ease caregiving responsibilities and promote independent living.)

• To the extent that government programs are effective in reducing poverty and increasing the standard of living, levels of participation in social activities should increase. For a variety of understandable reasons, poverty has been prominent among the factors identified as impeding social participation. Poverty can sap energy and create access problems. Greater economic security, specifically in old age, would have an opposite effect. The abolition of mandatory retirement and an increase in opportunities for discretionary employment among older persons would also enhance participation, as some forms of social participation are facilitated through involvement in the labor force via work-related social networks.

• Efforts on the part of the Romanian government to enhance the health status of its citizens, to postpone the onset of disability and infirmity, and to extend the length of healthy life expectancy will result in higher levels of participation. Poor health works against social participation. Not only do frailties and infirmities make it more difficult for persons to have access to the sites of social participation, but their inability to take part in these forms of social activity also precludes reaping the health and other benefits of participation. Indeed, given the demonstrable benefits of social participation in general and volunteering in particular, “[v]olunteering of older people … should be recognized as an instrument of health policy…” (Stula, 2012, p.84).

• Companies must be encouraged to be more proactive in their support for employee participation in volunteering activities. Support for volunteering activity among businesses and corporations have been spotty in Romania so far. Where such support exists, it most often takes the form of encouraging participation after working hours and on weekends. Companies can give their employees – employees of all ages and all levels of seniority – time off to make such contributions. Additionally, pre-retirement programs and counseling should routinely include information about voluntaristic opportunities and its benefits. (See Box 3 in Chapter 2 for examples of volunteer programs designed to promote preretirement counseling.)
In every way possible Romania should take a hard look at images of ageing, at respect accorded to the aged, and at the nature of relations between generations. Respect for elders – and for their actual and potential contributions to society – should be emphasized. A number of comments from those interviewed addressed the place of elders in Romanian society. Most respondents said that elders were not accorded a great deal of respect. Evidence in support of this perception is also seen in Figure 4.9, which gives mean scores by country for persons 60 years of age and older on a question asking how people 55 years of age and older are generally perceived in that country. Of the 28 EU countries in 2011, only 5 countries have lower scores – indicating more negative perceptions of people 55 and older – than Romania. For elders not to be respected sets the stage for ageism, discrimination, and social exclusion based on age.\(^{39}\) And as shown in Figure 4.10, of the 28 EU countries, Romania ranked 3\(^{rd}\) (behind Croatia and Hungary) in the amount of intergenerational tension (tension between young people and old people) seen by persons 60 years of age and older.\(^{40}\) (See Box 7 for examples of programs designed to promote volunteer activities among elders, strengthen their self-esteem, prevent social exclusion, and promote social inclusion and a sense of prestige in this stage of life.) Just under one in three older Romanians report either

---

\(^{39}\) For research on the detrimental health effects of negative perceptions of old age, see the work of Becca Levy (e.g., Levy, 2003).

\(^{40}\) Based on Q.25d in the 2011-2012 EQLS: In all countries there sometimes exists tension between social groups. In your opinion, how much tension is there between … old people and young people … in this country?
having personally experienced or having witnessed discrimination based on age (see Figure 4.11).  

Figure 4.9 Perception of People 55+ in Country: Among Population 60+

![Bar chart showing perception of age discrimination among people aged 60+ in various European countries.

Source: Eurobarometer 76.2 (2011): Employment and Social Policy, Job Security, and Active Ageing

Policies and practices that discriminate against older persons based solely on their chronological age should be examined carefully, abolished where unnecessary (e.g., mandatory retirement), and restricted only to spheres of activity where age can be shown to be a bona fide criterion for action. Government Ordinances No. 137/2000 and 137/2007 prohibit discrimination of all types, including age, and the National Council for Fighting against Discrimination (NCCD) reporting to the Romanian Parliament is responsible for compliance and enforcement (Bazilescu, 2009). The availability of these channels of litigation against age discrimination must be publicized and access to them made easier.  

41 Based on questions QB24.1-5 in the 2011 Eurobarometer Survey on Employment and Social Policy, Job Security, and Active Ageing: “Age discrimination can affect people of all ages. However, for this question I would like you to think only about those situations where people have been discriminated against because they are perceived to be too old. In the last two years, have you either been a victim of such discrimination because of your age yourself or have you witnessed age discrimination in any of the following areas? In the workplace or looking for work, in access to education and training, in health care, in access to financial products and services, in leisure (tourism, sports, etc.).” Perhaps a slightly more favorable picture is portrayed by the data presented in Figure 4.11 which compares Romania with its EU28 counterparts on the percentage of the population 60+ who report either having experienced age discrimination or having witnessed it. Only eight countries have the same or a lower percentage of persons 60+ reporting that they have experienced age discrimination and only 12 countries have the same or a lower percentage of persons 60+ reporting that they have witnessed age discrimination.

42 In actuality, very few cases of age discrimination are brought to NCCD. By one estimate, only 1.2% of the 836 discrimination cases before NCCD in 2007 involved age discrimination (see http://www.agediscrimination.info/international/Pages/Romania.aspx).
made to reduce any intimation that relations between generations are of a zero-sum nature – i.e.,
that one generation can only gain at the expense of another. Rather, inter-generational solidarity
should be promoted, mutual inter-dependence between generations emphasized, and the common
stake generations have in one another should be highlighted (Kingson, 1986).

**Figure 4.10 Opinions: Tension between Old People and Young People in This Country:
Mean Scores for All Persons 60+ (0=none, 1=some, 2=a lot)**

![Mean Tension Graph](image)

*Source: 2011-2012 EQLS*

**Figure 4.11 Percentage of Population 60+ Experiencing or Witnessing Age Discrimination**

![Experienced vs. Witnessed](image)

*Source: Eurobarometer 76.2 (2011): Employment and Social Policy, Job Security, and Active Ageing*
Box 6. Examples of Programs to Promote Self-Esteem and Social Inclusion

Gente 3.0 is a project implemented in Spain and designed to promote volunteer work among seniors, strengthen their self-esteem, prevent social exclusion, and promote social inclusion and a sense of prestige in this stage of life. Among other activities, this program provides seniors with operation skills of a computer and other ICT devices, which then fosters intergenerational relationships through participation and active involvement of seniors in working with children and young people as volunteer work. Within the framework of "CiberCaixa en Centros Penitenciarios" (CiberCaixa in Prisons) senior volunteers teach young prisoners how to use a computer. Seniors, who gained their first experience with computers in "CiberCaixa" courses, get involved as volunteers in ICT courses directed to people with disabilities, immigrants, prisoners and other seniors. Volunteering activates seniors socially, by supporting at the same time the activities for other disadvantaged groups (children with mental disabilities, migrants, prisoners). Through collaboration with other institutions, including local and central government units, the presence of seniors in the community is promoted. Cited in Kryńska & Szukalski, 2013, pp. 248-250; see also http://obrasocial.lacaixa.es/lCaixaFoundation/olderpeople_en.html

Ageing Differently, City of Rotterdam, Netherlands. Group meetings and informative events are organized by older people for older people. The topics are self-chosen and the groups act independently. Some groups target people at risk of social exclusion, for example homosexuals, older people with hearing loss, and older people from ethnic minorities. Cited in European Foundation for the Improvement of Living and Working Conditions, 2011.

• Surveys should be prepared and conducted, and analyses be carried out to document whether and how the health, economic, and social situations of older members of ethnic minorities differ from those of members of older Romanian majority groups. How the situation of ageing minorities may differ surely represents a topic of considerable significance. However, discussion of ethnic differences in social participation was constrained by unavailability of data. Hungarians who made up 6.5% of the Romanian population in 2011 and Roma who made up 3.3% are the two largest minorities according to official statistics (NIS, 2011). Yet, the omission of any items by which ethnicity might be identified in the surveys we have used and the relatively small sample sizes that would have resulted if such data had been available precluded any analyses based on ethnic differences. Moreover, ethnic differences were not mentioned in any of the conducted interviews.

• Finally, the Romanian government should be applauded for acknowledging the issues associated with population ageing and for its concern with addressing these issues sooner rather than later. At the same time, determining whether progress is being made requires a data system for monitoring social and behavioral (as well as biomedical) aspects of ageing. It has been repeatedly pointed out to us that Romania has not yet developed a data infrastructure for monitoring trends related to the ageing of its population. Hence, government support for social and behavioral research on ageing needs to be increased at the earliest possible moment. Specifically, the Government should ensure that Romania become part of the Survey of Health, Ageing, and Retirement in Europe (SHARE), so that comprehensive data on the older population of Romania and, via its panel design, on
the ageing of Romanians can be collected and analyzed. Regular participation in SHARE will also allow cross-sectional and longitudinal comparisons with 15 other participating European countries, as well as permit additional comparisons via the harmonization of the data with the U.S. Health and Retirement Study and the English Longitudinal Study on Ageing. Data archives – such as the Romanian Social Science Data Archive at the University of Bucharest – need to have the most recent data readily accessible and available to the research community. The ready availability of high quality data on Romanian elders – based on and derived from the gerontological research literature – will also represent a major step toward supporting the growing interest in ageing among Romanian educators, scientists, and policy makers.

To conclude, Romania would benefit from introducing an Office of Community Service, charged with making voluntarism more visible, rewarding, and attractive. Communication channels between the Government and older population could be improved through better representation and an increased range of discussion topics. Media and role models could be better employed to creatively promote the idea of active ageing. More options for formal child and elder care would allow the older population to consider a wider array of options to participate in the society. Finally, reducing poverty, health and infrastructure barriers for participation would also lead to increased volunteerism.
Chapter 4 Bibliography


European Centre Vienna (2013): *Active Ageing Index 2012 Concept, Methodology and Final Results*. Vienna: Methodology Report Submitted to European Commission’s DG Employment, Social Affairs and Inclusion, and to Population Unit, UNECE.


Chapter 5 TOWARDS HIGHER INDEPENDENCE IN LONG TERM CARE

Romania’s ageing population with increasing life expectancies and declining fertility rates requires rethinking of existing ageing policies and the development of a strategy. The substantial emigration of younger population groups from Romania poses additional challenges, especially in rural areas. As shown in the Chapter 1, Romanian’s life expectancy has increased; however the healthy life years have not been added at the same pace. It is therefore expected that Romanians will live longer but will experience more chronic disease accompanied by disabilities. Unless appropriate measures are taken, this will also increase health care costs and put pressure on the demand for long term care (LTC)\(^{43}\). Health and social policies will need to deliver appropriate systems to respond to the needs of ageing populations. Although the key approach is to keep people as healthy as possible and at home as long as possible, there always will be a number of people in need of LTC. More recently, attention to remaining healthy, rehabilitation and continued activity are also a key focus of the LTC system itself.

At present, most EU Member States face challenges in planning, funding, governance, organization and monitoring of service delivery in the area of long-term care, and Romania is no exception. Rather than being a generic system on its own, long-term care may be described as a rather loosely coupled system between health and social care, as an area of fragmented services, with various kinds of residential facilities, and often inconsistent policy initiatives and governance mechanisms for (potential) users and informal caregivers (Leichsenring et al., 2013). An idea of an integrated long-term care system with its own identity, pathways and processes, policies, management and organizational structures as well as proper means and resources (see Figure 5.1) is only just emerging. Some countries are more advanced than others in bridging the divide between health and social care as well as between formal and informal care and may provide valuable lessons.

Romania may be characterized as a new Member State with relatively less developed policies and practices in this area, given the level of funding, the extent and quality of facilities and services as well as coverage and the regulatory framework. Table 5.1 provides an overview of the basic indicators of LTC provision in Romania at present and compared to OECD averages. The proportion of older people with self-perceived long-term limitations in usual activities is slightly below the OECD average, which is also a result of the lower life-expectancy of Romanians. The supply of services and facilities is far below other countries in Europe. With a minimum of at least about 800,000 Romanians with care needs above the age of 65, only a very small proportion receives formal care services, most relying on family help.

---

\(^{43}\) According to the OECD, long-term care “is a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living (ADL), such as bathing, dressing, eating, getting in and out of bed or chair, moving around and using the bathroom. This is frequently provided in combination with basic medical services such as help with wound dressing, pain management, medication, health monitoring, prevention, rehabilitation or services of palliative care. Long-term care services also include lower-level care related to help with instrumental activities of daily living (IADL), such as help with housework, meals, shopping and transportation. Long-term care can be received in institutions or at home.”
Table 5.1 Key-indicators of LTC demand and supply in Romania

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>Male</th>
<th>Female</th>
<th>OECD Ave.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LTC demand:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>20,020,074</td>
<td>9,761,480</td>
<td>10,258,594</td>
<td></td>
</tr>
<tr>
<td>Population 65+</td>
<td>3,258,198</td>
<td>1,310,147</td>
<td>1,948,051</td>
<td></td>
</tr>
<tr>
<td>Share of population 65+ (2010)</td>
<td>16.2%</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of population over 65 with severe self-perceived long-standing limitations in usual activities (2012)</td>
<td>24.6%</td>
<td>20.5%</td>
<td>27.4%</td>
<td>30%</td>
</tr>
<tr>
<td>Disability-free life expectancy at 65 (in years, 2012)</td>
<td>5.9</td>
<td>5.1</td>
<td>9.5</td>
<td></td>
</tr>
<tr>
<td><strong>Formal LTC supply:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of beneficiaries of cash benefits for LTC 2012 (all categories and age groups)</td>
<td>ca. 700,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of beneficiaries of home care services (nursing and home help) 2012 (average per month)</td>
<td>14,567</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- as proportion of population 65+</td>
<td>0.45%</td>
<td></td>
<td>8.5%</td>
<td></td>
</tr>
<tr>
<td>Number of places in institutional care (old-age and nursing homes)</td>
<td>11,584</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- as proportion of population 65+</td>
<td>0.36%</td>
<td></td>
<td>4.2%</td>
<td></td>
</tr>
<tr>
<td>Public expenditure on LTC in % of GDP (2011)</td>
<td>0.69%</td>
<td></td>
<td>1.7%</td>
<td></td>
</tr>
</tbody>
</table>

Sources: Eurostat; on-lina data codes [demo_pjan]; [hlth_silc_07]; [hlth_sha_ltc], OECD indicators 2013; Ministry of Labor, 2014.
This chapter identifies gaps and related options for improving funding, delivery and the utilization of long-term care services and facilities at the interfaces between health and social care in Romania. Based on interviews, conducted in Bucharest in March 2014 to explore the expectations and visions of relevant stakeholders, a particular focus will be on the creation of an integrated network of services for older people, involving users and family caregivers, as well as on the sustainable implementation of existing legislation (e.g. Law No. 292/2011) with defined responsibilities of stakeholders and new ways of funding. This is in line with intentions expressed in previous policy papers in the area of health and social welfare (cf. Government of Romania, 2008). Following the description of the Romanian situation and challenges, options for improvement based on experiences from other EU countries are provided. An ongoing survey on providers and long-term care services for older people in Romania will provide more detailed information and will be included in subsequent versions.

The fact that long-term care has been a ‘latecomer’ in social protection systems is also reflected in its scarce consideration in the construction of the Active Ageing Index (European Centre Vienna, 2012; see also Introduction of this document). However, some indicators in the area of social activity, participation of older people, independent and autonomous living of older persons and an enabling environment may serve as important sources of information concerning the status and potential areas for improvement. Particularly problematic areas in this respect from the view-point of enhancing Independent Living concern the access to services, material deprivation, mental well-being and social connectedness, while the relatively low share of healthy life expectancy at 55 – together with a generally lower life expectancy – provides hints at high demand for care and important needs for improvement (see Table 5.2).

Table 5.2 Selected individual Active Ageing Index indicators for Romania

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value Romania, in %</th>
<th>Value best-performing country, in %</th>
<th>Best-performing country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary activities</td>
<td>4.4</td>
<td>32.7</td>
<td>Austria</td>
</tr>
<tr>
<td>Providing care to own and grandchildren</td>
<td>28.7</td>
<td>53.7</td>
<td>Italy</td>
</tr>
<tr>
<td>Providing care to older adults</td>
<td>11.3</td>
<td>17.1</td>
<td>Finland</td>
</tr>
<tr>
<td>Access to services</td>
<td>77.4</td>
<td>99.0</td>
<td>Slovenia</td>
</tr>
<tr>
<td>Living independently</td>
<td>72.2</td>
<td>99.3</td>
<td>Sweden</td>
</tr>
<tr>
<td>No material deprivation</td>
<td>67.6</td>
<td>99.9</td>
<td>Luxembourg</td>
</tr>
<tr>
<td>Share of healthy life expectancy at 55</td>
<td>53.0</td>
<td>77.1</td>
<td>Sweden</td>
</tr>
<tr>
<td>Mental well-being</td>
<td>42.8</td>
<td>87.2</td>
<td>Denmark</td>
</tr>
<tr>
<td>Social connectedness</td>
<td>24.0</td>
<td>75.6</td>
<td>Portugal</td>
</tr>
</tbody>
</table>

Sources: http://www1.unece.org; http://www.euro.centre.org/aai
A. Developing an Identity of Long-term Care System (LTC) in Romania

Long-term care has only been acknowledged as a social risk in Romania over the past few years. Priority in developing social security structures had been given to pensions, health, and child and family policies while “social services addressing at-risk categories and active labor market programs were far slower to develop. This can in part be explained by the absence of a broader, integrated, legislative social assistance system” (Pop, 2013: 165) that was eventually introduced in 2011 (Law no. 292/2011). Specific policies for older people were only developed after the accession of Romania to the EU, with some legislation and related initiatives to extend social services for older people.

A few parallel benefit systems exist for people with disabilities and long term care needs. The need for long-term care is not limited to specific age groups, although the probability to become dependent on care and assistance rises sharply with age. This has led to partly distinct regimes as disabled people of working age are provided with some income replacement through the ‘invalidity pensions’, which are granted according to the assessed degree of (in)capacity to work if a potential recipient has contributed to the Social Insurance Fund for at least one day.44 As invalidity pension recipients reach the statutory retirement age, their invalidity pension is automatically transformed into an old-age pension. In addition, people can apply for a non-contributory “disability pension”, which provides basic income on the basis of the degree of disability and can be combined with the invalidity pension or other income. Furthermore, both people with disabilities at working age and at pension age may apply for additional benefits if they need long-term care to facilitate equal opportunities, autonomy and social inclusion (Law no. 448/2006).

The recent decentralization of social services has not helped the integration within the long-term care. The on-going reform process concerning social inclusion and social service development has been accompanied by strategies to decentralize responsibilities to local administrations, which contributed to further divides between disability policies and long-term care provisions and between local jurisdictions.

One of the reasons for the scarcity of services in this sector and the low priority assigned to it by some local administrations seems to be a generally adverse image of and towards older people, representing not only frailty, but also the ‘old generation’ and the ‘old regime’. Some contradictory features are characterizing the image of older people in Romania, as discussed in more detail in chapter 4 on social participation. On the one hand, specific

44 Degree I: total loss of working capacity and autonomy; Degree II: total loss of working capacity, but remaining autonomy; Degree III: loss of at least 50% of working capacity with remaining ability to work part-time.

45 In a distinct process (see 5.2) long-term care needs are assessed regarding functional restrictions in carrying out instrumental activities of daily living and respective loss of autonomy. People with severe disabilities and loss of autonomy are entitled to a number of benefits, some of which may be chosen according to individual preferences. For instance, they may employ a personal assistant, who is registered and paid by the local authority, or opt for an equivalent attendance allowance (‘indemnizatia de insotitor’) plus a complementary ‘personal budget’ (‘bugetul personal complementar’). The option to employ a family member as a personal assistant is also explicitly stipulated by law for older people with long-term care needs (Law no. 17/2000), but they may also opt for the above cash benefits according to Law no. 448/2006.
regulations such as, for instance, the exclusion of pensioners from accomplishing voluntary work – a regulation that had only recently been abandoned – are indicators for conceiving old age as a passive period of life. At the same time, many grand-mothers and grand-fathers are actively involved until high ages in parenting their grandchildren, whose mothers and fathers are working abroad.

At the same time, prevailing attitudes toward caring responsibilities underline the still widespread expectation that adult children should provide care to their older relatives in case of dependency. In a 2007 Eurobarometer Survey more than 70% of respondents in Romania stated that older people in need of care should live with one of their children and almost 50% agreed with the statement that care should be provided by close relatives, even if that means that they have to sacrifice their career to some extent. These attitudes are in line with other East European and Mediterranean countries, but in contrast with Western and Nordic countries. On average, only 43% of EU citizens preferred to live with their older relatives in need of care and 37% stated that care for older relatives has priority over a career (European Commission, 2007). In the current situation in Romania, these attitudes and expectations are seriously challenged by the fact that an estimated 3.5 million Romanians are working abroad (OECD, 2013) and most of them will not be in the position to return in order to take on caring responsibilities for their parents.

Informal care providers, often family, remain a key resource for the care of older people, albeit without any major support structure or measures to sustain such support. On the contrary, significant contributions are requested from family members of older people needing residential care. This often results, for instance, in negative effects on employment, in particular for women: Romanian women with care responsibilities engage in paid employment significantly less often than those in other EU Member States (Rodrigues et al., 2013). The general lack of facilities and services for older people with care needs has only very partially been compensated by the introduction of cash benefits and the possibility to employ informal care givers, including family members, as ‘personal assistants’.

With the important share of Roma population and the existing differences between rural and urban areas as well as between counties, an additional challenge is to guarantee equal access for hard-to-reach groups and ethnic minorities. For example, Roma people suffer from chronic disease at earlier ages and at higher rates compared to the non-Roma (Roma Inclusion paper, 2014).

Apart from legal reforms, an important stimulus to the development of social support and long-term care services has been triggered by NGOs, for instance in developing community care services and more multi-disciplinary cooperation. The multi-disciplinary assessment of needs must be underlined as an example of positive development, even if the legal guidelines have only partially been implemented (Briciu and Costea, 2013), and even though nurses are still mainly working under the supervision of medical doctors. This model of cooperation between social and health care professionals represents a first step towards coordination and cross-sectorial cooperation in long-term care and introduction of more activities geared towards remaining healthy and active.
More generally, an own identity of an integrated long-term care system remains yet to be developed in Romania in terms of preventive initiatives, empowerment, and interventions that enhance older people’s and their informal care givers’ quality of life. Such a system would be characterized by a clear vision for long-term care, based on values such as dignity, well-being and quality of life and would foster development of clear governance structures, inter-professional cooperation, and support to informal care givers. A public debate related to these issues could be initiated, for instance, on the basis of an existing ‘Charter of Rights’ for people in need of long-term care and assistance, as described for the case of Germany in Box 8 (Federal Ministry, 2007), and at the EU level (AGE Platform Europe, 2010).

Box 7. The German Charter of Rights for People in Need of Long-term Care and Assistance

<table>
<thead>
<tr>
<th>Article</th>
<th>Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Self-determination and support for self-help</td>
</tr>
<tr>
<td>2.</td>
<td>Physical and mental integrity, freedom and security</td>
</tr>
<tr>
<td>3.</td>
<td>Privacy</td>
</tr>
<tr>
<td>4.</td>
<td>Care, support and treatment</td>
</tr>
<tr>
<td>5.</td>
<td>Information, counseling, informed consent</td>
</tr>
<tr>
<td>6.</td>
<td>Communication, esteem and participation in society</td>
</tr>
<tr>
<td>7.</td>
<td>Religion, culture and beliefs</td>
</tr>
<tr>
<td>8.</td>
<td>Palliative support, dying and death</td>
</tr>
</tbody>
</table>

To summarize, the Romanian long term care system still has not yet developed its own identity. The LTC market is characterized by a low level of formal supply, which is fragmented across the health/social service divide, distinctions between older and younger people with disabilities, as well as across jurisdictions with uneven access to services. A heavy burden of care provision is therefore falling on family members without any major support structure. Historic cultural norms of care provision by the family have more recently been stressed by strong emigration flows and the pertaining negative image of older people, representing frailty and the communist past. Therefore, community involvement in the LTC area is very welcome and is being pioneered by NGOs. More public debate is needed to form a clearer vision for the long-term care system going forward.

B. Policy and Governance

The provision of long-term care services and facilities in Romania is regulated at different governance levels and implemented by distinct entities. Support mechanisms are either based on the rationale of a decentralized social assistance system or according to the logic of a rather centralized social health insurance.

At the central level, the Ministry of Labor, Family and Social Protection and Elderly, namely the Department of Social Assistance and Family Policies, is responsible for the implementation and supervision, mainly grounded on the following legal directives:
The Act on Social Assistance for older people (Legea privind asistenta sociala a persoanelor varstnice; Law No. 17/2000) describes the rights of older people to social assistance, eligibility criteria and assessment and access procedures. It also legislates the types of services and provisions as well as state and local funding responsibilities.

The National Social Assistance Act (Sistemul National de Asistenta Sociala; Law No. 47/2006) regulated the organization, operation and financing of the social assistance system in Romania until 2011 when it was amended by Law no. 292. The new Social Assistance Act helped define and regulate a number of issues, e.g. the definition of personal care services, formal and informal care, and cooperation between public and private stakeholders. In addition, it introduced and defined the term ‘long-term care’ for the first time in Romanian legislation: it specifies in Art. 32(2) that persons needing support with basic and instrumental activities of daily living for more than 60 days are considered to be in need of long-term care.

Several Decrees (for instance 318/2003; 246/2006) have regulated the organization and functioning of home care services, the authorization of service providers and structural minimum standards of services and residential facilities until recently. A by-law of the Social Assistance Act Law No. 197/2012 on quality assurance in social services eventually regulated accreditation mechanisms for private providers of social services as well as mechanisms for monitoring and control of quality. This reform process is currently being implemented, e.g. by developing performance indicators and inspection guidelines.

The Ministry of Public Health is responsible for developing national health policy, regulating the health sector, setting organizational and functional standards, and improving public health. It is supported by 42 public health authorities at the district level and the quasi-autonomous National Health Insurance Fund (Vlădescu et al., 2008). The latest health reforms aimed at ensuring the principles of social health insurance (solidarity, universal coverage and autonomy) and at stimulating privatization and competition between providers, mainly in the context of an ongoing decentralization process (Health Reform Law No. 95/2006).

At the county and the municipal levels both ministries are represented by County Councils and Local Councils respectively. However, rather than fostering the grounds for cooperation and coordination, the distinctions between health care and social care as well as the autonomy given to local and county authorities, in particular with respect to the use of budgets, seem to contribute to large variation of outcomes between individual jurisdictions. Therefore national strategies have stipulated a better linkage between health and social care services within a common, unified system of long-term care (Government of Romania, 2008), yet with limited success and difficulties in implementing and enforcing guidelines provided by the state level.

During the past two decades, a number of new stakeholders have emerged, thus creating new types of ‘welfare mixes’ across the country. As a consequence of lacking services, private non-profit organizations have been founded, often with support from international organizations (e.g. Caritas, Diakonia, Red Cross), to provide home care and residential care, in particular in rural areas. The cooperation of public authorities in terms of ‘public-private partnerships’ with these organizations has been explicitly strengthened by legal regulations specifying authorization and funding mechanisms. As a result of public policies that aimed at increasing privatization,
mainly in the area of health care, many private for-profit providers have entered the ‘market’ that, however, remained rather unregulated in the area of long-term care.

**Private for-profit care home providers are not subject to any kind of specific regulatory framework**, which also results in a **total absence of related quantitative data**. For-profit home care providers are mushrooming mainly in urban areas based on incentives and funding opportunities fostered by the ‘intermediate home nursing scheme’ that is funded by the social health insurance, and facilitates nursing care at home over a maximum period of 90 days. This service is free of charge for patients and supervised by the general practitioners, but in practice (anecdotal information) it covers only the post-acute phase for an average of no more than three weeks.

**In general, authorization and accreditation mechanisms, including quality assurance, have only started to be developed,** as respective guidelines and monitoring procedures are being elaborated according to Law no. 197/2012. Still, with respect to contracting, there are no general guidelines for negotiations between local authorities as ‘purchasers’ and provider organizations. Structures and regulations for ‘collective bargaining’ are missing, which is also due to the fact that there is no federation or entity that would be legitimized to represent provider organizations. ‘Prices’ for public and private non-profit organizations providing services or facilities are defined by the Local Councils, but usually cover only a small share of real costs. Public contributions are therefore considered by non-profit providers as ‘subsidies’ that have to be topped up by private contributions and donations (see section on ‘means and resources’).

**The role of informal caregivers and related support mechanisms have hardly been addressed by legislation.** Apart from the possibility of up to 15 days unpaid care leave, which mainly serves for short-term periods of urgency, the only existing support mechanism for family caregivers is to get employed by the local council as ‘personal assistant’ for family members with severe disabilities.

**Prevention and rehabilitation in long-term care have not been high on the agenda over the past decades.** While there are a number of health resorts providing rehabilitation, it is unclear in how far they target the older population with long-term care needs. A popular scheme of the health insurance covers costs for treatment in rehabilitation resorts for 21 days and subsidies for additional 9 days per year (Vladescu et al., 2008), but evidence on access, target groups and outcomes of such programs is scarce.

**First steps towards a legal framework and related funding mechanisms offering a small basis for adequate protection, security and care for older people have already been taken** in Romania. Some options for further improvement are presented below, based on examples of good practice from EU Member States.

---

46 General regulations related to gastronomy and accommodations apply.
47 Although article 37 in Law no. 292/2011 (Social Assistance Act) stipulates the possibility for for-profit providers to deliver social services, necessary decrees to define their activities have not yet been adopted. In the meantime residences for older people (with and without care) that are run by private for-profit organizations are mostly operating under hotel or other accommodation licences.
Apart from raising awareness about older people and their long-term care needs, it is of the utmost importance to create time and space to get together all types of relevant stakeholders and resources at the local level. These would include formal care providers, GPs, informal care givers, local administration officials, pharmacists, volunteers and others. The aim of dialogues on health and care that were promoted in Hamburg (Germany) was to gather these stakeholders to develop comprehensive health and care strategies, to initiate and monitor local networks and to establish continuous working groups on important issues of long-term care. This included the development of a local information system for formal care providers and informal care givers. Furthermore, older people with care needs and their care givers should be given a voice as co-producers of care for remaining as long as possible in their own homes. Working groups dealt with issues such as housing in old age, prevention, mobility, participation, terminal care as well as health and information technologies (Weigl, 2011).

Such initiatives at the local level could be incentivized with relatively small resources to develop bottom-up strategies in the respective local context. They will be of increasing importance and relevance in the future with an increasing population of older people.

‘Ageing in good company’ (Austria)

The multi-stakeholder approach that is needed to promote active ageing in the community has also been at the core of a social community development initiative by the regional government of Salzburg (Austria). The project ‘Ageing in good company’ supports local initiatives in the field of healthy and active ageing. They are sustained by local working groups consisting of representatives of associations for older people, mayors, social care associations and volunteers that set up their own agendas and objectives for different domains of independent and autonomous living of older people. These initiatives have achieved to establish and to set up (cf. Rodrigues et al., 2013):

- a case manager in the communities as contact person for caring relatives;
- trainings and workshops for older people in relation to security and mobility in daily life (transport, traffic, secure living environment) and in health topics (nutrition, diseases etc.);
- trainings for caring relatives, e.g. in cooperation with Caritas, to train volunteers for supporting and accompanying caring relatives and;
- starting in 2012, the pilot project ‘Gut umsorgt vor Ort’ (‘well cared-for in place’) that has been jointly implemented with a nursing school to provide technical support and guidance for caring relatives.

These type of initiatives demand relatively low investment costs on the local level, while having potential to incentivize civic engagement (see Chapter 4) and social cohesion with a focus on care-related improvements.
**Structural integration of health and social care (England)**

The division between health and social care has also characterized the governance of long-term care in England. To overcome this divide, joint organizational structures between health and social care were facilitated by a national government policy document in the year 2000 – Care Trusts were established in some local areas. In most cases this resulted in single organizational structures based on a traditional National Health Service model, with social care powers and responsibilities essentially being delegated to the health system. The model was therefore only partially successful as many local councils perceived Care Trusts as a form of ‘take-over’ of social care by the health care system. Nevertheless, the Care Trust model remains interesting as a structurally integrated approach to joint working across health and social care (Glasby, 2011).

Given the lack of formal integration and comprehensive funding for long-term care in Romania, the option to develop a ‘Care Trust’ or ‘Long-term care Fund’ at the state level could be explored, with respective branches at the county level to develop, steer, fund and monitor the delivery of long-term care. This approach would imply shifting budgets from public health and social care budgets which would both contribute to the ‘Long-term care Fund’ based on existing and future-oriented legislation in this sector.

**Incentives to avoid delayed hospital discharges (Sweden, Denmark)**

The lack of services and facilities forces many older people in need of long-term care to seek hospital care, occupying expensive acute care beds without solving any problems in a long-term perspective. In order to reduce the number of so-called ‘bed-blockers’ in hospital, the Swedish Ädel Reform (addressed to care for older people) introduced incentives for local authorities that are responsible for social care to increase the availability of community care services. This implied that hospital costs (generally paid by county councils) for patients who could not be discharged due to a lack of services in their municipality, have to be borne by the respective local authority.

This regulation resulted in a reduction of ‘bed-blockers’ by more than 50%, in particular due to an enhanced partnership working between hospital staff and community care managers. In practice, referral notes are communicated by the hospital to the respective municipality and the patient’s GP as soon as the patient in acute care is ready for referral to start joint care planning. Representatives from acute care and the municipality’s needs assessment unit meet with the patient and, if applicable, an informal caregiver, to plan rehabilitation and future care together, according to the patients’ needs. The municipal care services then have five days to organize care according to the plan. If the municipality is not able to provide a place in a care home or home care services, it has to reimburse the county (Emilsson, 2011). Although different responsibilities and flows of funding apply in Romania, similar mechanisms could be developed between state ministries, the social health insurance and local authorities.
In conclusion, there is a need for better coordination in the provision of long-term care services in Romania between the Ministries of Public Health and Labor, county and local councils, NGOs, private care providers, hospitals, GPs, pharmacists, informal caregivers and persons in need of care. Authorization and accreditation mechanisms, including quality assurance, have to be addressed, among other issues, and an emphasis on prevention and rehabilitation has to be strengthened. Successful examples from other countries offer ways to increase cooperation at the local community level, to structure formal integration between health care and social services, and to provide the incentives for fast placement of persons in need of care into the most appropriate setting.

C. Organizational Structures

The current infrastructure for the provision of long-term care has been described as insufficient on many occasions (Government of Romania, 2008; Popa, 2010; Briciu and Costea, 2013). This is also reflected in a lack of data and systematic information on the main sources of formal long-term care. The following discussion presents the current situation in Romania. However, infrastructure needs should be considered after a new approach, focused on home care, is developed. In the meantime, more data should be gathered to provide a clear picture of the current situation.

Nursing and residential care homes

Table 5.3 provides an overview of residential care facilities by types of providers, based on the latest data available (2012), provided by the Ministry of Labor. No data exist for private for-profit facilities. About 46% of facilities are run by NGOs (private non-profit organizations), providing almost one third of all residential places. NGO facilities are designed for on average about 50 residents, while public facilities, generally managed by the county (General Directorate of Social Assistance and Child Protection) and local councils, cater to an average of 73 residents per facility. There are no distinct data about residential care facilities with or without nursing care. Some older people are living in residential facilities for people with disabilities at working age. Only about 120 places in assisted or sheltered housing facilities are provided by NGOs (Ministry of Labor, 2012).

In spite of increasing capacities over the past ten years, all care homes are reporting high numbers of people on waiting lists. The total of more than 2,600 people on waiting lists is a clear indicator of scarcity both in the residential care sector and with respect to alternative care arrangements. The high number of people on waiting lists must however be interpreted with care, as at the same time the degree of capacity utilization seems to be relatively low according to these data. Potential reasons might be lack of staff, poor management or the fact that people who apply for a care home remain on waiting lists, even if they have currently found another solution.

Eligibility criteria for and, more importantly, criteria for priority admission to care homes are dependent on health conditions and the socio-economic situation of the older person in
need of care, including the absence of family support. A needs assessment is carried out by a team of health and social workers and is conducted with the direct beneficiary and her/his family.

Data about the quality of care in residential facilities are not available. Minimum standards include, for instance, that 60% of the total staff have to be specialized professionals, and the ratio between residents and staff has to be 2:1. With the implementation of Law no. 197/2012 it is to be expected that systematic monitoring and gathering of data will improve. Still, both the quantitative infrastructure and the quality of care homes, in which for instance the availability of single rooms, general accessibility and integration into the community are scarcely developed, will remain a major challenge over the next decade.

Table 5.3 Number of residential care facilities by region and by type of provider (2012)

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of facilities</th>
<th>Average no. of residents per month</th>
<th>No. of places</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>public*</td>
<td>NGO</td>
<td>Total</td>
</tr>
<tr>
<td>North-East</td>
<td>17</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td>South-East</td>
<td>21</td>
<td>10</td>
<td>31</td>
</tr>
<tr>
<td>South (Muntenia)</td>
<td>16</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>South-West (Oltenia)</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>West</td>
<td>13</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>North-West</td>
<td>8</td>
<td>30</td>
<td>38</td>
</tr>
<tr>
<td>Centre</td>
<td>14</td>
<td>33</td>
<td>47</td>
</tr>
<tr>
<td>Bucuresti-IIlfov</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Total</td>
<td>108</td>
<td>95</td>
<td>203</td>
</tr>
</tbody>
</table>

Source: Ministry of Labor, Family and Social Protection, 2014; own compilation.
Note: Public providers include both county and local councils.

Day care facilities

A total of about 6,700 places are available for older people needing day care, though with significant regional variation (Table 5.4). About 25% of those places are provided by NGOs. These centers are typically used by more autonomous pensioners who seem to be hesitant to visit such facilities as quite important differences between the number of available places and the actual number of users per month reveal. This is even more surprising as many of these facilities
are linked to medical support and may have a preventive function, in particular for older people living alone.

Table 5.4 Number of day care facilities by region and by type of provider (2012)

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of facilities</th>
<th>Average no. of users per month</th>
<th>No. of places</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>public *</td>
<td>NGO</td>
<td>Total</td>
</tr>
<tr>
<td>North-East</td>
<td>6</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>South-East</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>South (Muntenia)</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>South-West (Oltenia)</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>West</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>North-West</td>
<td>11</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Centre</td>
<td>10</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>Bucuresti-Ilfov</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>26</td>
<td>73</td>
</tr>
</tbody>
</table>

Source: Ministry of Labor, Family and Social Protection, 2014; own compilation.
Note: Public providers include both county and local councils.

**Formal care at home and in the community**

Home care services have only slowly developed over the past two decades in Romania. A number of NGOs started to pioneer them in the 1990s with support from international organizations. First activities included basic training courses for home helpers (80 hours theory and one month of practice in a care home), then training programs for social workers and for community nurses were developed, e.g. by the Foundation for Community Care Services and related projects (Vladu, 2001). A more structured development of home care has taken place during the past decade only, when the county health insurance funds started to reimburse home nursing (Ministry of Health Decision No. 318/2003). However, this still represents an almost negligible part of public expenditures for health. Except for community nurses, nurses are working under the supervision and responsibility of the General Practitioner.
### Table 5.5 Number of home care units and users by region and by type of provider (2012)

<table>
<thead>
<tr>
<th>Region</th>
<th>Public (county)</th>
<th>Public (local)</th>
<th>NGO</th>
<th>Total</th>
<th>Public (county)</th>
<th>Public (local)</th>
<th>NGO</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>North-East</td>
<td>1</td>
<td>6</td>
<td>27</td>
<td>34</td>
<td>38</td>
<td>394</td>
<td>1,919</td>
<td>2,351</td>
</tr>
<tr>
<td>South-East</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>11</td>
<td>0</td>
<td>297</td>
<td>220</td>
<td>517</td>
</tr>
<tr>
<td>South (Muntenia)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>32</td>
<td>22</td>
<td>11</td>
<td>65</td>
</tr>
<tr>
<td>South-West (Oltenia)</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>103</td>
<td>50</td>
<td>153</td>
</tr>
<tr>
<td>West</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>217</td>
<td>8</td>
<td>225</td>
</tr>
<tr>
<td>North-West</td>
<td>0</td>
<td>7</td>
<td>34</td>
<td>41</td>
<td>0</td>
<td>350</td>
<td>1,612</td>
<td>1,962</td>
</tr>
<tr>
<td>Centre</td>
<td>0</td>
<td>14</td>
<td>42</td>
<td>56</td>
<td>0</td>
<td>563</td>
<td>8,846</td>
<td>9,409</td>
</tr>
<tr>
<td>Bucuresti-Ilfov</td>
<td>3</td>
<td>0</td>
<td>12</td>
<td>15</td>
<td>206</td>
<td>0</td>
<td>1570</td>
<td>1,776</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td>39</td>
<td>126</td>
<td>170</td>
<td>276</td>
<td>1,946</td>
<td>14,236</td>
<td>16,458</td>
</tr>
</tbody>
</table>


Professional care at home is provided by home helpers, social workers as well as a few psychologists, medical doctors, nurses, nursing assistants and therapists. At present only about 16,500 users are cared for at home, more than 80% of which are from private non-profit organizations.
Table 5.5). Home care services provide mainly help with general and physical hygiene, dressing and cleaning, but also with involvement in cultural activities, occupational therapy and rehabilitation of physical and intellectual capacities as well as with medication, medical advice and treatment (Briciu and Costea, 2013).

The scarcity and most uneven distribution of home care services, with many localities remaining without any home care service, is also due to the fact that in Romania the system of ‘personal assistance’ has been implemented in a specific form, departing from the originally developed concept from the Independent Living Movement of people with disabilities. Starting from the assumption that family members are caring for their relatives anyway, people in need of care (with serious or medium care needs) may opt to have their family caregivers employed by the local council as a ‘personal assistant’ – although already foreseen in the legislation on Act on Social Assistance for Older People this opportunity became popular only after 2006 when a similar right was introduced for people with disabilities and application procedures were simplified.

Not much is known about the cooperation between professional home care services and ‘personal assistants’ as well as unpaid informal caregivers. Personal assistants get a basic training and are supervised once a year by professional staff.

People with long-term care needs are frequently ‘invisible’ – also due to a lack of infrastructure. Turning long-term care into a part of community life will be a cumbersome process, not only in Romania. A visible, multifunctional center where people with care needs and their caregivers can meet, exchange experiences, get information and services, can improve the visibility of long-term care. Existing day-care centers could be a starting point for activities trying to integrate care issues into ‘care-friendly’ communities. More generally, public infrastructure, including transport, should be made more accessible, for example through more even deployment of accessible buses, which comprise three-quarters of all buses in urban areas, but are very rare in more remote locations. These changes would also benefit younger disabled population, pregnant women, and adults with small children.

There is a general policy objective to keep older people in need of care as long as possible in their familiar surroundings and to develop an inclusive society (Government, 2008). Government Decision 45/2012 calls for additional efforts to extend the infrastructure for long-term care at home and in the community as well as for amendments in residential facilities. Particular pressure stems not only from population ageing, migration patterns and an increasing number of single-person households, but also from further expected improvements in Diagnoses Related Groups (DRG)-funded health care settings and the reduction of hospital beds. The direction of reforms has already taken shape by means of new legislation towards more coordinated approaches, prevention and professionalization.

The integration of housing policies into policies of active ageing represents a preventive and pro-active approach to social inclusion of older people with long-term care needs. This includes not only the adaptation of dwellings of older people (removal of barriers, technical aids, adaptation of bath-rooms etc.), but also structural changes in residential care in Romania. The scarce supply of institutional care could be used as an asset to promote ‘ageing in place’ and to extend assisted housing facilities with support by community care organizations. The following
examples from other countries could show ways towards valuable innovation of organizational structures.

Assisted living and social housing for older people with long-term care needs (Denmark)

The history of social housing for older people in Denmark goes back to the 1980s when the construction of traditional nursing homes was generally abandoned, and rules on housing for people with care needs were separated from rules on the provision of care. The national legislation concerning social housing for older people is effective for all types of housing for (older) people in need of care. The most relevant rules within this legislation state that housing for older people with care needs should be built under the general rules of social housing. Among other things this means that the residents are tenants with a contract like in any ordinary dwellings. They receive their pension from which they have to pay for rent, food and other necessities. As in ordinary dwellings, the rent can be subsidised depending on the individual income level. In most cases the dwellings consist of a flat with one or two rooms and kitchen facilities. In a few cases former nursing homes were re-constructed into buildings with apartments that consist of a single living room and shared kitchen facilities.

The residents do live autonomously and receive support services, e.g. personal care and help with cleaning are provided by facility staff according to individual needs. While most residents make use of these services, they are free to choose which services they want to receive from outside of this arrangement, e.g. from family members. There are no doctors attached to the facilities, as the residents continue to see their GP. It is unusual to receive help from professionals or volunteers from outside. In some facilities, however, volunteers provide assistance with social activities (Hansen, 2011).

Rehabilitation and prevention at home (Denmark)

The Danish municipality Fredericia started a complete paradigm shift in the provision of long-term care due to envisaged budgetary pressures. The main aim was to reduce the dependency of older people and to prolong the period of self-care. Among a number of other projects, a pilot on ‘Home-rehabilitation’ was implemented, positively evaluated and eventually rolled out to all existing clients. ‘Home-rehabilitation’ starts within two days from hospital discharge or in case of a request for home care and consists of an intensive training period of about 70 hours during one month at the home of the client. Multidisciplinary teams were trained to co-ordinate and deliver the training that aims at re-mobilization and self-care. This implied important efforts to change staff attitudes from ‘caring’ to ‘activating’. The model was successful in terms of substantially reducing the number of people who receive home help and in bottom-line savings, i.e. the initial investment for training and organizational development was compensated within
the first three months of operation. Furthermore, satisfaction of users and staff increased significantly (Campbell and Wagner, 2011).

The Romanian provision of ‘post-acute home nursing care’ with a maximum of 90 days offers a useful basis for extending preventive approaches for people with (potential) long-term care needs. Activating measures by a multi-professional team could enhance results of post-acute treatment, re-mobilization and rehabilitation in the usual environment of patients. Better communication between hospitals and primary care and community care agencies could prevent further deterioration of health conditions and/or re-admission to hospitals in many cases.

Integration of health and social services in the local community for people who need care (The Netherlands)

Coordination and cooperation between different types of formal care services and between formal and informal care has always been a main feature of long-term care. The aim of a project in Menterwolde (The Netherlands) was to provide opportunities for contact and support to vulnerable local citizens through cooperation between health and social services that should not only focus on care but try to find solutions for living independently in an integrated way. This includes activities to meet, day care for people with disabilities, 24 hours care, information and communication technologies etc. The multifunctional (meeting) center ‘De Gilde’ is at the heart of this initiative. It offers a number of apartments with assistance for older people, but also a public restaurant and services to people with disabilities and long-term care needs who are living in the neighborhood in their own houses. People with disabilities are able to participate in activities as volunteers. This type of participation increases their self-esteem and the level of integration in their own neighborhood.

To summarize, the current infrastructure for the formal provision of long-term care consists of nursing and residential care homes, day care centers, and formal care services at home. While this infrastructure is often described as insufficient, nursing and residential care homes are characterized by both low capacity utilization and long waiting lists, and day care centers seem to be underutilized in many cases. Services of professional caregivers seem to be in high demand, but not sufficiently funded and staffed, while the institution of “personal assistants”, as a form of formalized family caregivers, has been growing in importance since 2006. Integrating people with care needs into community life and creating an enabling environment so that they can live at home as long as possible remains the main challenge and a goal of the long-term care system. Examples from other countries on developing social housing for older people, rehabilitation and prevention services, and integrated community health and social services offer useful options to consider.
D. Pathways and Processes

An important factor for older people in need of care, as well as for their family, is information and advice about existing structures and institutions available to support their care needs. In the absence of specific counseling services or preventive home visits in most localities, the municipal social workers, community nurses, GPs or providers of home care are the first contact. Some providers, mainly private for-profit organizations, have started to contact potential patients already in hospitals in an informal way, as structured hospital discharge procedures and communication between hospitals and community care organizations are lacking.

Once a contact with the support system has been established, individual needs assessment becomes crucial for further care pathways. The specific needs assessment scheme that was introduced by the Romanian government in the year 2000 (Ordonanta de Guvern, 886/2000) was the first effort to systematically define social and health care needs of older people, thus distinguishing their needs from those of people with disabilities at working age. Current legal reforms are trying to unify assessment procedures for disabled and elderly persons, which are expected to be based not on causes of disability, but on their individual consequences of functional loss in terms of long-term care needs. Currently the so-called ‘National Grid for Needs Assessment of Older People’ embraces all items to assess an older person’s social and economic status, his/her health conditions and related care needs in order to determine three levels of care needs as well as the respective types of social and health services required, taking into account the preferences of the beneficiary and his/her informal caregiver, but also the availability of local services.

The levels of care needs (with 2-3 sub-categories each) are ranging from I (total loss of autonomy) to III (autonomous)\(^48\) (Popa, 2010). According to the law, the individual needs assessment for an older person should be carried out by a team of two social workers from the local council and the County Council’s General Directorate of Social Assistance, together with the general practitioner of the beneficiary and, if possible, by a representative of the Pensioners Organization or of a Non-Governmental Organizations (NGOs) that provides social services to the beneficiary. Although there are indications that this assessment is not always carried out by such multidisciplinary teams (Briciu and Costea, 2013), the interdisciplinary approach and character of this assessment is an important basis for further interventions.

---

\(^{48}\) The following levels of care needs are granted:
- I.A: complete loss of autonomy and need for continuous care
- I.B: problems to perform daily activities and need for medical care throughout day and night
- I.C: need for permanent surveillance and help due to behavioral disorders and regular care needs for activities related to personal hygiene
- II.A: perfect mental abilities but partial ability to move and need for daily care with basic activities
- II.B: need for help in getting up and for partial help with daily activities
- II.C: no problems to move, but help needed with daily activities related to personal hygiene
- III.A: regular help needed with daily life activities, but autonomous in residential care
- III.B: complete autonomy, no help needed to perform daily
The assessment process is considered to be an entry point to the support system, as individual services and provisions are linked to defined categories:

- **Beneficiaries with care needs of category I and II are entitled to an attendance allowance or a ‘personal assistant’, who may also be a family member, and who will be formally employed by the local council and paid from the social assistance budget.**
- **Further entitlements for community care services comprise formal home care that is organized by the local councils according to local priorities. As these are local decisions, based on the use of available local budgets, there are huge variations between individual localities. Personnel at the local level consist of community nurses, case managers, social workers and home-helpers (‘professional caregivers’) who are paid on a part-time or full-time basis, depending on the needs of care. This service is provided free of charge by county councils, and against means-tested user contributions by local councils and NGOs.**
- **Institutional care, which is funded from local budgets is not available in all localities and is unevenly distributed across the country. Furthermore, it is subject to means-tested out-of-pocket contributions by residents and their family members, sometimes resulting in substantial need for family contributions.**

Further improvements are needed in fostering cooperation between different actors in the area of needs assessment. Guidelines and agreements between different service providers have been developed over the past 15 years in the context of public-private partnerships between local councils and non-profit organizations such as Caritas or the White-Yellow Cross. However, cooperation is hampered by competition for funds, e.g. between non-profit and for-profit organizations. Also, the current funding mechanism is based on fee-for-service payment and is likely to promote a mentality of service provision, rather than a proactive approach towards self-care and remobilization of users.

**Better integration between acute care in hospitals and community care services is a key-objective of social and health care policies in Romania.** The challenge is to organize resources and opportunities to gather relevant stakeholders to overcome different organizational cultures and to mutually agree on shared practices. Facilitation of such meetings and their systematic support by case managers over a longer period is therefore necessary to make coordination and integration happen. Furthermore, appropriate incentives for different professional groups should underpin such processes.

**The coordination of multi-level governance and inter-sectorial cooperation in long-term care is a global challenge that has resulted in a wide range of national models and patterns that are often dependent on administrative and political legacies.** Examples of good practice have been developed by using case management, in particular with respect to hospital discharge, and inter-disciplinary work. As both methods are already used in Romania, their further roll-out could be supported by the experiences described in the following examples.

---

49 Health insurance funds medical services, devices and medications used in institutional care.
**Integrated home care and discharge practice for home care clients (Finland)**

In Finland, common problems between home and hospital care were well known and consisted of 1) shortcomings in the flow of information between hospital and home care, 2) a lack of clarity on responsibilities and the distribution of work, 3) ad-hoc discharges and 4) a lack of service integration. In response, Finland developed and implemented a generic ‘Integrated home care and discharge practice for home care clients’ (PALKO model) in a number of municipalities. The intervention was elaborated by home care and hospital staff and promoted clients’ participation in decision making. The main principles to better integrate care consisted in the development of shared visions and aims, and shared practice, resources and risks across care pathways. All stakeholders identified their place and tasks across the care pathway so that service users perceive their care as ‘seamless’. This also implied standardization of practices and introduction of written agreements between hospitals and home care agencies, and between home care providers in each municipality. Practices, responsibilities and support tools for the client’s entire pathway from home to hospital and from hospital to home were specified in writing and made available to all stakeholders involved. Furthermore, a care and case manager pair was assigned to each home care client as central contact person for the client inside the multidisciplinary team (Hammar, 2011).

**Improving communication between hospital and community care (Denmark)**

The Region Southern Denmark, consisting of 22 municipalities, responded to communication problems between hospitals and community care, in particular in the context of discharge processes, with a project using information and communication technology. The online application is based on cooperation agreements that were mutually agreed upon by hospitals and municipalities to ensure seamless transfer of older patients from hospital to the community. The strengthened cooperation between general practitioners, home care providers and hospitals enhanced patient satisfaction and facilitated a continuous dialogue between all parties involved, including patients and their relatives. The intervention resulted in reduced length of stay in hospitals, as primary care and community care providers are now better prepared to deliver care in a timely manner. (Møller Andersen, 2011).

The emergence of community care services in Romania has taken place in concomitance with innovations in information and communication technologies (ICT), contrary to many European countries, where community care services had developed since the 1970s or even earlier. Management and staff are therefore accustomed to these technologies. In the absence of this barrier to the utilization of new technologies, communication and information exchange between health and social care providers could perhaps be enhanced more easily through ICT applications.

**Integrated access-points (Italy)**
Many frail older people and their caregivers are not able to gain access to services as they simply do not know about them or are not able to reach the various responsible entities. As hospital and home care services often operate independently from each other, continuity of care is hampered. Several Italian local health agencies have therefore established Integrated Access Points (since 2009) in order 1) to provide information to citizens about opportunities of support in the local context; 2) to facilitate access procedures, e.g. by helping to fill in forms and by forwarding them to the competent body; 3) to promote integration between hospital, GPs, home care and other types of services such as rehabilitation centers or entities responsible for prosthesis and appliances. Integrated Access Points require the development of a new organizational structure where staff can directly activate counseling, assistance and care pathways, instead of users having to negotiate with different health and social care offices. Furthermore, staff of Integrated Access Points is able to collect, collate and provide data about activities and requests from its catchment area, both in qualitative and quantitative ways. Based on this information, political and institutional decision-makers can improve their response to citizens’ needs and prevent crises (Ceruzzi, 2011).

Integrated access points are relatively easy to establish but difficult to manage. As service at the interface between health and social care, having to negotiate between users and a number of different entities, they tend to become ‘nobody’s child’. However, they free users from having to confront a number of different entities, from several assessment and application procedures to local committees deciding upon eligibility and priorities for places in care homes. Integrated access points could be a helpful facility to make these procedures more efficient and user-friendly.

To summarize, information flow and the seamless transition of a person through different care pathways is a complicated but crucial part of a long term care system. Currently care needs in Romania are determined based on an integrated ‘National Grid for Needs Assessment of Older People’, based on which eligibility for three different care levels are assigned. However, the assessment is geared towards assigning care rather than the promotion of self-care and rehabilitation. The communication between hospital and home care is also lacking. Examples from other countries of integrated home care and hospital discharge practices, use of technology for communication between providers, and establishment of single integrated service access points can be used to further the agenda in this area.

E. Human Resources

Establishing a comprehensive long-term care system and introducing better coordination between health and social care requires a wide range of skills in management and leadership. These include: organizational development, human resource management, management of volunteers, quality management and networking. In Romania, recent legislative regulations have increased the list of specific competences needed by managers in social and health services, for instance with respect to quality assurance, data processing and working with performance indicators. Furthermore, basic competences in community care with older people,
empowerment, activation and self-care, dealing with people suffering from dementia, care planning and monitoring are necessary to modernize long-term care provision. Apart from basic education in a number of specialties, these skills may be acquired through continuous training, which is provided by a number of organizations, including schools of nursing, universities and private agencies in Romania. In particular NGOs play an important part in this process, often with support from international networks and foundations or in the framework of EU projects.

**However, there is a general lack of trained personnel in the long-term care sector.** The number of nurses, with about 400 nurses per 100,000 inhabitants, stands at about half of the EU average (data from 2006; Vladescu and Olsavsky, 2009), more than 5% of localities do not have a General Practitioner, and large areas are without specialist doctors (see Chapter 1). Care home managers do not need a specialized qualification in Romania but, according to Ministerial Order no. 246/2006 concerning specific minimum quality standards for residential facilities and home care, the service provider has to present an annual personnel training program, according to his mission and the minimum quality standards in the field. Social Workers are also needed, as they play an important role in community care for older people, as do home helpers and personal assistants, the latter with only very limited basic training.

As care professionals are also lacking in other EU Member States with higher wage levels, the tendency towards migration poses a major challenge in recruiting, training and retaining qualified personnel for all types of care providers in Romania. The exact number of Romanian caregivers, formally employed abroad as professionals or informally working as personal assistants in Italian, German, English or Austrian households, is unknown. However, a 2008 study has revealed that 20% of Romanian nurses are intending to seek work outside Romania (Vladescu and Olsavsky, 2009). Organizers of training courses report that, the higher qualifications are provided by the trainers, the higher the probability that training participants will take the opportunity to move to another country. Therefore, training more nurses and providing them with better skills in Romania may in fact stimulate emigration, contributing to the sustainability of family-based long-term care systems in Southern and Western Europe, rather than enhancing the quantitative and qualitative development of long-term care in Romania.

**Forecasts of the needs for the caregiving personnel based on current population and fertility rates thus also become problematic.** Most of the migration takes place unofficially and is hardly documented, although there are estimates that more than 350,000 children in Romania are growing up with their grandparents as their parents are working abroad, and, with a yearly growth of 50-80,000, almost one million Romanians are residing in Italy and more than 850,000 in Spain (OECD, 2013). As it is mainly younger age groups that are looking for work abroad, the number of older people remaining without family care options is likely to grow significantly. At the same time, the number of nurses and other care staff might continue to decline. One of the main reasons for migration is certainly the low level of wages. Most care professions do not earn much more than the minimum income (about €160 per month), and medical doctors earn hardly €300 per month.

**These challenges necessitate creating attractive work conditions and employing creative approaches to attract, train and retain the required numbers of caregivers.** Some experiences from other countries might be interesting in this regard.
Care in the neighborhood (The Netherlands)

The lack of time dedicated to users and the Tayloristic division of tasks between different professionals are the key complaints of older people and many home care professionals. These shortcomings were at the origin of a new type of home care delivery developed by ‘Buurtzorg’ (care in the neighborhood), a private non-profit organization in the Netherlands. It originated in 2006 from staff’s dissatisfaction with traditional home care organizations. Bureaucratic duties, working in isolation from other care providers, and, above all, neglect of their professional competencies, were amongst the complaints. The organizational model of ‘Buurtzorg’ is to have care delivered by small self-managing teams consisting of a maximum of twelve professional care givers (community nurses and nursing assistants), and to keep organizational costs as low as possible, mainly by using ICT for the management of care and by an efficient central back-office for administration. The care is financed through the Dutch health insurance system.

Based on the older client’s needs, the small autonomous teams consider all types of resources within a neighborhood starting with the family of a client and other local contacts. Furthermore, the care concept aims to deliver care to a client for as short a period as possible, by involving and reinforcing the client’s resources. Activities are reaching from a holistic assessment of needs, to mapping networks of informal care delivery and social support to the client, to the promotion of self-care and independence.

Once a team has a sufficient number of clients (usually about 50), a new team will be installed in the next neighborhood. With this strategy, the organization has expanded to more than 600 teams and over 7,000 employees. Other providers have also adopted the ‘Buurtzorg’ type of home care provision. Furthermore, systematic quality management and control showed very high user and staff satisfaction and high quality of care with up to 50% reduction in costs. The organization also won the award as ‘Employer of the Year’ in 2011 (Huijbers, 2011).

The specific approach to management and leadership in long-term care provision promoted by ‘Buurtzorg’ requires a number of preconditions, many of which can be found in Romania. The existence of community nurses and a number of motivated NGOs are certainly promising, while the lack of funding and clear contractual agreements between local councils as ‘purchasers’ and providers are likely to turn into major challenges. Still, the lack of standardization could also be seen as an opportunity to adopt more activating approaches in community care, for instance by establishing a ‘long-term care fund’ to promote not only the restructuring of residential care but also a community-oriented approach.

---

50 The perspective on organizational design that treats organizations as an array of independent tasks, each to be designed for maximum efficiency according to a trained expert and then integrated into a production system by the system designer and the leader of the organization.
The E-Qalin quality management system (Austria et al.)

Care home providers and managers in the general area of social services are increasingly challenged by ever more demanding legal regulations and requirements on delivering social and health care services. While the necessity to ensure quality of care is generally acknowledged, procedures are often developed without the involvement of practitioners and without training opportunities, and they are perceived as too bureaucratic. At the same time, generic quality management systems used in manufacturing and business are expensive and not always adaptable to the needs of social service delivery. This situation was the reason for federations of care homes and vocational training agencies from Austria, Germany, Italy, Luxembourg and Slovenia to develop a quality management system appropriate for care homes and related social services (home care, services for people with disabilities, social work).

The so-called E-Qalin management system is based on the organizations’ self-assessment process steered by ‘process managers’. Working groups of staff and other stakeholders assess 66 quality criteria concerning ‘structures and processes’, and 25 key-indicators for ‘results’. The outcome of the self-assessment process is expressed in percentage points, but more importantly in a list of improvement projects that will be prioritized by the steering group and implemented during the ensuing period (1-2 years), before a new self-assessment will take place. E-Qalin has been implemented by more than 250 care homes in the participating countries, where an external quality certification is also available (Leichsenring, 2011).

The recently established regulations on quality assurance in Romanian social services will be a major challenge for care providers. Appropriate training of staff (and inspectors) will be a precondition to implement these regulations and processes. This includes participative leadership and partnerships with all involved parties.

Vocational Skills in Elderly Care: Development and Certification (Greece et al.)

This EU Leonardo da Vinci project addressed the lack of vocational training and certification of elder care providers in home and residential care sectors in Greece and other EU countries. This gap was filled by introducing the distinct qualification ‘ECV Certificate’ within a vocational education and training (VET) system at the post-secondary, pre-tertiary level (ISCED 4VOC). The certification is based upon recognition of competencies acquired in the non-formal and formal vocational training environment and aims to enable staff with adequate qualifications and to attract newcomers, e.g. migrant care workers, into the sector of elder care throughout Europe. The pilot program included supervised places for practical training in two care homes, thus forming a core of trainers. The program is freely available to informal caregivers and migrant care workers, who wish to improve their care-giving skills. The ECVC e-learning curriculum consists of (a) the ECV e-learning web Software and (b) seminars that supplement basic ECV knowledge. The program conveys theoretical knowledge and practical experience in a variety of relevant subjects. These are reaching from basic knowledge about age-related
pathologies, basic care skills and first aid to mobility and social participation (Triantafillou, 2011).

The implementation of ‘personal assistance’ service into the provision of long-term care in Romania could represent an important factor for expanding employment in this sector and for recruiting caregivers beyond family care. A more formal acknowledgement of skills and further training could support such a strategy. At the same time, however, other mechanisms would be needed to prevent caregivers from migrating to work abroad. New types of incentives and pools of potential workers have to be found to disrupt this vicious circle. One option would be increased reliance on younger pensioners working part time as caregivers in their communities. The strategy would provide older population with jobs, many of which would be preferred on part-time basis. Social opportunities associated with elder care are also likely to be valued by younger pensioners. Finally, the strategy would be less likely to further boost emigration.

In summary, Romania faces a big challenge in recruiting, training and retaining required numbers of staff with relevant skills and qualifications. Recently many NGOs have been instrumental in providing training for caregivers, but the system is coping with significant “leakages” of graduates to other EU countries with a high demand for caregiving services at much higher wages. Currently, the number of nurses in Romania stands at only half the average number of nurses per 100,000 inhabitants in EU. Examples of more satisfying work conditions in small neighborhood care teams, employment of self-assessment in quality management processes, and more convenient learning and certification options are useful ways implemented in other countries to cope with these challenges. A stronger reliance on younger pensioners working as part time caregivers may be one of the interesting options to explore.

F. Financing

In the absence of a comprehensive long-term care system in Romania, the emerging health and social care services and facilities for older people are funded from general taxes via different sources at the county and local levels (social assistance and health insurance). Compensatory contributions from the state level as well as users’ out-of-pocket payments and donations are complementing these long-term care financial flows (Table 5.6).

In 2011, Romania’s total public spending on long-term care stood at 0.69% of GDP (Eurostat). The OECD average is 1.7% of GDP, including health and social components (OECD indicators 2013). There is a large variation in this indicator between countries, with Netherlands and Sweden being the biggest spenders with 3.7% and 3.6% of GDP respectively.

In Romania the long term care spending statistic includes all expenditures for people with disabilities and long-term care needs at any age. The difficulty in separating expenditures between spending on working age disabled people and spending on the elderly arises from the fact that older people normally are not eligible for cash benefits. However, if an older person does qualify as disabled according to disability legislation, he or she may get entitled to an attendance allowance (‘indemnizatia de insotitor’), which stands at 166 RON per month for severe disability, plus a complementary ‘personal budget’ (‘bugetul personal complementar’),
which is 91 RON, 68 RON and 33.5 RON for the three categories of disability, respectively. It is estimated that at least one third of the 542,000 beneficiaries of the attendance allowance and of the 659,000 beneficiaries of the ‘personal budget’ are over 65 years of age (MMFPSPV, 2012; Popescu, 2011: 139).

**Financing of residential care for older people**

Public residential facilities are funded from general taxes by county or local councils and by out-of-pocket contributions of residents. Local counties pay for maintenance, administrative and social care staff and county branches of the health insurance pay for nursing and medical staff. The beneficiaries themselves pay 60% of their income to cover costs for meals and accommodation, the price of which is determined by the local councils. If the resident’s income does not suffice, relatives with an income above 800 RON per month have to contribute as well. On average, user contributions cover about one third of total costs in residential care, while public expenditures pay for 58%, with other sources such as donations complementing the mixed structure of funding.

Residential facilities that are run by NGOs are also entitled to subsidies from local or state budgets. These subsidies are covering, however, no more than 10-20% of total costs that amount to about 1,900 RON per resident per month (information from Caritas). This is also reflected in Table 5.6 which provides an overview of funding sources in residential care, showing quite diverse mixes of funding between public providers and NGOs. For instance, while user contributions make up for 56% of total costs in NGO-provided care homes, they do so only by 15% in county council care homes. Furthermore, NGOs cover about one quarter of total costs by own and external contributions (fund-raising, donations, etc.).

Currently, a program of national interest is being implemented with a budget of 100 million RON to develop the “national network of care homes for older people”. The budget is being used to modernize and/or (re-)construct a total of 67 care homes (Government Decision from 27/1/2014; originally Government Decision no. 212/2011).

There are also a number of private for-profit care homes which are neither subsidized nor regulated by public authorities. Costs for a place in these facilities start from 3,000 RON per month and are to be borne by residents and/or their families alone.

**Table 5.6 Funding sources of residential care facilities, 2012**

<table>
<thead>
<tr>
<th>Source</th>
<th>Public (provided by county council)</th>
<th>Public (provided by local council)</th>
<th>Provided by NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RON</td>
<td>%</td>
<td>RON</td>
</tr>
<tr>
<td>Local or county council budget</td>
<td>41,436,551</td>
<td>78%</td>
<td>43,822,699</td>
</tr>
<tr>
<td>State subsidies</td>
<td>3,041,247</td>
<td>6%</td>
<td>8,729,012</td>
</tr>
<tr>
<td>User out-of-pocket</td>
<td>8,075,215</td>
<td>15%</td>
<td>19,181,046</td>
</tr>
</tbody>
</table>

138
Financing formal home care for older people

Post-acute home nursing care is paid by the health insurance fund for a maximum of 90 days per year. Home care, including both nursing home care and home help, is mainly provided by NGOs which are partly reimbursed by subsidies from local councils based on a locally determined maximum subsidy per client per month. This creates a wide range of different funding models with non-profit provider organizations having to find ways to cover differences between full costs and various levels of subsidies. Table 5.7 shows some examples from Caritas organizations.

Table 5.7 Funding structure of selected home care providers

<table>
<thead>
<tr>
<th>County</th>
<th>Total cost/month/beneficiary</th>
<th>Covered by subsidies (RON)</th>
<th>Own/private funds (RON)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home care (RON)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alba</td>
<td>212</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>Sibiu</td>
<td>212</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>Iasi</td>
<td>155</td>
<td>93</td>
</tr>
</tbody>
</table>

Sources: Caritas Blaj, Caritas Iasi; Note: the maximum amount from subsidies is 120 RON/beneficiary/month.

Table 5.8 presents the structure of public expenditures for home care that are coming from various sources and cover costs of public providers and subsidies for NGOs. Unequal conditions can also be observed across these different providers. For instance, while user contributions cover 10% of costs of NGO-provided services, no or almost no user contributions occur in the few home care services provided by some county and local councils.
Table 5.8 Funding sources of home care services (2012)

<table>
<thead>
<tr>
<th>Source of Funding</th>
<th>Public (provided by county council)</th>
<th>Public (provided by local council)</th>
<th>Provided by NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RON</td>
<td>%</td>
<td>RON</td>
</tr>
<tr>
<td>Local or county council budget</td>
<td>5,233,429</td>
<td>77%</td>
<td>4,236,647</td>
</tr>
<tr>
<td>State subsidies</td>
<td>53,104</td>
<td>17%</td>
<td>946,560</td>
</tr>
<tr>
<td>User out-of-pocket contributions</td>
<td>151,589</td>
<td>3%</td>
<td>2,559,089</td>
</tr>
<tr>
<td>Own resources</td>
<td>54,948</td>
<td>1%</td>
<td>3,379,038</td>
</tr>
<tr>
<td>External sources</td>
<td></td>
<td></td>
<td>2,127,998</td>
</tr>
<tr>
<td>Other</td>
<td>109,001</td>
<td>2%</td>
<td>4,092,185</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,498,745</td>
<td><strong>100%</strong></td>
<td>5,286,533</td>
</tr>
</tbody>
</table>

Average no. of users per month

- 276
- 1,708
- 14,236

Source: Ministry of Labor, Family, Social Protection and Elderly, 2014; own compilation.

The ‘personal assistant’ model – blurring boundaries between formal and informal care

Older people with total loss of autonomy have the right to a ‘personal assistant’ who is trained and employed by the local council with a wage that is equivalent to a junior social worker. Personal assistants may also be family members caring only for their relative, while personal assistants external to a family usually work in various households. Although this approach to organize and fund care in the community is based on national idiosyncrasies and traditions, it might represent a costly solution. Data provided by the Directorate for the Protection of Persons with Disabilities show that expenditures for personal assistants increased from about 494 million RON in 2006 to more than 1,148 million RON in 2013, but more tangible data concerning the age structure of beneficiaries and personal assistants as well as formal evaluation studies would be needed to provide further insight., the current approach might be a costly solution to the LTC system.

Other services

Minor expenditures are incurred to finance the few day-care centers and for stays at health resorts that are funded for a maximum of 19 days and subsidized for additional 9 days by the health insurance.

Cash benefits
Old-age pensioners with care needs are generally not eligible for cash benefits but, due to overlaps with the legislation concerning disability, around one third of people over 65 years of age also receive attendance allowances and the complementary ‘personal budget’. Although the individual amount per person is relatively small, the relatively broad coverage results in an important share of the social security budget.

With present LTC expenditures in Romania being below 1% of GDP and forecasts that predict a rising demand in the future, a review of funding modes and a general debate on LTC funding will be inevitable. As shown in this chapter, current LTC-financing in Romania comes from general tax transfers and health insurance funds as well as from local government and private contributions. Although some data is available, much is still lacking to allow a more comprehensive analysis, which is also hampered by the undefined position of LTC between health and social care sectors and their multi-level governance. Therefore, an important part of the strategy development in Romania consists of reviewing the options for LTC financing and designing the mix of benefits in cash and in kind. While the definition of LTC benefits would be a first step, the decision for or against a universal coverage, which would be the most equitable solution, would also have important cost implications. Choices related to LTC financing will then crucially depend on preferred options for benefit and coverage levels (see WB, 2010).  

Table 5.9 Public expenditures for cash benefits, 2011

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Amount per month per beneficiary (RON)</th>
<th>Public expenditure (in 1,000 RON)</th>
<th>No. of beneficiaries*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance allowance for adults with severe or accentuated disability (Indemnizaţia pentru persoanele cu handicap)</td>
<td>Severe disability: 202 Partial disability: 166</td>
<td>1,156,708.6</td>
<td>543,266</td>
</tr>
<tr>
<td>Personal budget for people with disabilities (Bugetul personal complementar)</td>
<td>Severe disability: 91 Partial disability: 68 Medium disability: 33.5</td>
<td>564,387.0</td>
<td>661,311</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>1,721,095.6</td>
<td></td>
</tr>
</tbody>
</table>

Source: Ministry of Labor, Family, Social Protection and Elderly; National Institute of Statistics (2013); own compilation.
Note: including people with disabilities below pension age.

Experience from OECD countries shows that LTC can be expensive, creating a financial burden for households and individuals. Increasingly, OECD countries have promoted the acknowledgement of LTC as a social risk that calls for universal coverage as ‘good practice’.

---

51 The WB report on Long Term Care Policies for Older Populations in new EU-member states and Croatia provides an excellent overview of the challenges and opportunities in financing LTC.
However, with growing older populations and shrinking pool of tax payers, issues of fiscal sustainability have caused many countries to look at alternative modalities.

**First option is to finance the so-called ‘fifth risk’ in social security as part of the social insurance, such as in the Netherlands, Germany or Japan, with shared contributions by employees and employers.** This would create earmarked funds for LTC, but would increase the cost of labor especially since the shrinking labor force would have to contribute for a rising number of people in need of care, likely resulting in ever rising contribution rates. Furthermore, there is no clear link between employment and long-term care needs, raising a question of whether this form of financing is most appropriate. Finally, in the German case, the presence of LTC insurance has not been able to avoid beneficiaries becoming dependent on additional social assistance payments, in particular when moving into residential care, as insurance payments and beneficiaries’ own income and savings often do not suffice to cover total costs.

**The second financing option is to partially cover costs of LTC from general taxes, such as in Austria (LTC allowance), France (Allocation personnalisée d’autonomie/APA), and the Nordic countries, where general taxes are used to fund mostly in kind services.** This type of funding is relatively flexible and based on solidarity contributions from the entire population (depending on the general design of the tax system). While the Austrian LTC allowance is conceived as a benefit to partially compensate for LTC dependent expenditures (according to seven levels of care needs) without any strings on its utilization, the French APA is more akin to a voucher system, as the use of services according to an individual care plan has to be precisely accounted for.

**Both types of funding in Western Europe, with the exception of the Netherlands, are still subject to important individual out-of-pocket contributions.** Only the universal, tax-based funding of LTC, established in the Nordic countries, has succeeded in substantially reducing individual payments for LTC services and facilities, at the expense of fierce targeting of funds to those groups with the most heavy care needs (Kröger, 2011) some cases, e.g. in the case of France, general tax or social insurance financing may be complemented by private insurance. In France a relatively large market for private LTC insurance has developed mostly due to important subsidies and tax-incentives with a related ‘middle-class bias’. At present France has proportionally the largest private insurance for LTC with 3 million policy-holders in 2007, although this is a small proportion compared to the potential market of about 14 million people over 60 in France. The system began in 1980 and offers a guaranteed monthly cash benefit in the event of dependency (AGGIR scale based on 6 levels of dependency).

**In contrast to the US with similar insurance scheme, France pays a fixed-sum benefit and policy holders are free to choose the institution, including staying at home and purchasing homecare.** In the US, services are reimbursed, adding complications. The French scheme benefit is paid to finance a specific package of services as determined by a team of professionals based on the dependency needs. The use of the benefit is regulated and monitored, the care can be provided by professionals or relatives, except the spouse. Private insurance for Long-term Care also suffers from the main obstacles any insurance encounters, such as moral hazard and adverse
selection. In France, however, research also demonstrated that a large part of the coverage can be explained by altruistic behavior; especially policy holders responded their desire to reduce the burden on potential informal caregivers. Public-Private partnerships maybe options to explore further (Le Bihan and Martin, 2011).

Another innovative option to complement financial resources of long-term care system is to use time-banking, where individuals can contribute their time, including by providing long term care, and then claim a right to the same or different services provided by others, for example a few years later when they themselves need long term care. Over the past few years a number of initiatives have emerged in search of innovative ways to re-distribute time and individual competencies in a non-monetary way, also with a view to make civic engagement more attractive for specific groups of society and to increase the visibility of the non-market economy. ‘Time-banking is a tool to strengthen communities and raise social capital through co-production’ (www.timebanking.org). In various local contexts this system of time-banking has taken shape, including certain types of support for people with long-term care needs.

Important contributions to the debate on LTC funding (see also Costa-Font, 2011; Barr, 2010; Fernandez & Forder, 2012; Wanless, 2006) underline that LTC is a social risk that is characterized by unpredictability, actuarial inconsistencies, information problems in insurance markets and the inability of individuals to make informed choices. At the same time, individual costs in case of LTC needs vary immensely and will in many cases – under current framework conditions in most countries – imply under-insurance and/or the necessity to spend-down all assets. As a result, an important part of public spending will always be necessary, be it in the form of a social insurance or by general taxes. However, systems should try to make individual contributions over the life-cycle more transparent and technically feasible, for instance by defining a threshold for individual out-of-pocket contributions, e.g. oriented at the average cost of LTC for one year (Wanless, 2006).

As a next step, policy debates should focus on the organization of LTC and the proper mix between in cash and in kind benefits. The preferred mix will depend on contextual preconditions, the general construction of social protection systems and ethical as well as cultural considerations. For instance, while some countries have developed LTC as a way to boost (female) employment, others have insisted on the responsibility of families.

- In general, policy debates on LTC financing reforms should keep in mind the following issues (from WB, 2010): development of a universal LTC financing should be based on the concept of intergenerational fiscal sustainability.
- Before expanding LTC packages, efficiency has to be ensured. The chosen financing option should allow controlling demand for services and channeling of the funds toward appropriate types of services between home-based care, care-coordination, community centers, and institutional care.
- It is important to pro-actively leverage LTC service delivery reforms and engagement with private providers through the changes in regulatory environment.
- Monitoring of LTC-expenditures and trends, including analysis of the burden of LTC on households and household coping mechanisms, is essential.

To conclude, Romania’s total public spending on long-term care stood at 0.69% of GDP in 2011. Residential facilities are funded from general taxes by county or local councils and by private funds, with great variation in funding between public and NGO run facilities. Post-acute home nursing care is fully funded by Health Insurance for the first 90 days, after which care might be provided by an NGO, financed through public subsidies and private funds. The “personal assistant” model that has been employed in Romania is fully funded from public funds and tends to be an expensive solution, although further analysis is needed. Finally, cash benefits, which include attendance allowances and the complementary ‘personal budget’, involve small amounts for a relatively broad pool of beneficiaries, resulting in substantial costs for the social security budget. Going forward, decisions will have to be made on how to adjust the current funding mix, how to incorporate a broader range of support models, and how to make the funding model compatible with preferred benefit levels, benefit eligibility rules, and proper incentives.

Romania’s Long Term Care Flow of Funds

1: Old Age Pensions
2: Direct payment to institutions for care;
3: National transfer to municipalities – earmarked only for child-disability care, other not earmarked budget, allocation at the discretion of the municipality;
4: Towns
5: Villages & Communes
6: Districts (only in red)
7: Municipalities (3,300)
8: Non-Governmental Organizations (NGOs)
9: Social Services
10: Department of Health
11: Health Insurance House

Beneficiaries

Institutions (Nursing homes, Elderly Care Homes, Home-Care, Personal Assistance)

National Government - Municipality (3,300) - Towns - Villages & Communes - Districts (only in red)
Chapter 5 Bibliography


