Perceptions of the Family Receiving Social Benefits Regarding Access to Healthcare

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Abstract We start from the premises that the public health insurance system reform in Romania fall in the liberal trend of reducing the state's direct role in delivering and providing health care services, increasing decision autonomy and responsibility of the insured person. The present undertake aims to understand the universe of non-contributory social benefits based on financial means testing beneficiaries and the subjective meanings in regard to social care services access determinants. Synthesizing the analysis of social benefits based on financial means testing beneficiaries' perceptions, we observe that their way of relating to the health care system depends to a large extent on the lack of incomes. The interpretation of health care access perception of this category of users comes as a discontent and criticism to the system and to the social actors' transfers (informal payments, physician- patient relation, lack of information).

Keywords Healthcare access · Health determinants · Family · Social benefits · Means testing

1 Introduction

The perceptions and social representations of determinants in access to health care services reflects practices, experiences and lessons drawn from personal and professional situations, but also ways of relating to changes in the social protection and public health system. Arguments for their pinpointing lie in the necessity of

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synchronising interventions at the social policies and public health level with those at the citizens' level. The present tendencies of Romanian neoliberal health care reform can generate changes in the interactions between the main actors involved. The role of individual has been reconsidered within the present health system. The beneficiary is, at the same time, service user, insured person and citizen.

Some of the arguments we can invoke in favour of an explanatory study regarding perceptions and representations of health care services access difficulties are the necessity of knowing the socio-geographic particularities of health care services access, identifying associated purposes and motivations of beneficiaries' resort to health care services, but also the possibility of explaining the investigated issue- what are factors and underlying mechanisms influencing access.

National studies (Dragomirişteanu, Mihăescu-Pinţia, 2010, pp. 17–29) focus to a greater extent on evaluating the perception of professionals and decision-making actors within the system rather than on beneficiaries' perspective. Research conducted between 2006 and 2008 in the North-Western region of Romania, regarding disparities in having access and using health care services, has concluded the following: the opinions of the majority of family physicians and that of the representatives of local authorities converge with the results of the questionnaire-based inquiry which identified accentuated vulnerability to the risk of illness and difficult access to treatment for the rural population, especially children, elderly and uninsured persons (Popescu et al. 2009). In the research "Ethical perspectives and determinants of access to primary assistance for vulnerable groups[1]", the groups/individuals perceived by medical, social and socio-medical service providers as being vulnerable regarding access to primary assistance were people with no income or low income, elderly (particularly those residing in rural areas), social welfare beneficiaries, disabled people and youth, those not attending any form of education. According to medical and socio-medical services providers' perception, lack of income and health insurance are the main triggers of vulnerability in access to health care. The area of residence is also mentioned as a limiting factor of access valid for other categories of people as well, but it is estimated that the patient's material resources can compensate the drawback. Other triggers considered responsible for difficult access are lack of education and information. In regard to individuals residing in rural areas, the degree of vulnerability of local families and citizens is more visible (Soitu and Rebeleanu 2012). Individuals engaged in subsistence farming are also included in the vulnerable group. In brief, underprivileged families, especially those that do not qualify to receive social benefits, along with some monoparental families have been identified by the afore-mentioned service providers as vulnerable groups (Rebeleanu and Şoitu 2013, pp. 109–116).

[1]The inquiry approach focused on analyzing the perception of primary assistance, social and socio-medical service providers and was conducted between July and October 2011 in Cluj and Iaşi counties as part of the project: "Postdoctoral Studies in the Ethics of Health Policies" implemented by "G.T. Popa" University of Medicine and Pharmacy, Iasi.

The present analytical approach is focused on the understanding of the social context of families granting from non-contributory social benefits based on the means-tested principle, together with the understanding of the subjective meanings in relation to the determinants of health care service access. In our opinion, their perceptions represent a good starting point in evaluating the accessibility of the Romanian public health care system.

2 Determinants of Health Care Access

With reference to the social determinants of health, McDonell (2002) mentions the socioeconomic status, the social structure and cultural factors. Going further to a macrosocial level, a state's economic and social development represents an important factor with a demonstrated impact on the state of health. While at an individual level determinants are rather traits that are important but usually unchangeable (gender, age, genetic factors), social determinants of the population's health are to be found at a macrosocial level and are out of individuals' control. The economic and social environment, education, physical environment, the social support network, health services, the quality of drinking water are all considered important determinants of the population's state of health. Social and community networks, in which family is also included, play an important role in the individual's health (Vlădescu et al. 2008). Moreover, in the social policy literature, the family is viewed as a social organisation unit, generating individual and collective welfare, even in the more developed societies (Gilbert et al. 1993, p. 4). The family provides both economic and non-economic support. The family is in many societies the main provider of protection for those/individuals in need, and in the rural area, it can be the only such provider.

Universal access to health care is considered to be the most important health determinant (WHO 2008, 2010; Raphael 2008). Even though it can be seen as a determinant of health per se, health services access is generally seen as a plurality of factors, such as: an existing medical infrastructure, logistics and specialists, existing personal factors (income, socio-educational factors, culture, interest, knowledge, personal health evaluation) and an existing legal and institutional framework. The behavioural model concerning the use of health services developed by Ronald Andersen (cited in Gruber and Kiesel 2010, pp. 351–356) describes the process of using health services as a causal interaction among three categories of factors: societal determinants (medical technology and social norms that configure and guide the medical protection system), the medical protection system (in charge with allocating available resources to medical protection institutions and the training of the organisational staff who provides medical services) and individual determinants (age, gender, genetic factors, etc.).

The family has an important role in ensuring access to health care for children. Heck and Parker (2002) have illustrated that the socioeconomic status and family structure are determinants of health services access. When drawing a comparison

between the access of children with single mothers and of those with both parents, Heck and Praker concluded that the greatest difference is made by mothers' educational level-mothers' high educational level does not breed differences in children's access to health care, for the two-parents family structures, whereas a low educational level of single mothers favours the access to care of children coming from one-parent families more than two-parents families. Nevertheless, in both situations health insurance coverage is a determinant factor (Heck and Parker 2002).

3 Overview on the Present Social Health Insurance System and on Family Social Protection

In relation to health care access, we mention the difference and dichotomy brought by Law 95/2006 concerning the healthcare reform: those insured with a contribution payment and those insured without a contribution payment. If we take into account that the right to social protection guarantees especially the protection of different categories, which are in social risk situations that emerged despite their will, we see that the health insurance regulations actually establish the right for social protection in case of illness of those exempted from the contribution payment who thus receive, due to the law, social and healthcare benefits, because they are considered to be indirectly vulnerable. In the category of non-contributory insured individuals we find the co-insured, children, social aid beneficiaries, people with disabilities and the unemployed.

The 2012–2013 Social Work Reform Strategy concludes that the protection of the least favoured categories has to be ensured through family policies and fight against poverty policies, as well as through adequate policies for the disabled and elderly people. Moreover, Law 292/2011 on social work defines the vulnerable group as "the people or families at risk of losing the capacity to satisfy their daily needs due to illness, disability, poverty, drug or alcohol dependency, or other situations that may lead to economic and social vulnerability" (art. 6, let. p). It is establishing state's responsibility to ensure the vulnerable persons access to some fundamental rights: housing, social and health care, education and employment. The following categories are mentioned in the in the category of people exposed to the risk of social exclusion: people living alone and families without income or with low incomes, the homeless, the victims of human trafficking and those serving a confining sentence.

At a European Union level, although there is not a common family policy, there are common directions for family protection: economic support for those exposed to social marginalization, among which is the monoparental family, reconciliation of labour and family life, support for children and young people (Popescu 2004). The most alarming trend observed in central and eastern European countries after 1990 is the importance given to the social benefits based on financial means testing

(Standing 1996; Ferge 1997). In Romania, the only family benefit with a universal character is the state child support allowance.

Within the Romanian legislation, there are two types of social benefits based on financial means testing: social aid and family support allowance. Both social benefits have undergone multiple changes from a normative point of view (Popescu 2004; Rebeleanu 2011).

In what concerns the family support allowance, the present regulation framework for this benefit is Law no. 227/2011. The benefit is granted to monoparental families and families that up bring children under the age of 18. According to the law that regulates the family support allowance, the family is represented both by the husband, wife and children who live together and by the one person who lives and provides for her children. The allowance is granted based on family incomes and number of children. The purpose of this benefit is to increase the family revenues in order to ensure better up bring, care and education conditions for the children, to stimulate children's school attendance if the family has low incomes. We believe that is important to remember that for the families with school age children, the child's school attendance becomes an eligibility criterion for the family support allowance; the allowance can be suspended/diminished if the children do not attend or interrupt school with good reason.

Designed as a last defense line against poverty, in Romania, social aid is given to families and single persons, since 1995. The domestic unit is represented by the person living alone or the family (married or single people, with or without children, who live and carry on a household together). The eligibility of the individuals without domicile is one of the positive changes brought by the Law no. 416/2001, allowing for the inclusion in the guaranteed minimum income system of a category (for example, the Roma) which was excluded by the previous legislation (Law no. 67/1995). The right to health is associated to the right to a minimum income (the beneficiaries of social aid have the quality of insured in the public health insurance system, without the individual contribution payment, the contribution to the social health insurance being paid from the state budget).

A study conducted in 2011 by Ministry of Labor, Family and Social Protection illustrates that 3/4 of the social benefits recipients are from the rural area and the percentage of female legal representatives is almost the same with the percentage of male legal representatives. The fact that the number of social aid recipients with a female legal representative is increasing might suggest that many of these family structures could be monoparental families (MMFPS 2011). If the guarantee minimum income comes with the right to health of the recipient and his family (insured without the contribution payment to the public health insurance system), for the recipients of the family support allowance there is no legal means to ensure their access to healthcare. In other words, we can speak of the law-maker's indirect acknowledgement of the vulnerability of the social welfare beneficiaries in accordance with economically determined health service access, but not of the families who apply for the family support allowance for the same reasons. The logic and order of resorting to these family financial protection means are probably based on the following affirmation concerning social welfare, which is 'the last safety net,

used after the persons have depleted all other forms of social protection' (Strategia naţională de asistenţă socială, 2011–2013).

It fact, the right to family support allowance is not associated, from a legal point of view, with the right to health. This aspect can lead to the following consequences: on the hand, in the case of monoparental families, is the parent is not working could be at risk of losing the health care system insured status; in this case, the person can elude soliciting family support allowance in favor of social aid which, although smaller when referring to the quantum, it guarantees the beneficiary the status of health care system insured without payment of contributions.

The aforementioned aspects are just a few of the legal arguments due to which the option to analyze the perceptions of the beneficiaries in relation to access to health care services has focused on beneficiaries of non-contributory social services, which even from a legal perspective can encounter difficulties in health care access.

4 Methodological Framework

Our choice is for the constructivism paradigm. In the study of perceptions, constructivism is concerned with perceptual and cognitive ways of seeing reality, trying to discover individual mental processes in building things (Parker 2005). We have tried to identify versions of the social reality concerning the access to primary healthcare services, in relation to its exercise and effective use. The perceptions concerning the possibilities and conditions of healthcare services usage of those holding a double capacity, that of recipient of non-contributory benefits based on means-testing (assimilated to the acknowledgement of an objective situation of economic and social deprivation) and that of user of healthcare services, show the instrumental and practical dimension of the access significance, seen as a social construct.

The data was gathered from two focus groups (one from the urban area and one from the rural area) of social benefit recipients, based on means tested (family support benefit, guaranteed minimum income). The focus groups were conducted in Cluj County, in November 2012. We included in the focus groups social benefits, more precisely recipients who were part of a family who receives social benefits. The reason is that the family is the reference unit for social aid and support allowance, based on present regulations, and our approach is focused on the family's vulnerability in relation to the access to healthcare services, aspects that are hardly researched in Romania. The research deontology elements were observed. The registered dialogues were transcribed and analyzed employing thematic analysis. The classification of the answers was done through content analysis, with topics emerged from the discussions. It is a thematic analysis, relying on the constructivist perspective. The thematic units are: *health representation, determinants of the access* to healthcare services, *perceptions* related to the health care system, and *perceptions* related to the responsibility in health.

Participants at the discussion groups are persons entitled to the right of receiving family support allowance and/or social aid. Each of them is the legal representative of the family. In spite of our attempt to create mixed groups, women have had a higher representation rate, which is in compliance with the latest national data regarding the distribution of the social benefits and one-parent family allowance beneficiaries by gender of the legal representative (MMFPS 2011). Some participants did not have the 'insured' status, benefiting from the family allowance as the legal representatives in a one-parent family. In every given case the beneficial owner was a woman. A single family allowance beneficiary had the 'co-insured' status—the husband was an insured taxpayer. There were cases in which the family allowance was allocated together with social benefits, which suggests a precarious financial situation of the respective families. Some participants, even if qualified for family allowance, whose limits and quantum are more generous than those of the social benefits, applied for the protection given through Law 416/2011 regarding the insured minimum wage system.

This research is exploratory and does not aim to be a comprehensive study. The data we collected can become a starting point for further research areas.

5 Results and Discusses

We aim to identify and analyse the factors contributing to the appearance and maintaining of inequalities regarding health services access among families receiving non-contributory social benefits from Cluj County. The emphasis lies on health care access from the beneficiary's and user's of medical care services point of view.

The participants in the focus group are mainly concerned with the lack of resources and insurance. A key element here is the lack of access to health services due to scarce financial resources. The lack of financial resources affects on the one hand the possibility to buy drugs prescribed by the family physician, and on the other, the direct access to the doctor and other specialised services.

> I should have an operation done but I haven't got any money; it costs 25 million [lei]; where can I get that amount from? From social benefits? (S6, rural)

> Even if my doctor prescribes reimbursable drugs for my children, I still have to pay to get them…Free of charge is not free of charge for the children either (S5, urban)

> "I don't go to the doctor because I know I don't have enough money for the drugs- they are very expensive. I can't even get free drugs for the children- there is only a discount for them. On the prescription it says "100% discount" but when you go to the drug store you have to pay 12 or 15 lei". (S2, urban)

If the lack of financial resources is accompanied by the lack of insurance, the access problem becomes greater. The only solution that the participants indicated is going to the emergency department. The lack of insurance also leads to avoiding medical care requests. The lack of financial resources is strongly felt also when one

has to cover costs regarding compulsory requests to the family physician for certain medical services, closely related to accessing social services. As a result, a pre-requisite for the family allowance is for the children to attend school and a pre-requisite for social benefits is a periodical issue of the "able to work" certificate. Not presenting the certificates on time leads to the withdrawal of the right to the allowance or social benefits.

> You have to pay the certificate to the doctor for the child to be able to go back to kindergarten after an illness (S5, urban)

> …for social benefits they have to testify that I am able to work and even that certificate costs 20 lei (S1, urban)

> I benefit from social welfare. I am insured, but I must take a certificate to the employment agency that proves that I am able to work and the doctor issues it only for money…I don't find this normal (S1, rural)

In the case of transfers between doctor and patient, informal payment is mentioned, many a times too high for the beneficiaries of non-contributory welfare.

> Those who have money treat themselves; those who don't, don't; I was hit and I stayed three days in the hospital, unconscious. They didn't operate on me before my wife and son gave money to the doctor (S6, rural)

> I had a problem with my daughter, ill with appendicitis; they kept her in the hospital for 10 days without drugs, only with ice on her tummy. I talked to the doctor on duty and he told me to take her home. After two days she was hospitalised again as an emergency case at a different hospital where they operated on her because of an ovarian cyst and appendicitis. At the first hospital they didn't do anything because I didn't have any money to give. Other parents told me they paid between 100 and 200 euro in hospitals for their children. It seems that only bribe works here. (S4, urban)

Informal payments are a reality of the medical system (Rebeleanu 1997; Popescu 2004; Vlădescu 2011) and reducing these represent concerns and priorities in matters of health policies at decision-making level. Due to lack of sufficient funds, the family's inability to pay affects the child's health and the parents feel guilty and helpless. Corruption and the lack of financial resources in the specialized medical assistance system determined participants to believe that the health care system is ineffective and incapable of attending to the participants' health requirements. We also estimate that the lack of information (even though it is not recognized as such) also plays a determining role in granting access and triggers discontent towards the system. As demonstrated, prior experience within the doctor-patient relationship generates certain expectations for patients. Changes in the access procedure for health care services and the public's ignorance related to them increase the level of frustration.

> The previous doctor understood our situation…he knew we couldn't pay…But the current doctor demands we make an appointment, or else we have to pay for the exam. (S5, rural)

> We have to make appointments for our children as well… I took my child to the doctor, but our appointment was set one month later. So I gave up the appointment and paid for the exam, because it was urgent. (S3, rural)

> I go to the doctor and I only get an appointment a few months from now. What am I to do in the meantime? Simply treat myself and then take the blame for it? (S2, urban)

> …I saw my family physician and he referenced me to the clinic for my sinus infection. But I didn't go because I knew I couldn't afford it (S4, urban.)

On the other hand, people whose children or family members have suffered from a medical condition are well aware of their obligations as policyholders. The obligations they were able to mention refer to preventing illness, offering correct information related to the history of disease and respecting medical decisions and treatment.

The majority of respondents believe that the relationship with the primary assistance system is an appropriate one. The family physician seems to have the best understanding of the family and its difficulties, while the impossibility of acquiring treatment tends to become a reality of the health care system. The family physician references patients to specialized services, but their access is affected by a lack of resources allocated by the National House of Health Insurance towards service providers.

> The family physician gave me a reference for medical tests. But at the clinic I was told they had no more funds. (S4, rural)

Another reality characteristic of the Romanian health care system is patient ignorance. This lack of information is also perceived by service providers and is present in the National House of Health Insurance reports, in the Presidential Committee Report (2008). We emphasize that current legal provisions state that the insurance contract is arranged between the House and the service providers, while the patient remains unaware of the health benefits he/she is entitled to. The patient also tends to be dissatisfied with situations in which he/she has the contractual obligation to partly or fully pay for certain services. The discontent of social welfare beneficiaries becomes accentuated, since the amount of their available resources is limited. Ignorance about the services covered in the basic health insurance package could influence the option for voluntary insurance. In theory, such an option would require a private health policy holder to be aware of the basic package provided under the compulsory social insurance. Yet, the question being raised is whether socio-economically underprivileged families could opt for a private policy. It is considered that this specific category may be excluded from private insurance (Eckenfels 2002).

In matters of health and service access, the main concern is the guarantee that medical care services can be used for children.

> I don't go to the doctor…I haven't been since God knows when. I haven't got an insurance nor money to pay for it. I only go with the children to the doctor, whereas I… (S6, urban)

> …I don't really go to the doctor…because I know I haven't got a good reason to. If you haven't got insurance…the former doctor understood us, the poorer ones, but now… (S4, rural)

> I go to emergency department…if it's the case. And also to the doctor, but if I haven't got insurance she can only see me but I have to buy the medicines (S3, rural)

The participants in the study are beneficiaries of means tested benefits, a financial support system addressing persons who are no longer qualified for or do not meet the requirements for any other form of social benefits. Local studies show that in the case of households with children under 15, the redistributive effect of the social services is more modest. Where there are no social protection services, a significant segment of households with children would be labelled as poor, on the basis of income obtained from the family's market capacity and its pensions (Raţ 2009, pp. 179–197). The deprivation gap is more profound when nobody in the family has a job and this aspect was identified in our one-parent family research, in which the adult (more often the mother in our study) does not have medical insurance as he/she is not active on the labour market. National statistics regarding the insured minimum wage is a confirmation of the fact that there is a great number of women legal representatives of the social welfare beneficiaries (a service that is available after accessing the family allowance according to the logic of granting social assistance benefits) (MMFPS 2011). The gender of the legal representative and the one-parent structure of the family represent a risk factor towards access due to lack of insurance, a fact that has been confirmed by the participants in the study, both from the urban and the rural area.

While the lack of sufficient funds appears in both residence areas—urban and rural-there is another important aspect to be taken into account in the rural area: the lack of human resources. In a village there is a single family physician that covers 2200 inhabitants. The differences between the urban and the rural areas are one of the factors quoted by the Romanian health analyses (Popescu 2004; Popescu 2009, pp. 152–167; Vlădescu et al. 2008). The huge gap between the rural-urban in what sanitary and medical infrastructure are concerned and a concentration of the poorest in the rural area (at least in Romania) are associated with the lack of qualified staff, other than the family physician. These factors shed doubt upon the issue of 'freedom of choice' among health services providers for those with poor health and the more economically vulnerable from the rural area. A distinction must be made between freedom of choice per se and the freedom of choosing something (and not something else); in other words the quality of alternatives for them to choose from. This distinction is analysed in detail by Alkire (2002) who distinguishes between having more alternatives (range of choice) and strengthening freedom of choice. Lack of choice is mainly felt in the rural area. There is a risk factor concerning access perceived by the focus group participants when they relate to their doctor. In other words, the pre-existent relationships of a retired family physician turned the persons on his/her list into "disadvantaged" (S2, S3, S6).

Even, the residence area is mentioned as a factor that puts a limit on access but it is estimated that the financial funds of the patient can compensate for this drawback.

> Those who have money go to the doctor. It doesn't matter if you're from the countryside or the city (S2, rural)

> If I have a problem and a person with money shows up, the doctor will forget about me and take him instead (S6, rural)

The residence area is seen by those from the urban area as an advantage in what access for the inhabitants of the rural area is concerned ("*I've often seen that they take those from the countryside in front of us, because we live close by and we can easily come back*' *(S4, urban);* '*I am often asked where I am from for the appointment, because those from the countryside have priority"(S3, urban)*). Nevertheless, this is also seen as a disadvantage, in what the medical care quality and access to specialised doctors are concerned ("*in the countryside the doctors aren't as good as those in the city" (S5, urban);* "*in the city there are better hospitals and doctors" (S5, urban)*). However, participants living in rural areas consider that inhabitants of urban areas have a clear advantage:

> ...you are treated differently if you are from the city… (S3, rural)

> I was waiting at the doctor's, queuing at the clinic when somebody showed up after me and he was called in by the doctor. He looks on your referral and sees that you come from the countryside and tells you to wait because you've got plenty of time while those from the city are in a hurry (S4, rural).

Social welfare beneficiaries consider education as a possible trigger of difficulties in accessing services, as well as in entering the labour market. On the one hand, lack of education is associated with ignorance about the demarche for requesting medical care, while being on the other hand perceived as a discriminative factor related to privileged access to health care.

> When I went in for medical tests, they asked me about my studies and after I answered, they had nothing more to ask me. (S3, rural)

> Not having any studies is bad. You can't find work. And if you don't have a job…you have no choice, you get social welfare…at least we have insurance, but what about those who don't? They just wait home to die… (S2, rural)

> If you attended primary school and go see a doctor, you can get informed and prevent a disease…But it's better to go to school. Now they have personal hygiene classes in schools. And sometimes, the child ends up teaching the parent. (S2, urban)

Ethnicity is only perceived as a determinant of access in urban areas.

> I would get a job, but nobody wants to hire me…And I have tried to work. I get positive answers on the phone, but when I show up and they see I am a Roma woman, they immediately tell me the job is no longer available. Some doctors don't even pay attention to me when I ask questions. (S3, urban)

> I also submitted my CV, but nobody called to schedule an interview. And even if they did…they never try to see what I am capable of once they learn I am a Roma. I want to get a job to apply for insurance. (S2, urban)

Belonging to the social work beneficiaries category is also perceived as a discrimination reason in relation to access to health care.

> I spent two weeks in the hospital with my child, I slept on a chair. They wouldn't pay any attention to me because I am a social work services beneficiary. (S4, urban)

> Doctors sometimes reference patients underhand. I am not even aware of every illness I have. But if for example I had the flu and I went to the doctor, I would not get the expensive compensated drugs, only the cheap ones. I think we are all entitled to the best. (S5, urban)

Such cases are being documented, namely illegal situations in which prescriptions are paid even though the specified drugs never reach patients (some are deceased or out of town). These occurrences are possible as a result of the rudimentary control system used by the National Health Insurance House that has been trying, for more than 10 years, to implement a software system for monitoring drug consumption (Vlădescu et al. 2008).

Regardless of contribution, social welfare beneficiaries claim undifferentiated treatment. Their arguments revolve around the necessity of health care services for them, as well as their families.

According to respondents' opinion, equal access is also conditioned by the preparation and availability of the physician, the latter's behavior in the doctor-patient relationship and the quality of medical training.

> My neighbor and I suffer from the same illness. We saw different doctors and we got distinct treatments. I am doing well, but my neighbor has tried three treatment plans. Equal access depends on the doctor's quality and willingness;" "They should not talk down on us, we are patients too and they should treat us well because they took an oath… (S5, urban)

> The previous doctor understood our situation…he knew we couldn't pay… (S5, rural)

> Our doctor is kind, but she can't see us without an appointment because she has a lot of patients. (S2, urban)

It has been observed that uninsured people who lack the financial resources to pay for a consult depend on the doctor's willingness and availability to work without remuneration. This is related to the social expectations that patients have of their family physicians, which are probably rooted in the socialist health system era. Another similar expectation is related to handing out medical certificates free of charge, although the law states that family physicians may charge patients for certain medical certificates. The equity principle represents a benchmark in the health care policy (WHO 2008, 2010) and stands as focal point in the continuous reform of the Romanian health care system. In retrospect, amending the primary assistance system represented a primordial objective for the Romanian health reform process after 1990. We emphasize the fact that Romanian legislation distinguishes contributing policyholders form non-contributing policyholders. The exemption from paying contribution for social welfare beneficiaries and children (categories indirectly deemed vulnerable by the legislator) is perceived by participants as state protection granted to groups of people that would otherwise not be able to access health care services.

> I get social welfare, but… it's a good thing because we have insurance. (S2, rural)

> I think of my children…I personally have insurance, I am coinsured and I also had it when I was out of work. (S3, rural)

> I am a social welfare beneficiary so I am insured, but if I only had a one-parent family payment, I would not have enjoyed insurance. (S3, urban)

Social aid and family support allowance beneficiaries are willing to learn and assume preventive health behaviors, which indicate a recognized responsibility towards individual health, as well as towards the family members' state of health. On the other hand, in the eyes of the respondents, the responsibility of granting access to health services falls to the state.

> Money or no money…one should have access to free health care, or at least to compensated care for children; The Ministry of Health ought to make sure the law is abided by.... (S1, rural)

> Free healthcare for the deprived…and access for the uninsured. (S5, urban)

> Yes…national authorities and the Ministry of Health…they should enforce equal rights for everyone. (S4, urban)

Taking into account previously mentioned aspects pertaining to the importance of the doctor-patient relationship in accessing services, non-contributory welfare beneficiaries partly place responsibility in the hands of doctors.

6 Final Remarks

Our inquiry approach has highlighted at least two categories of vulnerable beneficiaries regarding access to health care services, overlooked or ignored by legislators: the one-parent families in which the mother (the woman) is the legal representative and the families eligible to receive family income supplement.

Summing up the perceptions of means based social aid beneficiaries, the risk of exclusion from health care services for this category of people is confirmed. Their relationship with the health care system is largely dictated by the lack of income. Poverty makes covering the costs of compensated drugs impossible, generates fear and uncertainty related to seeking services beyond primary assistance or emergency services (for the uninsured). The informal payments, patient ignorance and doctor-patient relationship are the other factors in order to affect the families access to health care.

Developing a supportive environment for the family's state of health is crucial and can be attained through reducing social inequalities via the wellbeing policy, by addressing unemployment on the long term in order to consolidate the labour market and by fighting discrimination. Combating poverty and social exclusion is vital for tackling or correcting social inequalities in the health care system.

Another desiderate is the formation of primary assistance networks to secure continuity in granting primary assistance in disadvantaged areas. This translates into expanding services at community level and developing health care services in rural areas and small localities in which the population's needs are presently not well covered. These recommendations are taken into account in the Committee Report.

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