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HEALTH – THE MOST IMPORTANT DIMENSION OF LIFE QUALITY? A RUMANIAN CASE STUDY

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In the last decade's literature it has become clear that in order to adequately understand people's quality of life it is necessary to use a set of indicators as different as possible. They have to include not only the global indicators, but also aspects that concern households, families and personal life, including the subjective dimension of current conditions, the degree of satisfaction felt as well as dissatisfaction and frustration. The idea of approaching health as a social phenomenon is on the ascendancy. One should not forget the fact that the social welfare of the population is often a precondition of somatic health. Neglecting or ignoring the social pathology aspects inherent to a society (unemployment, poverty, high crime rate, different family dysfunctions, alcoholism, etc.) or treating them in isolation, any health strategy shall only partially reach its major objective, the improvement of the population's health status. Although health reforms aim to increase the quality of health services, to raise the health status of the population, to reduce health disparities, Rumania had the lowest life expectancy among the ten East and Central European countries that applied for EU membership before 2004. The incidence of tuberculosis decreased until the mid-80s and then started to increase again. More than a decade after starting the reforms in the economic and social areas, and five years after beginning experimenting with the social health insurance system, Rumanians are most afraid of disease.

Keywords: health insurance, health perception, health status, health system, life quality, reform, subjective well-being, transition

Gesundheit – die wichtigste Dimension der Lebensqualität? Betrachtet man die Veröffentlichungen des letzten Jahrzehnts, so wird deutlich, dass man für ein adäquates Verständnis von der Lebensqualität des Menschen eine Reihe möglichst unterschiedlicher Indikatoren benötigt.

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Diese müssen außer den globalen Elementen auch andere Aspekte wie zum Beispiel Hausstand, Familie, Privatleben sowie die subjektiven Projektionen des aktuellen Zustandes, den Grad der Zufriedenheit und wohl auch den Grad der Enttäuschung und Frustration berücksichtigen. Die Sichtweise von Gesundheit als eine zentrale soziale Erscheinung findet zunehmend Akzeptanz. Man kann und darf nicht außer Acht lassen, daß das soziale Wohlergehen der Bevölkerung Voraussetzung für ihr körperliches Wohlbefinden ist. Jede Gesundheitsstrategie wird ihr Ziel, die Sicherung der Gesundheit, zum Teil verfehlen, wenn sie isoliert agiert und die sozialen Probleme der Gesellschaft, wie Arbeitslosigkeit, Armut, hohe Kriminalitätsrate, familiäre Belastungen, Alkoholismus usw. ausblendet oder ignoriert. Obwohl die rumänische Gesundheitsreform sich zum Ziel gesetzt hatte, die Qualität der medizinischen Versorgung und den Gesundheitszustand der Bevölkerung zu verbessern und die Widersprüche im Gesundheitssystem zu beseitigen, hat Rumänien die niedrigste Lebenserwartung unter den zehn Mittel- und Osteuropäischen EU-Betrittskandidaten vor 2004. Die Inzidenz der Tuberkulose nahm bis Mitte der achtziger Jahre ab und steigt seither wieder an. Nach einem Jahrzehnt der Reformen im ökonomischen und sozialen Bereich sowie fünf Jahre nach der Einführung der Sozial- und Krankenversicherung haben die Rumänen mehr als alle anderen Angst vor Krankheiten.

Schlüsselbegriffe: Gesundheitssystem, Gesundheitsversicherung, Gesundheitswahrnehmung, Gesundheitszustand, Lebensqualität, Reform, subjektives Wohlbefinden, Übergang

1. Introduction

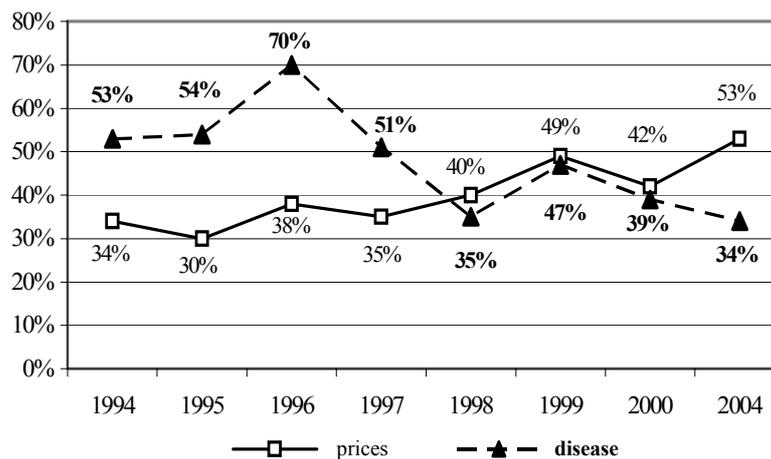
When the object of discourse, regardless of its nature, is the exhaustive concept of life quality, common sense suggests the concept of well-being. The quality of life depends on the harmonious and simultaneous satisfaction of all human necessities: health, civilised life conditions, economic security, supportive and positive interpersonal relationships, a rationally organised society based on liberty, democracy and constructive morality, etc. Good quality of life is an inherent condition of individual and collective well-being. When referring to health as a basic element of life quality, it is sufficient to reiterate the definition of health given by the World Health Organization: health is 'not merely the absence of disease or infirmity' but 'a state of complete physical, mental and social wellbeing' (*Declaration of Alma-Ata* 1978, 1). A health-related quality of life suggests the appreciation of the physical, emotional and social aspects of health and disease.

The idea of approaching health as an essentially social phenomenon is becoming more and more important. We should bear in mind that the population's social well-being represents a condition of somatic health. Neglecting or ignoring the social pathology aspects inherent to a society (unemployment, poverty, high crime rate, different family dysfunctions, alcoholism, etc.) or treating them in isolation, any health strategy shall only partially reach its major objective, the improvement of the population's health status. Social and political disintegration, low social stability, the deterioration of the public health system, high unemployment and/or migration rates, alcoholism, and delinquency are just a few of the factors included in the notion of 'social stress'

(SUNDIN & WILLNER 2004). Social and economic exclusion are negative for the welfare and health of the population in a given social context. Economy, social structure and collective actions interact and mutually depend on each other.

2. Arguments

After 1989 numerous opinion polls and specialised studies showed a sharp drop in the health status of the population and in the quality of medical services in Rumania. Faced by the need to improve and make changes in the social policy area, during a period characterised by major changes in the economic, political, social, and cultural fields, Rumania was confronted with the necessity to reform and to revise the health care system. More than a decade after starting the reforms in the economic and social areas, and five years after beginning experimenting with the social health insurance system, Rumanians are most afraid of disease. *Figure 1* illustrates this development, in comparison to the fear of prices; prices and disease clearly being the two greatest fears of the population in Rumania.¹



Source: OSF 2004b. 'The Public Opinion Barometer' program was founded by the Open Society Foundation in 1994.

Figure 1

What are Rumanians most afraid of? Rumanians' disease perception during 1994–2004

¹ Other variables taken into consideration when assessing Rumanians' fears were crime, unemployment, a war in the area, social troubles, their children's future (this variable was introduced in 1998). The interviewees could choose only two options. The data confirms that even in the past few years when disease was overtaken by prices, it was mentioned as one of the first options.

The present paper wishes to systematically present the following aspects: the developments in the health system in Rumania after 1989, the reference points for the health status of the Rumanian population and Rumanians' perception of health. All these aspects try to provide an answer to the question why more than five years after officially starting the reform in Rumania, the worst fear of Rumanians is disease.

3. Developments in the health care system and the state of health after 1990: An overview

3.1. Health care reforms: A brief survey

The reforms which started in Rumania after 1990 have redefined the fundamental role of the state in every sector (economic, social, and political). The transition towards a market economy from a centralised economy was accompanied by a series of oscillating choices in economic and social policy decisions. Their lack of coherence and consistency was to influence the reforms' stability, progress and temporal distribution. The same characteristics have also marked the reform of the health care system. Those responsible for political decisions had to cope both with the perennial aspects of the past, with their weaknesses and strengths, and with the costs that the transition involved, most of the time higher than expected, and which the population was insufficiently informed to cope with.

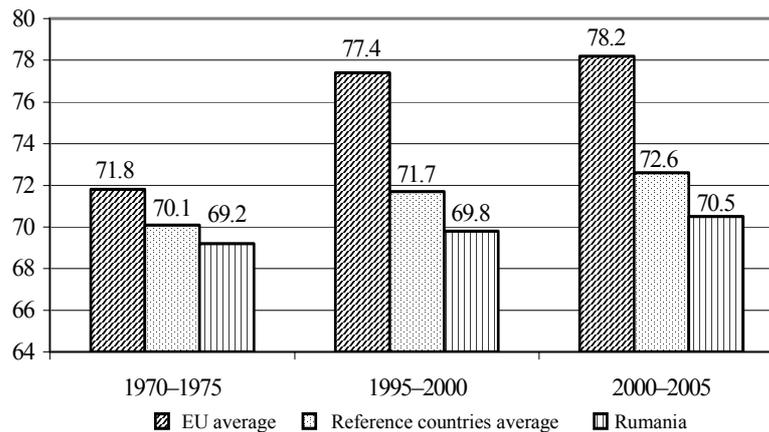
The idea of an insurance system appeared in Rumania in the post-revolutionary period, pressed for by doctors and as a consequence of the total rejection of the communist regime. The population was still unaware of the advantages and disadvantages of the different financial and organisational models of the health care system. Several years passed before an insurance-based model was enacted in the country's legislation, and important changes occurred in the status and behaviour of the main actors of the health care system during the intervening time. Although offering a high level of accessibility of services, the Rumanian health system was inefficient, poorly managed and underequipped. In 1997 a social health insurance law was passed that marked a structural and functional change in financing the Rumanian health care system. A model predominantly financed through general taxes was replaced with a model based on obligatory insurance contributions. Still, such contributions were not effectively collected before 1999. In 2002 the government issued Urgent Ordinance No. 150 which, effectively replacing previous legislation, settled the organisation and function of the present social health insurance system. The new regulations came into effect in 2003. There are some differences between the two texts (Law No. 145/1997 and Urgent Ordinance No. 150/2002), the latter being even more complex and leaving less room for interpretation.

The health insurance system is based on the principles of subsidiary and solidarity in collecting and using the funds, the principles of free choice of physician and

insurance organisation by the patient, the principles of equality and indiscriminate access to services. A new law (No. 212/2004), providing for private health insurance, was enacted in 2004, but it was not put into practice, and the health insurance fund had no administrative autonomy. The Nicolaescu reform (Law No. 95/2006), also called the new reform of the health care system, reorganises the entire Rumanian health care system, taking into consideration the same principles, but with a more liberal application, emphasising the individual's responsibility for their own health and their contribution to the costs of health insurance, by announcing voluntary insurance schemes and promising effective implementation. At present, it is being introduced, coming into full force in 2007.

3.2. Aspects of the population's health status in Rumania

Social and economic changes during the transition period strongly influenced the demographic situation and the health status of the Rumanian population. Although during the past few years serious efforts have been made to improve the population's state of health and to assure appropriate medical services, one cannot talk about a serious improvement. Rumania had the lowest life expectancy among the reference countries, and also compared to the EU average (*Figure 2*).²

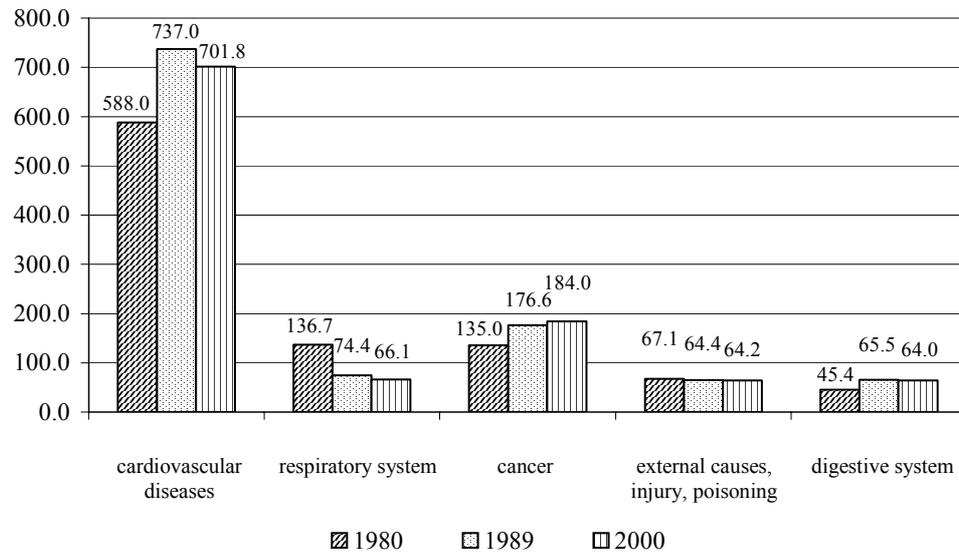


Source: *Human Development Report 2001*, 141–44 and *Human Development Report 2003*, 262–63.

Figure 2

Life expectancy at birth (in years) in the EU, reference countries, and Rumania between 1970–1975, 1995–2000, and 2000–2005

² By 'reference countries' I mean the ten Central and Eastern European candidate countries for accession to the EU before 2003: Bulgaria, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Rumania, Slovakia, and Slovenia.



Source: *Anuar de statistică sanitară* 2001, 30–31.

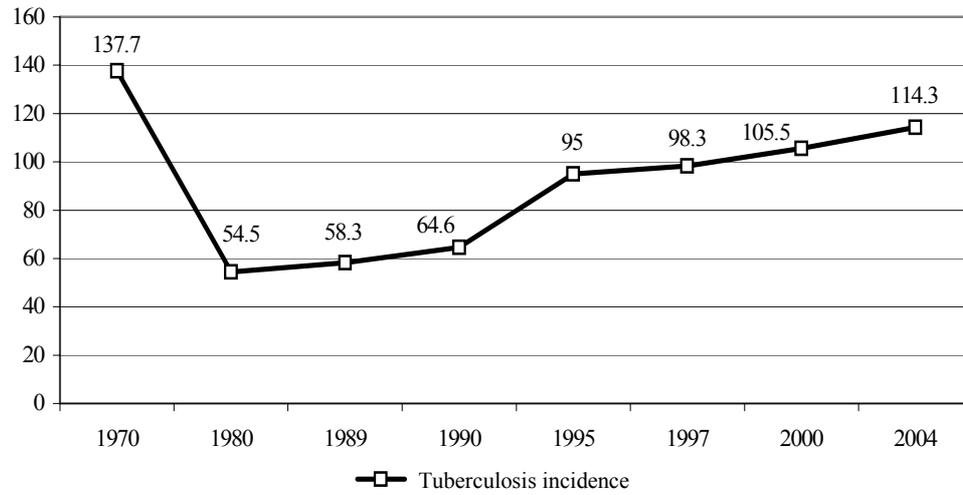
Figure 3

Structure of mortality by main causes of death in 1980, 1989, and 2000 (per 100,000 inhabitants) in Rumania

In Rumania the main causes of death are cardiovascular diseases and cancer (*Figure 3*). Cardiovascular diseases and cancer are also the most frequent causes of death in the reference countries. The infant mortality rate has decreased in almost all reference countries since 1985. Even though Rumania's infant mortality rate dropped by 49.4‰ to 16.8‰ by 2004, Rumania still had the highest rate among the reference countries (*Anuar de statistică sanitară* 2004, 50–51 and 312). The morbidity table is structurally similar to that of other European states, but the rates continue to be high in comparison to the EU. Thus, the most important causes of death, morbidity and incapacitation are the diseases of the circulatory system. The resurgence of tuberculosis in the last years (*Figure 4*), considered a social disease, can be directly attributed to the decrease of living standards, caused by a stagnant economy and higher inflation. *Figure 4* shows the evolution of tuberculosis incidence for children 0–14 years of age.

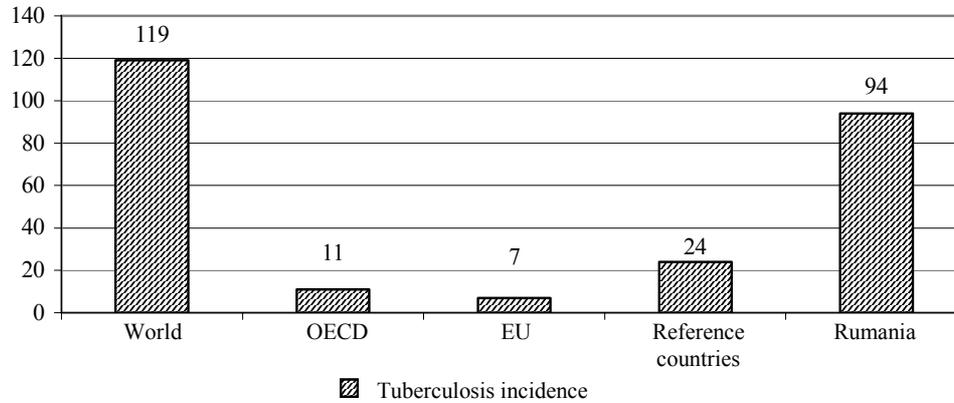
The tuberculosis incidence in Rumania is almost nine times as high as that registered for the OECD states and almost four times as high as that registered in the reference countries (*Figure 5*).

While syphilis incidence is decreasing in Europe in general, in Rumania the situation is exactly the reverse; the incidence of the disease is increasing (*Anuar de statistică sanitară* 2004, 76–77 and 321). Possible explanations for this trend are connected on the one hand to the lack of basic knowledge among the population regarding the ways of transmission, and on the other hand to the lack of information about the importance of contraception (condom use) in the case of sexual contact with multiple



Source: *Anuar de statistică sanitară* 2004, 68–69.

Figure 4
The tuberculosis incidence dynamics in Rumania during 1970–2004
(new cases per 100,000 inhabitants)



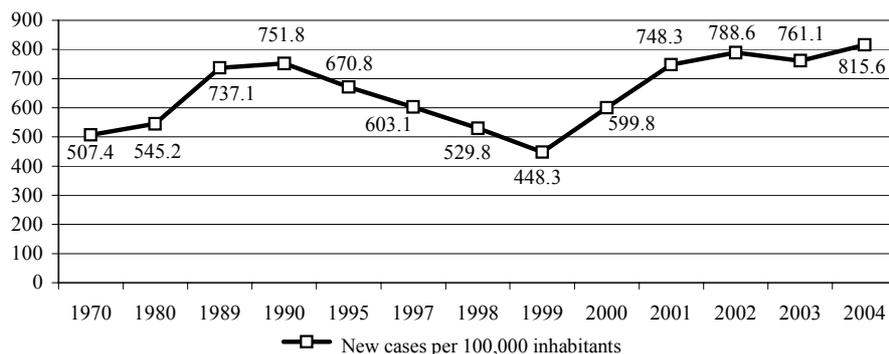
Source: *Human Development Report* 2003, 213–16.

Figure 5
Comparison of tuberculosis incidence in 2001 (new cases per 100,000 inhabitants)

partners, and also to the proliferation of prostitution and the failure of its control by the authorities.

Turning to the dynamic of psychic diseases in Rumania, studies reveal some significant trends during the 20th century. Psychosis (predominantly exogenous) showed a significant increase until the sixties, after which the numbers decreased. Following an increase in the first decade after the Second World War, psychosis (predominantly endogenous) showed a stable tendency after 1955. On the other hand, depression in children and women increased. The morbidity of psychic diseases increased between 1959 and 1965. The number of new cases of psychic diseases has been higher since 1990, even though there was a visible tendency of incidence decrease between 1970 and 1990. It is important to note the incidence increase over the last four years, during which the values exceeded the data for 1990 (*Figure 6*).

The risk factors (in the context of transition, mainly the social ones) implied in the etiology of psychical diseases need only to be alluded to: it is well known that they can generate an increase in the number of psychic disease cases (the absence of an adequate emotional frame which is associated with personality disturbances in the case of orphans, abandoned children or who come from a disorganised family, with persons over 65, with an increased risk of a senility, with a high rate of unemployment among the adult population, with the deterioration of life conditions as a consequence of poverty, etc.).



Source: *Anuar de statistică sanitară* 2004, 140–41.

Figure 6

The dynamics of mental disorder incidence during 1970–2004

3.3. Perceptions and expectations

The population's expectations after 1990 were high for all areas of life, including health. As regards satisfaction or dissatisfaction with the state of health, after 1997 (the year when the social health insurance system was introduced), the situation was as follows.

Table 1
The Rumanian population's degree of satisfaction with the personal state of health during 1998–2004 (%)

		1998	2001	2002	2003	2004
<i>Your health</i>	<i>satisfied</i>	45	52	49	53	51
	<i>not satisfied</i>	49	48	51	41	49

Source: OSF 1998, 2001, 2002, 2003b, 2004b. The missing percentages (to add up to 100%) represent non-responses and those who replied with 'I don't know'.

In 2005, 18% of the Rumanian population stated that their own state of health was bad; 7% said that it was very bad; 27% said it was satisfactory; 38% responded that it was good, and 10% responded that it was very good (CPSS 2005). The perception of the state of health according to age, income and residence area is presented in *Table 2*.

Table 2
The perception of the health status of the Rumanian population according to age, income and living environment, in 2005

<i>Variable</i>		<i>Good + very good</i>	<i>Satisfactory</i>	<i>Bad + very bad</i>
<i>Age</i>	55+ years	25	32	43
	35–54 years	48	29	17
	18–34 years	72	19	8
<i>Income</i> ³	High	57	17	3
	Average	49	30	21
	Below average	40	30	30
<i>Residence area</i>	Urban	53	27	20
	Rural	41	28	31

Source: CPSS 2005, 5. The missing percentages (to add up to 100%) represent non-responses and those who replied with 'I don't know'.

³ According to the source cited, high income is equal to 5,000,000 Lei (€138) per capita and above, average income is between 3 and 4.9 million Lei (€83–€137), and below 3 million I combined what the CPSS considered low and very low income, renaming the group 'below average wage'. At the same time, in 2005 the minimum wage specified by law was 3,300,000 Lei (€92), the net average wage was 7,370,000 Lei (€205). The Euro/Lei conversions are based on the average currency exchange rate for 2005.

The inequalities in the perceptions of the health status are visible. The correlation between income and the state of health is frequently mentioned in the literature: low income is more frequently associated with a precarious health status. A higher proportion of the population who has a below average income perceives the state of health as 'bad' or 'very bad', confirming the presupposition. The fact that 43% of the over 55 population perceives the situation as bad or very bad, and in comparison to other age groups only a small proportion feel it is good or very good, is partially explained by the demographic profile of the Rumanian population. The socio-economic data for Rumania indicates a higher share of elderly persons in rural areas than in urban areas, as well as a higher poverty rate and a greater number of families with three or more children in rural areas (REBELEANU 2005).

As regards the perception of access to health services, the situation is this. In 2002, 77% of respondents declared that they had easy access to a primary care physician. In 17% of the cases the office of the primary care physician is in another locality, and among these in 8% of the cases the doctor's office is located over 20 km away. This kind of situation is more frequent in rural areas than in urban ones because of the lack of personnel in such areas, and sometimes because of transportation difficulties. In approximately 70% of the cases, people mainly approach their primary care physician with requests, regardless of age, residence area, or income. Still, access to other medical services is different than to those available through the primary care physician's offices. The data is presented in *Table 3* according to age, education, living environment and income.

Table 3
Access to medical services other than those offered by the primary care physician

<i>Variable</i>		<i>Easy access (%)</i>	
		<i>Yes</i>	<i>No</i>
<i>Education</i>	University degree	74	26
	High-school diploma	79	21
	Elementary school	64	36
<i>Age</i>	55+ years	71	29
	35–54 years	74	26
	18–34 years	73	27
<i>Income</i>	Above average	80	20
	Below average	68	32
<i>Residence area</i>	Urban	77	23
	Rural	65	35

Source: CPSS 2002, 72, 93, 103 and 109.

In the Public Opinion Barometer of November 1998 (a year after the publication of the social health insurance law) (OSF 1998) the following question was introduced: ‘In order to be properly treated, is it or is it not necessary to offer “presents” (money, products, or services)?’ Several institutions were listed to contextualise the question: court, city hall, police, school, hospital, and the work place. 30% of respondents answered ‘yes, sometimes’, and 37% answered ‘yes, always’ when mentioning hospitals. For the rest of the institutions the share of similar responses varied between 8% and 18%. At the same time, based on residence area, the hospital was placed first, ahead of other institutions (*Table 4*).

Table 4
Distribution of those offering ‘presents’ in order to be properly treated (%)

<i>Residence area</i>	<i>Yes, always (%)</i>	<i>Yes, sometimes (%)</i>	<i>No (%)</i>
<i>Urban</i>	42	29	23
<i>Rural</i>	3	31	32
<i>Total</i>	37	30	27

Source: OSF 1998.

In the following years hospitals continued to receive the highest share of informal payments from the population in order to obtain proper services. The arguments predominantly used in justifying the practice include habit, better care from doctors, showing gratitude, ensuring a better relationship in the future. The medical personnel asked for a ‘present’ only in a very small number of cases (4%).⁴

The Public Opinion Barometer of May 2003 and that of October 2004 (OSF 2003a and 2004b, respectively) provide an overview of how Rumanians regard the use of informal payments. They corroborate the above findings: a very high frequency of informal payment in healthcare in comparison to public administration, the juridical system, and the educational system. The frequency of informal payment is higher among those who are well connected or know somebody in the medical system for such relationships do not replace informal payment but are only another guarantee for the quality of care. With regard to age, persons under 30 are the most prepared to offer informal payments to medical personnel: half of them paid more than the legally sanctioned price for health care received in comparison to approximately a third in the other age groups (CPSS 2002, 78; OSF 2004a). It is no exaggeration to recognise a kind of legitimacy of informal payments in the public opinion. 28% of Rumanians consider that it is normal to ‘give the doctor or the nurse a small present because they have treated you well’ – a rate twice as high as in the case of presents for superior, over three times higher than in the case of presents for teachers and over four times

⁴ CPSS 2005, 27–30.

higher than in the case of payments to police officers (OSF 2004b). Offering presents to a doctor in order to get special attention has a share of 37.3% and people do not associate this with corruption (CPSS 2005, 37).

According to the results of the poll carried out by CPSS in 2005, a great number of respondents do not have sufficient information about the health care system. 79% of the respondents do not know what is included in the package of services, and 69% do not know what percentage of their income is retained as a contribution to the health insurance system. In order to benefit from supplementary services in addition to the basic package, 52% consider that the state should pay supplemental insurance for each citizen, 18% consider that those who need these services should pay an official tax, 9% consider that each citizen should pay insurance contribution to some private insurance organisation, and 2% think that those who want these kind of services should offer presents. In comparison to the previous years, it is important to note the decrease in the percentage of those who hold the state responsible for supplemental health insurance. It is worth recalling that Rumania is currently poised to introduce voluntary health insurance. The population's readiness to pay supplemental health insurance is higher for persons between 18–34 (13%), but the difference is not marked from the group aged 35–54 or from those over 55 (9% and 7% respectively). Persons with a high income are more willing to pay supplemental insurances than those with a low or average income. In terms of residence area, persons living in urban areas are more willing to pay a supplementary contribution than those in rural ones. One problem of the present system is the occasionally poor access to health services, yet 56% of the people questioned are not willing to pay supplementary taxes for faster and better quality services. The persons who are less willing are those over 55, those living in rural areas, and those with an income below the average (CPSS 2005, 48). Of the health care system in Rumania, 46% think that 'there are good parts in the present system, but fundamental changes are needed for a better functioning', 31% hold that 'the Rumanian health care system functions so badly that radical change is needed', 14% find that 'in general the system functions rather well and needs only small modifications that will make it function better'.⁵ Beyond all these details, the overarching fact remains: one of the greatest fear of Rumanians in 2004 was disease, and the situation did not change in 2005.

4. Subjective well-being versus objective development

A retrospective analysis of the assessment of the subjective well-being from the point of view of the population's possibilities to manage their income is indispensable. The last ten years show an increase in the percentage of those who consider their house-

⁵ The rest of the respondents gave no answer, or they 'did not know'.

hold income insufficient even for the bare essentials of life, and also a high percentage, with values maintained between 36% and 42%, of those who see their income sufficient only for the essentials of life. The share of those who declare that their income is sufficient for a decent living, but without buying expensive objects, decreased in 2004 in comparison to 1995.

Table 5
Self-evaluation of the living standards during 1995–2004

%	1995	1996	1997	1998	1999	2001	2002	2003	2004
<i>We manage to have everything we need without sacrifices.</i>	1	1	1	2	1	1	1	1	1
<i>We manage to buy some expensive objects, but we have to limit other things.</i>	9	5	7	8	3	3	3	5	4
<i>We have enough for a decent living, but we cannot afford expensive objects.</i>	23	23	23	22	15	14	16	17	14
<i>We have no more than is necessary.</i>	36	38	40	37	42	38	34	39	40
<i>We do not have enough even for the necessary objects.</i>	31	33	29	31	39	44	45	36	39

Source: OSF n.d., 1998, 1999, 2001, 2002, 2003a, 2004a. The missing percentages (to add up to 100%) represent non-responses and those who replied with 'I don't know'.

After 1990 (especially between 1990 and 1992, and 1997 and 1999) the Rumanian economy had a severe decline, seen in the predominantly negative dynamics of the main macro-economic indicators. Since 2000 the trend has been positive, but the Gross Domestic Product has still not reached the level of 1989. The country's economic performance continues to be modest. Inflation, devastating for many years, has been on the decline only since 2001. The hidden economy is very significant, having a share of approximately 40% of the GDP according to some unofficial estimates (POPESCU 2004, 59–82). Between 1990 and 1995 both income and employment significantly decreased. The legal minimum wage lost 52% of its 1989 value while the depreciation of the average wage was 31%. The average pension lost a portion of its value both against its 1989 level and against the average wage. The decrease was more drastic for farmers, whose pension was inferior to social welfare (CASPIIS 2003, 7–8). In 2000 the average monthly income per capita represented a little over three fourths of the 1995 income. Thus, the inequality is emphasised with the increase of the real level of income, and the employee status no longer guarantees a decent living. In families with social welfare income, the situation is even more dramatic.

5. Final remarks

Romania's economic and social evolution during the transition period has strongly influenced the demographic situation and health status. Although there has been a great effort in the last years to improve the population's health status and to provide adequate medical services, the health problems have not shown signs of significant amelioration. Romanians' fear of disease is part of their larger insecurity concerning income, living standards and life in general. It is more accentuated among the population with economic vulnerability (low wages, social welfare income) but there is also a vulnerability connected to a dependence on medical services (those suffering from chronic diseases, those who regularly have to buy medicines, etc.). The concern caused by dependence upon health services is becoming ever more visible in the perceived legitimacy of informal payments for health care personnel, especially for society's most vulnerable members (the old, the poor, families with more than three children). Moreover, statistics show that for most people who offered presents in 2004 (over 50%) this action represented a financial effort or the renunciation of certain goods and services (CPSS 2005, 33).

Health status as a dimension of life quality is decisively influenced by how society constructs its standard of decent living and how it structures its values. The continuous rise of living expense, not sustained by a progressive economic growth, significantly contributes to the continued existence or growth of income inequalities, and, consequently, to the decline of the population's purchasing power and, especially, consumption. Inevitably, a series of modifications appear in people's habits, to the detriment of a healthy life style (alimentary habits, stress management, extent and use of free time, etc.). Increase in the prices of medicine, difficulty in accessing medical services, the loss of faith in their quality (see the arguments for offering presents), the uncertainty of employment under conditions of the market economy are just a few of the aspects that have an impact on the quality of life and on the population's health status. The prevalence of some chronic afflictions which imply higher risk factors, and the incoherence and inconsistency of policy decisions in organising the health care system have surely taken their toll as indicated by the morbidity table of Romania, characterised by morbidity and mortality indicators higher than the EU average. On the whole, the combined effects of those influences have resulted in the population's shrinking capacity to cope with pressures of everyday life, transition stress and its inevitable costs. For all social actors, the real costs of the changes since 1989 have been higher than estimated. We shall have to see to what extent the prevailing conditions following Romania's accession to the EU in 2007 shall influence the current main fears of the Romanians (disease and prices).

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