Lot 3 - Evaluation of ROP Interventions 2014-2020

FINAL REPORT

Theme 8

Development of Health and Social Infrastructure by Increasing the Accessibility of Health Services, the Efficiency of Emergency Hospital Care and Increasing the Coverage of Social Services

August 2019

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Lot 3 - Evaluation of ROP 2014-2020 interventions

Contract no. 266/19.09.2018

Theme 8. Development of Health and Social Infrastructure by Increasing the Accessibility of Health Services, the Efficiency of Emergency Hospital Care and Increasing the Coverage of Social Services

EVALUATION REPORT – FINAL VERSION

August 2019

DISCLAIMER

This report is the result of an independent evaluation conducted by the consortium led by the Lattanzio Advisory Spa (Association Leader) and Lattanzio Monitoring & Evaluation Srl (Associate 2), under the contract concluded with the Ministry of Regional Development and Public Administration in September 2018.

The opinions expressed herein are of the consortium and do not necessarily reflect the views of the Contracting Authority, namely the Ministry of Regional Development and Public Administration, nor of the Managing Authority for the Regional Operational Program 2014-2020.

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List of Abbreviations

AC	**The contracting authority**
ADR	Agencies for Regional Development
AM POR	Managing Authority for the Regional Operational Program
AP	Priority Axis
BE POR	The Evaluation Office of the Regional Operational Program
CCE	Evaluation Coordination Committee
CdS	Terms of Reference
CJ	County Council
CM POR	Monitoring Committee of the Regional Operational Program
CPU	Emergency Reception Center
DGASPC	General Directorate of Social Assistance and Child Protection
DSU	Department for Emergency Situations
FEDR	European Regional Development Fund
IGSU	General Inspectorate for Emergency Situations
INS	National Institute of Statistics
INSP	National Institute of Public Health
ISU	Emergency Inspectorate
ITI	Integrated Territorial Investments
MMJS	Ministry of Labor and Social Justice
MS	Ministry of Health
PNDR	National Program for Rural Development
OI	Intermediate Body
POR	Regional Operational Program
SAJ	County Ambulance Service
UAT	Territorial Administrative Unit
UPU	Emergency Reception Unit

This evaluation report was made in Phase 2 implemented under contract no. 66 / 19.09.2018 “Lot 3 - Evaluation of the ROP 2014-2020 interventions” concluded between the Ministry of Regional Development and the Public Administration and the association of companies Lattanzio Advisory Spa and Lattanzio Monitoring and Evaluation SRL.

The report is based on the results generated by the analysis of the data collected for this study and presents the conclusions and recommendations resulting from these findings. This report is the result of an independent evaluation, and the opinions expressed belong to the evaluators and do not necessarily reflect the opinions of the Ministry of Regional Development and the Public Administration.

1. Executive Summary

Priority Axis 8 of the 2014-2020 ROP aims at investments in health and social infrastructures that contribute to the development at national, regional and local level, reducing inequalities in health status and promoting social inclusion by improving access to social, cultural and social services. recreation, as well as the transition from institutional services to services provided by communities. According to the data provided by the Managing Authority for the Regional Operational Program (MA of ROP) the total value of the allocation for PA 8 is 348,117,301 euros.

1. *Findings*

- There is a constant tendency to increase the number of high performance equipment purchased and the number of investigations / treatments performed with these equipments;
- The territorial distribution of the created / renovated medical services is extensive at national level;
- Accessibility is premature to quantify and extremely difficult, if not impossible to quantify the quality and efficiency of services;
- The rate of continuous hospitalization decreased steadily during the analyzed period;
- The process of reforming large residential institutions for adults with disabilities is successfully carried out;
- Progress in the process of deinstitutionalization of children in the special protection system is delayed. Providing the elderly with improved social services is also delayed;
- The availability and retention of the medical and technical human resources necessary to properly use the purchased equipment influence the effectiveness of the projects.
- In the social field, the most efficient mechanism for ensuring the implementation of the interventions (project initiation by the DGASPC) was the impetus to reform the system through legislative changes;
- ATUs in the urban area have the capacity to ensure the sustainability of the services to be provided within the social infrastructure developed through the projects financed from PA 8. The administrative-territorial units in the rural area seem to have difficulties in ensuring the sustainability, despite the contractual commitments.

2. *Conclusions*

- Positive effect by decreasing the unmet need for medical services for the lower quintile from the initial value of 13.3%, to the value of 8% in 2015 and, more recently to the value of 3.4% in 2018 according to Eurostat. The value already exceeds the proposed target for 2023 (9.3%), and the population served by improved medical services far exceeds the proposed target value for 2023 (500,000 people). The evolution must be considered as the result of several factors, such as the projects completed in the ROP 2007-2013, legislative changes in the field of health, fiscal changes, etc.;
- Reducing the response time requires improvements: two thirds of the ambulance park is physically advanced, the available staff is insufficient, and the road infrastructure has not improved significantly;
- In the absence of a relevant indicator it can be considered that new or multiple equipment increases the quality and reliability of the services offered, decreases the waiting time and, in certain situations, are positioned in a healthcare unit near the patient's home, factors that should increase the satisfaction of the services received by the beneficiaries;

- Even if the rate of admissions decreased steadily during the analyzed period, approx. 30% of the hospitalizations are for conditions that could be treated in the outpatient (family doctor or specialized outpatient) if the services were available and efficient;
- The target of achieving the number of beneficiaries (persons with disabilities) of deinstitutionalization infrastructure built / rehabilitated / modernized / extended / equipped was achieved in a proportion of 45%, but the progress of the indicator regarding the provision of social services as close to the place of living is low (3%);
- Increased availability of efficient outpatient services is essential for relieving UPU and hospitals of cases that do not require care at that level;
- The analysis of the progress regarding deinstitutionalization of children in the special protection system is premature: at the deadline of the evaluation there was only one contracted project. However, more recently 7 projects have been contracted and another 15 are in preparation, which ensures the premises for meeting the proposed targets;
- The creation of social services for the elderly is far behind the target, with an achievement level of 9%;
- Effective interventions are those with integrated activities: construction services / rehabilitations / upgrades / equipments, as well as attracting and training additional staff, and the resources come from complementary projects financed and from other operational programs;
- In the social field, when the call for projects is competitive, the communities that have experience in the process of project development and administration benefit the most, and the disadvantaged communities are lagging behind;
- The resources were distributed mainly for the regions of development with social needs and the demand for social services accentuated. However, at the level of the distribution of resources within the development region, most investments are made at urban level, although the need for social services is, first and foremost, at the rural level;
- The medico-social integrated community centers distinctively mentioned in the National Health Strategy 2014 - 2020 and one of the important links on which the logic of the ROP intervention was built, have not been funded so far;
- Reintegration of persons with disabilities requires financial resources for awareness / development of tolerance in the community and for the provision of social services for all members of the community;
- The role of public funders, respectively CNSAS and the Ministry of Health, is essential in the sustainability of the rehabilitated and endowed health units through the ROP;
- The concern of local public administrations in rural areas to ensure the sustainability of the social services created is high, if it is dependent on the existence of a financing instrument.

3. *Recommendations*

- Financing projects to reduce the inequity gradient between people with high socio-economic status and disadvantaged people by developing integrated community centers and community health care for the vulnerable population;
- Remodeling and transforming of small and medium healthcare units into specialized outpatient / comprehensive diagnostic and treatment centers, including with the capacity for day hospitalization in order to reduce the difference between equipping different regions and the model where ambulatory services are concentrated in certain cities. the same endowment model to the detriment of smaller centers;
- Involvement of the Ministry of Health in defining the intervention monitoring framework, aligning the indicators with those commonly used by the medical units, limiting their number to

those considered absolutely necessary and relevant, considering that a large part of the indicators of immediate and even realization chosen the result were not completed;

- Reconfiguring outpatient services (consultations and investigations offered during the same visit) and updating the tariffs, taking into account their effectiveness and sustainability in increasing access to health services especially for the vulnerable population;
- Developing county-level partnerships and defining the project portfolio: DGASPC together with the ATUs and social service providers should conduct an analysis of the needs of the beneficiaries at the county level in order to identify the priorities and elaborate the project concepts. Estimating the real need for the types of social services for each target group is essential, as well as developing a list of institutions, centers that need to be rehabilitated, but also the communities in which new centers must be created;
- Conducting a solution competition by the DGASPC for ATUs, and those selected to serve as a basis for the elaboration of a larger project by the DGASPC in which to be leader;
- Strategic planning between the MA ROP and the Ministry of Health (MS) should promote the correlation of county / regional / national and sectoral development strategies and of feasibility studies / opportunity studies / impact studies updated and available at the level of the health institution. for major investments;
- Developing clear and sustained coordination mechanisms and tools at national level for standardizing instruments that can assess infrastructure, equipment, human resources needs, prioritizing investments, variability of equipment acquisition costs and similar work;
- The equitable development of these services should include providing ROP support to local public authorities, especially those from disadvantaged communities, with opportunities, resources and tools through a call for projects dedicated to this theme. The call should not be competitive because the quality of the application development or the innovative aspect of the project is not important, but the need for concrete social services in certain localities. The current legislation provides that integrated community centers can be set up only as public entities in the subordination or structure of the local public administration authority;
- Launching a call for projects from the ROP for setting up integrated community service centers and day centers in rural communities, but also providing technical support for building partnerships at county level and defining the project portfolio for better coverage of these services. communities. Also, it is recommended to correlate with the NRDP interventions with social objectives;
- Clarification of the status and institutional role of the community centers integrated in the functional architecture of the health system and of the decentralization process in health, imperative necessary to improve the logic of the intervention of this program;
- Increasing the role of the line ministries (Health Ministry and the Ministry of Labor and Social Justice) in monitoring the provision of services that maintain or increase inequalities of access for disadvantaged groups and the possibility of intervention when this happens;
- For the effectiveness of projects for people with disabilities, it is necessary to involve a large number of stakeholders from the respective community. This involves planning more complex consultation processes, with appropriate allocation of time and resources;
- Strengthening the role of the management team and the local decision maker in the optimal planning of the activity of the integrated ambulatories, the hiring of the necessary personnel for the new equipments and the additional contracting of the services that can be offered;
- MA ROP should support the Health Ministry which, together with the local decision makers, will promote the remodeling and transformation of some of the small and medium healthcare units into specialized outpatient / comprehensive diagnostic and treatment centers, including with the capacity for day hospitalization according to the objectives SNS and the funding sources identified for its implementation (eg, ROP 2014-2020).

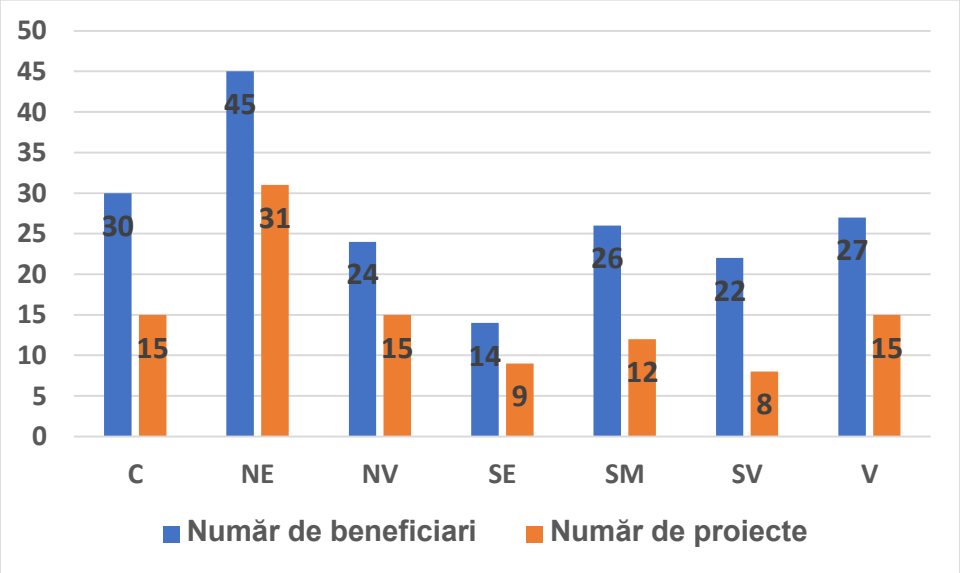
2. Existing Situation

Priority Axis 8 of the 2014-2020 ROP aims at investments in health and social infrastructures that contribute to the development at national, regional and local level, reducing inequalities in health status and promoting social inclusion by improving access to social, cultural and social services, recreation, as well as the transition from institutional services to services provided by communities. According to the data provided by the Managing Authority for the Regional Operational Program (MA of ROP) **the total value of the allocation for PA 8 is 348,117,301 euros**.

Until **25.02.2019**, which represents **the date set as the deadline for this study**, 15 calls for project proposals totaling 277,383,091 euros have been launched, 407 financing applications have been submitted, and **105 projects have been contracted** covering 7 of the 8 development regions (BI only). **The total contracted amount is 379,864,822 euros** (Figure 1), and the total value of the grant is 275,334,857 euros. All projects are under implementation, with only 3 projects starting in December 2017, the rest being started in 2018 or 2019. No project is reported as being completed.

The **105 projects** have 218 beneficiaries - medical units and social units - of which most beneficiaries are hospital units (147), and the few are represented by social units (42). Most projects are carried out in partnership with the Ministry of Health (MS), respectively the General Inspectorate for Emergency Situations (IGSU) as project leader, and with administrative-territorial units (UAT) from the county where the beneficiary unit is located.

Figure 1 - Regional Distribution of Projects and Beneficiaries - Situation on 25.02.2019[1]



[1] Source : MA of ROP

3. The stages of the Study

3.1. Description of the Methodology

The evaluation had two dimensions, one quantitative and one qualitative - the first focused on processing secondary data collected for ROP indicators and statistical data from reports or databases of the institutions involved, and the qualitative one on identifying the factors that influence the implementation and depth certain information.

The analysis model was constructed taking into account: the documentary analysis, the evaluability analysis, the recommendations of the Multiannual Evaluation Plan (SME), as well as the lessons learned from the previous evaluations. In particular, starting from the progress in the implementation of the interventions under Axis 8 (105 projects, all starting at the earliest in 2018), we mention that in this phase it was not possible to estimate the impact achieved effectively, but rather, the progress in implementation was analyzed. . A model of interpretative and participatory type was adopted.

The methodological design of the evaluation considered two evaluation criteria (efficiency and sustainability) and seven evaluation questions. The evaluation matrix is presented in Annex 1.

Five methods of data collection described below were used in the evaluation process.

1. Documentary Research

The following data sources were used (Annex 2):

Documents

- The requests for financing of the projects contracted up to the agreed deadline for this study (25.02.2019);
- Progress, visit and monitoring reports for the same projects;
- Reports of the central reference institutions for the two areas of the study (health and social);
- Specialized literature (studies, analyzes, etc.).

Database

- MA of ROP database on contracted projects (SMIS);
- Other relevant databases and statistical data sources (INSP, Eurostat, etc.).

Websites

- Websites of local authorities;
- Websites of other medical units;
- The websites MFE (www.fonduri-ue.ro), MS (www.ms.ro) and POR (www.inforegio.ro).

2. Semi-structured Interviews

The purpose of the interviews was to gather qualitative information that is indispensable for providing an answer to the evaluation questions and to deepen certain aspects resulting from the secondary data.

The interviews were conducted face-to-face with representatives of the beneficiaries, but also with the employees of the units that provide selected health/social services for carrying out the case studies, as well as with representatives of the local public administration. In addition, ADR staff members directly involved in program management were interviewed and responsible for the elaboration of Regional Development Plans, MA ROP Departments, Monitoring, Contracting and Programming and other central public entities involved in the management of health and social services policies. For the interviews, we used an interview guide which can be found in Appendix 3.

3. Nominal Groups

Nominal groups are usually organized in the final stage of the evaluation activity, to discuss and analyze the information previously collected in the evaluation process. The participant group analyzes the collected information, prioritizes the relevant problems and results, identifying potential new scenarios. There were organized 2 nominal groups: the first, in the county selected as a case study for interventions in the field of health services and the second nominal group in the county selected as a case study for interventions in the field of social services. The nominal groups were conducted according to a SWOT scenario and included the analysis of the validity of the program's terror (AP 8), as well as the validation of the empirical aspects found in the evaluation. The reports for the two nominal groups are presented in Annex 4.

4. Case Study

The purpose of conducting the case studies was to supplement the qualitative and quantitative information already obtained in order to detail and explain certain findings already outlined from the data previously collected. There have been 8 case studies, two of them depth and the remaining 6 of lower complexity. In-depth case studies were selected according to the following criteria: 1/priority county identified in the Regional Health Plans; 2/county with a greater number of projects in progress; 3/county in which several different types of health and social services were created. Complexity studies were conducted as follows:

- 2 case studies carried out in small, marginalized communities - to identify the problems they face and the degree to which the intervention has contributed to solving them.

- 2 case studies in the Roma communities - to identify the problems of project implementation, as well as the degree to which the intervention contributed to solving the problems of the final beneficiaries.

- 2 case studies in counties with a minimal number of projects carried out (to identify differences, explanations for causal relationships).

The case studies were conducted through documentary research, interviews (with the project managers and legal representatives of the beneficiaries, staff of the visited institution, etc.), on-site visits, direct observation. The case studies are presented in Annexes 5.1 - 5.8.

5. Expert Panel

The target group of the expert panel included 6 experts in the field of health services, respectively social, so 2 panels of experts were organized. The experts were selected from within the academic community, from the managers of the medical units, and from the experts

in the social and public health fields. The expert panel consultation was organized to collect specific information on the 2 areas of evaluation (one in the social field and one in the public health field). In particular, the panel of experts contributed to:

- identifying the current and new challenges for the future development of medical and social services, taking into account the data collected in the territory and the experience of the participants;
- examining the sustainability of the 2 categories of interventions;
- stimulating the mutual contribution of each experience to enrich the knowledge base for evaluation.

The reports of the two expert panels are presented in Annex 6.

3.2. Specialty Literature

All the important strategic documents elaborated during the last 15 years recognize the need to reform, even to restructure the public health system so that the socially vulnerable groups become a priority for the provision of services. The most vulnerable groups are affected, especially from the rural areas, including or especially people living in small, isolated rural localities. The principle of equity, which is to increase access to basic health services for all, especially for the vulnerable and disadvantaged, is one of the principles underlying the National Health Strategy 2014-2020.

The foundational study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 indicates that poverty risk is three times higher in rural areas than in urban areas. The characteristics of the urban / rural gap within the Romanian society are reflected by the very large difference between the values of the AROP indicator[2] for these two areas. In 2012, while only 11% of people living in densely populated or intermediate areas were at risk of poverty, 38% of those living in poorly populated areas were exposed to this risk.

The Elderly, Especially Women. Although the relative well-being of the elderly has improved over the years, there is a larger gender gap within this group. The difference in terms of poverty between men and women aged 65 and over is 10 percentage points (19.3% for women, versus 9.2% for men). The difference is even greater for people aged 80 years and over. In 2012-2013, an estimated number of over 725,000 people over the age of 80 was included in the category of vulnerable persons.

Roma are at a much higher risk of poverty than the general population, regardless of age, education or residence environment. According to the national threshold of absolute poverty determined based on consumption in 2013, Roma citizens are at a risk of poverty ten times higher than the rest of the population, the absolute poverty rate among Roma being 33% in 2013, while only 3.4% of non-Roma were below the poverty line. In 2012-2013, an estimated number of 1.85 million Roma was included in the category of vulnerable persons. Healthcare is another area in which the government targets the Roma and disadvantaged groups (rural people, where access to health services is limited) through the mediation program in the health field,

[2] "At risk of poverty rate" - is a EUROSTAT indicator that refers to the percentage of people living below the poverty line.

integrated as part of the national programs developed by the Ministry of Health. in which it is mentioned that, apart from the program of Roma health mediators, there is no other specific health care program that targets only the Roma.

Poor Children. In 2012-2013, an estimated 1.4 million poor children (aged 0 to 17 years) were included in the category of vulnerable persons. There are large groups of vulnerable children who have too few social services or whose situation does not improve significantly over time. The social assistance system is not yet sufficiently well developed throughout the country to ensure the identification of all vulnerable cases in the community, to orient them towards forms of institutional support, including financial ones, and to prevent aggravation of situations. Poverty-related disorganization processes have increased the number and incidence of problems faced by certain categories of children, such as parental leave, juvenile delinquency, drug use, abuse / neglect / exploitation, including exploitation through work or other forms, human trafficking, street living, etc.

Children and Adults with Disabilities. About 687,000 children and adults with disabilities living in the family and another 16,800 living in institutions, over 62,000 children included in the special protection system (either in placement centers or in family-type services) and about 1,500 abandoned children in medical units.

Quality of Medical Services. The discrepancy between urban and rural medical services continues to persist and is significant. From the point of view of the sanitary personnel that ensure the health care of the population, in the rural area it was poorly represented, for example the independent medical offices with the specialized dentistry provided medical services through 10,800 thousand units of which 10,400 in the urban and only 381 in the rural. The number of inhabitants belonging to an independent specialized office is 23 times higher in the rural area than in the urban one[3].

The health system's performance is also affected by internal determinants: a large part of the health services are provided directly in the hospital, this segment being highly hypertrophied, while the services provided in the community are offered in a much lower volume (for example, health services for mother and child, home care services for dependent patients, monitoring services for patients with diabetes, etc.).

The need to reorganize the public health system is recognized by experts in the field[4] who find that patients avoid attending primary medicine, requesting ambulance services or going directly to hospitals where emergency medical services are offered, during working hours. Thus, the primary medical services remain unsolicited, the emergency or hospital services being over-requested. A large number of cases where an ambulance has been requested are resolved at home, without hospitalization, which repeatedly indicates the over-demanding of the ambulance services and the under-request of the primary medicine.

Informal Payments. The lack of integrity of the system of services in the field of public health is its main feature. The MCV report indicates the problem of informal payments in the field of health, a problem that primarily affects the socially vulnerable blankets.

[3] National Institute of Statistics, 2018, www.insse.ro
[4] *Health Systems in Transition* Vol. 18 No. 4 2016, *Romania Health System Review*, Cristian Vlădescu, Silvia Gabriela Scîntee, Victor Olsavszky, Cristina Hernández-Quevedo Anna Sagan

Large Number of Children in Placement Centers. The child protection system in Romania is still one of the largest, being responsible for providing care services for approximately 60,000 children (of which 52,000 under the special protection system). At the end of 2014, about one third of the children in the special protection system were placed in residential services, of which about half still lived in placement centers (similar to 2011).

Accessibility Means Providing Services as Close to the Beneficiaries as Possible. The National Strategy "A society without barriers for people with disabilities" 2015-2020 recommends providing health services at a reasonable cost and as close as possible to the communities in which people with disabilities live. Adopting the European model with peripheral structures that serve the basic needs, with large centers and with specific specialties could be an opportunity to balance the strong territoriality of health services, especially for the poorer and more isolated areas. . The causes of these structural deficiencies are also due to poor strategic historical investments in health, as well as to external factors (for example, road infrastructure), resulting in a limited ability to support equitable access to quality healthcare. (Impact Assessment of DMI 3.1, 2015). The same approach can be found in the National Health Strategy 2014-2020. It mentions the need for decentralization in health, increasing the competences of local communities and making them responsible for the most effective use of the resources available to health services, in order to improve the health of the population. This should be accomplished through a series of actions, such as:

1. A system of basic community assistance services for vulnerable groups.

2. Increasing the efficiency and diversification of primary health care services.

3. Consolidating the quality and efficiency of the services provided in the specialized ambulatory.

4. Increasing the degree of safety of the population by strengthening the integrated emergency system and ensuring accessibility to the appropriate emergency medical care in an equitable manner.

5. Regionalization/concentration of hospital health care and creation of regional reference networks with hospitals and laboratories of different degrees of competence interconnected with the specialized primary and ambulatory care sector.

6. Increased access to rehabilitation, palliative and long-term care services.

Deinstitutionalization of Childcare Services. The National Strategy for the Protection and Promotion of the Rights of the Child 2014-2020 declares priority objectives such as 1 / increasing the coverage of services at the local level, 2 / reducing the gaps between children in rural areas and children in urban areas and 3 / continuing the transition from care institutional care of children in community care.

Reversing of the Flawed Pyramid of Services. The National Strategy for Health 2014-2020 aims to make the outpatient a much more important part in providing specialized medical services and to be an effective filter in reducing avoidable hospitalizations. The vision for the period 2014-2020 is to reverse this flawed pyramid of services and to gradually ensure a greater coverage of the population's health needs through the services at the base of the system (community assistance services, assistance services provided by the family doctor and the

specialized ambulatory). The foundation study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 recommends as national priorities several specific objectives that ensure the development of a supportive social ecosystem for vulnerable social groups, especially from rural communities:

- Consolidation and improvement of social assistance at community level
- Created integrated community intervention teams
- Improved horizontal and vertical coordination and ensuring the integration of social services

In addition, the Foundation study also recommends specific objectives for ensuring access to public health services, which coincides with the vision set out in the National Health Strategy 2014-2020.

Ensuring Accessibility Starts from the Design Phase. All local policies need to be analyzed to what extent they promote accessibility of services. In all policies, programs, services, products and resources in the community intended for people with disabilities, issues regarding cost, availability, adaptation, proximity, to prevent the creation of new barriers, as well as identifying and eliminating existing barriers that limit access for people with disabilities in all areas of life. Studies recommend as national priorities several specific objectives that ensure the development of a supportive social ecosystem for socially vulnerable groups, especially from the rural areas:

- Consolidation and improvement of social assistance at community level;
- Creation of community integrated intervention teams;
- Improving horizontal and vertical coordination and ensuring the integration of social services;
- Rigorous estimation of costs and allocation of adequate budget;
- Developed clear methodologies, protocols and working procedures.

Development and diversification of social services for vulnerable groups (the elderly, children without parental care, Roma, institutionalized children, people with disabilities, young people leaving residential institutions, mothers).

Informing and Promoting Newly Created Services. Simultaneously with the development of measures to prevent institutionalization and to support an independent way of life in the community, information and promotion measures must be planned and implemented.

The deinstitutionalization reform of children must follow a rigorous planning of the reform of all local services and policies. The Operational plan for the closure of children's placement centers in Romania[5], offers five main lessons to be considered by decision makers in this new phase of reform.

The main lessons learned show that:

1 / planning the closure of centers and the development of new services should be based on the specific needs identified for each child and his family, as well as their consultation;

[5] World Bank (2017)

2 / the closure of the placement centers must necessarily be accompanied by the development and consolidation of the services for preventing the separation of the family children from the community level;

3 / it is necessary to considerably increase the activities of monitoring and evaluation of the situation of children post-closure placement center, as well as the quality of the newly established alternative services;

4 / the achievement of deinstitutionalization should be based on public-private partnerships, as NGOs are valuable partners in the field of child protection;

5 / it is necessary to organize information and awareness campaigns at the level of the general population and the decision-makers at the local level in order to increase the level of acceptance and integration of these children, especially those with special needs, in the community.

Similar instructions on deinstitutionalization are provided by European experts[6], which recommends that the transition to the social services system at the community level should follow several implementing rules:

1 / everything must start from a community level assessment (resources, services and existing problems);

2 / based on the evaluation, a strategic and action plan (involving the beneficiaries in the process) is elaborated;

3 / the community services must be provided in a framework of public policies that regulates them;

4 / community services are developed and diversified by elaborating various measures to prevent institutionalization;

5 / adequate planning must also include the allocation of financial, material and human resources;

6 / follows the elaboration of the individual plans (the involvement of each beneficiary in the elaboration of his own plan);

7 / providing support for deinstitutionalized beneficiaries and the community to overcome resistance;

8 / developing and implementing a continuous quality monitoring system and continuous training for the specialists involved.

Independent evaluation and monitoring of public health services. All health services, especially from rural localities, should be better evaluated and monitored by the National Commission for Accreditation, in order to address the low effectiveness and quality control[7].

The Development of Programs for Marginalized Communities (where Roma live). Integrated cross-sectoral regeneration projects, which seek to achieve a balance between social inclusion

[6] *Common European Guidelines on the Transition from Institutional to Community-based Care, European Expert Group on the Transition from Institutional to Community-based Care*, November 2012
[7] National Health Strategy 2014-2020

and economic competitiveness, are the best way to reduce concentrated poverty at the territorial level in marginalized urban areas, Roma communities and certain isolated rural areas. These interventions can be effective if they are supported by a large number of public and private actors (public institutions, owners, tenants, and companies). Policies to combat segregation may target a certain geographical area (area interventions) or certain sectors (policies addressed to the population). The "problematic" areas need affordable and quality services - affordable housing, education, jobs, childcare, healthcare and public transportation[8].

3.3. Data Collection

The purpose of the quantitative data collection was to present the statistical and quantitative presentation of the results of the documentary research, namely the analysis of the available databases. The data on the project portfolio were obtained from EO of POR, MA of POR and from ADRs. Statistical data were collected on the health infrastructure and users, their access to medical services, from available statistical databases of the National Institute of Public Health and Eurostat.

The collection of qualitative data was performed using several methods presented in Table 1.

Table 1 - Methods of collecting qualitative data and data sources

Method of data collection/ analysis	**The sources used in the collection of qualitative data**
Semi-structured interviews: - at central level - at the regional level	62, out of: - 10 - 52 (of which 23 group interviews and 29 individual interviews) – Annex 7
Nominal group	2 groups, one in Cluj (7 participants) and one in Bacău (8 participants) - Annex 8
Case Study	8 (Annexes 5.1 - 5.8)
Expert panel	2 panels, one in the field of health services (7 participants), one in the field of social services (6 participants) - Annex 8

Regarding the 8 case studies (Annexes 5.1 - 5.8), they had as themes either a county in which several projects with financing from PA 8 were implemented, or a project (projects from all those were chosen). Three specific objectives of AP 8). The topics of the case studies are presented in Table 2.

Table 2 - The Topics of the Case Studies

Project Titles and SMIS Code	**Theme**	**Beneficiary**	**Region**	**County**
"Community services for adults with disabilities Tg.Ocna" (SMIS 119327); "Investments in community social	Development of social services in Bacău county	DGASPC Bacău, UAT Tg. Ocna, UAT Filipeni, UAT	NE	Bacău

[8] Foundation Study for the National Strategy on Social Inclusion and Poverty Reduction 2015-2020

services for adults with disabilities in Tamași commune" (SMIS 119325); "Alternative social services for adults with disabilities" (SMIS 119324); "Community social infrastructure for adults with disabilities" (SMIS 119326); "Rehabilitation and extension of the building regarding the setting up of a day center for the elderly with home care unit" (SMIS 116130); "Establishment of a day center for the elderly in the city of Dărmănești, Bacău county" (SMIS 114627)		Dărmănești, UAT Tamași, UAT Răcăciuni, UAT Municipiul Moinești, CJ Bacău		
"Ensuring access to ambulatory health services for the population in the North West Region by providing high-performance equipment" (SMIS 125231); "Ensuring access to ambulatory health services for the population of Cluj County" (SMIS 125321); "Ensuring access to ambulatory health services for the population of Cluj Napoca" (SMIS 125322); Improving the access of the population in the North West Region to emergency medical services, by equipping them with high performance equipment (SMIS 125223); "Improving the access of the population from Cluj county to emergency medical services" (SMIS 125318); "Improving the access of the population from Cluj-Napoca to emergency medical services" (SMIS 125320); "Improving the emergency response capacity - North West Region" (SMIS 125450)	Development of health services in Cluj county	15 specialty outpatients and 9 UPUs from hospitals in Cluj Napoca, SAJ Cluj, ISU Cluj	NV	Cluj
"Rehabilitation, modernization, extension and endowment of the building, in order to set up an integrated multifunctional social center for the elderly, Munteni commune, Galați county" (SMIS 117294)	Establishment of an integrated multifunctional social center for the elderly, Munteni commune, galați County	UAT Munteni	SE	Galați
"Improving the capacity for emergency response in the South-East region" (SMIS 125456)	Improvement of the capacity for intervention in medical emergencies in Braila county	IGSU, SAJ Brăila, ISU Brăila	SE	Brăila

"Ensuring access to outpatient health services for the population of Argeș, Teleorman and Calarasi counties" (SMIS 125358); "Improving the access of the population from Argeș, Teleorman and Calarasi counties to emergency medical services" (SMIS 125357)	Improving the access of the population from Argeș county to medical services (ambulatory and emergency) - Pitești Pediatric Hospital	Ministry of Health, Pitești Pediatric Hospital	SM	Argeș
„Complex of 3 Protected Housing and Day Center, Băbana commune, Lupueni village, Argeș county" (SMIS 120367); "Complex of 4 Protected Housing and Day Center, Tigveni Commune, Bârseștii village below, Argeș County" (SMIS 120699)	Development of social infrastructure for people with disabilities in Arges county	DGASPC Argeș	SM	Argeș
"Improving the access of the population from the South-West Oltenia Region to emergency medical services, by equipping them with high-performance equipment" (SMIS 125220); "Ensuring the access of the population to health services in the ambulatory care for the population in the South-West Oltenia Region by equipping them with high performance equipment" (SMIS 125228); "Improving the access of the population from Mehedinți, Dolj and Olt counties to emergency medical services" (SMIS 25356); "Ensuring access to ambulatory health services for the population of Mehedinti, Dolj and Olt counties" (SMIS 125378)	Improving the access of the population from Dolj County to medical services (ambulatory and emergency) - Craiova County Emergency Clinical Hospital	Ministry of Health, Craiova Emergency Clinical Hospital	SV	Dolj
"Change of destination from offices in the day center for the elderly, extension and shelving from P to GF + 2, fencing, drilled well, watertight pool, paved platform" (SMIS 115458)	Modernization Day center for the elderly in Malu Mare commune, Dolj county	Global Help Association	SV	Dolj

3.4. Limitations in Conducting the Evaluation and Method of Solving

The early stage of implementation of many contracts has substantially limited the analysis of the progress in implementation, the achieved achievements, and the way in which sustainability is ensured. In the absence of progress and monitoring reports, particularly for UAT projects, the evaluation results were built predominantly based on estimates resulting from contractual commitments and information provided in interviews and nominal groups.

The large number of evaluations carried out in parallel has considerably limited the availability of certain groups of evaluation participants (especially at the level of some ADRs), and this fact, coupled with the incipient phase of project implementation, has sometimes led to

resistance and delays in conducting field data collection. Combining interviews for several studies was a practical way to approach and overcome this situation.

The limited access to quantitative data in a reasonable time, considering the planning of the evaluation activities reduced the number of data sources, and, implicitly, the possibility of analysis. However, alternative data sources have been identified to maintain the robustness of the analyzes.

4. Analysis and Interpretation

4.1. Evaluation Question 1: To What Extent Has AP8 Contributed to Increasing the Accessibility, Quality, and Efficiency of Public Health Services, including Emergency and Secondary Education, Especially in Poor/Remote Areas?

The increase of accessibility, quality, and efficiency of public health services was analyzed according to the following indicators and sub-indicators of evaluation:

- Needs not covered by medical services (for the lower quintile)
  - Health care needs that remain unmet
  - Equipment available / not available
  - Territorial distribution of created / renovated medical services
- Population served by improved medical services
  - Reduced response time / response
  - The satisfaction of the beneficiaries
  - Reducing the distance to home
  - Reduction of waiting time for the service
  - Equipment for people with disabilities / the elderly
  - Hygiene, cleanliness
- Beneficiaries of medical infrastructure built/rehabilitated/modernized/extended/equipped
  - Daily flow of beneficiaries (increase/decrease).

a / Collected Data

In order to formulate a robust answer to this evaluation question, both quantitative and qualitative data were collected.

Quantitative Data: data were collected from the funding applications and from the progress reports of the interventions contracted within PA 8 at the deadline set for evaluation (63 projects). In addition, secondary quantitative data were collected regarding the three indicators with the related sub-indicators presented previously. The data sources used were the annual reports of the State Department for Emergency Situations (DSU), the Eurostat online database, as well as the database of the National Institute of Public Health (INSP).

Qualitative Data: collected through interviews and nominal groups targeted the opinions of different stakeholders on the quality and accessibility of services, as well as the factors that influenced the effectiveness and efficiency of the interventions financed from PA 8, etc.

b / Data Analysis

Needs not covered by medical services (for the lower quintile)

Unmet health care needs are evaluated annually and reported by Eurostat in the European Commission's health questionnaire (EU-SILC). They show the difficulty of accessing health services because the health costs are either too expensive, or the distance to access health services is too large, or there are waiting lists or all these impediments in one place. The inequalities of access are in direct relation with the socio-economic status so that vulnerable / disadvantaged people have higher values than the people with a high socio-economic status, the difference being greater as the inequities are more pronounced. The base value established for Romania in 2012 was 13.3% for the lower quintile of incomes (the most vulnerable), and the target value for 2023 was 9.3 for the same category of persons. According to Eurostat data, during the period analyzed (2012-2017) there was a constant decreasing trend of this indicator from 8% in 2015 to 3.4 in 2018, already below the expected value for 2023. This is only partially an indication with on the effectiveness of the interventions in the field of health financed from PA 8, because there are other factors that have actually led to the decrease of the mentioned indicator level, such as for example the projects finalized by the ROP 2007-2013, interventions realized by the state budget, changes health legislation, tax changes with impact in the field, etc. In contrast, the difference in access between people with high and low socio-economic status remains important (5.7%), which shows that inequalities of access are still a problem to be addressed.

From the perspective of the monitoring and evaluation of PA 8, it is important to note that although this indicator is available annually on the Eurostat website, it was not completed in any funding request for the evaluated projects or in the monitoring reports that were made availableby esvaluators.

- **Available Equipment**

According to the collected field data [9], the health infrastructure and technology platform is worn and impaired both physically and morally, most of the equipment used being outside the warranty term, without appropriate service contracts and with a very high degree of wear. Some of these equipment are overloaded, frequently damaged, and may pose potential safety risks to patients and thus to the staff who serve them. Although the stock of new medical equipment has been increasing in recent years, this is especially true for the private sector. Equipment in the public sector is not sufficient for the need for existing health services, and those in the private sector are often inaccessible at a price when the patient must make the payment of medical services or when waiting times for examination or treatment are unreasonable.

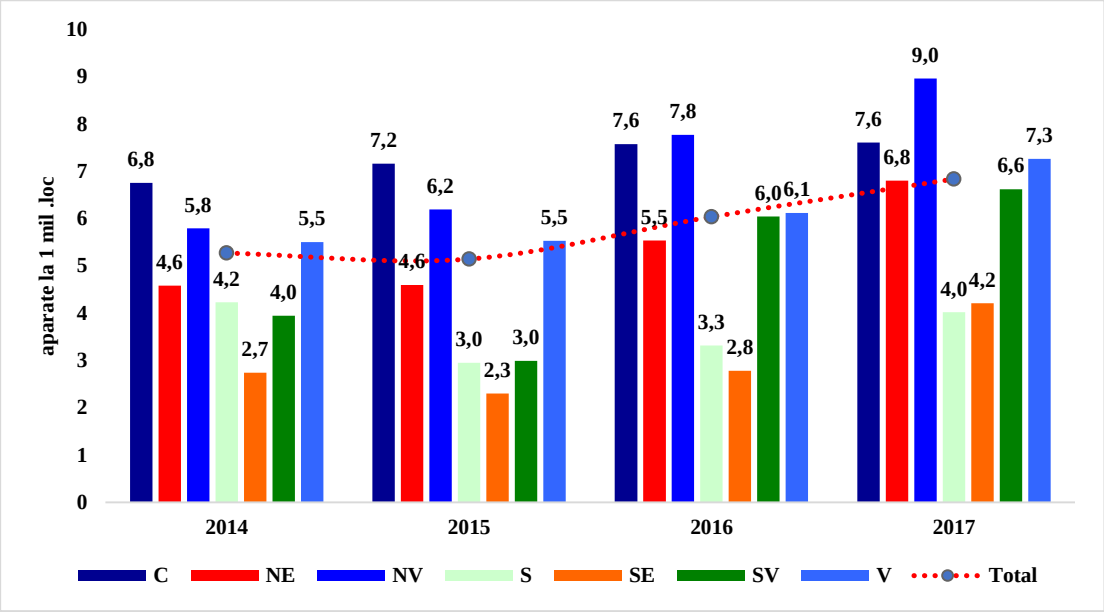
In this sense, the provision of modern equipment for both the integrated outpatient hospitals and the emergency medicine sector and support units is a welcome initiative within this funding axis, on the one hand as a complement to previous operational funding (ROP 2007- 2013) for

[9] Interviews with project beneficiaries and interviews at central level, nominal group with project beneficiaries

rehabilitated ambulatories, or as a new initiative for public hospitals that did not access the previous financing, given that hospitals from their own income or their owners (UAT or MS) could not financially support the endowment at this level.

According to Eurostat data, as well as local administrative data, the provision of high performance equipment, as well as its use, has steadily improved between 2012 and 2017 as shown in Figures 2 and 3.

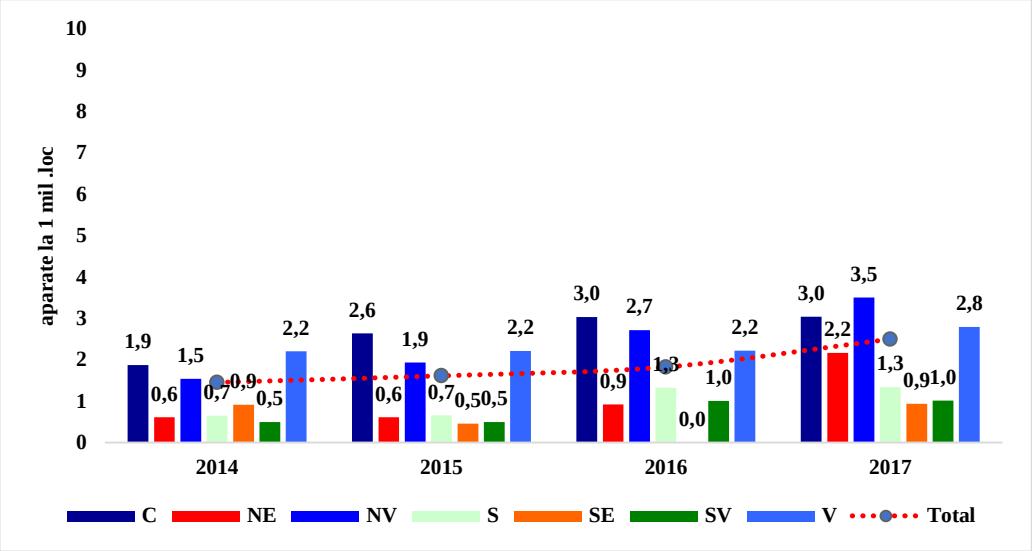
Figure 2 - Dynamics of the availability rate of CT devices at national and regional level (excluding BI) during 2014-2017[10]



Equipment with high performance devices (CT) is highly variable in the development regions from 2.3 devices per 1 million inhabitants in the Southeast region, up to 9 devices per 1 million inhabitants in the West region. Between 2014 and 2017, the trend is increasing for all the analyzed regions, at the end of the period analyzed twice more CT equipment per 1 million inhabitants were in the North-West region than in the Southeast region.

[10] Source: INSP

Figure 3 - Dynamics of the availability rate of MRI devices at national and regional level during 2014-2017[11]



Equipment with high performance devices (MRI) is highly variable in the development regions from 0.5 devices per 1 million inhabitants (South-West) to 3.5 devices per 1 million inhabitants (North-West). Between 2014 and 2017, the trend is increasing for all the analyzed regions, from sub-unit values in most regions at the beginning of the programming period, to supra-unit values in almost all regions, at the end of the analyzed period (Figure 2).

From the data presented by regions it can be observed that there are still significant differences between different development regions, this being partly explained by the health infrastructure and the human resources available in a greater number in the regions with important university medical centers.

For these projects, except for the purpose of equipping them with equipment purchased through the World Bank, the hospitals have previously purchased or were in the process of carrying out purchases for their own equipment based on necessity reports and procurement plans that are their own, not standardized and which does not always reflect the regional service plans or the positioning of the respective health unit in a county or regional healthcare network that provides these services efficiently, planned and coordinated (Annex 9).

- **Territorial Distribution of the Created/Renovated Medical Services**

According to the data provided by the project documents (funding requests and progress reports) and the interviews conducted during the visits to the regions, all the counties of the country have benefited from projects on PA 8 so far, the vast majority on all investment priorities (ambulatory, emergency medicine and ambulances), and only a small part on two of the priorities (usually emergency medicine and ambulances). The territorial distribution was made

[11] Source: INSP

according to the existing infrastructure that was to be modernized in order to increase the efficiency and quality of the medical act, as well as the satisfaction of patients and medical staff, but also to comply with the strategic directions set out in the Regional plans for health services for 2014 -2020 (Annex 9).

- **Population Served by Improved Medical Services**

The sanitary units equipped with equipment within the evaluated projects are found throughout the country in the seven development regions eligible for funding. These sanitary units are of different types from the integrated / specialized ambulatories of some small and medium hospitals (city/ municipal) that serve the population of these cities and the rural and bordering localities up to the integrated ambulatories / the specialized ambulatories of the county hospitals or institutes, regional clinics serving the population of the county, respectively of the region for certain niche medical specialties. Therefore, it can be said that a relatively large part of the country's population is covered and has potential access to improved medical services.

The immediate achievement indicator for PA 8 "Population covered by improved health services" has a target value for 2023 of 500,000 person's value which is exceeded at present if the geographical area covered by the modernized health units is considered.

However, even if this indicator is available, it was not completed in all funding applications for the evaluated projects or in monitoring reports that were made available to the evaluators.

For the *specialized outpatients* (including endowment with support sections equipment) in 29 projects, the value of the indicator is not available in the funding application; a project from the South-West region that covers Dolj, Mehedinți, Olt counties has passed the value of 575,106 people.

For *emergency units/emergency units* (including equipment with support sections) in 23 projects, the value of the indicator is not available in the funding application; two projects from the North-West region have passed the values 323.48 (Cluj Municipality) and 4,000 (Bistrița Năsăud and Satu Mare counties), but it is not known the rationale behind these values.

- **Reduction of Intervention/Response Time**

The reduction of response time is strictly dependent on the number and reliability of the available ambulances, as well as the personnel working in this field. According to the DSU report even if the ambulance park is physically used, over 62% of the ambulances available in 2018 are over 10 years old, the number of interventions performed by the ambulance crews has increased continuously (over 200,000 additional interventions during 2015- 2018) reaching over 8,000 interventions/day. According to the DSU Activity Report for 2018, the average response time of the County Ambulance Service crews was 14 min. and 30 sec. in the urban area and 27 min. and 20 sec. in rural areas. These values are relatively higher than those previously envisaged in D.M.I. 3.3, respectively 8 min. in the urban area and 12 min. in rural areas. This target is difficult to reach given that on the one hand two thirds of the ambulance park is in a state of advanced physical wear, the available personnel is insufficient, and the road infrastructure has not significantly improve

- **The Satisfaction of the Beneficiaries**

Recently, MS has made available to users of medical services an application that records information related to the satisfaction of the provided medical services, but this is only available for a representative sample of patients who have had at least one hospital admission. The system is not available for patients receiving outpatient or emergency medical services. In addition, each healthcare unit is required to provide patients with a space for collecting suggestions, complaints or satisfaction questionnaires administered at the end of the medical act, but these are not available for consultation by external evaluators.

However, based on the collected field data, it can be reasonably estimated that new equipment increases the quality and reliability of the services offered, decreases the waiting time and, in certain situations, are positioned in a health unit closer to the patient's home, factors that it should increase the satisfaction of the services received by the beneficiaries.

- **Reducing the Distance to Home**

A significant number of integrated outpatients from the structure of city and municipal hospitals were provided with equipment within this funding, which presumes that patients no longer have to travel so frequently to the specialized outpatient hospital in the county, and for minor health problems or simply receive full medical care in the outpatients of these small and medium hospitals.

To date, 49 municipal hospitals and 35 city hospitals (integrated ambulatories/UPU/CPU and support units) have been provided, outside all county hospitals and clinical institutes in university medical centers, which shows that medical services for diagnosis and treatment they will be available closer to the citizens' home, provided they are used properly. This change of behavior should also reduce the agglomeration of county and regional medical centers and their efficiency by allocating more time for solving complex cases.

- **Reduction of Waiting Time for the Service**

The same hypothesis as above should lead to the reduction of waiting time for medical services, either by introducing new services in the small and medium hospitals closer to the patients' homes, or through the increased number of equipment purchased in these units. In addition, an essential condition is the availability of the medical team to provide the medical services at this level and in a way that allows access to as many categories of patients as possible (*for example, two shifts in the integrated ambulatory/specialized ambulatory*). Considering that the salaries of the medical staff have become attractive since last year, due to the substantial wage increase and that the total number of medical personnel has increased significantly but steadily in recent years, this hypothesis may be plausible.

- **Equipment for People with Disabilities/the Elderly**

The case studies carried out (Annexes 6.1 - 6.8) indicate that the provision of units for persons with reduced mobility / disabilities is at an early stage, the projects aimed at developing

services for these target groups have recently begun. Therefore, purchases of equipment have not yet been made, so no value judgments can be made regarding progress.

- **Beneficiaries of Medical Infrastructure Built / Rehabilitated / Modernized / Extended / Equipped**

This indicator is difficult to measure because at the outpatient level there are no people registered, but medical services performed (consultations, investigations, treatments), and a person can access one or more services in a visit to the medical unit, which makes this indicator to require a computer system available in the healthcare unit that allows the quantification of patients according to a unique identifier (for example, the insurance code - CID available on the health insurance card).

The indicator "Beneficiaries of medical infrastructure built/rehabilitated/modernized/ extended/equipped" has a target value for 2023 of 230,000 people, a target value that can be achieved faster if we consider the geographical area covered by the modernized healthcare units.

Although the values for this indicator are relatively available, it has not been completed in all funding applications for the evaluated projects or is not found in the monitoring reports that have been made available to the evaluators.

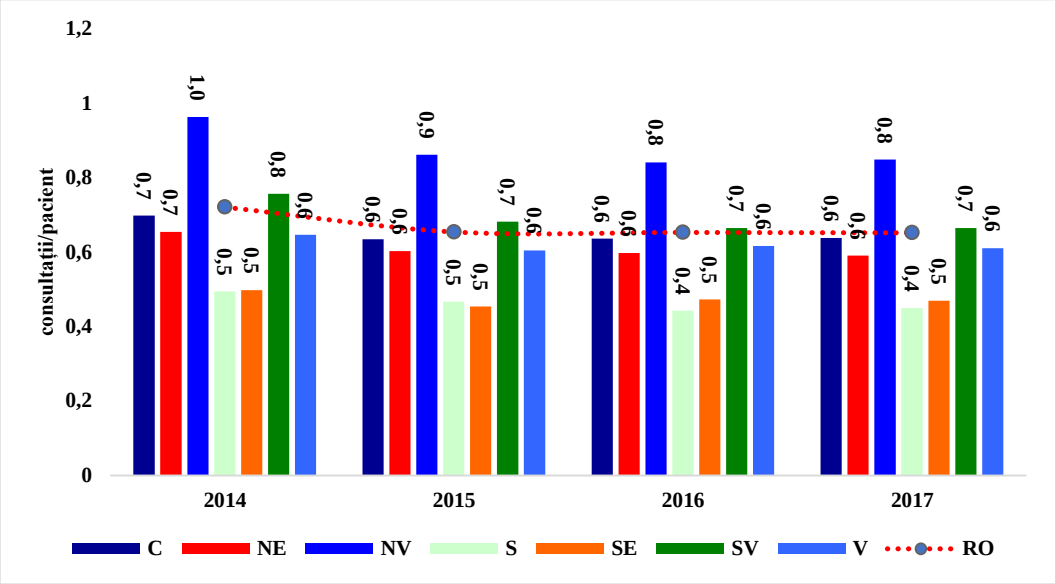
For *specialized outpatients (including endowment with support department equipment)* the sum of the target values of the indicator resulting from the projects that indicated values in this regard is 2,524,282 persons. It is not clear what the basis for this value was.

- **Daily Flow of Beneficiaries (Increase/Decrease)**

At national level, the daily flow of ambulatory services beneficiaries has been steadily decreasing during the last 10 years, mainly due to the chronic under-financing of this sector, the inadequate infrastructure, and the missing or physically used equipment, which made the population to recover within the hospital and to agglomerate this sector, especially for hospitals in university medical centers (Figure 4).

The rate of outpatient consultations is slowly decreasing during the analyzed period, the highest values being in the North-West region, and the lowest values are in the South and Southeast regions. The difference between the number of consultations offered in the North-West and South region is twofold, this fact being possible to be partially explained by the large number of outpatients in the North-West region, but also by reducing the number of specialists from the neighboring counties of Bucharest. It seems that the interventions financed under PA 8 did not have an influence on the evolution of this indicator.

Figure 4 - Dynamics of the Rate of Outpatient Consultations at National and Regional Level during 2014-2017[12]



c / Results following the analysis (findings)

Target proposed for 2023 for the indicator "unmet medical needs (for the lower quintile)" for the most disadvantaged people [13] decreased from 8% in 2015 to 3.4% in 2018, **but there is still a significant degree of inequity between people with high socio-economic status and disadvantaged people**.

The healthcare units have purchased a variety of medical equipment from low value items and frequent use to high performance equipment for diagnostics and treatment. There is **a constant tendency to increase both the number of high performance equipment purchased and the number of investigations/treatments performed with this equipment**. However, there is a difference between the equipping of different regions, which can be explained in part by the existence of university medical centers.

Given the number and diversity of healthcare units that have benefited from endowments in these projects, we can consider that **the territorial distribution of created/renovated medical services is extensive at national level**, with the mention that for certain regions where ambulatory services are concentrated in certain cities, the same endowment model to the detriment of smaller centers.

The immediate achievement indicator of PA 8 "Population covered by improved health services" has a target value for 2023 of 500,000 person's value which, at an estimated level, is currently exceeded if we consider the geographical area covered by the modernized health units. However, **achieving the target for this indicator is difficult to measure rigorously**

[12] Source: INSP
[13] https://ec.europa.eu/eurostat/data/database

because it has not been mentioned in all funding applications for the evaluated projects or in the available monitoring reports.

Reducing the response/response time requires improvement, and this is difficult to achieve given that on the one hand, two thirds of the ambulance park is physically used, the available staff is insufficient, and the road infrastructure has not significantly improved.

In the absence of a relevant indicator available, it can be considered that **new or multiple equipment increase the quality and reliability of the services offered**, decrease the waiting time and in certain situations they are positioned in a health unit closer to the patient's home, factors that should increase the satisfaction of the services received by the beneficiaries.

It can be estimated that the proposed target value for the beneficiaries of built/rehabilitated/ upgraded/upgraded/extended medical infrastructure will be reached including with the contribution of UAT projects, however the factors that do not make the specialized outpatient attractive must be remedied quickly (eg sub- constant financing and restrictions on completion of the medical act). **It is also necessary to improve the outpatient IT infrastructure** in order to be able to properly measure this indicator.

Given that the unfinished projects consisted of endowments with equipment that were purchased between 2015 and 2018 and that the projects with UAT project leaders were contracted a few months ago, it is premature to quantify the accessibility and extremely difficult **if not impossible to quantify the quality and efficiency of the services provided** for the following reasons:

- Accessibility can be measured by the number of people who benefit from services offered with the equipment purchased according to their domicile. The hospital records the patient's domicile in case of a day or continuous hospitalization, but this is not valid at national level for the consultations and investigations offered in an outpatient regime. It is clear from the discussions with the decision makers involved that data was collected regarding the users of the purchased equipment, but these data were not made available to the evaluator until the time of writing the report;

- The quality and efficiency of the health services offered in the public health system cannot currently be objectively quantified in the absence of indicators provided by the regulatory authorities.

4.2. Evaluation Question 2: To What Extent Did AP8 Contribute to Improving the Cost and Quality Efficiency of Emergency Care in Hospitals, with a View to Reducing the Number of Hospitalizations in Acute Illnesses in Hospitals/or the Number of Beds for Acute Hospitalizations, by Establishing an Integrated Functional Targeting of Patients?

The cancellation of the PA 8 contribution to the improvement of the costs and the quality in the emergency care of hospitals was made based on the following indicators:

- Costs per patient
- The rate of acute hospital admissions out of total admissions
- Emergency units/emergency units

- Medical units built/rehabilitated/modernized/extended/equipped
- Efficiency of targeting patients
  - The place/medical service at the first address and the reasons for choosing the service
  - Number of cases/hospitalizations/consultations in hospitals - without referral tickets
  - The rate of acute hospital admissions out of total hospitalizations.

A / Collected Data

The answer to this evaluation question was formulated based on of both quantitative and qualitative data analysis.

Quantitative data: data were collected from the funding applications and from the progress reports of the interventions contracted within PA 8 at the deadline set for evaluation (63 projects). Also, secondary quantitative data were collected regarding the five indicators with the related sub-indicators presented previously. The secondary data sources used were the database of the National Institute of Public Health (INSP) and the annual reports of the DSU.

Qualitative data: collected through interviews and nominal groups targeted the opinions of different stakeholders on the quality and accessibility of services, as well as the factors that influenced the effectiveness and efficiency of the interventions financed from PA 8, etc.

b/ Data Analysis

- **Costs per Patient**

The health system is chronically under-financed, with Romania having the lowest health allowance in all the Member States of the European Union (*5.2% of GDP compared to 9.6% of the EU average*). Also, the budget allocation on different areas of health care continues to favor hospital services and reimbursed drugs, to the detriment of primary health care and outpatient services.

The outpatient services are still under-financed, and their tariff is considered unattractive for some of the medical personnel who have a contractual relationship with the Health Insurance House. However, for the medical staff employed by the hospital and who also perform services in the specialized ambulatory, their payment is made on salary not on services performed so that the remuneration is considered satisfactory. However, a problem can be considered as financing the various paraclinical investigations that have out-of-date rates and which are not sustainable in the long term. Emergency services are financed from the state budget, and the average cost per intervention has increased steadily every year.

For patients, the availability of health services closer to their home decreases the additional costs of transportation in the county capital, and for the active population and the costs of lost productivity due to longer absence from work decrease.

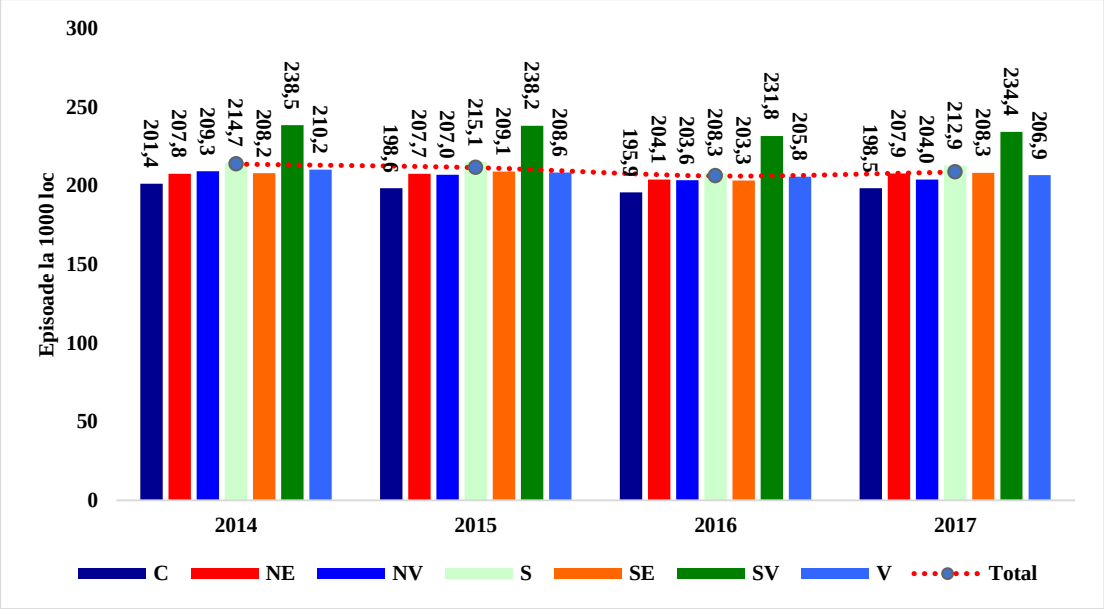
For the health care system, the costs associated with the hospitalized surplus cases because there was no availability for diagnosis and treatment closer to their home, or the costs with the complications because patients delayed presentation to the doctor due to lack of access to an outpatient service should decrease, in the medium and long term.

- **The Rate of Acute Hospital Admissions out of Total Admissions**

The rate of hospital admissions has steadily decreased from 25 hospital admissions / 100 inhabitants in 2010 to 20.8 hospital admissions / 100 inhabitants in 2017. This is in line with the objectives of the National Health Strategy, but it does not take into account the constant increase of the rate of day hospitalizations, which in the vast majority of cases represent a masked ambulatory service (consultation and investigations offered at the same time and very beneficial for the patient) financed advantageously by CNAS.

Even though this indicator is relatively available, *it has not been completed in any funding application for the evaluated projects or in monitoring reports from those that were made available to the evaluators.*

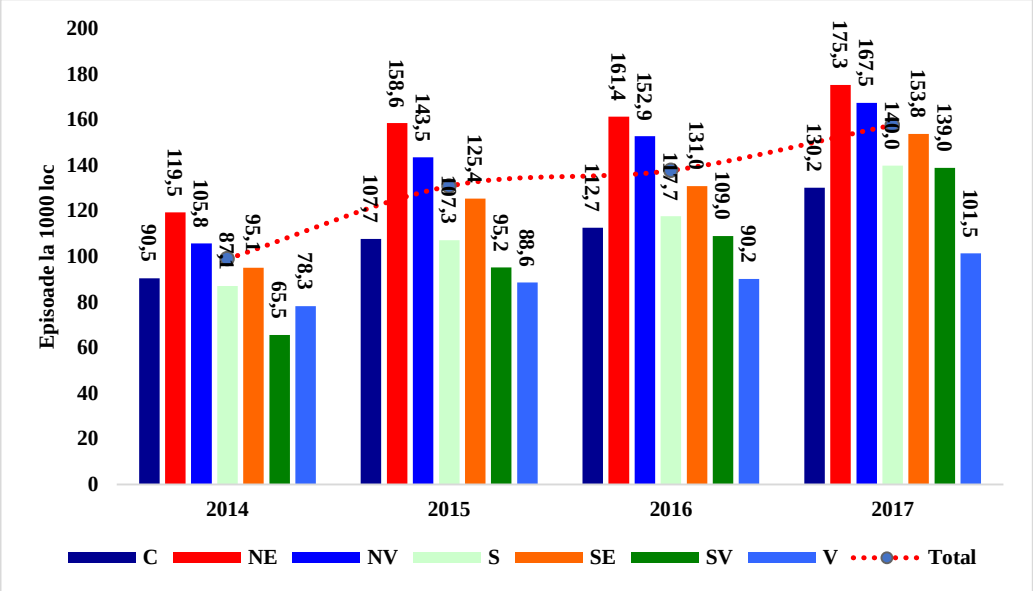
Figure 5 - The Dynamics of the Hospitalization Rate Continues at National and Regional Level during 2014-2017[14]



The rate of continuous hospitalization is relatively constant and slightly decreasing during the analyzed period, the highest values being in the South-West region and the lowest in the Center region (Figure 5).

[14] Source: INSP

Figure 6 - Dynamics of the Day-to-Day Hospitalization Rate at National Level and by Regions during 2014-2017[15]



The rate of day hospitalization is constantly increasing during the analyzed period, the highest values being in the Northeast region, and the lowest values are in the West region (Figure 6).

It is difficult to isolate the contribution of AP 8 to the dynamics of these indicators in the absence of the reconfiguration of the outpatient services together with the updating of their rates and the constant monitoring of the hospitalized cases in day hospitalization in order to offer a fair start to the rehabilitated/modernized outpatients.

- **Emergency Receiving/Care Units**

The Emergency Receiving/Care Units are an integral part of emergency medical care and represent the most crowded medical structures that run approximately 5.4 million patients per year, of which about a quarter are admitted to hospital[16]. One of the reasons for the agglomeration of these structures is their continuous availability, the possibility to offer consultations and medical investigations including high performance if required, free of charge for any person who presents with a medical problem. The average cost of an intervention at UPU was 238 lei/case in 2018[17], about equal to the cost of a day hospitalization in a medical department. Other reasons are related to the availability of family doctors in communities and their medical practice model, the program and availability of specialized outpatient services and analysis or imaging laboratories.

The default indicator for immediate achievement for Emergency Receiving/Care Units (including equipment with support sections) is not very clearly defined, meaning that the intervention on

[15] Source: INSP
[16] Ibid.
[17] http://www.dsu.mai.gov.ro/wp-content/uploads/2019/02/Brosura-Bilant-DSU-2018.pdf

them is not clear[18].

Din proiectele pe Axa 8.1 POR 2014-2020, contractate până la data limită a evaluării rezultă că 138 de unități de primiri urgențe/compartimente de primiri urgențe (nivel terțiar) au fost dotate cu echipamente prin contractele de finanțare ale MS (nefinalizate), în condițiile în care 4 proiecte nu au valoarea țintă disponibilă în cererea de finanțare. Având în vedere că ținta stabilită a fost de 35 de UPU/CPU, putem estima că se va ajunge la o depășire substanțială a acestei valori, mai ales că se vor adăuga și realizări din proiectele UAT contractate recent (după data limită a acestei evaluări).

- **Efficiency in Distributing the Patients**
    - **Place/Medical Service at the First Address and Reasons for Choosing the Service**

In Romania, the family doctor has the role of "gatekeeper" [19] and integrator of the health services provided to the patient in accordance with the legislation in force, except in cases of major emergency when the patient is taken over by the emergency system. The family doctor is the one who sends the patient to the more specialized health structures (outpatient or hospital) and he is the one who monitors his/her progress in the health system. In fact, only part of the patients follow the route described in the package of health services for the insured, one of the main reasons being the low availability and the inefficiency of the services in the outpatient clinic or paraclinic combined with the relatively easy way to get a hospital admission. Increased availability of efficient outpatient services is essential for relieving UPU and hospitals of cases that do not require care at that level, which would increase the efficiency of the health system by directing UPU funds and hospitals to cases requiring emergency or hospital care. The projects financed from PA 8 did not refer to interventions on "entry into the system", and the causal link between the activity of family doctors - the efficiency of the outpatients - the relieving of the UPU - the relieving of the hospital medical services cannot be documented due to lack of data.

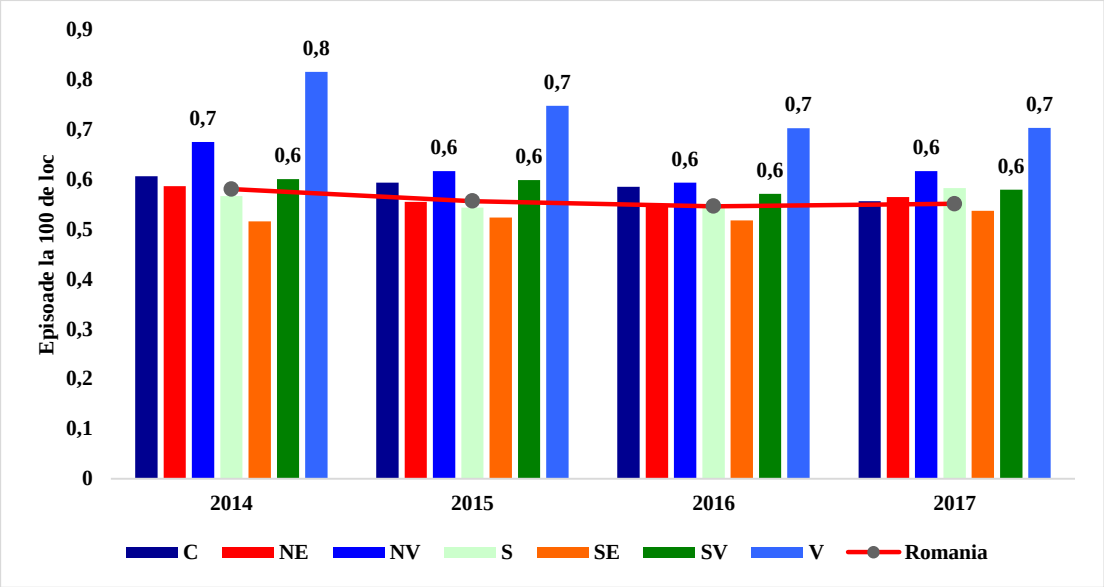
- **Number of Cases/Hospital Admissions - No Referral Tickets**

Approximately 2.5 million patients totaling around 4 million hospitalization episodes are admitted to Romania annually. Considering that about 1.4 million cases are admitted to UPU direct hospital every year, which represents 33% of all hospitalizations in a calendar year, we can conclude that 66% of patients admitted to the hospital should submit a referral ticket for hospitalization. In practice, obtaining the referral ticket for admission is mostly an administrative formality, its presence not representing in all cases a real reason for admission. About 30% of hospital admissions are for conditions that could have been treated in the outpatient setting (family doctor or specialty outpatient) if these services were available and effective. As presented in detail in the case study (Annex 5.2), in Cluj County in 2017, over one third of the top 10 diagnoses discharged from the hospital are conditions that could be treated outside the hospital, indicating the inefficiency of this sector. On the other hand, a large part of the small and medium-sized hospitals are interning additionally for a larger budget.

The measurement of this phenomenon is performed by means of the rate of avoidable episodes, which represent conditions for which patients should not be admitted to the hospital, when the outpatient services would be available and effective.

[18] This indicator is defined as: "Emergency Receiving/Care Units (tertiary level)"
[19] The term is used in the field of social and medical services and denotes entry into the service system.

Figure 7 - Rate of Avoidable Episodes at National and Regional Level in 2014-2017[20]



The rate of avoidable episodes (*diabetes, high blood pressure, chronic heart failure and chronic obstructive pulmonary disease*) is slightly lower during the analyzed period, the highest values being in the West region, followed by the North-West region, and the lowest values are in the Southeast region (Figure 7). Given that the dynamics of this indicator is strongly influenced by factors that, as explained above, appear so far as being too little influenced by the specificity of the interventions in PA 8, further analyzes are needed after the projects have been concluded in order to establish with certainty the contribution these projects to any changes in the behavior of the final beneficiaries of medical services of the projects.

C / Results following the analysis (findings)

In order to be efficient and sustainable, the ambulatory services must be reconfigured and their tariffs updated. Also, the additional costs for the patient should be reduced by reducing the distance and access time. **The costs associated with hospitalized surplus cases** because there was no availability for diagnosis and treatment closer to their home, or the costs with complications because patients delayed presentation to the doctor due to lack of access to an outpatient service **should decrease, in the medium term and long**.

The rate of continuous hospital admissions decreased steadily during the period analyzed together with the average length of hospitalization at national level. However, the rate of day hospitalizations is constantly increasing and an important part of the day hospitalization is represented by a masked ambulatory service with more favorable financing.

The increased availability of efficient outpatient services is essential for relieving UPU and hospitals of cases that do not require care at that level. It is estimated that **improving the**

[20] Sursa: INSP

outpatient medical services will increase the efficiency of the health system by using UPU funds and hospitals only for cases requiring emergency or hospitalization assistance.

It is found that approximately 30% of hospital admissions are for conditions that could have been treated in the outpatient (family doctor or specialized outpatient) if these services were available and effective. Given that the projects evaluated at national level are still not completed, it is relatively premature to be able to observe effects on socio-economic development. However, since the vast majority of equipment purchases were made up to three years ago and the equipment is functional, certain effects could be foreseen. This fact, however, is not achieved because so far **there is no objective way to monitor the socio-economic effects**. So:

- For purchased equipment that has replaced older equipment (eg equipment from operating rooms, ATI or UPU units), the reliability of new equipment is expected to increase the satisfaction and ergonomics o the medical staff[21], but also the quality, efficiency and safety of the act. medical and implicitly satisfaction and, in some cases, patient productivity;
- For new equipment that contributes to the provision of new medical services or which allows faster completion of the diagnostic and treatment procedure (eg high performance imaging equipment, surgical equipment for new surgical techniques) is expected to generate new locations work for medical and auxiliary personnel, to increase the beneficiaries' budget by providing reimbursable services from social health insurance funds or services paid directly by patients; also, it is expected that these equipments will increase the quality of the medical act and implicitly the quality of life and the productivity of the patients, considering that the active population benefits from fewer days of medical leave and is more quickly reintegrated into work;
- For new equipment that has been purchased in integrated outpatient facilities (eg diagnostic equipment - endoscopy, screening - mammography and HPV testing, functional scans - spirometry or treatment - radiotherapy) is expected to provide new health services to be reimbursed, to reduce waiting times and the distance traveled by patients for diagnostic investigations and treatment, to allow the early diagnosis of serious illnesses which can increase survival, healthy life expectancy, quality of life and productivity of patients, given that the working population benefits less days off and she is more quickly reintegrated into work.

4.3. Evaluation Question 3: To What Extent Did PA 8 Contribute to Increasing the Coverage of Social Services, including for the Various Vulnerable Groups Targeted?

Similar to other countries in the European Union, Romania in the last decades has been affected by profound social phenomena, such as the aging of the population and the reduction of the active population, as a result of the reduced participation of some categories of population

[21] Used medical equipment, by their mode of operation can maintain difficult working conditions, even unsafe for medical personnel (increased irradiation for old radiology equipment, electrocution risks / electrical burns to old electrosurgical equipment, etc.).

(persons with disabilities/Roma persons, etc.) on the labor market. The rural environment is deficient in terms of the existence of the social centers and the necessary personnel, highlighting the need to finance the interventions in the infrastructure of the social services of the day. In this context, the contribution of PA 8 to increasing the coverage of social services for different vulnerable groups was analyzed on the following two dimensions:

- The degree of coverage with social services (by target group category
  - Social assistance needs that remain unmet
  - Equipment available/not available
  - Territorial distribution of created/renovated social services
  - Beneficiaries of the social services of residential type granted in old type institutions - children/persons with disabilities
  - Beneficiaries of day-to-day social infrastructure/rehabilitated/upgraded/extended/ equipped/endowed with target group typology (children, people with disabilities, elderly)
- The population served by improved social service
  - The degree of satisfaction of the beneficiaries
  - Reducing the distance to home
  - Equipment for people with disabilities / the elderly
  - Hygiene, cleanliness.

A / Collected Data

The answer to this evaluation question was formulated based on both quantitative and qualitative data analysis.

Quantitative Data: Data were collected from the funding applications and from the progress reports of the interventions contracted under OS 8.3. of AP 8 at the deadline set for evaluation (42 projects). Also, secondary quantitative data regarding the two indicators with the related sub-indicators presented above were collected. The secondary data source used was the Minister of Labor and Social Justice.

Qualitative Data: collected through interviews and nominal groups aimed at the opinions of different stakeholders regarding the quality and accessibility of services, as well as the factors that influenced the effectiveness and efficiency of the interventions financed from PA 8 (OS 8.3), etc.

B / Data Analysis

In the social field, AP 8 aims to increase the degree of coverage with social services of three vulnerable social groups: the elderly, people with disabilities and children in the special protection system. From the consideration of maintaining the coherence of the data analysis presentation in the following, it is structured according to each vulnerable group concerned.

Regardless of the target group concerned, the main strategy for carrying out the intervention is to reform existing residential institutions by limiting up to 50 people in a residential institution, constructing protected housing to reduce the number of people in large residential institutions and creating social service centers in each community (in urban communities specialized on

certain socially vulnerable groups, and in rural localities community centers integrated with medical and social services).

- **Persons with Disabilities**

The process of reforming the large residential institutions was driven, first, by the legislative modifications of GEO no. 69/2018 for amending Law no. 448/2006, which establishes at 50 places, the maximum capacity of the residential centers for persons with disabilities. Based on this express requirement, it is foreseen the obligation to reorganize the residential centers with a capacity of less than 50 places and to elaborate the restructuring plans for those with a capacity of more than 50 places.

The number of residential social welfare institutions for adults with disabilities is increasing: from 417 in December 2017, to 434 in December 2018. The reform of the existing institutions and the opening of new protected housing explain this. About two-thirds (59.68%) of public residential institutions for adults with disabilities are 1 / care and assistance centers (27.88%), with 6,397 beneficiaries and 2 / protected housing (31.80%), having 1,002 beneficiaries. They represent 41.32% of the total number of 17,908 persons in residential institutions. The average number of people with disabilities in a residential institution at the end of 2018 was 41 people[22].

Regarding the number of beneficiaries (users) of the interventions contracted within the PA 8 for this target group, based on the projects contracted until the deadline for carrying out this study, it is estimated that improved social services will be offered for 231 persons with disabilities in sheltered housing we and 304 persons with disabilities will benefit from social services in rehabilitated day centers (Table 3).

Table 3 - AP 8 achievement indicator on social services for people with disabilities [23]

Indicators of ROP Achievement	Target	Realised	Degree of achievement
Beneficiaries (persons with disabilities) of social infrastructure of rehabilitated /modernized/extended / equipped	10.000 people	304 people	3%
Beneficiaries (persons with disabilities) of social infrastructure of rehabilitated /modernized/extended /equipped	516 people	231 people	45%

[22] http://anpd.gov.ro/web/transparenta/statistici/

[23] Source: MA of ROP (Applications for the financing of projects targeting social services for persons with disabilities contracted within the deadline of 25.02.2019).

The degree of satisfaction of the beneficiaries cannot be measured because all the investment contracts were concluded at the end of 2018 or the beginning of 2019, and the projects are at most at the stage of obtaining the building permits or purchasing the construction services.

- **Children in the Special Protection System**

The process of deinstitutionalization of children in the special protection system after a period of progress, somewhat slower during the last years or, at present, is even in a slight decline. As of December 31, 2018, there were 3,358 children and 455 children in classic private placement centers, with 463 children more than in December 2017.

Regarding the number of beneficiaries (users) of the interventions contracted within PA 8 for this target group, based on the only project contracted until the deadline for the completion of this study, it is estimated that improved social services will be offered for 20 years. children benefiting from the daily social infrastructure and 48 children, beneficiaries of the modernized infrastructure (Table 4).

Table 4 - AP 8 Achievement Indicator on Social Services for Children in the Special Protection System [24]

Indicators of ROP Achievement	Target	Realised	Degree of achievement
Recipients (children) of rehabilitated/modernized / extended/equipped social infrastructure	75.000 people	20 people	0.03%
Beneficiaries (children) of the deinstitutionalization infrastructure built / rehabilitated/modernized	750 people	48 people	6.4%

However, according to the data of the National Authority for the Protection of the Rights of the Child and Adoptions (ANPDCA), at the end of the first quarter of 2019, 8 projects were contracted (7 more in addition to the one contracted in 2018). In addition, ANPDCA also issued 15 opinions for other projects.

ANPDCA was consulted when the indicators corresponding to this target group were established and estimates that through the 8 projects, plus the 15 for which opinions that are more recent have been issued, the target values for these indicators will be achieved. Regarding the effects of these projects, they are considered to create all the conditions pertaining to the physical environment. However, in reality, the effects of the projects are highly dependent on the quality of human resources in the child protection system.

[24] Source: MA of ROP (Applications for financing the social services for children in the protection system contracted within the deadline of 25.02.2019).

Regarding the recent increase in the number of projects, this is the consequence of the fact that the process of reforming the residential institutions received a legislative impulse (in June 2019), the Government approved the modification and completion of Law no. 272/2004 regarding the protection and promotion of the rights of the child, the main changes aiming to complete the deinstitutionalization of children by the end of 2020. Thus, this adopted normative act prohibits the placement of children in residential services with the characteristics of the classical type centers, starting with January 1, 2021 Also, from 2021 the placement centers will have an operating ban, only the Family Houses and the Emergency Placement Centers will be able to operate. This has stimulated the interest of stakeholders to identify resources for reforming placement centers.

- **Senior People**

The number of social services for the elderly is increasing, but far below the needs. According to the National Strategy for the Promotion of Active Aging and the Protection of Older Persons 2014 - 2020, in each locality there should be an integrated social services center for this target group.

According to the data of the Ministry of Labor and Social Justice, on December 31, 2018, at regional level, the number of social services licensed for the elderly has the following: North-East - 85, South-East - 71, South Muntenia - 50, South-West Oltenia - 35, West - 93, North-West - 183, Center - 189, Bucharest-Ilfov - 42. Most services are offered at urban level although the number of rural localities is much higher, the distribution of services being as follows:

- Residential care and medical-social assistance centers for the elderly, terminally ill patients: urban - 27, rural - 29.
- Residential care and assistance centers for the elderly: urban - 212, rural - 183.
- Day centers for the elderly: urban - 93, rural - 23.
- Home care services for the elderly, people with disabilities, dependents: urban - 190, rural - 69.

This tendency was also relatively maintained in ROP interventions. Of the 33 interventions aimed at the elderly target group, 11 are located in urban and 22 in rural areas.

According to the estimates made on the basis of the projects contracted up to the deadline set for this evaluation, through the ROP interventions contracted under PA 8 for this target group will be offered improved social services for 3,114 elderly (in rural localities) and 2,208 elderly (in urban). , as shown in Table 5.

Table 5 - AP 8 Achievement Indicator on Social Services for the Elderly [25]

Indicators of ROP Achievement	Target	Realised	Degree of achievement
Beneficiaries (elderly) of rehabilitated/modernized/ extended/equipped social infrastructure	62.040 people	5.322 people	9 %

[25] Source: MA of ROP (Applications for the financing of projects concerning social services for the elderly contracted within the deadline of 25.02.2019).

The degree of satisfaction of the beneficiaries cannot be measured because all the investment contracts were concluded at the end of 2018 or in 2019, and the projects are at most at the stage of obtaining the building permits or purchasing the construction services.

c / Results Following the Analysis (Findings)

The process of reforming large residential institutions for adults with disabilities is successful - the target achievement level is 45%. The interventions concerning the provision of daily social services of the deinstitutionalized / integrated people in the family / community remain practically unrealized - the target achievement level being 3%.

The progress in the process of deinstitutionalization of children in the special protection system is insignificant - a single residential institution reformed at the time of assessment. However, based on the ANPDCA estimate, the target values of the indicators will be achieved because of the recently contracted and recently approved projects.

The degree of achievement of the target of ROP interventions in the field of **ensuring the elderly with improved social services** is also low (9%). The share of social services developed at the level of rural localities remains low, although the need is higher than in urban areas.

4.4. Evaluation Question 4: What Types of Interventions/Implementation Mechanisms Have Proven to be Effective and why?

The analysis of the effectiveness of the interventions was done on three dimensions:

- What types of interventions are most effective? Why?
- Difficulties encountered in implementation and causes
- Successes achieved and the causes that determined the successes.

A/ Colltected Data

The answer to this evaluation question was formulated based on qualitative data analysis.

Qualitative Data: collected through interviews and nominal groups aimed at the opinions of different stakeholders regarding the effectiveness of the medical and social services realized through the interventions financed from PA 8, as well as the factors that influenced the effectiveness of these interventions.

B/ Data Analysis

- **Interventions/Mechanisms with the Highest Effectiveness Rate**

One of the results of the evaluation of the previous operational financing mentioned as efficient interventions, the interventions in which integrated or complementary services were carried out, both construction services/rehabilitations/modernizations, as well as equipments and possibly attracting and training additional personnel. In the projects evaluated so far most are only equipments with ambulatory or emergency structures in hospitals, but some of the outpatient facilities or support sections have been rehabilitated/modernized in the ROP 2007-2013. In addition, during this period, the clinical hospitals and the regional institutes also run other projects from non-reimbursable funds, an initiative that increases the added value of each

project individually and of the beneficiary as a whole. For example, the Cluj Napoca Oncological Institute, which has received facilities to increase the screening performance in cervical cancer screening, a mobile screening unit and within a POCU-funded project, updates the methodology and curricula for cervical cancer screening, Train the medical staff and implement the screening procedure for the target group.

The centralization by the Ministry of Health of the coordination activity for the unfinished projects of the MS contributed by aggregating several beneficiaries in a project to increase their number, considering that on the one hand some beneficiaries were no longer eligible if they applied alone or on the other alone, they did not have the capacity to elaborate and implement the respective project, according to the discussions held with the interviewed persons both within the Ministry of Health and the beneficiaries.

More recently, it seems that the involvement of certain territorial administrative units (county councils / local councils) that have considerable local experience in project management on non-reimbursable funds has significantly contributed to the successful implementation of these projects.

From the discussions with the beneficiaries, it emerged that another factor with high efficiency and effectiveness rate was the presence at the level of the beneficiary, but also at the level of the local councils of a team with previous experience in project management and stable for a relatively long period of time. For example, the existence of a very good and stable team within the Regional Development Directorate of the Galați County Counci[26], which is currently running 24 projects financed from the 2014-2020 ROP, has managed to attract funding for three projects under PA 8 for three hospitals in the county[27]. According to the interviews conducted during the field visit, the personnel involved in the preparation and implementation of these projects already have experience from the previous programming period, knows very well the needs in the county and works very well with the beneficiary institutions.

The positive institutional relationship of the management team of the health unit with the owner of the health institution (the local council, the County Council, the Ministry of Health) and with the local health decision-makers (DSP, CNAS[28]) is considered an advantage for ensuring the premises for the success of the project.

The increased addressability of the health unit and the provision of specialized services for the healthcare units located in a large city or the increased addressability and availability of usual paraclinical services for the healthcare units that are in small cities, located at important distances from the main city in the county ensure a greater potential and high efficiency of projects.

Predictability of the procurement budget and the existence of fully documented acquisition plans, solidly based on the health needs of the population served at the level of the beneficiary,

[26] The team is made up of four people: one director and three specialized references.
[27] Emergency County Clinical Hospital „Sf. Apostol Andrei ”Galati, Galati Pneumophysiology Hospital and Târgu Bujor City Hospital.
[28] CNAS decides after negotiating with the providers of medical services (the beneficiaries of the projects) the amounts that they allocate annually for the services provided to the insured, and a positive institutional relationship can be an advantage in the negotiation.

the medical services reimbursed by the CAS and the introduction of transparent and objective prioritization criteria of the requested investments increase the efficiency and sustainability of the projects through decrease the percentage of ineligible expenditures and ensure a constant source of financing upon implementation[29].

From the discussions with the persons interviewed in the territory it was found that the availability and retention of the medical and technical human resources required at the beneficiary level to properly use the purchased equipment is an essential factor for the effectiveness and impact of the projects given the lack of specialized personnel in niche areas (for example medical physicists), the learning curve for the use of complex equipment and the fluctuation of high medical personnel (for example ATI, medical imaging, etc.), especially through their migration to regional centers or abroad.

- **Difficulties encountered in the Implementation and Their Causes**

The most difficulties were encountered either in the conduct of the procurement procedures, or in the institutional communication with some ADRs, mainly due to the lack of a common "specialized language" or the lack of specialized personnel in the management of this type of projects at the level of the beneficiary, aspects arising from the interviews with the beneficiaries who stated that the administrative and medical personnel in the health units generally do not have practical experience in the management of these projects.

The short time for preparing these projects, as well as the lack of prior training of the personnel from the level of the beneficiary, are difficulties that were perceived by the beneficiaries of projects.

In addition, the administrative burden in the job description, to which was added the management of these projects, doubled by a salary considered insufficient for the volume and complexity of the work submitted were factors that contributed to the demotivation of the administrative staff. In the long term, the mentioned human resources category seems to have a tendency to avoid participating in these types of projects, an aspect highlighted in the interviews with the beneficiaries, which states that the factors presented above act as an additional reason for stress and "burn-out" at work.

For social projects, having as target groups persons with disabilities and children in the special protection system, it is found that although there are many eligible centers, the number of applicants is very small. For projects to deinstitutionalize people with disabilities, two calls were announced at national level, and at the time of evaluation only 6 projects were implemented. According to the data presented in the case studies (Annexes 5.1, 5.3, 5.6 and 5.8) but also of the interviews conducted at central level, the lack of projects is motivated by the following causes: 1/lack of spaces/locations belonging to the public administration, 2/reduced capacity of to ensure the sustainability of the projects from a financial point of view by the DGASPC, as well as by the local public administrations (especially those from the rural areas), the non-eligibility of the NGOs to apply as the main beneficiary. The same situation holds true for projects to deinstitutionalize children in the special protection system.

[29] The visits to the territory highlighted that certain health care units tend to make "shopping lists", and not strategic purchases, especially for the purchase of medical equipment, in the absence of predictable procurement budgets and properly documented procurement plans. effectiveness of projects.

Regarding the need for the creation of residential centers and social services for the elderly, although this is higher in rural areas, the number of applicants is very small. At regional level there is potential for a large portfolio of projects. The development of social services is one of the priorities formulated also in the Regional Development Plans. The main responsibility for providing social services lies with the county councils (through the General Directorates of Social Assistance and Child Protection) and the local public administrations. However, it has a rather high intention to carry out such projects.

- **Successes Achieved and the Causes that Determined the Successes**

The centralized approach for equipping projects with MS equipment (not finalized) was considered a successful initiative considering the time constraints, the diversity of the beneficiaries and the large number of projects.

The continuous collaboration of the beneficiaries with the local council / county council at all stages of the project, considering the limited expertise of the technical team at the beneficiary level, was considered a success factor.

The stable managerial teams from the level of the beneficiary, who already had a common working practice, are necessary factors in the successful implementation of these projects.

C / Results following the Analysis (Findings)

Effective interventions are those in which the activities were carried out in an integrated or complementary way, comprising both construction/rehabilitation/modernization services, as well as equipments and possibly attracting and training additional personnel.

The positive institutional relation of the management team of the health unit with the owner of the health institution (local council, county council, Ministry of Health) and with local health decision makers (DSP, CNAS) is considered an advantage for the successful implementation of the projects.

The availability and retention of the medical and technical human resources needed to properly use the purchased equipment influence the effectiveness of the projects.

The problems related to the procurement procedures, the lack of specialized personnel at the beneficiary level and the overloading of the personnel, but also the difficult communication with some ADRs due to the lack of a common approach were considered **the main difficulties encountered in the implementation**.

The centralized approach at the MS level, the continuous collaboration with the local councils / the county councils and the existence of a stable managerial relationship at the beneficiary level were considered success factors for the implementation of these projects.

Although there are many eligible residential centers, and the number of localities, especially rural ones, where there are no social centers or integrated community service centers is high, the number of applicants is very small.

The most effective mechanism for ensuring the implementation of the interventions (project initiation by the DGASPC) was **the impetus to reform the system through legislative changes**. These refer to limiting the number of beneficiaries of a residential institution to 50 persons and to prohibiting the institutionalization of children in traditional placement centers.

The lack of legislative and methodological regulations for the creation of integrated medical-social services centers at the rural community level has determined the reluctance to propose social projects for people with disabilities and for the elderly, because at local level, especially at the level of UATs, the concept of integrated medical-social services is not well understood, there is confusion as to the role of different types of services.

4.5. Evaluation question 5: How are the effects of AP8 differentiated from the territorial perspective - were the resources used in cases/areas where social needs and demand for social services had the highest values? (in line with the conclusions of the 2007-2013 ROP impact assessments)

The analysis of the way in which the resources from the territorial perspective were used was carried out on two levels:

- Territorial distribution of projects / resources
- Territorial distribution of social needs and requests for social services.

A / Collected Data

Răspunsul la această întrebare de evaluare a fost formulat pe baza analizei de date atât cantitative, cât calitative.

Quantitative Data: Secondary quantitative data were collected on the two indicators with the source of the Minister of Labor and Social Justice.

Qualitative Data: collected through interviews and nominal groups targeted the opinions of different stakeholders on the factors that influence the distribution of projects.

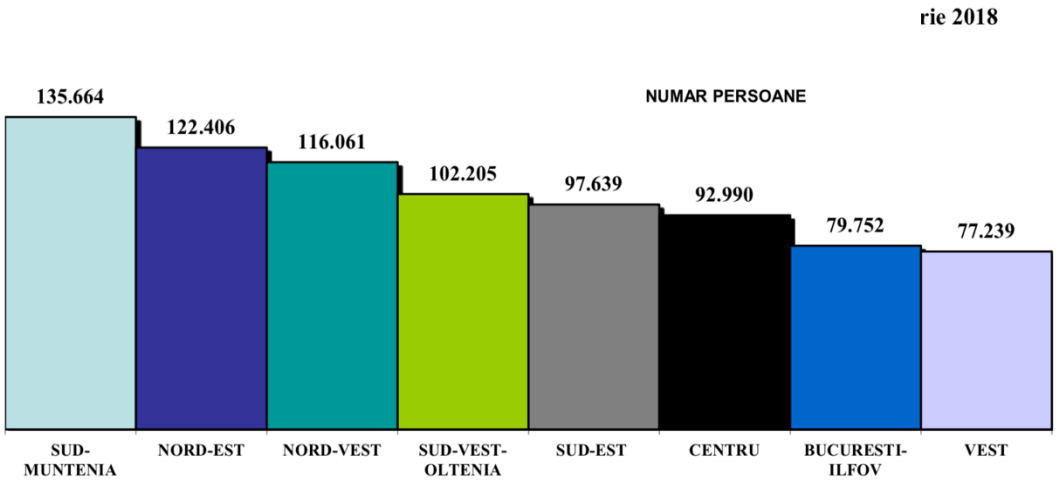
B / Data Analysis

According to the geographical distribution, most projects in the social field are in the Northeast region (13), followed by the West (6), Center (4), South Muntenia (3), South-West (3), North-West regions (2) and South-East (2). This distribution of projects corresponds to the geospatial analysis of rural marginalization: the proportion of the population living in marginalized rural areas is almost twice as high in the Northeast as compared to the national rural average (11.3% compared to 6.2%). In the Center region, there is a higher marginalization rate than the national average marginalization rate (8%). At the other extreme, the West regions with 1.2% and Bucharest-Ilfov respectively with 0.6% have very low marginalization rates[30].

The DGASPC benefited from the ROP investments to restructure the remaining large residential institutions, at the deadline set for this evaluation, existing in Bacău county 4 projects, in Vaslui county 2 projects, respectively in Argeș county 2 projects. The projects are therefore from the NE (6) and MS (2) regions. This distribution of projects corresponds to some extent to regional needs, meaning that the largest number of people with disabilities are in the two regions (MS and NE), but the hierarchy is reversed (Figure 8).

[30] Atlas of Marginalized Rural Areas and Local Human Development in Romania. World Bank. http://www.mmuncii.ro/j33/images/Documente/Minister/F6_Atlas_Rural_RO_23Mar2016.pdf

Figure 8 - Distribution of the Number of Persons with Disabilities by Regions as of 31.12.2018[31]



In the previous programming period, larger communities (especially urban ones) benefited from projects in this area. However, the average age in rural communities is higher, and, in fact, the need for social services for the elderly is higher in rural areas. Home care teams (day centers) should exist in every rural community and the National Strategy recognizes this for Promoting Active Aging and Protection of Older Persons. The teams of social workers at rural level should have the responsibility to identify the needs, to carry out the initial evaluation of the beneficiaries and to provide social services in each community. However, there have been very few requests to set up day centers for the elderly at the level of rural localities.

c / Results Following the Analysis (Findings)

The geographic distribution of current interventions corresponds to the geospatial analysis of marginalization. However, there were very few requests to set up day centers or integrated community centers at the level of rural localities. According to the data presented in the case studies (Annexes 5.1, 5.3, 5.6 and 5.8) UAT at rural level did not show initiative for several reasons: they do not know the social field well, they do not have specialists in the field of social services at rural level, the administrative capacity to implement the projects is low and, most importantly, they do not have sufficient financial resources to ensure the sustainability of the newly created social services.

4.6. Evaluation question 6: How Can the Logic of Intervention be Improved within this PA or for Similar Future Interventions?

The analysis of this evaluation question was based on the following five indicators:

- To what extent the logic of the intervention is confirmed by the practice

[31] Source: National Authority for People with Disabilities

- Difficulties encountered in implementation and causes
- Solutions to improve the intervention logic
- To what extent have the changes / conditions affected the implementation of the projects, the expectations? (political, economic, financial, migration, legislation, other changes)
- What external conditions / causes contributed to the desired effects or did they stop? What exactly?

A/ Collected Data

The answer to this evaluation question was formulated based on qualitative data analysis.

Qualitative data: collected through interviews and nominal groups aimed at the opinions of the various stakeholders on how the logic of the intervention for PA 8 is confirmed in practice, as well as the ways to improve it in the future.

B/ Data Analysis

- **The logic of Intervention in Practice**

The programmatic documents for the period 2014-2020 define the field of health as a priority area of development, considering 1 / unsatisfactory indicators of health status (life expectancy at birth, deaths due to preventable diseases and hope of healthy life), 2 / precarious state of health. health infrastructure (outpatient health units or hospitals with improper medical equipment) and 3 / low number and disproportionate distribution of medical staff.

The network of health infrastructure proposed for financing in the period 2014-2020 initially took into account especially the rural, isolated communities, the localities mainly affected by urban segregation and the marginalized communities and in particular the population's access to these basic health services, together with the increase of the diagnostic and treatment capacity of the specialized outpatient primary care structures and the emergency medical structures according to the vision of the National Health Strategy 2014-2020 to reverse the pyramid of the provision of health services.

However, to date, the projects financed by PA 8 have considered the construction/ rehabilitation/extension/modernization/endowment of specialized outpatient units and emergency units and the provision of support sections, as well as the social services infrastructure, but not of multifunctional centers, permanence centers or integrated medical-social centers, the main reason being the delayed appearance of the specific legislation for the field of community health care.

The integrated medical-social community centers distinctively mentioned in the National Health Strategy 2014 - 2020 have not been funded so far from the ROP 2014-2020. Several possible causes have led to this and delayed the financing of these imposed community structures as conditionalities for financing specialized health structures (eg regional hospitals). Of these, we mention the different understanding by the various government teams from the ministries involved (MS and MMJS) about the term of "medico-social integrated community centers" and their role in the architecture of the health and social security system. In addition, another

impediment was the delay in adopting the technical norms regarding these recently integrated centers[32].

- **Encountered Difficulties in Implementation and Their Causes**

The problem of identifying building spaces is a big problem for the DGASPC. For example, for the first call for projects to deinstitutionalize the infrastructure for children, Iași county had 8 centers on the closure list, for which 25 land on which to build family-type houses had to be identified. In the case of the Bogdănești center, the local public administration was opened and offered the land. The municipality of Iași did not offer any land, although the residential institutions are located in the municipality. However, three lands were offered by the Iasi County Council. For this reason, no projects were submitted at the first financing call. In the meantime, it was possible to obtain the agreement from some mayors from the suburb of Iași to provide land, and the DGASPC Iași planned to submit some projects for the appeal, which ended on July 1, 2019.

Most beneficiaries in rural areas face various problems in terms of procurement (eg, the procurement of technical projects is refused due to incomplete documentation or disputes arising after signing contracts), but also in the project management process.

The first versions of the guide were very strict, which conditioned the disqualification of several applications for financing for insignificant criteria (eg, the budget formulated with 2 decimal places). The requirements regarding the documents proving the ownership of the property disqualified several applications at the initial stage, and later, after the guides were adjusted, anyway they contributed to blocking the process because the beneficiaries have long waited for the Government Decisions that certify the right for the property ownership. Subsequently, the reduction of requirements in this regard also led to an increase in the number of applications.

The modification of the legislation regarding the minimum wage in construction increased the own financial contribution of the beneficiaries, for example the contribution of DGASPC Bacău increased by 25%, which is a very big financial effort. The search for the possibilities of co-financing the projects also conditioned the delay of the acquisitions in projects. The Bacău County Council will cover these differences, but being a beneficiary in four projects, the 25% difference will be quite a burden. A large number of beneficiaries reported this problem.

The existence of new services in the community requires financial resources for promotion / awareness activities/dezvoltare a toleranței în comunitatea în care sunt realizate intervențiile.

- **Solutions to Improve the Intervention Logic**

In order for the intervention logic to be improved, it is imperative to clarify the status and institutional role of the integrated medical-social community centers in the functional architecture of the health system. It is also necessary to clarify the status of the decentralization process in the field of health as these directly affect the organization and financing of community health care. This is one of the factors that still determines a marked variability in the supply of such services at national level. The notion of "integration" of the

[32] Decision no. 324/2019 for the approval of the Methodological Norms regarding the organization, functioning and financing of the community health care activity (published in the Official Gazette on June 7, 2019)

medical and social services at the community level, as well as the way of providing the respective services in the territory, requires clarification at the level of the line ministries.

The line ministries (MS and MMJS) need to strengthen the role of developing sectoral policies regarding equitable access to health services of the whole population and monitoring their implementation and to create mechanisms through which they can intervene when there are indications that where and how services are provided maintains or increases access inequalities for disadvantaged groups.

- **Effects of Changes on Project Implementation**

The frequent political changes of the government teams from the line ministries, together with the almost as frequent change of the technical decision-makers and the personnel involved in the monitoring of these projects had a negative impact on the way the financing was carried out on the AP 8. Certain conditionalities were not fully resolved or, when resolved, no longer had the expected effect such as: National Health Strategy Monitoring Plan, regional health services plans, regional hospitals development, legislation regarding integrated community centers).

c / Results Following the Analysis (Findings)

According to the initial National Health Strategy 2014-2020, the proposed health infrastructure network for funding in 2014-2020 took into account **especially rural, isolated communities, localities mainly affected by urban segregation and marginalized communities**. In addition, priority was given to increasing the access of the population from these localities to basic health services and increasing the diagnostic and treatment capacity of the primary care structures, the specialized outpatients, and the emergency medical structures.

The integrated medical-social community centers distinctively mentioned in the National Health Strategy 2014 - 2020, one of the important links on which the logic of the intervention of this operational program was built, **have not been funded so far** from the ROP 2014-2020. Clarifying the status and institutional role of the integrated medical-social community centers in the functional architecture of the health system and the decentralization process in health is imperative in order to improve the logic of the intervention of this program.

Line ministries should play a more important role in monitoring the provision of services that maintain or increase access inequalities for disadvantaged groups. In this sense, it is necessary to develop a functional feedback mechanism with MA ROP, ADRs and local decision makers, in order to prioritize the projects aimed at **reducing inequalities of access for vulnerable groups**.

The availability of specialists in the field of public procurement and project management at the level of the UATs in the rural area remains low, which determines delays in the procurement of services or even the resistance of the UATs to elaborate financing applications in the social field.

According to the data presented in the case studies (Annexes 5.1, 5.3, 5.6 and 5.8), the best integration of the users of services in the community implies that the investments made/the project indicators include **the provision of common social services with other members of the target community**, including references to volunteer participation.

4.7. Evaluation Question 7: What is the Level of Sustainability of the Social and Medical Services and the Social Dimension of the Actions Promoted by the ROP?

The analysis of the sustainability of the social and medical services was carried out according to the following two indicators:

- Financial resources budgeted for the maintenance and further development of the social and medical services created for each category of intervention (including maintaining and equipping)
- The flow of beneficiaries of the infrastructures (users).

A / Collected Data

The answer to this evaluation question was formulated based on qualitative data analysis.

Qualitative data: collected through interviews and nominal groups aimed at the opinions of the various stakeholders regarding the sustainability of the medical and social services realized through the interventions financed from PA 8.

B / Data Analysis

- **Sustainability of Medical Services**

The vast majority of the equipment used is included in the patients' clinical circuits; CNAS or MS pay the services provided to them. For the new services, which are provided with the purchased equipment that are already in operation, there is the possibility of contracting their corresponding services from CNAS on an annual basis, provided the respective services are in the basic package of medical services. The equipment that allows the shortening of the hospitalization time at the same rate offered by CNAS allows the hospital to carry out additional hospitalizations paid by the Health Insurance House.

The management team has the duty to plan as optimally as possible the activity within the integrated ambulatory, the additional contracting of the new services offered and the attraction of the additional medical personnel who could offer more services on the purchased equipment.

Given that a year ago the salaries of the medical staff have increased significantly and that their number is increasing, it is expected that the sanitary units equipped with modern equipment will be attractive to the medical staff and will contribute to their retention and thus to the sustainability of the project. .

The positioning of the healthcare units closer to the patients' home will stimulate the increase of the number of outpatient visits and implicitly the decongestion of the county and regional hospitals, under the conditions where the medical act can be finalized at the level of the small and medium health units, thereby increasing the sustainability of the medical services provided by PA 8.

From the interviews applied in the field, but also from the available public information regarding the activity of the Professional Association of Ambulatory Doctors, there are

indications that steps are being taken so that CNAS can allocate more adequate financing to the specialized ambulatory, to allow the provision of consultations and investigations during the same visits and to update the rates of outpatient medical services.

- **Sustainability of Social Services**

Each new service created for people with disabilities leads to increased spending and implicitly requires an increase in the budget of DGASPCs who are concerned that in the coming years more resources should be planned to ensure the quality of services in all newly created centers. According to the data presented in the case studies (Annexes 5.1, 5.3, 5.6 and 5.8), these institutions take all the necessary steps to ensure continuity of services.

An important factor in ensuring the sustainability of projects is the existence of qualified human resources working in the newly created service infrastructure. Many of the contracted projects mention in this respect the complementarity of the ROP - POCU, which, however, cannot be ensured as planned at the time the funding applications were submitted to the RAP 8 AP. It is possible that this lack of coordination will generate syncope in providing qualified personnel with the services to be provided in the newly created infrastructure.

In the case of services for the elderly, sustainability is ensured by UATs. Ensuring the sustainability of the services developed in the urban environment does not seem to be a problem because an urban public administration has the necessary resources (financial and human). As far as rural UATs are concerned, where these services are most needed, sustainability seems to be a major impediment, manifested in several aspects:

- Lack of social workers with specialized higher education in rural localities, higher education being necessary, primarily, for the accreditation and licensing of services.
- The need to license each social service separately creates obstacles for the diversification of services at rural community level.
- Limited financial resources create difficulties for hiring social workers or contracting social services from licensed providers.

The concern of the local public administrations (rural level) to ensure the sustainability of the social services created is major. In the absence of an instrument of direct financing from the state budget of social services at community level, the capacity of these UATs appears to be quite low.

c / Results Following the Analysis (Findings)

The Health Insurance House and the Ministry of Health are the main financers of the health services provided in the rehabilitated health units and equipped with PA 8 services, which are currently under-financed and have up-to-date rates. The role of UATs is also important in ensuring the sustainability of the rehabilitated and equipped sanitary units through PA 8.

The role of the management team and of the local decision maker is essential in the optimal planning of the activity of the integrated ambulatories, the hiring of the necessary personnel for the new equipment and the additional contracting of the services that can be offered.

The complementarity of the ROP - POCU cannot be ensured as planned when the projects were submitted on PA 8, which seems to have a negative effect in terms of providing qualified personnel with the services that will be provided in the new social infrastructure. .

5. Conclusions, Recommendations and Lessons Learned

In relation to the objectives of AP 8, taking into account the findings resulting from the analysis and starting from the answers to the evaluation questions, the following conclusions and recommendations can be drawn:

Evaluation Question 1: To what extent has PA 8 contributed to increasing the accessibility, quality, and efficiency of public health services, including emergency and secondary education, especially in poor/isolated areas?

The implementation of the projects financed on PA 8 has a positive effect by reducing the unmet need for medical services for the lower quintile from the initial value of 13.3%, to the value of 8% in 2015 and, more recently to the value of 3.4% in 2018 according to Eurostat[33]. This recent value already exceeds the proposed target for 2023 (9.3%), and through the projects implemented in each county in Romania, practically the population served by improved medical services far exceeds the proposed target value for 2023 (500,000 people). However, this evolution must be considered as the result of several determinants, such as the projects finalized in the ROP 2007-2013, legislative changes in the field of health, fiscal changes etc.

A total of 49 integrated outpatients from the structure of the municipal hospitals and 35 from the structure of the city hospitals were provided with equipment within this financing, concomitant with the consistent increase of the salaries of the medical staff, which assumes that the patients receive services closer to home and faster.

Reducing the response / response time requires improvements when two thirds of the ambulance park is physically deployed, the available staff is insufficient, and the road infrastructure has not significantly improved.

In the absence of a relevant indicator available, it can be considered that new or multiple equipment increase the quality and reliability of the services offered, decrease the waiting time and in certain situations they are positioned in a health unit closer to the patient's home, factors that should increase the satisfaction of the services received by the beneficiaries.

The quality and efficiency of the health services offered in the public health system cannot currently be objectively quantified in the absence of indicators set by the regulatory authorities.

> R1. It is recommended to promote the priority financing of projects, which aim to reduce the marked inequality gradient between people with high socioeconomic status and disadvantaged people by developing in the next period-integrated community centers and community health care for the vulnerable population.
>
> R2. It is recommended to remodel and transform some of the small and medium healthcare units into specialized outpatient / comprehensive diagnostic and treatment

[33] http://ec.europa.eu/eurostat/data/database

centers including with the capacity for day hospitalization in order to reduce the difference between equipping the different regions and the model where the ambulatory services are concentrated in certain cities keep the same endowment model to the detriment of smaller centers.

R.3 Considering that a large part of the indicators of immediate achievement and especially those of the result have not been completed, it is recommended to involve the MS in defining the monitoring framework of the intervention, aligning the indicators with those commonly used by the medical units, limiting their number to those considered absolutely necessary and relevant.

Evaluation Question 2: To what extent did PA 8 contribute to improving the cost efficiency and quality of emergency care in hospitals, with a view to reducing the number of hospitalizations in acute illnesses in hospitals or the number of beds for acute hospitalizations, by establishing an integrated functional targeting of patients?

A number of 30 Emergency Receipt Units / Emergency Receipt Units (target value 35) at national level are contracted so far for works under UATs financing contracts, and 138 hospitals with UPU /CPU/support units are contracted up to currently for equipping with equipment in financing contracts of the Ministry of Health (unfinished).

Even if the rate of continuous hospital admissions has decreased steadily during the period analyzed, approximately 30% of the hospital admissions are for conditions that could have been treated in the outpatient (family doctor or specialized outpatient) if these services were available and effective.

The increased availability of efficient outpatient services is essential for relieving UPU and hospitals of cases that do not require care at that level, which would increase the efficiency of the health system by directing UPU funds and hospitals to cases requiring emergency or hospital care.

R4. It is recommended to reconfigure the outpatient services (consultations and investigations offered during the same visit), and update their tariffs taking into account the effectiveness and sustainability of these services in increasing access to health services especially for the vulnerable population.

Evaluation Question 3: To what extent has AP8 contributed to increasing the coverage of social services, including for the various vulnerable groups targeted?

The target of achieving the number of beneficiaries (persons with disabilities) of deinstitutionalization infrastructure built / rehabilitated / modernized / extended / equipped was achieved in a proportion of 45%, but the progress of the indicator regarding the provision of social services, as close to the place of living is minor. (3%).

The progress regarding the deinstitutionalization process of children in the special protection system is premature to be analyzed, given that at the evaluation deadline there was only one contracted project. Thus, at national level, the targets were practically unfulfilled: 0.03% beneficiaries of social infrastructure for rehabilitated day and 6.4% of children who will benefit from new protected housing. However, more recently, 7 projects have been contracted and another 15 are in preparation, which ensures the premises for meeting the proposed targets.

The creation of social services for the elderly is far behind the target having a level of achievement of 9%. However, even from this target, through the ROP interventions contracted in 2018-2019 will be offered improved social services for 2208 elderly people in urban areas and only 3114 elderly people in rural areas. Moreover, from the projects implemented at the rural level only a few projects will provide medical and social services in integrated centers, which had to be a priority for these interventions.

R5. It is necessary to develop partnerships at the county level and to define the project portfolio. At the county level, the DGASPC together with the UATs and the social service providers should carry out an analysis of the needs of the beneficiaries at the county level, identify the financing priorities, and elaborate the concepts of projects. In the planning process, the DGASPC must carry out the analysis of the real needs of the target beneficiaries (persons with disabilities, the elderly, and children) up to the level of each rural community and make an inventory of all the day centers that can be rehabilitated or the constructions where day centers can be created. Based on this study, the real need to create different types of social services for each target group should be estimated and a list of institutions, centers to be rehabilitated, and a list of communities in which new centers should be created should be developed.

R6. Another way in which DGASPCs could reduce the pressure on rural LPAs is to contest solutions in which UATs are invited to participate. In addition, the selected project concepts serve as a basis for the development of a larger project by the DGASPC in which to be a project leader.

Evaluation Question 4: What types of intervention /implementation mechanisms have proven to be effective and why?

The interventions that prove to be effective are those in which the activities were designed and implemented in an integrated way, including construction services/rehabilitations/upgrades, equipment endowments, as well as attracting and training additional staff, and the resources come from complementary projects funded and from other operational programs.

R7. MA ROR together with the Ministry of Health should promote the existence of strategic planning at the level of health institutions in accordance with county/regional/national development strategies and with sectoral strategies and feasibility studies/opportunity studies / impact studies updated and available at the level of the healthcare institution for major investments to increase the effectiveness of the intervention.

R8. In the field of health for improving the quality of projects, it is recommended to develop clear and sustained coordination mechanisms and tools at national level to ensure the standardization of the instruments that can evaluate the necessary infrastructure, equipment, human resources, prioritization of investments, variability of equipment purchase costs and similar works.

In the social field, if the call for projects is competitive, the communities that have experience in the process of project development and administration benefit the most, and the disadvantaged communities remain disadvantaged.

R9. Current legislation provides that integrated community centers can only be set up as public entities in the subordination or structure of the local public administration authority. Therefore, the equitable development of these services should include providing ROP support to local public authorities, especially those from disadvantaged communities, with opportunities, resources, and tools through a call for projects dedicated to this theme. The call should not be competitive because the quality of the application development or the innovative aspect of the project is not important, but the need for concrete social services

Evaluation question 5: How are the effects of AP8 differentiated from the territorial perspective - were the resources used in cases / areas where social needs and demand for social services had the highest values?

From a territorial perspective, the resources were mainly distributed to the development regions in which the social needs and the demand for social services registered the highest values. However, at the level of the distribution of resources within the development region, most investments are made at urban level, although the need for social services is, primarily, at the rural level.

R10. Launch a call for projects from ROP that give priority to the creation of integrated community service centers and day centers in rural communities, but also to provide technical support for building partnerships at county level and defining the project portfolio for better coverage with services of these communities. In addition, it is recommended to correlate with the interventions from PNDR.

Assessment Question 6: How can the logic of intervention be improved within this PA or for similar future interventions?

The integrated medical-social community centers distinctly mentioned in the National Health Strategy 2014 - 2020 and one of the important links on which the logic of the intervention of this operational program was built, have not been funded so far from the ROP 2014-2020.

R11. It is recommended to clarify the status and institutional role of the community centers integrated in the functional architecture of the health system and of the decentralization process in health is imperative in order to improve the logic of the intervention of this program.

R12. It is recommended to increase the role of the line ministries (MS and MMJS) in monitoring the provision of services that maintain or increase the inequalities of access for the disadvantaged groups and the possibility of intervention when this happens.

Reintegration of persons with disabilities requires financial resources for awareness / development of tolerance in the community and the provision of social services for all members of the community in order to achieve the best integration of the target beneficiaries.

R13. In order to increase the effectiveness of the projects that are addressed to people with disabilities, it is necessary to involve as many stakeholders as possible in the respective community. This involves planning more complex consultation processes, with

Evaluation question 7: What is the level of sustainability of social services and the social dimension of the actions promoted by the ROP?

The role of public funders is essential in the sustainability of rehabilitated and endowed health units through the ROP. The National House of Health Insurance and the Ministry of Health are the main financers of the health services provided in the rehabilitated health units and equipped through the ROP.

R14. It is recommended to strengthen the role of the management team and the local decision-maker in the optimal planning of the activity of the integrated outpatients, the hiring of the necessary personnel for the new equipment and the additional contracting of the services that can be offered.

R15. MA ROR should support the MS which, together with local decision makers, will promote the remodeling and transformation of some of the small and medium healthcare units into specialized outpatient/comprehensive diagnostic and treatment centers including with the capacity for day hospitalization in line with the objectives of the National Strategy of Health and of the financing sources identified for its implementation identified for its implementation (for example ROP 2014-2020).

In the case of the projects managed by the DGASPC, sustainability is ensured from their budget. For this reason, the DGASPC cannot allow several projects to be carried out in parallel, as each project will subsequently request additional expenses to ensure sustainability.

The concern of local public administrations in rural areas to ensure the sustainability of the social services created is high. In the absence of an instrument of direct financing from the state budget of social services at community level, the interest from the local public administrations of rural level tends to remain low.

R16. It is necessary to consult MA of ROP, MA of POCU and MA of PNDR in order to identify a support tool for UAT beneficiaries from rural communities regarding:

- The structure and services provided by a community center of integrated services, various types of social services that can be provided in a day center depending on the target groups of beneficiaries in the locality (elderly, persons with disabilities, children in need of social protection)

- Accreditation and licensing of social services / community center for integrated services;

- Financing models for social services/integrated community service centers;

- Models of collaboration with DGASPC and county social service providers;

- Ways to ensure the complementarity of POR-POCU;

- Models for organizing volunteering activities.

Lessons Learned

The realization of an efficient collaboration in the investigation of the needs at county level, the design of the project and in the realization of the infrastructure has remained deficient and in the current period of programming.

It is necessary to provide technical support for project development and partnership projects (DGASPC, UAT, licensed social service providers) for the implementation of interventions at rural level.

The main challenge for social services infrastructures is to ensure the sustainability of the results obtained. This has motivated many beneficiaries, especially from the rural areas, to access the funds.

It is recommended to train / consult rural UATs in applying different models of social services design and sustainability assurance. It would be preferable for these activities to be carried out with the Association of County Councils and with the Association of Municipalities of Romania, so that there is a way to disseminate information as best as possible.

Poor monitoring of some projects, especially those centralized in the health field, is maintained in the current programming period, even though the vast majority of indicators are relatively easy to collect and quantify.

It is necessary that any public institution that assume the role of leader for projects in which there are numerous partners should allocate sufficient resources for designing and monitoring the projects to ensure the evaluability of the projects.

6. Annexes

Annex 1. Evaluation Matrix

Annex 2. Bibliography of the Specialized Literature

Annex 3. Interview Guides

Annex 4. Nominal Group Reports

Annex 5. Case Studies

Annex 6. Expert Panel Reports

Annex 7. List of Interviews

Annex 8. List of Participants in the Nominal Groups and Expert Panels

Annex 9. Strategic Directions for Health Infrastructure Planning in Relation to Regional Priorities

Annex 10. List of Comments and Address