

**VULNERABILITY OF HEALTH SYSTEMS:
LEGAL VERSUS ETHICAL PERSPECTIVE.
COMPARATIVE APPROACH HUNGARY AND ROMANIA**

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“The idea of the protection of vulnerability can ... create a bridge between moral strangers in a pluralistic society, and respect for vulnerability should be essential to policy making...” (The Barcelona Declaration]

Abstract:

The concept of vulnerability is inscribed in the universal specificity of human condition. On the one hand, it expresses human limits and frailty; on the other hand, it represents moral and ethical action principles. Vulnerable persons are those whose autonomy, dignity and integrity are being threatened (Barcelona Declaration, 1998).

We propose a comparative analysis of vulnerability in the access to health services in the framework of the health systems reforms from Romania and Hungary, as of 2012. From a methodological point of view, the legal framework is critically analysed (situate ourselves in the paradigm of critical analysis). We use content analysis of the main law texts from the two national contexts. The association between health and politics happens when the health associated risks are shared in the name of solidarity. Thus, the state presents itself as managing health and, indirectly, individual health. Health policies become a necessity. Or, in this management process, through politicizing the health system, medical practice becomes directed from outside in a bureaucratic way, for the worse of the true beneficiaries of health policies and makes the population become vulnerable.

Keywords: vulnerability, legal framework, principles, health insurance, vulnerable people

1. Introduction

Since 1990, the reforms that began in the countries of Central and Eastern Europe have redefined the fundamental role of the state in all sectors (economic, social, and political). This redefinition involved, at least in terms of intent, an orientation and a more efficient allocation of resources through market mechanisms, greater institutional freedom following gradual decentralization of responsibilities and organization. The transition to market economy was accompanied by a series of oscillations in choosing the options in terms of economic and social policy. Their coherence and consistency also influenced the stability, performance and extent of the healthcare reforms.

The literature considers that the economic liberalization, the citizens' possibility to choose their physician and the health insurance agency and the rejection of the communist model are the main issues that have activated and marked the developments in the health systems in the countries of Central and Eastern Europe after 1990 (Roemer, 1993; Barr 1994; Precker and Feachem 1995; Zarcovic, Enăchescu, 1998; Dobrossy, Molnar, 2004).

Most governments have introduced *a new legal framework for the recognition and regulation of the private medical sector* (property and provision of private services), activities of the health professionals' union, *decentralization of the decision making process*, and last but not least *regulation of the health insurance system*.

As related to the reform of the healthcare system, both Romania and Hungary, chose the shift from the centralized Semascko model to the Bismarck model, although inland specialists in both countries pleaded rather for the Beveridge model (Ferge 1991; Enăchescu and Vlădescu 1997). In the case of health care and providing health care, as well as in other sectors, we needed incentives so that the individuals become more aware of their own health, development of competitive markets to improve the efficiency of the services provided and management decentralization, meaning the increase of the responsibilities of the suppliers depending on the local needs of the users.

The change of the financing method of the health care systems in the two countries was achieved in order to overcome the common challenges of the health care systems in the two countries: lack of financial resources, poor infrastructure, low salaries for medical staff, general dissatisfaction with the system, poor health of the population, inefficient organization (Ferge 1991; Zarkovic and Enăchescu 1998; Popescu 2004). The changes

raised high expectations among the population, both in Hungary and in Romania, but the developments in the two contexts show that sometimes legislative changes rather made vulnerable certain categories of population, especially affecting their access to health care and freedom of choice by restricting options.

Vulnerability draws attention to political, social, legal and cultural contexts that spawn exclusions and deprivation, and communal and inter-personal spaces that encourage subordination, neglect and discrimination (Allotery and al. 2012).

The roots of most health inequalities and of the bulk of human suffering are social: the social determinants of health (WHO 2012). If in the sociological literature, social vulnerability is often associated with marginalization and social exclusion (Cojocaru 2005), as related to health, vulnerability refers to the risk factors involved in the etiology of various diseases - biological, genetic, and also social and economic ones, facilitating, or on the contrary, jeopardize the access to health care services (Eckenfels 2002:179-183; Shi and Stevens 2005:148-154). Vulnerability may be also seen from a gradual perspective. Tacitly, any hierarchy in the access to health is vulnerable (Eckenfels 2002). To that effect, we may speak of "vulnerability factors". The studies undertaken for this purpose operationalized the concept of vulnerability using as profile the combination of predisposing risk factors (e.g. ethnicity), access permissive factors (income, health insurance, regular source of medical care), which were associated with the access to health care (Shi, Stevens, 2005). The concept of vulnerability is part of the universal human condition specificity. On one hand, it expresses the human limits and fragility, on the other hand it is a moral and ethical action principle (P. Kemp and J. D. Rendtorff 1998).

In this analytical approach, we refer to vulnerability as a moral and ethical principle of action in the field of health policy. Thus, vulnerability works integratively, along with the other basic principles of bioethics and European legislation in order to promote solidarity, non-discrimination and social justice in health care systems.

Accessibility to health care is considered optimal if everyone is assured access to health care services, if there is great freedom of choice among various providers of health care services and even various payers that should be good enough for the options and possibilities of population, if there is continuous information related to all providers of medical care and these groups participate adequately in the organization of the health care

system. Equity in accessing health care services is an essential argument to explain equity in health as appropriate redistribution mechanism, focused on the need of health.

Equity and its challenges for health policy, inherent for a coherent social security system which should guarantee individual and collective well-being include: health equality, equality in access to health care, equality of free choice of the physician, equality related to the patients' rights, equality in funding (WHO 2008; European Commission 2010; Pascal 2003).

Equal access implies services available for everyone and a correct distribution at a territorial level, based on health care needs, and also removing barriers to access. Moreover, universal access to health care (WHO 2008; WHO 2010; Raphael 2008); Barcelona Declaration states among other things that each state should have a national health care system based on the principle of social insurance. Moreover, such system reviews the role of the individual in the medical care system. The individual is present in triple roles: service user, insured person, citizen (Satman and Figueras 1997; den Exter and van des Kraan 2004). In fact, this reconsideration of the role of the individual makes the policy-makers and health care providers more responsible to better inform the public, but, at the same time, it also makes the individual more responsible as related to affiliation at the system, rational use, responsibility related to their own health. Therefore, the health system becomes the ensemble of all synergistic actions of three groups of actors: population, service delivery and policy-makers responsible for drafting legal regulations, which generate the legal framework for conducting medical activities, with the administrative and financial organization of the health care system.

In the context of the two countries, may we speak about the users as active participants? Are all categories of individuals protected as a result of the regulation of the public and private health care insurance system or does the protection remain in the phase of intent? Are the principles based on which the security system works functional? These are just a few of the questions we would like to answer in this analytical approach.

2. Aim and Methodology

This analytical approach aims a comparative analysis of the vulnerability in accessing health care services in the context of health care system reforms in Romania and Hungary, in 2012.

Our methodological option is located in the paradigm of methodological criticism. We use the content analysis of the main legal regulations in force for the organization and operation of the health care systems in the two countries, and also different data sources (literature, reports of previous research, health insurance legislation, regulations associated with health care system).

We analyze the vulnerability in relation to the access to health care, from the point of view of the principles based on which health insurance systems work in both countries. We define vulnerability from the legislative perspective and in relation to the categories of population that are protected as a result of the regulation of the public / private health insurance, but also in relation to those who are not actually protected, although in the legislative intent, they seem protected. For example, in Romania, the payment of non-contributory social assistance is suspended if the beneficiaries fail to pay local taxes during the first three months of the year; or, for example, the suspension of the income support is equivalent to losing the quality of insured in the public health insurance system. We wonder if this responsibility of the individual is needed, while other citizens, who pay contributions, may choose to pay their local taxes until the end of the year, even if penalties are added.

We consider vulnerable persons those who have limited access to health care services base on the organization and functioning of the health care system. On the other hand, we also consider vulnerable persons those whose autonomy, dignity and integrity are threatened (Barcelona Declaration 1998).

We are making a synthetic summary of the key moments of the health care reform developments in the two countries. We also analyze the present intentions regarding legislative changes in both countries, trying to anticipate the effects from the perspective of the access ethics of vulnerable groups to health care services.

The thematic analysis units for the legislative framework are: operation principles, categories of insured (with or without payment of the contribution), and conditions for the

affiliation to the system and the possibility of using the system effectively, legal definitions of vulnerable populations.

The context for the achievement of this analytical approach is the economic crisis in the European Union, which certainly requires a range of responses as related to the national health care policies.

3. Results and discusses

A. Hungary

Principles, patients' rights

In Hungary the basic principles and the objectives of the health care system are either set explicitly in various law, regulations and policy documents¹, or implicitly by the actions taken by the government. With the adoption of the new Basic Law of Hungary² in April 2011 the basic principles related to right to health and right to social security have been reinterpreted. The new Basic Law states that the right to physical and mental health is a fundamental right for everyone [Article XX(1)]. According to this Law Hungary shall promote the exercise of this right by ensuring that its agriculture remains free from any genetically modified organism, by providing access to healthy food and drinking water, by managing industrial safety and healthcare, by supporting sports and regular physical exercise, and by ensuring environmental protection [Article XX(2)].³ Since new Basic Law of Hungary, the various effects on vulnerable populations of the legislative changes that have been already implemented and will be implemented based on the provisions of new Law can not yet be fully evaluated, but some possible consequence will be mentioned later in this section.

Vulnerability in relation to access to health care can be best conceptualised if social determinants of health are taken into consideration both in the definition of health and in the design and implementation of health care legislation and health care policies (WHO 2010). At the level of policy intention this idea is formulated in the preamble of the Act

¹The most important policy document of the current Hungarian government is the so called Semmelweis Plan. Ministry of Human Resources. State Secretary Responsible for Healthcare.

² Basic Law of Hungary, adopted on April 2011, entering into force on 1 January 2012.

³The old Constitution of Hungary (Article 70/E) provided for the implementation of the right to health through health institutions and medical care, however this provision is missing from the new Basic Law.

CLIV of 1997 on Health according to which the system of means and resources available to health services cannot serve the promotion, maintenance and restoration of health unless completed by a social welfare system, the protection of the natural and man-made environment, together with the social and economic environment, as well as by health promoting public policies and practices.

Act CLIV of 1997 on Health sets up the general framework for health care including patient rights, the organization of the health care system, major actors and responsibilities for health care (Article 143). It differentiates between health services all citizens are entitled to without restriction (entitlement based on citizenship) and those provided based on SHI status or private contracts. According to the Act, the right to health services is unconditional only for emergency life-saving services, services that prevent serious or permanent health damage, and services that reduce pain and suffering. The Act also declares that every patient has a right to proper, continually accessible and equitable health services according to health status, which are set in a properly defined legal framework (Article 7). It also defines the rights of patients, including the right to health care provision (Article 69), to maintaining personal contacts (Article 11), to information [Article 5(3a-b)], to autonomy [Articles 5(3) and 15, 19], to free choice of physician (Article 8). To promote the protection of patients' rights Act CLIV established the institution of the patient rights representative.

The principle of non-discrimination is detailed in Article 7. Healthcare is considered free from discrimination if, in the course of delivering healthcare services, patients are not discriminated against on grounds of their social status, political views, origin, nationality, religion, gender, sexual preferences, age, marital status, physical or mental disability, qualification or on any other grounds not related to their state of health [Article 7(4)]. Under the right to human dignity, provided in Article 10 it is also included that the patient may only be made to wait on grounds and for a duration which are reasonable. The provisions on waiting lists (Article 9) are also essential elements of the equitable access to health care. It is required that the patients' order on, and selection from the waiting list to be based upon unified, controllable and published professional criteria, in a manner justified by the state of health of patients on the waiting list and without any discrimination.

Principles and objectives that influence the equitable access to health care are also formulated in social security related regulations. There are five main branches of social security in Hungary. The first two branches, pensions and health care services, are classified as social insurance. The other three branches are the unemployment insurance, the family support system and the social assistance system.

The rights of the insured persons and basic principles affecting access to health care are formulated in the Act LXXX of 1997 on Persons Entitled to Social Security Benefits and Private Pensions, as well as the coverage of these services⁴ and Act LXXXIII of 1997 on the Services of Compulsory Health Insurance, which, along the Health Care Law are the fundamental legislative instruments on access to health.⁵

Act LXXX of 1997 defines social insurance as a regime for sharing risks within society among the citizens of Hungary, and other natural persons staying in the territory of Hungary in which participation is compulsory according to the regulations. The Act aims to govern the relations within the framework of the social security system in harmony with the requirements consistent with independent liability and self-support and the principles of social solidarity (Article 1). Benefits provided by the social insurance system are available through the health insurance and pension insurance systems. Health insurance benefits include: a) health services; b) cash benefits: b.a) pregnancy-maternity benefits, b.b) child-care benefits, b.c) sick-pay; c) accident benefits: c.a) emergency medical services, c.b) benefits for accident-related injuries, c.c) accident compensation d) benefits for persons with impaired work ability d.a) invalidity/disability benefits, d.b) rehabilitation benefits [Article 14(1-2)].

Eligibility to health care

In relation to eligibility to health care the law distinguishes between insured persons and entitled persons. Insured persons are employed persons, members of cooperatives, apprentices in industrial training, artisans, self-employed persons, independent farmers, performing artists, lawyers, and recipients of unemployment benefits.

The category of persons entitled for access to health care services are for example minors, schoolchildren, students studying during the day, pensioners, people on low

⁴ Adopted in 1997.VII.25, amended later.

⁵ Promulgated on 25.07.1997, amended later. In original language: 1997.

incomes who have reached retirement age, those receiving cash maternity and social protection benefits, persons placed in residential institutions providing personal care and those required to pay healthcare contributions. These persons are entitled to non-cash health insurance benefits only.

Since there is no exemption from compulsory health insurance in Hungary, persons not insured or not entitled to health care can enter into contractual arrangements with the Health Insurance Fund (Egészségbiztosítási Pénztár) for entitlement to health care services.

Financial coverage of health services

Health insurance benefits are financed by the National Health Fund (Egészségbiztosítási Alap). Its revenues come from compulsory health insurance contributions and taxation. The population in Hungary is divided into three main groups: (1) insured individuals who are entitled to all services covered by the NHIFA and who pay regular contributions based on their income, (2) individuals who are entitled to medical services but are not required to pay contributions, and (3) all other inhabitants with a personal identification card and permanent residence, who are obliged to pay a medical service fee (that is, a fixed-amount insurance premium) on a monthly basis.

The central budget shall pay a certain amount of health services contributions per month for the persons defined in the Law who are entitled to use the health care service (non-contributing groups are for example women on maternity leave, conscripts, the poor) [Article 26(5)].⁶ Health service contribution shall be paid by the resident person who is not insured and the health care service is not entitled under the Act, furthermore, the additional self-employed activities and other business activities, the joint venture company [Act LXXX of 1997 Articles 19(4) and 39(2)]⁷. To cover health services, the persons specified in specific other legislation are also required to pay health-care contributions. For example employed pensioners entitled to draw pensions on their own right shall pay health insurance contributions in kind and pension contributions on their income comprising the contribution base.

Benefits of the social health insurance, and rules of their utilization

⁶These persons are those defined in Paragraph b) of Subsection (1) of Section 16 other than employees and other than the persons engaged in auxiliary activities, for persons drawing child-care benefits, and for the persons referred to in Paragraphs c)-f), h)-o), s) and v) of Subsection (1) of Section 16.

⁷The amount to be paid in 2013 is 6660 HUF/month (aprx. 22 Euro/month)

There is a basic package which can be used by all Hungarian residents irrespective of their affiliation to the Health Insurance Found, which include the following services: ambulance and emergency services, disaster health services, services related to organizing the blood supply and making blood available, the use of rare or exceptionally costly therapeutic procedures, or therapeutic procedures that are a part of biomedical research, mandatory public health and epidemiological tasks, family planning counseling, prenatal care and care for mothers post-partum.⁸

The in-kind and cash benefits of the social health insurance (insurance package), the rules of their utilization, the rules that regulates entitlement to services for foreigners (Article 8), are provided in Act LXXXIII of 1997 on the Services of Compulsory Health Insurance. The Act also provides for the right to free choice of family doctors and change of providers and medical professionals and define which health services are free of charge, which are covered but require some user charges, and which are excluded from HIF coverage. The Act defines a list of those services which are not covered by HIF, based on the premise that, in principle, health services are covered.

Regarding choice of doctor there is free choice of a general practitioner. Patients have to register with one general practitioner. There are no geographical restrains. Patients are allowed to change a doctor once a year, more than once a year only for good reason. Regarding access to specialists in general it happens through referral by the general practitioner, except in cases of emergency. Direct access is provided to dermatology, gynecology, laryngology, ambulatory surgery and accident/emergency surgery, ophthalmology, oncology, urology, psychiatry. The referral is addressed to the type of specialty and to a service provider who is geographically obliged to the maintenance of the care (EC 2011).

Co-payments are charged in the following cases: pharmaceuticals, unnecessarily changing the contents of prescription treatment, causing extra costs; extra services (better room, meal condition etc.); accommodation, nursing, pharmaceuticals and meal costs for those suffering from designated ailments, confirmed by primary health care provider; using sanitary provisions; certain dental prosthesis, orthodontic braces provided for persons under the age of 18; change of external sex organs with the exception of developmental

⁸ Act CLIV of 1997 on Health, Article 142.

abnormality. The amount of the co-payment is fixed by the service provide. Special rules apply to a few services, such as infertility treatments, or, since 2007, treatment for injuries resulting from extreme sport activities. The individual might also pay part of the cost of medicines and medical appliances. Medicines administered in hospital are free of charge. Otherwise, the OEP covers part or all of the cost when the medicine prescribed is on the social insurance assistance scheme list.

The use of the term vulnerable/vulnerability

In Hungarian language the term vulnerability translates to “sebezhetőség/sérülékenység”, but instead of this word in policy making the terms “hátrányos helyzetű” (disadvantaged/defavorized) is used more often, in the form of disadvantaged populations/groups, persons with multiple disadvantages, or disadvantaged regions. These denotations broadly correspond with that covered by the term vulnerability.

The term vulnerable is used explicitly in the Act XCVIII of 2006 on safety and efficient supply of pharmaceuticals and medical devices which acknowledge that medicinal products are purchased by persons who are vulnerable due to their sickness. As we can see in this context vulnerability it is defined in biological term (sickness). Based on the legislative measures that aim to protect certain groups of people (to offer access to health, through special programs) the following categories of persons are seen as vulnerable: minors, pensioners, dependant wife, prisoners, unemployed, disabled, those with chronic diseases, Roma ethnic group, homeless persons, those living in defavorized regions, persons with multiple disadvantages, persons with different addictions (drugs, alcohol).

There are special provisions related to access to health for persons considered as vulnerable (in need for special protection) both in the social insure legislation (those entitled without direct contribution to the Health Insurance Fund (HIF), for example) and in other social security related legislation too, such as on the family support system or social assistance system.⁹

Local governments are responsible for the provision of social care and Act III of 1993 on Social Services determines the types of care to be provided, the rules of eligibility

⁹According to a synthesis of social provisions prepared by the Ministry of National recourses the following health related provisions were provided over and above the ones under Act III of 1993 in Year 2011: Invalidity annuity, Temporary invalidity annuity, Regular social annuity, Health damage annuity to miners, Transportation allowances for the mobility-impaired, Parking card, Disability benefit, Work accident annuity.

and the rules of financing.¹⁰ The scope of services includes cash and in-kind benefits. The nursing allowance is a cash benefit bestowed by local governments to support care provided by laypeople, including relatives, to individuals with severe disabilities or chronically ill children under 18 years of age. In-kind benefits take two main forms: (1) in-kind benefits for impoverished people and (2) in-kind benefits for people with disabilities (services of personal social care). Benefits for impoverished people can take the form of either reimbursement of actual expenses or the provision of services in-kind. The two main health care related in-kind benefits are pharmaceutical co-payment exemptions and eligibility for health care services. In case of the former, the government covers the user charges for essential drugs and medical aids and prostheses. For the latter impoverished people who otherwise would not have HIF coverage become eligible for health care. In both cases, the local government tests for eligibility and issues an identity card to the recipients certifying it to the provider.

Equity in access to health care in practice

In relation to same benefits for all in practice there are large variations in service delivery. First of all there are great variations in the physical infrastructure quality of the health service delivery system (Simmelweis Plan 2011]. Richer municipalities usually have better facilities, some poorer municipalities have accumulated debt in order to maintain a proper infrastructure, while others have simply ignored this obligation due to lack of funding. These territorial-regional differences as well as the urban-rural split create inequalities both in access and in quality of available services. One of the declared aims of the so call Semmelweis Plan elaborated in 2011 by the current Hungarian government was to eliminate or at least to reduce the territorial inequalities in terms of accessibility, by dividing the country into 10 newly defined healthcare regions. However, the redistribution of resources from rich to poorer regions did not happened, and with the exception of those residing in the capital city of Budapest and its suburban area the free choice of health care service provider unit was limited (Mihályi 2012:173-186). This further increased already existent inequalities in access to health care between those living in Budapest and those in other parts of the country (Belicza, É. 2006; Vitray and al. 2011).

¹⁰ In original language 1993. évi III. törvény a szociális igazgatásról és szociális ellátásokról

Another problem of the Hungarian health care system is that the absolute and relative shortage of places, the geographic disparities, insufficient coordination between health and social care, and contradictory financial incentives (high user charges in social care as opposed to low or no user charges in health care) have led to the abuse of acute inpatient care capacities by chronic and social care cases. This is a fundamental issue that needs to be addressed for a successful health care reform (Gaál and al. 2011; Baji and al. 2012).

Many of the discussions about health equity make reasonable claims that there are in-equalities in health status and access to care for different categories of people, whether identified by social class (as measured by income, wealth, and/or formal education), spatial distribution, gender, or ethnicity (Gaál and al. 2011; Baji and al. 2012).

Large segments of the Roma population in Hungary live under disadvantageous conditions, typically in underdeveloped regions of the country. This is reflected in their health status, which is worse than that of the non-Roma population, with life expectancy being 10 years shorter. The frequency of certain diseases is also considerably higher among the adult Roma population (over the age of 19) than in the general population (Babusik 2004). Comparative studies on the health of people living in Roma settlements and that of the general population in Hungary found that minority status may play an important role in access to health services. Compared to the general population, Roma were less likely to use health services, especially those offered by specialists and dentists. The study also indicated that the use of health services by Roma individuals was similar to that seen in the lowest income quartile of the general population (Kósa and al. 2007; Kósa 2009). A more recent study also found that socioeconomic status is a strong determinant of health of people living in Roma settlements in Hungary and thus ethnicity per se may not be the only explanation (Vokó 2009:455-460).

Not only ethnicity and poverty, but disability can also hinder access to health. Although the right to physical and mental health is a fundamental right for everyone in Hungary, this right is not properly upheld in case of persons living with autism and intellectual disabilities due to following circumstances: geographical inequalities, lack of personal and material conditions, especially the lack of special training of medical staff, and the lack of specialised health care providers. Their right to health does not prevail,

neither in the area of basic, nor in specialized health care (especially in the field of gynaecology and dental care)¹¹. On the basis of the authorization of the new Basic Law of Hungary, a new act replaced the disability pension system with a completely new disability and rehabilitation benefit system, which are now part of the health insurance benefit. Some studies have already warned that these changes will negatively affect those concerned. For many the forthcoming changes will mean loss of incomes, loss of support (for ex. for transportation) which in turn will also affect their access to health care.

B. Romania

Principles and rights in the social health insurance system in Romania

The objectives of the health insurance system are: a) to protect the insured against medical costs in case of illness or accident, b) to protect the insured generally, equitably and non-discriminatory in the conditions of effective use of the unique national health insurance fund (Article 208, Law 95/2006). Health insurance is mandatory and operates as a unitary system, based on the following principles: free choice of the health insurance agency, solidarity and subsidiarity in the creation and use of funds, free choice of the medical services providers, medicines and medical devices, according to this law and framework agreement, decentralization and autonomy in management and administration, mandatory participation in the payment of the health insurance contributions for the to set up the unique national health insurance fund, participation of the insured, the state and employers to the management of the unique health insurance fund, providing a basic package of health services, in a fair and non-discriminatory way, to any insured, transparency of the health insurance system and free competition among the suppliers who sign agreements with the health insurance agencies.

Voluntary health insurance does not exclude the obligation to pay contributions to the health insurance.

Aspects related to the obligation to pay the contribution. Extending the deadline for the proof of full payment of the contribution to the health insurance fund from 3 years (as stipulated in Government Emergency Ordinance no. 150/2002) to 5 years (Law no.

¹¹Hungarian Disability Caucus - List of issues submissions prepared for the 7th session of the UN Committee on the Rights of Persons with Disabilities, April 2012.

95/2006) resulted in the decrease in the number of patients on the list of family doctors, patients who were not insured as proven by the verifications made by the health insurance agencies. Some of these patients chose the minimum package, others tried to solve the legal situation, for the purpose of paying the due contributions and delay penalties. Roma, young people under 26 years old (not included in a form of education and not carrying out a paid activity), self-employed and those who carried out paid employment abroad were the vulnerable categories (Popescu and al. 2009).

We synthetically list here some of rights of the insured in the context of Romania: freedom to choose the service provider and health insurance agency, the right to be enrolled on the list of a family doctor, the right to change the family doctor, to enjoy healthcare, medicines, medical services in ambulatory and hospitals in contractual relations with health insurance agency, home care without discrimination, the right to quality health care and to be respected as a human being without any discrimination, patients' right to medical information, etc. (Law 95/2006; Law no. 46/2003 on patient's rights).

Eligibility to health care

To qualify for the basic package, the person should be insured in the health insurance system (to be able to prove the payment of the contribution if he / she has the obligation to pay contributions to the fund) and be registered on the list of a family doctor. The persons required to be insured, who may not prove the payment of the contribution, in order to become insured shall be required to pay the monthly contribution for the last six months if they have not obtained taxable income during the prescription periods for tax liabilities, calculated on the minimum gross salary, and the delay penalties. If they obtained taxable incomes during the last five years, calculated as of the time of the requested medical care, the persons who are required to be insured should pay the monthly contribution calculated for the taxable incomes, as well as delay penalties, for the entire prescription period. The persons of working age and able to work without income obtained from their work in Romania, who do not take full time courses in higher education and do not receive minimum income have to pay the monthly health insurance contribution from their own resources, in order to remain insured. The use of public medical services compensated by the state is determined by the proof of continuing payment of the contributions for the last five years. If the citizens may not prove this payment, but had

taxable incomes either in Romania, or in another state, they have to pay retroactively the contribution for each month when they obtained taxable incomes. If in the last five years, they did not have taxable incomes, they are required to pay the contribution "only" for the last six months prior to the use of the public system. Given these rules, the persons working abroad (without legal documents), the beneficiaries of social security according to the law on the minimum guaranteed income, having periods of interruption, and freelancers, especially those in the agricultural sector with lower financial incomes represent categories where the uninsured rate is particularly high. Although they are registered with a family doctor, the use of health services is hindered by the failure to pay the health contribution.

The eligibility for the affiliation to the private sector is determined by only one requirement: mandatory affiliation to the public health insurance system. This aspect may be interpreted in two ways. On the one hand, the decision makers are concerned to ensure access to the basic health services included in the basic package covered from the unique national fund of health insurance without discrimination and in accordance with the compliance of the principle of equal opportunities. On the other hand, it is possible to maintain the initial inequalities related to the access to health services, the affiliation to a private system being more accessible in the context of the developments in the Romanian society to only certain categories of population (people with average or higher income), mainly residing in urban areas (Rebeleanu and Şoitu 2013). The persons who obtain incomes from transfers and who were anyhow deprived of access to health services of the public health insurance system (elderly, Roma, persons receiving the minimum guaranteed income, families with many children, without limitative exposure) might not afford the option of private insurance. For those who would afford the double option, mandatory and voluntary, as related to health insurance, there is the alternative that they use the services covered by the private insurance, which would allow the saving or increase of the resources for the public fund.

Rules of healthcare services utilization

Family doctors may provide medical services to the insured patients registered on their lists or on the lists of other offices, and also to uninsured patients. Uninsured patients may benefit only from the minimal package. Therefore, we may say that, legally,

inequality related to the use of services resides from the failure of the citizens to fulfill their legal obligation to be insured in the public health insurance system, not from discrimination. The basic package of health services is granted without discrimination to any insured (Law no. 95/2006). When we refer to the ethnic distribution of the insured, we may find a lower percentage with the Roma citizens (Popescu and al. 2009; Popescu 2009:152-167). On the other hand, local researches (Project ECHISERV¹²) confirms that in the current system of health insurance, the lack of medical insurance is not a feature of the Roma ethnics. The use of health care services to a lesser extent is the consequence of failure to fulfill the obligation of paying the contribution to the health insurance in order to set up the fund. We appreciate that the vulnerability of this ethnic group is rather social than legal.

Indirectly, the category of insured without the payment of the contribution is also assimilated to vulnerable groups, according to the law (see art. 213 Law no. 95/2006; Law no. 116/2002). They receive the same package of care as the category of insured persons who pay the compulsory contribution. In this context, we question the horizontal equity. The ignorance by insured of their rights as insured in the health insurance system is one of the problems of the Romanian system. Knowing the rights and obligations of the insured means knowing the framework contract. It is annually renewed by Government decision. In 2005, the study made by the Center for Health Policies and Services (CPSS) on a representative sample indicates that 79% of the investigated population has no information about the contents of the basic package of health services (CPSS 2005).

Law no. 95/2006 provides for the obligation of the health care providers to display their rights and obligations of the insured at their offices. According to art. 14 of the *Framework Agreement on the terms of providing medical care within social health insurance*, the family doctor has the obligation to inform the insured about the basic package, the minimal package of medical services and the package for the insured who have optional insurance, the obligations of the provider of medical services in contractual relation with the health insurance agency, as well as the obligations of the insured as

¹² Project ECHISERV – Research project carried out in the North – West Region (2007 – 2008): “Disparities in the use of primary care services in the North – West Region Transylvania. Social – economic patterns” Director Prof. dr. Livia Popescu; Grant CEEEX 157/2006;

related to the medical service. The law provides that the family doctor should display in a visible place the rights and obligations of the insured, the composition of the basic package and the name of the health insurance agency with which he / she has a contract. Thus, one could say that there is legal framework guaranteeing the right to the information of the insured. The free choice of the doctor and the health insurance agency implicitly assumes prior information on the provider or agency chosen. The consequence of ignorance of the basic package may reflect on possible options for voluntary insurance. Theoretically, such an option would require the applicant for a private health insurance to know the content of the basic package offered according to the compulsory social insurance.

The concerns of the National Health Insurance Agency (CNAS) related to the information and protection of the insured are continuous, in terms of intent. Thus, in 2011, the framework contract also provided the obligation of the insurance agencies to update permanently the lists of medical care providers, pharmaceuticals and medical devices providers under contract with the agency, by posting the list on the website and at the registered office of the health insurance agency, within maximum 5 working days as of the date of the changes, and it also provided for the obligation of the pharmaceuticals suppliers to display the information materials prepared under agreement with CNAS in a visible place. The year 2012 marks, as lines of action, the need to increase awareness of the insured.

Freedom of choice. Accessibility to health care is deemed to be optimal if every person is granted access to medical services, if there is large freedom of choice among various providers of health care services and even various payers that should match the options and possibilities of the population, if there is continuous information on all providers of medical care and if there is adequate participation of these groups in the organization of the health system. If choosing a family doctor or general practitioner is free, unlimited by territorial barriers (as in the old centralized health care system), the access to specialists is subject to the recommendation of the general practitioner, while respecting the right of the insured to choose the specialist (EC 2007).

In Romania, the increased rural-urban division in terms of the equipment with health infrastructure and the concentration of the elderly and the poor in rural areas is associated with a lack of qualified personnel in rural areas, especially specialized

personnel, other than the family doctor. These factors mainly question the substance of the "freedom of choice" among health care providers for the people with health problems and economically vulnerable in the rural areas. An important distinction should be made between the freedom of choice as such and the freedom to choose *something* (and nothing else), in other words, the quality of the alternatives the individual has. The increase in the number of alternatives does not human raise the substantial human freedom, if none of the options is really favorable to the individual. This distinction is analyzed in detail by Alkire (2002), who distinguishes between the increase in the *range of choice* and strengthening of the *freedom of choice*. From a practical point of view, however, the insured in the rural areas have much less freedom of choice than those in urban areas, not only because the number of physicians serving a rural locality is naturally lower, but because they lack the means by which, if dissatisfied, the patients may choose for better services offered by another doctor in another locality.

Use of the term "vulnerable persons"

The Romanian legislation did not use the phrase of vulnerable people until 2006. But may we find references to excluded social groups or disadvantaged groups. Thus, Law no. 116/2002 on preventing and combating social exclusion reasserts the social character of the Romanian state, provided in the Constitution. The social character of the state requires the establishment of measures to avoid deterioration of the living standards and preserving the dignity of all citizens. The declared objective of the law is "to ensure effective access to basic and fundamental rights... such as: the right to employment, housing, health care, education and the establishment of measures to prevent and combat social exclusion¹³" (article 2, Law no. 116/2002). Section 3 of this law governs the access to health care of the groups at risk of social exclusion. The quality of insured without the payment of the contribution by the persons entitled to the minimum guaranteed income is reasserted, and this right is confirmed by the local councils (article 16). The law requires the local councils to ensure the conditions for the access to all forms of health care, including the organization of social units.

¹³Social marginalization is defined by peripheral social position, isolation of individuals or groups with limited access to economic, political, educational and communication resources of the collectivity; it is manifested by the absence of a minimum of social conditions (art. 3, Law no. 116/2002)

As related to the access, we retain the difference operating in the text of Law 95/2006 on dichotomy: insured with the payment of the contribution and insured without the payment of the contribution. If we consider that the social security right guarantees by excellence the protection of various categories of persons in social risk situations that occur independent of their will, the regulations on health insurance just establish the right to social protection, in case of illness, of those exempt from the payment of the contribution, enjoying, according to the law, specific health insurance services, being considered indirectly vulnerable. It is assumed that this category of persons may be excluded from the private insurance (Eckenfels 2002). In Romania, children under 18 years old, young people aged between 18-26 years, if pupils, apprentices, students, if they do not obtain incomes from employment, young people under 26 years including those who leave the child welfare system and do not obtain incomes from their work or they are not beneficiaries of social security, husband, wife and parents without their own income, dependent of an insured person, persons with disabilities, patients suffering of diseases included in the national health programs; pregnant women and postpartum women are considered insured without the payment of individual contribution to the public health insurance system.

The status of insured with the payment of the contribution paid from other sources is assigned by operation of law to the following categories of persons: unemployed with allowance, beneficiaries of social security, persons on parental leave for children under the age of 2 / 3 years for a child with disabilities, victims of trafficking, persons serving a prison sentence or who are in custody, beneficiaries of social security, pensioners, for the pension incomes up to the limit of the tax on income, persons on leave for temporary work incapacity, given after a labor accident or an occupational disease.

In the present form of the Law no. 95/2006, the word "vulnerable" is not present. The word "disadvantaged" is not present. Semantically close, the term "defavorized" which appears in a single context that requires the presence of the doctors beyond retirement age in disadvantaged areas, until the job is occupied through contest by another doctor. Another article (17) provided the duty of the county public health authorities to intervene in solving public health problems among defavorized groups of people.

In the Government Emergency Ordinance 162/2008, we find a term related to the concepts analyzed by us when the legislator specifies the beneficiary of the services and

community healthcare activities (art. 7) as being “the local community in a defined geographical area: the county, city, town and village, and within it, in particular, the categories of vulnerable people”. The same article does not specify these categories, but "vulnerable situations" (article 7, paragraph 2): economic level below the poverty threshold, unemployment, low educational level, various disabilities, chronic diseases, terminal illnesses that require palliative treatments, pregnancy, elderly, under the age of 16, part of single parent families and risk of social exclusion. It is considered that the insured risks as they occur in international documents on social security are called here "vulnerable situations" (Șoitu and Rebeleanu 2013).

The last legislative document introduced in the Romanian health system is Law 220/2011¹⁴ amending and supplementing Law no. 95/2011. This legislative instrument introduced the co-payment, defined as the contribution of the insured to health care system, in addition to the one settled from the unique national health insurance fund). According to this regulation following categories of persons are exempt from co-payment: children under the age of 18, young people between 18-26 years old, if they are pupils, high school graduates until the beginning of the academic year, but not more than 3 months, apprentices and students, if they do not have income from work; patients included in national health programs established by the Ministry of Health for medical services related to that condition, if they do not have income from employment, pension or other resources and pensioners with incomes from pensions of up to 740 RON / month¹⁵. The categories of insured without the payment of the contribution that are exempt from the co-payment are limited (in other words, indirectly considered vulnerable by the legislator). Of the categories of persons who are not exempt from copayments we mention: the co-insured; beneficiaries of social security; unemployed with no allowance; the disabled; and pensioners with incomes over 740 RON / month. The new law provides that all co-payment costs to be covered by voluntary complementary health insurance. It seems unlikely to have an additional contribution for these categories.

¹⁴ The law is not enforced yet; the co-payment was also included in the legislative project concerning the reform of the health care system

¹⁵ Almost 168 Euro/month

The Strategy on the reform of social protection 2011-2013 concludes that the most disadvantaged categories of the population should be protected through family policies and the fight against poverty, and appropriate policies for people with disabilities and for the elderly. Law no. 292/2011 on social security defines the vulnerable group as "persons or families who are at risk of losing their ability to meet the needs of daily living because of cases of disease, disability, poverty, drug or alcohol addiction or other situations that lead to economic and social vulnerability" (article 6, lit. p). The definition of "vulnerable group" extends the significance of vulnerability beyond incomes and assets. This is a possible starting point in linking the conceptual frameworks - social and health – the conditions listed referring to a greater extent to disease, disability, addiction. In fact, vulnerability is explained by risk or difficulty. In Chapter IV, Section I, of Law 292/2011 the state's responsibility to ensure the access of vulnerable people to some basic rights is regulated: the right to dwelling, social assistance and medical care, education and employment. In the category of people at risk of social exclusion the law mentions: single persons and families without incomes or low incomes, homeless, victims of trafficking and persons deprived of liberty.

Vulnerability of Roma. Roma were the most disadvantaged segment of population in the original form of the health insurance law, an aspect remedied, on the one hand, by amending the law on social assistance (Law 67/1995 by Law 416/2002 on the minimum guaranteed income, Rebeleanu 2007), and also because of the Government Decision 430/2001 regarding the approval of the strategy of the Romanian Government to improve the situation of Roma that provides among other things the institutionalization of the health care mediators in Roma communities. A decision that completes this government decision was the introduction of an order, in 2002, of the Ministry of Health and Family of the approval of the health care mediator occupation. According to data supplied by the research ECHISERV, in terms of ethnic distribution of those who are insured, it was found that the Roma ethnics have the lowest percentage. The existence of social protection measures targeting the Roma population is an argument for the acceptance and recognition of the status of vulnerable group of the Roma ethnics, at the level of decision makers.

4. Final Remarks

In both states, the right to health care is guaranteed by the Constitution and the state has the responsibility to guarantee this right.

The analysis of the current legislative provisions on health care and on health insurance in Hungary and Romania reveals that at the level of legislative intention many of the basic principles of an equitable access to health (social solidarity, non-discrimination, equal access to health care for all members of society, social health insurance, and patients' rights) are provided. However, there are analysts who warn that the new Basic Law (Article XIX on Social Security) actually undermines the constitutional fundament of social insurance by abolishing all legal links between health (and pension) insurance contribution payments on the one hand and the entitlement to health (pension) benefits on the other hand (Mihályi 2012). At this moment it is difficult to foresee how this constitutional change will affect the Hungarian social security system and its institutions, as it is also not yet possible to evaluate the effects of excessive centralization of the health care system, and of the abolishment of payer/provider split on equity in access to health.

The principles of non-discrimination and equality have two major contributions to the conceptualization and assessment of health equity. On the one hand, the existing societal agreements on non-discrimination oblige the decision makers to pay special attention to protect and fulfill the rights of social groups considered vulnerable based on the previous historical experience (they have encountered obstacles in exercising certain rights). On the other hand, it is possible to specify social groups defined as vulnerable groups because of discrimination, respectively, identifying groups that are characterized by inequalities in health, including through social conditions. These aspects are embodied in legislative intentions of the policy makers in Romania and Hungary (strategies for Roma, the quality of insured without the payment of the contribution for those indirectly assimilated to the disadvantaged groups from socioeconomic point of view – pensioners, co-insured of the insured, unemployed, welfare recipients, children, etc.).

In both states, the right to health care is based on citizenship, even if funding is made through contributions. There are some people who have limited access to services. The developments of the reforms in the two countries confirm that access to and utilization of services is limited for certain categories of persons as the Roma, beneficiaries of social

security. At the same time, dependence of the access and use of the residence is a reality. While in Romania, in 1997, the principle of territoriality was dropped. Hungary reactivated it in late 2010 (although it seems that it did not have great chances of implementing this approach, as it was rather seen as a restriction on the freedom of choice by limiting the right to choose the provider by the Hungarian users) (Mihályi 2012).

It is not enough that there is a legal framework that guarantees the access to health care. An individual responsibility assumed by potential users is also needed. The failure to pay the contribution and the impossibility to prove the quality of non-payer insured are sanctioned by the failure to receive the basic package and the loss of the quality of insured (Romania). Before 2006 the regulation on contributions and their payment was not fully enforced in Hungary. Patients receive necessary care even if their cards are not valid, but they are also informed that their insurance registration status is unclear and they need to contact the NHIFA. The Tax Office is also notified about such cases for further processing and eventually collecting unpaid contributions retrospectively (OEP 2012/03; Gaál and al. 2011:71).

Although health insurance was seen as a way to increase resources to finance health care system, and a necessary condition for improving the quality and for a more effective management to provide health care services, the incomes were often judged as insufficient. The costs of medical care tend to be chargeable to the patients as co-payment. In both countries, there is a tendency to reduce health expenditure as % of gross internal product; their amount and quantum being lower and more drastic in Romania, which remains the country with the lowest health expenditure in EU countries.

Neither in Romania, nor in Hungary, there is any mention in the health insurance legislation of the term vulnerable categories of persons when it is about insurance. By extension, we may say that the insured without the payment of the contribution are vulnerable, given the legislative intention of the legislator to protect them. In Romania, vulnerability does not seem to be a concern of the health system policies, being transferred to the "community health care", where the greatest responsibility is that of actors such as community nurse, social worker and health care mediator, all under the protection of the local government (which, in our opinion, does not have the necessary skills). To ensure equitable access to health care services, surely it is necessary to correlate the health

insurance legislation with that of social assistance. Defining in a normative instrument the vulnerable situations and the vulnerable groups brings to the attention of decision makers the need for measures to protect health care, meant for the increase the autonomy. The more so as there is a percentage of insured persons in both states (4% Hungary, almost 5% Romania) (Gaál, P. and al. 2011; Popescu 2009). The percentage of uninsured amongst the Roma ethnics is even higher. Even in principle, as it was presented, the Hungarian and Romanian health care system provides universal and comprehensive coverage with the same benefits for the entire population.

The Barcelona Declaration (1998) talks about patients' participation in making health decisions. But are they informed about health insurance? Do they know for instance what does the basic package contain? Do the patients sign the agreement with the agency for the public system? For Romania, the answer is negative. The signatories of the contract with CNAS are suppliers. Moreover, health care providers consider that by signing such a contract, the patients would be more disciplined, more responsible and might discuss the affiliation to the private health insurance system (Rebeleanu and Soitu 2013). Knowing the basic package by the citizen wants an additional insurance becomes an inherent condition for the payment of private insurance. The system is used mostly by those informed and also by those who have the possibility to pay, in Hungary. Those who have the possibility to pay, may raise objections to the compulsory character of affiliation to the public insurance system, an aspect that might jeopardize the long-term social solidarity.

In the conditions of economic crisis, the health systems in Romania and Hungary tend to limit their expenses (Hungary more drastically, but keeping them around 7%, Romania seems to have frozen them around 5.5%) (WHO 2012). Access to health is compromised by the consequences of the global financing crisis and the serious budget cuts in health care, coupled with a rapidly accelerating health workforce migration (Mihályi 2012). Is this desirable?

European recommendations say that it is the biggest mistake that a system of social protection may make in the conditions that the need for health and social care for vulnerable groups is increasing. It needed to develop the integrated social services, which in fact make the community more responsible, stimulates social solidarity and increases social cohesion, promoting social inclusion. In times of financial crisis new categories of

vulnerable groups appear. Large segments of population find themselves in vulnerable position due to loans, loss of jobs, small entrepreneurs without work, which increase for many people the danger of incapacity to pay the obligatory social insurance contribution. Those required to pay taxes on the base of being part of the active population (by their age, but often not active, without jobs, etc.) are also vulnerable.

From our point of view, regardless of the governments' stated goals and intentions related to health care policy, often, changing regulations regarding health protection was random. The categories of vulnerable persons were not taken into consideration, sometimes by other pieces of legislation (persons with disabilities, migrant workers, farmers, etc.). We think that the need to correlate health insurance legislation with that of social assistance is more than desirable, and also to maintain consistency between legislative changes that occur. Especially since the two countries will have to face new challenges related to the health care reform in the coming years.

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