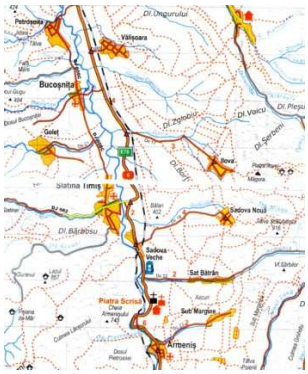
Being healthy or free to choose for a healthy life?
How the capability approach improves health.
Social Map Slatina-Timis
Influence of ADAMSlatina-Timis as social-medical center.



Slatina-Timis is a comune in the county of Caraș-Severin, Romania. Slatina-Timis consistes of 4 villages: Ilova, Sadova Nouă, Sadova Veche and Slatina-Timiș.

VZW GEELS ROEMENIËKOMITEE

ACTIE DORPEN ROEMENIË
ADR - VLAANDEREN

The Open network for community development
A Romanian - Flemish Initiative

Version 20170307

Content

1. Purpose of this social map

The purpose of this social map is to bring together information about Slatina-Timis in order to find out the needs of the local community. This paper can be used as a base for the development of new projects and activities in the future. The data mentioned in this paper are building on and using the data of the case study conducted by Bogdan Ileanu, Adrian Pană, Cristina Vladu and Ioan Suru in 2016. While the case-study is looking to health statistics and the level of being healthy, this paper is using another complementary approach. By adding the concept of the capability approach and other kind of data, this paper opens pathways for projects for improving the freedoms of persons to choose for a healthy life.

2. Introduction

The right to the highest attainable standard of health is commonly accepted as a fundamental right of every human being and being able to have good health is considered one of the core capabilities.

The right to health includes timely access to comprehensive, quality health care services. Access to care is important to ensure health equity and to improve or redress health for each individual. Universal health coverage, requiring large investments of collective resources, is a means to promote the right to health. To ensure universal health coverage, health systems provide a specified package of benefits to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes.

It should be noted that the health status of a population does not only depend on the efficacy of healthcare systems. Policies that address the socio-economic determinants of health, including quality of housing and working conditions can have a more important impact on population health than clinical care services. Also policies aimed at improving quality of water, air and food or improvements in road design can have an important effects on population health.

Health coverage has three dimensions:
1. the share of the population entitled to publicly financed health services,
2. the range of health services covered,
3. the extent to which people have to pay for these services at the point of use.

Although most European health systems provide nearly universal population coverage to a wide range of benefits, people with low income and vulnerable groups do in most countries have more difficulties to obtain access to care. At the same time, vulnerable and marginalized groups in societies tend to bear an undue proportion of health problems and thus have more healthcare needs. Financial access to care can be hindered by user charges. But also non-financial organizational features of a health system can present obstacles for access to care. These include distance to care, language or culture and waiting times. Some health systems fail to properly cover non-contributing groups, such as unemployed people and most EU countries do not provide comprehensive protection for undocumented people.

Social investment in the health sector thus should both address the obstacles in access to care, with a particular attention to protecting vulnerable groups, and address the underlying causes of ill health through a health in all policies approach.

The main philosophy of ADAMSlatina-Timis is the promotion of health in all policies approach by combining community development, citizens involvement, solidarity and a democratic governance. The already mentioned case study about the impact of ADAMSlatina-Timis on the health (status) of citizens of Slatina-Timis brings together data about the evolution of health regarding different health indicators. Measuring health can be done in different ways. Mostly the data are focused on what is achieved and less on what the possibilities are for people to live a healthy life. This social map focuses more on the second aspect. Next paragraphs compare these 2 approaches.

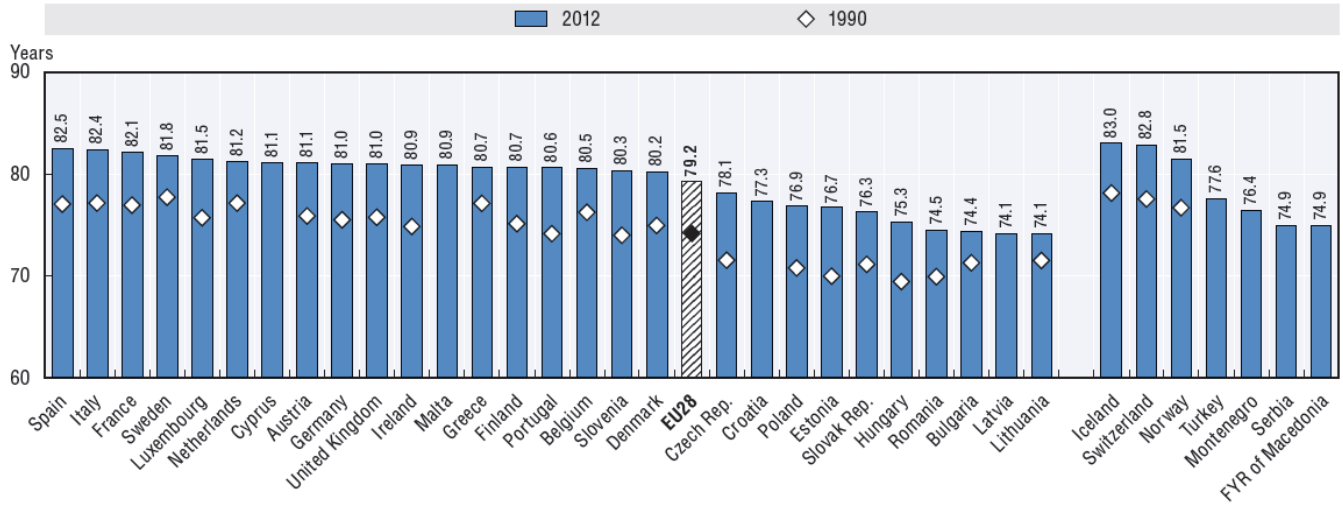
2.1. Measuring the health status

Different methods of measuring health and health status were developed. In our analysis of healthcare access and quality, we rely primarily on the following sources of comparative data:
the European Quality of Life Survey (EQLS)
the EU Statistics on Income and Living Conditions (EU-SILC)
WHO, Evaluation of structure and provision of primary care in Romania, 2012
Health Consumer Powerhouse, Euro Health Consumer Index 2015
European Observatory on Health Systems and Policies, Romania: Health System Review, 2016
European Observatory on Health Systems and Policies, Building primary care in a changing Europe, 2015
OECD, Haelth at a Glance: Europe 2014

Life expectancy and mortality

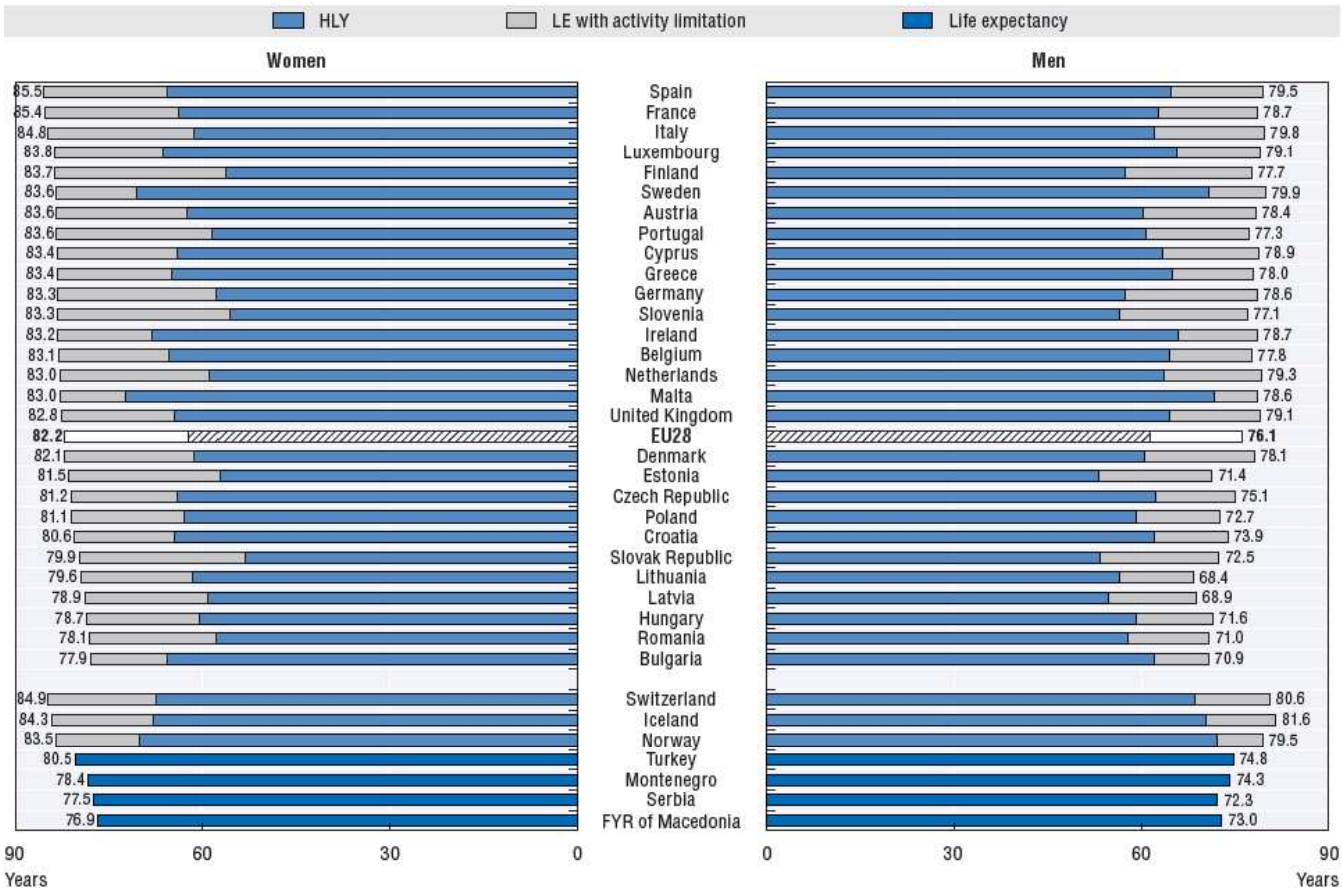
One approach is looking to the life expectancy and mortality. A study from 2014 conducted by the OECD gives some very interesting data on the European level.[1] The following graphics give an insight in this by comparing European countries.

1.1.1. Life expectancy at birth, 1990 and 2012

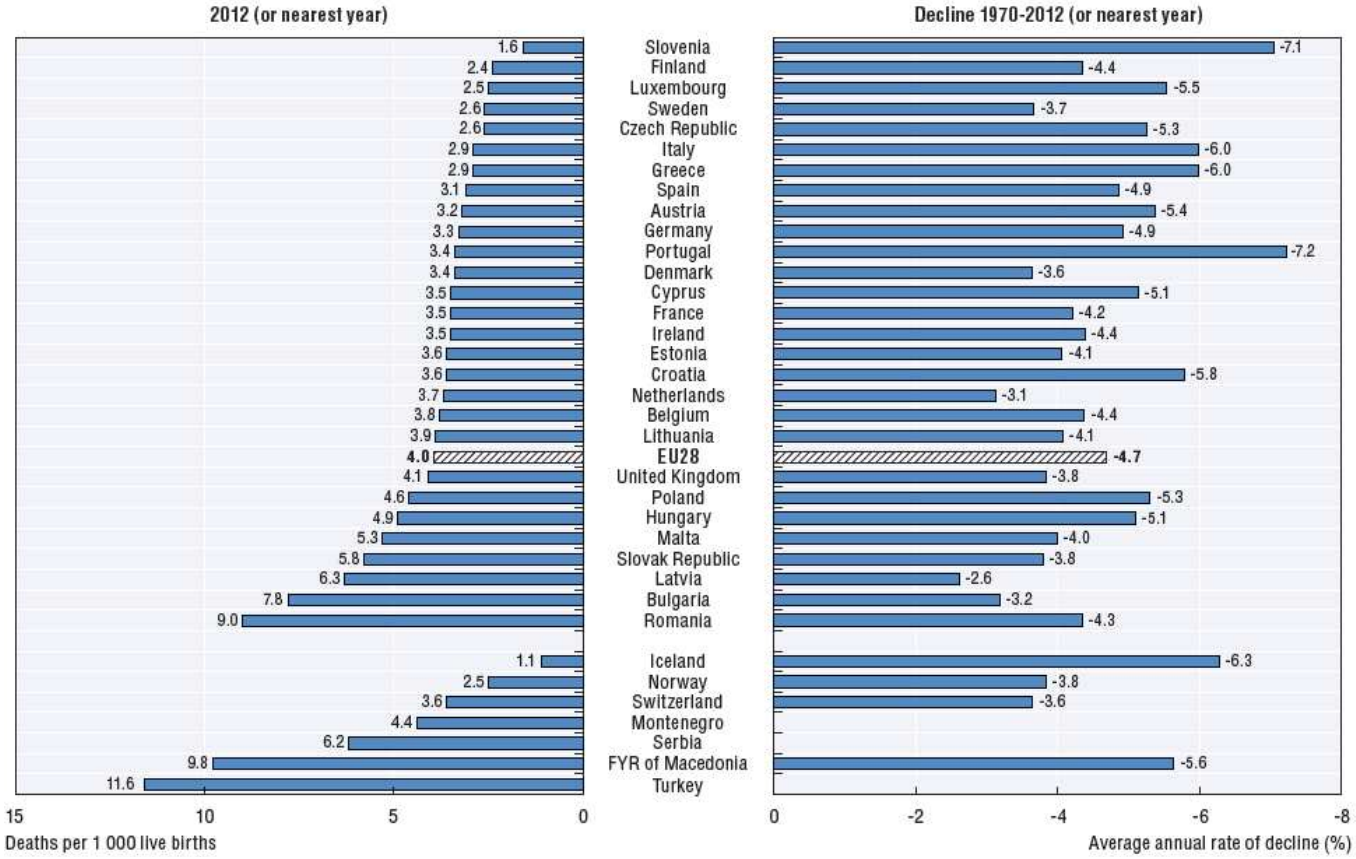


[1] OECD (2014), Health at a Glance: Europe 2014, OECD Publishing. http://dx.doi.org/10.1787/health_glance_eur-2014-en

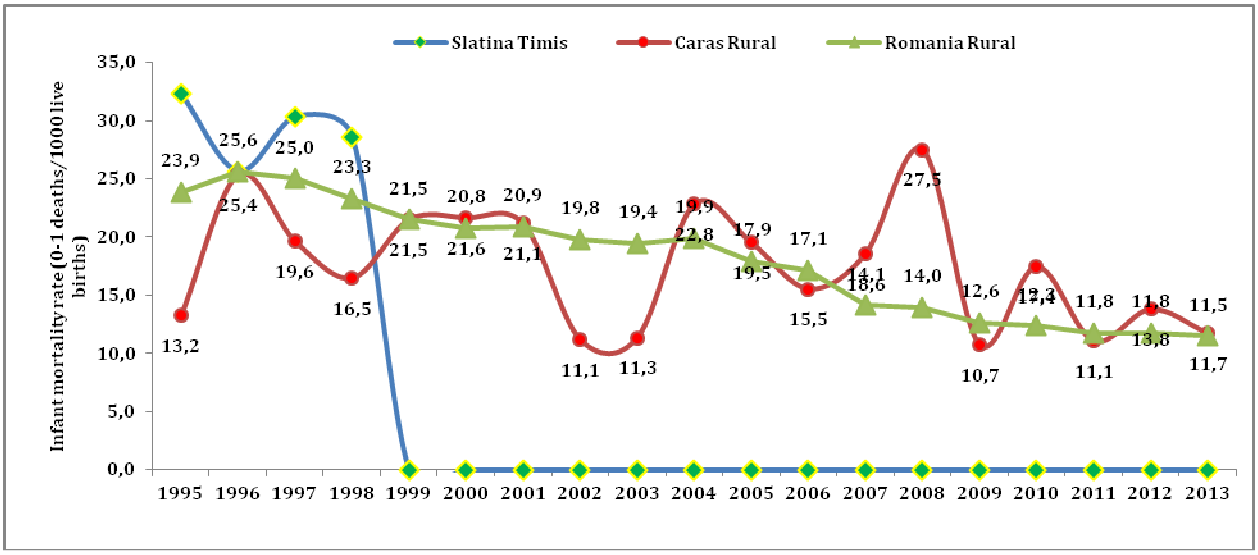
1.1.2. Life expectancy (LE) and healthy life years (HLY) at birth, by gender, 2012



1.8.1. Infant mortality rates, 2012 and decline 1970-2012



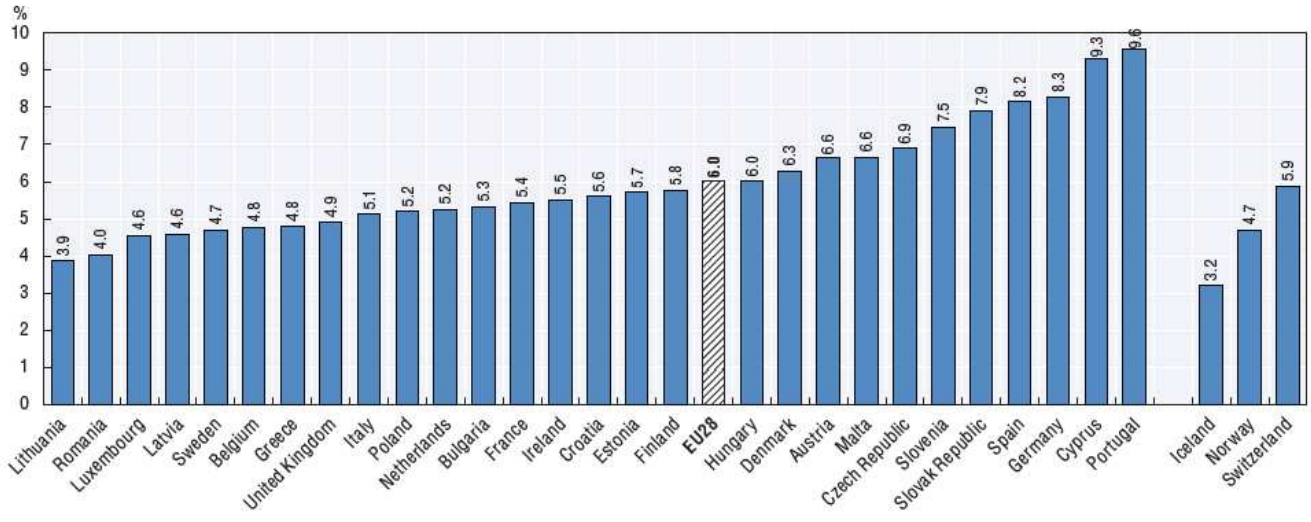
These data show that Romania is at the last quarter of the European ranking. With an infant mortality rate it is at the last place of the European Member States ranking. The Slatina-Timis case study conducted by Bogdan Ileanu, Adrian Pană, Cristina Vladu and Ioan Suru shows that Infant mortality in this community, although high during the first four years of observation became "zero" starting with 1999 and is still maintained at this level in contrast with district rates that is 11.7/1000 live births.



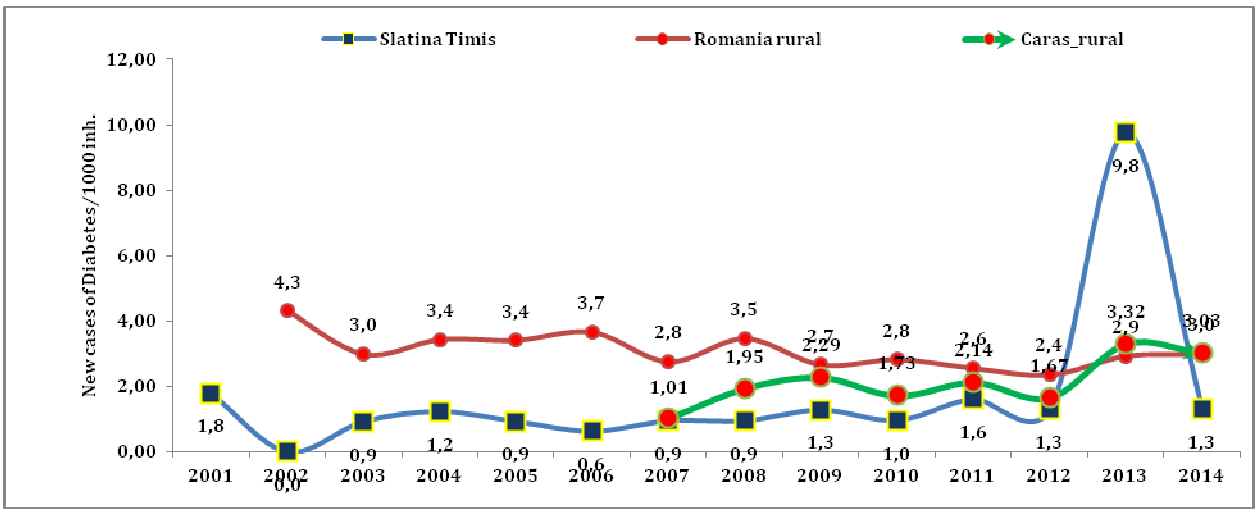
Incidence of diseases

The incidence and prevalence of diseases can be an indication of the health status of a community. In this social map we only give the example of diabetes: first on the European level and then for Slatina-Timis.

1.14.1. Prevalence estimates of diabetes, adults aged 20-79 years, 2013

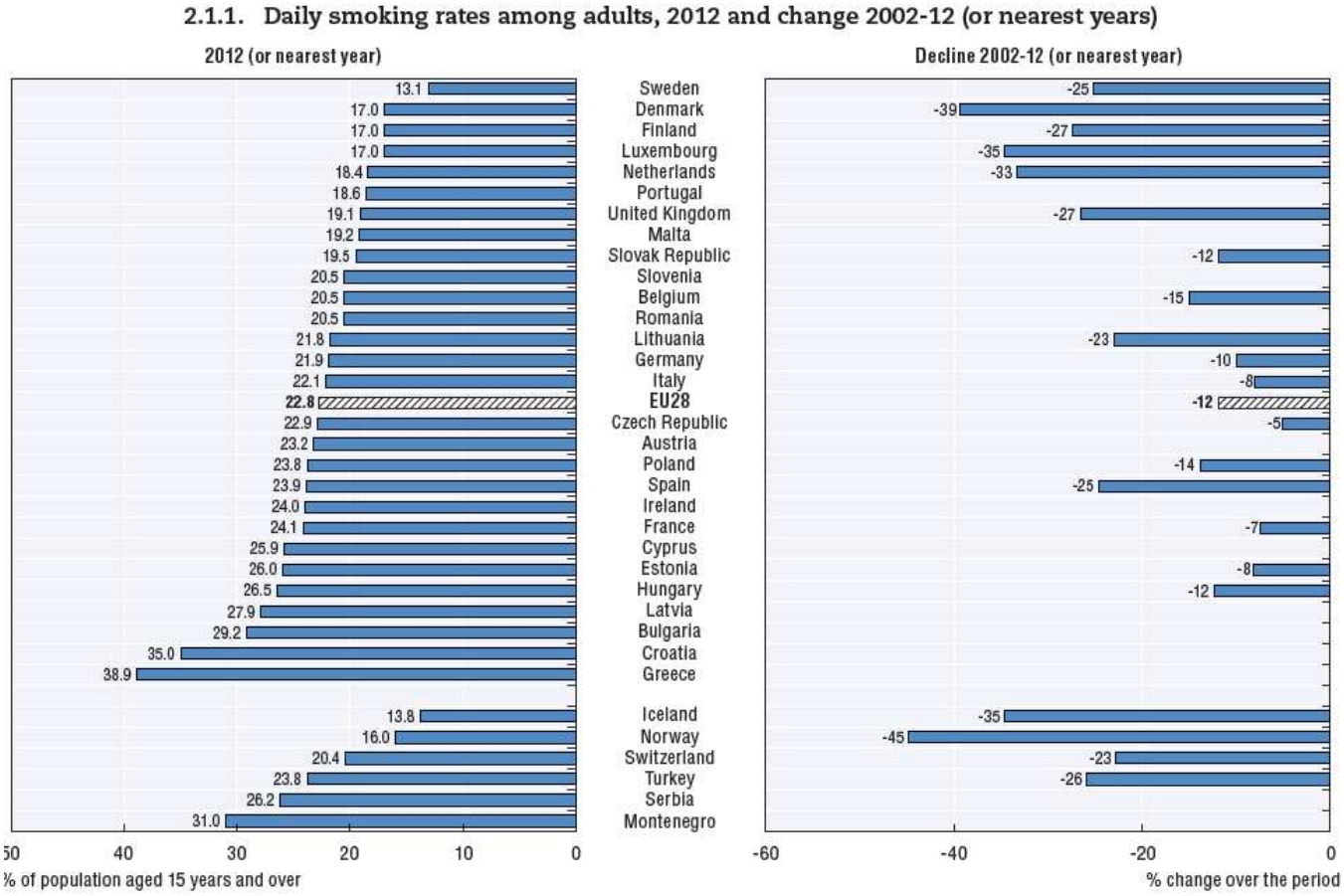


The incidence of diabetes in Slatina-Timiș is in general under the national rural average and also under the county rural average. However, noticeable during the last period of time there is an increase of incidence at all levels: national, county and Slatina-Timiș, with a visible „outlier" at the level of Slatina-Timiș in 2013. This pattern could be explained either through active surveillance provided at that particular period in time or a problem in reporting.

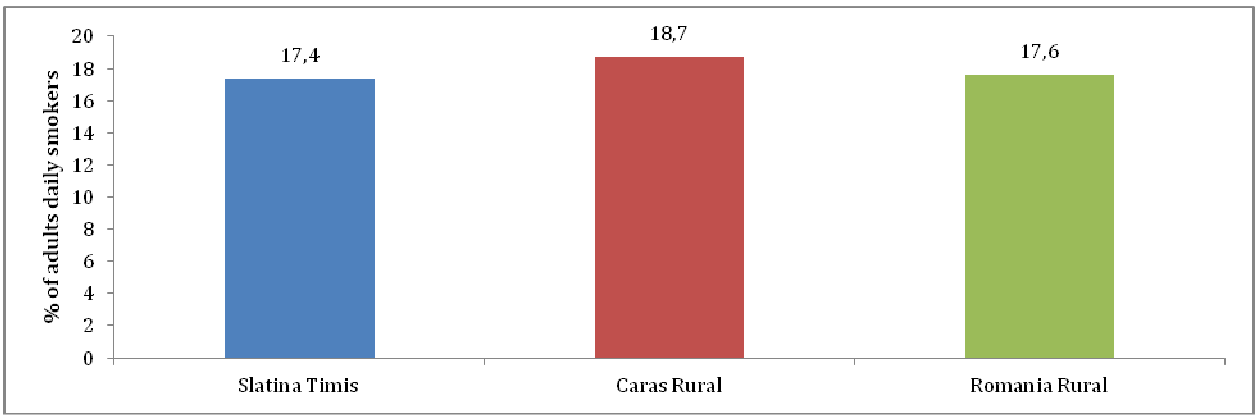


Determinants of health

A healthy lifestyle clearly influences the health status. Also for this category an example.



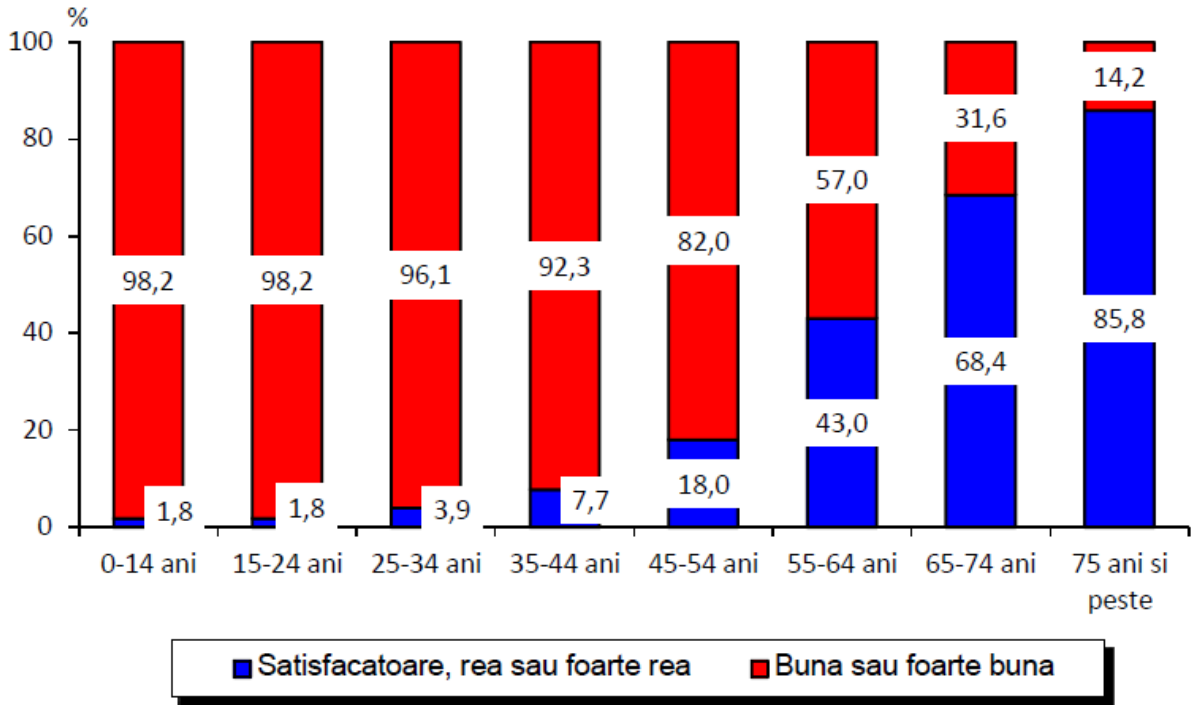
Slatina-Timis is following the Romanian trend.



Self reported health

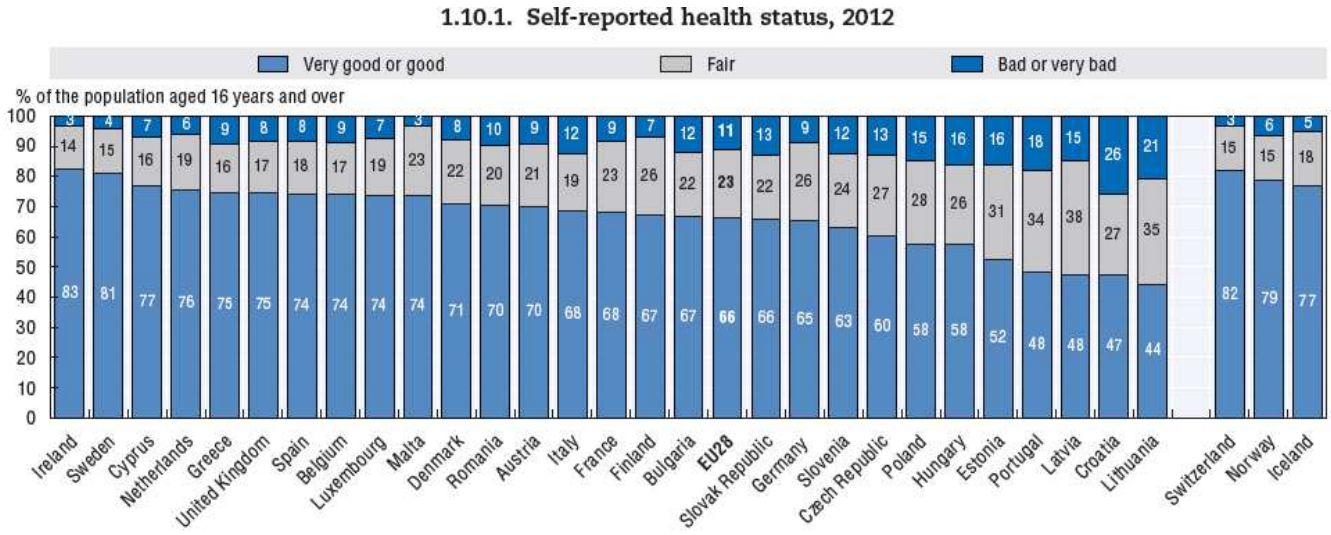
Now-a-days a very popular way of measuring health is how people think there health status is. In other words: how people feel. A recent study conducted by the Romanian National Institute for Statistics shows that until the age of 54 a big majority of people declares to be in good health. For the age category 55-64 this is half. From 64 on more and more people feel they are in no good health condition.[2]

Populaţia rezidentă după starea de sănătate declarată, pe grupe de vârstă (%)



[2] Starea de sănătate percepută în anul 2014 de populația din România, Comunicat de presa, INSEE, 15/12/2015.

Comparable data are given by the OECD study “Health at glance 2014: Europe”.



These data are very subjective and the risk is that people resign themselves into a situation. These statistics don’t say something about the real health status.

2.2. The Capability Approach: are we able / free to choose for a healthy life?[3]

Amartya Sen criticized this way of thinking in achievements and subjective feelings of health. The above mentioned data are focused on what we have or what we think we have. Sen developed the capability approach to have a better understanding on what we are able to achieve. The difference between capabilities and functionings can be defined as: “a functioning is an achievement, whereas a capability is the ability to achieve”. Functionings are, in a sense, more directly related to living conditions, in other words what we are. Capabilities are notions of freedom, in the positive sense: what real opportunities you have regarding the life you may lead”. In other words: what we are able to do or to choose. An example illustrates what the difference means: 2 people both of whom are starving – one without any alternative (since the person is very poor) and the other out of choice (since the person is very religious in a particular style). Their functioning achievements in terms of nourishment may be exactly similar, but both are undernourished. One is fasting and the other is not. It is the person without alternative (the one who is not voluntarily fasting) who has a limited set of capabilities. Nussbaum indentifies the following 10 central human capabilities: **life**; **bodily health**; bodily integrity; senses, imagination and thought; emotions; practical reason; affiliation; other species; play; and control over one’s environment. Although all 10 capabilities, closely related to the implementation of fundamental human rights, are important, this social map focuses on the first 2 capabilities mentioned in bold:

- ✓ Life: being able to live to the end of a human life of normal length; not dying prematurely, or before one’s life is so reduced as to be not worth living.
- ✓ Bodily health: being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.

In the case of health: capabilities and functionings usually tend to overlap, because if someone has the opportunity to achieve them if they have to choose, he will probably choose them. An important aspect in this

[3] Nussbaum, M., Women and human development: the capabilities approach. Cambridge New York: Cambridge University Press, 2000. Nussbaum, M., Beyond the social contract: capabilities and global justice, In: Oxford Development Studies, 2004, 32(1), p. 3–18.
Robeyns, I., The Capability Approach: a theoretical survey, In: Journal of Human Development, 2005, 6 (1), p. 93-114.
Sen, A., Equality of what?, In: S. McMurrin (Eds.), The Tanner Lectures on Human Values, Salt Lake City, Utah, 1980.

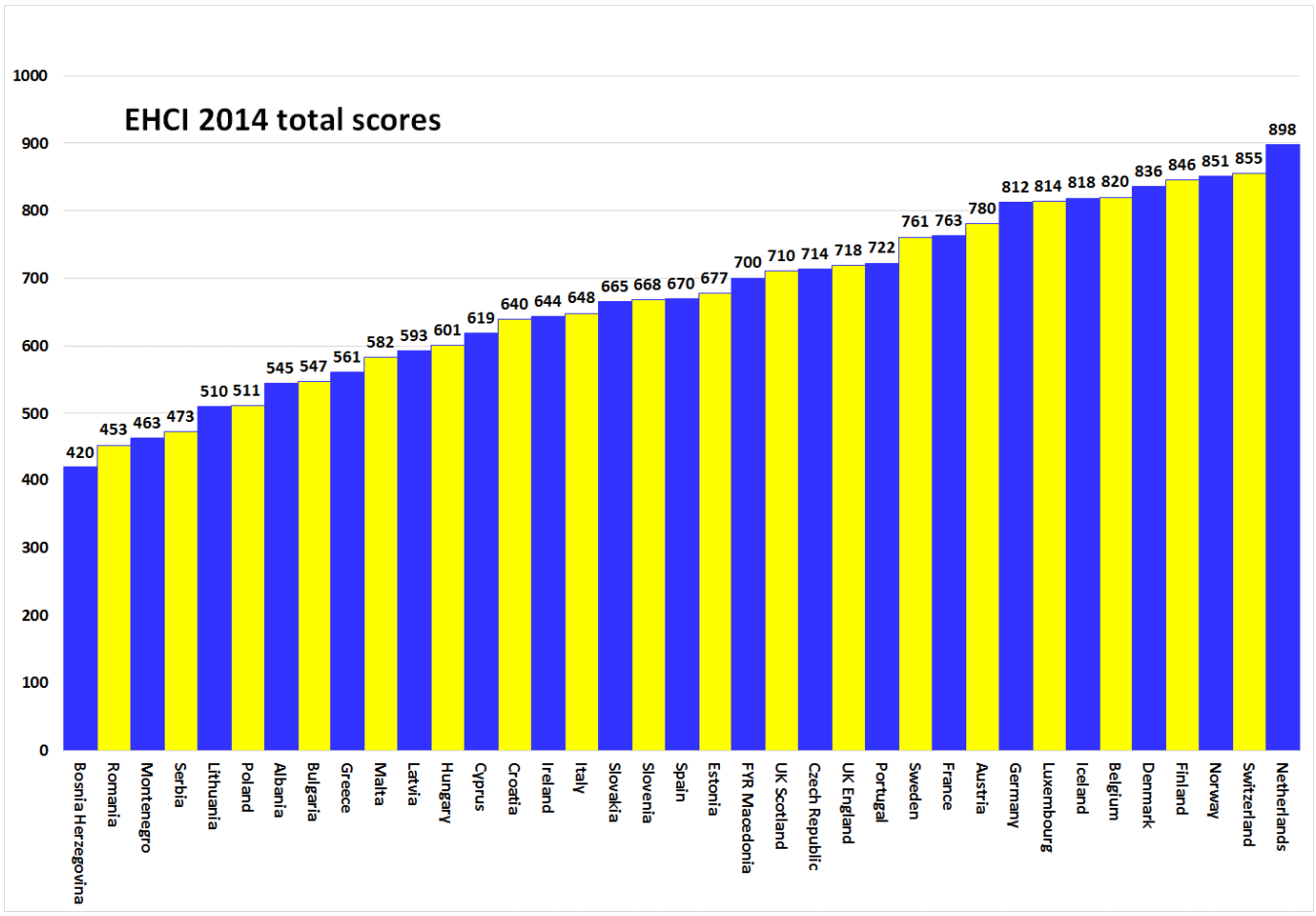
idea of capabilities is that having goods or services is necessary but not a guarantee for a healthy life. Or "we can bring the horse to the water, but not forcing it to drink". Conversion factors play an important role in the transformation of goods into freedoms of choice. The relation between a good and the functionings to achieve certain beings and doings is influenced by three groups of conversion factors. First, personal conversion factors (metabolism, physical condition, sex, reading skills, intelligence) influence how a person can convert the characteristics of the good into a functioning. Second, social conversion factors (public policies, social norms, discriminating practices, gender roles, societal hierarchies, power relations). And third, environmental conversion factors (climate, geographical location) play a role in the conversion from characteristics of the good to the individual functioning. An example makes it clear: a bicycle increases the mobility of people. But if a person is disabled or in a bad physical condition or has never learned to cycle, then the bicycle will be of limited help to enable the functioning of mobility. If there are no paved roads or if a government or the dominant societal culture imposes a social or legal norm that women are not allowed to cycle without being accompanied by a male family member, then it becomes much more difficult or even impossible to use the good to enable the functioning.

Taken the capability approach as conceptual framework, the impact of ADAMSlatina-Timis can be analyzed on different ways. It will be sometimes difficult to make a distinction between cause and effect. Knowing the goods a person owns or can use is not sufficient to know which functionings he/she can achieve; therefore we need to know much more about the person and the circumstances in which he/she is living. The capability approach thus takes account of human diversity in two ways: by its focus on the plurality of functionings and capabilities as the evaluative space, and by the explicit focus on personal and socio-environmental conversion factors of goods into functionings, and on the whole social and institutional context that affects the conversion factors. Health can be considered both as a result and as a prerequisite of other capabilities. Disease can limit an individual's capability set, which contains all potential functionings, both directly and indirectly. The functionings are described extensively in the case study Slatina-Timis conducted by Bogdan Ileanu, Adrian Pană, Cristina Vladu and Ioan Suru. The capabilities, or are citizens of Slatina-Timis able to life a healthy life or can they choose for a healthy life, are the focus of this social map. In this study firstly an overview of reasons for unmet medical needs on the European and Romanian level will be presented, afterwards specific conversion factors based on these reasons for Slatina-Timis and thirdly the way ADAMSlatina-Timis improves the capabilities of persons.

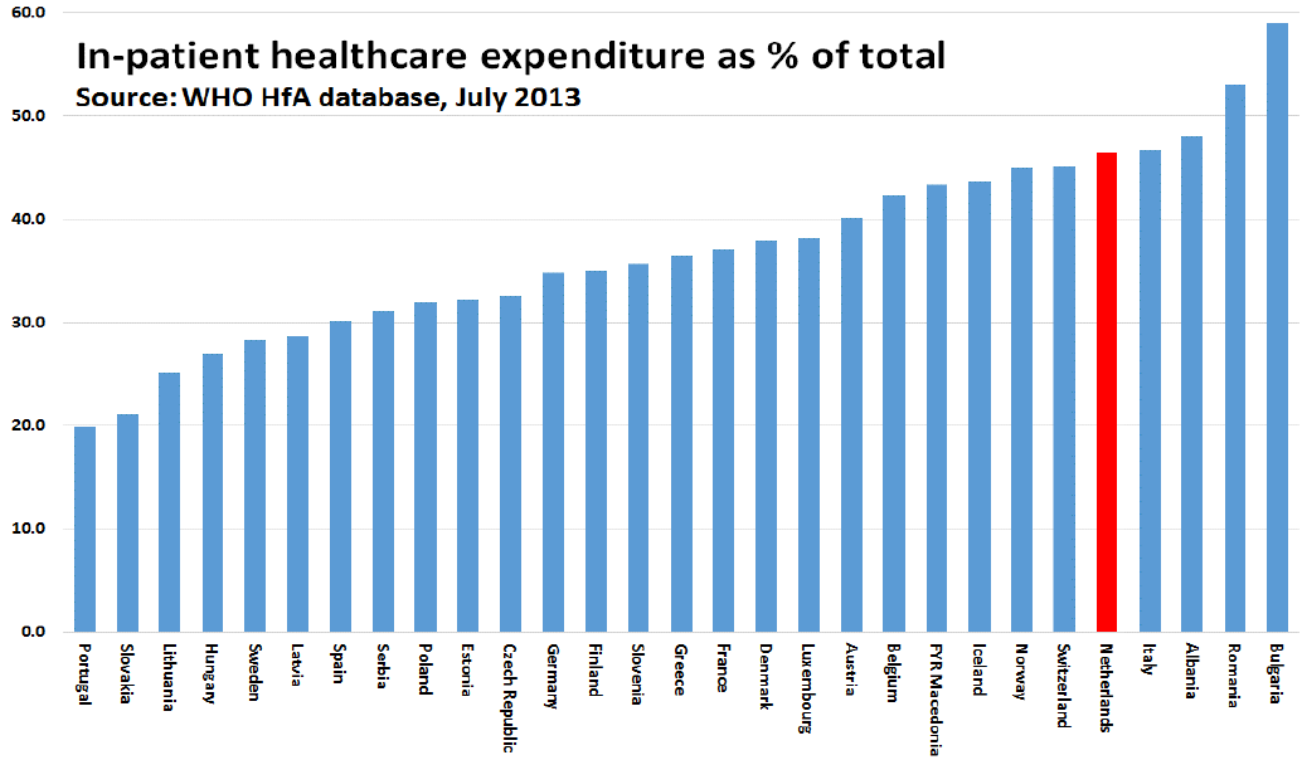
3. General data about reasons for unmet medical needs

One of the first indication for the problems and needs of the Romanian healthcare, can be found in the European Health Consumer Index.[4] The index takes into account 48 indicators divided over 6 domains (patients rights and information, accessibility, outcomes, range and reach of medical services, prevention, pharmaceuticals). For every indicator points are given and there is a maximum of 1000 points. The advantage of this index is that it takes into account different kinds of indicators and weights them in the total result. The latest version of this index of 2014 puts Romania with 453 points on the 35th of 36 investigated European countries.

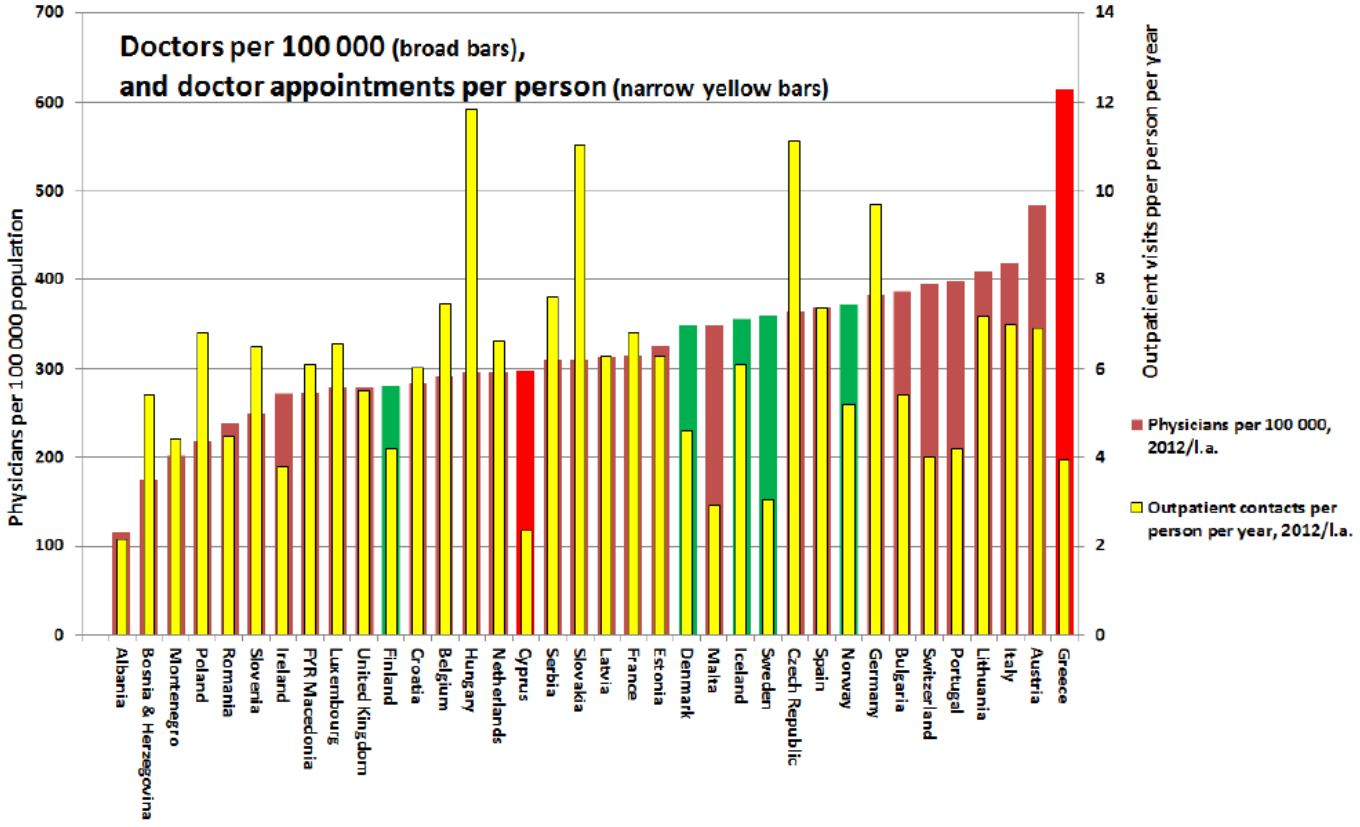
[4] http://www.healthpowerhouse.com/files/EHCI_2014/EHCI_2014_report.pdf



One the challenges for Romania, which can explain the low points, is the very high share of inpatient care and the low amount of outpatient care. The following graphic taken from the EHCI index 2014 show the high percentage of costs for inpatient care in comparison with the total spended money for heathcare.



The higher the share of in-patient care, the more antiquated the healthcare provision structure. The high share of inpatient care costs gives an indication for problems at the level of primary care. Primary healthcareis provided by the family physician chosen by the patient. The activity of familly physicians is very often only focused on medical assistance provided in their own office for those covered by medical insurance and less on home visits In addition, there are many situations where patients or people who cannot prove the payment of medical insurance are excluded from the family physician list, and do not have permanent medical assistance.[5] Recent data have shown that a bit more than 17 million Romanians (both contributing by their own and having an insurance through another financing source) are insured and around 3 million Romanians are not having an insurance.[6] This means that between 15 and 20% of the population are at risk to have no medical assistance because of not being insured. Besides the restrictions made by a family doctors, an estimation done in March 2015 calculated that there are around 550, mainly in rural area, too less in Romania.[7] This number is confirmed by the EHCI index 2014 (graphic below).[8] In the same line are the results of the study 'Building primary care in a changing Europe' and gives a insight in the gap between urban and rural areas. In urban areas the density of family physicians is 1 family physician per 1000 population and in rural areas the density is 1 family physician per 2500–3000 population.[9]



[5] Building primary care in a changing Europe – Case studies, p. 230.

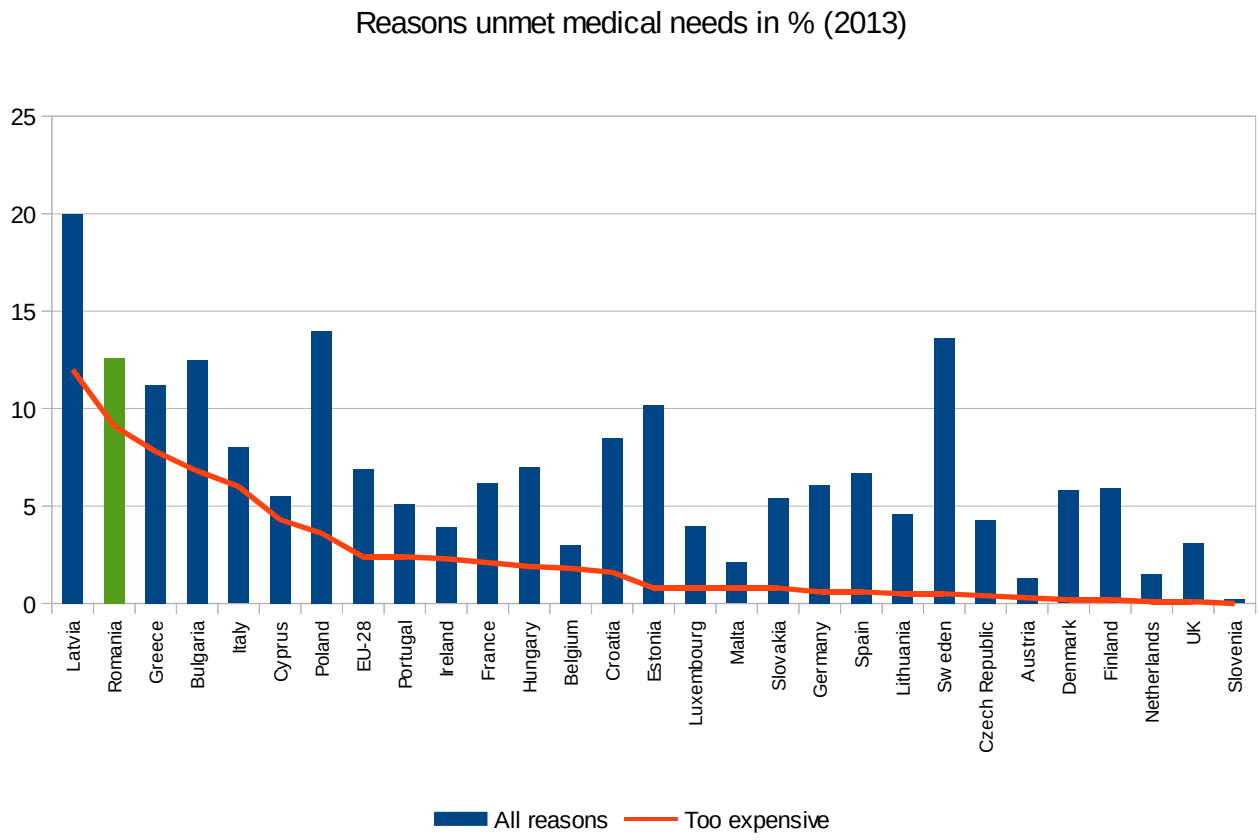
[6] CNAS, Raport Activitate 2014, p. 167-168. In this report a list is published with all categories of insured persons (a bit more than 5 million are employed persons). http://www.cnas.ro/page/rapoarte-de-activitate.html
http://www.zf.ro/companii/trei-milioane-de-romani-nu-au-asigurare-de-sanatate-ce-va-schimba-introducerea-cardului-13797989
A list of prices that have to be paid by insured persons and supplements by (in)sured persons can be found on http://www.medicina-familiei.com/files/tarife_FNPMF.pdf

[7] http://www.digi24.ro/Stiri/Digi24/Actualitate/Sanatate/Prea+putini+medici+de+familie

[8] EHCI Index 2014, p. 68.

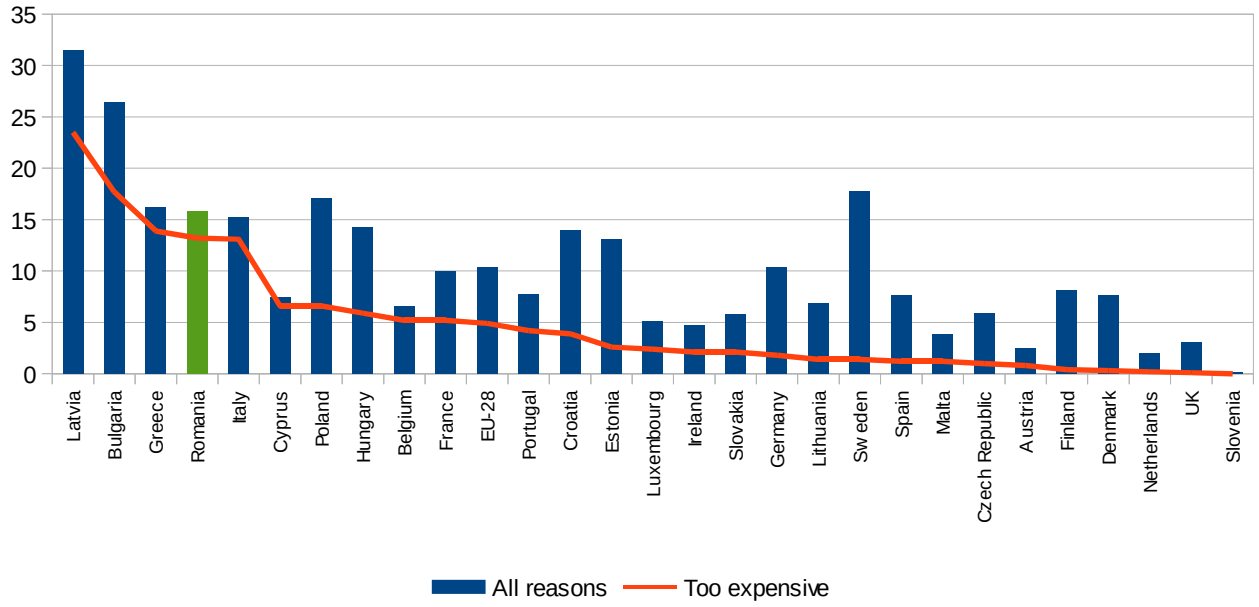
[9] Building primary care in a changing Europe – Case studies, p. 227.

The structure of the medical systems, the avalaibility of doctors and the issue of insured persons show clearly the difficulties in capabilities persons experience to life a healthy live. This, lets call them, social obstacles are accumulated by the difficult social-economical status of Romanians.[10]

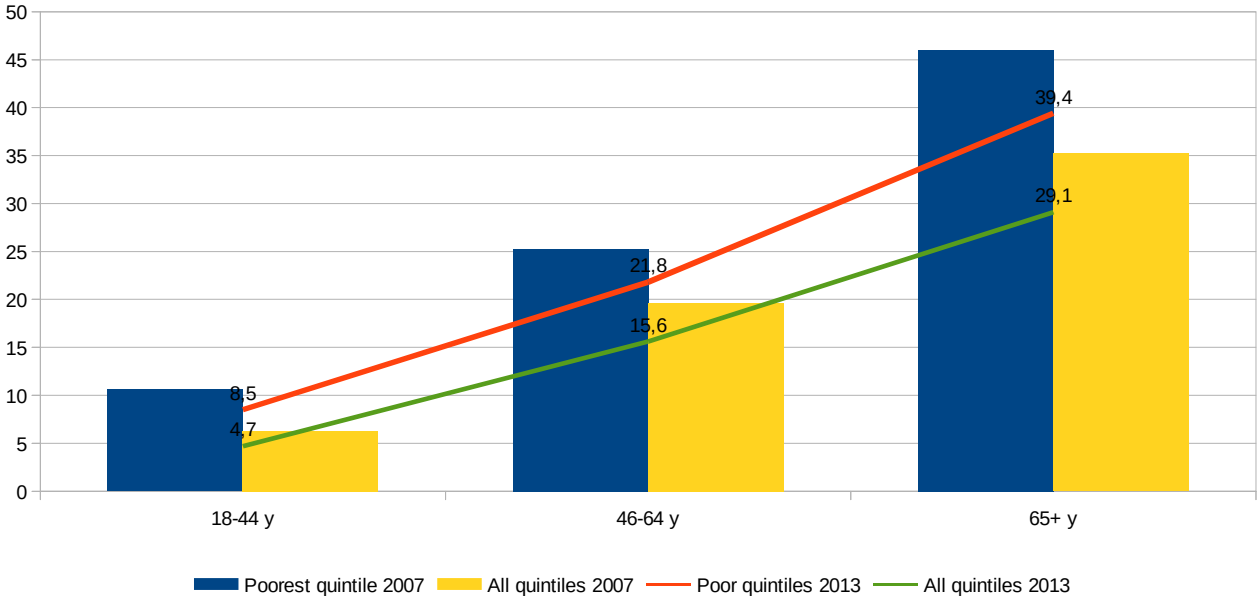


[10] Calculations are based on http://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics and hlth_silc_08 http://appsso.eurostat.ec.europa.eu/nui/show.do

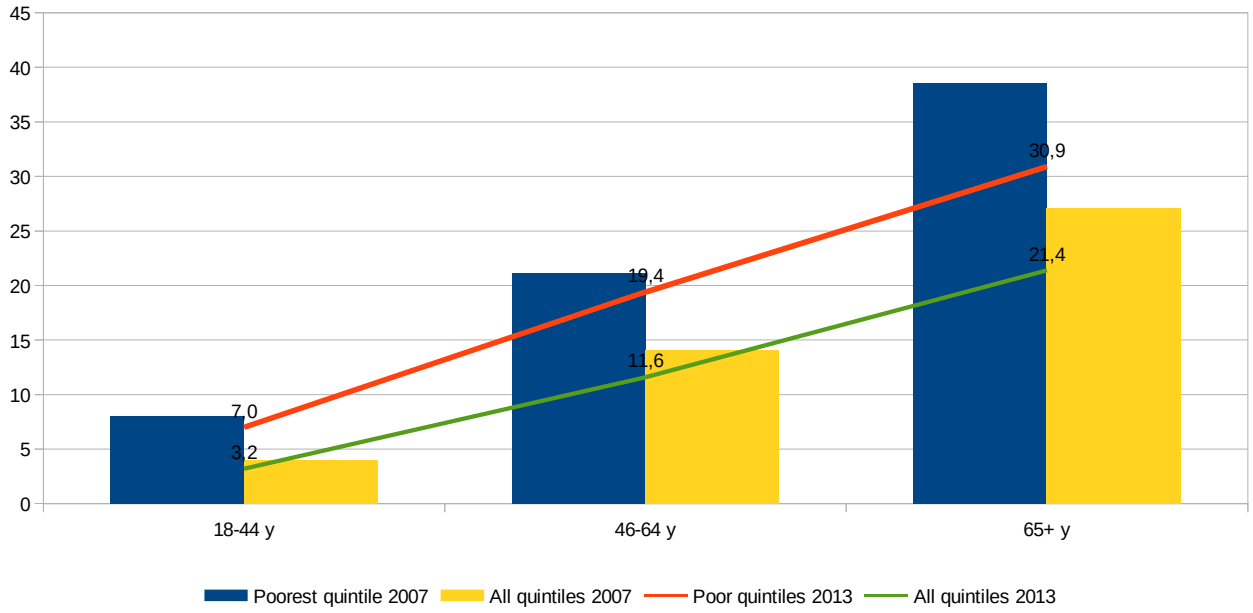
Reasons unmet medical needs first quintile of equivalised income in% (2013)



Romania: share of population (%) perceiving an unmet need for medical treatment, all reasons, 2007-2013



Romania: share (%) of population by age perceiving an unmet need for medical treatment for cost reasons, 2007-2013



The graphics above show clearly that there's a direct relation between income and experiencing difficulties to go to a doctor because a being too expensive. Based on statistics of the Romanian Institute for Statistics show that between 2007 and 2014 that from all reasons around 70% of persons, with an unmet medical need, give too expensive as the main reason.[11] An average of 11,3% of persons indicates to have unmet medical needs. Big differences can be seen in the economical status of persons[12], the area of residence[13] and gender[14].

GROUP	% Unmet medical need
TOTAL	11,3
Urban	9,7
Rural	13,2
Men	8,8
Women	13,6
Employed	3,1
Independent worker (not agriculture)	12,3
Unemployed	10,4
Independent worker (agriculture)	8,9
Retired	26,3

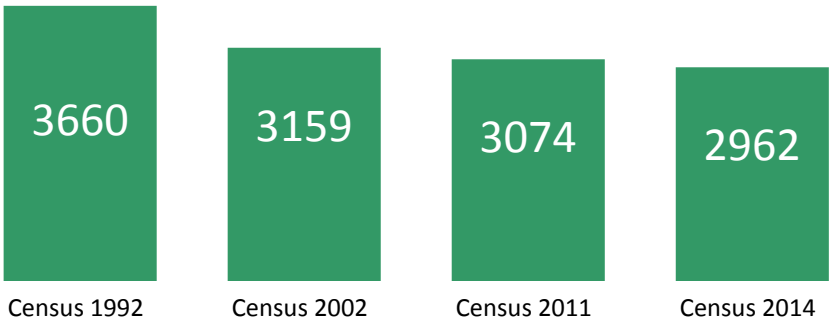
Difficulties in going to a doctor are described above. The next paragraph gives a social map of Slatina-Timis in which a profile can be made as a base for potential difficulties in correlation to the above described situation.

[11] Tempo-Online, CAV103R - Structura persoanelor de 15 ani si peste care nu au putut sa consulte un medic specialist, dupa motivul invocat, pe sexe.
[12] Tempo-Online, CAV103O - Ponderea persoanelor de 15 ani si peste care nu au putut sa consulte un medic specialist, pe statute ocupationale, in total persoane de 15 ani si peste din fiecare categorie.
[13] Tempo-Online, CAV103P - Ponderea persoanelor de 15 ani si peste care nu au putut sa consulte un medic specialist, pe medii de rezidenta, in total persoane de 15 ani si peste din fiecare categorie.
[14] CAV103M - Ponderea persoanelor de 15 ani si peste care nu au putut sa consulte un medic specialist, pe sexe, in total persoane de 15 ani si peste din fiecare categorie.

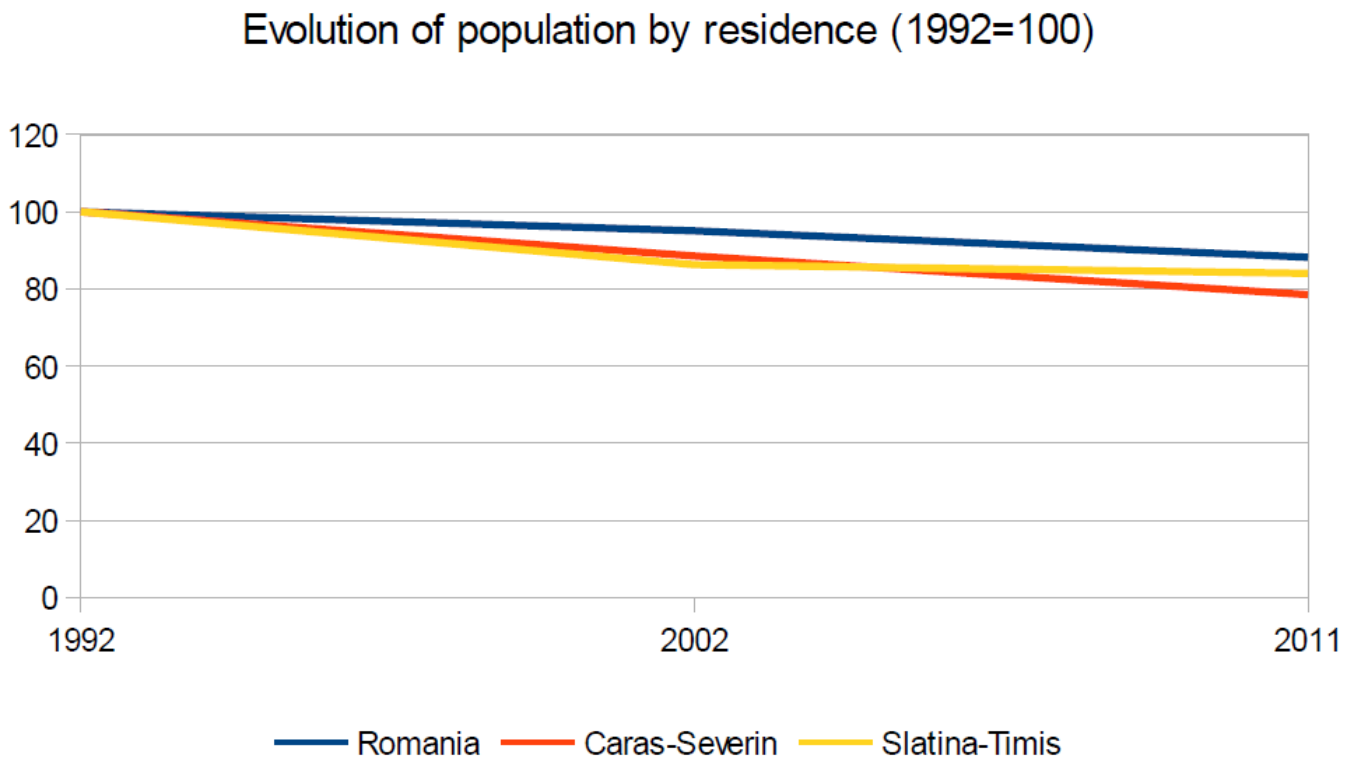
4. Conversion factors Slatina-Timis

4.1. Trends in population evolution

The first graphics give an overview of the population by residence for the years 1992-2002-2011-2014. This numbers are based on the counting of persons living in Slatina-Timis. They are present at the moment of the census.[15]

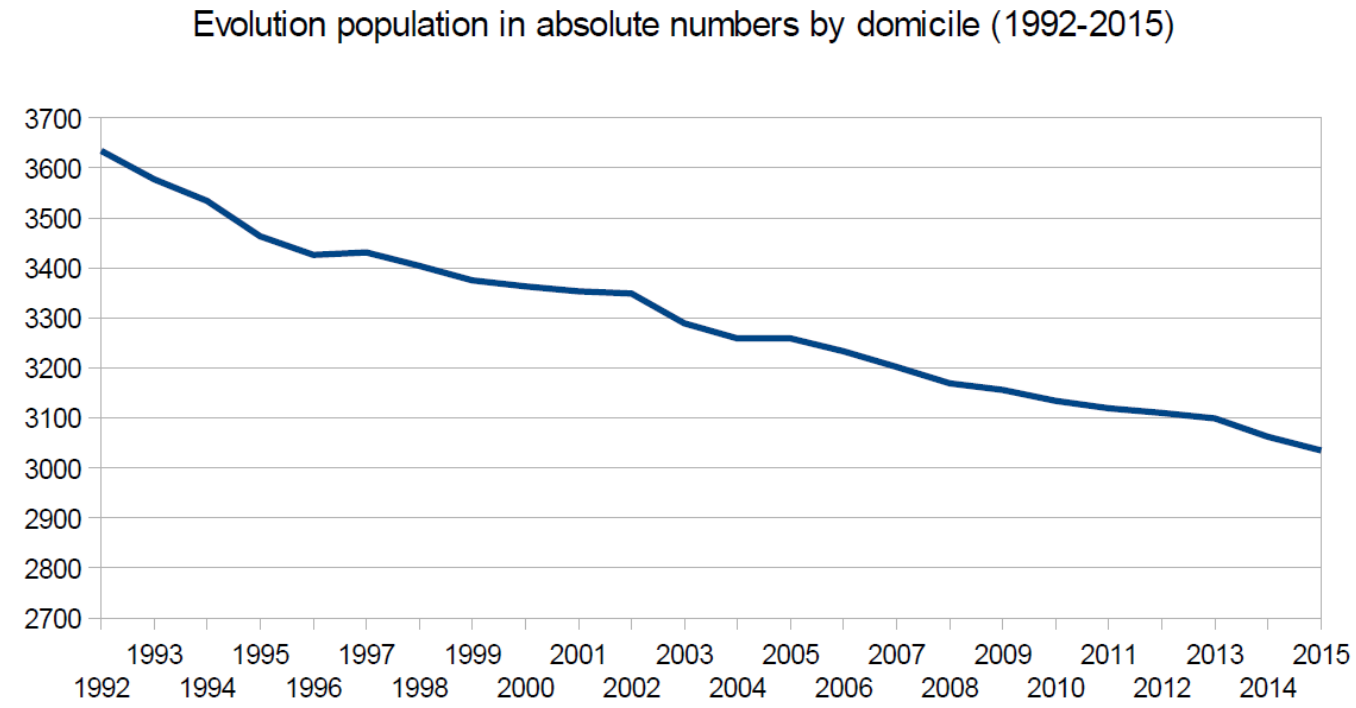


Slatina-Timis is following the trend as can be seen in the county of Caras-Severin and Romania.

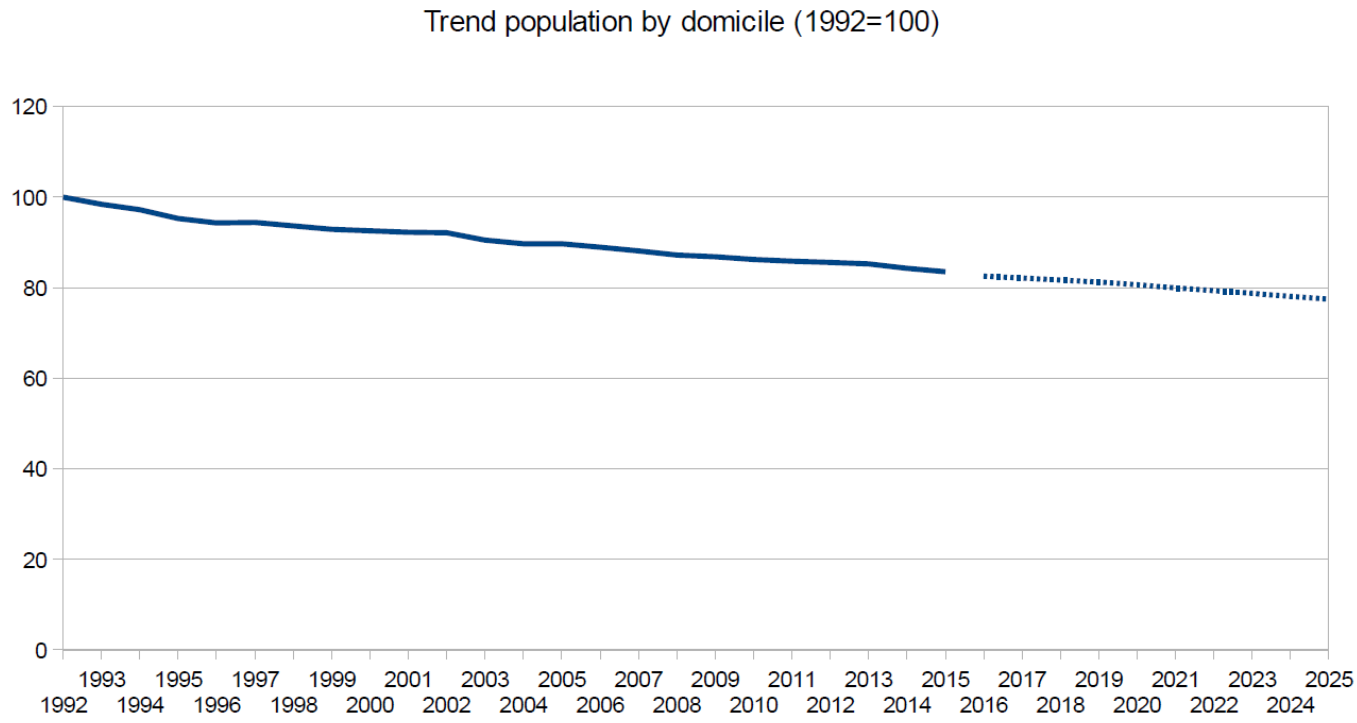


The same trend can be seen in the evolution of persons with a domicile in Slatina-Timis. Or those persons officially registered in Slatina-Timis, but not necessarily living in Slatina-Timis.

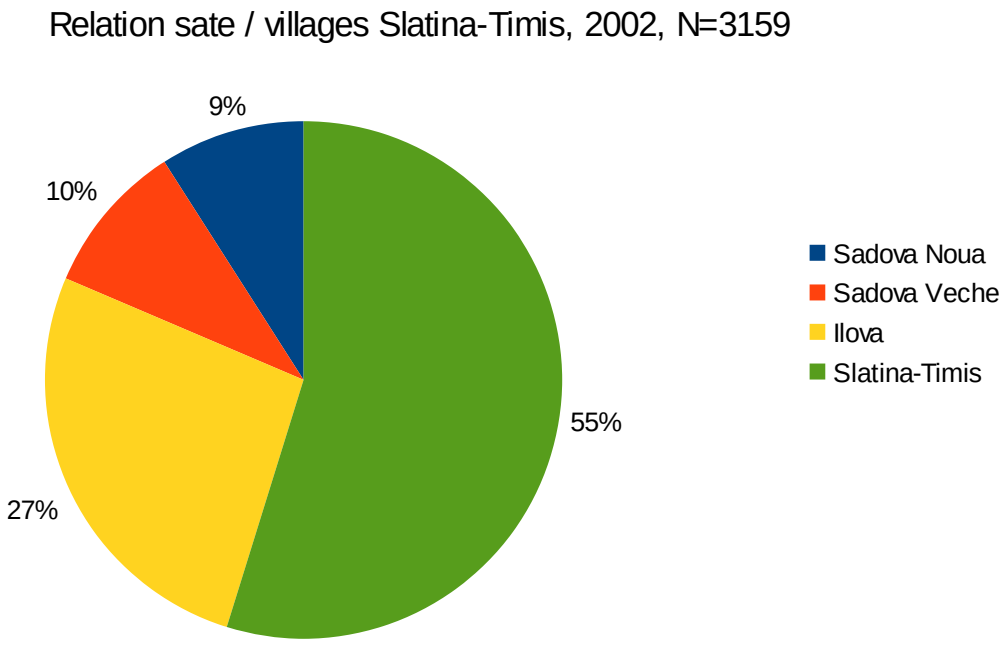
[15] Census 2011, www.recensamantromania.ro and 2014 data based on http://comuna.info/harta-slatina-timis-cs/



The prognosis is that this decline in population will continue the coming years. Depending on the structure of the population (see later), this can result in specific health (care) challenges.

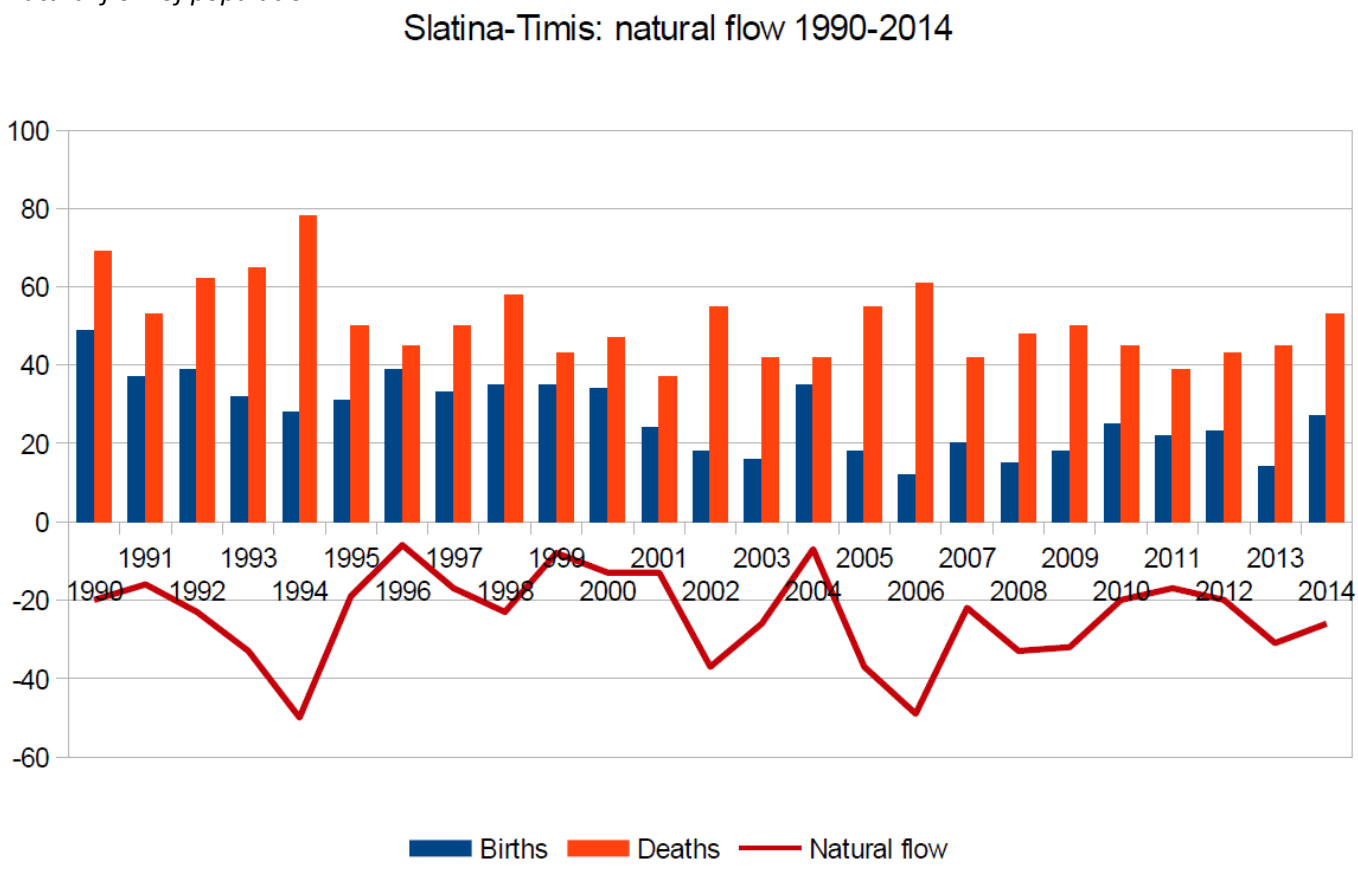


Slatina-Timis consists of 4 villages with the following ratio in 2002.[16]



4.2. Population flow in Slatina-Timis (natural and migration)

Natural flow of population[17]



[16] http://enciclopediaromaniei.ro/wiki/Index:Sate_%C3%AEn_jude%C5%A3ul_Cara%C5%9F-Severin

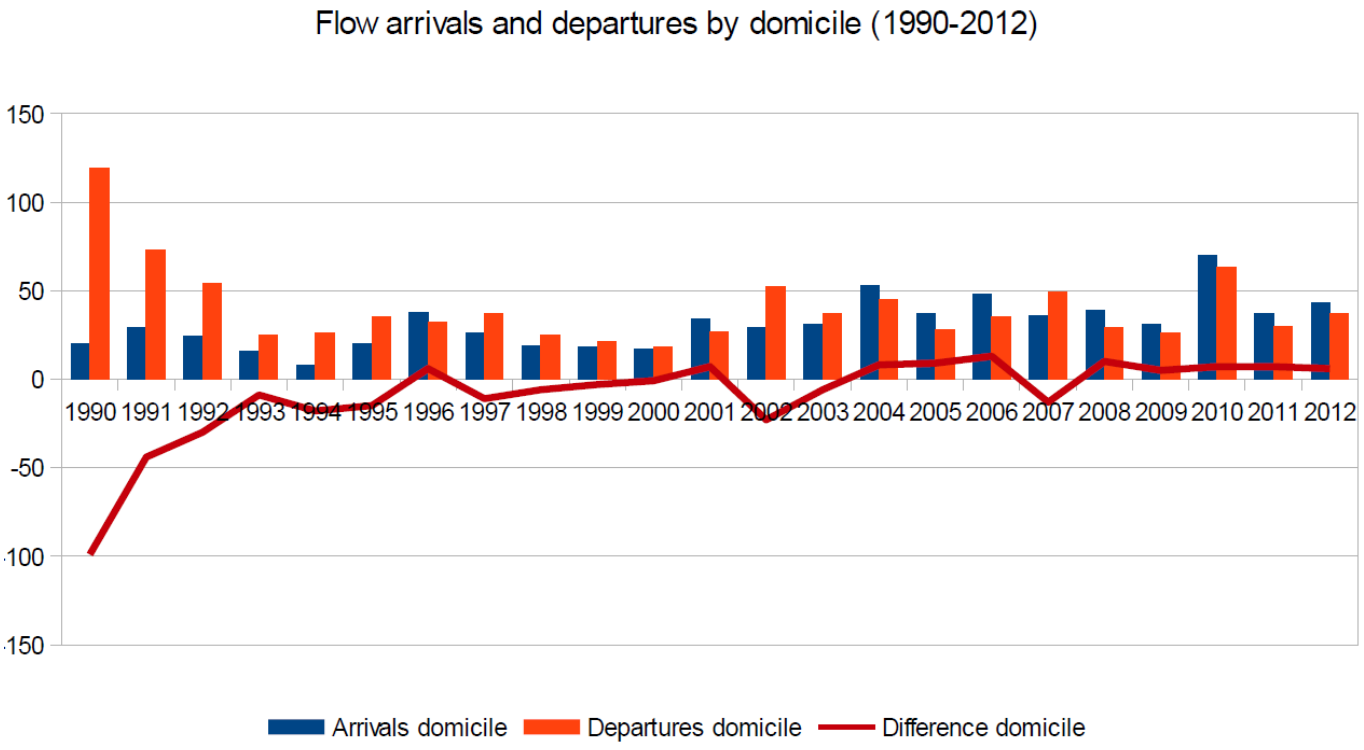
[17] Tempo-online: POP201D - Nascuti vii pe judete si localitati, POP206D - Decedati pe judete si localitati

Migration flow

The table below gives an overview in the difference between domicile and residence for Slatina-Timis.[18]

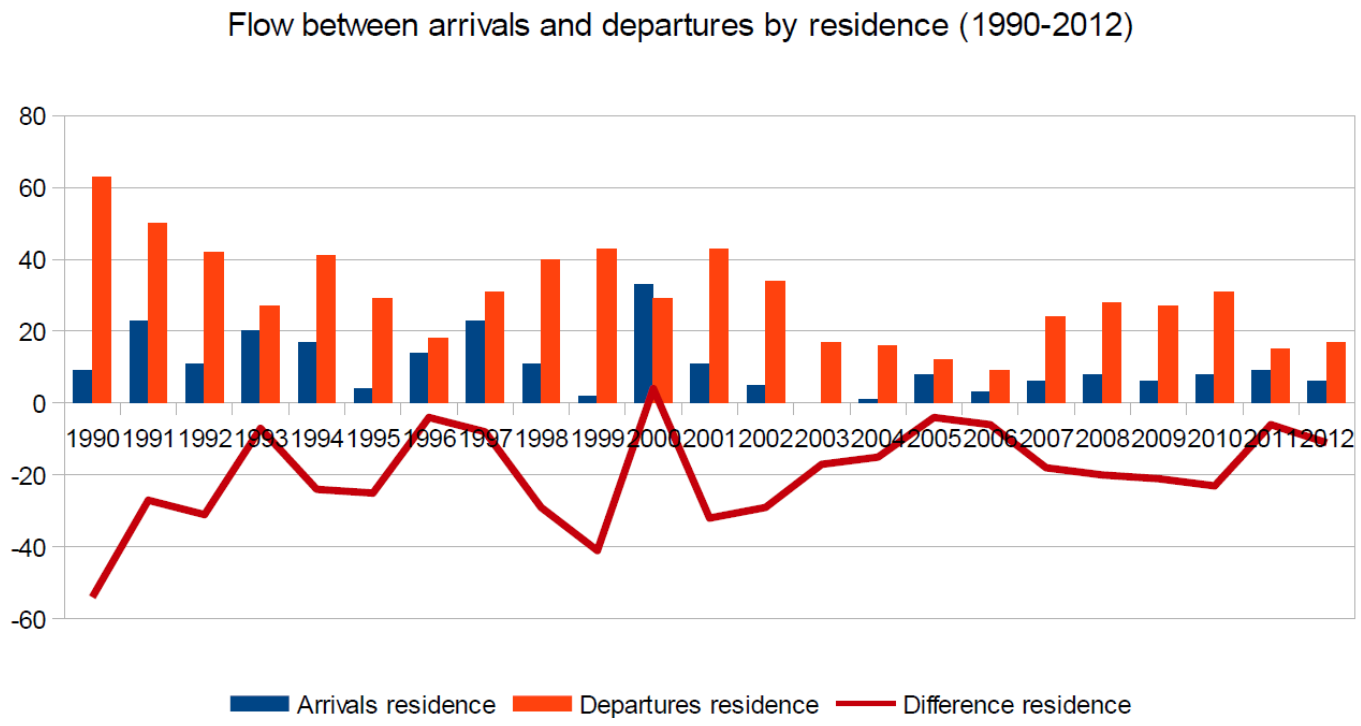
Slatina-Timis	By domicile	By residence
1992	3634	3660
2002	3349	3159
2011	3119	3074
2014	3062	2962

This means that in 2011 1,5% was not living In Slatina-Timis but having a domicile in Slatina-Timis. In 2014 this number was growing to 3,2%. But this is still under the national % of around 10-12%. This can be explained by the fact that or persons stay in Slatina-Timis or some are leaving and others having a residence in Slatina-Timis but do not have their domicile in Slatina-Timis.[19]

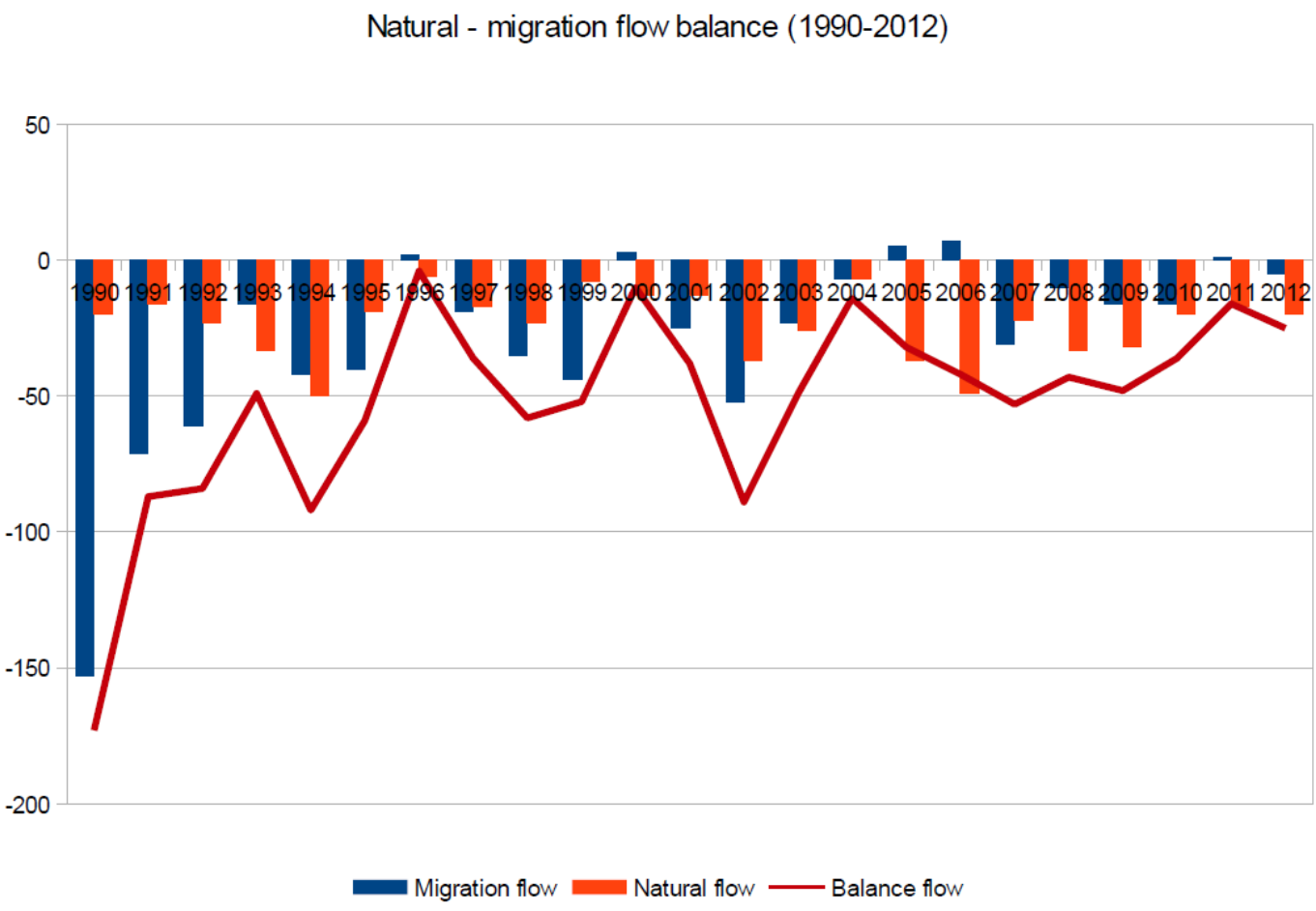


[18] Census 2011, www.recensamantromania.ro

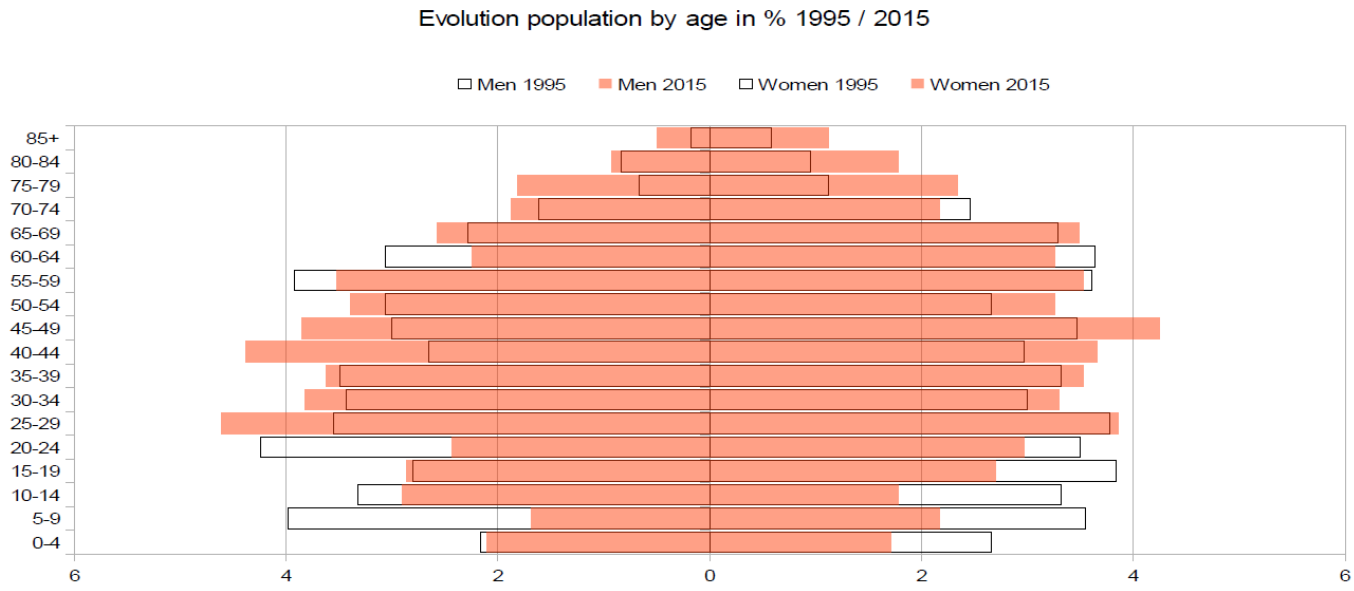
[19] Tempo-Online: POP304B - Stabiliri de resedinta pe judete si localitati, POP305B - Plecari cu resedinta pe judete si localitati, POP307A - Stabiliri cu domiciliul (inclusiv migratia externa) pe judete si localitati, POP308A - Plecari cu domiciliul (inclusiv migratia externa) pe judete si localitati

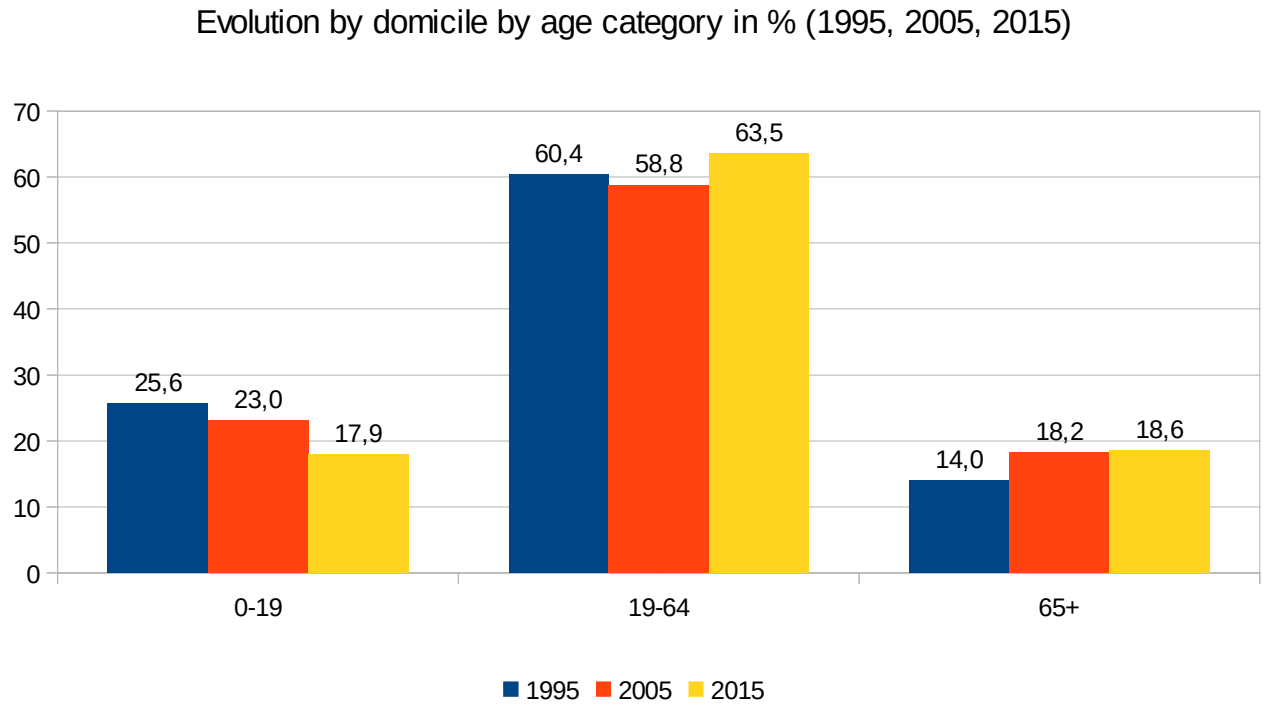


Natural – migration flow balance Slatina-Timis



4.3. Population structure - ageing of the Slatina-Timis population[20]





Based on this numbers and the broader range of data concerning the population by age category, a calculation of the different dependency ratios can be calculated. These ratios below are based on the census of 2011.

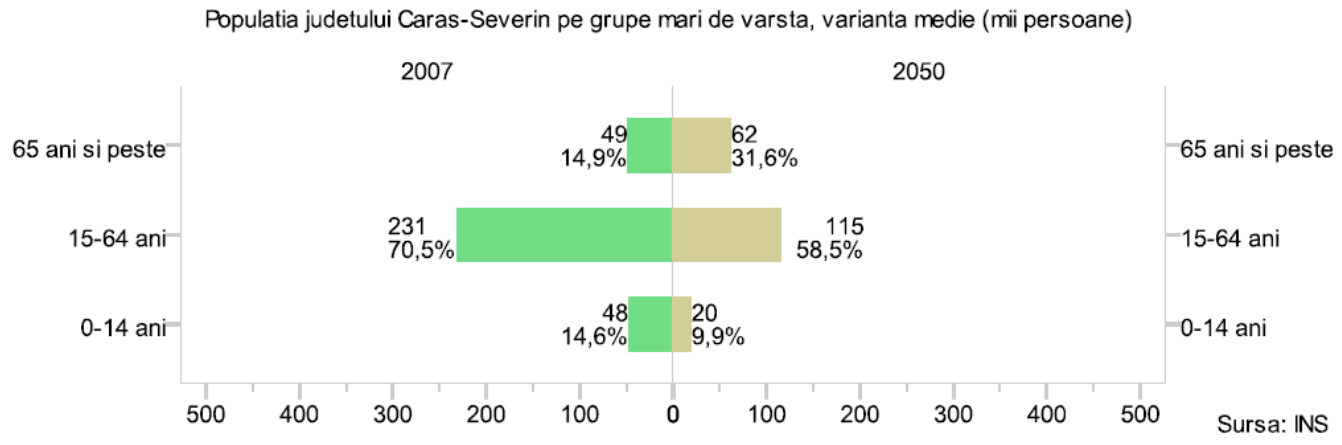
[20] Tempo-Online: POP107D - POPULATIA DUPA DOMICILIU la 1 ianuarie pe grupe de varsta, sexe, judete si localitati

Dependency ratio census 2011	Slatina-Timis	Rural CS	Caras-Severin	Romania	27 EU member states
Green pressure variant 1 (0-14 y to 100 15-64 y)	21,1	23,9	22,3	23,3	23,4
Green pressure variant 2 (0-19 y to 100 20-59 y)	33,5	40,6	37,0	37,9	38,3
Gray pressure variant 1 (65+ to 100 15-64 y)	26,6	31,2	24,5	23,7	26,7
Gray pressure variant 2 (60+ to 100 20-59 y)	42,9	53,4	42,7	39,6	43,4
Internal gray pressure (80+ to 100 60-79 y)	15,8	19,5	16,6	19,3	NA
Family care index (80+ to 100 50-59 y)	24,2	31,9	22,2	26,1	NA
Dependency ratio variant 1 (0-14 & 65+ to 100 15-64 y)	47,7	55,0	46,8	47,0	50,2
Dependency ratio variant 2 (0-19 & 60+ to 100 20-59 y)	76,5	94,1	79,7	77,6	81,7
Flow ratio (10-24 y to 100 50-64 y)	86,7	79,6	75,4	88,6	NA
Aging of active population (15-39 y to 100 40-64 y)	95,0	88,5	86,1	99,9	NA

The green pressure or the presence of young people is under the county and national level. The gray pressure is a bit above the county and national level but under the level of rural Caras-Severin. This means for Slatina-Timis that the pressure is still in balance. This can be also seen in the fact that the dependency ratio for all ages is under the European, national and county level. On the other hand in comparison with 1995 (see below), the gray pressure is growing fast and the green pressure is going down. In the future this can result in less younger and active people taking care of ageing persons.

Slatina-Timis	1995	2011
Green pressure variant 1 (0-14 y to 100 15-64 y)	28,3	21,1
Green pressure variant 2 (0-19 y to 100 20-59 y)	47,8	33,5
Gray pressure variant 1 (65+ to 100 15-64 y)	20,9	26,6
Gray pressure variant 2 (60+ to 100 20-59 y)	38,5	42,9
Internal gray pressure (80+ to 100 60-79 y)	14,0	15,8
Family care index (80+ to 100 50-59 y)	19,2	24,2
Dependency ratio variant 1 (0-14 & 65+ to 100 15-64 y)	49,2	47,7
Dependency ratio variant 2 (0-19 & 60+ to 100 20-59 y)	86,3	76,5
Flow ratio (10-24 y to 100 50-64 y)	105,4	86,7
Aging of active population (15-39 y to 100 40-64 y)	109,1	95,0

The gray pressure is growing. This will put a pressure on the active population, certainly in the age category of 50-59 years (taking care for parents). Also specific medical needs and care demands will appear. In the future this will be continuous growing. According to a 2007 study by the county of Caras-Severin this will increase in the future.[21]

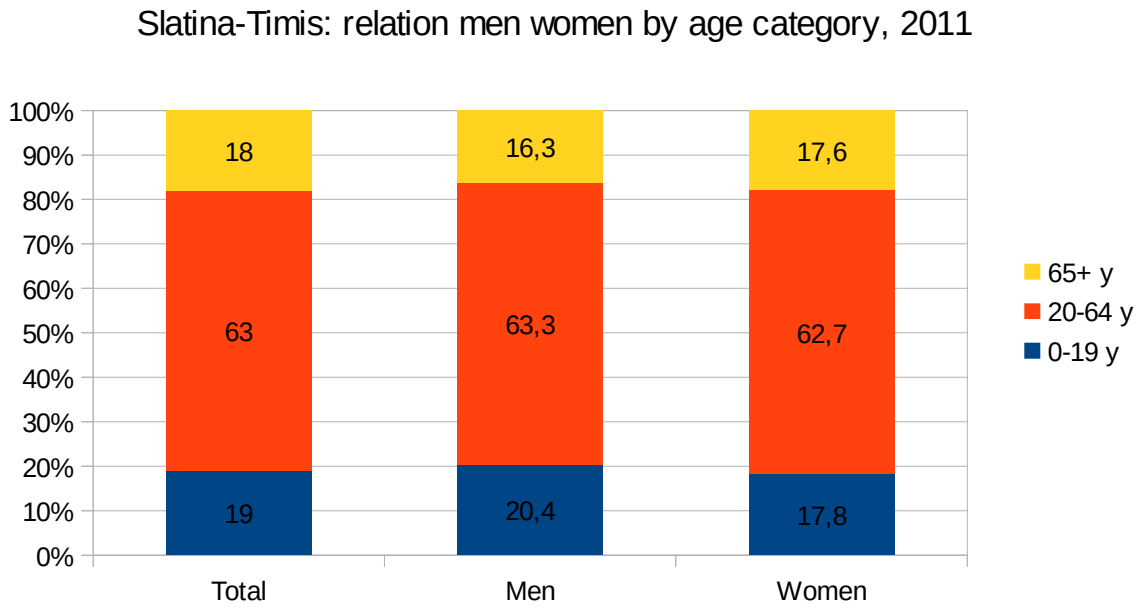


[21] ADR-Vest, Analiza tematica regionala evolutia demograpfica a regiunii Vest, 2007, Graphic 73, p. 89.

The traditional family care structure well come under pressure. Other solutions will be necessary for growing medical needs and demands for adapted medical services. One of the most convenient and less cost solutions is home care, as well medical as social. We see that medical problems often result in social problems.

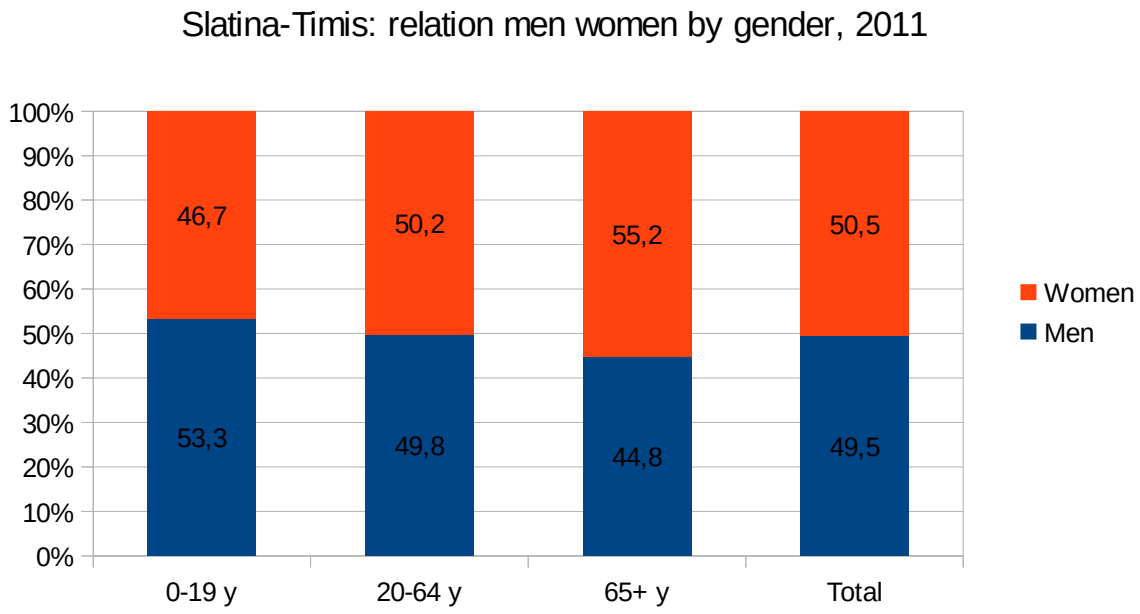
4.4. Feminization of the ageing

The ageing of the population of Slatina-Timis is bigger on the female side of the population. Women of 65+ represent almost 1/5 of the total population of women in Slatina-Timis. In Rural Cars-Severin this is 23,7%.[22]

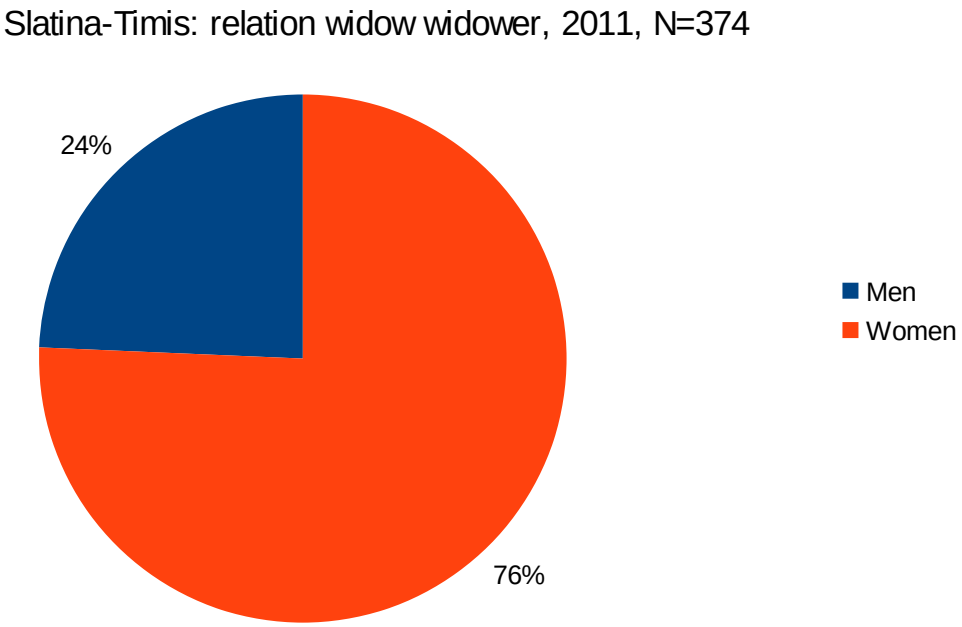


Interesting to add is the relation between men and women for each age category. For all 65+ citizens 55,2% are women.

[22] Census 2011: Tab3. Populația stabilă pe sexe şi grupe de vârstă – județe, municipii, orașe, comune



A possible influence on healthcare needs and demands can be the high share of widows in Slatina-Timis.[23]

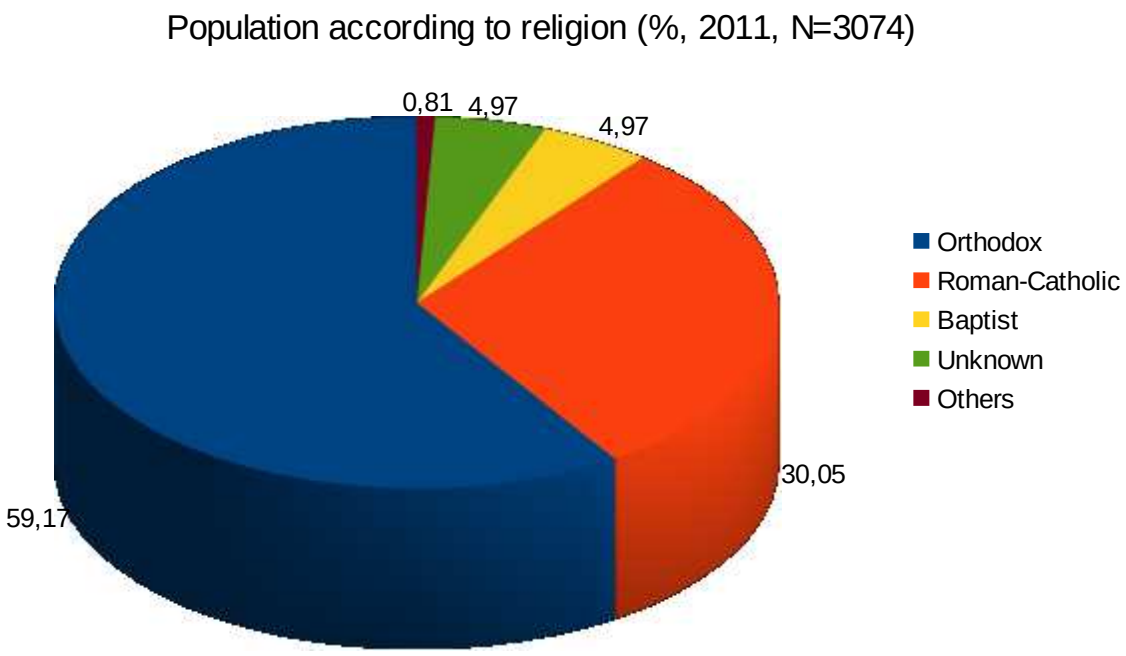


[23] Census 2011: Tab5. Populația stabilă pe sexe şi stare civilă – județe, municipii, oraşe, comune

4.5. Population according to religion

Religion and the connected institutes can have important influences on the way people and communities see their health and healthcare programs. This paper doesn't want to become to detailed on this issue, but only wants to give an idea. The Orthodox regards life and well-being as gifts from God, who is the creator and sustainer of life as well as the prime source of healing. God has also given humanity many talents and the freedom to use them. Therefore the Orthodox Church perceives the healing of illness by the medical professional as a God given art which, when properly used, serves God's purposes and helps restore people to a normal level of human functioning. This doesn't mean that people can replace God. In debates concerning birth control, abortion, death…, God's will is still primary. Also during the year fasting periods are kept according to religious moments in the year (Easter, Christmas…). The way priests are communicating the role and control of God towards the community can have an influence to the way persons make individual choices. On the other hand structures, developed by or conducted by religious community can influence the accessibility of medical services. Think about the hospitals run by religious groups. In this case it can be interesting to refer to a database of Orthodox initiatives dealing with social-medical matters: http://map.patriarhia.ro/. In the county of Caras-Severin 17 initiatives of the orthodox church can be identified.

For Slatina-Timis the map of religious denominations is presented in the following graphic.[24]



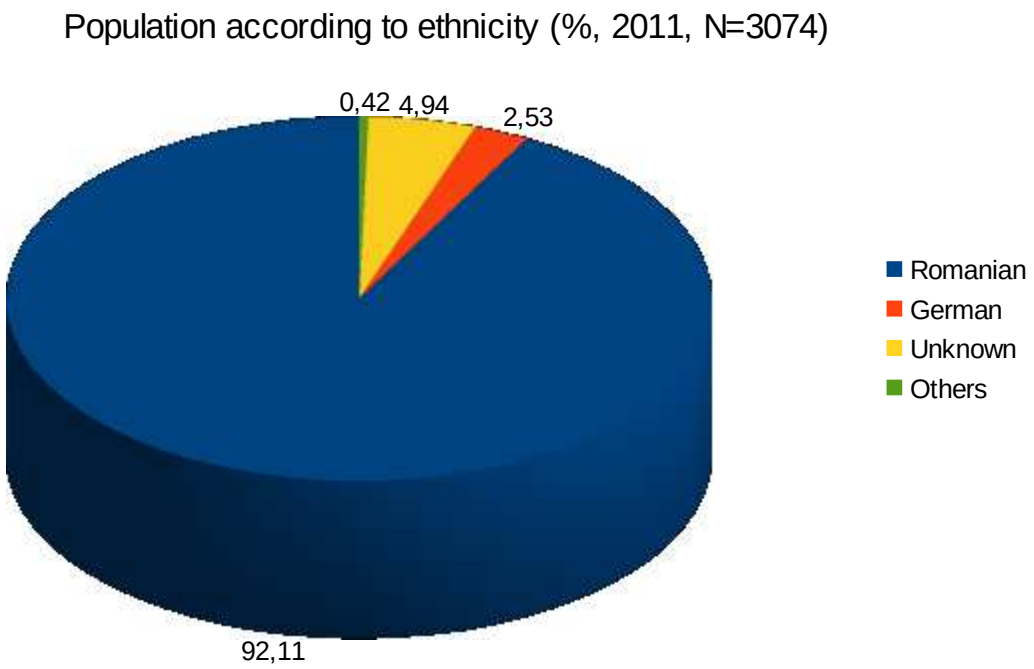
A further research is needed to map the influence of religion on health and healthcare on the local level. Influences to convince people to participate in a community oriented /mutual organization can be also influenced by belief and those carrying out this belief. For example: Solidarity is an important issue.

[24] Census 2011: Tab13. Populația stabilă după religie – județe, municipii, orașe, comune

4.6. Population according to ethnicity

Ethnicity or the level of integration into society can have a important impact on finding the way to and/or accepting healthcare services. Language and medical literacy play an important role.[25]

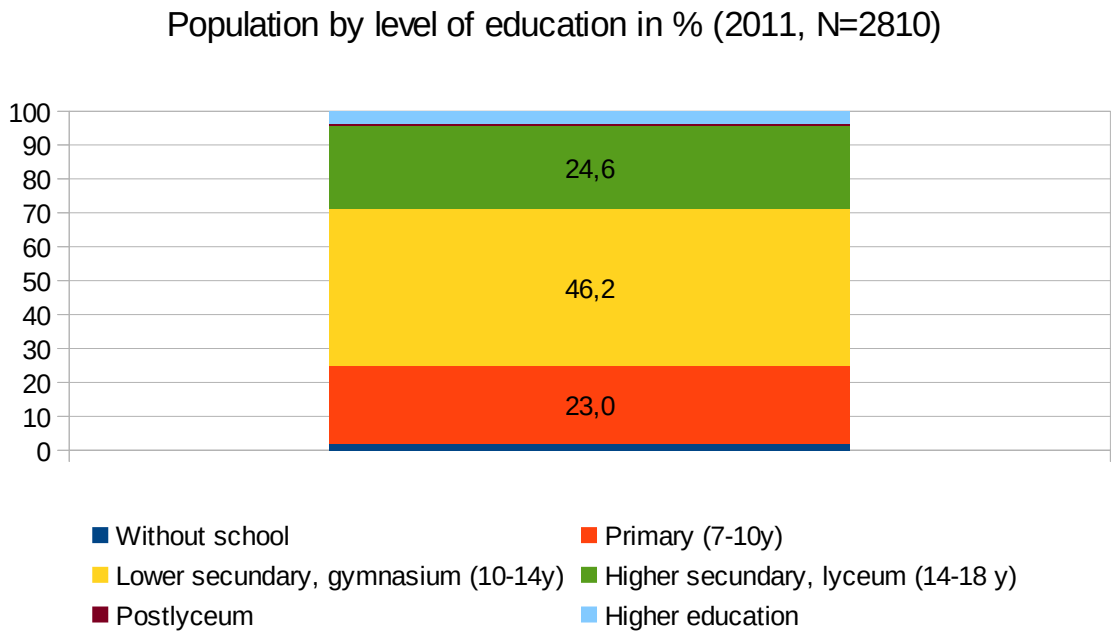
In the Slatina-Timis the majority of the population is Romanian.[26]



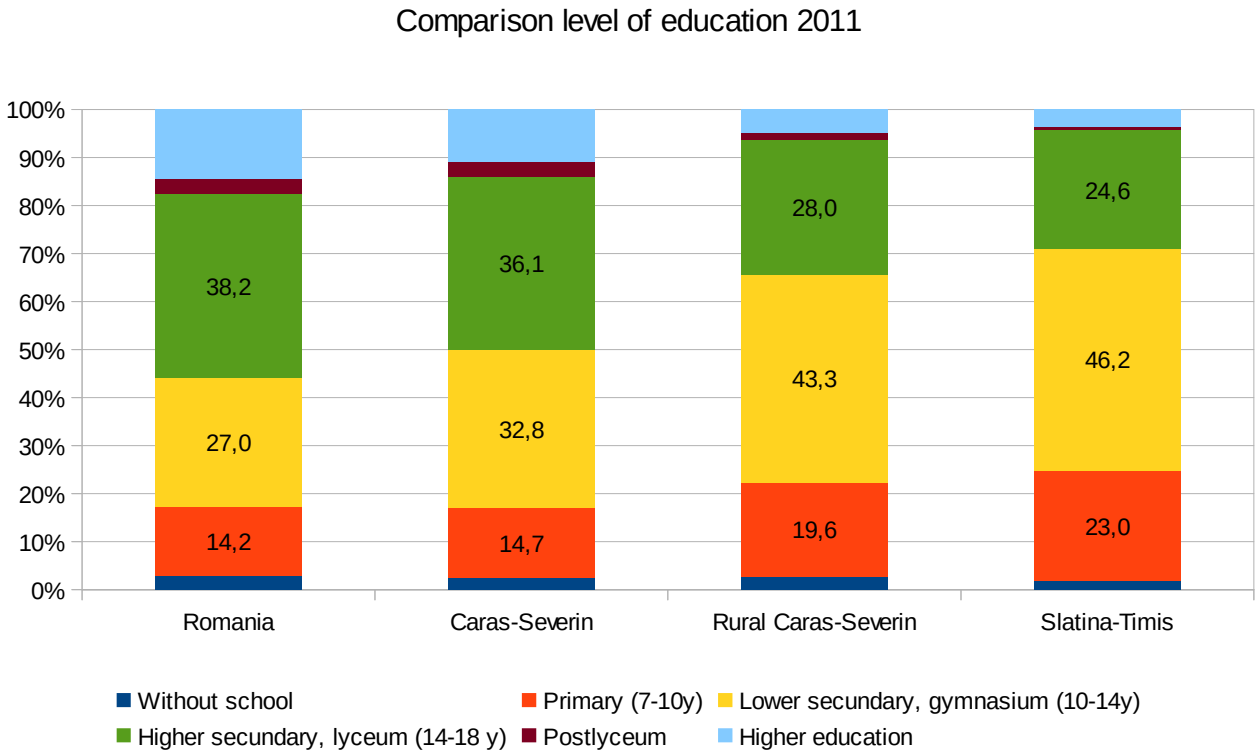
4.7. Population according to level of education

The population census of 2011 makes a picture of the level of education of the population residing in Slatina-Timis.[27] So it's a picture of the moment of the population older then 10 years old. The World Health Organization sees in education an important determinant of the health and the care for a healthy life. Lower education leads to difficulties in finding a proper job, sometimes less paid. As a consequence less money that can be used for health (services and/or healthy life styles). Also health literacy can be influenced by the level of education. Health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.

[25] Corina Iosif, Health, community and ethnic boundaries, In: Elena Barbulescu, People and the state. Divergent medical discourses, Cluj, 2011, p. 119-128.
Dorian Singh, Attitudes and Praxis of Traditional Forms of Healthcarein a Post-Communist Romanian Romani Community, online paper, 14 p.
[26] Census 2011: Tab8. Populația stabilă după etnie – județe, municipii, oraşe, comune
[27] Census 2011, Tab16. Populația stabilă de 10 ani şi peste pe sexe, după nivelul de educație – județe, municipii, oraşe, comune



In comparison to the national and county level, Slatina-Timis is scoring a bit lower on the educational level.

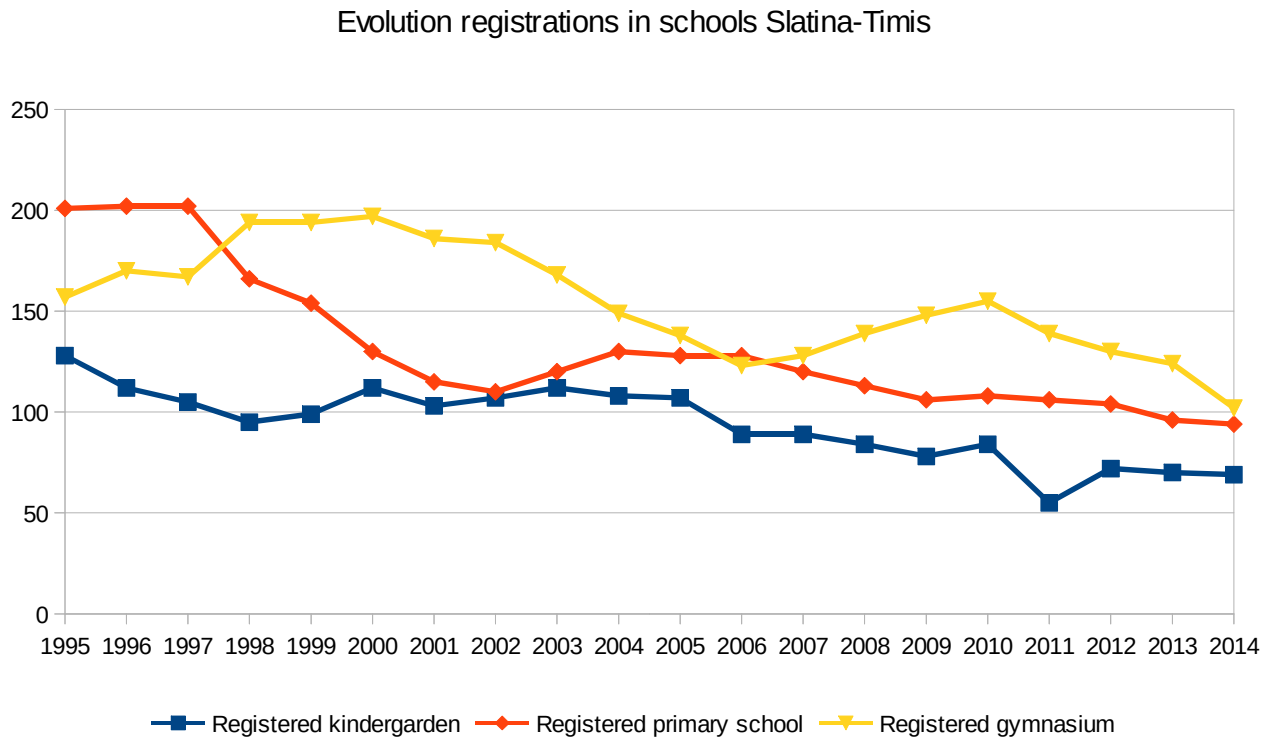


In Slatina-Timis there are the following schools present[28]:
Kindergarden Ilova
Kindergarden Sadova Veche
Kindergarden Slatina-Timis
Primary school Ilova

[28] http://scoli.didactic.ro/scoala-cu-clasele-iviii-slatina-timis

Primary school Sadova Noua
Primary school Sadova Veche
Gymnasium Slatina-Timis

The evolution of inscribed students is declining, but this decline can be explained by the fact that there is a lower birth rate and migration of people.[29]

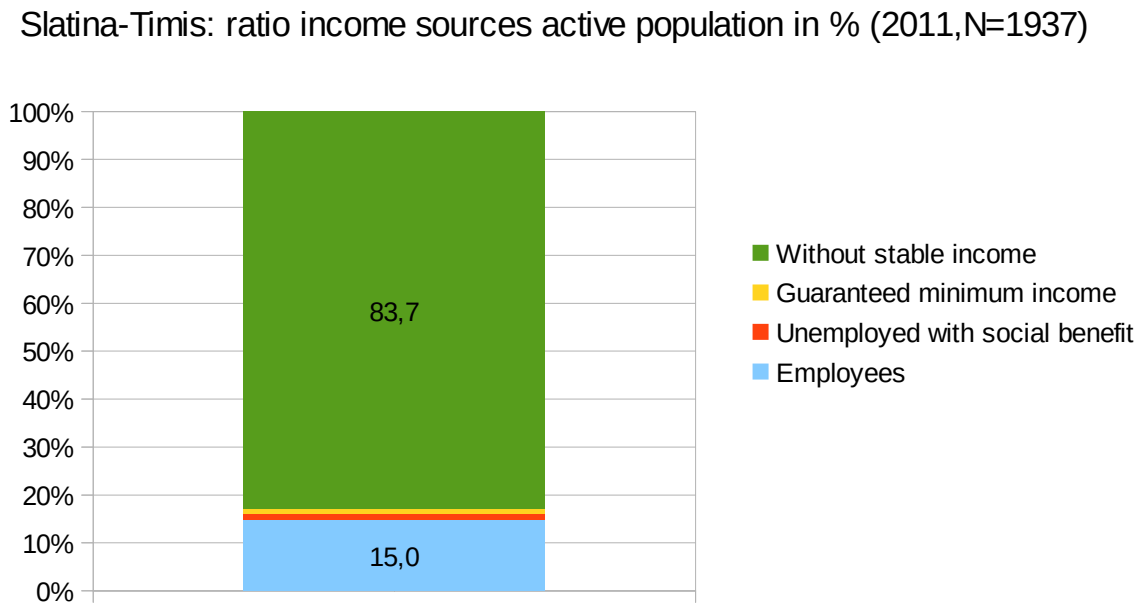


According to the last National Test (a test to be done after following Class 8) 21 students were participating in the national test: the average was 6,5/10 and 16 scored above 5/10.[30] This gives a result of 71% students have more than 5/10, For Caras-Severin this is 73% and on the national level 79%.[31]

[29] Tempo Online: SCL103D - Populatia scolara pe niveluri de educatie, judete si localitati
[30] http://evaluare.edu.ro/DefaultI.aspx
[31] http://stirileprotv.ro/stiri/evaluare-nationala-2015/rezultate-evaluare-nationala-2015-edu-ro-cum-se-calculeaza-media-de-admitere-la-liceu.html

4.8. Employment

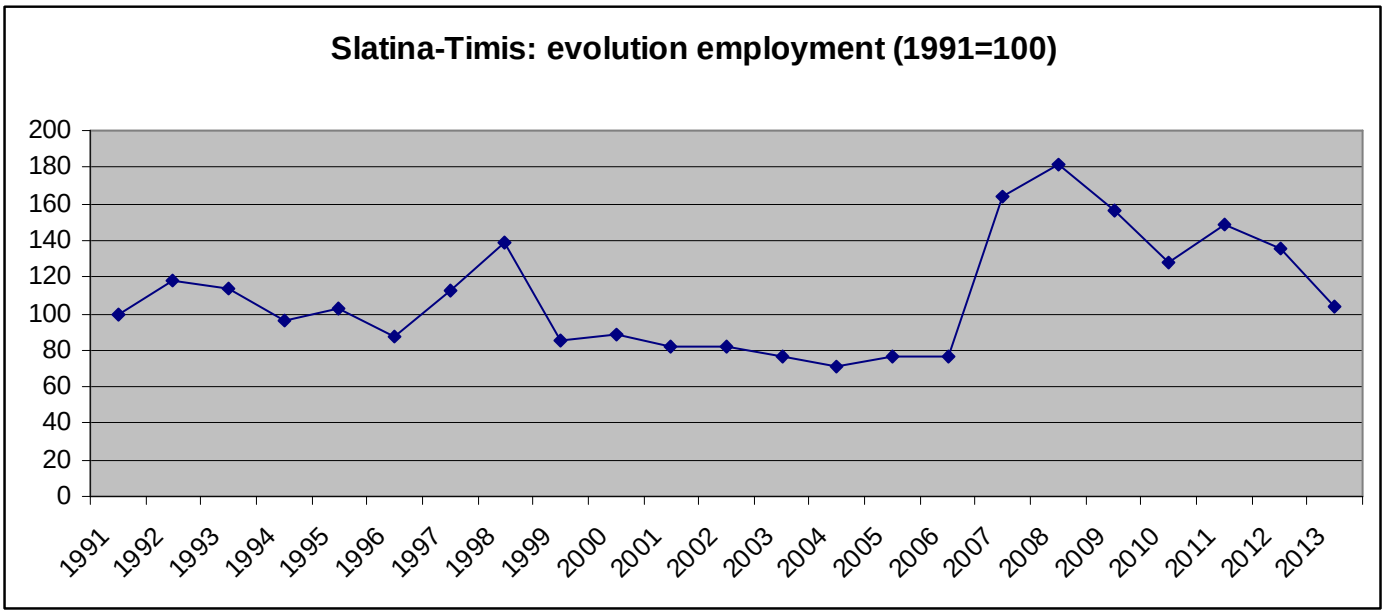
Employment and working conditions, in general people in employment are healthier, particularly those who have more control over their working conditions. Related to this a higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.[32] The rate of employment can have an impact on if people go to the doctor or because of lack of money delay a doctor visit. In the graphic below a calculation is made for the sources of income of the active population.[33] Eight of 10 don't have a stable income in Slatina-Timis.



Evolution of employment[34]

The employment rate of Slatina-Timis was going in an upward trend 2 years before the crisis. After 2008-2009, as a consequence of the global economical and financial crisis, employment was declining. The amount of unemployed persons with a social benefit was also declining from 56 in 2010 to 26 in 2014. This may indicate a growing long term unemployment, because of time restricted social benefits.

[32] http://www.who.int/hia/evidence/doh/en/
[33] Tempo-Online: SOM101E - Someri inregistrati la sfarsitul lunii, pe sexe, judete si localitati, FOM104D - Numarul mediu al salariatilor pe judete si localitati, Strategia de dezvoltare durabilă a județului Caraş-Severin 2015-2020, anexa I.7.2.
[34] Tempo-Online: FOM104D - Numarul mediu al salariatilor pe judete si localitati

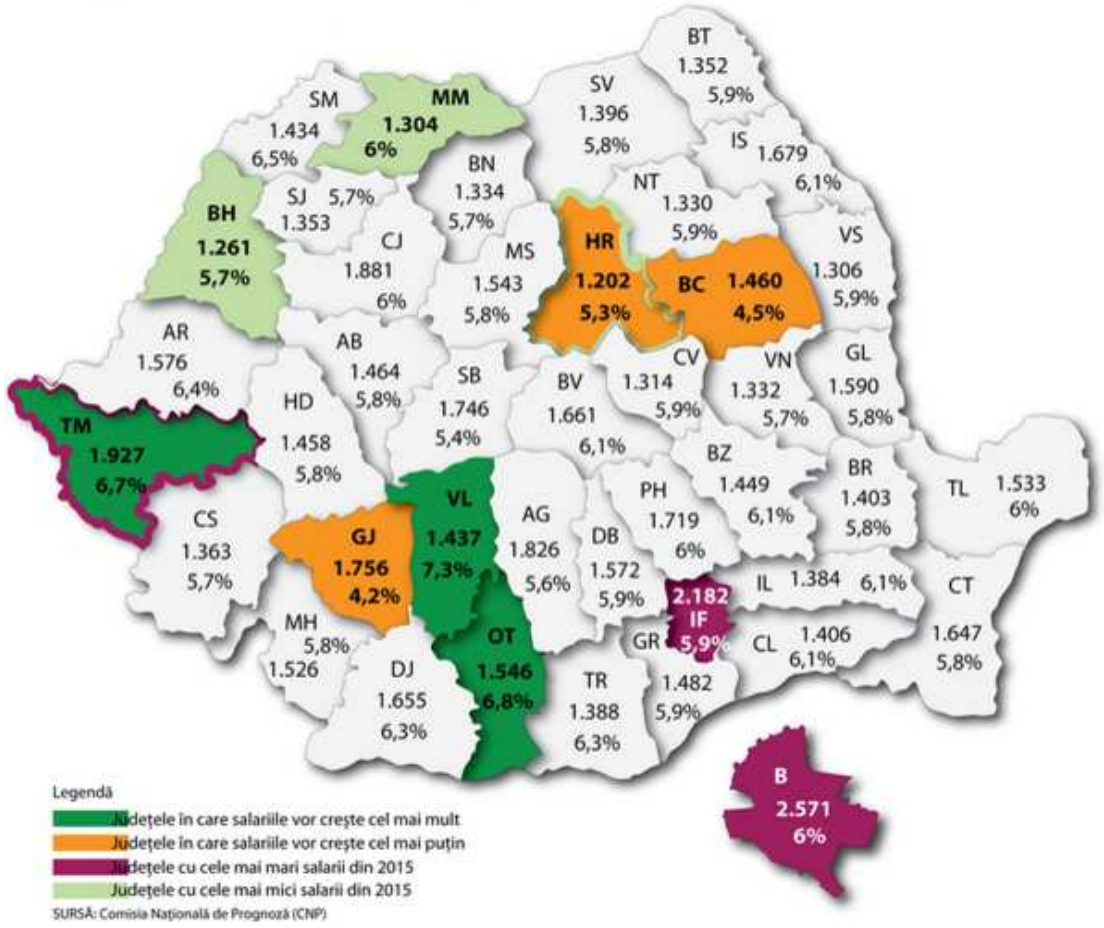


Companies active in 2013 in Slatina-Timis can be found on
http://doingbusiness.ro/financiar/cauta/an/2013/localitate/slatina-timis/judet/11/

Salaries[35]

Data about salaries for Slatina-Timis were not found. Therefore reference is made to the average salaries in the different counties. In the drawing and table below, Caras-Severin is scoring rather low concerning monthly salaries. The county is below the national average and is in the last quarter of all Romanian counties.

[35] http://www.gandul.info/financiar/harta-salariilor-in-2015-cu-cat-vor-creste-lefurile-romanilor-din-fiecare-judet-13743567
http://www.zf.ro/zf-24/salariul-mediu-net-trece-de-2-000-lei-in-cinci-judete-in-capitala-urca-mai-aproape-de-3-000-de-lei-care-sunt-orasele-unde-veti-castiga-cel-mai-bine-in-2016-14953431



Salariul mediu din Capitală, cu 65% peste media națională

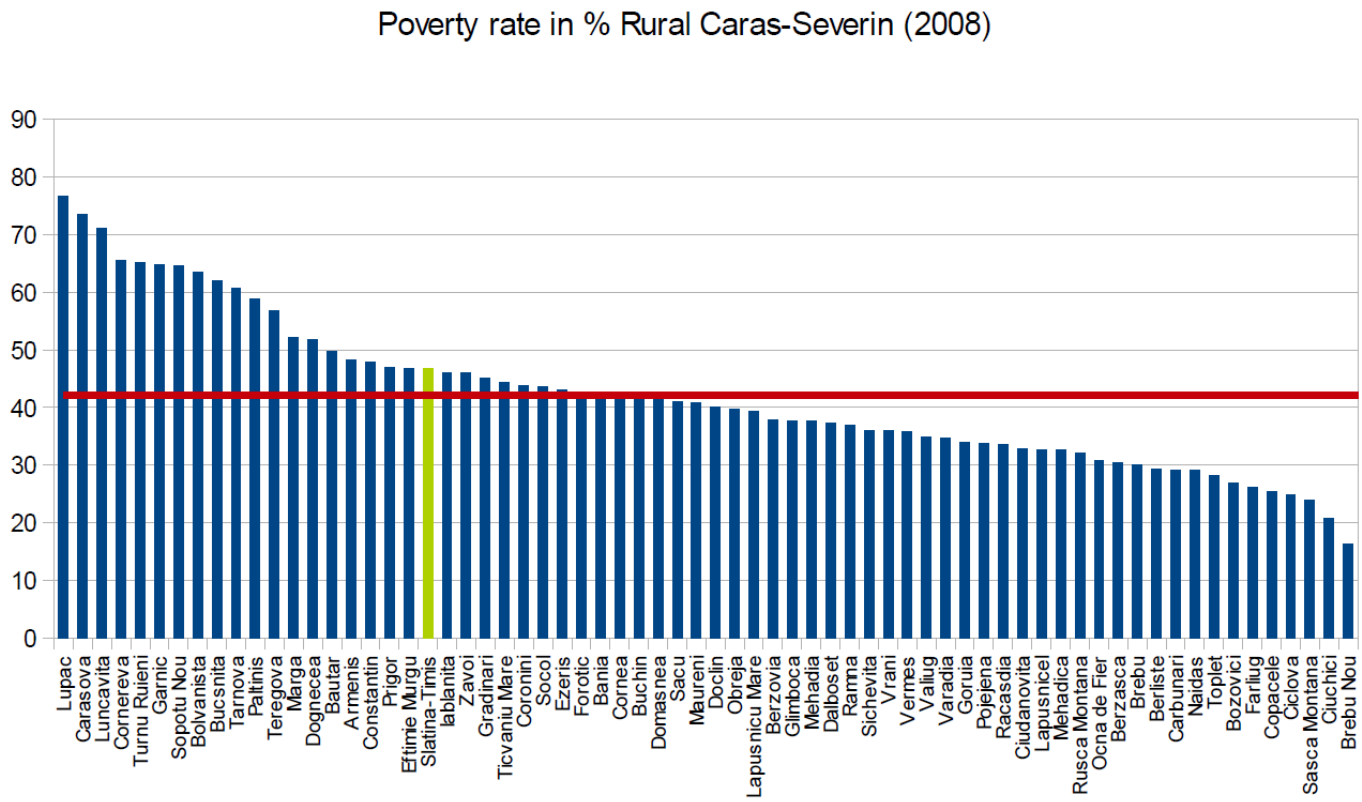
Topul salariilor medii pe județe în 2016

Județul	Salariul mediu net în 2016 (lei/lună)	Județul	Salariul mediu net în 2016 (lei/lună)	Județul	Salariul mediu net în 2016 (lei/lună)
Municipiul București	2.813	Dolj	1.752	Sălaj	1.536
Ilfov	2.363	Arad	1.726	Brăila	1.530
Cluj	2.166	Dâmbovița	1.710	Buzău	1.529
Timiș	2.136	Mehedinți	1.687	Teleorman	1.523
Argeș	2.050	Alba	1.653	Maramureș	1.520
Gorj	1.957	Bacău	1.645	Caraș- Severin	1.516
Prahova	1.942	Tulcea	1.637	Vâlcea	1.505
Iași	1.896	Giurgiu	1.617	Vaslui	1.492
Sibiu	1.885	Hunedoara	1.597	Vrancea	1.492
Brașov	1.859	Călărași	1.572	Bihor	1.490
Constanța	1.824	Ialomița	1.570	Bistrița-Năsăud	1.472
Olt	1.815	Satu Mare	1.552	Neamț	1.456
Galați	1.809	Suceava	1.545	Covasna	1.398
Mureș	1.760	Botoșani	1.544	Harghita	1.317

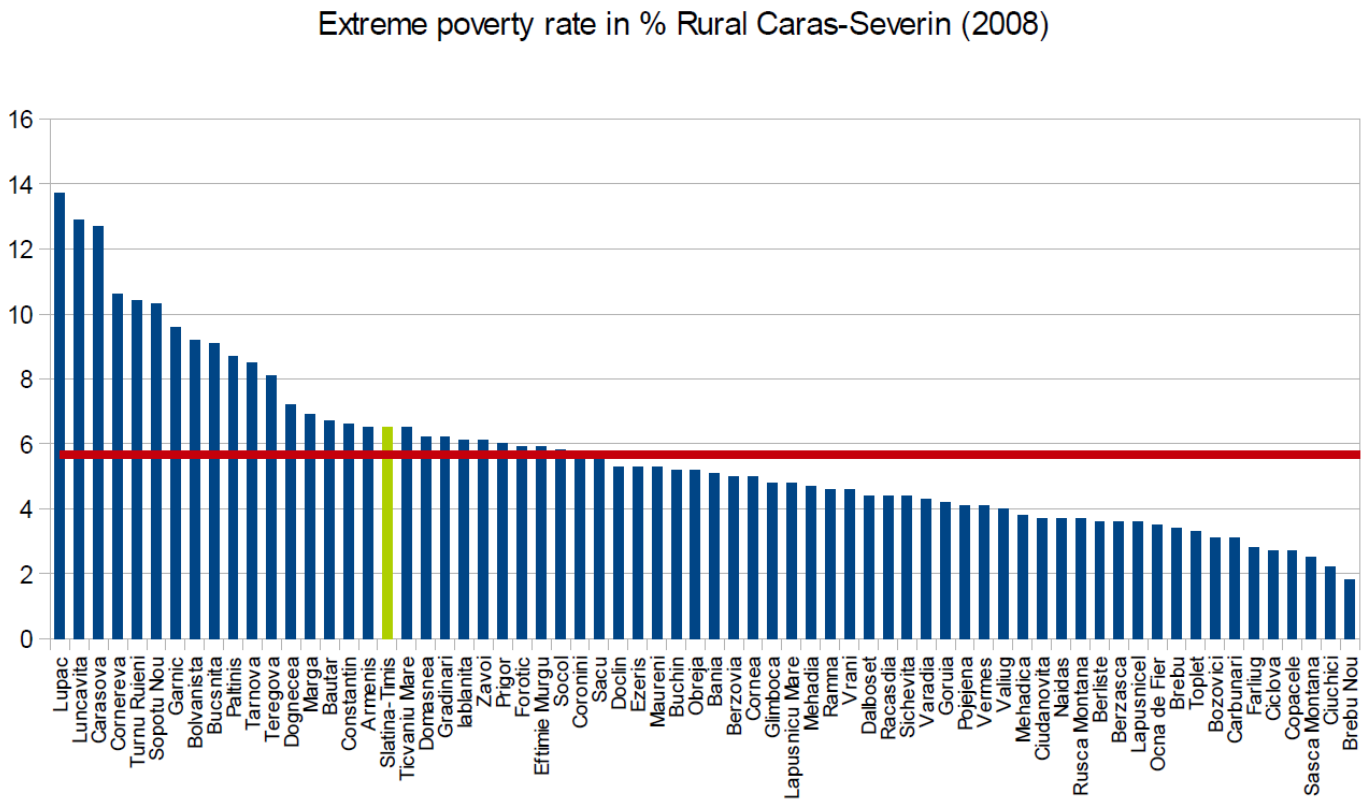
SURSA: **Comisia Națională de Prognoză**

4.9. Poverty rate Slatina-Timis

As described in paragraph 3 poverty does have a big impact on going to a doctor or not. In the next graphics data about the poverty rate in Slatina-Timis in brought together.[36]



[36] http://eufinantare.info/finantare/2008/3/322/Anexa_11_-_LISTA_COMUNELOR_si_GRADUL_de_SARACIE_aferent.pdf

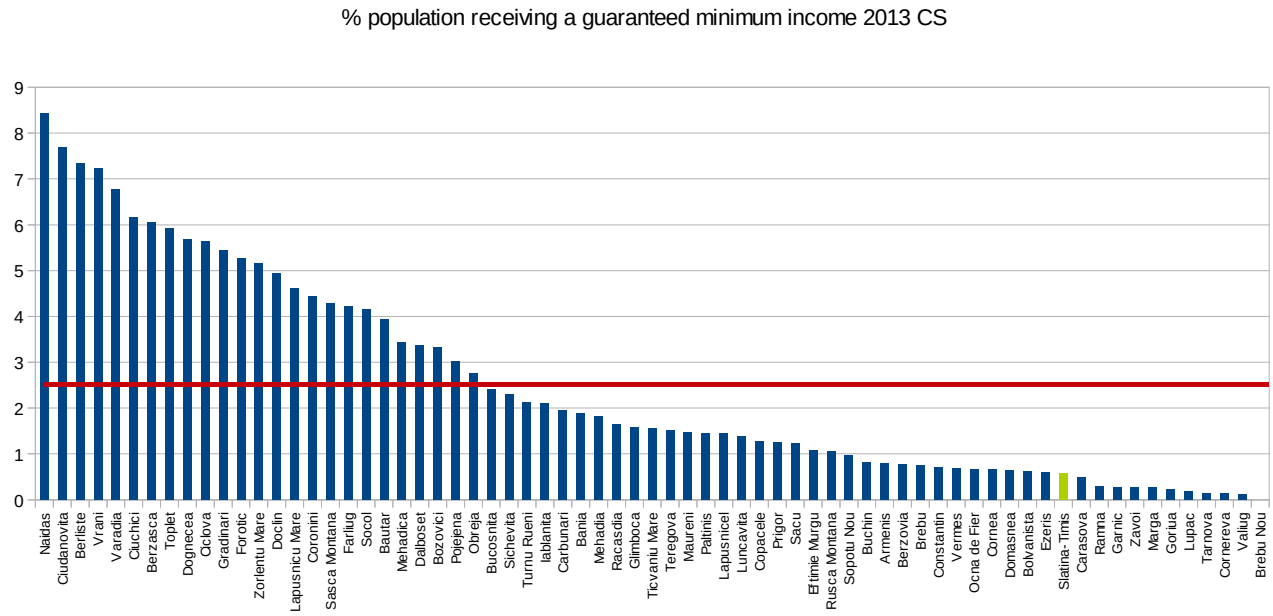


There is big difference in percentage of persons receiving a guaranteed minimum income in the county of Caras-Severin (see table below).[37]

	Population by domicile 2013	Persons receiving a guaranteed minimum income 2013	% population
Urban CS	197698	1828	0,92
Rural CS	139085	3225	2,32
Total CS	336783	5053	1,50

An average of 1,50% of the Caras-Severin population is receiving a guaranteed minimum income. In the rural area of CS this % rises to 2,32%. Also in the rural area different % can be seen. There's a gap of 8,44% between the community receiving nothing and the highest percentage of beneficiaries.

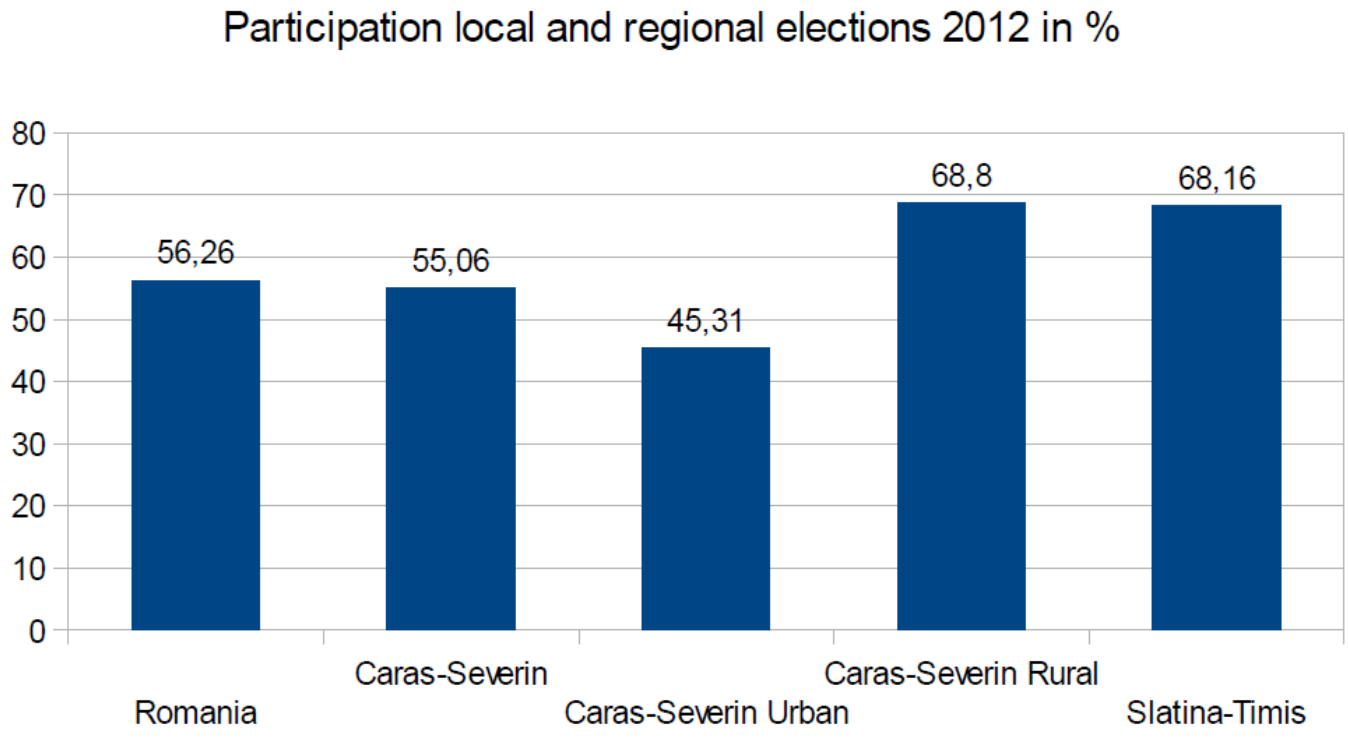
[37] Strategia de dezvoltare durabilă a județului Caraş-Severin 2015-2020, anexa I.7.2.



The villages struggling with poverty and extreme poverty don't receive automatically more minimum guaranteed incomes, even an opposite picture can be seen. Slatina-Timis with an extreme poverty rate of 6,5% only receives for 0,58% of the population a guaranteed minimum income.

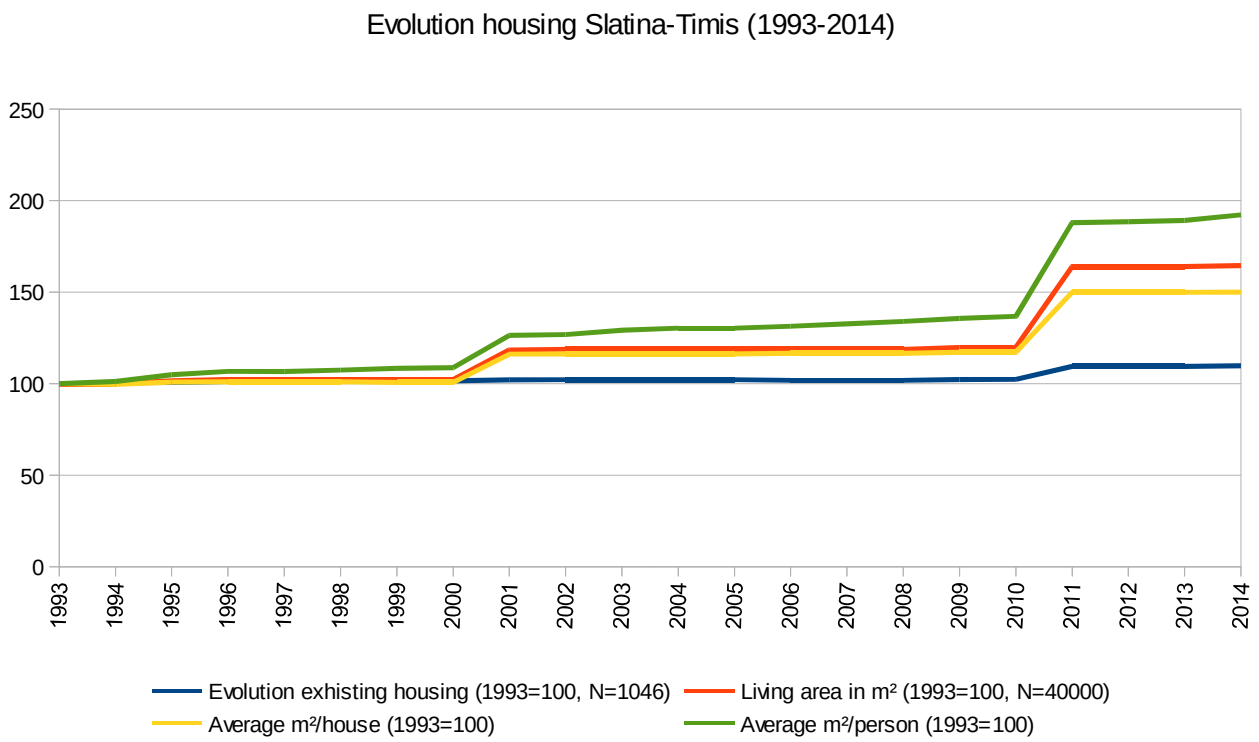
The problem of having no stable income, the (extreme) poverty rate and the low % of guaranteed minimum incomes can have an impact on going to a doctor.

4.10. Participation in local and regional elections



4.11. Houses – households – surface

The availability of houses and the conditions of housing can have an influence on the health status. In the graphic below an evolution of housing can be seen.[38]



The number of households is estimated to be 1115 (2012).[39]

4.12. Land use - water

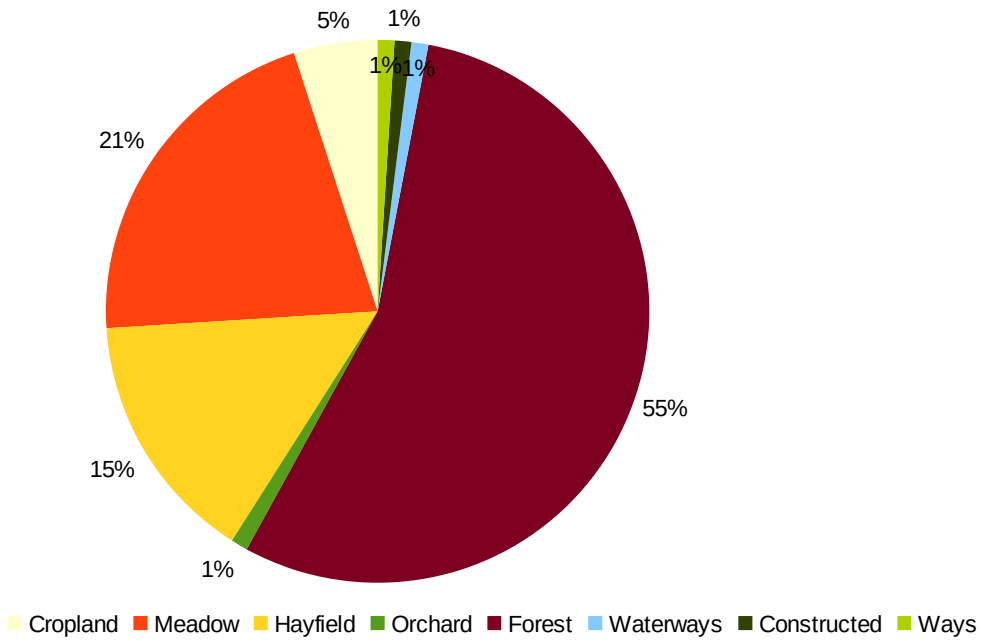
The total surface of Slatina-Timis is 15109 ha of which 6351 ha for agriculture use (42%). A further analysis can be done in separating public and private property.[40]

	All uses	Agriculture use	Non agriculture use
Private	6497	6336	161
Public	8612	15	8597
Total surface (ha)	15109	6351	8758

A more detailed insight in land use is presented below. The majority is used as forest.

[38] Tempo-Online: LOC101B - Locuinte existente la sfarsitul anului pe forme de proprietate, judete si localitati
[39] http://www.ghidulprimariilor.ro/list/cityHallDetails/PRIM%C4%82RIA_SLATINA_TIMI%C5%9E/44079
[40] Tempo-Online: AGR101B - Suprafata fondului funciar dupa modul de folosinta, pe judete si localitati

Slatina-Timis: ratio of land use, 2014, N=15109 ha



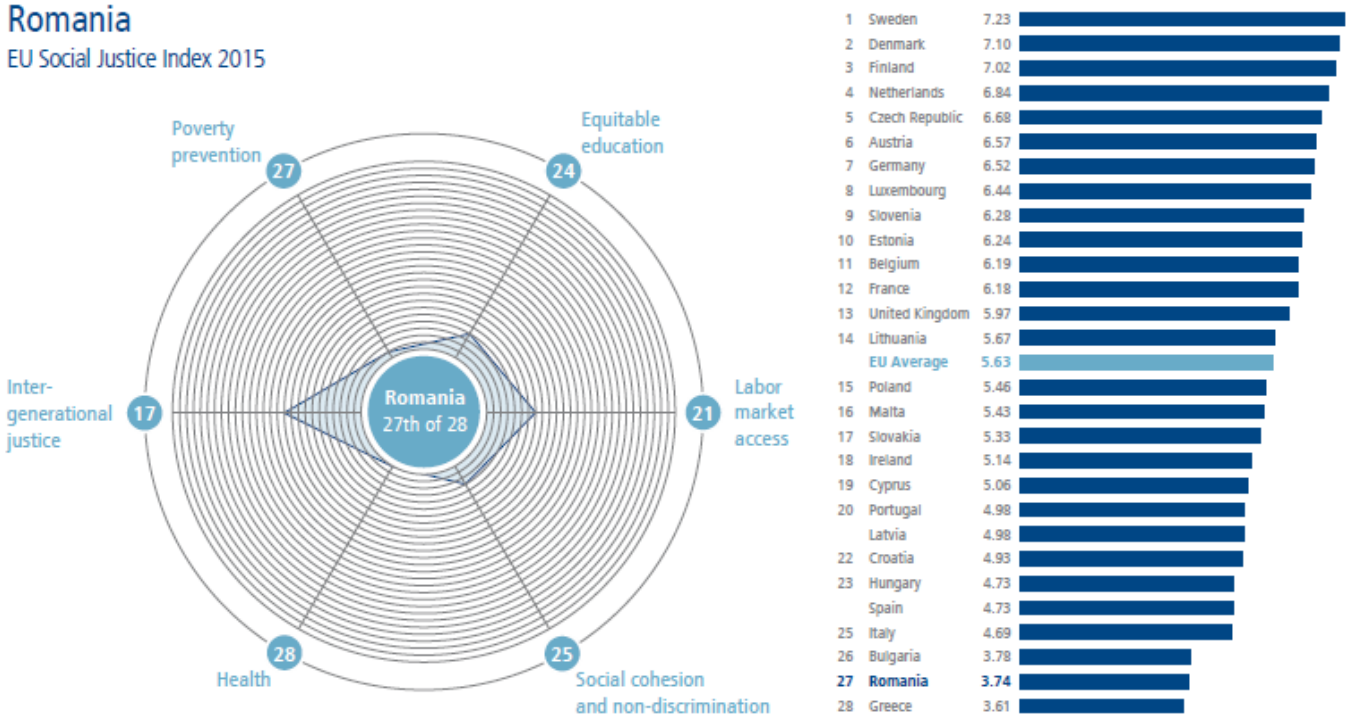
The total length of sewerage was in 2012 11,1 km, after investments done by the county Caras-Severing reached in 2014 14,2 km.[41] In the period 2015-2020 10 new km and renovation of 5 km are foreseen. There are 2 water waste management station and in the period 2015-2020 the construction of 2 others is foreseen.[42] Lines for drinkable water are representing 20,6 km and in the period 2015-2020 10 new km are foreseen.[43] This is good for 85m³ drinkable water.[44] In 2008 Slatina-Timis was putted on a list as zone vulnerable to nitrates.[45]

In the past the local Romania Group from Geel collaborated to improve water provisions and sewages.

[41] Tempo-Online: GOS110A - Lungimea totala simpla a conductelor de canalizare, pe judete si localitati
[42] Strategia de dezvoltare durabilă a județului Caraş-Severin 2015-2020, anexa Canalizare.
[43] Strategia de dezvoltare durabilă a județului Caraş-Severin 2015-2020, anexa Alimentare cu ape.
[44] Tempo-Online: GOS108A - Cantitatea de apa potabila distribuita consumatorilor, pe judete si localitati
[45] http://eufinantare.info/finantare/2008/3/agricultura-masura-322.html Anexa 12 - LISTA ZONELOR VULNERABILE la NITRATI

5. Temporary remarks paragraph 3 and 4

Recently the German Bertelsmann Stiftung published the European Social Justice Index 2015. In this index Romania is ranked 27 out of 28, just before Greece.[46]



The conclusions concerning the Romanian healthcare system are an urgent call for reform: "Because illness undermines an individual's capacity to fully achieve his or her potential, access to quality health services is considered a precondition for social inclusion. Romania, however, is failing to adequately provide this precondition to its citizens. With a score of 3.09, the country ranks last in the EU in our health dimension. According to Eurostat, in 2013, one in ten Romanians reported not getting medical attention because of cost, distance or long waiting lists (ranking the country 27th, ahead only of Latvia). According to Euro Health Consumer Index data, Romania's health system is the second worst performing, with long waiting times for treatment, a low range and reach of health services, and poor outcomes. Even more worrying, waiting times and the range and reach of services provided have each worsened progressively since 2008. Given these metrics, it should come as no surprise that the SGI country experts flagged Romanian healthy policy as inadequate, scoring it 4 out of 10. They credit inadequate funding with undermining the country's health system, which receives the lowest health budget allocation of any EU-member state. Due largely to this underfunding, the de facto availability of many medical services is severely limited, thereby leading to widespread bribe-giving by patients even for basic services. They recommend better monitoring of cost efficiency, investments and a streamlined regulatory framework for the relationship between public and private health sectors (p.131-132)."

Based on these European and national studies about the accessibility of medical services and the possibility to choose for a healthy life and the above described Slatina-Timis profile, we can suppose that quite a lot of people living in Slatina-Timis could and would experience healthcare problems. Among the possible excluded people are persons from families with no health insurance who live on incomes that are too low or on occasional incomes to

[46] http://www.bertelsmann-stiftung.de/fileadmin/files/BSt/Publikationen/GrauePublikationen/Studie_NW_Social-Justice-in-the-EU-Index-Report-2015_2015.pdf

allow them a health insurance; the people with an uncertain or transitory socio-economic status (pensioners, young people working with no sure employment status…); old people with no income or with very low incomes; children and young people with no stable residence.

How is ADAMSlatina-Timis cooping with this different target groups in order to improve the health of community member, but also to make it possible to life a decent live?

6. The impact of ADAMSlatina-Timis on the capabilities of Slatina-Timis

6.1. Start and concept of ADAMSlatina-Timis[47]

In August 1999, as part of a project financed by the Flemish Government, and with a partnership between the VZW Geels Roemeniëkomitee, the Christian Mutuality, appeared the Foundation for the Development of Mutual Help Associations. The main reason for the birth of FDAAM was, and still is, the idea of offering support to Mutual Help Associations. The first association in Romania, as a pilot project, was ADAM Slatina Timis in 1999. The basic characteristics of and ADAM (Asociatia de Ajutor Mutual) are:

- An ADAM is a social movement oriented towards the inhabitants of a village and which has an inclination for disfavored groups (sick persons, disabled persons, elders…).
- An ADAM is based on solidarity between groups and individuals in society.
- An ADAM must improve access to health services for all persons. This purpose will be reached through the cooperation with private and public health organizations. ADAM will first open the path to basic services and next to complementary services.
- Social services can be offered to members,
- An ADAM is a democratic organization opened to all citizens. It alone insures the participation of patients to all levels of health services. All members are represented in the General Assembly of ADAM. These members choose the board.
- The elimination of a polarized social system with different types of health systems.
- Cooperation with other organizations and different partners.
- An ADAM is based on the volunteer contribution on many levels: health services, directory council, social actions and complementary ones (young people, disabled persons, elders...)

An integrated healthcare is the basic philosophy of ADAMSlatina-Timis.

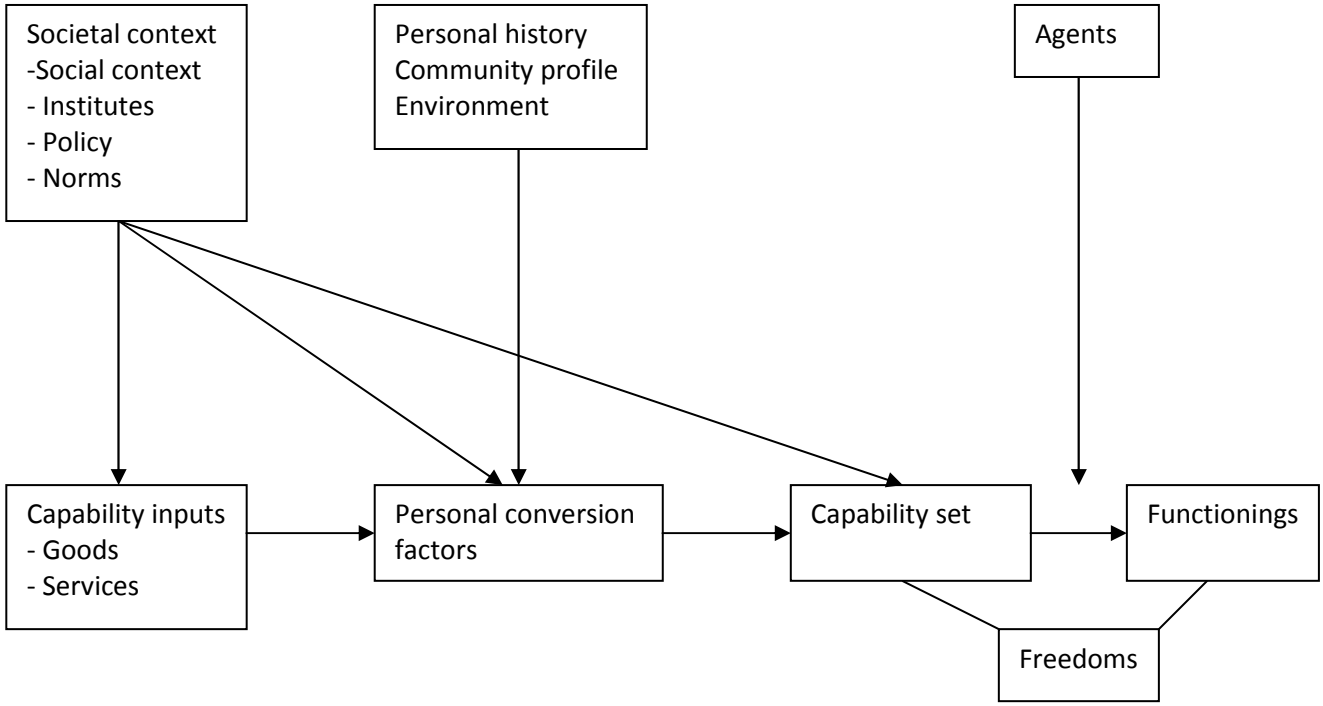
[47] http://www.benisi.eu/cases/asociatia-de-ajutor-mutual-slatina-timis-adamslatina-timis-with-support-of-actie-dorpen-roemeni%C3%AB-vlaanderen-adr-vlaanderen-and-the-open-network-for-community-development
https://www.changemakers.com/innovationinageing/entries/first-line-health-care-community-health-centers-rural-a

6.2. ADAMSlatina-Timis: improving the health capabilities through social investments

The table presents the general profile of members and patients at ADAMSlatina-Timis.

Number inhabitants:	3005				
Insured CNAS:	8				
Insured CJAS C-S:	2302				
Insured Private:	17				
ADAMSlatina-Timis:					
Number members:	1.725				
Insured CNAS:	8				
Insured CJAS C-S:	1.592				
Non-Insured:	313				
Membership Fee:	25 Lei/adult	>18 year	Max 3 pay/family		
Reduct. for members:	25% on all non-reimbursed acts				
Patients ADAMS:	**1.905**	File at ADAMS:	**1901+387**		
		Age:	**Pat. ADAMS:**	**Inhabitants:**	
Men:	898	0-1 year:	10	14	
Women:	1.007	1-4 year:	47	68	
Slatina-Timis:	1.732	5-14 year:	194	232	
Armenis:	61	15-29 year:	394	582	
Golet:	102	30-64 year:	872	1416	
Bucosnita:	11	>65 year:	388	693	
Medical activities ADAMS 2015:					
Total consultations:		4.877			
Home visits:		401			
Treatments:		1.512			
Home care ADAMS:		Numb. Pat.:			
	Accredited:	0	6 acts. Min.	50 Lei/day	
	Other:	36 in 2016	1-2 vis./week	10 Lei/mo.	
Social fund ADAMS:		48 in 2016		5.200 Lei	
Renting ADAMS:		142 in 2016			
Dental care ADAMS:	N° acts 2016:				
Slatina-Timis:	105				
Verendin:	128				
Volunteers at ADAMS:	31/12/16				
ADAMSlatina-Timis:	89				
ADAMCaransebes:	13				
ADAMResita:	15				
Activities ADAMS:	Total 2016:				
Info sessions:	11				
Prevention sessions:	9				
Workshops:	2				
Public events:	10				
Company visits:	35				

To describe the improvement of health capabilities the following representation of a person's capability set and her social and personal context are used.



Societal context: medical versus social model

The social context of medical services was already described above. Studies gave us an idea of a problematic healthcare system. The amount of unmet medical needs is extremely high. One of the causes is the availability of medical services. For Caras-Severin there's an average of 1 doctor for 1874 inhabitants. Differences can be seen between the urban and rural area.

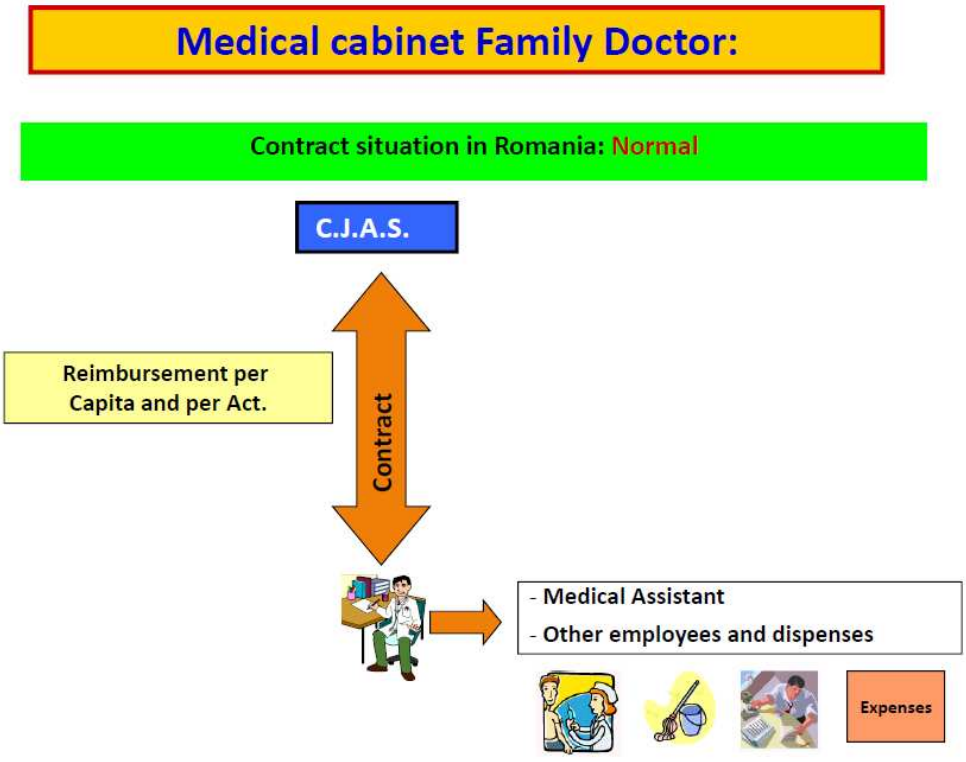
	Population by residence 2011[48]	Family doctors November 2015[49]	1 doctor for x inhabitants
Caras-Severin	295579	160	1847,4
Urban CS	160548	94	1708,0
Rural CS	135031	66	2045,9

Slatina-Timis has 1 doctor for around 3000 inhabitants. This is very similar to communes of Caras-Severin from the same size.

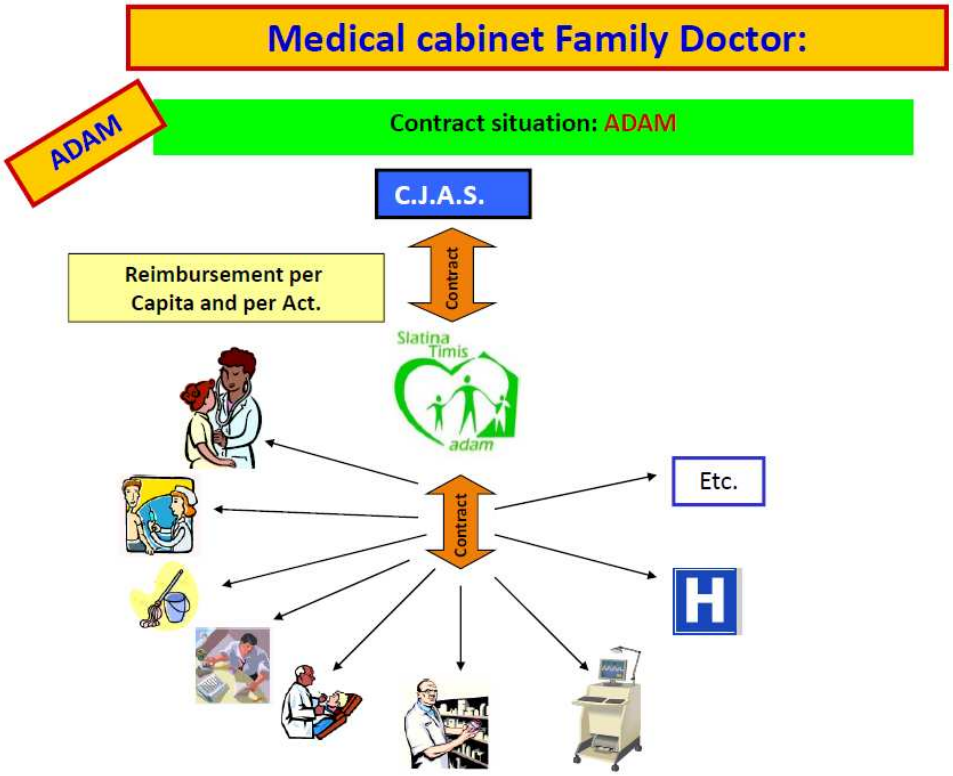
[48] Census 2011
[49] http://www.casan.ro/cjas-cs/media/pageFiles/Situatia%20medicilor%20de%20famile%20-%20contracte%2001.11.2015.pdf

Comune	Population 2011	Doctor(s)
Armenis	2454	1
Prigor	2577	1
Bautar	2604	1
Toplet	2625	2
Maureni	2646	1
Lupac	2677	1
Constantin Daicoviciu	2692	0
Berzasca	2848	1
Pojejena	2884	1
Bozovici	2924	2
Bucosnita	2978	1
Carasova	3110	1
Cornerva	3190	1
Obreja	3252	1
Turnu Ruieni	3342	2

Based on this numbers Slatina-Timis seems to have the same ***capability input*** as similar communes. Although this is only true if the medical model is taken in consideration. Meaning a model which considers illness as a problem of the individual that is directly caused by a disease, an injury, or some other health condition and requires medical care in the form of treatment and rehabilitation. The medical model strongly stresses on the curative aspect. ADAMSlatina-Timis has a much broader range of working area. By focusing on growing the capacity of nurses, the doctor of Slatina-Timis can concentrate on the core tasks.The goods and services are not strictly restricted to medical treatment but brings in practice a social model of healthcare. This social model sees health and illness as a social construct. Health is not only the attribute of the individual; instead, it is created by the social environment and requires social change. The development of a social medical integrated healthcare system is the priority. How this model was implemented in Slatina-Timis is very well illustrated by Ioan Suru, coordinator of ADAMSlatina-Timis.



A ‘normal’ situation is a contract between the Health Insurance House and a doctor, providing the community with medical treatments. ADAMSlatina-Timis is using an other approach: not an individual doctor is making an contract but the organization as such. This way of working makes it possible to integrate other medical services.



The range of services and goods are much bigger than in a classical model of healthcare:
- Family doctor
- 2 medical points for mountain villages Ilova and Sadova Noua
- Dentist
- Social pharmacy
- Home care
- Body care
- Revalidation room
- Mediotheque

Having services and goods is only the first necessary step in improving the health capabilities. ***Personal conversion factors*** will have to transform this services into a real set of capabilities. Obstacles can appear. As described in the community profile Slatina-Timis is struggling with a low employment rate and a relative high poverty rate. Lack of income can impede the access to healthcare. A set of capabilities is created to facilitate the use of offered medical services.

Capability set

The creation of this set takes into account the needs of the population. Everyone can become a member of ADAMSlatina-Timis by paying a member fee of around 5 euro. The decision making process is in the hands of all members. Everyone has a vote in the General Assembly. The ownership is a responsibility of the whole

community. By being a member is an act of solidarity, the money is used to facilitate to meet the medical needs of community members. This means concretely:
- A reduction of medical costs for uninsured persons
- A social fund in the form of a loan without interest for urgent medical operations.

Costly friendly goods such as glasses, diabetes passes, dietary guidelines, different informative leaflets, check-ups… are facilitating the access. Beside that ADAMSlatina-Timis is organizing prevention campaigns.
- Packets for new borns
- A pickup service by car
- Daily homecare
- Defending patient rights
- Information regarding specialists and hospitals and feedback
- Cooperation with DSP and CJAS and promoting official health insurance

This broad capability set increases the freedoms of people to choose for a healthy life and proper medical services. A last important step is how people can be stimulated to choose for these capabilities in order to improve their health.

Agents

To have goods and services, which are translated in concrete sets of capabilities, is essential but not the last step in improving public health. Go betweens are necessary to transform negative personal conversion factors in opportunities to improve. ADAMSlatina-Timis as open house for medical and social movements strengthens community development and directs people to local health (care) programs. Important players in this field are:

- Local HealthCareGroup
- VIZIDOM (volunteers visiting persons wit a (medical need)
- Men – women organization
- Youth movement
- Schools
- Civil society organizations (women (OLF), men (OLB), youth (GLT)… as stimulator and promoter of health and health promotion and represented in board ADAMSlatina-Timis. Cooperation with schools. Local council represented in board ADAMS.
- Networking.

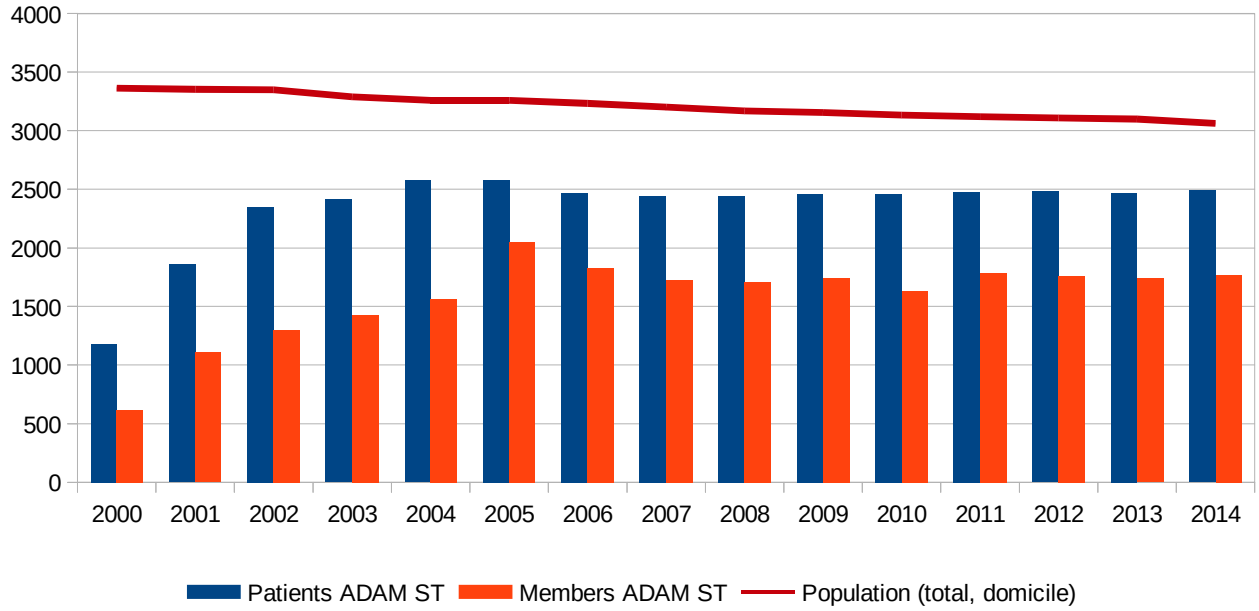
Functionings

At the end when all the components are fitting together results (achieved functionings) will appear. The case study already refers to some of them: a lower inpatient ratio, detection of diseases (f.ex. diabetes). Three more examples are added to this:
- Sustainability
- Tackling unmet medical needs
- Regional impact

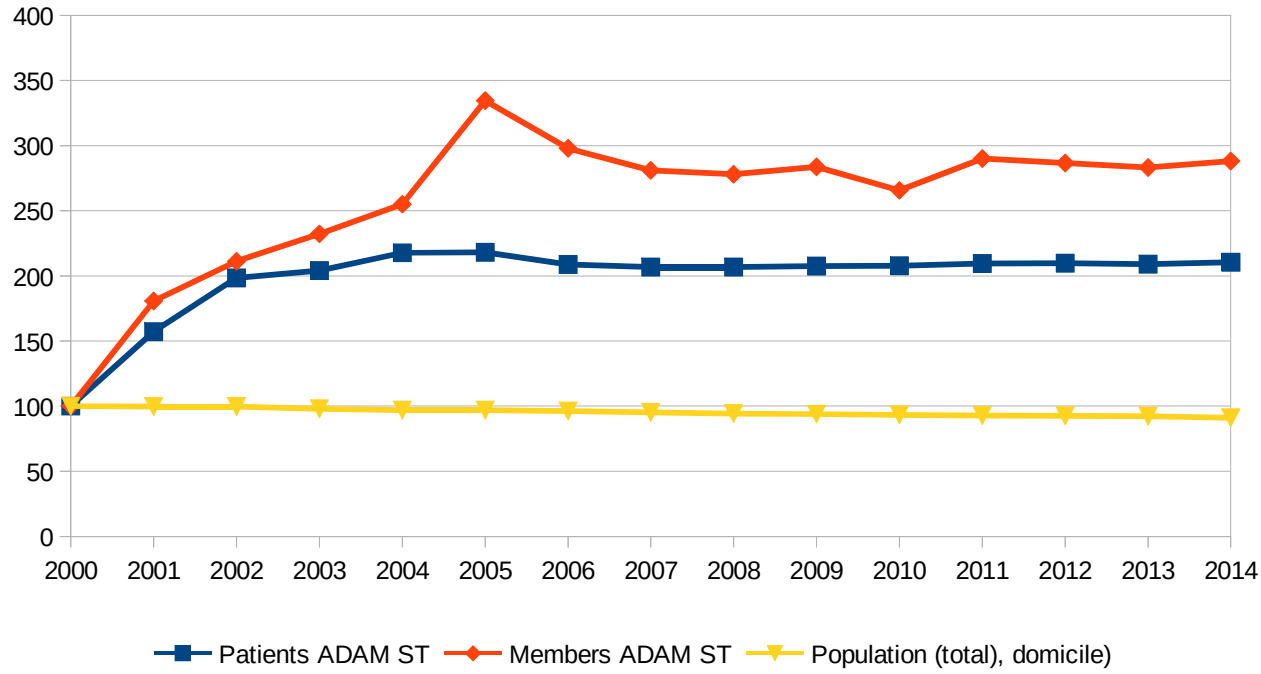
Sustainability

Although the population of Slatina-Timis is decreasing year-by-year: -9% between 2000 (start of ADAMSlatina-Timis) and 2014, the amount of members and patients stay stable and has a growing trend.

Absolute evolution population, patients and members Slatina-Timis



Evolution population, patients and members Slatina-Timis (2000=100)



Tackling unmet medical needs

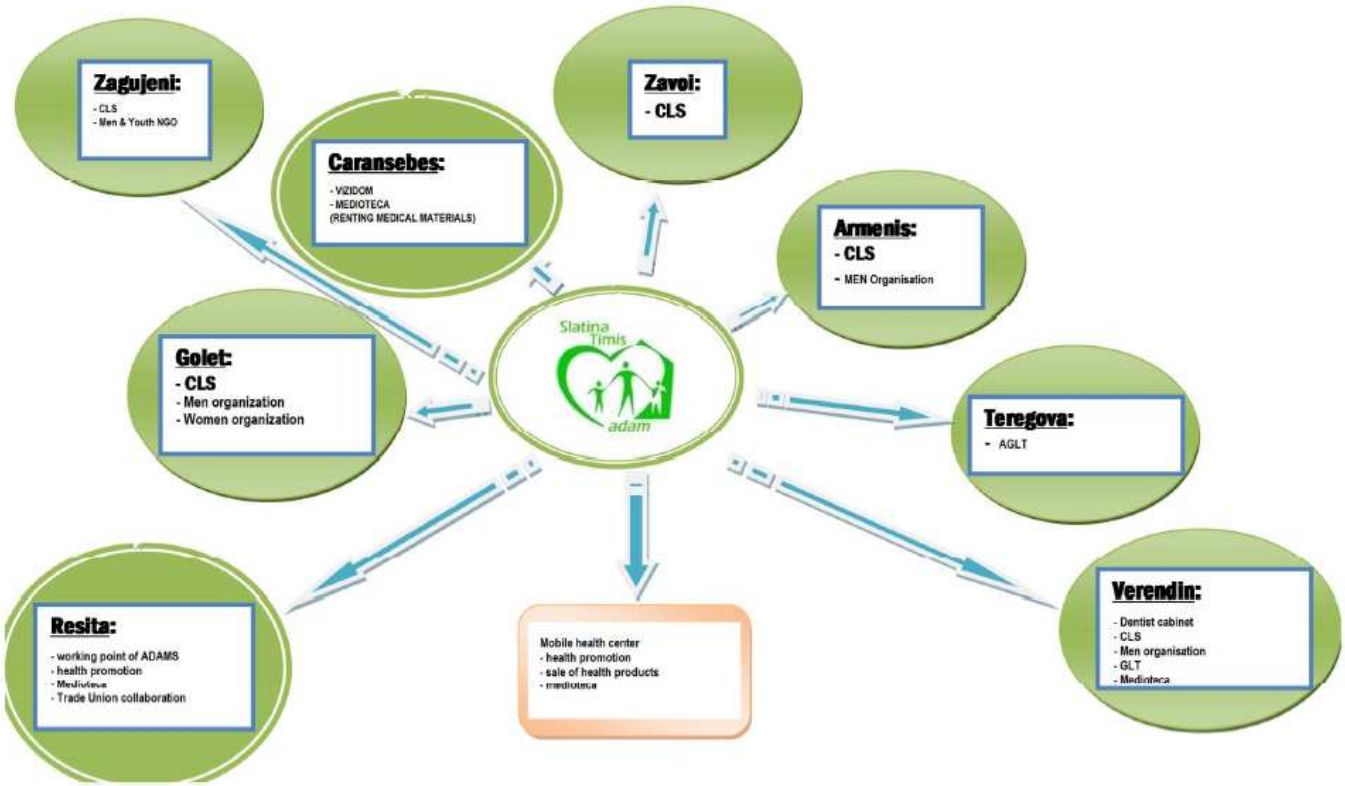
As shown before in Romania a significant part of the Romanian population is experiencing diffculties to go to a doctor. In total ADAMSlatina-Timis reaches 1723 citizens from Slatina-Timis or depending on the age category between 1/2 and 1/3 of the population. Even more patients from the rural villages Armenis (56), Golet (102) and Bucosnita (21) can be reached.

Because of the mutualistic approach also uninsured persons, through reduced prices, have access to medical care. Around 1/3 of the patients are uninsured.

An important aspect in developing medical services is trust building, one of the key challenges for ADAMSlatina-Timis as clearly underlined by one of the inhabitants: “It took me one day long to go to Caransebeș by buss and wait there in the line. I didn’t know that we could have these services in our community but at first I did not trust that it would be OK. Now I am sorry, as I saw that many people are very happy with the services provided at ADAMS dentistry. It is no question that next time I shall go to our doctor, here”.

Regional impact

The impact of ADAMSlatina-Timis is not restricted to Slatina-Timis, it has a appearance and impact on the regional. Patients from neighboring communes find the way towards ADAMSlatina-Timis. Also this was very nice illustrated by Ioan Suru, coordinator of ADAMSlatina-Timis.



7. Conclusion

Classical health policies in Romanian rural areas address objectives related to the provision of medical care and individual health. Here the target groups are primarily private individuals. In this area of health policy, the legal relations are predominantly arranged in contractual agreements: between hospitals and doctors, between doctors and patients, between insurance institutions and family doctors. ADAMSlatina-Timis takes up this responsibility by lowering the access to healthcare, but goes beyond this and has the objective to manage collective health risks and to organize prevention, in short local public health. The focus on health in the context of ADAMSlatina-Timis is not only in the area of medical care, but extended to public health safeguards A key example is the mutual work in which solidarity between people is essential and the core of the social medical open house. ADAMSlatina-Timis in many respects is one of the first local healthcare programs that was not only involved in the removal of barriers to medical care (negative integration), but also introduced a common public health responsibility and ownership at the local level. In relation to social welfare this integrated public-private healthcare system, under the heading of an overall local health policy, improved the health capabilities of citizens of Slatina-Timis.