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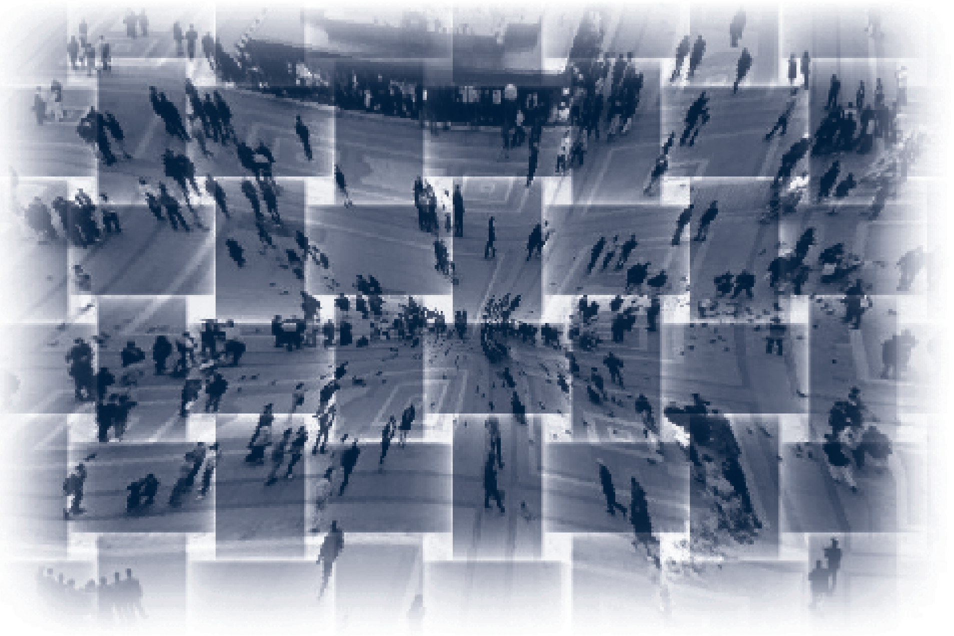

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WELFARE, HEALTH AND SOCIAL CHANGE

Special Issue. Guest Editors: Jan Sundin and Adina Rebeleanu

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Guest Editor's Note for the Special Issue on Welfare, Health and Social Change

As the coordinator of the PHOENIX Thematic Network working group on "Welfare, Health and Social Change", it is my honour to be guest editor of this special issue of *Studia Sociologia.* The articles emerge from a workshop held in Cluj in September 2007, aiming at a deeper understanding of the complex relationship between social change, welfare and health, bringing together scholars from many parts of Europe. In comparatively affluent western societies, socio-economic and demographic change is affecting the life conditions for large parts of the population. China's changing and growing economy is bringing rapid prosperity to certain groups, while at the same time causing greater inequalities in social safety, access to health services and to health itself. Developing countries are facing divergent trends, sometimes growing wealth and better health, sometimes more illness and death. Looking back in history, we find similar processes and events, which have affected welfare and health in visible ways. Typical groups of winners and losers can be identified and, for instance, the vulnerability of adult men (measured by cause and age specific mortality figures) has been evident in several cases. The role of social cohesion and political and institutional response (or non-response) to these social realities has been already extensively argued.

In former socialist states from Central and Eastern Europe, the transformations towards democracy and free market have had profound, in some cases dramatic, effects on people's health and life expectancy. It has been a privilege for the PHOENIX network to welcome many members of the academia from that part of Europe, providing us with deeper insights and understanding of the history and present state in their countries and contributing to a comparative and theoretical analysis. The authors of the articles of this issue give us interesting and illuminating examples of recent trends regarding health status, public health, welfare policies and their implementations. Both globalisation and local circumstances are playing important roles for the outcome. In the light of the economic and social constraints that threaten to follow upon the recent financial breakdown and general recession of the world economy, it becomes even more important to analyse and draw informed conclusions regarding the potential consequences of rapid change.

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PhoenixNT Coordinator's Note

The *PhoenixTN - Thematic Network on Health and Social Welfare Policy*, approved and financed by the European Commission in 2001, is a project developed in the framework of the program Socrates/Erasmus, that started with the participation of 45 (now 87), mainly European universities. Since the very beginning, one of the main goals of *PhoenixTN* has been to improve the understanding of health in the society, especially the interrelations between health and social change, contributing to the integration of new subjects in the field. This was pursued through the comprehensive and dedicated effort of all participants, a close collaboration and continuous dialogue between educational bodies and non-academic institutions. We also involved the mass media in order to foster the dissemination of the outcomes to a larger audience, targeting especially politicians and stakeholders.

Through the organization of a series of conferences, seminars, workshops and other activities, the program contributed to the internationalization of its partners. This has also been done through educational programmes (as the *Erasmus Mundus* master *PhoenixEM, Dynamics of Health and Welfare*) and several thematic publications, specific studies in the fields of health and welfare, proceedings of scientific meetings which were published or sponsored by *PhoenixTN*.

Within these efforts, it is a pleasure to celebrate the thematic issue of *Studia Sociologia,* the journal of one of the most active partners in the project. Our collaboration in this special issue constitutes an important scientific event and a significant contribution to the aims of the *PhoenixTN* network.

Laurinda Abreu

Coordinator of PhoenixTN –
Thematic Network on Health and Social Welfare Policy

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HEALTH POLICY IN THE POST-SOCIALIST ROMANIA – INTENTIONS VS. ACHIEVEMENTS

ADINA REBELEANU[a]

ABSTRACT. This paper investigates a topical issue of interest in the economical, political and social context of Romania in the transition period. The analysis in terms of intentions and achievements in the evolution of Romanian health policy reveals positive aspects, as well as weaknesses and inconsistencies between the enacted laws and the effective results. Starting from the assertion that health is an inherent component of the quality of life, it argues for the necessity to reduce the "vulnerabilities" which stem from the Romanian health care system. This requires a general, coherent and coordinate effort of policymakers, to stress the importance of health reform within the framework of social policies. The main changes which have been made in the Romanian health care system since 1990 are reviewed, and their most salient outcomes critically analysed.

Keywords: universal access; change in health care system; health insurance; coverage

Introduction

The following aspects concerning the health social policy are to be viewed as common points in the health reforms undertaken in all the Western European states: the right to health services guaranteed to all citizens, solidarity as a basic principle in the functioning of the medical care, the state being a guarantor for promoting the population's health, its role mainly consisting in providing sickness prevention programs and less in the financial management mechanisms. At the same time, the decentralization of the health system and the involvement of citizens in the process of decision taking are also promoted. The interpretation of the decentralization in the health sector cannot be exclusively functional, and the extent to which this latter aspect is materialized in concrete results depends on the Governments of the Member States (Fox, 2004: 525-533). The evolutions confirm the health status as a public social good, even if the state's role is being restrained in the new configuration of the medical care systems. The importance of the neoliberal ideology is reaffirmed also in this sector of social protection (Paquay, 2004: 155-123).

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The health systems in the post-socialist countries functioned until 1990, on the centralized model of health care. Even though they had positive elements in the communist period (assuring the right and the free access to the health services for the entire population), the health services in Central and Eastern Europe proved to be inefficient in promoting some measures for preventing sickness and invalidity from known and evitable causes.

The reforms started in 1990 in Central and Eastern Europe redefined the fundamental role of the state in all sectors (economic, social, and political). This redefinition required an orientation and an efficient fund allocation through market mechanisms, through a higher institutional freedom, as a result of a gradual decentralization of responsibilities and management.

In most post socialist countries, the health sector was not prepared for the problems that the reform has generated. One of these problems, considered to be inherent to the health reform in 1990, in the context of transition towards a market economy, was the confrontation with the protests against the negative effects of the transition, which, moreover, destabilized the whole process of the reform. The political decision-makers had to deal both with the persistent problems of the past, with their weaknesses and positive parts, and also with the costs that the transition process generated and which, most of the times, were higher than the initially estimated ones; even more, the population was not prepared enough to face these problems.

From my point of view, independently of the declared aims and intentions regarding the sanitary policy of the authorities of the post communist countries, the success was conditioned by the general context of the transition in these countries. This is primarily the transition towards a market economy. Second, the elaboration of the social protection mechanisms had to take into consideration the economic, social, cultural resources and particularities of each country.

Shortly, if in the last few years, most of the Western European countries have been preoccupied the necessity to increase the state's role in the health policy (see Paquay, 2004), due to the imperfections of the market, in Central and Eastern Europe the tendency was to limit the role of the state and to introduce the market forces in the health domain. The common problems faced by the ex-communist states can be resumed in the active deterioration of the health status, the decrease of the medical services quality, the insufficiency of the resources allocated to health. Part of these problems were inherited from the past, part of them were accentuated by the start of health reforms, in the conditions of economic and social pressure.

The option of the Central and Eastern European countries was to move from the centralized system of medical care to a system based on social health insurances. Nowadays there are only two models of health care in the European Union: the Beveridge system (the national system of health care) and the

Bismarck system (based on insurances). We have to keep in mind the fact that, all countries have been confronted with the need to reduce the expenditure connected to the health domain, with the decentralization of the responsibilities related to health care, to increase cost-efficiency and to enhance the quality of the medical act, with the introduction of the market mechanisms in the health system. If in the OECD countries the health expenditure represents more than 8% of the GDP, in the post-socialist countries this share was, on average, below this level*.* The private sickness insurances represent a quarter of health expenditure in the OECD countries, while in the post-socialist states this share is negligible (OECD, 2004). The aim of the private insurances is very diverse, from a basic coverage to a complementary role to the public insurance. But their efficiency is arguable in what concerns the effect in improving the access to health care, the impact on the quality of services, in reducing the financial pressures on the system, etc (OECD, 2004; Wasem et. al., 2002: 224-248). On the other hand, most analysts agree that state monopoly in the health sector has negative consequences on the quality of services and cost-efficiency, and advocate the necessity of market mechanisms, competition between suppliers and that the public and private health insurances should be complementary.

The analysis of the evolutions in the Romanian health system confirms the need to approach these reforms in the general context of social protection. It reaffirms health as an inherent component of a qualitative life. Health becomes the guarantee of the primary income. A good health status and a real guarantee of the equitable access to health services exclude the need for the dependence of transfers-related incomes. They become undesirable for a prosperous society. Undeniably, health represents a domain of a nation's life quality. Consequently, for a coherent economic development, social and health policies are needed to support the development of the politic, economic and institutional reforms. In other words, assuring the health status implies a general coherent and coordinated effort of the decisional factors, and cannot be reduced only to the sanitary sector, especially if health is considered an essential pre-condition for a productive life, both economically and socially. The development of a supportive environment is essential for health: reducing the social inequalities through a welfare policy, strengthening the labour market by acting on long-term unemployment, combating discrimination, influencing the living standard of those living in disadvantaged areas, assuring the conditions of economic macro stability.

Methodological approach

The specific objectives of the initiated analytical process are represented by:

a. the situational and legislative analysis of the promoted health policy,
b. establishing implicit aims and objectives of the health policy,

c. analysis of the health policy in terms of intentions and achievements for each government period,

For the analysis of the health policy in the România, the grid proposed by Peter Townsend was used as a starting point, which contains six items: (1) the existing organizational system; (2) the body of laws, statutes, regulations; (3) administrative procedures that govern the functioning of the institutions and the relationships between them; (4) the professional and auxiliary staff; (5) the source and the allocation of the financial resources; (6) the users and the population benefiting from services and the information about the objectives of the health reform, the existent services, the users' rights and obligations. The grid was adapted so as to allow us to complete the analysis of the health policy in terms of intention-achievements, advantages-disadvantages for users and the population of beneficiaries, the perceived quality of the services, the perception on the health system evolution, without insisting on the aspects related to the health care management (the organization of hospitals, the accreditation of medical institutions, the setting of the quality criteria, the management and the organization of medical institutions, etc).

In order to accomplish the analysis in terms of intentions and achievements for each governmental period, I have started from the governmental programs of each government and the strategies proposed for the health domain, in the context of the economic and social reform.

Evolution of Romanian's health system after 1990

Overview

România has a certain tradition of organized health care. Between the First and Second World Wars, certain groups of workers were insured by a social insurance system based on sickness funds. Nevertheless, only 5% of the population was covered (NHDR, 1995). Along with other Central and Eastern European countries in which a state socialist regime was installed, România adopted in 1949 a universal public health care system, which was highly centralized and granted free access to health care.

For the reform in the health care system after 1990, the reference moment is 1997, when the Law on the social health insurance system was passed. However, contributions to the health care fund started to be collected only in 1999. The insurance-based system started to be fully functional only in 2000.

In 2004 was passed the Law for private health insurance, but not transposed in practice.

Actually, the new packet of laws concerning the health reform was enacted in 29 may 2006. "The Nicolăescu Reform", as the new reform of health system is called after the name of the health minister Nicolăescu, reconsiders the health system taking into consideration the same principles, but with more liberal applicability, emphasizing the responsibility of each individual for his/her own health and the participation in covering the costs of health care, by the promulgation of the voluntary insurance and the promise of their transposing into practice.

The premises of the introduction of social health insurance system (1990-1996)

We remind the fact that the option of the Romanian policymakers was for a gradual transition towards the market economy. In the attempt to reduce the social costs of transition, plenty of hesitations have been made while imposing strict fiscal constraints and sustaining the real privatization of the unprofitable enterprises and the development of medium and small enterprises. The consequence – decrease of the living standards, attempts to impose a macro-economic stability, having as a result the decrease of the GDP at the end of the 90s, and the rapid rise of poverty. The negative evolution of the GDP was also reflected in the social and health expenditure. The salaries and also the values of social benefits have depreciated. The delayed and hesitant economic reforms had negative consequences on the economic growth, the budgetary deficit and the increasing inflation rate affecting the population's possibilities to make ends meet their diminishing incomes.

After 1990, from the political point of view, a multiparty system developed in Romania. But, unlike the rest of the post communist states, where the political fluctuations took place*:* from the political right to left-wing parties, in Romania the left-wing social democratic party was at governance until 1996, thus until the year previous to implementation of the health care insurance system.

In my opinion, during the period 1990-1996 there were no major changes in the Romanian health system, although the population's expectations were high for all the domains – economic, social, and politic, due to the political declarations made after 1989.

The measures taken by the Ministry of Health, during the period between 1990 and 1992 had rather a reparatory character, moulded on the Romanian social policy model characterizing the interval 1990 – 1993 (Zamfir, 2000: 13-34). The measures designed to reduce the maternal mortality, by liberalizing abortions and ensuring their medical security, as well as providing access to contraception*,* represented one of the most important changes from that period, with great impact on improving women's health (maternal mortality have been constantly reduced since 1990 until the present day).

The authorities' concern for a better management of the health funds, in the sense of additional resources, is expressed in the adoption of the Governmental Ordinance (G.O.) 22/1992~~,~~ which regulates the free medical services provided for the population from public funds. The national budget remained the main financing source, but beginning with 1993 a part of this responsibility was undertaken by local budgets and a special health care fund was set up. It is, in my opinion, the first measure for the decentralization of the health system. The prerequisites of G.O. 22/1992 enhanced the equity of the public health care system:

a. the pensioners, the unemployed, the persons without an income and their family members were exonerated from the payment of the contribution (these categories were later exonerated from the payment of the contribution to the social health insurances); this is an indirect confirmation of the socially disadvantaged status of these categories of population;
b. excises (additional taxes) for advertising and alcoholic beverages, tobacco and cigarettes constituted an indirect measure meant to discourage the consumption of these products, considered to involve risks for health, and also to raise funds for the public health care system. The measure was brought back at light in 2006, through the "Nicolăescu Reform" ("the vice tax").

The medical reform, in this period, had the following goals:

- To introduce a generalized system of health insurance;
- To develop primary assistance and the institution of "the family doctor";
- To set up functional links between primary, secondary and tertiary medical assistance within a mixed, public and private, system;
- To allow insured people to freely choose their GP's;
- To change the financing method of the health care system using the direct contributions of the population, employers, and the state;
- To ensure the autonomy of the suppliers of medical services.

One can trace back the following characteristics of the evolution of Romanian health system after 1990:

a. The real privatization within the sanitary sector has not been coherently sustained and regulated,
b. A real market of health services has not developed,
c. The private practice financed by public resources has been ab initio excluded and,
d. The income of the doctors has been 3-5 times smaller than in other post communist countries (Zarkovic and Enăchescu, 1998: 296-331).

There have been at least two major consequences of this situation: first, the radicalization of the trade union activism of the medical staff, who finally obtained a slight improvement of salary standards. Yet, as this improvement has not been accompanied by corresponding rise in the health budget and in the annual gross domestic product, a certain pressure on the other expenses such as drugs, medical technology, some categories of health treatments, occurred. Therefore, these expenses had to be restrained. The second consequence was the unregulated practice of exaggerates charges within public institutions. The results were the reduction of accessibility, increasing dissatisfaction of beneficiaries, the deterioration of the quality health care, the corrosion of trust between the medical staff and patients.

At the end of 1996, the health policy experts argued that, whether a main or complementary means of financing the medical services (Enăchescu and Vlădescu, 1997: 147-152). The replacement of the universal residence-based national health care system with an insurance-based system did not seem to be adequate and appropriate for this transition period, and was considered unreasonable for that moment. There were too many constraints and too many uncertainties concerning the decisions that had to be taken.

The social health insurance system (1997-2004)

During the period 1997-2004, two major legislative changes in the social health insurances system (SHIS) have occurred. It is important to emphasize the fact that, although it was adopted in 1997 and legally applicable since 1999, the social health insurances law was modified in 2002. At the moment of the introduction of the social health insurances regulation, the necessary infrastructure for implementing the law was lacking. The role to administer the insurance system was played by the Ministry of Health. Gradually, this role was delegated to the National House of Health Insurance (Casa Națională de Asigurări de Sănătate) and the Ministry of Health kept only some responsibilities in elaborating the national health policy, in designing and financing the national health programs, in setting the national personnel policy.

There were two main laws regulating SHIS during two different governments (centre-right during the 1997-2000 governance and social-democratic during the 2001-2004 one). Some significant differences exist between the two laws, but the text of the G.O. 150/2002 is much clearer and less prone to interpretation as compared to the Law 145/1997. Both documents use the following classification of insured persons according to their contribution payment: insured persons with a compulsory payment of the contribution, insured persons without the compulsory payment of the contribution and insured persons with the contribution paid from other sources.

The persons benefiting from social aid (the Law 67/1995 and later the Law 416/2001 on the Minimum Income Guarantee), the unemployed, the pensioners, disabled persons, the children, the prisoners and those in imprisonment but not yet convicted, belong according to both laws, to the category of insured persons without the payment of the individual contribution.

Although the medical system has started to register some initial progress from the point of view of its equipment, in what concerns the access to services, especially the period until 2000 was characterized by a rapid process of polarization. A large segment of the population was only marginally covered regarding the health services and this for different reasons. On one hand, the coverage with health services in rural areas decreased, and access to medical services was very difficult. Thus, between 1997 and 2000, the number of inhabitants per doctor in the rural area increased from 1475 to 1649, while in the urban areas, not only was the number of inhabitants per doctor smaller, but it also decreased (360 inhabitants per doctor in 1997 and 309 in 2000) (UNDP, 2002). The situation is also similar concerning the middle-rank sanitary personnel. The escalation of poverty was another factor which hindered access to medical services, especially because of collateral payments (either the official co-payment of public services or the unofficial, informal payments to the medical staff). The liberalization of the prices of medicines was also responsible for a reduced access to many treatments, vital especially in the cases of chronic diseases. The granting of the social aid was conditioned - according to Law 67/1995 - by restrictive criteria. The insufficiency of the local funds destined to the payment of these social benefits and the conditions of entitlement (such as having a stable address) created a niche in the service coverage in the detriment of a wide segment of the poor population. The Roma population was overrepresented in the category of those not covered by the social security, and, consequently, lacking health insurance. In order to limit the exclusion from the social health insurances system of a quite considerable segment of population, the social protection system required some changes.

The correction is attempted by Law 116/2002 regarding the prevention and fighting against the social marginalization and also through the new law on the guaranteed minimum income system (Law 416/2001). At the same time, special support measures for are designed for the Roma, as stipulated in the 2001 Governmental Strategy for improving the situation of the Roma in Romania.

Thus, in terms of intentions and achievements, during the governing period 1997-2000 there the former exceed the latter. Some of the outcomes fall in the category of “perverse effects”. Between 1997 and 2000 the share of health expenditure increased only 0.3 percentage points, while in 2000 it was at the same level as in 1990 (2.9% of GDP). The National Health Insurance Fund was set up in 1997, but it became autonomous only in 2000. As mentioned before, a large segment of the population was not covered by health insurance. Between 1998 and 2000, the share of funding from the central and local budget gradually decreased, and the share of funding from health care contributions increased. In 2000, almost 80% of the public health expenditures were covered from the insurance fund. The value of direct income taxes was reduced, but high health care contributions were charged. Voluntary insurances were not regulated and they functioned only at a small rate (international insurance companies, international firms and organizations, temporary travels abroad). Between 2000 and 2006, the allowances for sickness, maternity and child rising were included in the social insurances scheme, separately from the health insurances system.

The next government was more consistent in what concerns the economic and social policy. The social-democratic government (2001-2004) has implemented macro-economic policies in order to support the economic growth. The GDP has been constantly growing since 2000 (in 2004 the increase in real terms was by 8.3%, compared to 2003 and in 2001 by 5.3% compared to 2000). The inflation rate was steadily decreasing. The strict fiscal policy completed by a rigorous monetary one, has strengthened the financial discipline in the enterprises sector and has created a much stronger base for the financial system and for the public finances. It incremented the share of the expenditure allocated to health by 4% during this interval.

Medical care measures were set up for pregnant women and their babies up to two years old. These categories of population were included in the health insurances system, without the payment of the contribution. Needy families with small babies below one year old were provided with free powder milk[1]. The profession of sanitary mediator was created in order to support the medical assistance activities in deprived communities with difficult access to health services, and the overwhelming majority of the mediators were women acting in Roma communities.

Although the intention to reduce disparities in the access to health care between rural and urban areas was heavily promoted, this objective was only partially achieved at the end of the 2001-2004 social-democratic government. The improvement in the coverage with medical personnel at the national level was unevenly distributed: in urban areas the coverage improved, but in the rural the number of inhabitants per doctor or nurse has increased (1768 inhabitants per doctor in 2004, compared with 1649 in 2000, and 770 inhabitants per nurse in 2004, compared with 667 in 2000). Although the number of family doctors increased (this indicator has been registered only since 2000 in the official statistics), the number of inhabitants per family doctor in 2004 was 2076 in the rural areas and in the 1767 urban areas (INS, 2005).

At the end of 2004, home care did not represent yet a contractual practice for those providing this type of services, being rather perceived as a responsibility of families and the non-governmental sector. The medical legislation contains strong disincentives for the provision of home medical care: reduced

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[1] Since 2007, the power milk is providing only to dystrophic babies. The mothers must prove the dystrophy in each month, with a medical receipt from family doctor.

number of granted days for care, low prices for the services, insufficient coordination with the laws on social protection, no regulation of the palliative care (Rebeleanu, 2007:221-229).

In 2004 the administration of the insurance funds was still bureaucratic, and the CNAS's autonomy, although regulated by Governmental Ordinance 150/2002 was not complete. It was only in 2005 when this institution became really autonomous.

The compulsory existence of a unique insurance fund - the unique national fund for health insurances - remains a disadvantage of the health insurances system. The insured person cannot choose the insurance company, thus there is no competition between the existing insurance companies, which would be an extremely useful factor for generating improvements in the quality of the services provided by the specialized suppliers, with whom they would have contracts.

The lack of information regarding the organization and functioning of the health insurance system characterises more than 50% of the population, even five years after the reform (CPSS, 2005). The costs of medical services are perceived as being high. Informal payment to the medical staff constitutes a social norm rather than exceptions. Having acquaintances among the medical staff does not replace the informal payments, but it may serve as one more guarantee for the quality of care. Paradoxically, the precarious material situation positively correlates with the perception that material rewards for doctors are legitimate. However, those with higher incomes declared that they had given more frequently material rewards to the doctors than those with low incomes. In 2005, almost 80% of persons still did not know what was contained in the contractual "pack of health care services". Between 2002 and 2005 the people's propensity to pay private insurances decreased, but at the same time the number of those holding the state responsible for offering supplementary insurances also decreased (CPSS, 2005). Five years after the reform, Romanian citizens seemed to know better which their obligations as insured persons were. If we take into consideration the fact that the Law 145/1997 emphasized more the services that the insured persons were not entitled to receive and less those rightfully possible to be requested and accessed, the percentage of the people not knowing their medical rights is somewhat understandable (Rebeleanu, 2007: 177-229). The fear of becoming sick has increased: 53% in 2004, in comparison with 34% in 1994 (BOP, 2004). It should be noticed that this fear increased after 1997, which was the year when the public health insurance system was introduced.

A few questions which remained unanswered and outlined at the end of 2004[2]:

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[2] Statistically it is confirmed that there is a significant number of persons that do not have a clear insured status, although they are registered on the lists of some family doctors. At the same time, there is a significant number of persons that are not registered at a family doctor (almost 9% in 2005) (Rebeleanu, 2007:229-282).

- Which is the discount policy for the services delivered to those included in the lists of family doctors, but being in the category of the insured with unqualified status – in other words, those who have neither the status of insured with the payment of the direct contribution or from other ministries, nor the one of insured without the payment of the contribution?
- Who is supposed to check the insured quality of those individuals registered on the lists?

According to the legislation into force, on one hand, the insured persons have the obligation to inform the family doctor about any change in their identification data or which refer to their integration in a certain category of insurances (in 15 days) and also to make available to the medical services supplier the documents justifying the insured quality (art. 12, letter .d and letter .h, G.O. 150/2002). On the other hand, family doctors have the obligation to announce the insurance company about any modification regarding the obligatory conditions from the agreed contract, and also to solicit the justifying documents for the insured quality of the persons included in their lists (art. 15, letter .k and letter .s, H.G. 52/2005). It can be certainly affirmed the fact that the legal responsibility devolves upon both parties – medical services beneficiaries, but also suppliers (doctors). The possible explanations would be the lack of information concerning the obligations of the population who have the insured quality in the health system, or the doctor’s negligence in managing the lists, in requesting the justification acts or the great number of patients on the list etc. The problem that comes to the attention of the involved social actors is the fact that they discount services for persons who have a fictive quality of insured person, owed on the basis of the simple registration on a family doctor’s list.

Since 2005

The health care reform is still not fully accomplished, while the quality of health services remains inadequate and high morbidity and mortality rates persist. The 2005-2008 liberal government has established the following objectives as priorities in the health sector:

- To improve access to medical care, to increase the quality of life by improving the quality of the medical services,
- To improve the health status indicators so that they become comparable to those registered in the EU.
- The government also intended to decrease the pathology specific to the under-developed countries[3].

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[3] The Romanian social and economic evolution during the transition period strongly influenced the demographic situation and the health status. Although serious efforts have been taken, during the past few years, in order to improve the population's health state and to assure appropriate medical

In terms of its role, the Ministry of Health shall fulfill the following functions: to elaborate the general sanitary policy, elaborate and administrate the health programs, ensure the quality control of the medical services through the public health Institutions and the public health institutes, elaborate the standards specific to the medical field, ensure the emergency medical assistance, coordinate the negotiations for the frame contract, approve the minimum and the recommended fees that can be charged within the health insurance system, support the medical research, finance the unforeseen expenditures, regulate the access to different forms of social protection. This last aspect represents a clearer position as to the necessity of reforming the health care system in direct relation with the evolutions from the social security sphere, and guaranteeing the citizens' welfare.

Concerning the health insurance system, the intention is to grant the autonomy for the National Health Insurance House for the collection and use of the health funds. The key for solving the problem of the informal payments and for a better management of the health resources seem to be, in the opinion of the present authorities, the voluntary insurance. The tendency is similar to the one in the EU: most of the states are preoccupied with the development of the private insurances, but their success is arguable, from one national context to another (OECD, 2004).

For the persons who are still outside of the system and those receiving social aid certain shares from the health budget will be allocated. But, in my opinion, in the present circumstances of financial difficulties faced by the health care insurance budget this objective could be hardly met. Moreover, there are no reliable statistical data on the persons who are outside the health insurance system.

Since 2005, the allowances for sickness and maternity constitute social benefits paid from the unique fund of the health insurances.

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services one cannot talk about a serios amelioration (Ministry of Health, 1997). The weak individual and public concern for a healthy way of life, that is for a sensible and healthy nourishment along with the increasing poverty and the lack of sanitary education, all brought about a unsatisfactory health status for an important part of the population. All these aspects contributed to the tendency towards an increased rate of morbidity and consequently to a high level of mortality as compared to other European countries (Anuarul de Statistică Sanitară, 2005).

In some aspects, the health status in România is countinously deteriorating. If during the 60s România and the other European countries had many positive aspects in common, the following period registered a decrease of the life quality in many aspects. The natality in România is generally 5 times lower than in other Occidental countries and the infantile mortality 3 times higher. Some infectious diseases such as tuberculosis register high levels, as well. The recrudescence of these infectious and contagious diseases represents a simptom of the transition of primitive morbidity. In what concerns the level of chronic, degenerative diseases, România is characterized by morbidity of evoluated type (Rebeleanu, 2006:144-162).

In February 2006 the government took the responsibility to reform the health system. From May 2006 there is a new law that regulates the entire system of medical care (Law 95 on the reform in the health domain. At least some prerogatives of the new health law should be mentioned, which can be considered as relevant for the present analysis.

The emphasis in the whole law is laid on assuring equal opportunities and non-discriminated access to health services, on increasing the social cohesion by introducing the compulsory payment of the contribution for all of those having an income.

On one hand, this new regulation restrains the categories of beneficiaries without the payment of contribution, extends the categories of insured persons with the payment of contribution from other sources and it is more firm in what concerns the compulsoriness of the contribution for all the persons who make an income supposed to taxation. In the case of the young people, the quality of insured person without the payment of the contribution is guaranteed up to 26 years old, even if they do not have incomes supposed to taxation. For pensioners, the situation is different. Until now they were included, with no exception, in the category of insured persons without the payment of the contribution, but now they are part of the category who have the status of insured persons with the payment of the contribution from other sources, and the text of law includes this category "the pensioners, for the income from pensions, up to the limit which has to support the income tax" (art.213, alin.2 letter.i, Law 95/2006). At the same time, persons who are part of a family who has the right to social aid, according to Law 115/2006 on the minimum income guarantee are also included in the category of those who have the status of insured persons with the payment of the contribution from other sources. One has to include here the category of the ones who benefit of services offered through the public system of health insurances, with the payment of the contribution from other sources, a group remained outside the insurances system until 2006: the persons who were victims of the traffic of persons or the ones who were expelled or returned.

In my view, the intention of the administration is clear: to increase of the national single fund of the social health insurances by modifying the eligibility in what concerns the legal possibility to obtain the status of insured person.

The publicly financed community assistance, which aims to address the socially vulnerable groups, was also regulated in 2006. The text makes a clear reference to communities and identifies the vulnerable groups of population who benefit of these types of services: person with an economic level under the poverty threshold, the persons who are unemployed, who suffer from lethal diseases in terminal phases, the pregnant women, the old people, the children under 5 years old who belong to mono-parental families. The responsibility for these types of services is of partnership (The Ministry of Public Health, The

Ministry of Work, Social Solidarity and Family, The National Agency for Persons with Disabilities, The National Agency for the Protection of the Family, local authorities), and the financing is from funds from the state's budget, the budgets of the local authorities, other sources.

In order to benefit from the basic services pack, the proof of a mandatory contributions period for the last 5 years is necessary. If somebody does not have the proof of the payment of contribution, s/he shall benefit of medical services only in case of medical or surgical emergencies, of diseases with endemic potential, monitoring pregnancy, services of family planning, which are included within the minimum pack of medical service. This legislative measure led to the lost of the quality of insured person for a significant number of people registered at various family doctors. The data of the ECHISERV[4] Research Report indicate that lack of health insurance is more frequent the rural areas, and the affected population seems to be the young population, the ones over 18 years old who are not students, the migrant workers, the professionals (Popescu, 2008).

A governmental ordinance from August 2007 addressed this problems: persons who had no income supposed to taxation during the last 5 years had to prove the payment of the contribution only for the last 6 months in order to benefit from insurance-based health care services.

The new law does not ignore also the private health insurances. The mandatory character of the public health insurance is maintained even in the case of signing a private health insurance.

At the beginning of 2007, the Ministry of Health announced the fact that a 200 Euro sum, representing a bonus for volunteer private health insurance, shall be annually deduced from the gross income supposed to taxation, in the case of both employees and employers. According to the estimations of the Ministry of Public Health, almost 5 million Romanians shall be able to enter the private health insurances system (Press Release of the Ministry of Health, Rompres, 2007). This measure is destined to create, beginning with January 1st 2007, the fiscal premises to encourage the volunteer private health insurances. The implementation of this measure has not been discussed yet.

Final remarks

The guiding principles of Romanian health policies, equity and individual responsibility, can be identified at the level of political intentions, but only partially at the level of policy achievements. The legislative reforms were centred on the following objectives:

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[4] ECHISERV – research project carried out in the North West Region of Romania. "Disparities in the use of public health care services in the North-West Development Region of Romania. Socio-economic patterns and causes", director Prof. dr. Livia Popescu. The project benefited from the financing of the Romanian Ministry of Education & Research, the VIASAN program, Grant CEEX 157/2006.

- promoting equity in the access to medical care services,
- unlimited by territorial, economic or cultural factors,
- assuring the quality of medical services and the internal efficiency of the functioning of the sanitary system,
- setting and developing a mixed health care system, and the complementary roles of preventive, curative and recuperative services;
- the increase of the sanitary system funds.

Individual responsibility in choosing one's family doctor and other medical service suppliers, as well as making a private health insurance, are not truly encouraged by the current legislation.

Nevertheless, health policies between 1997-2008 reveal some coherent aspects:

- considering health as a collective social good,
- the duty of authorities has been to improve the morbidity and mortality indicators and to reduce the inequalities in the access to medical services.

As a consequence of the introduction of the health insurances, the role of family doctors and of primary assistance has increased, and this aspect was one of the anticipated effects of implementing the insurance-based health system.

The law of social health insurance is the one that created the legal framework for the diversification of the income sources for the health care fund. Since 1998, the contributions to the health insurances system had become the main income source.

In what concerns the freedom of choosing the insurance company, I consider that this would be compatible with the compulsory public insurances, in the conditions that the private system of health insurances would become functional.

A disadvantage for the present health insurances system remains the compulsory existence of only one insurance fund: the unique national fund for health insurances. This situation leads to the following consequences: the insured person cannot choose the insurance company, thus there is no competition between the insurances companies, a competition that would be extremely useful for the improvement of the quality of services provided by the medical service suppliers, according to their contracts with the insurance companies.

The present tendencies of neoliberal health care reform can generate changes in the interactions between the main actors involved. The role of the individual has been reconsidered within the present health system. The beneficiary is, at the same time, service user, insured person and citizen. The necessity of this triple perspective on the status of beneficiaries has been often discussed in the 90s (Saltman and Figueras, 1997; Wiedner et. al., 2004: 248-

263). The triple aspect transforms the individual from a passive participant into an active individual, who takes responsibility for his options in choosing the service supplier, who decides the most adequate insurance alternative for his needs, who tends to ensure at maximum his own good health. Each of these roles implies a relationship between the individual and the other actors in the health care system. Reconsidering the role of the individual also increases the responsibility of decision-makers and suppliers of medical care for better informing the public.

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BEING SENIOR IN HUNGARY. SOCIO-ECONOMIC SITUATION AND HEALTH STATUS IN LATE ADULTHOOD

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ABSTRACT. As the expected lifespan lengthened and the proportion of elderly persons extended, the social issue of ageing populations and life conditions during late adulthood became increasingly salient. Without a thorough understanding of the status of senior persons and their life circumstances, it would be hardly possible to face the challenges of the new age structure of the population.

The aim of the authors is to describe the life circumstances of seniors in Hungary and to foster the understanding of senior persons, their ways of thinking, values, and the importance of this age group for the whole society. The category of seniors is not homogenous: they live in different environments, have different incomes, schooling, family background, some of them are widows, while others live in marriage. And, above all, their ways of thinking about being a senior and their experiences of ageing are considerably different. The perception about health status varies according to the exact age, income, life circumstances, family background, the values and traditions shared. This paper first discusses the demographic trend of increasing lifespan and the definitions of the age group of late adulthood. Then, it turns to the analysis of the category of seniors from the point of view of their socio-economic situation and health status.

Keywords: ageing, social challenges, social and health status

Introduction

The analysis of social circumstances of seniors is not a new topic of sociology or other social sciences. Different studies on “traditional” societies laid much emphasis on the social status of the elderly, and the intergenerational conflict was a rather common topic of sociological research. Nowadays, these issues re-enter the focus of interest with novel aspects, and the ageing of the population constitutes a new social problem, which has its own salience and particularities.

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Conclusions of different studies bring us closer to understanding the seniors. The situation from Hungary can be considered illustrative for Central and Eastern Europe, and it is characterised by several limitations experienced during late adulthood, which are induced by low income, deteriorated health status, and other social factors (Halmos, 2002; Molnár, 2004). There are also significant differences between „younger" and „older" seniors. It is not surprising that poverty correlates with older age (Andorka and Spéder, 1996). During the last ten years, the society was marked by an unprecedented supremacy of the value of "being young" and "remaining young". This phenomenon – not without extreme forms – has made the effort of understanding and treating seniors somehow outdated and unreasonable. Seniors are connected to the stigma of the previous regime, and they are prejudiced as being unable to understand the present situation, the new technologies, the know-how of the new society. Everyday interactions, the mass media, public opinion in general can be characterised by a "beauty culture" penetrated by the quest for looking young. Companies connect their products and brands to young and beautiful faces, with which seniors can hardly identify, and they simply give up keeping pace with contemporary lifestyle and fashion. The attitudes towards seniors are often discriminatory and indicate latent problems in the relationship with older persons (Beauvoir, 1972).

A favourable turn for the seniors can be expected as their power on the market increases, deriving from their greater weight in the society and the increase of their purchasing power. However, research on the life circumstances of seniors in Hungary reveals the necessity of policies to improve their life circumstances and overall wellbeing. These policies should be based on a clearer articulation of expectations and authentic communication with the elderly. The investigation of the social and economic situation at different stages of late adulthood gains therefore more and more importance.

Average expected lifespan

For centuries of human history, the average expected lifespan had been increasing only slowly, due to the unfavourable natural and social environment. Mass poverty and indigence, long lasting wars, hunger, lethal epidemics and the high rate of infant mortality shortened the biologically possible lifespan. At the end of the 19th Century, in the most developed societies, the average expected lifespan was not higher than 40-50 years. In the 20th century, economic and social development, the improvement of modern medical sciences resulted in the increase of lifespan, especially in Europe, in the USA, in Canada and in some Asian countries. Nowadays, in the countries of the European Union, women may expect an average lifespan of 81-82 years and men of 75 years. In San Marino and in Italy the average expected lifespan of women is the highest (84 years), while men may expect the highest average lifespan in Island and Switzerland (78 years) (Eurostat, 2008).

The average lifespan of Hungarian women is 77 years and, and that of men 68 years. A Hungarian resident lives on average 6-9 years shorter than a Western European. The average lifespan of Hungarian men is highly influenced by the fact that the mortality among 45-60 years old men is extraordinarily high. The reasons might derive from lifestyle and social expectations.

The notion of senior age

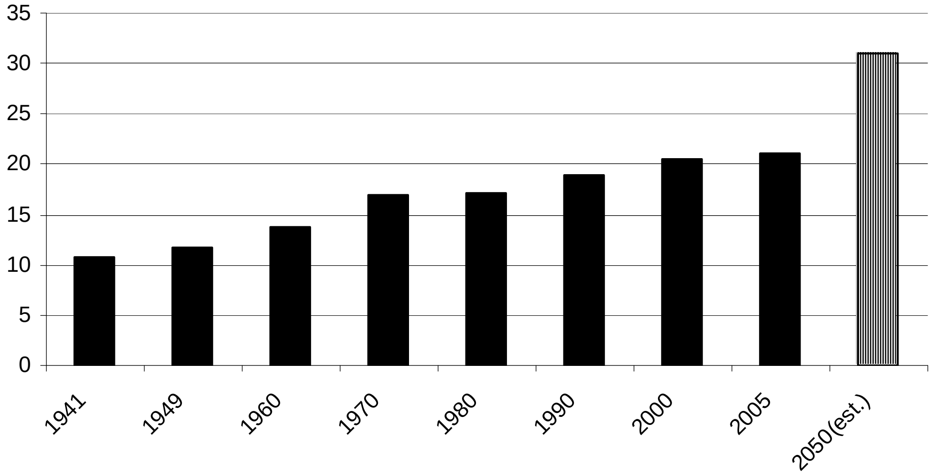
The World Health Organisation (WHO) uses the following categories for late adulthood:

- age 50-59: age of transition
- age 60-74: age of ageing
- age 75-89: elderly age
- age 90-99: very old
- over the age of 100: age of Methuselah.

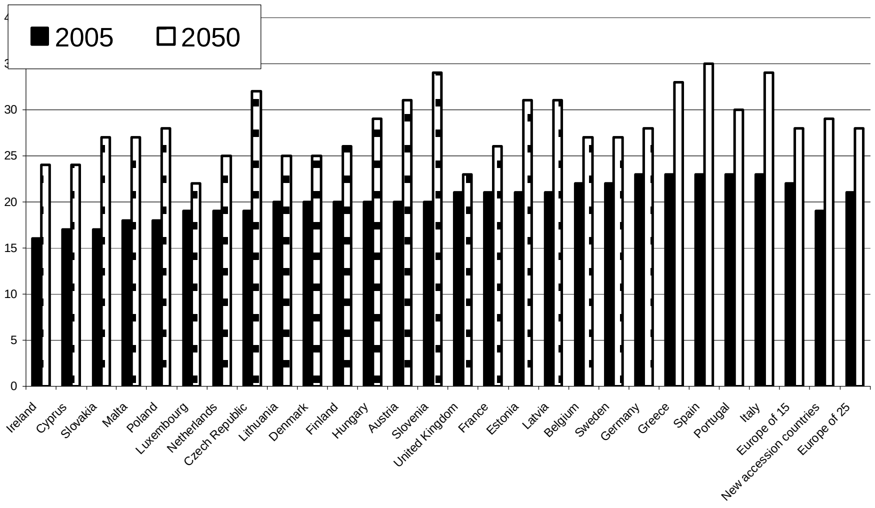
Following this categorisation, WHO reports that the ratio of seniors (people over the age of 60) within the world's population is around 10%, although their proportion has increased over 20% in all countries of the European Union. Seniors provide the highest ratio within the population of Italy, Portugal, Spain, Greece and Germany (more than 23% of the whole population belong to this group). Their proportion is the smallest in Ireland, Cyprus, Slovenia and Malta (see Graph 2). The ratio of people at and over the age of 60 in Hungary was 9.8% in 1930, 13.8% in 1990 and 20.8% in 2005. Every fifth person in Hungary has already celebrated her/his 60th birthday, which means two million seniors in Hungary (See Graph 1).

The ageing of the population does not depend solely on the lengthening of life expectancy for seniors, but also on the decreasing birth rates. The ratio of those above 60 to the infant population in various regions of Hungary ranges 145/100 infants in Pest County (the highest value) to 90/100. In most of the EU countries this situation is even less balanced, thus Hungary does not belong to the "oldest" European countries, considering the age structure.

There are different forecasts about the demographical changes in the 21st century, but they share the view that the process of population ageing will continue. Conservative estimations suggest that the present 6.1 billion population of the Earth will increase to 9 billion until 2050. Especially in the developed countries, this will go together with the growth of the proportion of seniors. Demographic forecasts indicate that in 2025 seniors will constitute 25% of the European population, while their ratio will be around 32-35% in 2050. At that time people over the age of 80 will constitute 10% of the global population, which means 50-60 million persons in their late adulthood, the most rapidly increasing age group (see Graph 2). The number of people over the age of 60 has exceeded 600 million, and it is expected to increase further to approximately two billion by 2050.



Graph 1. The share of persons above the age of 60 in the total population of Hungary (%)
Source: Hungarian Central Statistical Office, 2006



Graph 2. The share of people over the age of 60 in Europe in 2005 and in 2050 (%)
Source: Book of International Statistical Review 2006

The age-based approach to the category of seniors proposes to use only age in order to define groups within late adulthood. This approach can be considered simplistic, and it is contradicted by numerous researches, which indicate that the age category of those above 60 is extremely heterogeneous. Cohorts delimited by the one dimensional segmentation have more differentiating features than similar characteristics. This is the reason why other demographic and social characteristics should be taken into account when making classifications within the larger category of seniors. The interpretations of the process of ageing and the social roles of seniors depend on personal factors, but also on the social and cultural milieu.

It is necessary to differentiate between two approaches to what "being elderly" means (Senior-Marketing, 1997):

- The senior age is the stage after becoming economically inactive, when the person still has its mental and physical power. It is important to substitute labour and wage earnings with new tasks in order to satisfy new aims. This stage of the lifecycle will mean an even longer period of active life, in a larger sense of the term.
- Being biologically old means to decline physically and mentally. Activities are even more limited, illness appears and long-term care might be necessary. In this stage of life the aim is to preserve the achieved life standard and maintain health.

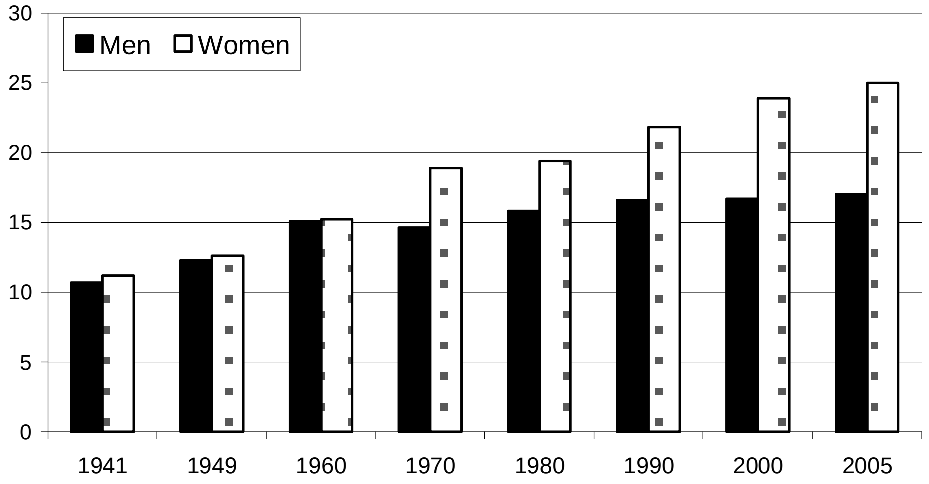
The social and demographic characteristics of seniors

Defining the notion of seniors is ambiguous because ageing is a multi-faced process, which is influenced by biological, genetic, psychological and social aspects. Consequently, the group of seniors is heterogeneous: they may be different according to their way of life, the place of residence, family circumstances, education, income, health, activity, autonomy, relationships (Lakatos, 2000). Ageing and the state of being senior cannot be considered as following similar patterns. Social research on the Hungarian seniors reveals that differences are significant in terms of both health status and quality of life (Iván, 2002).

For understanding the process of ageing it is necessary to adopt a systematic approach and examine the social and demographic characteristics of the groups of seniors.

Gender distribution

As in the other European countries, the "feminisation" of the group of seniors is present in Hungary as well (Iván 2002.). This is due to the higher life expectancy of women, especially during late adulthood. While until the 1960s the ratio of gender groups were almost equal for senior age categories, from the 1970s onwards the proportion of women increased significantly (see Graph 3). As a result of this process, nowadays, among people around the age of 60, the proportion of women is 58%, while among those over the age of 70 the corresponding proportion is 66%.



Graph 3. The share of persons above the age of 60 in Hungary by gender.
Source: Hungarian Central Statistical Office, 2006

Family and household structure

When describing the circumstances of seniors, the following questions should be considered: Do people remain alone as they get older? Do they have any connection to their family? What characterises these relationships? Can they count on their family or on the help of anyone else?

Based on the above considerations, senior households can be divided into three large categories: single households; old people living together with another senior; seniors living together with younger persons. According to the results of the Hungarian Census conducted in 2000, 30% of seniors live alone, 47% lives together with their husbands or wives, 9% shares the household with another relative (usually one of the children and his or her family), 14% live together with other family members (brother or sister) or with other people. Concerning the overall structure of households, 70% of the population lives in a household where there is at least one person over the age of 60.

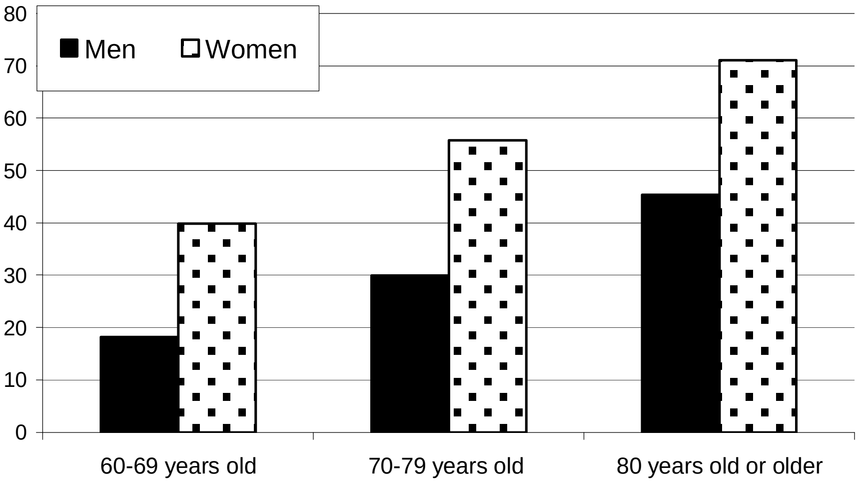
Concerning family status, 51% of the seniors are married, 38% are widowers, 7% divorced and 4% single. There are significant differences among seniors concerning family status based on gender and age. While 75% percent of senior men are married and only 15% are widowers, 52% of women over the age of 60 are widowers and only 33% are married. These differences derive from mortality dissimilarities (Dobossy et. al., 2003) and make the experience of old age different for women and men.

When examining cohorts of 5 years, dissimilarities in family status become even more significant. Almost two-thirds of men over the age of 80 are married. Marriage not only means an opportunity to receive direct help in the household, but also creates psychosocial protection, which has great importance for seniors.

Graph 4. The distribution of married and widow males and females by age groups
Source: Hungarian Central Statistical Office, 2006

Although the number of single households shows an upward tendency, it is important to differentiate young, yet single people starting their lives and seniors who remained alone as they got older. In Hungary, 25% of households are single households, which is partly deriving from a lifestyle trend of living alone. However, single households are more frequent in the case of the older age categories: 30% of people between the age of 60 and 69, 48% of people between the age of 70-79, 62% of people over the age of 80 live alone. As mentioned before, because of the difference in age-specific mortality rates, proportionately more women than men live alone (see Graph 5).

More than four-fifth of seniors have at least one child (mainly one or two). However, research results indicate that only 70-80% of seniors may count on the help of their children concerning housework, financial aid and illnesses (Lakatos, 2000). According to a study conducted in 2000 (Lakatos, 2000), one-fourth of people over the age of 60 live together with their children, a situation that confers some safety in terms of getting help when needed. Keeping contact is easy when the senior lives at the same settlement with his or her relatives. Two-thirds of Hungarian seniors are in this situation, but there are differences according to the type of settlement: 76% percent in Budapest and only 56% in smaller settlements. Physical closeness may contribute to keep contact, but not necessarily means a profound human relationship.



Graph 5. The share of singles among seniors by gender in Hungary in 2004
Source: Hungarian Central Statistical Office, 2006

Even when the family background is appropriate, seniors generally have less social connections. After retirement, some of the former workmates and friends disappear from the lifeworld of seniors. The same happens with relatives living far away. When the husband or wife dies, the seniors lose their partners, with whom they were living for decades. The deepening social isolation is one of the main causes of mental and psychosomatic disorders among seniors (see Table 1) and also of high suicide rates (see Graph 6).

Place of residence, place of living

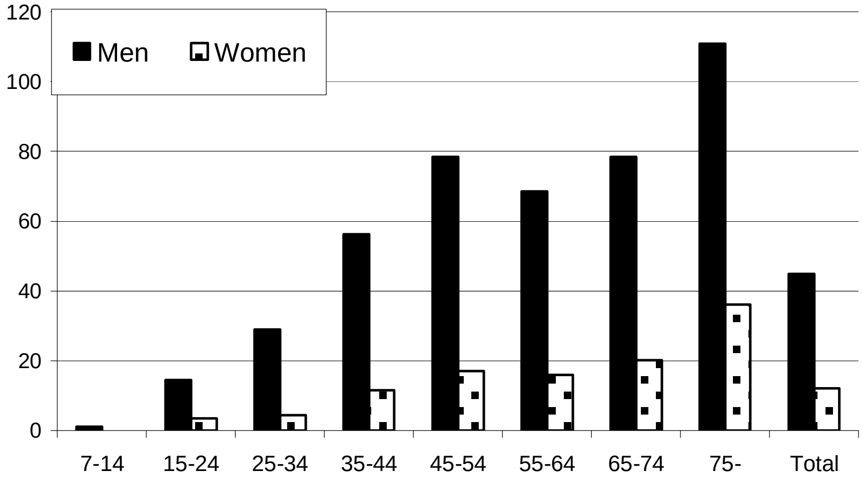
Concerning territorial distribution, the proportion of seniors is smaller in the capital city (16%), and higher (almost 40%) than the nationwide average in smaller settlements, especially where there are less than 1000 residents.

Table 1

Mental and physical symptoms of mental problems within among adults and seniors in 2002 (%)

Symptoms of mental problems	Adults	People between the age of 60-69
	Mentioned symptoms (%)	
Frequently tired	61.2	68.0
Frequently has hard heart beating	34.2	50.2
Always nervous	30.5	38.3
Frequently has intense headache	30.0	39.3
Being all of atremble frequently occurs	21.1	30.7
Usually feels unlucky	57.3	66.1
Worries a lot about his/her health	40.8	63.8
Totally gets confused, when has to do a lot within a short time	28.8	35.6
Can not get rid of fears and agonies	19.8	27.6

Source: Kopp et. al. (2002)



Graph 6. Distribution of suicides by age groups and gender in 2004 (per 100 000 people)
Source: Hungarian Central Statistical Office, 2006

Seniors usually live in old buildings, but in better density circumstances (fewer persons per apartment/house size) than the rest of the population. In the case of senior households, 40% of the net income is spent on household maintenance.

During the last decades, the comfort from the households of seniors significantly improved. Since the 1980's, the proportion of people between the age of 60 and 64, living in a non-comfort house has decreased from 54% to 13%; in case of people between the age of 65 and 69 it has sunk from 63% to 14%. Nowadays, only 20% of people over the age of 70 live in poor-comfort houses, compared to the 70% in 1980. Although still 250,000 seniors live in a poor-comfort house or flat, these only count for the half of the residences of seniors (Dóra, 2000).

Educational qualifications

The educational qualification of people over the age of 60 is significantly lower than in case of the middle aged or young populations. Most of them attended only the elementary school (38% of men and 67% of women) or apprenticeship school (29% of men and 13% of women). As low as 19% of men and 15% of women have a GCSE[1]. These differences have historical roots, they emerge from the way society and gender roles were configured at that time. Among people over the age of 60, the proportion of those who have post-secondary education is very low (only 7%) and they is a significant gender discrepancy (14% in case of men and 5% in case of women).

Retirement and activity

The stages of lifecycle are often connected to some kind of "ceremonies" (GCSE, Diploma, marriage, etc.), and in case of seniors mostly this is the retirement. Connecting the starting point of becoming senior to retirement is widespread, although in some countries retirement age varies by gender and there are categories like disability pension, widower's pension, which do not depend on age or on losing one's job, but on health and family status.

Retirement is a specific event that ends wage-earning activity, decreases disposable income, narrows the range of possible activities and human relations, and changes social roles within a short period of time. Retirement has to receive substantial attention not only because the number of retired persons is increasing, but also because the length of retirement is enlarging.

Many people prepare for retirement, make plans this stage of life, while others refuse to accept it, they find it distant even when only a few years remained until their retirement. Some are afraid of these years, because they only see the disadvantages. The research carried out, among others, by Dobossy and his colleagues (2003) indicates that most of those who have higher educational

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[1] General Certificate of Secondary Education (GCSE) means the final exam of the secondary school in Hungary. GCSE is generally taken in a number of subjects by students aged 18-19 in secondary education.

qualification have more exact plans for the retired years, while those with lower educational qualification lack these plans or strategies for facing retirement. The most "popular" activity is taking care of grandchildren. This is feasible because the delayed age of childbirth, as compared to previous generations. Thus, it is highly probable that at the age of retirement one's children will have an infant, who needs continuous care that can be provided by grandparents.

Some seniors also plan to work during the years of retirement – 40-50% of those who retire soon. This could mean both full and part time jobs, or no set working hours, such as agricultural work or entrepreneurship. Labour statistics indicate that these plans do not harmonise with the offer on the labour market, and the possibility to achieve these plans is modest. On the Hungarian labour market only 7% of the people between the age of 60 and 75 are active. Most of the retired seniors are absent from the labour market, however, some manage to find a job after retirement. Over the age of 60, one-third of people with higher educational qualifications can find a fixed or unfixed term job requiring high qualification. Nonetheless, only 5% of those who only finished primary school found a casual job (Dobossy et. al., 2003).

Income and financial conditions

The economic and political transition in 1989 caused many changes in the life of Hungarians. In previous decades before the transition, retirement was almost equal to becoming poor. Researches focusing on income inequalities and poverty after the transition (Andorka and Spéder 1996; Kolosi and Sági, 1996), pointed out that – in contrast to the tendencies in the 70's and 80's – retirement even at the beginning of the 90's was always leading to impoverishment. The Hungarian Household Panel of TÁRKI Social Research Institute showed that between 1992 and 1998 the number of retired people belonging to the poorest quintile of the society has decreased. The same tendency was found by Dobossy and his colleagues in 2002 (Dobossy et.al, 2003). This does not mean that the income circumstances of people over the age 60 improved after the transition. It only means that their circumstances worsened at a slower pace than the income circumstances of the population in general. Thus only their relative situation improved during these years. It also has to be mentioned that, while the chances of seniors to become poor lowered, the possibility of belonging to the highest quintile has also dropped. The majority of seniors since the transition belong to the lower middle class, and their income circumstances are more homogeneous than in case of the whole society. Although their chance to become rich did not rise, they are secured from impoverishment.

Considering the amount of pension, the most significant differences can be found between gender categories, men on average receive 20% higher pensions than women. Given that single seniors are mostly women, it is easy to realise why impoverishment is more probable among senior women. At the other end of the distribution, we can find highly qualified seniors, who live in partnership, are settled in Budapest, have continuous or casual job, and receive additional income from capital (interest, dividend, house rental, etc.) (Dobossy et.al., 2003).

State transfers – primarily pensions – are responsible for the 80% of income received by people over the age of 60. Only 10.8% is paid as wage or salary. The proportion of income from entrepreneurship or other capital is low (8.6%), but increasing. The ratio of social aids within state transfers is 11%, the half of which is public health benefit, while the benefits for disabled, continuous or temporary allowances constitute another 25% (Dobossy et. al., 2003).

There are different approaches to the notion of poverty (absolute, relative), but most indicators are based on income and expenditures. Empirical data show that among the people over the age of 60%, the rate of relative poverty[3] was 14% in 2002. The poverty rate was 7.5% for people between the age of 60 and 69, 10.8% for people between 70 and 79 and 16% for people over 80. The group of poor seniors consists mainly from people living from ordinary pension, but also of single seniors receiving only widower's pension or some kind of welfare allowance. The real poverty rate might be even higher, as many elderly persons live in institutions of long-term care (Dobossy et.al, 2003).

Health circumstances, quality of life

At the beginning of the 21st century sustainable health, prevention, personalised healthcare and social services, and the notion of living together with illnesses came into focus together with the maintenance of acceptable quality of life (Ware, 1986).

Chronic diseases constitute the most important health problem of seniors. In present study, in order to characterise the health condition of seniors, subjective evaluations are used as indicators of health status. This procedure is often used in social research, and there are two main reasons for measuring health status with this methodology. Firstly, it does not narrow the measurement to specific dimensions. It provides a general picture about the health status, as people themselves perceive it. Secondly, it comprises knowledge about health status that only respondents possess (Ware 1986).

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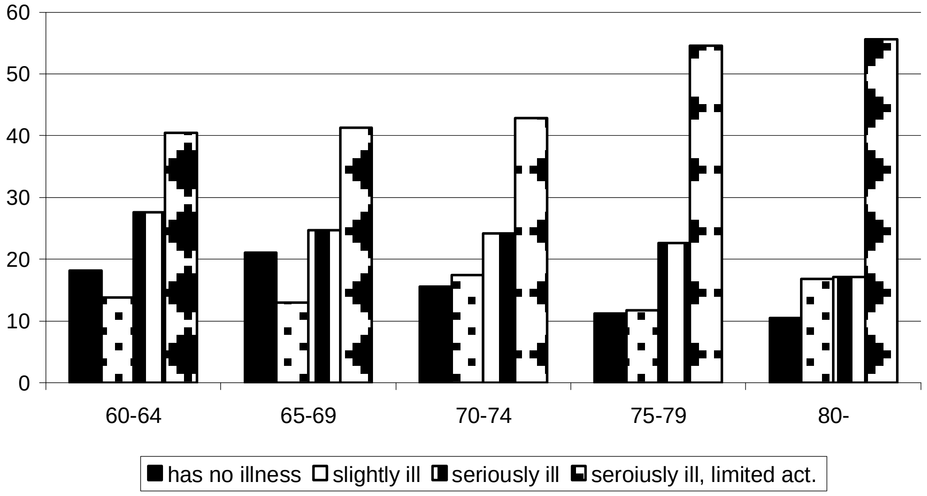
[3] Absolutely poor: someone whose income is lower than the income securing necessities or essentials for living. Relatively poor: someone whose income is lower than the 40-60% of the national median (Andorka and Spéder, 1996).

The subjective health status of seniors is generally poor. Numerous studies indicate that only 10-15% of seniors consider that their heath status is similar or better than the health of their peers. Every second person over the age of 60 reports chronic illnesses and 75% have persistent health problems. Almost half of the seniors have illnesses deriving from circulatory problems. Among these people the proportion of those who have some kind of angiophaty is high (especially hypertension and variation of blood pressure). Diabetes and diseases connected to the skull and the muscular system are also frequent. Among senior men respiratory diseases are more prevalent, a phenomenon most probably caused by smoking. The hardness of hearing and asthenopia are other specific problems, which affect around 30% of people over the age of 60 (OLEF 2000).

These diseases do not only result in discomfort, but they also limit everyday activities. Limitations caused by diseases are typical for 40% of the people between the ages of 60 and 69. They affect 60% of men and 72% of women over 70.



Graph 7. Self-reported health status among the seniors (%) in 2000
Source: Health Status of Hungarian Population, Ministry of Health, 2000

Seniors, due to their poor health state, are the most frequent users of healthcare systems. In Hungary, half of the yearly expenditure on healthcare is used by people over 60, and one-third by people over 70. Research data shows that a man at the age of 73, as compared to a 28 years old man uses out-patient services four times more frequently, uses hospital services ten times more frequently, and receives prescriptions twelve times more frequently (Iván 2002).

The role of the health care system goes beyond medical treatment, and it comprises senior care and nursing, and sometimes even emotional support (Czibulka and Lakatos, 1996).

The lifestyles of seniors

Concerning the lifestyles of seniors, Karmasin distinguishes three groups: *go-goes, slow-goes, non goes* (Karmasin, 1995).

Although *go goes* are seniors, but they don not feel themselves to be aged and they firmly think that biological age does not equal to the subjectively felt age. For their leisure time it is characteristic that they are active, they do things which they always wanted to do, but they did not have the time or the chance. They spend their money on themselves, they do not hold back their consumption in favour of their grandchildren. They do not lag behind young people, they travel and they try to fulfil themselves. It must be added that these are typical for seniors who have a good financial situation.

For the *slow goes* it is highly important to provide an independent life with acceptable quality – as long as possible. In purchasing, they are looking for real benefits, it is not easy to convince them to buy or to consume. The main driving forces are quality, stability and authenticity. Communication and product design must reflect these requirements, this is the only way to win them over. Concerning the brand, they are rather conservative and they decide based on their previous experiences and expectations.

Non-goes mainly consist of single women, who have health problems. They need products balancing their physical-mental deficiency in an intelligent way. In the communicational situations, problems – mainly physical ones – are considered as taboos. We do not talk about them and, if possible, we even do not want to realise them (Karmasin, 1995).

The financial problems of the pension system

It is essential to discuss the difficulties of maintaining the pension systems. In 2000, in the European Union, the proportion of people over the age of 60 compared to the people between the age of 20 and 59 was almost 39%, while in 2005 it was 41%.

Until 2050, the proportion of European people over the age of 65 is expected to be twice higher than the proportion of people under the age of 15. In the European Union, in 2000, for every person over 65 there were only 4.25 persons between the age of 15 and 65. This number is expected to decrease to 1.85 by 2050. Nowadays, in the economically developed societies, the contribution of people between the age of 15 and 25 to active work and the production of national product decreases. Among the population close to the age of 65, the number of economically active is small. This demographic situation of increasing dependency rates may have serious consequences on the sustainability of the pension and the healthcare system. The PAYE (Pay as You Earn) pension system, based on intergenerational exchange, is now endangered.

Concluding remarks

The research results discussed in this article reveal that the process of ageing cannot be considered as homogeneous, and the increasing population of seniors is differentiated along several factors. In Hungary, the experience of getting older is different for men and women, for persons with different social statuses and living in different parts of the country. Further research should be conducted for a better understanding of the meanings of being senior for various people, in their particular circumstances of life. By improving health condition and access to the labour market in late adulthood, the issue of ageing populations could be reconsidered in a different light.

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THE INTRODUCTION OF THE CALL-RECALL METHOD IN THE ORGANIZATION OF THE NATIONAL CANCER SCREENING PROGRAM AND SOCIO-ECONOMIC DETERMINANTS OF PARTICIPATION

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LAJOS BÁLINT[d], **MÁRIA SZÜCS**[e], **ESZTER PÉNTEK**[f]

ABSTRACT. Although life expectancy in Hungary increased in recent decade, the mortality statistics remained high for malignancies of cervix and breast preventable by screening. The call-recall method based organization of screening has been recently introduced in the Hungarian practice through a governmental project, supporting screening centres with trained staff and providing mammographs in outpatient services. This study aims to describe the geographical heterogeneity of participation in the screening programs and to investigate the relative impact of socio-economic determinants on screening rates. It looks at the whole population of Hungary. The screening rates and their relationships with socio-economic factors were computed for periods before and after the call-recall operation system had been launched. The age adjusted relative screening participation rates were computed for the sub-regions of Hungary using discharge reports of outpatient services for cervical cytology and mammography. The socio-economic characteristics of sub-regions were available from national surveys. The correlation between sub-region specific data on screening participation rates and the socio-economic characteristics were analysed. For the entire female population, the examination rates for cervix cytology were 11.4 % in 2001 and 15.8 % in 2005, while for mammography 6.7 % in 2001 and 10.4 % in 2005. The relative age-standardized sub-regional examination rates varied to a great extent for both types of examinations. For the cervix examination, the ranges of values were 0.065 – 1.741 in 2001 and 0.676 – 1.598 in 2005. The variance decreased significantly in this time period (F= 3.438; p<0.001). For mammographies, the corresponding ranges were 0.235 – 4.078 in 2001 and 0.308 – 1.756 in 2005. The degree of variability decreased in this case as well (F= 4.014; p<0.001). In 2001, cervix cytology proved to be independent of socio-economical factors. Mammography, on the other hand, demonstrated a significant correlation with many the indicators of social deprivation. In 2005, cervix cytology showed similar independency of socio-economic factors. In this year, mammography

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did not reveal any association with any parameter of the socio-economic situation. The introduction of the new organization of screening, recommended by the World Health Organisation, resulted in improved performance at the national level, and it was accompanied by the narrowing of the gap between the sub-regions with fair and unacceptably low examination rates. It is evident that in the case of mammography the limitations of opportunistic screening can be solved by the invitation based methods: improved general performance, reducing geographical inequality and weakening the influence of socio-economic factors at the level of the population. No correlations were found between cervix screening participation and socio-economic factors.

Keywords: the organisation of cancer screening; determinants of screening participation; regional differences in participation rates

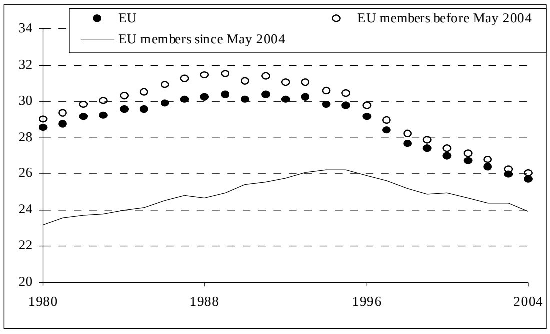
Introduction

The public health importance of breast cancer had been increased in the '80s in the countries of the European Union (EU15). This trend turned back in the early '90s. The last 15 years showed steady decrease. The mortality statistics are similar for the Eastern and Central European countries, but this region has some specific patterns: mortality rates were always under the EU15's level; the turning point was 5 years later; the gap between the former and newer EU members has narrowed in the last 1.5 decade (World Health Organization), (Graph 1.) According to the GLOBOCAN project (Ferlay et al., 2004), incidence in Europe varied between 36.0×10^{-5} and 92.0×10^{-5}, while the mortality ranged from 15.3×10^{-5} to 29.6×10^{-5} in 2002 (Graph 2). The age standardized incidence shows significant correlation with the age standardized mortality ($r^2=0,335$; $p<0,001$) (Graph 3): [mortality] = 0.121 × [incidence] + 12.397.

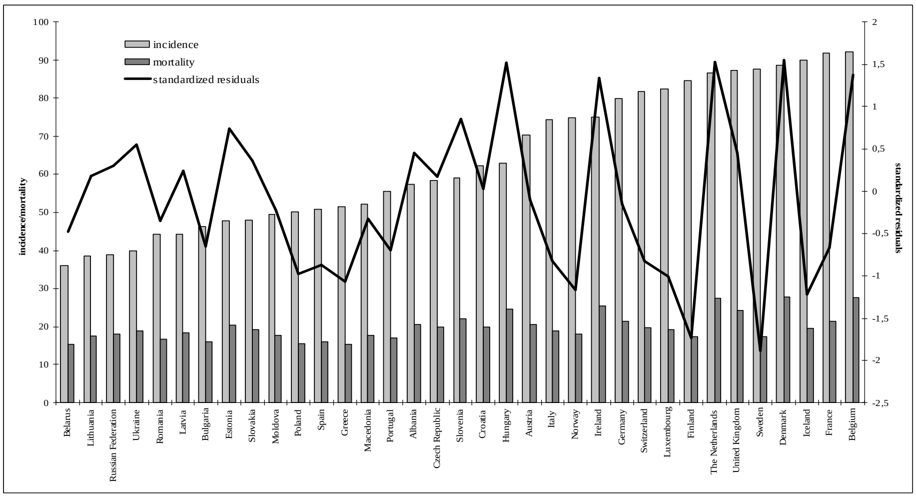
The difference between incidence and mortality varied in wide range, which can be explained by the huge variability in the screening policies and treatment effectivity within Europe. The Nordic countries show much less mortality rates than expected on the basis of the association between incidence and mortality observed in the European countries. Unfortunately, the Hungarian mortality is much higher than it is expected considering the incidence rates (Graph 2).

The importance of socio-economical determinants of breast cancer health burden can be demonstrated by the significant association between real gross domestic product (PPP 1000$ per capita) and mortality ($p=0.023$); keeping in mind that the explanatory role of real GDP is not too strong ($r^2=0.146$): [mortality] = 0.107 × [real GDP] + 17.725. The explanatory role of real GDP is much stronger for incidence rates ($r^2=0.607$) and the association between real GDP and incidence is also significant ($p<0.001$): [incidence] = 1.149 × [real GDP] + 41.499 (Graph 4).

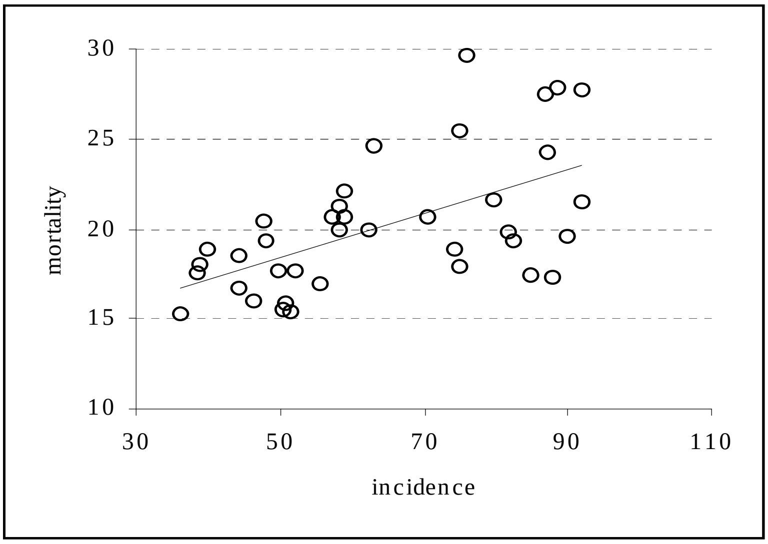
There was no association between real GDP and the residuals from the linear regression analysis for the influence of incidence on mortality (p=0.420); such a fact demonstrates that the screening-treatment effectiveness in these countries is not determined solely by the economical circumstances and that the social determinants as well as the health policy have important roles (Graph 5). In accordance with previous observations, in developed countries, incidence (Braaten et al., 2004), screening participation (Lagerlund et al., 2002), survival (Lagerlund et al., 2005) and mortality (Sarfati et al., 2006) are seriously influenced by the socio-economical status of females .



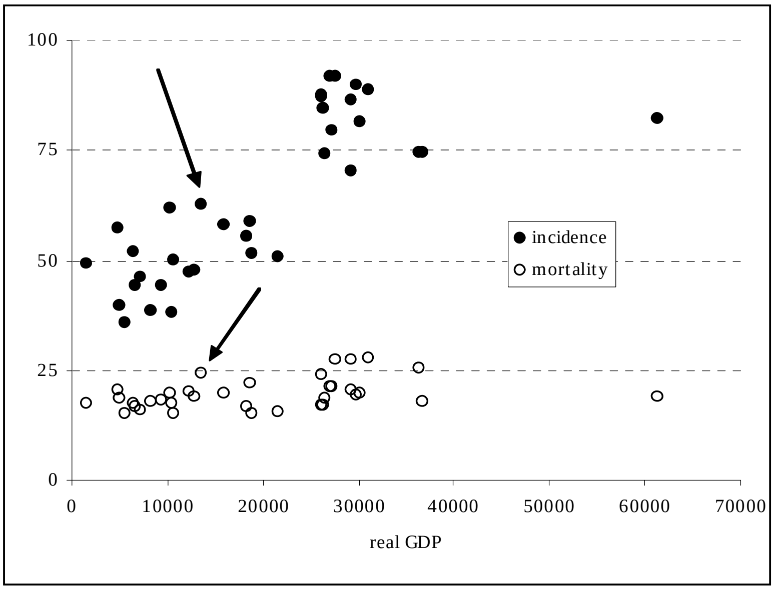
Graph 1. Age-standardized mortality rates in Europe for breast cancer (×10^{-5})
Source: WHO.



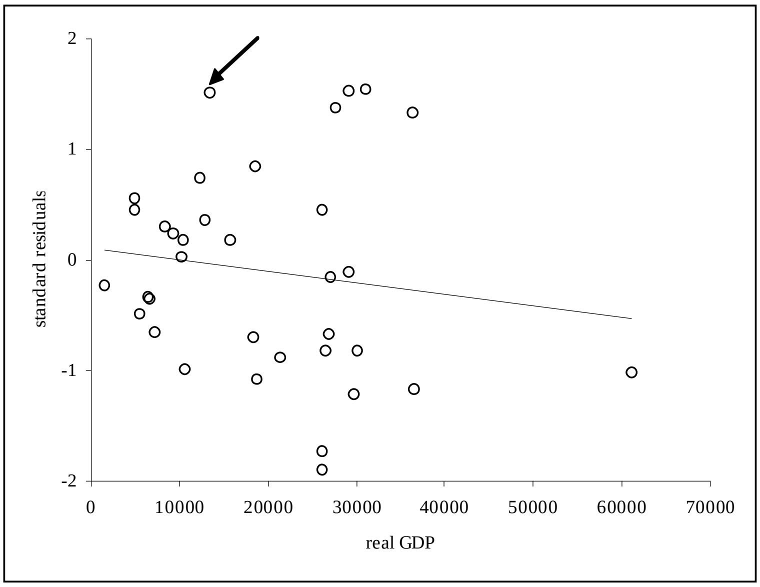
Graph 2. Breast cancer incidence and mortality for 100 000 females in 2002 for European countries (standardized by world population) and standard residuals for the association between age standardized breast cancer incidence and mortality in 2002 for European countries
(The influence of incidence on mortality has been assessed by linear regression)
Source: WHO, 2008.



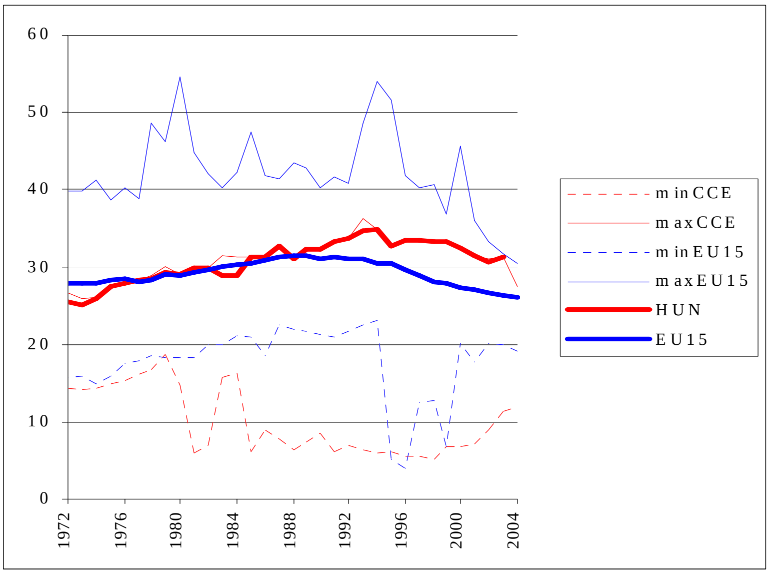
Graph 3. Correlation between the incidence and mortality for breast cancer in Europe
Source: WHO, 2008.



Graph 4. Influence of the real gross domestic product on the age standardized breast cancer incidence and mortality in European countries
(**arrows:** Hungarian observation)



Graph 5. The association between real GDP and the residuals from the linear regression analysis for the influence of incidence on mortality
(**arrow:** Hungarian observation)

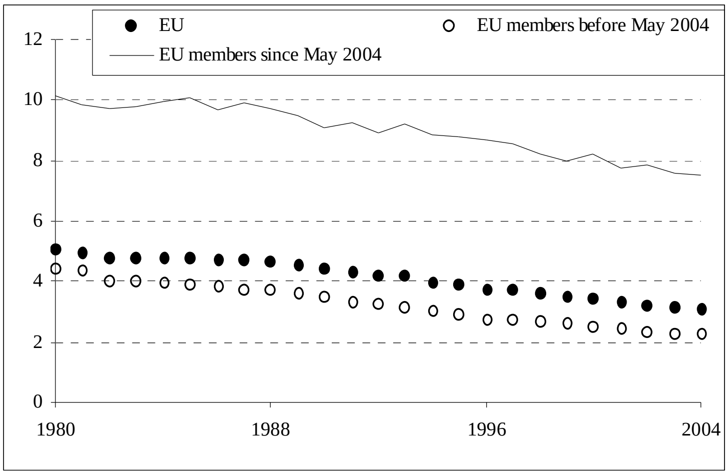


Graph 6. Standardized breast cancer death rates (×10^{-5}) in the EU15 and Hungary with the minimum and maximum country level rates for EU15 and Central and Eastern Europe
Source: WHO, 2008.

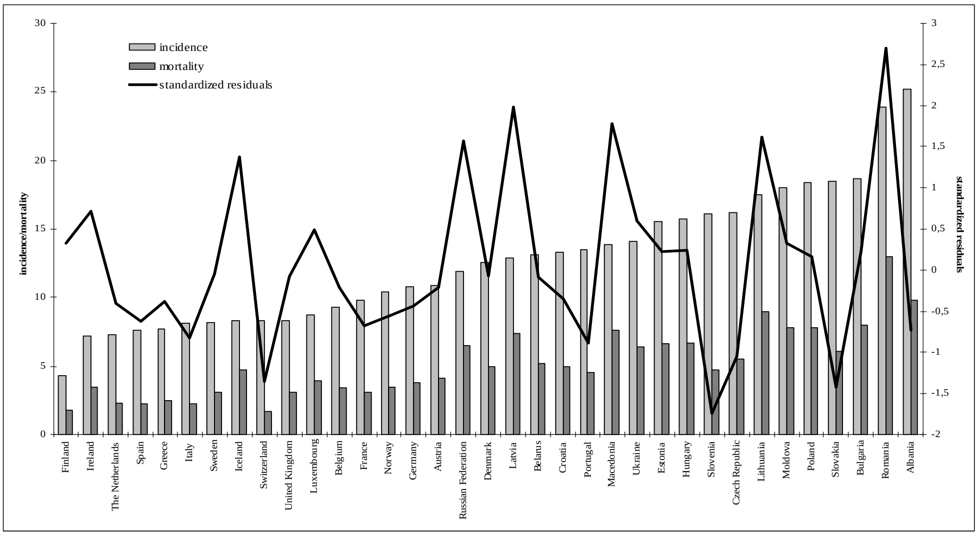
The Hungarian mortality trend does not fit the Eastern and Central European pattern: The mortality rate is higher than the EU15 reference: in the last three decades in Hungary have been observed the most serious Eastern and Central European breast cancer mortality rates (Graph 6). In fact, he Hungarian mortality has become almost the highest in Europe by 2004, showing that the breast cancer control needed urgent reconsideration in this country.

The public health importance of cervix cancer had decreased in the 80s in the European countries. The mortality statistics shows similar trends for the Eastern and Central European countries and for the EU15 countries as well. However, the mortality was always higher in Eastern and Central European countries, and the gap between these regions had not been lessened in the last 1.5 decade (Graph 7) The incidence in Europe varied between 4.3×10^{-5} and 27.3×10^{-5}, while the mortality ranged from 1.6×10^{-5} to 13.0×10^{-5} in 2002 (Graph 8). The age standardized incidence shows very strong, significant influence on the age standardized mortality ($r^2=0,832$; $p<0,001$): [mortality] = 0.439 × [incidence] – 0.450 (Graph 9).

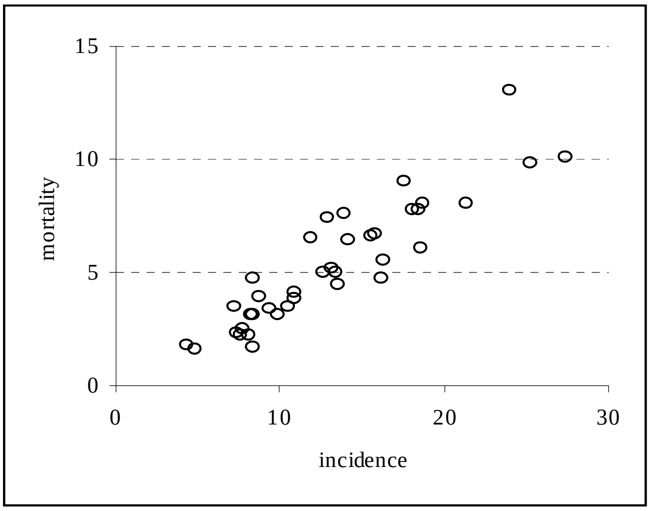
The difference between incidence and mortality varied in wide ranges, a fact which is explainable by the huge variability of the screening policies and treatment effectiveness within Europe. For instance, Slovenia has much less mortality rates than expected on the basis of the association between incidence and mortality observed in the European countries, while the Hungarian mortality – from the incidence rates' point of view –reaches an expected level (Graph 8).



Graph 7. Age-standardized mortality rates in Europe for cervix cancer ($\times10^{-5}$)
Source: WHO, 2008.



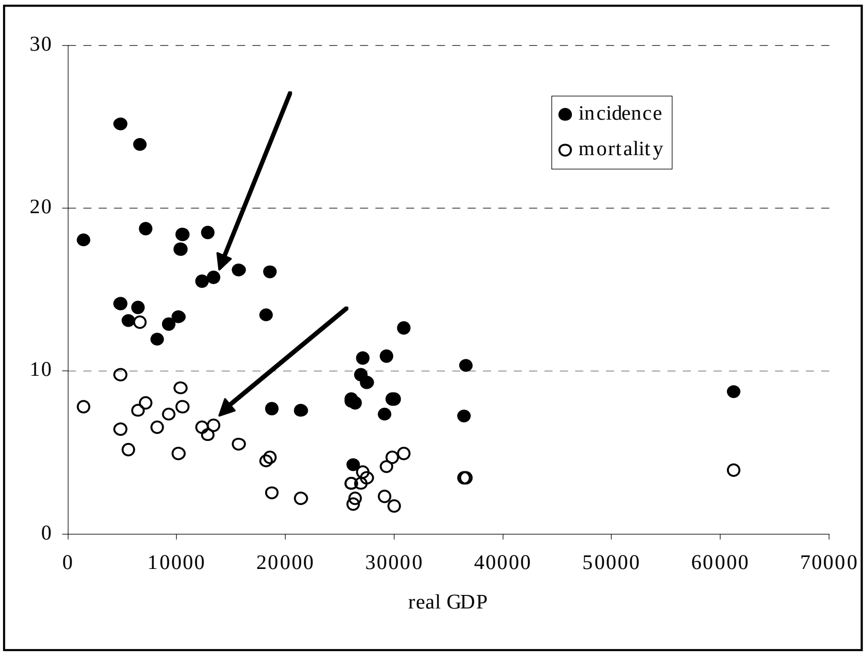
Graph 8. Cervix cancer incidence and mortality for 100 000 females in 2002 for European countries (standardized by world population) and standard residuals for the association between age standardized cervix cancer incidence and mortality in 2002 for European countries
(The influence of incidence on mortality has been assessed by linear regression)
Source: WHO, 2008.



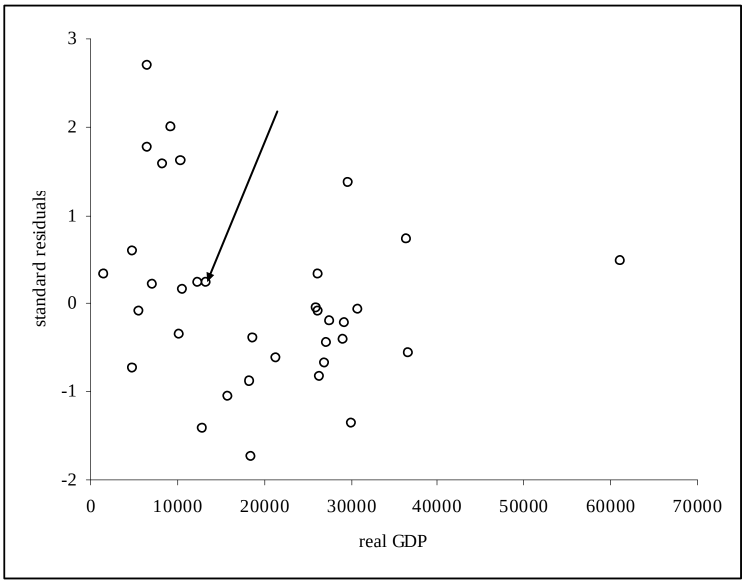
Graph 9. Correlation between the incidence and mortality for cervix cancer in Europe
Source: WHO, 2008.

The association between real GDP and incidence was significant ($p<0.001$): [incidence] = - 0,266 × [real GDP] + 17.906 as proved to be the association between real GDP and mortality as well ($p<0.001$): [mortality] = - 0.138 × [real GDP] + 7.887 (Graph 10). As in case of breast cancer, there was no association between real GDP and the residuals from the linear regression analysis for the influence of incidence on mortality ($p=0.170$), a fact which demonstrates that the screening-treatment effectiveness in the European countries is not determined simply by the economical circumstances and that the social determinants as well as the health policy have important roles as well (Graph 11). In accordance with the literature, incidence (Braaten et al., 2005), screening participation (Segnan, 1997), survival (Brooks et al., 2000) and mortality (Bouchardy et al., 1993) are seriously influenced by the socio-economical status of females.

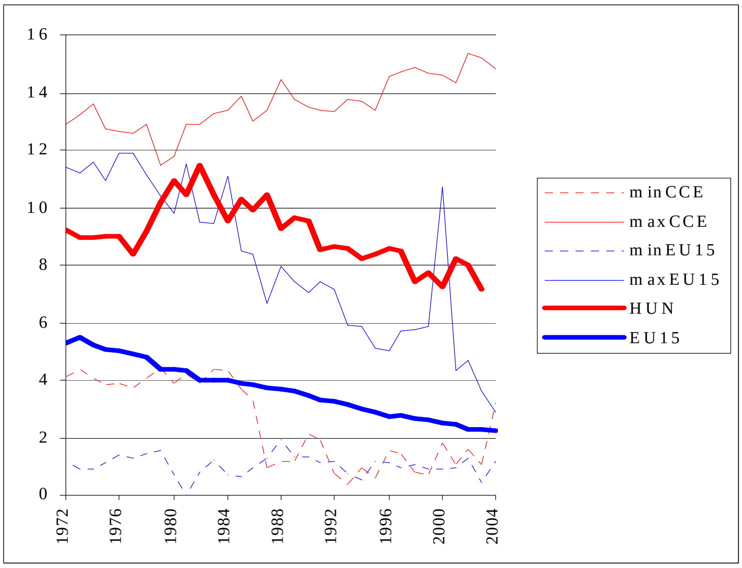
The Hungarian mortality trend follows the Easter and Central European pattern: mortality rate is higher than the EU15 reference, and the gap is not decreasing at all. (Graph 12). As far as the Hungarian mortality could not get closer to the EU15 reference level, it can be concluded that the cervix cancer control needs thorough re-evaluation.



Graph 10. Influence on the real gross domestic product on the age standardized breast cancer incidence and mortality in European countries
(**arrow:** Hungarian observation)



Graph 11. Association between real GDP and the residuals from the linear regression analysis for the influence of incidence on mortality (**arrow:** Hungarian observation)



Graph 12. Standardized cervix cancer death rates ($\times 10^{-5}$) in the EU15 and Hungary with the minimum and maximum country level rates for EU15 and Central and Eastern Europe

The Hungarian government, as a result of international evidence (de Wolf and Perri, 1996; European Commission, 1992) and some Hungarian experiences (Bodó et al., 1997; Döbrőssy et al., 1978; Péntek and Döbrőssy, 1999) decided to replace the opportunistic screening by an invitation based system, firstly, in 2002 for the case of breast cancer and, a bit later, in 2004 for that of cervical cancer.

According to the new policy, in the case of breast cancer screening, mammographs had been installed to achieve a fair density in accordance with appropriate geographical distribution; the investment was financed by the government. Similar steps were unnecessary for cervix cancer screening because the capacities for Pap smear taking and cytological examination had been set up formerly. For every screening centre, catchment areas were established and the invitation system was based on the patients' personal records in the Hungarian Health Insurance Fund, wherein all the Hungarian citizens are registered. Screening centres had been built up in the county departments of the Hungarian Public Health Service, which were responsible for posting the calling letters, registering the participation, and for sending the re-call letters, if necessary. The quality control and the monitoring of the screening centres operation were elaborated on the basis of international guidelines. Staff was trained and the financing of the screening had been regulated by the Hungarian Health Insurance Fund, which ensures the free-of-charge availability of these services. The legal background was ensured through a new national program called *National Public Health Programme for Healthy Nation* launched in 2001 and a new decree of the Hungarian Parliament (*Decades of Health National Program*, 2003). The latter was based on a former decree of the Ministry of Health (*Preventive and screening health services*..., 1997) which defined the target groups (females aged 45-65 for breast cancer, and 25-65 for cervix cancer) and the screening frequency (2 years for mammography and 3 years for cervical cytology).

The aim of our investigation aimed was to generally describe the improvement of screening effectiveness, respectively to determine the role of socio-economical factors in utilizing this new approach.

Data and methodology

The headcount of females in the Hungarian population summarized by year according to 1st of January 2001; 1st of January 2002; 1st of January 2005 and 1st of January 2006 was provided by the Ministry of Interior, Central Data Processing, Registration and Election Office. Settlement names, statistical sub-region definitions and their local codes are here used in accordance with the Hungarian Central Statistical Office and the definitions provided by the National Office for Regional Development in Governmental Act 244/2003. (XII. 18.). Postal codes were obtained from the website of the Hungarian Post Co.

Indicators of representative socio-economical status for the sub-regions were provided by the Central Statistical Office. Indicators for unemployment (unemployment rate %; long-term unemployed %, long-term unemployed as a % of total unemployment), utilization of the social services (bed places of clubs for the aged per 1000 people aged 60 and over; unemployed persons receiving income supplements per 1000 inhabitants, number of persons with public medical care card per 1000 inhabitants), capacity of the medical service (inhabitants per general practitioner and family paediatrician; consulting hours in outpatient service, hospital beds in use), income (number of tax-payers per 1000 inhabitants; gross income serving as basis of the personal income tax per permanent population, personal income tax per permanent population), demographical distribution (distribution of population by age-group, %: aged 14 or below, aged 15–39, aged 40–59, aged 60 or over), educational level (educational attainment as % of the population of corresponding age: at least 8 grades in primary school for aged 15–X, at least secondary school for aged 18–X, university college etc. degree for aged 25–X, and average number of school grades) were those indicators we've taken into consideration.

Databases for cervix cytology and mammography (having outpatient service records from 2001 and 2005) covering the entire female population of Hungary were provided by the Ministry of Health, National Centre for Healthcare Audit and Improvement and their predecessors. The records contained the age, the postal code and an identification code for each patient. Records which missed any of these data were excluded from the analysis. Every record was linked to a particular settlement through the postal codes.

Demographical data were arranged for each settlement (s) in 5-year age-groups (a) as follows: <15; 15-19; 20-24; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; 70-74; 75-79; 80-84; 85+. (The data for the population with 65 years were not available for the study; as a result, the upper age limit of the study was 64 year, instead of 65, which is the actual limit for screening programs.) The number of females in the middle of 2001 ($N_{as,2001}$) was calculated by average the data from 1st of January 2001 and 1st of January 2002. Similarly, the number of females in the middle of 2005 ($N_{as,2005}$) was calculated as the average of the data from 1st January 2005 and 1st January 2006. The age-specific headcounts of settlements belonging to the same statistical sub-region (r) were summarized ($N_{ar,2001}$, $N_{ar,2005}$).

The investigated population was arranged into age-groups used for the description of the demographical distribution. The age-specific numbers of total cytological (c) and mammographical (m) examinations observed (O) were calculated for each settlement ($O_{cas,2001}$, $O_{cas,2005}$ and $O_{mas,2001}$, $O_{mas,2005}$, respectively). The age- and settlement-specific data were summarized for each sub-region (O_{ar}). National age-specific examination frequencies (f_a) for both years were calculated based on the age-specific numbers of observed cases and the size of the population:

$$f_{ca,2001} = \Sigma_r\, O_{car,2001} / \Sigma_r\, N_{ar,2001}$$
$$f_{ca,2005} = \Sigma_r\, O_{car,2005} / \Sigma_r\, N_{ar,2005}$$
$$f_{ma,2001} = \Sigma_r\, O_{mar,2001} / \Sigma_r\, N_{ar,2001}$$
$$f_{ma,2005} = \Sigma_r\, O_{mar,2005} / \Sigma_r\, N_{ar,2005}$$

The number of expected examinations for each sub-region was calculated using the national age-specific examination frequencies and the demographical distribution of the particular sub-region:

$$E_{car,2001} = f_{ca,2001} \times N_{ar,2001}$$
$$E_{car,2005} = f_{ca,2005} \times N_{ar,2005}$$
$$E_{mar,2001} = f_{ma,2001} \times N_{ar,2001}$$
$$E_{mar,2005} = f_{ma,2005} \times N_{ar,2005}$$

Age-standardized relative examination frequencies (S) for each sub-region were calculated as follows:

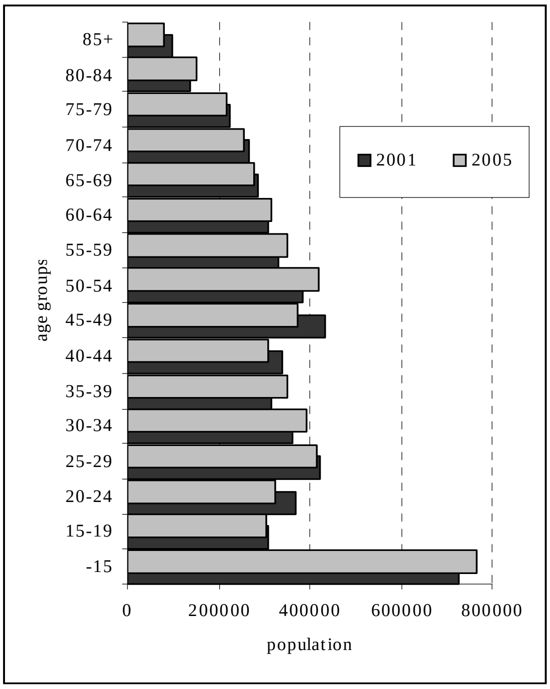
$$S_{cr,2001} = \Sigma_a\, O_{car,2001} / \Sigma_a\, E_{car,2001}$$
$$S_{cr,2005} = \Sigma_a\, O_{car,2005} / \Sigma_a\, E_{car,2005}$$
$$S_{mr,2001} = \Sigma_a\, O_{mar,2001} / \Sigma_a\, E_{mar,2001}$$
$$S_{mr,2005} = \Sigma_a\, O_{mar,2005} / \Sigma_a\, E_{mar,2005}$$

Association between local socio-economical parameters and examination frequencies was analysed by linear regression. Results were expressed by the regression coefficients, the related p values and determination coefficient.

Results

The headcount of females in 2001 and 2005 was 5,319,858 and 5,300,919, respectively (Graph 13). Indicators of the socio-economical status varied within a wide range (Table 1). In 2001, 701,739 cervix cytologies were recorded. After excluding the repeated examination (11.7 % of all reported cases) and other records with missing data on age or postal codes, 606,363 cases remained for the analysis. In 2005, 1,124,606 cervix cytologies were recorded and after we excluded the repeated examinations(43.1 % of all reported cases) and other records with missing data on age or postal codes, we remained with 837,743 cases.

Concerning mammographic examinations, in 2001, 378,261 cases were reported. After excluding the repeated examinations (5.1 % of all reported cases) and other records with missing data on age or postal codes, for the analysis remained 357,057 cases. For 2005, 974,941 mammographic examinations were reported. After we've excluded, here as well, the repeated examinations (25.3 % of all reported cases) and other records with missing data on age or postal codes, 554,588 cases remained for the analysis.



Graph 13. Age distribution for Hungarian women in 2001 and 2005 ($N_{ar,2001}$= 5 319 857.5; $N_{ar,2005}$= 5 300 918,5)

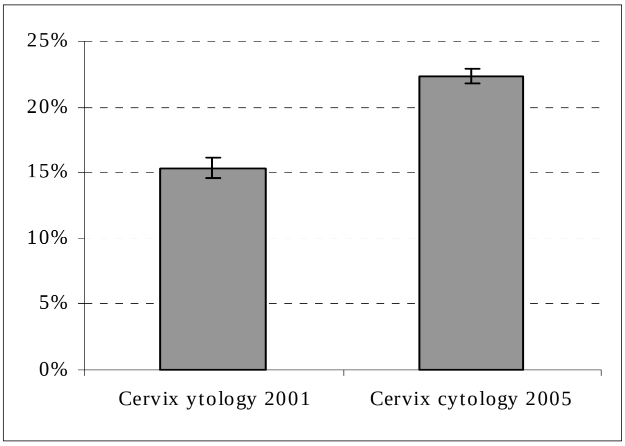
Table 1.

Distribution of socio-economical status indicators in the subregions (2002)

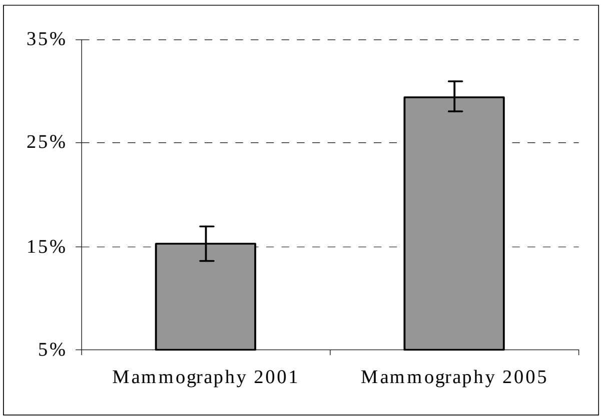
	mean	SD	minimum	maximum
Unemployment rate %	7.1	4.1	1.3	22.6
Long-term unemployed %	3.3	2.6	0.5	14.8
Long-term unemployed as a % of total unemployment	43.4	9.5	14.4	65.4
Bed places of clubs for the aged per 1000 people aged 60 and over	23.9	18.4	0	128
Unemployed persons receiving income supplements per 1000 inhabitants	1.0	0.9	0	3.9
Number of persons with public medical care card* per 1000 inhabitants	53.5	19.1	22	148
Inhabitants per general practitioner and family paediatrics	1587.2	182.6	1050	2379
Consulting hours in outpatient service, 1000	98.2	417.5	2	5282
Hospital beds in use	478.2	1835.6	0	22943
Number of tax-payers per 1000 inhabitants	402.7	51.5	280	525
Gross income serving as basis of the personal income tax per permanent population, 1000HUF	377.3	104.8	179.9	697.3

	mean	SD	minimum	maximum
Personal income tax per permanent population, 1000HUF	77.638	32.772	29.9	206,0
Aged 14 or below (distribution of population by age-group, %)	17.7	2.0	12.8	24.3
Aged 15–39 (distribution of population by age-group, %)	34.0	2.0	28.5	39.7
Aged 40–59 (distribution of population by age-group, %)	27.7	1.3	23.1	29.9
Aged 60 or over (distribution of population by age-group, %)	20.6	2.3	15.5	28.3
At least 8 grades in primary school (educational attainment as % of aged 15–X)	85.9	4.3	77	94.2
At least secondary school (educational attainment as % of aged 18–X)	29.1	8.6	14.1	58.7
University, college, etc degree (educational attainment as % of aged 25–X)	8.2	3.9	3.4	23.8
Average number of school grades	9.0	0.6	7.94	10.89

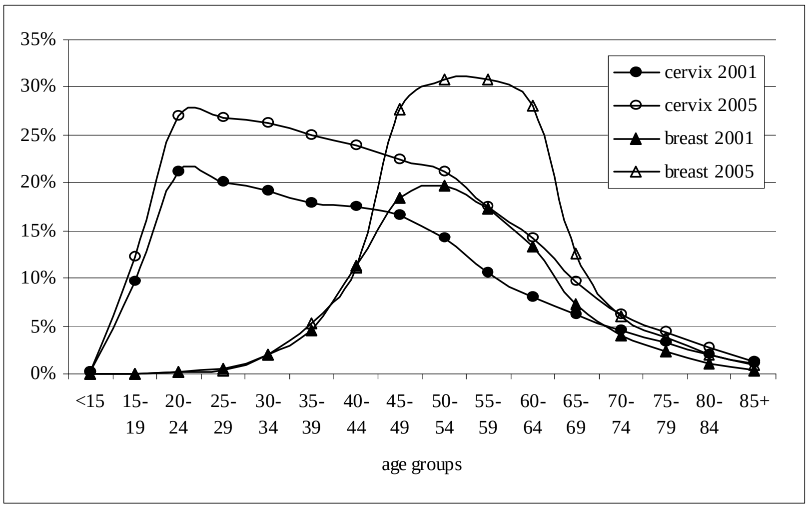
The examination frequency of cervix cytology in the entire female population was observed as 11.4 % in 2001 and 15.8 % in 2005 (Graph 14), while the frequency of mammography was 6.7 % and 10.4 % in 2001 and 2005 (Graph 15), respectively. In the primary target population of cervix cancer screening (females aged 25-64), the examination frequency was 15.7 % in 2001 and 22.4 % in 2005. In the primary target population of breast cancer screening (females aged 45-64), the frequency of mammography was 17.5 % and 29.4 % in 2001 and 2005, respectively (Graph 16).



Graph 14. Cervical cytology frequency (with 95% confidence interval) in 2001 and 2005 for females aged 25-64

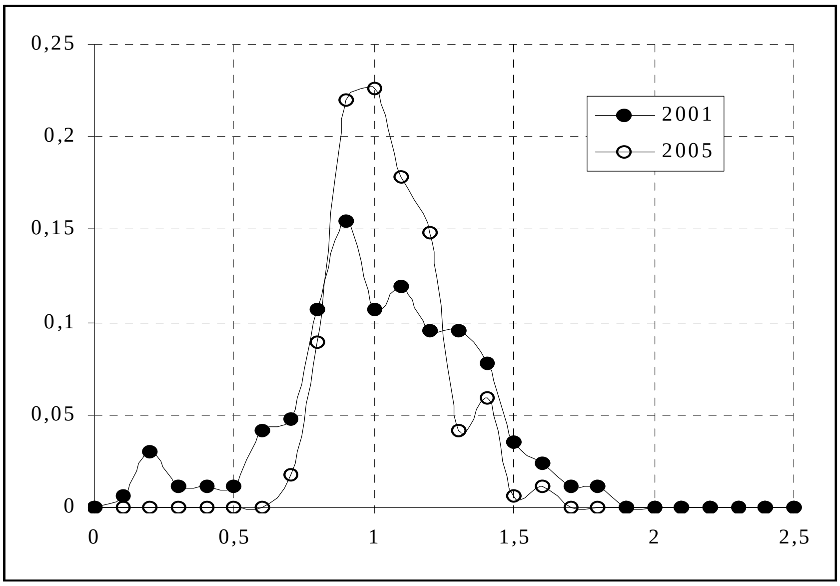


Graph 15. Mammography frequency (with 95% confidence interval) in 2001 and 2005 for females aged 25-64

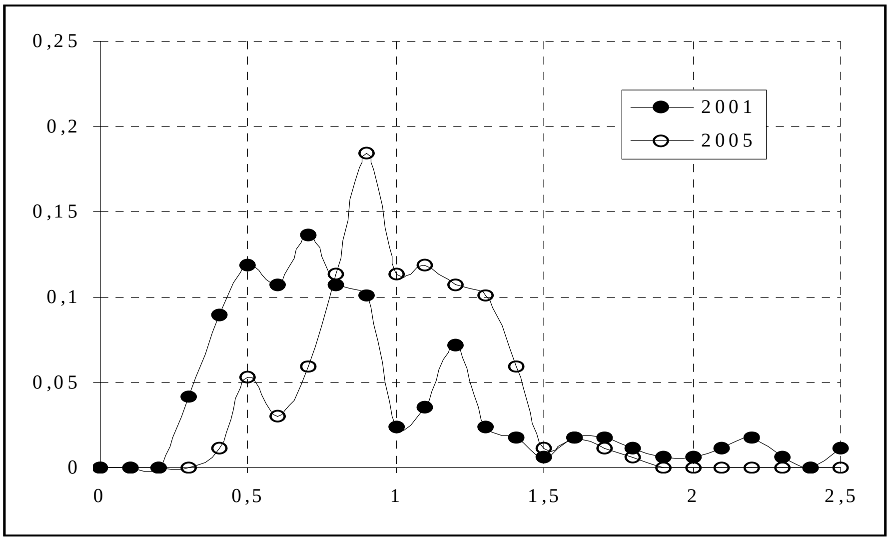


Graph 16. Age group specific coverage for cervical and breast examinations in 2001 and 2005 for Hungary

The relative age-standardized sub-regional relative examination frequencies varied in wide ranges for both examinations. The minimum-maximum values were 0.065 – 1.741, 0.676 – 1.598 for cervix examination in 2001 and 2005. The variance decreased significantly in this time period (F= 3.438; p<0.001), (Graph 17). The similar values for mammographies are: 0.235 – 4.078 and 0.308 – 1.756. The degree of variability decreased in this case as well. (F= 4.014; p<0.001), (Graph 18).



Graph 17. Distribution of relative cervical examination coverage for the subregions in 2001 and 2005



Graph 18. Distribution of relative breast examination coverage for the sub-regions in 2001 and 2005

Correlation analysis revealed significant association in the relative age-standardized sub-regional examination frequencies between 2001 and 2005. The correlation was much stronger in the case of cervix cytology than in the case of mammography (cervix cytology: beta=0.347, $p<0.001$, $r^2=0.415$; mammography: beta=0.080, $p=0.039$, $r^2=0.026$). In 2001, the relative age-standardized sub-regional examination frequencies for cytological and mammographic screening did not reveal any correlation with each other (beta=0.179, $p=0.167$, $r^2=0.011$), while in 2005, significant weak positive association could be observed (beta=0.318, $p=0.008$, $r^2=0.042$).

In 2001, regarding to the socio-economical status, cervix cytology revealed statistically significant correlation only with the rate of long-term unemployment ($\text{beta} \times 10^{-3}=5.6304$, $p=0.037$, $r^2=0.026$). Mammography, on the other hand, demonstrated a significant inverse correlation with the indicators of unemployment (unemployment rate %: $\text{beta}\times10^{-3}= -0,041$;$p< 0,001$; $r^2= 0,094$; long-term unemployed %: $\text{beta}\times10^{-3}= -0,068$; $p= 3,385$; $r^2= 0,099$; long-term unemployed as a % of total unemployment: $\text{beta}\times10^{-3}= -0,016$; $p< 0,001$; $r^2= 0,075$) and the utilization of social services (unemployed persons receiving income supplements per 1000 inhabitants: $\text{beta}\times10^{-3}= -0,163$; $p< 0,001$; $r^2= 0,078$; number of persons with public medical care card per 1000 inhabitants: $\text{beta}\times10^{-3}= -0,007$; $p= 0,001$; $r^2= 0,063$). Significant positive correlation could be observed between mammography and the indicators of income (number of tax-payers per 1000 inhabitants: $\text{beta}\times10^{-3}= 0,003$; $p< 0,001$; $r^2= 0,092$; gross income serving as basis of the personal income tax per permanent population, 1000 HUF: $\text{beta}\times10^{-3}= 9,615$; $p= 0,019$; $r^2= 0,033$; personal income tax per permanent population, 1000 HUF: $\text{beta}\times10^{-3}= 2,687$; $p= 0,040$; $r^2= 0,025$), as well as between mammography and the educational level (at least 8 grades in primary school among aged 15–X as %: $\text{beta}\times10^{-3}= 0,028$; $p= 0,006$; $r^2= 0,045$; at least secondary school among aged 18–X as %: $\text{beta}\times10^{-3}= 0,013$; $p= 0,010$; $r^2= 0,039$; university, college, etc degree among aged 25–X as %: $\text{beta}\times10^{-3}= 0,028$;$p= 0,019$; $r^2= 0,038$; average number of school grades: $\text{beta}\times10^{-3}= 0,257$; $p< 0,001$; $r^2= 0,070$). The low proportion of children related inversely to the relative frequency of cervix cytology (aged 14 or below, %: $\text{beta}\times10^{-3}= -0,101$; $p< 0,001$; $r^2= 0,137$), the higher proportion of middle aged was associated with higher coverage (aged 40–59, %: $\text{beta}\times10^{-3}= 0,137$; $p< 0,001$; $r^2= 0,098$), (Table 2 and 3).

In 2005, cervix cytology was correlated, again, only with the indicators of unemployment (unemployment rate %: $\text{beta}\times10^{-3}= 8,1624$; $p= 0,015$; $r^2= 0,035$; long-term unemployed %: $\text{beta}\times10^{-3}= 13,625$; $p= 0,011$; $r^2= 0,038$). In this year, mammography did not reveal any association with any parameter of the socio-economical status.

Table 2.

Relationship between socio-economical factors and coverage of the cervix examination (age-standardized examination ratio for all age groups) in 2001 and 2005 with the influence of these factors on the change of coverage between 2001 and 2005.
(Regression coefficient [beta], result of the statistical test [p], and the explanatory role [r^2] from univariate linear regression analysis)

	Relative coverage in 2001			Relative coverage in 2005		
	beta ($\times 10^{-3}$)	p	r^2	beta ($\times 10^{-3}$)	p	r^2
Unemployment rate %	3.6534	0.560	0.002	8.1624	0.015	0.035
Long-term unemployed % 2002	14.311	0.155	0.012	13.625	0.011	0.038
Long-term unemployed as a % of total unemployment 2002	5.6304	0.037	0.026	2.7433	0.060	0.021
Bed places of clubs for the aged per 1000 people aged 60 and over	-1.0672	0.447	0.003	1.4104	0.061	0.021
Unemployed persons receiving income supplements per 1000 inhabitants	-2.7607	0.919	<0.001	25.660	0.079	0.018
Number of persons with public medical care card per 1000 inhabitants	-1.8000	0.181	0.011	0.0195	0.979	<0.001
Inhabitants per General Practitioner and family paediatrics	-0.2441	0.082	0.018	-0.1343	0.076	0.019
Consulting hours in outpatient service, 1000	0.0366	0.553	0.002	0.0091	0.784	<0.001
Hospital beds in use	0.0036	0.793	<0.001	0.0003	0.996	<0.001
Number of tax-payers per 1000 inhabitants	-0.1569	0.754	0.001	-0.4272	0.112	0.015
Gross income serving as basis of the personal income tax per permanent population, 1000 HUF	0.0477	0.846	<0.001	-0.1723	0.193	0.010
Personal income tax per permanent population, 1000 HUF	0.1098	0.889	<0.001	-0.4526	0.285	0.007
Aged 14 or below Distribution of population by age-group, %	-15.605	0.220	0.009	2.0446	0.766	0.001
Aged 15–39 Distribution of population by age-group, %	-17.844	0.158	0.012	-6.9169	0.311	0.006
Aged40–59 Distribution of population by age-group, %	24.141	0.234	0.009	2.1323	0.846	<0.001
Aged 60 or over Distribution of population by age-group, %	18.509	0.094	0.017	3.0706	0.608	0.002
At least 8 grades in primary school (educational attainment as % of the population of aged 15–X)	2.0896	0.730	0.001	-0.9004	0.783	<0.001
At least secondary school (educational attainment as % of the population of aged 18–X)	-0.7929	0.792	<0.001	-1.0827	0.504	0.003
University, college, etc degree (educational attainment as % of the population of aged 25–X)	-4.0394	0.540	0.002	-1.9390	0.585	0.002
Average number of school grades	6.1052	0.892	<0.001	-10.419	0.668	0.001

Table 3.

Relationship between socio-economical factors and coverage of the breast examination (age-standardized examination ratio for all age groups) in 2001 and 2005 with the influence of these factors on the change of coverage between 2001 and 2005

(Regression coefficient [beta], result of the statistical test [p], and the explanatory role [r^2] from univariate linear regression analysis)

	Relative coverage in 2001			Relative coverage in 2005		
	beta $(\times 10^{-3})$	p	r^2	beta $(\times 10^{-3})$	p	r^2
Unemployment rate %	-41.479	<0.001	0.094	-1.6424	0.754	0.001
Long-term unemployed % 2002	-68.257	<0.001	0.099	-4.4850	0.595	0.002
Long-term unemployed as a % of total unemployment 2002	-16.044	<0.001	0.075	-2.5917	0.253	0.008
Bed places of clubs for the aged per 1000 people aged 60 and over	-4.0029	0.087	0.018	1.6007	0.171	0.011
Unemployed persons receiving income supplements per 1000 inhabitants	-163.64	<0.001	0.078	6.9894	0.759	0.001
Number of persons with public medical care card per 1000 inhabitants	-7.2968	<0.001	0.063	1.0567	0.348	0.005
Inhabitants per General Practitioner and family paediatrics	-0.4470	0.057	0.022	0.0777	0.510	0.003
Consulting hours in outpatient service, 1000	0.1318	0.201	0.010	0.0363	0.482	0.003
Hospital beds in use	0.0332	0.157	0.012	0.0075	0.523	0.002
Number of tax-payers per 1000 inhabitants	3.2767	<0.001	0.092	0.1314	0.753	0.001
Gross income serving as basis of the personal income tax per permanent population, 1000 HUF	0.9615	0.019	0.033	0.1517	0.460	0.003
Personal income tax per permanent population, 1000 HUF	2.6866	0.040	0.025	0.6671	0.309	0.006
aged 14 or below Distribution of population by age-group, %	-101.58	<0.001	0.137	-2.0225	0.850	0.000
Aged 15–39 Distribution of population by age-group, %	14.843	0.484	0.003	18.528	0.079	0.018
aged40–59 Distribution of population by age-group, %	137.11	<0.001	0.098	8.2688	0.626	0.001
aged 60 or over Distribution of population by age-group, %	24.342	0.189	0.010	-15.411	0.095	0.017
At least 8 grades in primary school (educational attainment as % of the population of aged 15–X)	27.629	0.006	0.045	7.1486	0.157	0.012
At least secondary school (educational attainment as % of the population of aged 18–X)	12.763	0.010	0.039	4.3583	0.082	0.018
University, college, etc degree (educational attainment as % of the population of aged 25–X)	27.506	0.012	0.038	7.9055	0.150	0.012
Average number of school grades	257.44	<0.001	0.070	59.537	0.112	0.015

Discussion

The Hungarian breast cancer and cervix cancer screening system was opportunistic until 2001. The limited efficacy of this approach was reflected in the very poor mortality data for cervix cancer and in the not improving mortality rates of breast cancer. Based on such evidence, national programs had been launched to build up a new, invitation based screening organization for both disease.

The cervical cytology and the mammography are financed by the National Health Insurance Fund. Reporting is required to be financed. The reports are inserted into the outpatient discharge database which is exclusive and comprehensive, because the National Health Insurance Fund is the only health insurance company in Hungary. The reports contain data on the patients, providers, and examinations, which enable the investigators to follow the patients' state over repeated examinations. Because the data collection was unchanged in the period of 2001 to 2006, the effect of replacing the opportunistic screening with invitation based system could be investigated.

It is well known that the usage of health services is highly dependent of socio-economical status. It is also well recognized that the screening participation has social determinants. The spatial inequality of socio-economical parameters is substantial, which establish the opportunity to investigate the relationship between socio-economical determinants and participation.

The dataset used by our study is based on the equipment that supports the health care financing. Therefore, quality of data does not meet the criteria usually applied in epidemiological investigations. It can not be ruled out that the financial interest of the providers biases the reports sometimes. Most probably, the examination can be mal-coded, and the diagnostic and screening investigations can be exchanged (according to the actual economical status of the health centres.) The coding rules had been changed as well during the study period. Considering these factors, our study summarized the screening and different diagnostic examinations: the prevalence of examination was the basic indicator.

This study had no access to individual-level socio-economical data, therefore all of the investigations have an ecological design. Consequently, the results can not be extrapolated to the individual level: for instance, personal socio-economical status and participation in the screening programs can not be described by this approach. We've based the logic of investigation on the fact that health providers have catchment areas for which they are responsible and thus, results from an ecological analyses can be directly interpreted for them without biasing.

The demographical data were available in 5-year age groups. This breakdown does not fit the definition of target groups by screening programs. Both programs define the upper age limit as 65 years. Our study could not handle separately the data for people aged 65. The age groups of screening programs (25-65 for cervix cancer and 45-65 for breast cancer) had been replaced by 25-64 and 45-64. It was assumed that this method will not bias the target group's specific results. On the other hand, the age standardized relative examination frequencies covered the whole population and thus resulted performance indicators for all females.

The study relied on a huge number of cases. Excluding the repeated examinations and poor quality reports there were 606,363 and 837,743 cervical examinations in 2001 and 2005 respectively. For mammography data were 357,057 and 554,588 in 2001 and 2005, respectively.

The study revealed significant improvement of both screenings. The examination frequency of cervix cytology in the entire female population increased from 11.4 % to 15.8 % in the period of 2001-2005. The same improvement for mammography was the elevation from 6.7 % to 10.4 %. The examination frequency among females aged 25-64 was 15.7 % in 2001 and 22.4 % in 2005. Frequency of mammography for females aged 45-64 was 17.5 % and 29.4 % in 2001 and 2005, respectively.

Huge geographical variability was descried for both screening programs and for both years. The relative age-standardized sub-regional relative examination frequencies varied between 0.065 and 1.741 in 2001, 0.676 and 1.598 in 2005 for cervix cytology. The ranges for mammographies were 0.235 – 4.078 in 2001 and 0.308 – 1.756 in 2005. The geographical differences were stabile over time, since there was a strong correlation between the performances in 2001 and 2005 for both programs. Altogether, there are significant geographical patterns for cervical cytology and mammography in Hungary. Theoretically, it can be caused by the time-stable differences between providers, or by the time-stable characteristics of the populations provided. As far as performance indicators for cervical cytology and mammography were not correlated in 2001, but were correlated in 2005, the role of variable quality of health service is suspected to be the dominant factor.

The distribution of sub-region level performance indicators narrowed significantly between 2001 and 2005 for cervical cytology and for mammography. The improved nation level performance had been accompanied by the narrowing gap between the sub-regions with fair and unacceptably low examination frequencies.

The sub-regional cervix cytology frequency is hardly related to the socio-economic status indicators. Different measures of unemployment show positive correlation with it. Since neither of the other deprivation indices were in association with this performance, emerged that an important, but not investigated factor can increase the unemployment and the cervical cytology frequency without influencing other deprivation measures. (Perhaps, it can be a late effect of the collapse of the Hungarian industry. (a) The unemployment increased dramatically in the industrial zones. (b) In the eighties, gynaecological centres used to organize cervix cancer screening days on the site of the bigger industrial firms. This practice was supported by the management as a part of occupational health service. Females who participated in this mobile screening could get positive experiences on cervix cancer screening and the program's effect on their attitude was reflected in the permanently high participation willingness.)

The frequency of mammography was affected by a lot of socio-economical indicators in 2001. The deprivation was associated with lower level of utilization, in general. The unemployment, the poverty (indicated by unemployed persons receiving income supplements per 1000 inhabitants and by number of persons with public medical care card per 1000 inhabitants), poor economic force (number of tax-payers per 1000 inhabitants; gross income serving as basis of the personal income tax per permanent population, personal income tax per permanent population), and the low level education have this effect. The high proportion of the population aged 14 or below showed relatively strong inverse association with the occurrence of mammography. (It can be explained by the fact that the high fertility rate is characteristic to the Roma populations, which usually lives in extremely poor conditions.) The number of inhabitants per general practitioner correlated inversely with the mammography frequency. This is the only observation which can not be explained simply by the deprivation theory.

This strong association with the socio-economical status has been abolished entirely by implementing the invitation based organization. There was only one factor with significant effect: bed places of clubs for the aged per 1000 people aged 60 and over. The higher the proportion of females living in clubs (where the social support is obviously high and formed by health professionals) the higher the participation in screening programs.

It has to be also emphasized that the consulting ours in outpatient services did not relate neither to the examination frequency. This shows that the capacities – at least in the present – are able to meet the needs and thus, the capacity building of the governmental project was appropriate in this sense.

It is evident that the limitations of opportunistic screening can be solved by the invitation based methods: improved general performance, narrowed geographical inequality, weakened influence of socio-economical status at population level. The results also suggest that the geographical inequalities are determined basically by factors related to the providers. The refinement of organization and the search for more resources, more participants to be involved seem to be necessary in the future.

This later conclusion is augmented by the fact that the overall performance of the programs is far less than acceptable. The high-risk group concept and the differentiated invitation methods could improve the performance. In spite of the general practitioner care (which is rather equally distributed), the specialist care is much more intensively utilized by patients with a better economical status in Hungary (van Doorslaer et al., 2006). The gynaecological specialist care utilization and the participation in breast cancer screening have this character as well (Hajdu, 2005). The Hungarian screening organization should thus accept the internationally well established knowledge that the socio-economic differences in participation can be decreased by removing the socio-cultural obstacles and by improving patients' attitudes towards such programs.

An important additional resource would be localized on the level of the general practitioner who nowadays is not involved in the invitation process. The general practitioner has the knowledge about local specificities and local reputation, which make them able to force the participation. The formerly mentioned decree of the Hungarian Ministry of Health obliges the general practitioners to register the participation of the people in the screening programs and to register the screening results also. In practice, this decree is not respected and the general practitioners are not fully involved. This neglect has to be considered: there was a pilot program in Tolna county before the national program on mammography wherein a Public-Private-Partnership program was carried out based on the co-operation between a mammographic centre and general practitioners. (The inhabitants' registers of general practitioners were the base of inviting system. The mammographic examinations had been carried out in a centre established by the collaboration of a private firm and the county hospital of local government.) The 5 sub-regions belongs to Tolna county had the 4th, 5th, 6th, 11th and 12th best results in the rank of the 168 Hungarian sub-regions in 2001. There were 18,278 examinations carried out, while 8768.8 was the number of expected examination calculated on national age-specific references. (Age-standardized relative examination ratio: 2.08.) The number of examinations declined to 12,792 by 2005, when the national program was implemented. (Age-standardized relative examination ratio: 0.94.) The ranks for the sub-regions' of Tolna county were 46th, 61st, 95th, 132nd, 151st.

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THE ROLE OF HOSPITALS IN COUNTY-LEVEL SECONDARY ASSISTANCE. A CASE STUDY OF THE BISTRIŢA COUNTY EMERGENCY HOSPITAL

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ABSTRACT. The organization of secondary medical assistance and the management of hospitals have crucial impact on the access of the population to quality medical services. This paper offers insight into the role of hospitals in secondary assistance in Romania through the in-depth analysis of the particular case of the Bistrița County Emergency Hospital.

The hospital is defined as a legal entity which provides, for the population of the county and transitory persons, a whole range of medical services: preventive, curative, recovery and palliative, as well as assistance in case of pregnancy, maternity, and newborn care. From a functionalist point of view, hospitals need to adopt to the changing health status and health care needs of the population, as well as to the constraints of the re-organisation of the health care system. The paper provides a detailed analysis of this adaptation process, which is considered illustrative and helpful for a better understanding of recent evolutions in the Romanian secondary assistance.

Keywords: secondary medical assistance; hospital management; access to health care services

Introduction

The health status of the population is determined by the access to health and to health services. The access to health depends mainly on the external factors of the health system: genetic factors, environmental factors, economical development, and socio-cultural factors. The access to health care is highly influenced by the sanitary system organisation.

The accessibility of medical health care services results from the interplay between "offer" and "demand", in other words of the real reserve of health care facilities as compared with the demand based on the real necessity for health. The inequalities in access stem from at least for four factors: ethnic belonging, economic situation, the geographical location of care facilities, and the

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uneven quality of services offered by various providers. The economic situation is particularly important, given that there are direct costs paid by the population (payment for certain services, costs related to treatment and hospitalisation) as well as the indirect costs (transport, waiting time, emotional costs).

In the last few years, the press has been focusing on endless series of medical and administrative failures of the Romanian sanitary system. It is difficult to assess whether policymakers were able to identify the causes of these failures. Partly, the problems could be attributed to the lack of professionalism and deficiencies in resource administration. However, the scale of the problems suggests that there are systemic causes responsible for the alarming situation.

The autochthonous debate has apparently eliminated the topic of health reform in favour of financial issues related to the system. Two trends seem to dominate the interpretation of one or the other factors.

Some blame the "*chronic under-financing of the system*" and others stress "*the inadequate use of resources*". If we gave exclusive credit to the first, we should accept the fact that Romania is a developing country, in need to find its minimum level of resources necessary for the system to work. If we embraced unconditionally the discourse of the inadequate use of resources, Romania would be a developed country concerned about cost containment.

One may say that Romania is "original", again. On the one hand, only about four million inhabitants (from twenty million representing Romania's population) pay their contribution to the health insurance fund and, in many cases, they do it only partially given that they have undeclared incomes. Arrears, overdue payment terms and payment exemption characterise many of the insured persons.

The amount of financial resources of a health system makes the object of difficult political decisions, bound to find the balance between the necessary resources and the amount that the society is willing to pay for health.

Until now, the process of health reform has been completed only in primary medical assistance, which has practically privatized entirely. Less progress has occurred in the hospital sector, where the ownership problem is still unclear and the financing structure remained basically the same. One critical aspect is that, in relative terms, Romania spends more for the hospitals and less for primary assistance, as compared to the other EU countries.

Romania started the reform with an oversized hospitalisation system, a problem that other ex-communist countries had to deal with as well (Bocşan, 1999; Enachescu, 1990). According to the latest statistics provided by the Ministry of Health, the main indicators used for evaluating the efficiency of a hospital suggest a rather low performance: the internment rate (20%) and the average term for hospitalisation (10 days) are the highest across Europe, although close to the average in Central and Eastern Europe. The value of bed occupancy rate (75%) falls into the inferior half, whereas the number of beds ($7^0/_{00}$ inhabitants) ranks at the superior limit (Romanian Ministry of Health, 2008).

On the other hand, Romania uses, to some extent, top range medical technology, pharmaceutical industry and sanitary products. Admittedly, some of them are inadequately used, from a clinical and managerial viewpoint. If we accept this assumption, we must think of expense/cost limitations. This is not the only argument in favour of adopting cost containment strategies. The limitation of costs is necessary when health expenses are increasing at a higher rate than the double of the increasing rate of the national gross income.

The national health insurance offices, which are theoretically the buyers of health services, have not succeeded in becoming real partners towards providers; they still behave as owners imposing their own despotic rules, whereby financial laws and not socio economical realities are important.

In addition, the autonomy of hospital executives is limited, a fact that prevents even the reorganisation measures initiated by the administrators. In the last few years, sanitary policies have become a sort of game between the political and scientific bodies, in which the technical aspects had to adapt to the social and political decisions.

Having in mind the above considerations, it becomes clear that the managerial teams of county hospitals face difficulties in fulfilling their duties, having to mantain a balance between the medical ethics and financial restrictions.

Bistrița-Năsăud County – A Case Study

Bistrița-Năsăud county has an area of 5305 km^2 (2,2% of Romanian territory) and is situated to the North Centre part of the country. From an administrative point of view it is within the North-West Developing Region, surrounded by Maramureș county to the north, Suceava county to the East, Mureş to the South and Cluj to the West (National Institute of Statistics, 2007).

The landscape of Bistrița-Năsăud county is varied and complex, formed of montainous structures (36%) opened like an amphitheatre on the Someşul Mare Valey and hill structures (64%) belonging to the Transylvanian Plateau. In the South-East part of the county there is a part of the Transylvanian Plain. The county's climate is continental-moderate and mountainous, mostly in the Transylvanian Plateau and the Northern and Eastern boundaries and in the high mountains, with alpine lawns. The effect of Western maritime polar air masses is stronger during the cold season (October through april), when the frontal activity is very intense. Transition seasons, such as spring and autumn, are shorter than in the Southern parts of Romania, while winters are longer and damper and summers hotter. All these climatic aspects influence the morbidity of the inhabitants.

The population of Bistrița-Năsăud county counts aproximatively 319,090 persons, representing 11.58% of the North-Vest Developing Region. The county's population lives in proportion of 36.3% in urban environment and 63.7% in rural environment (see Table 1). This is important, given that access to health care services is more difficult in rural areas.

Table 1.

The residential distribution of the population in 2007

Total inhabitants	319,090	100%
Urban	115,686	36.3%
Rural	203,404	63.7%

Source: Statistical Department of the Bistriţa County Emergency Hospital, 2008.

The gender distribution in the Bistriţa-Năsăud County is similar to the national distribution, with a slight domination of female population (see Table 2).

Table 2.

The gender distribution of the population in 2007

Total inhabitants	319,090	100%
Men	158,657	49%
Women	160,433	51%

Source: Statistical Department of the Bistriţa County Emergency Hospital, 2008.

The age-distribution of the population (see Table 3) indicates that the age-group of seniors is significant, a fact with special relevance for the organisation of medical activities.

Table 3.

The age distribution of the population in 2007

Total inhabitants	**0-19year old**	**20-49 year old**	**50-69 year old**	**>70**
319,090	89,214	141,079	62,256	26,541
100%	28 %	44.2%	19.5%	8.3%

Source: Statistical Department of the Bistriţa County Emergency Hospital, 2008.

The birth rate in Bistriţa-Năsăud County was 11.03% in 2007, an indicator that situates the county at a superior level in the country (9.7% at the national level). Even so, following the general tendency in the country, the birth rate is decreasing.

General mortality rate at the county's level was 9.8% in 2007, below the national value (12%), recording a relative stability of this indicator between 1990 and 2007.

The Bistrița County Emergency Hospital

The Bistrița County Emergency Hospital is the sanitary unit endowed with beds, for public utility, a legal entity that provides the following medical services: preventive, curative, recovery and palliative, as well as care in case of pregnancy, maternity and newborn care. At the hospital, there are activities related to medical and pharmaceutical education, at undergraduate, graduate and postgraduate levels, as well as scientific medical research.

The hospital ensures conditions for medical research, treatments, accommodation, hygiene, alimentation and prevention of nosocomial infections, in accordance with the approved standards of the Public Health Ministry. It is its obligation to give the first aid and emergency medical assistance to any person in need, whose health condition is critical; after stabilising the vital functions, the hospital will ensure the medically assisted transport to another medical sanitary unit.

The hospital will be permanently ready to ensure medical assistance in case of war, disaster, terrorist attacks, social conflicts and other crises and it has the obligation to participate with all its resources to oust their effects.

The Bistrița County Emergency Hospital functions with a total number of 1195 beds, distributed in five building centres (See Table 4).

From the point of view of its activities, the hospital offers medical assistance for acute and chronic affections.

Table 4

The number of hospital beds in 2007

Total number of beds	Acute diseases		Chronic diseases	
	M	Ch.	M	Ch.
1195	812	297	86	---

Source: Statistical Department of the Bistrița County Emergency Hospital, 2008.

The spatial-functional structure of the hospital in general and for each of sectors and divisions in particular is organised according to user categories, the specific technological conditionings of activities imposed by the medical gear, equipment, hygiene, and asepsis criteria. Thus, according to the National School of Public Health and Sanitary Management (2006), there are four zones:

- *Clean zone:* includes the divisions for the hospitalised patients (stay wards, surgery units, ATI service, obstetric unit, sterilisation).
- *Dirty zone:* is the interface in relation with the technical services and performed services. It comprises divisions strictly separated from the asepsis zones, having its own staff (technical medical services, household activities zone, and technical services.).

- *Neutral zone*: represents the interface of the hospital on the medical compound, in relation with patients, staff and visitors. It includes the casualty ward, the outpatient unit, and hospitalisation section for day patients' reception department.
- *Transition zone*: includes medical laboratories, functional exploring, and administration zone.

Medical services provided by the hospital outpatient unit are clinical investigations, diagnosing, medical treatment and/or surgical, care, recovery, providing drugs, sanitary materials, and prostheses (See Table 5).

Table 5.

Outpatient structure of the County Emergency Hospital in 2007

Total number of activities	Specialised	SJ for forensic medicine	Pharmacy department for health programs	C J for reproduction health and familial planning	Sports medicine activity	School and pre-school general medicine and stomatology
8	1	1	1	1	2	2

Source: Statistical Department of the Bistrița County Emergency Hospital, 2008.

To ensure good quality hospital services, there are several technical-medical activities (sterilisation, prospectors etc), auxiliary services for the personnel, patients and dependants (locker room, cloakroom, kiosks, chapel etc), and specific provisions (heating system and oxygen supplies, communication facilities etc).

Personnel structure of the Bistrița County Emergency Hospital

The County Emergency Hospital has 1228 job position:

- physicians 128
- sanitation supervisors 28
- other sanitary personnel 670
- statisticians and office staff 14
- nurses 146
- carers, porters, barrier nurses 118
- other 204

The services offered to the patients depend on the following: the number of medically qualified care personnel, the organizational schema (which defines the structure, functions and the responsibilities of the care personnel, as well as their evaluation), patients' healthcare plan (centred on the reliability and the efficiency of care), and by the health care staff (which participates in training and program of continuous education).

The management of the hospital expects from the employees:

- Loyalty, which implies the attachment and moral fidelity to the institution; loyalty norms also involve behaviour patterns in relation with the public or when an employee is asked to do an unpleasant job.
- Clear job standards as to how much effort, type of performance, and outcomes are expected from them.
- Clothing code comprises indications about the garment style acceptable in the institution, which is influenced by the life style of the employees and the particular work conditions.

An important factor for the performance of the hospital is represented by the motivation of the health care staff and auxiliary service providers. Similarly to the medical field, where there is no same treatment for all diseases, there is no universal prescription for motivating the employees of an institution. This can be obtained only through experience, observation and a close relationship with all employees.

Clinical data flow analysis on provided service type (coding, collecting, transmission, validation)

Any hospital has the mission to offer health care services to help patients' solve their problems (effectiveness), in the best possible way (quality) and most economically (efficiency). In this context there has been introduced the DRG (diagnostic related groups).

DRG is a patient classification system based on diagnosis, procedures and other clinical information about the patient, which makes it possible to correlate the type of patients (meaning the complexity indicator of cases or case mix index) with the due costs of the hospital.

Necessary data for patient grouping based on diagnosis and procedures in DRG class are listed below: age, gender, hospitalisation time, main diagnosis, secondary diagnosis, procedures, health condition after leaving the hospital and weight at birth (in the case of newborn).

To be able to classify each patient leaving the hospital into a diagnosis group, four stages are necessary:

1. Obtaining/ registering of the clinical data about the patients out of hospital. DRG classification needs 7 variables for each patient: age, sex, hospitalisation time, main and secondary diagnoses, surgical intervention, or other procedures effectuated, health condition after leaving the hospital and weight at birth (only for the newborn);

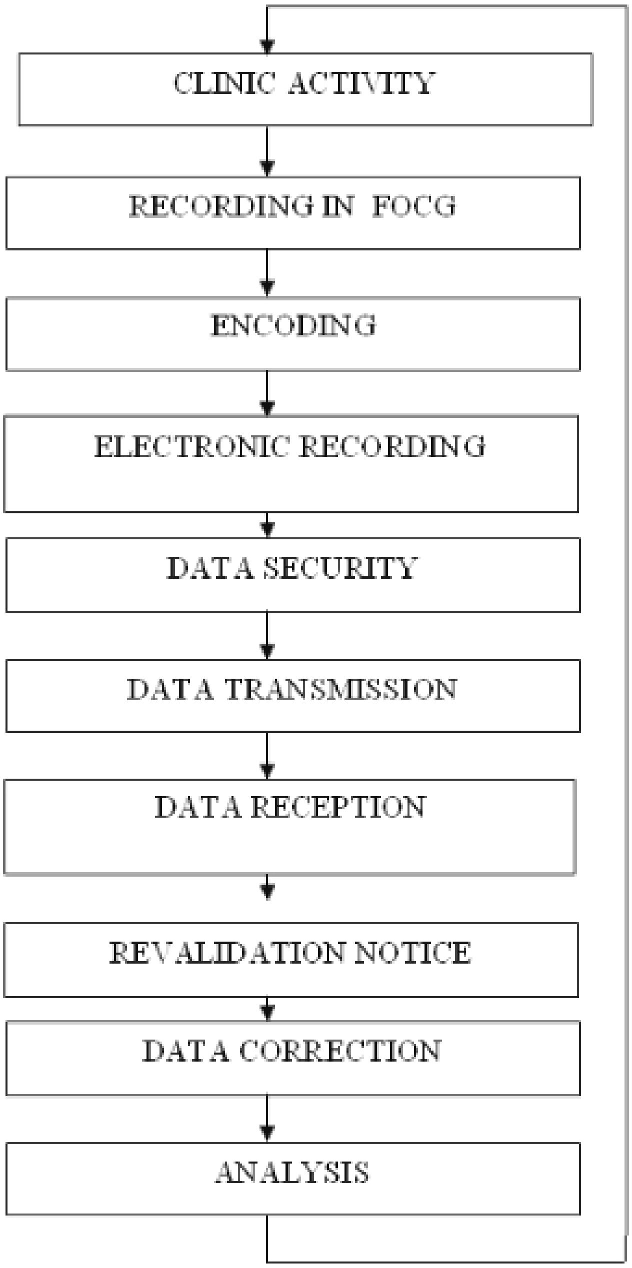

Figure 1. The Flow of Clinical Data

2. Necessary data encoding (for diagnoses and procedures) in view of using a standardized language for these variables, making them readily usable;

3. Electronic data collection;

4. Automatic patient allocation to a diagnostic group (using a computerized grouping application called "grouper").

After grouping the patients, there are two additional stages in order to use the DRG system for financing purposes.

1. Prices are set for each diagnostic group (or relative price values); these are based on the corresponding patient costs; they can either be imported with the grouper or can be developed locally; once calculated, these costs are transformed in prices and used for all hospitals participating in the financing scheme.

2. The budget allocation for hospitalisation assistance is based on the number and types of patients leaving the hospital (case-mix of each hospital) and the price list (or relative values) for each DRG.

By DRG financing system, hospitals that, for a certain DRG, register higher costs than the established price, will lose resources at that patient category whereas those with lower costs will earn resources at that patient category. Overall, hospitals are stimulated to keep costs at a lower level of prices for each type of patient, to be able to save resources and use them for other purposes.

When DRG's are used as basis for hospital financing, other data are needed to establish a "price" or a price list for each DRG. These concern the relative input of resources among patient categories. In Romania, this information is provided by the ExBuget2 application (costs at the level of hospital wards) and from the relative indicators of resources accepted at international level. In addition, the total health budget is used for price setting.

Patients' rights

According with the Law 46 on Patients'rights, which has been enacted since 2003, the patients have the following rights, provided by The Patients' Rights Charter and included in the Internal Rules and Regulations:

- The right to be informed regarding the relation patient-hospital;
- The right to satisfactory services meeting their needs for medical assistance;
- The right to access medical information on their condition by means of the members of the therapeutic team and from the papers received when leaving the hospital;
- The right for a civil care;

- The right to be informed and to take a decision on research activities that involve his person;
- The right to privacy and confidentiality of all information related to his disease;
- The right to care continuity;
- The existence of an Ethics Committee that supervises the observance of patients' rights in accordance with the current legal provisions.

The medical activities assessment from the Bistrița County Emergency Hospital in 2007

In the county hospital there are patients from all social categories. The total number of patients in hospital in 2007 was 34,592 patients in acute and chronic care - regular hospitalisation, 5,815 day hospital patients and a number of 80 kidney dialysis patients for 10,749 dialysis sessions.

The main indicators of medical activity are presented schematically below:

Social and demographic indicators

In 2007, 55.68% of the patients treated at the Bistrița County Emergency Hospital were females, and 44.32% males. Patients from rural areas (40% of total patients) were outnumbered by those from the urban (60%). The patients were from all age groups. However, 60% of total patients were above 50 years old, while this age category represents only 18% of the total population of the county. Several factors account for this, such as physiological aging, and the migration of the active population of the county. Thereby the organization of the medical services and integrated outpatient must be orientated through this age category.

Table 6.

Patients' distribution according to age groups in 2007

Total	Under 1 year	1-4	5-14	15-24	25-34	35-44	45-54	55-64	64-74	75-85	Over 85
34,592	2,303	865	1,354	2,983	3,272	3,107	6,127	5,772	5,406	3,082	321

Source: Statistical Department of the Bistrița County Emergency Hospital, 2008.

Bistrița County Emergency Hospital also offers services for the socially disadvantaged. Among them, patients with no medical insurance (almost 6%) and, even worse, patients with no identity documents (2%) for whom a correct observation chart with minimal data cannot be set; thus, these charts cannot be validated and the hospital pays these patients' expenses (Statistical Department of the Bistrița County Emergency Hospital, 2008).

General indicators for the volume and intensity of health care activities at the hospital

In 2007 the use indicator for beds at Bistrița County Hospital was 242.07 in comparison with the optimal indicator of 290 in accordance with the Order of MS 1778/2006, indicating a satisfactory usage of beds per institution. The analysis of the wards situation points to important differences regarding the optimal value. The rate of bed occupancy confirms it. Wards such infectious diseases, chronic diseases, ORL, ophthalmology, and paediatrics, registered a low rate of bed usage; therefore, an adjustment of the ward structure is needed in view of optimising the values.

Table 7.

Indicators of volume and intensity of medical activities in 2007

	Ward	Annual average beds number	Nr. of patients leaving the hospital	Values or beds usage	DMS
1	Infectious diseases	79	1,784	166.48	7.18
2	Cardiology	68	2,294	229.05	6.67
3	Surgery	80	2,873	250.93	7.10
4	Chronics	26	509	200.16	10.24
5	Dermal venereal	31	1,055	283.77	8.26
6	DZ, nutrition diseases	25	1,024	298.52	7.22
7	Internal medicine I	75	2,774	268.44	7.1
8	Internal medicine II	30	1,139	288.76	7.15
9	Neonatology	55	1,881	208.34	6.01
10	Neurology	54	1,819	268.24	7.79
11	Obstetrics-gynaecology	94	4,026	222.89	5.16
12	Ophthalmology	30	1,557	243.63	4.66
13	Oncology	36	1,648	295.77	6.56
14	Orthopaedic and traumatic	52	2,025	274.98	6.96
15	ORL	26	1,140	257.96	5.98
16	Paediatrics	75	1,895	174.1	6.74
17	Psychiatry	90	1,832	296.12	14.37
18	Rehabilitation, balneology, sports med	56	1,623	312.21	10.71
19	Urology	15	516	237.8	7.13
20	Pneumonias I	22	343	182.72	12.07
21	Pneumonias II	19	228	135.15	11.36
22	Pneumonias TB I	50	387	246.76	29.58
23	Pneumonias TB II	33	220	205.66	27.93
Total		1121	34,592	242.07	7.89

Source: Statistical Department of the Bistrița County Emergency Hospital.

Table 8.

ICM's level on wards comparing with the values registered at national level in 2007

Nr.	Ward	ICM	ICM-national conf. OMSP 1567/2007
1	Infectious diseases	0.7049	0.630
2	Cardiology	0.8049	0.713
3	Surgery	0.9492	0.832
4	Dermal venereal diseases	0.7690	0.683
5	Diabetes -nutrition diseases	0.7370	0.672
6	Internal I	0.8219	0.6790
7	Internal II	0.9059	0.6790
8	Neurology	0.8502	0.829
9	Neonatology	0.4410	0.347
10	ORL	0.5264	0.647
11	Obstetrics-gynaecology	0.5558	0.599
12	Ophthalmology	0.6855	0.566
13	Oncology	1.0302	0.985
14	Orthopaedic and traumatic	0.7563	0.986
15	Paediatrics	0.6338	0.520
16	Psychiatry	0.9206	0.783
17	Pneumonias I	0.8556	0.719
18	Pneumonias II	0.9561	0.719
19	Urology	0.7676	0.730
	Total hospital	**0.7462**	-

Source: Statistical Department of the Bistrița County Emergency Hospital.

Most of the wards show a higher ICM than the national average with some exceptions: Orthopaedic and traumatic, and ORL wards.

High blood pressure represents the most frequent DRG from DRG 134, that is why the optimisation for hospitalisation time can lead to important savings. High blood pressure has been dealt with in each hospital ward, with high DMS in the chronic and psychiatric wards and lower in neurology. An analysis in medical care assistance for HTA should start from these wards.

The same model is applicable to all DRG's in the County Hospital wards.

An analysis of the physicians' activity according to ICM in both Internal medicine wards also raises problems on the manner money is spent by each physician.

Table 9.

Level ICM /Physician in 2007

	Physician **1**	Physician **2**	Physician **3**	Physician **4**	Physician **5**	Physician **6**	Physician **7**	Physician **8**
ICM	**0.64493**	**0.64886**	**0.67110**	**0.69371**	**0.61405**	**0.61525**	**0.71192**	**0.71201**

Source: Statistical Department of the Bistrița County Emergency Hospital, 2008.

Indicators for provider type

Patients' distribution on ward type in 2007 was the following: 36% in survey wards and 64% in medical wards.

Indicators for hospitalization circumstances

In what concern the patients' situation according with hospitalization type, 28% of patients were referred by the family doctor, 15 % by specialist physician. Mostly situation are emergency (56%).

Indicators of external circumstances

In 2007, the majority of patients (70%) left the hospital cured or with their health condition improved, only 8% had the same health status, 1% deceased; the remaining 2% were in other various situations.

Indicators for the distribution of medical activities

The number of major diagnosis categories (CMD) was 26 at the County Hospital as compared to 27 recorded at national level in 2007 and the number of diagnosis groups (DRG) was 410 compared to 493 at national level.

1. Diseases and ailments of the circulatory system -4109
2. Pregnancy, birth and confinement -3368
3. Diseases and ailments of the digestive system-2690
4. Diseases and ailments of musculoskeletal system-2662
5. New born, healthy and ill- 2059
6. Diseases and ailments of nervous system-2048
7. Diseases and ailments of hepatic system and of the pancreas-1970
8. Diseases and ailments of the ear, nose, mouth and breast-1944
9. Diseases and ailments of the respiratory system-1913
10. Mental diseases and ailments-1863

Quality indicators

In some wards such as cardiology, neurology, oncology there is a high rate of mortality as compared with the national values; the phenomenon is due in some cases to delays in addressing hospital services; in other cases, the family hoped that something can be done and postponed until the last moment. There is no registered deceased case blaming medical practice.

Table 10.

Quality indicators of hospital activities in 2007

Nr	Ward	Mortality rate	Mortality rate Cf. OMSP 1567/2007	Concordance index Dg hospitalisation -. Dg external	Concordance index Dg. hospitalisation- Dg. external Conf. OMSP 1567/2007
1	Infectious diseases	0.61	0.34	0.97	0.68
2	Cardiology	2.57	1.79	0.88	0.69
3	Surgery	2.41	1.55	0.97	0.79
4	Chronics	0.78	0.73	0.97	0.82
5	Dermal venereal	0	0.06	0.98	0.94
6	DZ,nutrition diseases	0.19	1.08	0.96	0.64
7	Internal medicine I	1.8	1.22	0.65	0.73
8	Internal medicine II	1.49	1.22	0.79	0.73
9	Neonatology	0.79	1.01	0.85	0.69
10	Neurology	6.59	4.16	0.85	0.72
11	Obstetrics-gynaecology	0.02	0.01	0.51	0.61
12	Ophthalmology	0.06	0.01	0.94	0.79
13	Oncology	3.27	0.86	0.99	0.58
14	Orthopaedic and traumatic	0.34	0.52	0.97	0.91
15	ORL	0.17	0.13	0.88	0.92
16	Paediatrics	0.31	0.23	0.99	0.73
17	Psychiatry	0.27	0.23	0.92	0.87
18	Recovery, balneology , physics med	0	0.01	0.99	0.95
19	Urology	0.77	0.5	0.35	0.66
20	Pneumonias I	0.87	1.13	0.98	0.77
21	Pneumonias II	4.38	1.13	0.83	0.77
22	Pneumonias TB I	1.29	1.45	0.87	0.66
23	Pneumonias TB II	5.45	1.45	0.91	0.66

Conclusions

The organization of secondary medical assistance and the management of hospitals have crucial impact on the access of the population to quality medical services (Marcu, 2002). This paper offered insight into the role of hospitals in secondary assistance in Romania through the in-depth analysis of the particular case of the Bistrița County Emergency Hospital.

From a functionalist point of view, hospitals need to adopt to the changing health status and health care needs of the population, as well as to the constraints of the re-organisation of the health care system. The the adaptation process experienced by the Bistrița-Năsăud county hospital is illustrative and helpful for a better understanding of recent evolutions in the Romanian secondary assistance. We assert that, in order to ensure appropriate health care services, the management strategy of county hospitals should be to develop harmonious relationships with all actors involved in the medical system: The Offices for Public Health, The County Office of Health Insurance, The County College of Physicians, The Order of Medical Assistants, city hospitals from the area, family doctors, political-administrative institutions, trade unions and the organisations of employers/entrepreneurs.

The optimal performance of the role of county hospitals depends on the collaboration between wards, services, and the employees. The setting of a group for diagnosis (DRG), which can assess dynamically the health needs of the population, would contribute to a more efficient management of funds, the reorganization of wards and subsections, and a better administration of existing resources.

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QUASI-MARKETIZATION AND SECURITY IN THE PUBLIC HEALTH CARE SYSTEMS: THE CASE OF THE NORTH-WESTERN REGION OF ROMANIA

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ABSTRACT. The unequal distribution of risks can be seen as a social division *per se,* which fuels further inequalities. The engagement to limit the amount of insecurity faced by individuals is embedded in the very notions of social citizenship (Mashall, 1950) and welfare state (Briggs, 1961), being particularly salient in the case of public health care systems. State retrenchment from the role of service provision and the introduction of market forces in the functioning of public services had specific consequences on the quality of the "safety belt" provided by the public health care systems. Looking at the particular case of the Romanian public health care system, this paper investigates the socio-economic structural factors which lead to inequalities in the insured-status, presenting some of the findings of the research project ECHISERV 2007: *Disparities in the Use of Public Health Care Services in the North-West Development Region of Romania*[1]. Three dimensions of (in)security in the public health care system are investigated: coverage (having or not health insurance), knowledge about rights and duties, and trust in the system. The results are discussed in the light of Sen's concept of "protective security" and its congruencies with the critiques of quasi-marketization of health care services.

Keywords: health care systems; inequality; quasi-markets; capability approach

Introduction

Public health care systems promise to confer "protective security" and limit social inequalities by reducing health-related risks that fuel such inequalities (Wilkinson, 2000). The very notion of the welfare state implies the commitment to restrain the insecurity faced by individuals (Briggs, 1961), by sharing the costs (mainly but not only financial costs) related to the protection of health.

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However, the vision on the meaning and enactment of "social citizenship" (Marshall, 1950) in the field of health is changing, together with the controversies over the role of the state in controlling, purchasing and providing health care services. The introduction of market mechanisms has been advocated based on their potential to strengthen "freedom of choice" and, indirectly, to enhance the quality of provisions and services. In Europe, state retrenchment in subsidizing health care became manifest, for example, by limiting the number of free consultations at personal request or introducing co-payments of beneficiaries for medical services and pharmaceuticals, while the role of the state in the direct provision of services diminished substantially. Nonetheless, the essence of "social citizenship" in terms of *some* rights and duties in the public health care system was not seriously disputed, and the existence of social rights[2] kept its "strong normative reference" (Bode, 2008).

The present paper discusses potential congruencies between the critiques of (quasi-)marketization of health care services and Sen's concept of "protective security", rooted in his distinction between the "constitutive" and the "instrumental" roles of freedom in human development (Sen, 2001, p. 36) and the primarily role of market mechanisms to promote "freedom to interchange" (Sen, 2001, p. 6), and not necessarily "freedom of choice". Benefiting from a protective health care system constitutes an "instrumental freedom" which underlies certain "achieved functionings" (Sen, 2001). Therefore, it contributes to enhancing the capabilities of individuals to "live the lives they value and have reasons to value" (Sen, 2001). We try to apply this theoretical framework in order to investigate socio-economic structural factors leading to inequalities in the use of health care services granted by the state. Our primary purpose is not to assess the amount of risks to good health posed by various environmental or behavioural factors, but to analyse the quality of the "safety belt" provided by the Romanian public health insurance system, seen as a social arrangement designed to promote "freedom" (Sen, 1992; Alkire, 2002).

Quasi-Marketization of the Romanian Public Health Care System. An overview

Similarly to stream of reforms from other post-socialist countries, the Romanian health-care reform from 1997-1999 opened the door for quasi-markets in the public system. The universal residence-based health care system was replaced by an insurance-based model, financed from the contributions of the economically active population (Popescu, 2004; Rebeleanu, 2007). By the end of 2006, the system was slightly changed again (Law 95/2006), leaving more

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[2] "Healthcare policies, although overall augmenting the financial burden left to the sick, have not erased the foundations of the social-citizenship rational inherent in the post-was settlement" (Bode, 2008: 206).

room to the already existing market forces, while introducing national health programs for severe diseases which were financed from the national budget. Primary care was entirely contracted-out by the state to private family doctors (GPs), while specialised medical services remained provided by state clinics and hospitals (except from some medical tests that were contracted-out to private laboratories). Access to state-subsidized medicines became administered by private pharmacies contracted by the National Office of Health Care Insurance (CNAS).

The introduction of "market forces" throughout the European public health care systems came with the promise to improve the quality of public health care and increase the freedom of choice of beneficiaries. Clarke et. al. (2007) links the reforms in public services to the "hyphenated figure of citizen consumer" and the claim that "choice (…) is both what people want and the driver of service improvement" (Clarke et. al., 2007: 24). Bode (2008) asserts that "marketization of citizenship and a selective (re-)emphasis on universalism" (Bode, 2008: 192) marks both residence-based universal health care system rooted in the Beveridge model and insurance-based systems designed after Bismarck's model, however:

> … both welfare regimes exhibit *procedural fragmentation* as the recourse to (quasi-) market governance (via regulated commercial provision; internal markets) tends to generate uneven outcomes in terms of coverage and quality, notwithstanding the new (discourse on) rights to 'consumer empowerment' (Bode, 2008: 207).

Left to quasi-market governance, health care systems are prone to "creaming-effects" (opportunistic selection) on behalf of private providers and differing responsibility from private to public agents or the other way around.

In a poststructuralist reading of these changes inspired by Baudrillard, Henderson and Petersen (2002) argue that, in contemporary societies, it is neither citizens' *right* nor their *option* to have healthy lives and use health-care services, but it is their *duty* to *consume* health as a *commodity.* Similarly to Bode (2008) and Clarke et. al. (2007), they are deeply sceptical about increasing freedom of choice by marketizing health care systems and "empowering" the "consumers" of health care services:

> Consumerism is often presented in terms of personal empowerment and freedom of choice. However, behind the rhetoric of 'freedom of choice', 'right to know', and 'entitlement to participate', that has recently come to dominate discussions in health care, lie compulsions surrounding the exercise of choice and an array of pre-defined and limited options for action" (Henderson and Petersen, 2002: 2-3).

In Henderson and Petersen's view, the assumption that it is possible for health care services to operate similarly to markets (i.e. governed by freedom and perfect competition) is essentially wrong. Their arguments could be summarized as follows: (1) in order to be meaningful, health policies should look at health not only in terms of individual freedom, but also "in collective, community terms"; (2) it is difficult to decide who are the "consumers": the beneficiaries or the providers of health care services; (3) the use of health care services is culturally determined, strongly shaped by one's status and class position; (5) individual themselves do not act as consumers, *preferring* to refrain from decisions and to comply to the authority of the medical staff; (6) interactions between patients and doctors are essentially unequal in terms of "power and knowledge", therefore the conditions of a perfect market are not met (Henderson and Petersen, 2002: 3-4). It is beyond the purpose of this paper to discuss any of these arguments at length. Nevertheless, concerning the last statement, one ought to bear in mind that relations between patients and doctors are *authority relations* as defined by Weber (1978) and discussed later by Dahrendorf (1959), and *power* comes in when compliance is extended beyond the roles of "doctor" and "patient" (see also Lupton, 2004; Charles et. al., 2004). It is unclear whether Henderson and Petersen refer to "authority" or "power". Moreover, "knowledge" (i.e. medical expertise) can be seen as a *source* of both authority and power through prestige, as a symbolic capital in Bourdieu's terms (Bourdieu, 1990).

The reluctance of social policy analysts towards the operability of quasi-markets in the domain of health care applies both to the public and the private systems in advanced capitalist states. In the case of post-socialist countries from Central and Eastern Europe, additional factors endanger the potentially positive outcomes of releasing market forces in health care: the strong rural-urban divide in terms of infrastructure and income, and the concentration of needy elderly population in remote villages where heath-care services (even at the level of primary care) are hardly available; a legacy of overbureaucratisation in the public sector, which makes corruption possible through bureaucrats' control upon access to information and timing; the absence of a clear demarcation between public and private medical experts, given that most physicians from public hospitals and clinics also work in the private health care sector. An expected positive effect of these changes was to alter the mentality of the population on the necessity of informal payments to the medical staff in the public sector (Murthy et.al., 2003). The accomplishment of this objective has been contested by recent studies on the Romanian health care system (Popescu, 2004; Rebeleanu, 2007).

Sen (2001) would argue that the failure of (quasi-)markets in health care to enhance the quality of services and the "freedom of choice" is symptomatic to any "real" (i.e. empirically observable) market. Although the free operation of markets intended to secure freedom, actually it undermines freedom by reducing it to individualistic utility:

> The shift in the focus of attention of pro-market economies from freedom to utility has been achieved at some cost: the neglect of the central value of freedom itself (Sen, 2001: 28).

Sen's *capability approach* tries to identify human capabilities by exploring "achieved functionings" (Sen, 1984; 1992; 2001) prone to empirical inspection, while taking into account "what people value and have reasons to value" (Sen, 2001). Hence, it sets forth a methodological framework for operationalising the concept of freedom (Alkire, 2002) and analysing the role of social institutions:

> A person's capability to achieve functionings that he or she has reason to value provides a general approach to the evaluation of social arrangements (Sen, 1992: 5).

The socially constructed and, as such, socially contingent nature of values does neither contradict their salience nor lead to total value-relativism, given that it leaves room to comprehension and argumentation *(have reasons),* re-evaluation and, consequently, change in the system of values and social norms. "Citizens's empowerment" within public health care systems, read through the lenses of the capabilities approach, means the development of individuals who are able to enact their well-informed choices concerning their health status and the use of health care services.

The regulations on the quasi-marketization of public health care services had uneven effects on the empowerment of citizens as users of public services. Investigating the particular case of Romania, we argue that the reforms hindered the access to public services for persons from low-income households, especially those from rural areas and/or with irregular participation on the formal labour market.

Empirical data and methods

In order to explore the structural factors underlying dissatisfaction with public health care services in contemporary Romania, macro-level indicators were complemented with a case-study of the North-West region of Romania, using the findings of the research project ECHISERV 2007: *Disparities in the Use of Public Health Care Services in the North-West Development Region of Romania.* The purpose of the ECHISERV survey was to reveal the major problems confronted by various categories of the population in the access to and use of public health care services. The North-West region of Romania belongs to the economically more developed regions of the country, with lower poverty rates and relatively higher proportions of urban population (National Statistical Institute, 2007).

The fieldwork took place in November 2007 on three representative samples for the Romanians, Hungarians and Roma living in the North-West region of Romania. The samples were clustered stratified-random samples, all major cities from the region were included and, based on size, age structure and ethnic distribution, clusters of similar localities were constructed. Households were selected with the method of random walk; within the household, respondents were selected based on pre-established quotas. The sample was validated[3]

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[3] Details concerning the sampling procedure and its validation are available upon request from the authors.

using territorial statistics provided by the National Statistical Institute, 2007. The questionnaires were printed in Romanian and Hungarian, and filled in during face-to-face interviews at respondents' homes, in the language they felt more comfortable to speak. The Romanian sub-sample contained 423 respondents, the Hungarian[4] – 410, and the Roma – 277 respondents.

Detailed information was asked about respondents' self-assessed heath status, the types of health problems they were suffering from, satisfaction with health care services, interactions with the medical personnel, informal payments, "out-of-pocket" expenditures on medicines and private health care services, knowledge of rights and duties of insured persons and their perceptions of their own status as insured persons. A set of socio-demographic variables served as controls for the statistical testing of the relationships between predicted and explanatory variables (most importantly age, residence, gender).

Macro-level indicators of the performance of the Romanian public health care system as compared to other CEE countries

Among the other Central and Eastern European (CEE) countries which joined the EU in 2004 or 2007, Romania (see Table 1) has the lowest score on the UNDP Human Development Index (HDI). It also score considerably lower than its neighbours in terms of public spending on health as % of GPD, although its private spending (1.7%) is close to the CEE average (1.98%). Per capita expenditures on health (433 $PPP) represent only half of the CEE average (950 $PPP), while the number physicians relative to inhabitants corresponds to 60% of the CEE average (329 physicians/ 100,000 inhabitants).

Table 1.

Human Development Indicators for Central and Eastern European Countries. Commitment to health: resources, access and services (indicators for 2004)

Country (HDI)	Public expenditure on health as % of GDP	Private expenditure on health as % of GDP	Per capita expenditures on health (in PPP $)	Physicians/ 100,000 inhabitants
Bulgaria (0.824)	4.6	3.4	671	356
Czech R. (0.891)	6.5	0.8	1.412	351
Hungary (0.874)	5.7	2.2	1.308	333
Poland (0.870)	4.3	1.9	814	427
Romania (0.813)	3.4	1.7	433	190
Slovakia (0.863)	5.3	1.9	1061	318

Source: UNDP, 2008.

Note: Figures between brackets indicate the value of the Human Development Index (HDI) based on 2005 values of national indicators.

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[4] The final sample contained three respondents of German ethnicity. They were included in the Hungarian sub-sample.

The 2007 *Special Eurobarometer on Health Care and Long-Term Care* included a set of items which investigated respondents' evaluations of primary, specialised and hospital medical care in the public system on three dimensions: accessibility, affordability, and quality of the services. In order to assess the relative satisfaction of Romanian citizens as compared to other CEE countries, we computed a synthetic index. For each level of medical services (primary, specialised and hospital medical care) the three dimensions were expressed in relative terms, as % of the EU-27 average, and combined into three composite indicators of general accessibility, affordability, and perceived quality (the un-weighted average of the corresponding values for primary, specialised and hospital medical care). Then, a synthetic index of relative satisfaction with health care services was calculated as the average of the values of the three composite indicators of accessibility, affordability and perceived quality. It is expressed in relative terms, its values representing % of the corresponding EU-27 average (see Table 2).

Table 2.

Satisfaction with health care services in CEE countries in 2007

Country	Index of perceived quality of health care services	Index of accessibility	Index of affordability	Relative satisfaction index
Bulgaria	73.7	88.1	70.7	77.5
Czech R.	108.8	104.8	118.0	110.5
Hungary	77.0	86.0	80.9	81.3
Poland	74.4	92.3	103.2	89.9
Romania	74.5	84.8	70.9	76.6
Slovakia	94.4	102.7	107.9	102,3

Source: Own calculation based on data provided by the 2007 *Special Eurobarometer on Health Care and Long-Term Care.*

The value of the synthetic index was the lowest for Romania and Bulgaria, representing only 77% of the EU-27 average.

Similar results emerged from the analysis of the *European Social Survey 3rd Round 2006* dataset. Only a more general indicator of satisfaction with health care services was available: the score on a scale from 1 (extremely bad) to 10 (extremely good) assigned by respondents to the "state of health care services in the country". The average scores were the lowest for Bulgaria (2.56), Hungary (3.29), and Romania (3.76). For the very same countries anxiety regarding one's health (as indicated by self-reported bad health) was the highest (see Table 3).

Table 3.

Average satisfaction with health care services and reporting bad health in CEE Countries in 2006

	Average evaluation of health care services in the country	% reporting self-rated bad health
Bulgaria	2.56	16.5
Hungary	3.29	18.4
Poland	3.85	11.4
Romania	3.76	17.6
Slovakia	3.93	10.8

Source: ESS 3rd Round, 2006. Own calculations.
Note: Evaluation with health care services in the country was done on a scale from 1 (extremely bad) to 10 (extremely good).

Three dimensions of security: coverage, knowledge and trust. A case study of the North-Western region.

For the analysis of the performance of the Romanian health care system in securing equal rights to healthy life and healthcare as capabilities (the *substantive rationality* of the system) it is useful to look at the institutional arrangements intended to guarantee *protective security* as an *instrumental freedom* through the lenses of the *functionings* they sustain and also which they presuppose. For this purpose, the following two parts of the paper try to infer inequalities in terms of capabilities to use public health care services from certain *policy outcomes,* interpreted as "achieved functionings". Let us now turn to the health-care dimension of social citizenship: coverage (having or not health insurance), knowledge about rights and duties, and trust in the system.

Insecurity within the public health care system: coverage, knowledge, satisfaction with services

In order to benefit from public health insurance, Romanian citizens ought to register at a general practitioner (family doctor) who has a contract with the National Office of Health Care Insurance (CNAS) and to contribute monthly to the Health Care Fund through income-related payroll taxes[5]. The cost burden of health-care insurance is shared between the employer and the

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[5] Starting with January 2008, the contributions of the employers to the health care fund were reduced to 5.5%, and those of the employees to 6% of the wage income (the latter were further reduced to 5.5% in July 2008). Self-employed pay the whole contribution on their own: 11% of the imposable income.

employee, while self-employed persons should pay the whole contribution from their declared income. The contributions are covered from public and social insurance funds in the case of the registered unemployed receiving state benefits (first six months of unemployment), disabled persons and those on welfare (the Minimum Income Guarantee, Law 416/2001 modified by Law 116/2006). The contributions of pensioners are subsidised up to a certain ceiling from the Pension Fund. Children below the age of 18 benefit from universal coverage, while young people in formal full-time education up to the age of 26.

Citizens who do not earn incomes and rely economically on an insured person, may have the status of "co-insured" for a contributor. This is the case of housewives who are financially dependent of their husbands, for example. Those who do not qualify for the compulsory coverage of employed persons (for example irregular workers) might pay voluntarily a monthly contribution equal to the value of the contribution corresponding to the minimum national wage.

In order to benefit from subsidized public health care services, the proof of the payment of the contribution is necessary: in the case of those who did not have any earnings during the last five (!) years, it is necessary to prove that the contribution has been paid for *the last five months*. In the case of those who had earnings during the last five years (in Romania or abroad), the proof of the payment for *the whole five years* is necessary. After the 2007 EU integration, the period of contribution from any EU member state can be assimilated with the same period of contribution to the national health care fund. Nevertheless, for the remaining months (before January 2007) contributions ought to be paid *in addition* to the Romanian state as well[6].

These regulations lay obstacles in the access to public health care services especially for those with irregular labour-market participation, who may not qualify for unemployment benefits or the Minimum Income Guarantee, and therefore have to pay the contributions themselves – usually retroactively, for (at least) five months[7]. Roma persons from disadvantaged areas often face this situation (ERRC, 2006; UNDP, 2005).

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[6] For example: imagine a person has been working abroad for six years, returns to Romania in September 2007 (after the EU integration) and it is gainfully employed in Romania since then. In order to obtain the European Health Insurance card or to benefit from subsidized hospitalization, let's say in July 2008, s/he ought to pay retroactively the contribution to the Romanian health care fund for the period July 2003 – January 2007. For January-August 2007, his contribution to the foreign EU state health care fund is assimilated to contributing to CNAS. This means that s/he has to pay an amount of money corresponding to the health care contribution for the minimum wage (i.e. around €8/ month) for 42 months and some penalties for delay, i.e. around €340.

[7] Before August 2007, the necessary period of retroactive pay of health care contribution (corresponding to the national minimum wage) was five years for those without any income sources as well.

The following sections investigate the quality of the security provided by the public health care system: *coverage* (having or nor a valid health insurance), *knowledge* about the rights and duties within the public system, and *trust* in the quality of services.

On the coverage dimension: overall, 14.7% of the adult population of the region did not have health insurance, and 3.8% were not registered at a general practitioner physician (GP). In the case of active population (students and pensioners excluded) 16.2% were not covered by health insurance; the percentage was considerably higher in the case of the Roma: 38.4%. The same cleavage was found concerning registration at a GP: 3.9% of the active population for the overall sample, and 17.8% in the case of the Roma (see Tables 4 and 5). The results are concordant with previous studies on the vulnerability of the Roma in the public health care system (Fleck and Rughiniş, 2008; ERRC, 2008; UNDP, 2005).

Table 4.

Registration at a general practitioner (family doctor) among the working-age population in the North-West region, 2007

Are you registered at a family doctor? (working-age population, retired and/or disabled persons excluded)	North-West region	Romanians	Hungarians	Roma
Yes	95.6	95.6	98.2	82.6
No	3.9	3.7	1.8	17.4
Don't know/ No answer	0.6	0.7	0.0	0.0

Source: ECHISERV 2007. Own calculations.

Table 5.

Coverage of public health care insurance among the working-age population in the North-West region, 2007

Do you have health insurance? (working-age population, retired and/or disabled persons excluded)	North-West region	Romanians	Hungarians	Roma
Yes	81.6	82.4	83.6	57.6
No	16.2	15.0	16.1	38.4
Don't know/ No answer	2.2	2.6	0.4	4.0

Source: ECHISERV 2007. Own calculations.

A logistic model was used in order to test potential determinants of not having health insurance in the public system for those below the age of 55: age, gender, residence (urban *versus* rural), Roma ethnicity, education, household income per equivalent member (LOG), and financial strain. The predicting power of the model was rather weak (Nadelkerke R-Square=0.065), but household income was once again a robust predictor: Exp.(B)=0.423, Sig.=0.007.

The knowledge dimension was investigated using a set of five statements, which should be judged as correct or false by respondents. The median value was of three correct answers. Differences between Roma and non-Roma were small, but statistically significant. In the case of Hungarians and Romanians, residents from rural areas gave significantly less correct answers than those from the urban; in the case of the Roma, area of residence did not influence significantly the number of correct answers (see Table 6).

Table 6.

Average number of correct answers to questions related to health states by ethnicity and area of residence in the North-West region, 2007

	Romanians	Hungarians	Roma
Rural	2.48	2.5	2.2
Urban	3.14	3	2.4

Source: ECHISERV 2007. Own calculations.

Significant differences were found on the knowledge dimensions between respondents from different income quintiles, those from better-off households being significantly more aware of their rights and duties in the public health care system.

Table 7.

Average number of correct answers to questions concerning health insurance by income quintile. The North-West region of Romania, 2007

	Poorest quintile	Second	Third	Fourth	Richest quintle
Average number of correct answers	2.4	2.7	2.7	3.0	3.3

Source: ECHISERV 2007. Own calculations.
Differences are statistically significant: F=5.433, sig.=0.000.
Note: Income quintiles based on equivalised household income, OECD-2 equivalence scale.

The differences were also significant between respondents from households below the poverty threshold and those above the threshold (2.38 *versus* 2.9 correct answers on average, F=11.351, sig.=0.000).

For the trust dimension two composite indicators were used: the average score assigned to the activity of the GP or "family doctor" (7 items, Alpha=0.848) and making use of informal payments to the medical staff in order to ensure the quality of services (negative indicator). At the regional level, on a scale from 1 to 10, the average score of satisfaction with GPs was 8.26. For Roma persons from rural areas, living below the poverty line, average satisfaction was only slightly lower: 7.67 (see Table 8).

Table 8.

Average satisfaction with one's family doctor, by ethnicity and residence. The North-West region, 2007

	Romanians	Hungarians	Roma
Rural	8.41	8.25	7.9
Urban	8.21	8.08	8.25

Source: ECHISERV 2007, own calculations.
Differences are not statistically significant.

Table 9.

Average satisfaction with the family doctor by income quintile. The North-West region of Romania, 2007

	Poorest quintile	Second	Third	Fourth	Richest quintle
Average satisfaction with the family doctor	8.2	8.4	8.3	8.2	8.1

Source: ECHISERV 2007. Own calculations. Differences are statistically significant.
Note: Income quintiles based on equivalised household income, OECD-2 equivalence scale.

There were no statistically significant differences in the average degree of satisfaction with the services of the family doctor between respondents from households below and those above the poverty threshold: the average score was 8.3 points in both cases.

At first sight, this result seems counter-intuitive. However, previous researches indicated that respondents from low-income households, with a modest educational background, are more satisfied with the medical services received than better-off and more educated patients (Lupton, 2004). In order to test these results, a multivariate regression was run, using as potential predictors of (dis)satisfaction with the family doctor the following variables: residence (urban/rural), respondent's age, gender, educational qualification, Roma ethnicity (dummy variable, Roma=1), and the LOG of equivalised household income. The goodness of fit of the model was very weak, below the significance threshold (R-Square=0.013, Sig.=0.097). Among the potential predictors, only education had a weak negative effect (Beta=-0.062, Sig.=0.042) and income a weak positive effect (Beta=0.103, Sig.=0.017).

Informal payments indicate not only distrust in the system, but also the extent of "commodification" in public health care, especially in post-socialist transition countries (Murthy et. al., 2003; Bambra, 2005; Popescu et. al., 2007a). At the regional level, 46% of respondents admitted that they offered a sum of money to the physicians in the hospital, when a close family member or they themselves were hospitalized (only hospitalizations taking place after 2000 were selected). The average sum was 315 lei (cca 91 Euro) and half of the respondents gave at least 200 lei (cca 58 Euro). This average sum represented 80% of the minimum national wage. Excluding those who refused to answer or could not recall the last hospitalisation of themselves or a close family member, 42% of Romanians and 53% of Hungarians admitted that they offered a sum of money to the doctor and/or the nurses in order to receive better care. In comparison, only 18% of the Roma who responded declared that paid extra for the medical care. In the context of strong informal pressure for "out of pocket" extra payments, this fact can be interpreted as an invisible barrier in the access to health care services in the case of the impoverished Roma.

Differences in the incidence of informal payments at the doctors in the hospital between household income quintiles are significant only for the poorest and the richest quintiles:

Table 10.

Frequency of informal payments to doctors during hospitalization by income quintiles. The North-West region, 2007

	Poorest quintile	Second	Third	Fourth	Richest quintle
Percentage of respondents who gave informal payments	37.0	43.5	43.9	48.0	58.8

Source: ECHISERV 2007. Own calculations. Differences are statistically significant.
Note: Income quintiles based on equivalised household income, OECD-2 equivalence scale.

In the case households below the poverty threshold, 38.6% declared informal payments to the doctors during hospitalization, whereas in the case of respondents from non-poor households 44.7% (the differences are not statistically significant).

Using private services. High demand of outpatient private services can be interpreted as an indicator of low trust in the public system. Lack of health insurance in the public system, long waiting time, the necessity to cover some of the costs and the perceived poor quality of public services constitute the main "push" factors from the public towards the private system. At the same time, there are several "pool" factors of the private system: the availability of the well-qualified medical staff from the public system in their private practices, the better medical technology offered, the promise of more attentive care, and the transparency of costs. The combination of public and private health care services is present both at the level of providers (medical staff), and that of users (insured persons). Overall, 29.5% of the Romanians, 33.5% of the Hungarians and 17.4% of the Roma respondents reported that they used private health care services during the last twelve months. As one may expect, consuming market/ private health care is more frequent among respondents from the upper income quintiles:

Table 11.

Frequency of using private health care services during the last 12 months by income quintiles. The North-West region, 2007

	Poorest quintile	Second	Third	Fourth	Richest quintle
Percentage of respondents who used private health care services	20.9	22.2	20.0	37.3	48.7

Source: ECHISERV 2007. Own calculations. Differences are statistically significant.
Note: Income quintiles based on equivalised household income, OECD-2 equivalence scale.

For the use of private health care services respondents paid, on average, 230 Ron (i.e. around €65), while half of them paid 125 Ron (i.e. around €35) or more. Even the latter amount represented more than 40 percent of the net minimum wage and 12% of the average wage in 2007 Romania (National Statistical Institute, 2008).

Enhancing *choice* of *the range of* choice? Quasi-marketization of primary-care and access to medication in the North-Western region

An important domain of state-retrenchment that gives room to market forces in Romania is primary care. Starting with 1999, each person with health insurance has the option to "freely choose" her or his general physician (GP) or family doctor. GPs work as self-employed persons and they are contracted by the CNAS for providing health care services, receiving a contractual payment based on the number of insured persons who registered on their lists. In the case that patients are dissatisfied with the services of their GPs, they have the right to "unsubscribe" after six months and to turn to another GP. However, what is the range of option in the case of residents from rural areas, given that villages have only one or two GPs (the majority of them commuting from the city)? Moreover, what is the "freedom" of doctors to reject certain "clients", given that their payment does not depend on the number of medical consultations performed, but the number of registered insured persons?

The results of the ECHISERV project indicate that only 21% of the respondents declared that they have *ever* changed their family doctor, and differences between rural and urban areas are not statistically significant. The very majority of the respondents changed their GPs only once, the average being 1.14 times in urban areas and 1.12 times in rural areas. The declared *reason* for changing the one's GP is not dissatisfaction with her or his activity, but rather “objective” factors: retirement or leave of the GP, changing residence or workplace. It is noteworthy that in rural areas 80% of respondents who had ever changed their family doctor motivated this fact by external “objective” constraints, only 10% referring to dissatisfaction with his or her services. In urban areas, more than 25% of respondents moved to another GP because of dissatisfaction with the services of the previous doctor.

In the case of respondents from households below the poverty threshold who had changed their GPs only 8.3% motivated their decision by dissatisfaction with the medical services, whereas in the case of respondents from relatively better-off households 21.7% (Table 12).

Table 12.

Declared reasons of changing one’s family doctor by area of residence. The North West region, 2007

	Urban	Rural
% of those who have ever changed their family doctor	22.5	19.8
The previous doctor retired, went on parental leave or moved out.	25.6	40.0
The respondent changed his/her residence or workplace.	34.9	40.0
Dissatisfaction with the activity of previous doctor.	25.6	10.0
The distance to the doctor was too large.	9.3	3.3
Personal reasons: moving to the doctor of other family members, wishing to have a same-sex doctor, etc.	4.7	6.7

Source: ECHISERV 2007. Own calculations.

Table 13.

Declared reasons of changing one’s family doctor by income position. The North West region, 2007

	Below the poverty threshold	Above the poverty threshold	*Overall in the region*
% of those who have ever changed their family doctor	***16.9***	***21.9***	***20.9***
The previous doctor retired, went on parental leave or moved out.	41.7	30.0	*31.94*
The respondent changed his/her residence or workplace.	25.0	38.3	*36.11*
Dissatisfaction with the activity of previous doctor.	8.3	21.7	*19.44*
The distance to the doctor was too large.	16.7	5.0	*6.94*
Personal reasons: moving to the doctor of other family members, wishing to have a same-sex doctor, etc.	8.3	5.0	*5.56*

Source: ECHISERV 2007. Own calculations.
Note: Poverty threshold set at 60% of median household income per equivalent persons (OECD-2 equivalence scale).

Users might assess whether something is valuable or not for them, and this evaluation is strongly marked by one's *habitus* (Bourdieu, 1984), a "structured structuring structure", a set of dispositions for evaluation and action, such as lifestyle or taste (Bourdieu, 1984). In the domain of health care, one may think of undertaking voluntary health tests. According to the Romanian legislation, insured persons have the right to complete a comprehensive evaluation of their health status once a year, the costs of examinations being covered by CNAS. Needless to say, persons living in urban areas have more opportunities to undertake these evaluations; however, whether people do the tests or not is much shaped by their social status. Between July 2007 - July 2008 the Romanian Ministry of Health carried out the National Program of the Evaluation of the Health Status of the Population. All citizens, regardless of having or not health care insurance, were requested to undertake for free a set of basic medical examinations during the month of their birthday. Within the first 9 months of the one-year program, only 50% of those born in that period of the year carried out the examination, and 11% of those who undertook them did not have health insurance (Romanian Ministry of Health, April 2008).

In the case of the public health care system, expectations about enhancing the freedom of choice of insured persons by introducing "market forces" are also undermined by the way in which the state organized and established the amount of subsidies for the providers of medicines. According to the Romanian legislation, each person with insurance in the public health care system benefits from state subsidies for acquiring the medicines prescribed by physicians. The county-level agencies of the National Office of Health Care Insurance (CNAS) contract private pharmacies to sell the subsidized medicines (there is a list of subsidized medicines), paying the subsidy to the pharmacies on a monthly basis. However, CNAS does not fully reimburse the pharmacies for all medicines that were required upon prescription, but only up to a certain ceiling, established by CNAS. In other words, persons who require subsidized medicines at the beginning of the month are much more likely to obtain the subsidy than persons who ask them by the end of the month, when the fund of state subsidy had been already exhausted. They have the "choice" to buy the medicines at full price (without compensation) or to wait until the beginning of the month. In the case of the chronically ill, who know that they need to take certain medicines regularly, one may say that "the first come, the first served!" is right, as long as the system is not corrupt. Bu it is difficult to leave aside the anecdotic images of long cues of pensioners waiting in front of the pharmacies in the early morning at the beginning of each month, images that were quite common in Romania until 2008.

In the ECHISERV survey, 20.5% of respondents from urban and 16.2% from rural areas reported that they did not manage to buy with state compensation all medicines subsidized prescribed by the doctors, and 15.4% (urban), respectively 19.6% (rural) they did not manage to buy with state compensation any of them. The prevalent cause in both areas was that pharmacies ran out of the state subsidy and offered medicines only at full price (see Table 14):

Table 14.

The reason for not managing to buy with state compensation the subsidized medicines prescribed the doctor in the North West region, 2007

	Urban	Rural
The pharmacy ran out of the state subsidized funds.	68.5	61.9
The pharmacy did not have the medicine.	36.4	31.6
I had no money to by the subsidized medicines.	10.7	18.4

Source: ECHISERV 2007. Own calculations.

The above analysis resonates with Alkire's remark on the implications of embracing the capability approach in policy design:

> The implications for welfare economics of assessing social states in terms of 'capabilities' rather than utility are substantial. In particular, the role of the market is subordinate to an enlarged framework of decision-making, that employs an extended informational basis, and substantive rationality (Alkire, 2002: 13).

Conclusions

Investigating the main indicators of "insecurity" within the public health care system in the North-West region of contemporary Romania, this paper tried to offer a case-study on the ways in which the "protective security" of the welfare state, seen as an "instrumental freedom" (Sen, 2001), can be undermined by its own regulations, which commodify both health status and work. The proliferation of quasi-markets within health care services was envisaged to increase "freedom of choice" and individual responsibility. As the present study illustrates, it may actually increase only "the range of choice" (Alkire, 2002) but limit "freedom of choice", especially for the economically vulnerable categories. It may also swing over responsibility between public and private agents, fuelling distrust in the public health care system and the desire to opt out in the case of the better-off. Although there are no legal ways of opting out, the refusal to pay the contributions constitutes a backdoor for exiting the public system. Needles to say, this endangers the values of social solidarity and mutual risk-sharing lying at the underpinnings of insurance systems.

In the case of the North-West region of Romania, persons from low income households and members of the Roma ethnic minority were more likely to lack health insurance and to possess limited knowledge about the rights and duties of insured persons in the public system. However, they did not differ considerably from the better-off categories in terms of the evaluation of primary health care services, adjusting their appreciations to a lower level of expectations, rooted in their social and economic disadvantage. Giving informal payments at the hospital and using private services for specialised medical care, seen as indicators of (dis)trust in the public system, were often reported by both the better-off and worse-off respondents. Nevertheless, the relative frequencies of these indicators were lower in the latter case. In other words, they were "empowered" with the "freedom of choice" of health care consumers without having the capability to use it for enhancing their substantial freedom and well-being.

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APPROACHES TO DISABILITY AND THE HEALTH STATUS OF PERSONS WITH DISABILITIES

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ABSTRACT. The aim of this article is to review the main conceptualisations of disability and their influence on the approach to the health status of persons with disabilities. There are multiple perspectives that provide a framework for understanding the way in which impaired people experience disability. These perspectives influence the nature of health care services that people with disabilities receive. In the *medical framework*, disability pertains to pathology; it is a dysfunction, which is intrinsic to the individual. In this context, the disabled person is seen as a medical issue. This model promotes a negative, disempowered image of people with disabilities, rather than casting disability as a political, social and environmental problem. The *social framework* presents disability as socially constructed, a function of social practices and attitudes; it results from barriers, prejudice and social exclusion. A core aspect of this model concerns ensuring equal opportunities for disabled persons. Finally, the paper presents some *sociological approaches* to disability, such as the functionalist theory, which links disability and social deviance. The latter approach pays little attention to subjective interpretations and emphasises the viewpoints of authorities, such as physicians. Bourdieu's concept of *habitus* provides useful tools for analysing the relation to human body, leading to a better understanding of social inequalities lying at the cornerstone of lives of people with disabilities.

Keywords: disability; health care; social inequalities; habitus

Introduction

Within the hermeneutic framework of understanding the experience of disability, previous analyses excluded from the meaning of the concept the economic, political and cultural factors involved. However, these factors are relevant for revealing what "disability in society" is about.

In order to have a functional society, its members must fulfil their appropriate social roles. This is the context in which 'individual' needs interact with the general system. Health is defined as a 'normal' and stable state, associated with optimal capacity. In contrast, disease is seen as a disruptive

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and abnormal condition, which determines the individual to be dependent and unproductive (Barnes et. al., 2003). According to this approach, disease is analogous to a form of social deviance that, if not controlled properly, threatens both the individual role performance and the functioning of the system as a whole.

The quest for preventing social exclusion and promoting equal opportunities on the labour market has renewed the efforts to have policies in which disabled persons are supported to be economically active and get suitable workplaces, while those who cannot work on the formal labour market are included in rehabilitation programs. Persons with disabilities are one of the largest groups targeted by anti-discrimination policies.

The medical versus the social model of disability

The medical model of disability represents the traditional approach to disability, which considers that disability is a medical issue. This approach forces the disabled persons to deal with their disability as a personal problem, and to accept that they are unable to do several things. This model emphasizes that disabled persons depend on others and it fuels stereotypes about disability and "pity" for disabled persons. It induces fear from the disabled persons and a patronizing attitude. The focus is laid on the impairment rather than the needs of the person.

Decisions concerning school attendance, the kind of support needed, the place to live or even procreation are usually made by others, who usually are non-disabled persons. According to Parsons (1977) the social system influences the definition of illness by conferring a temporary and conditional alternative, and illness becomes a form of deviance that is socially sanctioned. From a social perspective, assuming the role of the sick patient is only conditionally accepted due to the concern that this might lead to 'rewarded deviation', which assumes that someone may avoid on purpose to end his social dependence and continuously avoid to return to 'ordinary' social roles and responsibilities (Barnes et al., 2003: 34).

Parsons' approach to disease has opened the possibility for a sociology of health and illness, but has also faced many critiques. Leaving aside the attacks on its functionalist perspective, "the sick" have been identified as an ideal-typical description based on acute illness that cannot be generalized to a long term or permanent condition. Disability becomes the defining feature of self-identity for the disabled person and determines their expectancies. Parsons (1977) considers that the majority of patients for which full recovery is not a realistic possibility, such as people with diabetes, can be medically controlled in ways that maintain a reasonable capacity of 'normal' functioning (Barnes et al., 2003:41).

Although social scientists heavily criticized this perspective, the rehabilitation practice perpetuated it in the case of on chronic disease and disability. There is considerable empirical evidence which contradicts this description: the stages do not follow sequentially, the viewpoint on the adjusting process is definite, and its progress assessed in terms of professional criteria and interests. Consequently, this rules out the subjective understanding of the sick or disabled individual. It is a product of 'psychological imagination' built on a foundation of 'non-disability' assumptions with regard to what experiencing disability means (Barnes et al., 2003:42). Despite all the concern and care, considering the problems faced by disabled person from this standpoint induces a form of control over them, which in turn reinforces the disability. Many people with disabilities assume negative attitudes, which create a sense of low self-esteem; moreover, it encourages people without disabilities to take charge of their fate.

In contrast, the social model of disability does not define disability in terms of a person’s disability. Its major premises include the fact that all persons are equal and that the society develops barriers that prevent people with disabilities to participate equally along with the others, restricting their opportunities (Campbel and Oliver, 1996). The fact that a part or parts of a person’s mind or body are functionally limited does not imply that the person is less human or has health problems. The prejudices, the socially induced fear and the social barriers create disability.

According to the social model of disability, the 'treatment' of disability consists in restructuring the society to fit the special needs of disabled persons. In contrast to the medical model, which focuses on 'treatments' targeting the person and his or her inability, the social model regards both the persons and their social environment. Barnes and Oliver (1993) refer to Burry, who expressed in 1992 his concern with regard to the increasing interest in the research methodologies engaged in the 'social persecution' approach of disability and its associated implications in the field of chronic disease and disability (Barnes and Oliver, 1993). Hammersley had a similar perspective (Barnes and Oliver, 1993) and he agreed with some ideas introduced by the feminist research, for example, the trend of 'prioritizing experience over the sociological research methodology'. For the field of research, this change has been perceived as a threat, mainly because 'non-disability' researchers carry on the research.

Other sociological approaches to understanding disability

The research on disability has to take into consideration the functionalist theory. Early functionalist writing, such as those of Herbert Spencer, propose an analogy between the society and the human body. To study an internal organ, such as the heart, we must understand its links with the other parts of the body. Thus, by pumping blood in the body, the heart plays a vital role in the organism survival. Similarly, the analysis of a social phenomenon, such as social and professional integration of persons with disabilities, requires an understanding of the role they play in the life of the society, namely, their immediate contribution to its development (Barnes and Oliver, 1993).

Later, the writings of Durkheim shaped the functionalist conceptualisation of the social in Europe. In the US, the functionalist perspective returned to sociology through the works of Talcott Parsons. Talcott Parsons (1902-1979), a very influential theoretician, asserted that the study of any society should be concerned with the way in which its various component parts or institutions are intertwined in order to make the entire social system work through an extended period of time.

Sociological writings concerning disability inspired by Parsons' theoretical framework have a relational approach: they relate disability with behaviour. This happened because Parsons' theory initiated two distinct and independent approaches, which had, explicitly or implicitly, affected all subsequent theories. These two approaches associate the "sick-role" with social deviance and disability and emphasize the understanding of the notion of health as a concept related to adjustment, as long as the disability can be adapted to the social environment. The outcomes of this adjustment process consist of the fact that the condition of disabled persons increasingly resembles the normal condition of a healthy person (Barnes and Oliver, 1993). Parson's model presupposes that, by neglecting contextual parameters or socio-economic factors, anyone would behave in the same way. Hence, this approach pays little attention to subjective interpretations and emphasises the viewpoints of those who are socially representative, who are credited with rehabilitation responsibilities: such as, for instance, the representatives of the medical profession.

For many years, Jeffrey Alexander (2004) and Richard Munch (1989) were among the most prominent supporters of a neo-Parsonsian approach in social theory. To a greater extent than Munch, Alexander distances himself from Parsons' understanding of culture and aim towards a theory that contains elements from Durkheim's later writings. Alexander's approach starts from the following assertion: a cultural drama takes place when members of a community feel that they have been subjected to a terrifying event deeply influencing its collective memory and changing its future identity in a fundamental and irreversible manner. In contrast to the psychological definition, which emphasises individual aspects, this approach concerns the community. It is well motivated since the occurrence of a terrible traumatic event affects not only the isolated individual but also an entire community. They are likely to suffer the trauma as well and their collective social identity might be irrevocably disturbed. The same thing happens when a disability occurs in a family, consequently affecting the entire family life, changing its daily routines, and altering its active functionality.

The symbolic interaction theoretical framework is another approach which should be mentioned here. This perspective highlights the creative dimension of a person, and does this on a larger scale than any other perspective. According to this approach, the human understanding and the meaning of the world are constructed through interaction and are subject to permanent reinterpretation. The researcher or the social worker can regard their patients and themselves as parts of a broader social and political context, enriched with complex meaning. Hence, the process of social integration and professional inclusion for disabled persons stems from many interacting factors: the family (educational level, economic welfare, overprotective environment, etc.), the disabled person herself/himself, the educational system, the labour market, employers' attitudes, community at large, and the legislative environment.

Furthermore, Pierre Bourdieu's theory on social distinction and *habitus* plays an important role in the development of disability theory (Bourdieu, 1990; Jenkins, 1992; Painter, 2000). The question is how far Bourdieu's concept of *habitus* can provide a useful tool for analysing the human body, which will eventually lead to a better understanding of social inequalities, the major aspect in the lives of persons with disabilities. Research within this framework reveals that the disabled persons' lives are overloaded with various depreciative adjectives regarding the shape of the body and involving a system of representations and meanings which derive from these.

Studies on disability offer little insight into the interrelations between body-functions in the case of persons with disabilities and aspects regarding cultural values and social practices. Since post-structuralist ideas regarding the human body and social construction dominated literature on gender for many years, theories regarding disability tended to revolve around the dichotomous choice between medical and social models of disability. Whereas recent naturalist approaches consider any dysfunctional element as rooted in a biological condition leading to disability, the pioneering authors defined disability as a social construction by means of which society oppressed the disabled. Although they incorporate aspects concerning the lives of disabled persons, all these approaches are problematic due to their failure to acknowledge the existence of a dialectic relation between the individual and the society or of the fact that inter-subjective and subjective experiences are deeply intertwined.

Beyond theoretical movements leading to a reduction of the conceptual dimensions of disability, Barnes (1999) appeals to "applying sociological imagination in the disability research field" which "focuses the attention towards the exploration of the links between structural conditions and disabled persons' life experience". Other authors suggest that analysis concerning the human body should be the meeting place for the sociological theory and disability theory. In order to represent the notion of disability, such claims are characterised by various ambiguities in their approaches and classifications, ranging from studying the body as such to considering the body as a place in which knowledge and power are obtained.

For Merleau-Ponty (1962) the body is actively creating meaning and a place of expressive understanding or, as Marks (1999: 129) suggests, "the body should not be seen as a matter set apart from subjectivity and the environment, but as an entity inextricably bound up with creative meaning and context". A reaction to such observations is the development of Bourdieu's conception regarding the body as value bearer in society, or as "a possessor of power, status and distinctive symbolic forms integral to the accumulation of various resources" (Shilling, 1993: 124). For Bourdieu (1990), the body and its social placement are interlinked, while body coordination is essential in achieving social status and in what makes it distinct from other entities. As Bourdieu comments, the body can be understood within the broader context or habitus or, in Jenkins's words, "habit or the typical conditions or appearance, particularly of the body" (Jenkins, 1992: 74). Consequently, the way someone talks or moves, the behaviour and appearance in general, are all components of the habitus or, as is noted by Marks (1999: 129), "the body adopts a particular habitual way of relating to the environment". The habitus tries, consequently, to focus on embodiment, appearance, daily experiences, and on understanding the interactive systems that shape individual social fulfilment and social structures producing and recreating social inequalities.

Some authors note that the medical and social models of disability (Claire and Imrie, 2003) do not support the development of sociological concepts of disability. The medical model is primarily concerned with the analysis of the physical body, or the propagation of medical issues that design bodies as objects to be taken care of through medical treatment and rehabilitation techniques.

In contrast, the social model seeks to understand disability as a category generated at the social level, in relation to a series of experiences occurring outside the human body. Thus, disability represents the transformed body due to its 'living in society'; similarly, a person is considered as being disabled because of attitudes and norms defined by the society to which they belong.

Meekosha (1998) comments on the perspective of the social model considering the disabled body as "untouchable and undisputed'; or, as Shilling suggested (1993), the social constructivist models imagine the body only to the extent that the body is seen as a theoretic space, but often remains neglected as an object of analysis (Claire and Imrie, 2003: 37). Such conceptions resonate with Bourdieu's theory of practice that denies that social practices have to be understood in terms of objective social laws or as a result of 'subjective decisions that make the independent man a free person' (Bourdieu, 1999). The practice revolves around the concept of *habitus*, which has exerted a considerable influence in the field of social sciences. This theory attempts to show that social agents develop strategies that are adapted to the needs of the social worlds they inhabit. These strategies are unconscious and act on the level of a bodily logic.

As Painter (2000) suggests, habitus represents the link between social structures and the individual actions and refers to the embodiment of social norms at the individual level. Bourdieu notes that 'to talk about behavioural habitus means to say that at the individual level, even personal subjectivity is social, collective. Habitus is a socialised subjectivity." (Bourdieu in Claire and Imrie, 2003). Habitus is defined as "a system of durable and transposable dispositions" (lasting, acquired schemes of perception, thought and action) (Bourdieu, 1990) or "as the axis of the knowledge people carry as a result of living in a specific culture or subculture" (Cunningham, 1993, in Claire and Imrie, 2003: 243). According to Bourdieu, habitus provides an understanding of how people react in an appropriate manner, often unconsciously, in various situations, events and interactions with other people. More important, habitus represents the embodiment of specific mentalities and practices. It provides significance for understanding the dispositions that influence our thinking as illustrated by our behaviour, through the way we stand, we look at others, or we eat etc.

Medicine and the medical discourse represent a dominant social field for people with disabilities, which serve, as Foucault (1980: 54) writes, "to ensure the physical vigour and moral cleanliness of the social body; it promised to eliminate defective individuals... it justified the racisms of the state... it grounded them in "truth". However, the relation between habitus and social field is reciprocally established.

Fowler (1997) notes the parallel Giddens (2003) draws in his work regarding Bourdieu: "the people, the collectivities or individualities transform or reproduce their social structures, but they do that in some specific conditions, including those that they internalize as part of their own habitus" (Claire and Imrie, 2003). Bourdieu's *habitus* represents the socially acquired, embodied systems of dispositions and/or predispositions. These patterns are the result of internalizing culture or objective social structures through the experience of an individual or a group. The fundamental opposition in the structure tends to establish itself as a fundamental structural principle of practice. Hence, *habitus* is a valorisation source or symbolic support in acquiring prestige and status. However, disabled people's acquiring a "valuable" body or bodily prestige and status is obstructed by the viewpoint of mainstream society, which tends to define and characterise their bodies as 'abject' and abnormal (Claire and Imrie, 2003:37).

Bourdieu's sociology deals with the discovery of the socio-cultural processes underlying the reproductive structures of social inequalities. Moreover, as Shilling suggested, in Bourdieu's conception the body is "an incomplete entity which develops in conjunction with various social forces and plays an integral part in maintaining social inequalities" (Shilling in Claire and Imrie, 2003: 37). The body of people with disabilities expresses the values of a society that can consider them as less valuable than "normal" bodies. Starting with pre-natal genetic testing and going through the cultural and social meanings of the *habitus*, disabled people have to face social marginalisation and socially reinforced negative status.

In particular, the dominant discourses of disability reproduce the dualistic concept of disability. Thus, disability is defined either as a biological deficiency or as a social construction. Bourdieu's contribution is important because it attempts to prevent such dualist conceptualisations in theory and practice. According to him "to act is to act with a structured body which has incorporated the immanent structures of a world or of a particular sector of that world – a field - and which structures the perceptions of that world as well as action in that world" (Bourdieu, 1990: 81)**.** In his view, a proper sociological grasp of "practice" or action requires the overpass dualisms such as structure *versus* agency; transcendental subject (consciousness, intentionality) *versus* agent (structuralist conceptions of unconscious rule-following or concealed imperatives governing perception and action); objective physicalism *versus* subjective psychologism. Yet, the importance of Bourdieu's work for the theory of disability represents much more than just passing over such dualisms. For Bourdieu, social inequalities are to be understood partially in relation to bodies as bearers of values. This issue is important because it highlights the embodied nature of the body as an analytical category of research. We suggest that Bourdieu's sociology represents a significant contribution to these efforts of understanding.

Approaches on disability in the Romanian public policies

The analysis of disability policies in Romania reveals an evident progress since 2003. Thus, The European Year of People with Disabilities 2003 marked the beginning of radical reforms in this area. The first change was represented by the administrative restructuring and institutional decentralization. The National Strategy for Protection, Integration and Social Inclusion of Persons with Disabilities developed in 2006 for the 2006 – 2013 period has been elaborated for people with disabilities as "full citizens with equal rights" (GD 1175/2006) and represents the platform for all future actions. It starts from the premise that the person with disabilities is equally important and valuable as any other person (GD 1175/2006). The aim of the Strategy is to enable people with disabilities to exercise the same rights and enjoy their human rights, fundamental freedoms and full citizenship, in order to enhance the quality of their life.

The concept of „choice" represents the central feature of this Strategy: "the disabled people are capable to make decisions regarding their life, manage their budget, choose which services they need and the providers of these services based on individual service contracts" (HG 1175/2006). In accordance with Standard Rules on the Equalization of Opportunities for Persons with Disabilities, the terms of disability and disabled have been clarified, in order to abandon the primacy of the medical diagnosis and the disregard of the relationship with the environment. In addition, the definitions and the use of these terms should exclude any discriminatory tendencies or those inducing the risk of stigmatization by negative, categorical or depersonalization connotations.

In this context, the critical mark of the social inclusion and equality of chances for people with disability is what they can do. Hence, disability is seen from a social model perspective that tries to elude the phenomenon of excessive medicalisation, dominant so far.

The new definition of disabled people as "persons who, because of physical impairments, mental or sensory impairments, lack the skills to operate normally in everyday activities and require protective measures for rehabilitation, integration and social inclusion" (Law 448/2006) has stimulated the progress of all policies in this area. In addition, policy makers have recognized the necessity of a coherent disability evaluation system that promotes social integration through maximizing the functional capacity of people with disabilities.

The new multidisciplinary evaluation criteria represent the shift from a strictly medical approach to a complex medico-psycho-social approach. The multidisciplinary evaluation results in a rehabilitation program containing individual activities and services aimed at fulfilling disabled persons' needs and at promoting social integration. This makes possible the identification of real needs and of feasible solutions.

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SOCIAL IDENTITIES AND SOCIAL SUPPORT FOR THE EUROPEAN UNION IN ROMANIA

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ABSTRACT. Since their first application, Eurobarometer surveys have been indicating in Romania one of the highest levels of support for the European Union and for European integration. This paper[*] attempts to capture the profiles of sustainers and opponents of the EU integration and enlargement, looking at social identities in terms of categorical identities and self-identifications. The analysis is carried out on national representative samples from various surveys: Romanian Public Opinion Barometers (2001, 2002) for the investigation of support for integration; the European Values Survey (2005) concerning the self-ascribed European citizenship; and the European Social Survey (2006) regarding the issue of further enlargement of the EU.

Keywords: social identity; support for the European Union; EU integration; EU enlargement

Introduction

Last century's progress and conflicts opened the gates for new ways of interaction, cooperation and established new goals for the European countries. What was thought at first as a way of improving the economic cooperation between a few Western European states gradually has grew into an integrated socio-political construct aiming to play leading roles in the global arena. For the populations of the founding member states of the European Community, this process of integration was something natural: the changes took place over a few decades and were incremental up to the end of the 80's. At the beginnings of the post Cold War era, the European Union (EU), already there, not necessary tangible but economically functional, started to be a significant actor in the political and social fields. The EU started to promote new ideals of cooperation, underlying the idea of the community of people under a set of common values, i.e. the collective identity.

On the other hand, for the populations that escaped from the communist regimes, the European Community was a reality aspired. There is no secret that the space "beyond", the occidental world and implicitly its organizational modes of functioning, "haunted" for a long time the imagology of the Eastern and Central European populations, mainly as a symbol of welfare and freedom. Moreover, the European Union of the 90's represented

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for the post communist regimes a factor of political, economic and social stabilization (see Jacobsen, 1997). These factors determined the Eastern and Central European states to put forward the idea of their European heritage and to claim and obtain their place in the European Union.

Firstly the Maastricht Treaty (1993), based on the idea of further integration, and then the new enlarged formula of the European Union, brought into the light more than ever the issue of its legitimacy – although this issue was always important (Slater, 1982). The legitimation mediated by the national institutions of the member states started to be perceived as contradictory or insufficient (Lindseth, 2003). The value priorities of the citizens or the subjective level of legitimacy (Meyer, 1994) – i.e. perceptions, attitudes, beliefs – are becoming an issue of greater importance: the failure of referendum for the European Union's Constitutional Treaty in Netherlands and France or the failure of the referendum for the European Union's Lisbon Treaty in Ireland are the most significant examples in this respect. Indirect legitimation (Wallace, 1993) is not enough when social support is missing. Therefore it is important to assess much more closely the population's support for the European Union. This issue can be addressed either in terms of types of support (identification with EU) or in terms of supporters (social identities); in other words we can ask "What kind of support do we have?" or "Who supports (or not) the European Union?" In this paper, I intend to explore the latter, more precisely, the social identities of the Romanians that underpin the European Union.

The paper is not focused on the levels or types of support, but on the social identities of those who sustain (or not) the EU in Romania. I will pursue questions like: What is the profile of the Romanian EU sustainers? Which of their characteristics are the most important?, etc. For a better assessment I consider different dimensions of social support: emotional, instrumental/utilitarian (Gabel, 1998) and "participative". Firs, I try to determine the profiles of the EU sustainers based on their participative and utilitarian support. Then I explore which are the most important characteristics of the profiles of the EU sustainers based on the emotional and utilitarian support.

The paper has the following sections: a first section dedicated to the social identity concept, a second section dedicated to the description of the methodology and the used indicators; a third section where I'm shortly sketching the steps Romania took towards the EU integration, a fourth part dedicated to the analyses and data presentation; finally, the last part where I outline some conclusions.

Social identities and the European Union

Here, two vivant debates meet each other: the debate over identities and the debate over the support for the European Union. In this paper they melt together into the issue of "who supports what" in Romania in respect with the European Union.

The generic answer to the question of "who", is an identity, namely a social identity, following the idea of Jenkins (1996: 4) that any type of human identity is a social identity. Besides the fact that it is a very common word in everyday life, identity is one of the most ubiquitous concepts of the literature concerned with social sciences today, to which a lot of definitions were given and which encompasses a great number of differences. Presently, these differences or oppositions are transposed in a quasi-unanimous way – see: Sayer (1997), Bacová (1998), Woodward (2001), Brubaker, Loveman and Stamatov (2004), etc. – in the terms of essentialism and constructivism. I will not pursue this debate here (for more details see Rusu, 2008), but I will simply point out that constructivism reunites those perspectives that support the idea of some contextual, processual, instrumental, changing or invented identities, and essentialism reunites those perspectives that advance or start from the idea of the existence of some fixed, static, determinist character, of affective, homogenizing identities. I take the stance of constructivism when I use the social identity concept and when explore the social identity profile of the European Union's supporters.

Broadly defined, social identity "refers to the ways in which individuals and collectives are distinguished in their social relations with other individuals or collectives" (Jenkins 1996: 4). The criteria for differentiation, or the social boundaries, are either biological or cultural based – attitudes, behaviours, values, etc. (see van den Berghe, 1995; Barth, 1985 ; Tajfel 1959,1974; Wallerstein, 1960, 1972; etc)

The collective social identity is a dialectical product, a combination of internal (self) and external (others) definitions (see also Jenkins 1994, 1996). The first, is usually called a self identification process, while the latter means a categorization process. Thus, social identities can be classified in respect with the subject of identification into hetero-identities (categorizations) and self-identities (self identifications). The self-identity is the identity one ascribes for him/herself. The categorical identity is ascribed by others. Hence the distinction I will use between categorical identities and self identifications. This differentiation between categorical identities and self identification is inspired not only form Jenkins' (1996) distinction between nominal and virtual identities, but also from Calhoun's (1994, 1997) distinction between relational and categorical identities, respectively from Tajfel and Turner's (1979) social identity theory.

Consequently, on the one hand, I will refer to social identities, i.e. categorical identities, using a classificatory grid in terms of socio demographic characteristics: gender, age, education, etc. On the other hand, I will construct "collective" identities, out of the actor's identifications: I will search for common aspects of individual identities, meaning for the elements of common identification of the social actors: values, images, feeling, etc.

The main question I am asking in this paper is "What are the social identities of those who support (or not) the European Union?" Consequently, I will test the following hypotheses using empirical data:

- (H1): People who do not support the European Union in Romania are rather older persons, living in rural areas, conservative, pessimists and have low levels of social capital. In Romania, characteristics like these usually designate categories of people disadvantaged by the social changes brought by the fall of communism. These categories were elsewhere labelled as the "losers of transition" (see Sandu, 1999).
- (H2): The level of support for unification depends in terms of self identifications on the: level of conservatism/openness to change, level of trust and satisfaction, and in terms of categorical identities on the level of education and residence. I expect that the level of support will increase with the increase of trust, life satisfaction, and education, respectively with the decrease of conservation.

Both hypotheses are constructed based on Inglehart's (1970) theory of post-materialism, which ultimately states that the more a person is oriented towards postmaterialist values and the more educated he/she is, the more positive is his/her attitude towards the European integration.

Indicators and methodology

The empirical analysis I use is, by and large, an exploratory one, aiming especially to point out the structure, stability or the dynamics of the social identities of the European Union's sustainers and opponents in Romania. The main data I use are survey-based data: Public Opinion Barometers[1] (POB) from 1999/second wave, 2000/second wave, 2001/first wave, 2001/second wave, 2002/second wave; World/ European Values Survey (WVS/EVS), the 2005 wave[2]; and European Social Survey (ESS) the 2006 wave[3].

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[1] All these databases (Pubic Opinion Barometers) are available on the Internet thanks to The Open Society Foundation, Romania (the financier of these series of surveys) at the address: www.osf.ro. They comprise national samples of about 1,500 cases per wave. Details about each Barometer (sampling method, sample size, representatives, etc) are available at the above mentioned Internet address

[2] see: European and World Values Surveys Four-Wave Integrated Data File, 1981-2004, V.20060423, 2006. Aggregate File Producers: Análisis Sociológicos Económicos y Políticos (ASEP) and JD Systems (JDS), Madrid, Spain/Tilburg University, Tilburg, The Netherlands. Data Files Suppliers: Analisis Sociologicos Economicos y Politicos (ASEP) and JD Systems (JDS), Madrid, Spain/Tillburg University, Tillburg, The Netherlands/ Zentralarchiv fur Empirische Sozialforschung (ZA), Cologne, Germany:) Aggregate File Distributors: Análisis Sociológicos Económicos y Políticos (ASEP) and JD Systems (JDS), Madrid, Spain/Tillburg University, Tilburg, The Netherlands/Zentralarchiv fur Empirische Sozialforschung (ZA) Cologne, Germany. Details about the sampling methods, sample size, representatives, etc are available on the Internet at: http://www.europeanvalues.nl/

Methods

In order to asses the profiles of the European Union's supporters or opponents I will use at first the Romanian Public Opinion Barometer databases. The statistical procedure adopted here is the analyses of the data in contingency tables using χ^2 and adjusted residual value tests. The assessment of the social identities of the European Union's supporters or opponent – based on the World/ European Values Survey and the European Social Survey databases – consists in the analyses of the data using the methods of logistic and linear regression.

Dependant variables

The dependant variables indicate the support for the European Union from three perspectives: emotional, instrumental/utilitarian and participative. Through emotional support I understand the type of support based on the self ascribed European Union citizenship: it is a support that consists in a sense of collective European identity. Instrumental/utilitarian support is based on the understanding and recognition of positive benefits (see also Lindberg & Scheingold, 1970; Gable, 1998). By participative support I understand here one of the basic levels of political participation: the potential participation.

The following dependant variables were used in order to asses the profiles of the supporters and opponents of the European Union in Romania:

- for the emotional support: "I see myself as a citizen of the European Union" (item from WVS/EVS-2005). The answers are coded on a four point scale, where 1 means strongly agree and 4 means strongly disagree.
- for the participative support – the voting behavior in case of referendum on integration: "If next Sunday a referendum regarding the accession of Romania to the European Union took place, would you vote for accession or against?" (item from POB, 2001/second wave; POB 2002/first wave). The answers are coded on the following scale: 1-Vote for accession, 2- Vote against accession, 3-I will not participate.
- for utilitarian support – the evaluation of the usefulness of the EU integration (dichotomous items from POB, 1999/second wave; POB 2000/second wave): "Do you believe that European integration for our country is: a) useful, b) not useful?"; and the support for further unification: "Thinking about the European Union, some say European unification should go further. Others say it has already gone too far" (which according to ESS questionnaires refers to further integration than further enlargement.) (dichotomous item from ESS-2006)

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[3] Norwegian Social Science Data Services (NSD) is the data archive and distributor of the European Social Survey data. Details about the sampling methods, sample size, representatives, etc. are available on the Internet at: http://www.europeansocialsurvey.org/

Independent variables

The independent variables are grouped on the one hand in variables indicating categorical identities, which mainly measure socio-demographic characteristics, and on the other hand, in variables indicating various dimensions of self identifications[4]. Although the databases I use are different, I try to use as much as possible independent variables (even if different), that theoretically point out the same dimension.

The variables indicating categorical identities are: age categories, residential area, geographic area, socio-economic status, occupation, marital status and education (measured for the POB databases in level of education achieved and for ESS database in years of education).

Variables indicating the self-identifications – for the analyses performed on ESS and WVS/EVS databases – are mainly directed towards three dimensions: an axiological dimension (here were included variables measuring the level of individual modernity/conservatism – see also Sandu [1999] for the POB indicators used in analyses – or tolerance) a social capital dimension (here were included variables measuring trust in others and in institutions) and an evaluative dimension (here were included variables measuring life satisfaction). Each of these dimensions reflect distinct attitudinal and behavioral aspects that are indicators for one's own identity. For the POB databases additional variables are considered: the level of information, subjective poverty, volunteering, etc. Table 1 synthesizes the methods and independent variables used for the assessment of the self identifications of the Romanians in the case of each survey series.

The items used in the analyses performed on POB are based on the answers to a single question. In the analyses performed on ESS and EVS databases for each dimension of the social identity I employed specific indexes computed as factor scores as described in the Annex A and C.

Schwartz (1994, 2006) model was the main source of inspiration in what concerns the self identifications on the axiological dimension (regarding conservatism and openness to change). Conservatism is expressed by the search for security, conformism and tradition. It was measured in the analyses on ESS using the following indicators: living in secure and safe surroundings, government is strong and ensures safety, to do what is told and follow rules, to behave properly, to be humble and modest not draw attention, to follow traditions and customs (see the Annex, part A, Table A-1, for the index construction). In the analyses on EVS, I used the theoretically opposed value dimension: openness

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[4] Considering the framework of Easton (1965) on political support, the variables indicating self-identifications could be labeled on the one hand as variables indicating the diffuse support (i.e. values) and on the other hand as variables indicating the diffuse-specific support (i.e. trust in institutions and general satisfaction).

to change. It was measured using indicators the following indicators: important to think up new ideas (self direction), important to have a good time (hedonism), important to take risk (stimulation), (see the Annex, part B, Table B-1, for the index construction).

Table 1.

Self-identification variables

	POB surveys	WVS/EVS 2005 survey	ESS 2006 survey
Method	Contingency tables/ Adjusted residuals	Logistic regression	Regression analysis
Self identification variables	*Axiological dimension:* conservatism variables: the attitude towards risk, the support for democracy, the support for the free market economy.	*Axiological dimension:* openness to change (factor), tolerance towards other ethnic groups (item), ecologist.	*Axiological dimension:* conservatism (factor), tolerance towards immigrants (factor).
	Social capital dimension: generalized trust, membership in non profit associations.	*Social capital dimension:* trust in international institutions (factor).	*Social capital dimension:* trust in international institutions (factor).
	Evaluative dimension: life satisfaction, optimism, subjective poverty.	*Evaluative dimension:* life satisfaction (factor).	*Evaluative dimension:* life satisfaction (factor).
	Level of information dimension: frequency of papers reading, TV watching and radio listening.		

Ecologist preoccupation is an index which measures the postmaterialist orientations. I used this index in the analyses on EVS having in mind Inglehart’s (1970) hypothesis. It was constructed as a factor score from the following indicators: giving part of income to prevent environmental pollution, agree to an increase in taxes if the extra money were used to prevent environmental pollution (see the Annex, part B, Table B-2, for the index construction).

Tolerance is generally understood as the acceptance of differences. Another way to understand it is the acceptance of some behaviours or attitudes with which we do not agree or which we do not like (Medrano & Rother, 2006). Here I refer to tolerance towards immigrants or other ethnic groups, as the willingness to accept in Romania people belonging to other countries or ethnic groups. In the analyses on ESS, tolerance is determined on the basis of the acceptance of the ideas that people from other countries are good for the economy, they enrich cultural life, and make Romania a better place to live in (see the Annex, part A, Table A-2, for the index construction). In the analyses on EVS is determined on the answers to a single question (see the Annex, part B, Table B-3).

Trust represents one of the dimensions of the social capital (Coleman, 1990, 1998; Putnam, 1995). In the analyses on ESS, I used two combined indicators measuring institutional trust: trust in the European Parliament and trust in the United Nations (see the Annex, part A, Table A-3, for the index construction). In the analyses on EVS, I also used two combined indicators measuring institutional trust: trust in the European Union and trusts in the United Nations (see the Annex, part B, Table B-4).

Life satisfaction is measured in different ways. It can be viewed either as a moral, spiritual resource in dealing with future, along with optimism, or as an indicator of the latest (see also Sandu, 1999: 33-51). In the analyses on ESS, life satisfaction is measured as a factor based on three indicators: satisfaction with life as a whole, happiness, satisfaction with how life turned out so far (see the annex, part A, Table A-4, for the index construction). In the analyses on ESS I used two combined indicators: satisfaction with life as a whole and satisfaction with the financial situation of the household (see the Annex, part B, Table B-5).

Romania and the EU project

Various data (see the Eurobarometers) indicate that Romanians are amongst the most supportive European citizens when it comes about most of the aspects of the European Union. Graph 1 and Graph 2 indicate the relative position of Romania in respect with other European countries when talking about the confidence in the European Union, the support for further unification and the self ascribed European Union citizenship.

Romanians always called and perceived themselves as Europeans, but the dream of being European citizens[5] started to become a tangible reality – due to the longer transition period – with the beginnings of the new millennium.

The Romanian transition is similar to that of the other Eastern and Central European countries. Maybe the fact that it took longer to achieve the current status makes the situation to look a bit different. Otherwise, the reform processes were fundamental, like elsewhere in these countries and meant the transformation of the political system, the change of the legislation, reforms in agriculture, transfer of the state property to privates, reforms in educational system, etc. Anyway, this period was far from being smooth. Probably more than in other countries that acceded to EU, the transition in Romania encapsulated elements[6] of chaos, desperation, lack of morality and lack of perspectives[7]. The

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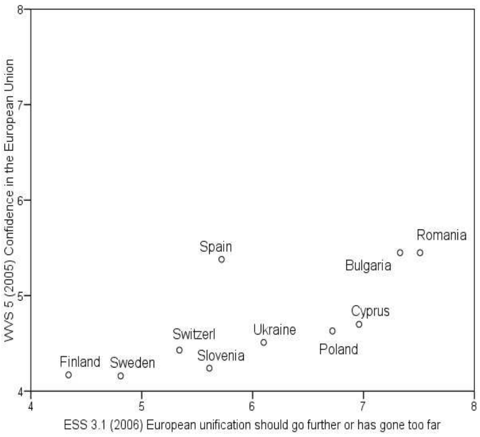
[5] The formal criterion in knowing who belongs to Europe and who does not is the citizenships. The one who holds a citizen status in a member state is an European citizen.

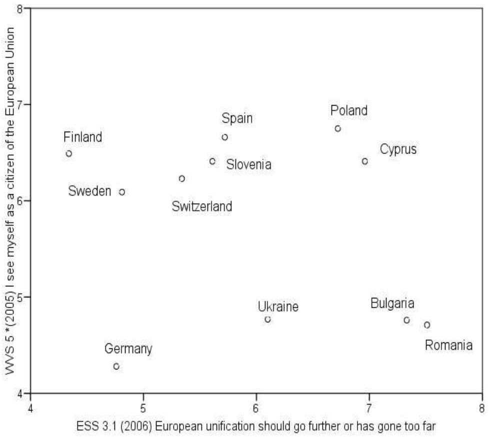
[6] like: violent social movements (the repeated miners assaults – called "Mineriade"), bankruptcy of Dacia Felix or Bancorex, collapses of mutual funds like SAFI or FNI, pyramidal games like Caritas, political and corruption scandals, etc.

social polarization grew exponentially: a small category benefited from transition, and an important category of people became the losers of it, exposed to poverty, unemployment etc. (see Sandu, 1999). By contrast, the occidental Europe and the European Union always represented a desired reality, a world of stability, welfare and opportunities.



Graph 1. EU confidence and unification support in Europe

(**Source:** WVS, 2005; ESS, 2006)
The answering scale (originally 4 point) measuring the confidence in the European Union was transformed to vary from 0 to 10.



Graph 2. EU citizenship and unification support in Europe

(**Source:** WVS, 2005; ESS, 2006)
The answering scale (originally 4 point) measuring the self ascribed European citizenship was transformed to vary from 0 to 10.

The attitude of Romania towards the EU and NATO at the beginning of the 90's was ambiguous. For instance, immediately after the '89 revolution, when Ceausescu was overthrown, the new leaders from Bucharest reaffirmed – difficult to estimate if it was lack of perspective or fear of foreign interventions – their fidelity to the Warsaw Treaty. Later, the Romanian Presidency also had an obscure attitude, in generally catalogued rather as a pro-Russian one: in 1993 declared that NATO integration was a target, and in 1994 that a close relationship with Moscow would be preferable (see Groşu, 2006). These first five to six years of indecision or incoherence after the downfall of the communist regime are probably the most important source of delay compared the other Eastern European countries, reflected not only in economical evolutions, but also in the mentalities.

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[7] Elements like these made Sztompka (1996; 1998) to speak about a "culture of distrust" in the Eastern European emerging democracies.

Only in June 1995 the pro-occidental option becomes evident, when Romania puts forward the request for EU membership. Although the following period of the 90's is intense regarding the compliance to the NATO and EU objectives[8], up to the end of the decade[9], the case of the European integration seldom appeared in the public agenda and only somewhat more often in the political agenda (especially in the electoral campaigns).

European integration became a substantial reality when the negotiation process was officially launched in February 2000. In 2001, the new ruling party in the government the Social Democratic Party (PSD) established a Ministry of European Integration and a National Delegation for Negotiation of Accession to the EU. In 2002, Romania opened the negotiations for all the 30 thematic chapters, and by the end of 2004 the negotiations were closed.

Starting with the end of 2002 when NATO integration became an "achieved" target[10], the cultural and political elites (no matter of right or left subscription) began to shift their interest, discourse and actions towards the process of European integration[11]. This shift became more visible and prominent, at least on the political agenda, when in 2003 the government party[12] promoted the idea of before term elections. But definitive and prioritised attention was given to this subject at the end of 2003 when the Country Report presented by the European Commission showed that Romania is a country without a functional market economy and with a high level of corruption. In other words and at least in economical terms, according to that report, Romania in 2003 was still far away from the European Union's standards. Nevertheless in April 2005 the European Parliament has given the green light for the entry of Romania and Bulgaria into the European Union in 2007, and in the same month the Treaty of Accession was signed.

Results

This section is dedicated to the empirical findings. I will try to capture – considering the available data in a chronological order – the social identities of those supporting or not the European Union.

The social identities assessment based on the Public Opinion Barometers data

Here I try to capture the social identities of the EU sustainers and opponents – using the POB data – first considering the utilitarian type of support and then the participative support. The evaluation of the usefulness of

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[8] Especially the 1996-2000 period, the first period of governance of the right-wing forces.

[9] In December 1999 the European Council invited Romania to start accession negotiations.

[10] Romania, Bulgaria, Slovakia, Slovenia, Estonia, Latvia, and Lithuania became full members of NATO in 2004.

[11] All parliamentary parties support European integration.

[12] The Social Democratic Party.

integration into the European Union in 1999 and 2000 indicate the following situation (Table 2). Can be observed that a significant percentage of the whole population (an average of 68 % over two years) considered European integration as a useful process. A quite high percent (20 % of the people) was undecided or did not respond. A relatively small percentage of the population, averaging around 11 % (over the two years), believed that the EU integration was not useful.

Table 2.

Opinions regarding the usefulness of European integration in 1999-2000 (%)

	European integration is useful	European integration is not useful	Don't know / Non response
Survey/ Year/Wave			
POB 1999/2	67	12	21
POB 2000/2	68	10.8	21

Source: Romanian Public Opinion Barometers 1999/second wave, 2000/second wave

Table 3.

Social identities of the EU supporters and opponents in Romania (1999 and 2000)

	EU supporters	EU opponents
Categorical identities	Graduated high school or equivalent, live in Transylvania, in urban areas, are employed.	Aged over 56, have maximum 8 grades, come from Muntenia, are widowed, live in rural areas, are retired and/or are agricultural workers with privately owned land.
Self identifications	*Axiological dimension*: favour risk, support the free market economy, support democracy. *Social capital dimension*: trust other people, are members in associations. *Evaluative dimension*: less dissatisfied with life, optimists (appreciate that country goes into the good direction). *Level of information dimension*: very informed people (read papers, watch TV and listen radio more often then the rest)	*Axiological dimension*: anti-risk attitude, don't support the free market economy, doesn't support democracy. *Social capital dimension*: do not trust other people, have no memberships in associations. *Evaluative dimension*: not satisfied with life, pessimists (appreciate that country goes into the wrong direction), consider their income is not enough for living. *Level of information dimension*: not informed people (never read papers, watch TV few times a week).

In order to asses the social identities of those supporting the European integration and of those opposing it both databases were analysed. An analysis made on data collected in different years is a better indicator for the profile of these people. The statistical procedure adopted was an analysis of the data in contingency tables using χ^2 and adjusted residual value tests. The results are synthetically presented in the following table (Table 3)[13].

Results suggest that in terms of categorical identities, EU supporters are rather urban, educated people, coming from the most developed region of Romania. In terms of self identifications, data suggest that the people having higher levels of modernity, higher levels of social capital, are informed, optimists and satisfied with life, are more supportive with the EU.

On the contrary, the EU opponents are – in terms of categorical identities – older persons, living in rural areas, retired, and persons who practice subsistence agriculture. In terms of self identifications, they are more conservative, have lower levels of social capital, are rather pessimists and less informed.

The assessment of the social identities considering the participative support measured through the voting behaviour in case of referendum in 2001 and 2002 indicate the following situation (Table 4).

Table 4.

Voting behavior in case of referendum on accession 2001-2002 (%)

Survey/ Year	Vote for accession	Vote against accession	Won't participate	Don't know	No response
POB 2001/2	76.35	3.65	9.09	9.86	1.06
POB 2002/2	78.01	4.37	7.00	9.68	0.94

Source: Romanian Public Opinion Barometers 2001/second wave, 2002/second wave

Can be observed that a significant percentage of the whole population (an average of 77 % over two years) appreciate that would vote for accession. The proportion of population declaring to vote against is relatively small (around an average of 4 % over two years). A more important proportion (10 % of the people) was undecided or did not respond. A relatively small percentage of the population, averaging around 8 % (over these two years) declared that they won't participate.

In order to asses the social identities of those supporting the European integration and of those opposing it I have analysed both databases. The statistical procedure adopted was the same as above, an analysis of the data in contingency tables using χ^2 and adjusted residual value tests. The results are synthetically presented in the following table (Table 5)[14]:

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[13] A detailed description of the results can be found in the Annex, part C.

[14] A detailed description of the results can be found in the Annex, part D

Table 5.

Social identities of the EU supporters and opponents in Romania (1999 and 2000)

	EU supporters	EU opponents
Categorical identities	Graduated high school or equivalent, come from Transylvania, live in urban areas.	Aged over 56, have maximum 8 grades, are widowed, live in rural areas.
Self identifications	*Axiological dimension*: support democracy. *Social capital dimension*: trust other people. *Evaluative dimension:* less dissatisfied with life, optimists (appreciate that country goes into the good direction). *Level of information dimension*: very informed people (read papers, watch TV and listen radio more often then the rest).	*Axiological dimension*: support less democracy. *Social capital dimension*: do not trust other people. *Evaluative dimension:* not satisfied with life, pessimists (appreciate that country goes into the wrong direction), consider their income is not enough for living. *Level of information dimension:* not informed people (never read papers, never listen radio watch TV few times a week).

These results suggest that in terms of categorical identities, EU supporters are rather urban educated people, coming from the most developed region of Romania. In terms of self identifications, the data suggest that the people supporting change (democracy), higher levels of social capital, informed and optimists or satisfied with life, are more supportive with the EU.

On the contrary, the EU opponents are, in terms of categorical identities, lower educated, older persons, more likely to live in rural areas. In terms of self identifications, they are more conservative (do not support change – democracy), have low levels of social capital, are rather pessimists and less informed.

It is important to say here that sketch portraits of the people supporting or not the EU, do not necessary indicate a homogenous, real world, category. Each class should be rather seen in terms of overlapping strata of people. Nevertheless these analyses show that in time a series of characteristics (both in terms of categorical and self identifications) are rather stable.

No matter of the type of support considered, we can generally say that more educated people, urban residents coming from wealthier areas of the country, less conservative, more satisfied people who have more social capital and are more informed - represent the category which supports the EU. The opponents of the EU are less educated, older, live in rural areas, are conservative, have lower levels of social capital and are less informed. We can say now, that these data confirm our first hypothesis, namely that the people who do not support the European Union in Romania are those named “losers of transition”.

The social identities assessment based on World/European Values Survey data

The social identities impact (self identifications) on EU support is measured here using a variable indicating the affective support. The analysis is based on EVS. Data were analyzed using logistic regression (Table 6).

Table 6.

Logistic regression on the dependent variable: affective support for unification

	B	Wald
Constant	-.574***	27.74
Trust in international institutions	.449***	37.82
Life satisfaction	.124*	3.78
Tolerance (ethnic)	.089***	21.13
Openness to change	$.141^{+}$	3.31
Ecologist concerns	.262***	17.626
Cox & Snell R Square	.105	
Nagelkerke R Square	.141	
Omnibus test	$\chi^2=152.7$; $p<0.001$	
Hosmer and Lemeshow Test	$\chi^2=13.295$; $p=.102$	

Notes: the coefficients are standardized regression coefficients
***p<0.001, **p<0.01, *p<0.05, $^{+}$p<0.1
Source: EVS, 2005

The model shows that trust in international institutions, ethnic tolerance and ecologist preoccupations have the highest positive effect on EU support. These results partially confirm the second hypothesis, namely that the level of support for unification depends in terms of self identifications on the level of openness to change, tolerance, level of trust and satisfaction.

The social identities assessment based on ESS data

In this section I try to determine the effect of the social identities (categorical and self identifications) on the EU support. Here, I refer to the EU support in terms of the utilitarian type of support – the evaluation of the utility of further unification. The analysis is performed on the ESS, through the use of linear regression (Table 7).

The first model shown in Table 7 tests the effect of variables which indicate categorical identities. Although the years of education and urban residence have a significant effect, and although the categorical identities were determined as important/significant in the previous analyses, this model basically shows that solely the categorical identities cannot predict the level of support for unification.

Table. 7

Linear regression, dependent variable: utilitarian support for unification

	Model 1	Model 2	Model 3
Constant	6.936	6.747	6.760
Years of full-time education completed	.110***	.078**	.060*
Urban	.049*	.085***	.094***
Male	-.025	-.025	-.015
Orthodox	-.030	.046^{+}	.059*
Age	-.042^{+}	.003	.001
Trust in international institutions		.310***	.266***
Life satisfaction		.172***	.125***
Tolerance immigrants			.241***
Conservatism (1)			-.088***
Adjusted R Square	.021	.170	.237

Notes: the coefficients are standardized regression coefficients
***p<0.001, **p<0.01, *p<0.05, $^{+}$p<0.1
Source: ESS[15], 2006

The second model included the life satisfaction and trust as additional predictors (evaluation and social capital variables). All the effects of the categorical identities variables (the years of education and urban residence) remain significant when controlling for these predictors. The model shows that trust in international institutions and life satisfaction are those self identification variables which have the highest positive effect on the EU support. The amount of explained variance significantly increased but it is still not satisfactory.

The third model included additionally self identification variables on the axiological dimension. All the effects of the categorical identities variables and self identification variables used before remain significant when controlling for these predictors. The model shows that trust in international institutions, immigrants' tolerance and life satisfaction have the highest positive effect on the EU support, while conservatism has a negative impact on the outcome variable. The amount of variance has slightly increased again this last model explaining .237 of the variance.

These results confirm the second hypothesis, namely that the level of support for unification depends in terms of self identifications on the level of conservatism/traditionalism, level of trust and satisfaction, and in terms of categorical identities on the level of education and residence. Moreover, results show that the level of support for unification increase with the increase of trust, life satisfaction, and education and with the decrease of conservatism.

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[15] The database for Romania was weighted on demographic variables (sex and age).

Conclusions

The paper investigates the social identities of those WHO support or oppose the European Union in Romania. Based on secondary analyses (on CSDS, POB, ESS and EVS data) I have tried to find answers to questions like: What does European Union mean for Romanians? What is the profile of the Romanian EU sustainers? Which of their characteristics are the most important? From the analysis several conclusions arise.

All the analyses indicate (as the Eurobarometers show, too) a high level of support for the European Union; actually, we can speak about one of the highest support in Europe, no matter which type of support (i.e. question asked) is considered in the analyses. The most important meaning of the European Union in the Romanian's mental space is positive, especially in terms of a better quality life.

Again, no matter of the type of the considered support, in general we observed that the more educated people, urban residents coming from wealthier areas of the country, the less conservative, more satisfied citizens who have more social capital and are more informed are those who support the EU. The opponents of the EU are less educated, older, live in rural areas, are conservative, have lower levels of social capital and are less informed. These data confirm our first hypothesis, namely that the Romanian people who do not support the European Union are those who are "lost in transition".

The second hypothesis was also confirmed. The analyses showed that the level of support for unification increases with the increase of trust, life satisfaction, education and with the decrease of conservatorism.

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ANNEX, part A

Table A-1.

Conservatism (1)

Variables	Communalities	Saturations
Important to live in secure and safe surroundings	.388	.690
Important that government is strong and ensures safety	.471	.686
Important to be humble and modest, not draw attention	.211	.679
Important to follow traditions and customs	.476	.668
Important to do what is told and follow rules	.461	.623
Important to behave properly	.447	.459
Explained variation	40.89%	
KMO	0.799	

Note: All of the correlations are significant for p=0,000. The used method of extraction: Principal Component Analysis. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

Table A-2.

Tolerance

Variables	Communalities	Saturations
Immigration bad or good for country's economy	.782	.897
Country's cultural life undermined or enriched by immigrants	.745	.884
Immigrants make country worse or better place to live	.805	.863
Explained variation	77.72%	
KMO	0.729	

Note: All of the correlations are significant for p=0,000. The used method of extraction: Principal Component Analysis. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

Table A-3.

Trust in international institutions

Variables	Communalities	Saturations
Trust in the European Parliament	.915	.956
Trust in the United Nations	.915	.956
Explained variation	91.45%	
KMO	0.500	

Note: All of the correlations are significant for p=0,000. The used method of extraction: Principal Component Analysis. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

Table A-4.

Life satisfaction

Variables	Communalities	Saturations
How satisfied with life as a whole	.754	.872
How happy are you	.760	.868
Satisfied with how life turned out so far	.671	.819
Explained variation	72.85%	
KMO	0.706	

Note: All of the correlations are significant for p=0,000. The used method of extraction: Principal Component Analysis. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

ANNEX, part B

Table B-1.

Openness to change

Variables	Communalities	Saturations
Important to think up new ideas	.713	.894
Important to have a good time	.799	.875
Important taking risk	.765	.844
Explained variation	75.91%	
KMO	.716	

Note: All of the correlations are significant for p=0,000. The used method of extraction: Principal Component Analysis. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

Table B-2.

Ecologist preoccupations

Variables	Communalities	Saturations
I would give part of my income if I were certain that the money would be used to prevent environmental pollution	.876	.936
I would agree to an increase in taxes if the extra money were used to prevent environmental pollution.	.671	.936
Explained variation	87.57%	
KMO	0.500	

Note: (The answering scale is a 4-point scale, where: is 4=strongly agree; 1=strongly disagree) All of the correlations are significant for p=0,000. The used method of extraction: Principal Component Analysis. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

Table B-3.

Tolerance (ethnic)

It is measured based on the accord with the idea that more ethnic groups in a country enrich life, The used question was: "Turning to the question that in a country there may be more ethnic group living together, with which of the following views do you agree? Please use this scale to indicate your position:"

1	2	3	4	5	6	7	8	9	10
Having more ethnic groups erodes a country's unity					Having more ethnic groups enriches life				

In the analysis the cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

Table B-4.

Trust in international institutions

Variables	Communalities	Saturations
Trust in the European Union	.850	.922
Trust in the United Nations	.850	.922
Explained variation	84.95%	
KMO	0.500	

Note: All of the correlations are significant for p=0,000. The used method of extraction: Principal Component Analysis. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

Table B-5.

Life satisfaction

Variables	Communalities	Saturations
Satisfaction with the financial situation of household	.794	.891
satisfaction with life as a whole	.794	.891
Explained variation	79.44%	
KMO	0.500	

Note: All of the correlations are significant for p=0,000. The used method of extraction: Principal Component Analysis. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

ANNEX, part C

POB 1999 (2) ; 2000 (2)

Table C-1.

Categorical identities of those considering that *EU integration is* ***not*** *useful* in 1999 and 2000

Categorical identity		1999				2000			
		Adj. resid	% of Respondents	% of **EU integration is not useful**	Difference (%)	Adj. resid	% of Respondents	% of **EU integration is not useful**	Difference (%)
Age	18 -35	-	32.3	26.0	-6.3	-	20.3	16.1	-4.2
	36 – 55	-	40.2	36.4	-3.8	-	50.6	47.9	-2.7
	56 +	+3.8	27.5	**37.6**	10.1	+2.2	29.1	***35.9***	+6.8
Studies	**Maximum 8 grades**	+4.3*	30.4	**42.1**	11.7	+4.0	33.7	**46.6****	+12.9
	High school or equivalent	-	56.9	47.9	-9	-	56	47.6	-8.4
	University	-	12.7	9.9	-2.8		10.3	5.8	-4.5
Geographic area	Moldavia	-	20.1	23.6	3.5	-	21.1	15.1	-6
	Muntenia	+2.6	38.0	**45.5**	7.5	+4.8	35.2	**50.5**	+15.3
	Transylvania	-	31.4	23.1	-8.3	-	33.5	26.6	-6.9
	Bucharest	-	10.5	7.9	-2.6	-	10.2	7.8	-2.4
Residential area	**Rural**	+3.6	41.7	**52.1**	10.4	+3.6	42.1	**54.2**	+12.1
	Urban		58.3	47.9	-10.4	-	57.9	45.8	-12.1
Status	**Retired**	+2.9	26.9	**34.4**	7.5	+3.3	33.3	**43.8**	+10.5
	Student	-	4	1.7	-2.3	-	2.6	1.0	-1.6
	Unemployed	-	5.1	3.3	-1.8	-	4.7	4.7	0
	Housewife	+2.8	6.7	**10.8**	4.1	-	11.0	9.4	-1.6
	Unregistered unemployed	-	5.2	6.2	1	+2.4	5.2	***8.9***	+3.7
	Occupied		52.1	43.6	-8.5	-	43.2	32.3	-10.9
Occupation	**Agricultural worker having its own land**	+5.2	14.1	**24.8**	10.7	+3.0	10.1	**16.1**	+6
Marital status	**Widow(ed)**	+3.8	7.3	**13.2**	5.9	+2.3	7.8	***12.0***	+4.2

Notes: *Reading example 1: we can say with a probability of 99% that the people belonging to the 'maximum 8 grades' category would rather say that the "EU integration is not useful" than those belonging to other educational categories. (The statistical test performed is the adjusted residual value test. For the categories that are **bolded** the p≥0.99; for the categories that are ***italics bolded*** the p=0.95.) ** Reading example 2: In 2000, 46.6% of the people considering that "EU integration is not useful" have 'maximum 8 grades'; within the total population that answered to this question 33.7% had 'maximum 8 grades'; thus we can say that those having 'maximum 8 grades' are overrepresented within the category of respondents considering that "EU integration is not useful".

Table C-2.

Self-identifications of those considering that *EU integration is not useful* in 1999 and 2000

Self identification	1999				2000			
	Adj. resid	% of Respondents	% of **EU integration is not useful**	Difference (%)	Adj. resid	% of Respondents	% of **EU integration is not useful**	Difference (%)
Disagree with the idea that only those who risk can win	+4.9	15.1	**25.9**	+10.8	+2.8	24.2	**32.6**	+8.4
Consider that the free market economy is not good	+2.8	10.0	**15.2**	+5.2	+10.9	9.2	**31.3**	+22.1
Consider that a unic party should exist	+7.6	40.0	**62.2**	+22.2	+5.9	39.6	**59.9**	+20.3
Not satisfied with life in general	+3.3	84.1	**91.3**	+7.2	+3.3	78.9	**87.9**	+9
Never read papers	+5.0	13.9	**24.1**	+10.2	+6.2	22.8	**40.3**	+17.5
watch TV few times a week	+3.4	9.4	**15.3**	+5.9	+3.5	10.2	**17.3**	+7.1
Never discuss politics	-	37.3	31.1	-6.2	+3.3	24.1	**33.5**	+9.4
Discuss politics few times a month	+1.7	19.8	***23.8***	+4	-	21.3	17.8	-3.5
Country goes into the wrong direction	+4.3	85.9	**95.5**	+9.6	+3.9	82.7	**93.3**	+10.6
No membership in associations	-	95.2	97.1	+1.9	+2.6	89.4	**94.8**	+5.4
Do not trust other people	-	69.7	67.4	-2.3	3.1	67.1	**77.0**	+9.9
income not enough for living	+5.4	36.7	**52.1**	+15.4	4.6	36.8	**51.6**	14.8

Table C-3.

Categorical identities of those considering that *EU integration is useful* in 1999 and 2000

Categorical identity		1999				2000			
		Adj. resid	% of Respondents	% of **EU integration is useful**	Difference (%)	Adj. resid	% of Respondents	% of **EU integration is useful**	Difference (%)
Age	18 -35	+2.3	32.3	***33.4***	+1.1	-	20.3	21.0	+0.7
	36 – 55	-	40.2	40.9	+0.7	-	50.6	51.0	+0.4
	56 +	-	27.5	25.7	-1.8	-	29.1	28.0	-1.1
Studies	Maximum 8 grades	-	30.4	28.3	-2.1	-	33.7	31.7	-2
	High school or equivalent	+3.0	56.9	**58.5**	+1.6	+2.5	56	***57.3***	+1.3
	University	-	12.7	13.2	+0.5	+2.2	10.3	***11.0***	+0.7
Geographic area	Moldavia	-	20.1	19.5	-0.6	+2.2	21.1	***21.1***	+0
	Muntenia	-	38.0	36.6	-1.4	-	35.2	32.8	-2.4
	Transylvania	+3.0[*]	31.4	**32.9**[**]	+1.5	+2.2	33.5	***34.6***	+1.1
	Bucharest	-	10.5	11.0	+0.5		10.2	10.6	+0.4
Residential area	Rural	-	41.7	39.8	-1.9	-	42.1	40.2	-1.9
	Urban	+3.6	58.3	**60.2**	+1.9	+3.6	57.9	**59.8**	+1.9
Status	Retired	-	26.9	25.5	-1.4	-	33.3	31.6	-1.7
	Student	-	4	4.5	+0.5	-	2.6	2.9	+0.3
	Unemployed	-	5.1	5.4	+0.3	-	4.7	4.7	0
	Housewife	-	6.7	5.9	-0.8	-	11.0	11.2	+0.2
	Unregistered unemployed	-	5.2	5.1	-0.1	-	5.2	4.6	-0.6
	Occupied	+2.9	52.1	**53.6**	+1.5	3.3	43.2	**44.9**	+1.7
Occupation	Clerk	+2.2	9.2	***9.8***	+0.6	-	9.9	10.3	+0.4
Marital status	Not married	-	16.4	17.0	+0.6	2.2	13.9	***14.7***	+0.8

Notes: [*] Reading example 1: we can say with a probability of 99% that the people from Transylvania would rather say that the "EU integration is useful" than those belonging to other geographic areas. (The statistical test performed is the adjusted residual value test. For the categories that are **bolded** the p≥0.99; for the categories that are ***italics bolded*** the p=0.95.)

[**] Reading example 2: In 1999, 32.9% of the people considering that "EU integration is useful" are from Transylvania; within the total population that answered to this question 31.4% are from Transylvania, thus we can say that Transylvanians are overrepresented within the category of respondents considering that "EU integration is not useful".

Table C-4.

Self-identifications of those considering that *EU integration is useful* in 1999 and 2000

Self identification	1999				2000			
	Adj. resid	% of Respondents	% of **EU integration is useful**	Difference (%)	Adj. resid	% of Respondents	% of **EU integration is useful**	Difference (%)
Agree with the idea that only those who risk can win	+4.9	84.9	**86.8**	+1.9	+2.8	75.8	**77.1**	+1.3
Consider that the free market economy is good	+2.8	90.0	**90.9**	+0.9	+10.9	90.8	**94.3**	+3.5
Disagrees with the idea that a unic party should exist	+7.6	60.0	**64.2**	+4.2	+5.9	60.4	**63.6**	+3.2
Satisfied with life in general	+3.3	15.9	**17.2**	+1.3	+3.3	21.1	**22.5**	+1.4
Daily read papers	+4.4	26.6	**28.9**	+2.3	+2.3	25.7	***26.8***	+1.1
Watch TV almost daily	+4.7	84.1	**85.9**	+1.8	+2.1	80.0	***80.9***	+0.9
Listen radio almost daily	+5.0	67.1	**69.6**	+2.5	+2.8	57.6	**59.1**	+1.5
Country goes into the good direction	+4.3	14.1	**15.9**	+1.8	+3.9	17.3	**19.1**	+1.8
Membership in associations	-	4.8	5.1	+0.3	+2.6	10.6	**11.5**	+0.9
Trust other people	-	30.3	29.9	-0.4	+3.1	32.9	**34.4**	+1.5

ANNEX, part D

<u>POB</u> 2001 (2) ; 2002 (2)

Note: Here the support for EU is measured based on answers to the question: "*If next Sunday a referendum regarding the accession of Romania to the European Union took place, would you vote for accession or against?*" (The answers to choose: 1 - I would vote for accession, 2 - I would vote against accession, 3 - I wouldn't participate, 4 - Don't Know, 5 - Don't want to answer). Within the "wouldn't participate" category I identified those people who simultaneously answered that wouldn't vote for Parliamentary elections and Presidential elections. I've categorized them as passive voices and considered further in the analysis as Non Respondents. The others were considered "passive protesters". Then the answers were transformed into dummy variables where the people bonging to *vote for EU accession* category received the value of 1 and those belonging to *vote against* category and the "*passive protesters*" were given the value of 0. The cases of a refusal to the answer (*I will not answer*) and in the case of indecision (I do not know) were treated as missing values.

Table D-1.

Categorical identities of those *against EU accession* in 2001 and 2002

	Categorical identity	2001				2002			
		Adj. resid	% of Respondents	% of **Vote against accession**	Difference (%)	Adj. resid	% of Respondents	% of **Vote against accession**	Difference (%)
Age	18 -35		30.3	28.6	-1.7		34.0	32.1	-1.9
	36 – 55		37.6	30.5	-7.1		36.9	36.4	-0.5
	56 +	3.0	**32.1**	40.9	8.8		29.2	31.6	2.4
Studies	**Maximum 8 grades**	4.1	**30.8**	42.7	11.9	1.8	27.1	32.4	5.3
	High school or equivalent		58.8	55.0	-3.8		62.5	60.9	-1.6
	University		10.4	2.3	-8.1		10.4	6.8	-3.6
Geographic area	Moldavia		20.9	20.5	-0.4	2.0	21.6	26.6	5
	Muntenia		35.3	39.1	3.8		34.5	32.1	-2.4
	Transylvania		33.8	32.7	-1.1		33.2	29.2	-4
	Bucharest		10.0	7.7	-2.3		10.7	12.0	1.3
Residential area	**Rural**	3.3	**43.0**	53.2	10.2		42.5	45.0	2.5
	Urban		57.0	46.8	-10.2		57.5	55.0	-2.5
Marital status	**Widow(ed)**	2.4	**10.4**	15.0	4.6	2.0	9.2	***12.9***	3.7

Notes: [*]Reading example 1: we can say with a probability of 99% that the people belonging to the 'maximum 8 grades' category would rather vote against the accession than those belonging to other educational categories. (The statistical test performed is the adjusted residual value test. For the categories that are **bolded** the p≥0.99; for the categories that are ***italics bolded*** the p=0.95.) [**] Reading example 2: In 2001, 42.7% of the people declaring that "will vote against accession" have 'maximum 8 grades'; within the total population that answered to this question 30.8% had 'maximum 8 grades'; thus we can say that those having 'maximum 8 grades' are overrepresented within the category of respondents declaring that "will vote against accession"

Table D- 2.

Self-identifications of those *against EU accession* in 2001 and 2002

Self identification	2001				2002			
	Adj. resid	% of Respondents	% of **Vote against accession**	Difference (%)	Adj. resid	% of Respondents	% of **Vote against accession**	Difference (%)
Consider that a unic party should exist	3.5	28.6	**40.1**	11.5	4.9	18.7	**31.6**	12.9
Not satisfied with life in general	2.6	74.1	**81.5**	7.4	1.8	64.2	***70***	5.8
Never read papers	2.5	22.5	**29.1**	6.6	4.2	24.1	**35.9**	11.8
never watch week	3.6	6.4	**11.9**	5.5	5.7	6.9	**16.3**	9.4
watch TV few times a week	3.6	10.8	**17.8**	7	2.6	12.3	**17.8**	5.5
Never listen radio		14.8	**17.7**	2.9	3.3	15.5	**23.4**	7.9
Country goes into the wrong direction	6	56.1	**77.5**	21.4	6.4	57.5	**79.2**	21.7
Do not trust other people	4.8	64.4	**80.6**	16.2	2.0	63.9	***70.4***	6.5
income not enough for living	2	41.6	***47.9***	6.3	3.4	31.3	**41.5**	10.2

Table D-3.

Categorical identities of those *voting for EU accession* in 2001 and 2002

Categorical identity		2001				2002			
		Adj. resid	% of Respondents	% of **Vote for accession**	Difference (%)	Adj. resid	% of Respondents	% of **Vote for accession**	Difference (%)
Age	18 -35		30.3	***30.6***	0.3		34.0	34.2	0.2
	36 – 55	2.3	37.6	38.6	1		36.9	36.9	0
	56 +		32.1	30.8	-1.3		29.2	28.9	-0.3
Studies	Maximum 8 grades		30.8	29.1	-1.7		27.1	26.4	-0.7
	High school or equivalent		58.8	**55.0**	-3.8		62.5	***62.7***	0.2
	University	4.2	10.4	11.5	1.1	1.8	10.4	***10.9***	0.5
Geographic area	Moldavia		20.9	20.9	0		21.6	***20.9***	-0.7
	Muntenia		35.3	34.8	-0.5		34.5	34.8	0.3
	Transylvania		33.8	**34.0**	0.2		33.2	***33.7***	0.5
	Bucharest		10.0	10.3	0.3		10.7	10.5	-0.2
Residential area	Rural		43.0	41.6	-1.4		42.5	42.4	-0.1
	Urban	3.3	57.0	**58.4**	1.4		57.5	**57.8**	0.3
Occupation	Intellectual occupations	3.9	8.3	9.2	0.9		12.6	12.4	-0.2
	Clerk	1.6	7.4	7.7	0.3	2.1	8.0	8.7	0.7
Marital status	Not married	3.1	70.7	72.0	1.3		17.2	17.2	0

Table D-4.

Self-identifications of those *voting for EU accession* in 2001 and 2002

Self identification	2001				2002			
	Adj. resid	% of Respondents	% of **Vote for accession**	Difference (%)	Adj. resid	% of Respondents	% of **Vote for accession**	Difference (%)
Disagrees with the idea that a unic party should exist	3.5	71.4	**72.7**	1.3	4.9	81.3	**82.9**	1.6
Satisfied with life in general	2.6	25.9	**26.9**	1	1.8	35.8	**36.5**	0.7
read papers daily	2.4	20.1	**20.9**	0.8	3.0	21.5	***22.5***	1
Watch TV daily		79.3	**81.3**	2	5.2	76.9	***78.6***	1.7
Listen radio daily	3.9	54.9	**56.6**	1.7	3.1	55.6	**59.6**	4
Country goes into the good direction	6.0	43.6	**46.3**	2.7	6.4	42.5	**45.2**	2.7
Trust other people	**4.8**	35.6	37.8	2.2	2.0	36.1	**36.9**	0.8

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MENTAL HEALTH AND UNEMPLOYMENT IN NOWADAYS ROMANIA

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ABSTRACT. Globalisation and regional economic imperatives have led to problems like "not enough work" and even "no work" for an increasing number of people. This paper attempts to highlight the main emotional effects in the manifestation of stress due to unemployment in pre-accession Romania. The core variables are optimism, positive and negative affect, and the main coping mechanisms. Previous results (Baciu, 2008) showed that unemployed persons have higher levels of stress. The present study highlights differences in coping strategies for optimists and pessimists and tries to underline the influence of positive and negative affect on stress management. Data showed that pessimistic persons are using more often mental disengagement, substance abuse, instrumental support and behavioural disengagement.

Keywords: unemployment; emotional effects; optimism vs. pessimism; coping strategies

Introduction

Unemployment became a major social issue during the last 20 years. For an increasing number of people, globalisation and regional economic imperatives led to problems like "not enough work" and even "no work" rather than optimal "healthy-productive" work, although work has been seen as an important element of mental health and in developing one's identity for quite a while (Dollard and Winifield, 2002). There is growing evidence that the negative consequences of these changes are not merely economic, but also psychological, affecting person mental health (Saurel-Cubizolles et al. 2000, Thomas et al., 2005, Joutsenniemi et al., 2006).

Stewart-Brown (1998) highlighted a definition of health adopted by the British Department of Health, which focuses mostly on emotional well-being: "being confident and able to cope with the ups and downs of life" (Stewart-Brown, 1998: 1608).

Exposure to stressors does not necessarily cause health problems for all people. While the experience of stress may be accompanied by feelings of emotional discomfort, and may significantly affect well-being at the time

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being, it does not necessarily lead to the development of psychological or physiological disorders. In cases where the stressor is prolonged, stress may affect health or it may sensitise a person to other sources of stress by reducing their ability to cope. There is accumulating evidence supporting the common assumption about the existence of a relationship among stressors, the experience of stress and poor health (Dollard, 2001).

Losing a job implies not only losing their regular source of income, but also personal ties with workmates, daily structures, and an important sense of self-purpose. Unemployment can be, and often is, a shock to a person's entire system. The unemployed can experience some of the same feelings and stress that somebody would if they were seriously injured, going through a divorce, or mourning the loss of a loved one. Persons can go through some or all of the stages of grieving just as they would in the case of any other major loss. They may be shocked, angry, or deny that anything bad has happened. They will probably worry or feel anxious about how they are going to pay the bills. This can also make them feel frustrated and depressed. Feelings of frustration, anger, hope and excitement will all come and go while the person is looking for a new job.

Jahoda (1979) pointed out the fact that already in 1930s there had been many studies, 112 papers from Central Europe, UK and America, talking about the negative effects of unemployment on health status. Jahoda (1979), as well as Murphy and Athanasou (1999) consider that depressive symptoms are the most frequently considered psychological variables in the study of stress. Many other studies sustain the relationship between employment and mental health, underlying also the relationship between unemployment and higher rates of depression (Rodriguez et al., 1999; Blakely et al., 2003; Agerbo, 2005; Zimmerman and Bell, 2006).

Harvey Brenner (1979) directed his attention towards the estimation of the strain produced by unemployment. He investigated how indicators of national economic performance relate to measures of strain like deaths related to cardiovascular disease, psychiatric hospitals admission rate, suicide rate, alcohol-related disease rate. He found that the rates of these health problems increase sharply during periods of economic decline.

Cummins et al. (2005) stated that very bad self-rated health significantly correlates with six neighbourhood attributes, among which high rates of unemployment. In the same year, van Lenthe et al. (2005) conducted a study in which the degrees of correlation between neighbourhood unemployment rates and all cause mortality were compared across samples from six countries (United States, Netherlands, England, Finland, Italy, and Spain). Their results indicate the existence of associations between neighbourhood unemployment and all causes of mortality (van Lenthe et al., 2005). The linkage between material deprivation and mortality from various causes was also supported by the studies of Ocana-Riola et al. (2008).

Other recent studies highlight the idea that job insecurity is a predictor for decline in health-status (Benach and Muntaner, 2007, Rugulies et al., 2008).

The correlation between high unemployment rates and ill health remains strong enough to justify the use of high unemployment rates as a predictor for the number of psychiatric beds (Bellaby and Bellaby, 1999, Murphy and Athanasou, 1999). The relationship was examined in several longitudinal studies relevant to the claim that a change to one's employment status affects one's mental health. The studies conclude that there are reasons to believe that job loss, on average, affects the mental health of the unemployed but we still need to examine the extent of it.

Corporate restructuring, acquisitions and merges, and structural changes in the nature of work itself have led to many downsizing and company closings over the past decade. These changes were accompanied by the increasing research interest for the problem of job-loss. If in the past full employment was the "official reality" for state-socialist Romania, nowadays unemployment is a "worrying reality", as Brown (2007) stated for post-communist countries after 1990.

The present article is a follow-up to a previously published study of the author on stress predictors for the employed and unemployed in pre-accession Romania (Baciu, 2008).

Research design, objectives and hypotheses

The general objective was to compare the particular aspects of stress management in the case of unemployed persons and those employed.

A specific objective was to measure the emotional reactions to job loss, and the ways of coping with stress for both the employed and the unemployed.

Working hypotheses:

(1) Optimism determines more action-oriented stress management strategies while pessimism leads to rather passive stress management strategies for both unemployed and employed people;

(2) Positive and negative affect influences stress management strategies used by unemployed.

Research methodology and participants

We selected 269 unemployed people registered at the County Unemployment Agency in Cluj (North-West Romania) in June 2006, and 191 employed people who agreed to participate in the research. All the interviews of the unemployed people took place at the County Unemployment Agency[1].

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[1] A detailed presentation of participants and instruments can be found in C. Baciu, 2008, Stress Predictors for the Employed and Unemployed in Pre-Accesion Romania, *Studia Universitatis Babeş-Bolyai*: *Sociologia*, 1:18-37

Research instruments and variables

We measured stress with the help of the *Perceived Stress Questionnaire* elaborated by Levenstein et al. (1993).

The *Life Orientation Test* (LOT) elaborated by Scheer and Carver (1992) measured optimism level.

For the analysis of stress management strategies we used brief COPE, elaborated by Carver (1997).

For negative and positive affect we used PANAS-X, elaborated by David Watson and Lee Anna Clark (1994).

Results and discussion

The prior results of the study, reported elsewhere (Baciu, 2008) showed some differences in using behavioural disengagement and acceptance in favour of unemployed and venting , substance abuse and self-blaming for employees. No significant difference was found in the use of planning.

No statistically significant differences were registered between unemployed persons and those employed regarding the use of other stress management strategies: mental disengagement, active coping, denial, and use of emotional support, of instrumental support, of positive reframing, of planning and religion (Baciu, 2008). As expected, empirical results indicated that unemployed persons face higher levels of stress than the employed. At the same time, no significant differences were found in the level of optimism (Baciu, 2008). No differences were registered in the measures of negative affect, but there was a significant difference regarding the positive affect, which was on average higher for those employed.

Westman, Etzion and Horovits`s (2004) study focuses on the crossover of state anxiety between spouses in *working couples* in Israel, when one of them faces unemployment. Findings demonstrate that on both occasions, the economic hardship was a positive predictor of anxiety for both the unemployed and their spouses and social support was in inverse ratio to their anxiety.

Although we did not find any significant difference on negative affect to support the hypothesis that unemployment stress determines/increases emotional problems (Baciu, 2008), a previous study indicates that depression symptoms can become an issue when talking about job loss (Baciu, 2003). In the case of unemployed persons, 46% showed to different degrees symptoms of depression, out of which 6.5% were severely depressed.

Despite the importance attributed to coping as a factor in psychological and somatic health outcomes, Folkman et al. (1986) consider that there is not enough evidence about actual coping processes, the variables that influence them, and their relation to outcomes of stressful encounters that people experience in their day-to-day lives.

As mentioned before, in the previous study on *stress management strategies* (Baciu, 2008), we found that both the unemployed and those in employment were using planning as strategy. There were also no significant differences concerning mental disengagement, active coping, and denial, or appeal to emotional support, instrumental support, positive reframing, and religion. The unemployed were using significantly more frequently behavioural disengagement and acceptance, whereas the employees were using more frequently venting, substance abuse, humor, and self-blaming as coping strategies (Baciu, 2008). We found a negative correlation between stress level and positive affect and a positive correlation with negative affect, for both the unemployed and the employees. These results converge with the findings of previous researches (Billings et al., 1983, Cutrona and Troutman, 1986, Monroe et al., 1986). Consequently, our data validates that different positive and negative affects have the same pattern of correlation with stress for both unemployed and employed people (Baciu, 2008: 30).

Several studies highlight that optimism and pessimism generate different coping mechanisms. More precisely, the optimistic persons are apparently using an active coping style, and they are problem oriented, while the pessimistic persons use more frequently emotional coping (e.g. Scheier, Wentraub, Carver, 1986). Folkman, Lazarus, Dunkel-Schetter, DeLongis, and Gruen (1986) define coping as "the person's constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (Folkman et al., 1986: 993). Lazarus and Folkman (1984) discuss two coping strategies: problem focused and emotion focused. Leana and Feldman (1994) consider that individual differences in response to job loss stem from the fact that some individuals may react in a passive manner, while others respond more proactively, searching for a new job, staying physically active, enrolling in retraining programs etc.

In our study, we obtained for the unemployed positive correlations between optimism and the following coping styles: active coping (r= .174, p=0,01), positive reframing (r= .363, p=0,01), planning (r= .220, p=0,01) and humor (r= .224, p=0,01). There were negative correlations between optimism and mental disengagement (r= -.134, p=0,05), denial (r= -.190, p=0,01), substance abuse (r= -.155, p=0,05), behavioural disengagement (r= -.265, p=0,01) and self-blaming (r= -.124, p=0,05). We found no significant correlations between optimism and the use of emotional support, of instrumental support, venting, planning, acceptance and religion (see Table 1).

For employed persons, optimism positively correlates with active coping (r= .225, p= 0,01) positive reframing (r= .451, p= 0,01), planning (r= .279, p= 0,01) and humor (r= .206, p= 0,01). Optimism negatively correlates with: mental disengagement (r= -.237, p= 0.05), denial (r= -.328, p= 0.01), substance use (r= -.145, p= 0,01) and behavioural disengagement (r= -.296, p= 0,01) (see Table 2).

Table 1.

Optimism correlation with coping styles for the unemployed

	Active coping	Planning	Positive reframing	Acceptance	Humor	Religion	Using emotional support
Pearson's r	-.134*	.174**	-.190**	-.155*	.045	-.023	-.265**
Sig. (2-tailed)	.028	.004	.002	.011	.462	.705	.000
No. of cases	269	269	269	269	269	269	269
	Using instrumental support	Self-distraction	Denial	Venting	Substance abuse	Behavioural disengagement	Self-blame
Pearson's r	-.086	.363**	.220**	.224**	.097	-.008	-.124*
Sig. (2-tailed)	.158	.000	.000	.000	.112	.894	.042
No. of cases	269	269	269	269	269	269	269

** Correlation is significant at p= 0.01; * correlation is significant at p= 0.05

Table 2.

Optimism correlation with coping styles for employed persons

	Active coping	Planning	Positive reframing	Acceptance	Humor	Religion	Using emotional support
Pearson Correlation	-.237**	.225**	-.328**	-.145*	.007	-.051	-.294**
Sig. (2-tailed)	.001	.002	.000	.045	.923	.483	.000
No. of cases	191	191	191	191	191	191	191
	Using instrumental support	Self-distraction	Denial	Venting	Substance abuse	Behavioural dis-engagement	Self-blame
Pearson Correlation	-.026	.451**	.279**	.206**	.061	-.127	-.123
Sig. (2-tailed)	.717	.000	.000	.004	.404	.080	.089
No. of cases	191	191	191	191	191	191	191

** Correlation is significant at p= 0.01; * Correlation is significant at p= 0.05

If we analyse the results presented in Tables 1. and 2. we notice that coping styles that correlate positively with optimism, are the same for the employed and the unemployed: active coping, positive reframing, planning and humor. As far as negative correlations are concerned, results show that optimism negatively correlates with mental disengagement, denial, substance use and behavioural disengagement, for both populations. Only for the unemployed there is also a significant negative correlation between optimism and self-blaming.

To test the hypothesis that optimists and pessimists use different coping strategies we split the participants (N=460) into two categories according to their optimism level. We calculated the indicators of central tendency for the level of optimism and we obtained the mean value of 28.12 and a median of 29.

Table 3.

Optimism level *(N=460)*

Mean	28.12
Median	29.00
Mode	29.00
Standard Deviation	5.05
Minimum	14.00
Maximum	40.00

We considered pessimistic those who had a level of optimism under 29 (N= 217) and optimistic those with level equal to 29 or higher than 29 (N=243). The next step was to test the significance of difference between optimists and pessimists regarding the coping strategies adopted. Using the Chi-Square test, we obtained significant differences for mental disengagement (p=0.01), substance use (p=0,015), use of instrumental support (p=0.02) and behavioural disengagement (p=0,00) in favour of the pessimistic. Coping strategies like venting (p=0.04) and humor (p= 0,00) were significantly more often used by optimists. Planning as a coping strategy is the only one used by all pessimists and optimists.

These results indicate that the use of more active stress coping strategies by optimist persons as compared to the pessimists, who appeal more often to passive coping strategies, is somewhat explained by the fact that pessimists adopt more frequently mental and behavioural disengagement.

Table 4.

Optimism/pessimism and coping styles

	Strategy is missing	**Strategy is present**	**Total**
	Mental disengagement		
Pessimism	1	216	217
Optimism	10	233	243
	11	449	460
	Substance use		Total
Pessimism	156	61	217
Optimism	198	45	243
	354	106	460
	Use of instrumental support		Total
Pessimism		217	217
Optimism	6	237	243
	6	454	460
	Behavioural disengagement		Total
Pessimism	82	135	217
Optimism	153	90	243
	235	225	460
	Venting		Total
Pessimism	16	201	217
Optimism	8	235	243
	24	436	460
	Humor		Total
Pessimism	54	163	217
Optimism	21	222	243
	75	385	460

Note: Figures indicate number of cases.

The data has not revealed any significant difference in the use of active coping between pessimistic and optimistic persons, although the Chi-Square test indicated that optimistic persons tend to use more active coping than pessimistic ones, the value of significance was not adequate (p=0,06).

Table 5.

Optimism/pessimism and active coping

	Strategy is missing	Strategy is present	Total
	Active coping		
Pessimism	3	214	217
Optimism		243	243
	3	457	460

Analyzing the correlations between negative and positive affect and the stress management strategies, we obtained the following results for unemployed people:

- *mental disengagement* correlates with negative affect (r= .253, p=0,01);
- *active coping* correlates with positive affect (r= .175, p=0,01)
- *denial* corelates with negative affect (r= .253, p=0,01)
- *substance use* correlates with positive affect (r= -.206, p=0,01)
- *instrumental support* corelates with positive affect (r= .154, p=0,05)
- *behavioral disengagement* correlates with negative affect(r= .251, p=0,01) and positive affect (r= -.153, p=0,05)
- *venting* corelates with positive affect (r= .178, p=0,01) and also with negative affect (r= .139, p=0,05)
- positive *refraiming* correlates with negative affect (r= -.127, p=0,05) and positive affect (r= .226, p=0,01)
- *planning* correlates with positive affect (r=.207, p=0,01)
- *humor* correlates with positive affect (r= .133, p=0,05)
- *acceptance* correlate with positive affect (r= .244, p=0,01)
- *self-blaming* correlates with negative affect (r= .215, p=0,01).

We can observe that there are significant correlations between *positive affect* and active coping, instrumental support, venting, positive reframing, planning, humor and acceptance. Those results suport the idea that persons` positive affect enhances the use of the more „desirable" stress management strategies. The results also show that persons with positive affect tend to appeal less to substance use and behavioral disengagement as coping strategies.

Negative affect significantly correlates with mental disengagement, denial, behavioral disengagement, venting, and self-blaming. The only negative correlation was between negative affect and positive reframing. It is confirmed also here the idea formulated by Lazarus and Folkman (1984) that persons with higher negative affect are prone to pasive coping, and to using emotion-oriented coping strategies.

It is important here, as it was in the study on the influence of optimism on stress management stratesies, that positive affect is strongly related to coping strategies that we can consider „positive", „desirable" more than „action oriented".

An interesting observation is that venting correlates significantly with both positive and negative affect. We can conclude that persons who report high emotional effect on stress, no matter if these are positive or negative, will use frecquently this type of emotion-oriented coping.

There were no significant relations between emotional support and religion as coping strategies and positive and negative affect.

Conclusions

All jobs generate strain to some degree. However, the analysis of the differences between those in employment and the unemployed points out that the level of stress is significantly higher in the case of the latter.

Coping is considered an important part of the stress process. It is usually viewed as a complex set of processes that may moderate the influences of stressful life events on the individual’s physical and mental health (Billings and Moos, 1981; Folkman and Lazarus, 1986; Lu and Chen, 1996).

Scheier, Weintraub and Carver (1986) found significant positive correlations between optimism and problem-focused coping, seeking of social support, and emphasizing positive aspects of the stressful situation. Pessimism, in their study, was associated with denial, disengagement from the goal which a stressor was associated with.

Our study revealed that pessimists use additional passive coping strategies, among which mental and behavioural disengagement, but also substance use. The optimists use significantly more often venting and humor.

When talking about coping strategies/mechanisms, we have to bear in mind that the defence mechanisms are considered as being unconscious and designated a priori as maladaptive, while the coping strategies are considered as consciously chosen and responsive to environmental demands. However, DSM-IV (American Psychiatric Association, 1994) orders the major types of defence mechanisms hierarchically from less to more adaptive. Among the most maladaptive ones is denial, while highly adaptive defence mechanisms include, among others, humor. Cramer (2000) compared the similarities and differences between defence mechanisms and coping styles and stated that defence mechanisms are nonintentional, unconscious, associated with pathology, while coping processes are conscious, used intentionally and associated with normality.

Although there is a general understanding of the coping process as a normal and flexible response to environmental demands, which depends on personal preferences, there are studies pointing out that some coping strategies are associated with poor outcomes. For instance, Aldwin and Revenson (1987) consider that avoidance, withdrawal and substance use lead to poor outcomes. Similarly, we stated in our study that mental and behavioural disengagement and substance use, used by pessimistic persons, are less “desirable” and with less successful outcomes.

Following Lazarus and Folkman (1984), we consider that the processes by which people cope with stress have three parts: primary appraisal, secondary appraisal and coping, and that these processes do not necessary follow a linear sequence. We also agree that an outcome of one of the process may re-invoke a preceding process as Carver et al. (1989) stated. This means that, after realizing that a coping strategy is available, a person can feel optimistic and he can reappraise the stressor as being less threatening. This gives her/him more confidence in the positive outcome of her/his coping strategy. In another situation, from a pessimistic perspective, due to a less effective coping response, a person can reappraise the level of threat or the appropriate coping strategy. Seeing these processes as cyclical, we can acknowledge the importance of optimism in determining the choice of certain coping strategies and the success of their outcomes.

There are also results in our study showing that persons with positive affect tend to appeal less to substance use and behavioral disengagement as coping strategies.

The conclusions do not undermine the importance of work, given that employment (even bad jobs) can provide latent benefits, such as a time structure for the waking day, regular contact with people outside the nuclear family, involvement in shared goals, a sense of identity and enforced activity Jahoda (1982). We can consider that having secure employment in favorable working conditions greatly reduces the risk of healthy people developing limiting illness. On the other hand, as Bartley and Clarke (2004) concluded, secure employment increases the likelihood of recovery from illness.

Although the experience of joblessness is attributable to a wide variety of circumstances, it is apparent that unemployment is commonly a serious threat to health and the general quality of life.

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