

Ensuring a functioning health care system in regions with declining and ageing populations

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Romania – at a glance

Romania is located in the south-eastern part of central Europe and covers an area of 237 500 km². The ethnic population composition is 89.5% Romanian, 7.1% Hungarian, 1.8% Roma and 1.6% other nationalities. Romania is divided into 41 counties and 2686 communes. Romania is a member of the United Nations, the Council of Europe and the North Atlantic Treaty Organisation and, since 1 January 2007, a member of the European Union. The country is undergoing a dynamic period of development and investment. The country shows continual progress in its economic development, with steady GDP growth of 4.5% on average for the past five years and estimated to exceed 8% in 2004, among the highest in southeastern Europe. Despite a 4.1% increase in GDP in 2005, in the first three quarters of 2006 the increase again exceeded 7%. However, according to World Bank and European Commission assessments, Romania still has problems with poverty in some population groups, corruption and local administration. Social, economic and financial reforms are ongoing to improve the performance of the health and social protection system to reach the required EU levels.¹

The demographic situation

Over the past decades, the Romanian population has experienced significant and alarming alterations, with long-term negative trends. Beginning with 1990, the total population has decreased each year, with an average annual rhythm of 0.2%. The most significant decrease was during the decade 1992 – 2002, when the population decreased by 1.1 million inhabitants. The negative values of the natural increment together with those of the external migration balance caused the population to decrease during 2002– 2007 by 268 thousand people. The demographic evolutions over the past years have led to a decrease in the young population of ages 0 – 14 and to an increase of the elderly population of 65 or older. Data indicate a decrease by 8.3 percent in youth during 1990 – 2007 (23.7% in 1990 and 15.4% in 2007, respectively), as well as a growth by 4.6 percent (10.3% in 1990 and 14.95 in 2007, respectively) in the elderly population of 65 or older. The potentially active population, of ages 15 – 64, which provides Romania's labour force, oscillated between 66.0% in 1990 and 69.8% in 2007.

From the analysis of both national and international data and to the forecasts and without considering the external migration but estimating a growth in life expectancy at birth, Romania's population will decrease from 21.5 million inhabitants in 2007 to 21.2 million in 2013, to 20.8 million in 2020 and to 19.7 million in 2030. If we take into account the growth of mobility and the effects generated by the external migration, Romania's population could reach 20.8 million inhabitants in 2013, 20 million in 2020 and 18.6 million in 2030, according to the forecasts. These

¹ WHO official site report

aspects have very important consequences in all the areas of the economic and social life, such as education, labour force employment, professional training, social and health services etc.

According to the data supplied by the National Institute of Statistics in 2007, approximately 18.5% of the Romanian citizens are poor (18.3% of men and 18.8% of women). During 2004 –2007, there was a stabilisation of the relative poverty rate level around 18% - 19%. From the point of view of the residential environment, the rural environment continues to deal with a greater occurrence of poverty and severe poverty, while poverty rates in the rural environment came up to 29.6% in 2006, compared to 9.6% in the urban environment. The comparative analysis of 2007 as to 2006 shows that the poverty rate in the rural environment grew from 29.6% to 29.9% in 2007. Consequently, approximately 70% of those exposed to the poverty risk live in the rural environment.

From the point of view of the household type, there are four types of households that experience a higher poverty rate, namely: single persons, namely 27.9% (22% of men and 30.8% of women), thus 9.4 percent more than the national poverty rate; single parent families (31%); families with 3 or more children (40%), as well as single persons above the age of 65 (33.4%).

Furthermore, there is also a regional discrepancy as far as poverty rates are concerned; the highest poverty rate in 2007 was in the North – East region (26.2%) and the lowest in Bucharest–Ilfov (4.6%). There is also a high poverty rate in the South – East regions (24.2%) and the South – West regions (23%).²

Current situation in Romania

In Romania, urbanization is extremely low, especially compared to other European countries. In 2007, Romania's urbanization was of 54.9%. In Europe, only Albania and the former Yugoslav republics have a lower percent of urban population. Between 1997 and 2006, while Romania was in the re-modernization period, our country registered an anomaly in the migration flow, the process being dominated by the migration from the city to the countryside. 1997 was a crucial year in Romania's social history because the city-village migration became the most important characteristic of the internal migration. After decades, people rather move to the countryside than to the city. From a social point of view, the Romanian post-communist transition ended in 2005-2006. The year 2006 is the first year when the migration flow is dominated by city to city migration instead of city to village. Still, city-village migration remains second in importance (28% of all migrants).³

² Strategic National Report Regarding Social Protection and Social Inclusion 2008-2010

³ Urban(ization) In the World, Rural(ization) In Romania report, UNFPA Romania

Law No. 17 of 6 March 2000 regulates the social care for elderly persons. According to this law, institutional care is organized as follows. Community services provided for older people in their home include:

- *social services*, particularly for prevention of social marginalization and supporting social reintegration, legal and administrative counselling, payment of some services and current obligations, home and household attendance, help for the household, and food making;
- *medico social services*, particularly for help with personal hygiene, adaptation of the home to the elderly person's needs, encouraging economic, social and cultural activities plus temporary attendance in daily centres, night shelters or other specialized centres;
- *medical services*, such as medical consultations with attendance at home or in public health institutions, consultations and dentistry attendance, medicine administration, supporting sanitary materials and medical devices.

Medical services are provided on the basis of legal regulations regarding social health insurance. In 2006, there were a total of 60 units of so-called medico social facilities, with a total of 2365 beds. (Ministry of Public Health, 2007b). In 2005, there were 19 care homes for elderly people in Romania.

Service organisation is the responsibility of local councils, which provide services directly or through contracts with NGOs and religious organisations. In order to ensure home care services for dependent elderly persons, local councils can hire attendance personnel by the hour, on a part time or full time basis, depending on the necessary period of attendance.

The quality of long-term care is regulated by Order no. 246 of 27 March 2006, issued by the Ministry of Labour, Social Solidarity and Family. The quality standards of long-term care refer to organisation and administration, human resources, access to services, service provision, rights and ethics.⁴

There are great differences between mortality in the rural and urban areas.

The north-eastern regions, south Muntenia and south-eastern Oltenia have rates of the population that lives in the rural area which is over 50 % from the total population (respectively 56.75%; 58.35% și 52.57%). In some counties, this rate can be over 60%: (Neamț 61,36%; Vrancea 62.20%; Dâmbovița 68.75%; Giurgiu 68.89%; Teleorman 66.37%).⁵

The forms of care provision that are suitable for maintaining medical and nursing care in rural regions are scarce represented. In this regard, recent analysis has revealed that there are severe regional inequalities regarding the medical personnel. So, the number of inhabitants treated by one medical doctor in the rural area is 6 times bigger than in the urban areas, for the year 2005, as it is shown in the *National Strategic Plan of the Ministry of Health 2008-2010*. The most underprivileged regions are the south and the south-east (773, respectively 655 inhabitants /1 doctor). The northern region of Romania is registered as the most uncovered medical part of the country in the rural region (2778 inhabitants/1 doctor). At the same time, the number of

⁴ HIT, vol.10, No. 3, 2008.

⁵ Final report on hospital infrastructure

communitary nurses is totally insufficient, that is for one communitary nurse there are 26265 persons. In the rural areas there were 98 communes without any medical assistance(doctor).⁶

It is well-known that probably all governments tend to increase the intake to medical universities and raise the rate of return to investing in medical skills by raising salaries and offering good working conditions, as probably one of the well-known strategy to get new doctors. Lately, in Romania there is a high rate of doctors and nurses that are leaving the country in order to work in other EU states or in the USA. This trend is in favour since the 1st of January 2007 and it is a great issue, as well as a problem for the remaining population on what concerns the medical assistance.

The Health Systems in Transition (HiT) profiles are country-based reports that aim to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

Regardless of the political approach of the parties, the high turnover of ministers and the lack of strategies with clearly defined objectives contributed to slow or delayed reforms in the health sector. Furthermore, the abilities, skills and competencies of those involved with implementing reforms have not been adapted in line with the changes made to the system. The former government elected at the end of 2004 engaged in a new health care reform defined by a comprehensive Health Reform Law, which came into force in May 2006.

The home care is the most efficient strategy for dependant elderly care not only because this method involves a reduced cost as compared to the institutionalized care, but also because it is preferred by the persons at issue, representing an essential attribute for ensuring the life quality increase.

In order to provide home care services, in Romania the programmes allowing the development of the social infrastructure likely to support an actual network of services which is to be coordinated with other structures, namely to the medical and social ones, are treated as high priorities. This implies sufficient financial means, granted according to a well structured model defined at national level, specialized personnel, whose dimensions are established according to the social problem, the involvement of the civil society, development of the voluntary services, granting support to families and carers.

Most of the dependant elderly people benefit from the care services provided inside the family. This reality raises numerous problems that need to be solved. Most family carers are women, wives, daughters or nieces. Many carers are, in their turn, elderly persons and may become dependant. Paradoxical, the family care is ensured mainly in the rural area, where the traditions and moral values are maintained to a higher extent.⁷

Health care in general and especially on elderly people is and will continue to be a challenge in the future decades. Positive solutions should be found in order to provide quality healthcare for everyone, regardless of the region where they live and what human or financial resources they have!

⁶ Ministry of Health of Romania official site.

⁷ Strategic National Report Regarding Social Protection and Social Inclusion 2008-2010.

One of the specific objectives of the *National Strategic Plan of the Ministry of Health 2008-2010* is the development of human resources in concordance with the population's needs:

- identification of some facilities in order to attract medical personnel in the isolated areas, underprivileged economically;
- developing the criteria for classifying the accessibility for these identified zones (served population, distance from the ambulatory to the hospital, type of predominant pathology, mortality and morbidity indicators);
- quantification of the criteria in order to establish the isolation degree and the geographical, temporal and socio-economical accessibility);
- establishing financing of different financial and professional stimulants;
- elaborating an information system of the medical gradulators and personnel regarding the advantages in order to make these areas attractive, even for a short period of time (2-3 years).
- assuring a business residence by the local public administrative authority for the medical speciality personnel who lives in other places: until the business residence is given, the medical personnel receives, on request, by compensating the public local funds of the local authority on a leasing contract made under the law;
- receiving a free land inside the town to all the doctors who want to build their house in that town, on the legal urban documentation, from the private territorial administrative domain where the local counsels have such fields;
- giving the settlement indemnization equivalent to two basic salaries at the maximum level provided by law for the medical doctor specialist in the sanitary system which is beard by the territorial house of health insurance, in the heavy conditions places in the rural areas and in communes with declining population;
- according a 50% bonus to the basic salary to the medical personnel with an individual working contract;
- endowment of the medical primary care and ambulatory consulting rooms with furniture and medical equipment; the funds are allocated from the local budget.

Conclusions

All these objectives have as a final aim the good efficiency in using all the funds which is a very stressing necessity and not only a general objective of the new medical system. The new provisions regard these important problems. The access of the insured patients to the medical services, as well as to free and reimbursed drugs is to be improved thru the framework approved in the second trimester with the National House Health Insurance, regarding the ambulatory treatment, especially in the rural areas, as the minister specified at the beginning of this year.

Source

<http://www.ms.ro/> (Ministry of Health of Romania official site)

http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/nap/romania_en.pdf

http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2009/country_profiles_en.pdf

http://www.unfpa.ro/presa/com_presa/StateoftheWorldPopulation/?limba=En

http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_rou_en.pdf

<http://www.euro.who.int/Document/E91689.pdf>