Macaresti – Prisacani

Macaresti (Prisacani, Romania) – Towards a healthy community

Being able to choose for a mutual based healthy life

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provincie Oost-Vlaanderen

V.Z.W. S.O.S. Măcărești

The Open network for community development

ACTIE DORPEN ROEMENIË

ADR - VLAANDEREN

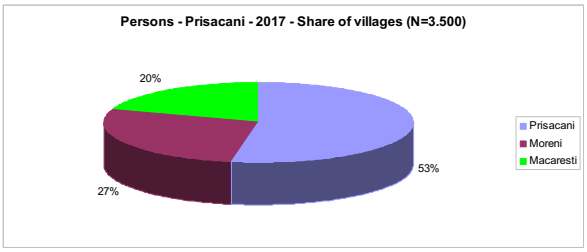
1. Introduction

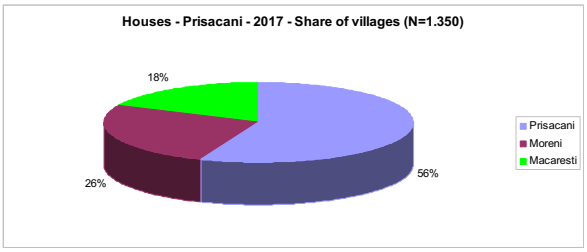
Health and health care system are important issues for all, either political or social actors interacting in a social arena and reflect a particular context and a certain social reality. Usually, the social reality depends on the political system and on the way society organizes itself. The health care system is a key factor for public health which theoretically should meet the needs of the population. Better health outcomes depend on effective interventions delivered by better health systems. Uneven distribution of health care resources, the social inequalities may affect the access of particular groups of population to health care services, generating inequities and inequalities in medical services utilization. In order to reduce such inequalities, particular importance must be paid by stakeholders and political actors to the role they are playing in organizing the health system and planning health care resources or implementing health policies. The final resolution of the United Nations Conference "*The Future We Want*", also highlighted the importance of health universal coverage "*we recognize the importance of universal health coverage to enhancing health, social cohesion and sustainable human and economic development*". This is also reflected in one of the 17 Sustainable Development Goals: "*Ensuring healthy lives and promoting the well-being for all at all ages is essential to sustainable development. Significant strides have been made in increasing life expectancy and reducing some of the common killers associated with child and maternal mortality. Major progress has been made on increasing access to clean water and sanitation, reducing malaria, tuberculosis, polio and the spread of HIV/AIDS. However, many more efforts are needed to fully eradicate a wide range of diseases and address many different persistent and emerging health issues.*"

Recently research of health care services has focused on access inequalities to health care in Romania. However this issue is still far for being comprehensively analysed at a local level. A limitation of this report is the lack of statistical data relating to health and health care at micro-territorial level that reduces the possibility of building a comprehensive health care needs assessment. On the other hand by combining national, regional and local data a qualitative insight in the needs can be made. The health needs incorporate the wider social, economical and environmental determinants of health, such as deprivation, housing, diet, education, employment, so that we can say that the health care needs of a population are constantly changing according to the determinants of health.

In this report the analysis is done for a village Macaresti, which is a part from the commune Prisacani. Prisacani is a commune in Iași County, Romania at the border with the Republic of Moldova. It is composed of three villages: Macarești, Moreni and Prisacani. For already more than 20 years Maldegem and Macaresti (Prisacani) are collaborating. Since then a diversity of projects and actions are realized. A specific focus was going to the improvement of social medical services. The renewal of the 'dispensar' is one concrete example of the collaboration. Besides the importance of infrastructure, the development of services and raising the citizens involvement is equally important. A turnover is made from health care as such towards 'healthy communities'. Quantitative and qualitative data are the base for future developments.

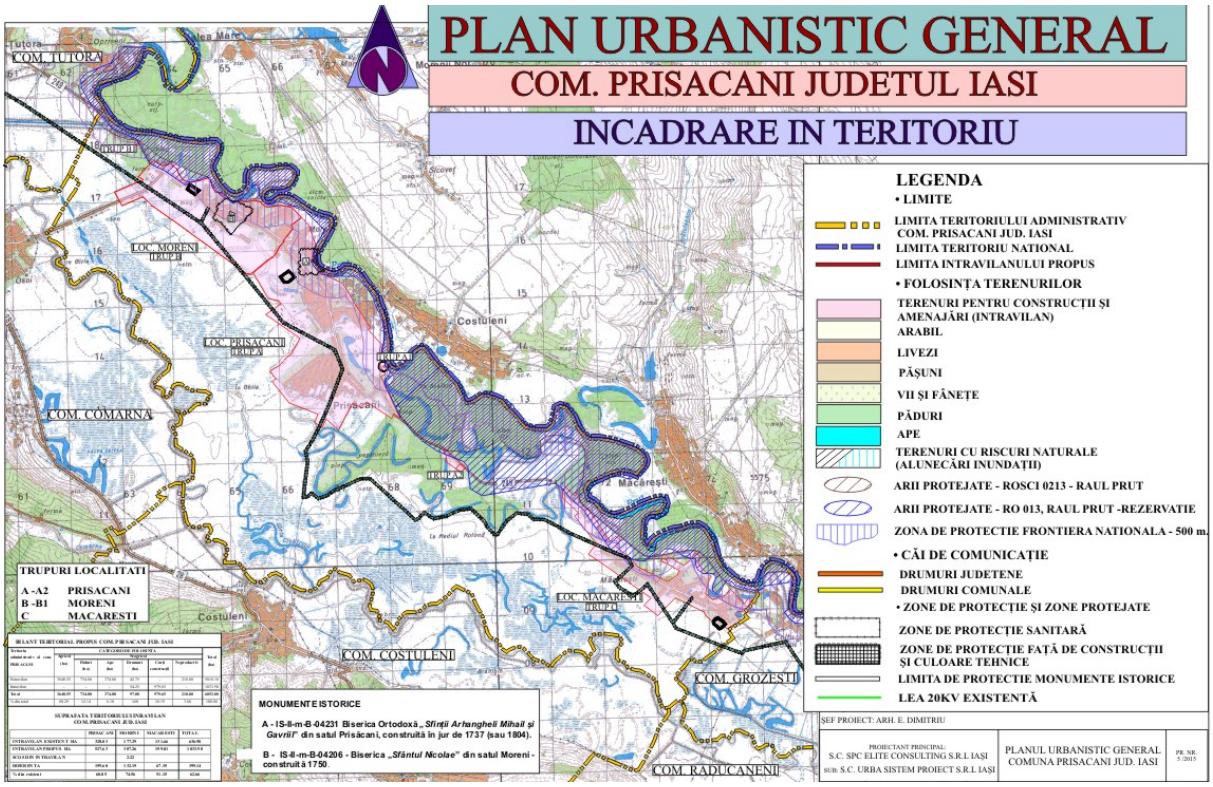
Prisacani has a population of around 3.500 inhabitants: most of them are Romanians (97%) and are belonging to the Orthodox religion (97%). Prisacani as the main village has around 1.850 inhabitants, where as Moreni counts 960 and Macaresti 690.





In the commune of Prisacani there are different schools, all under the supervision of one school group. The 3 villages have their own primary school, the main village is having a gymnasium. Youngsters are in other words able to follow classes until the age of 14 in their home commune. Afterwards they can go to a lyceum or vocational training in another place, mostly in the city of Iasi.

Prisacani is a predominant rural area with not so much economic activity. Most of the people are depending on self sustainable agriculture.



Some of these data are more explored in the chapter 6 in which the needs concerning health and health care are mapped.

For the elaboration of this project a connection was made with the foundation “The Open Network for community development” (TON). TON is a network organization that has been built bottom up. This foundation is the result of 30 years of cooperation between Flemish (Belgian) and Romanian communities. The Belgian NGO ‘ADR-Vlaanderen’ connects and represents approximately 100 twinning partnerships. Romanian partners have been organized within Romania in TON, as exchange and collaboration were deemed essential for future progress. At the moment, TON encompasses about 20 twinning partnerships, including partnerships that have evolved for more than 25 years. The Belgian-Romanian cooperation proved a big advantage for both partners, though having a Belgian partner is not requested as a condition for becoming part of the TON network. TON is in a unique position to better articulate the needs of rural communities in Romania, to advocate for their fulfilment and to facilitate learning within the network. As access to healthcare does represent a basic need of any individual, family or community, defining and supporting the process of TON communities becoming ‘**healthy communities**’ represents a key priority for the TON Foundation.

Through this preliminary report, authors intend to point out at the importance of a needs assessment as well as (inter)local strategies can meet these needs, taking into account the socio-economic-geographic reality.

2. Methodology

2.1. Social mapping Flanders – Vitality mapping Netherlands – Healthy community

In general the methodology is based on existing methodologies in Flanders, the Netherlands and Romania. For this research we made use of:

Flanders
Profiles of communes - http://www.statistiekvlaanderen.be/monitor-gemeentelijke-profielschetsen

The Netherlands
Vitality mapping of communes and villages - https://roosendaal.buurtmonitor.nl/
On October 3 2017 a meeting was organized in Roosendaal in which the methodology was presented.

Romania
- Atlas of Rural Development, 2016 → mapping of marginalized areas in Romania
- List of communes according to the Local Human Development Index, 2011
- List of communes according to the rate of poverty, 2008

2.2. Review of national and regional strategies

To acquire a general insight in the evolutions in Romania, the documents produced by the European Commission in the context of the European semester were consulted together with the publications of the European Social Policy Network.

In the context of this report, several national strategies were consulted:

- Strategy development of Romanian territory 2014-2020
- Strategy for social inclusion and reduction of poverty 2014-2020
- Strategy for health 2014-2020

Going from the national level towards the regional and county level, the following development plans were consulted:

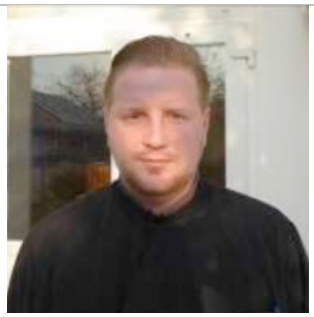
- Development Strategy Region North East 2014-2020
  - http://adrnordest.ro/index.php?page=REGIONAL_RDP
- Development Strategy of the county of Iasi 2014-2020
  - http://www.icc.ro/ro/strategia-de-dezvoltare-jude%C8%9Bului-ia%C8%99i-materiale-pentru-dezbatere-7225
- Local Action Group Stefan Cel Mare of which Prisacani is part of - Development Plan 2014-2020
  - http://galstefancelmare.ro/pdl/

More detailed information based on articles is integrated in the specific paragraphs.

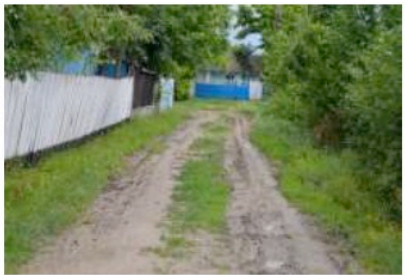
2.4. Participatory action

Quantitative data published on websites of Eurostat and the Romanian National Institute for Statistics are used. To keep the balance between quantitative and qualitative data, interviews, 3 site visits and stakeholder meetings were organized:

- 1-to-1 meeting with key informants such as the mayor, social assistant, doctor, teachers, priest

			
Mayor STANCIU Ghiorghe	Social Assistant ZAHARIA Ana	Priest BOGOS Valentin	Coordinator School Macaresti IFTIME Valentina

- Site visits


- A community meeting was organized in the context of the European ReInvest project

The RE-InVEST project aims to contribute to a more solidary and inclusive EU, through an inclusive, powerful and effective social investment strategy at EU level. Moreover, the project itself adopts a participative approach that gives voice to vulnerable groups and civil society organisations (see also: http://re-invest.eu/). October 23-25 2017 a meeting was organized in Iasi. A one day visit to Macaresti was integrated in the program. The day program had 3 parts:

- A meeting with the local authority and administration
- Site visit (houses, doctor cabinet, school)
- A community meeting

During the community meeting people from the commune Prisacani had the opportunity to go in interaction with the researchers of the ReInvest project.

The main points of concern were:

- Small interest of the doctor to come to Macaresti to keep consultations
- To need to develop home care
- The former 2 are also connected to the difficult accessibility of Macaresti (road in a bad condition)
- A demand of improvement of doctor cabinet (water supply, heating)

3. International legal and policy framework

The **right to healthcare** is recognized by key **international** conventions, which generally stress the dimensions of **adequacy** and **quality** of healthcare. To start with, the United Nation *Universal Declaration of Human Rights* (1948) states that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and *medical care* and necessary social services […]' (art. 25 (1)). The right to the highest attainment standard of health is recognized as a 'fundamental right' in the *Constitution of the World Health Organisation* (WHO). The WHO attributes to governments '[…] a *responsibility for the health of their peoples* which can be fulfilled only by the provision of *adequate health* and social measures'.

At the **European level**, the *European Social Charter* (1961) drafted by the Council of Europe states that 'Everyone has the right to benefit from any measures enabling him to enjoy *the highest possible standard of health attainable*' (Part 1, art. 11) and that "*Anyone without adequate resources* has the *right to social and medical assistance*" (Part 1, art. 13). Furthermore, the European Social Charter devotes a whole article (Part 2, art. 13) to the right to social and medical assistance. These principles and rights were then restated in the revised European Social Charter of 1996. Compared to the previous documents, the Charter adds a more explicit reference to **access** as a key dimension of the right to healthcare (together with adequacy and quality).

The *Charter of Fundamental Rights* of the EU (2000) recognizes that 'Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment […] (art. 35), while the *Treaty on the Functioning of the European Union* states that 'A high level of health protection shall be ensured in the definition and implementation of all Union policies and activities' (Title 14, art. 168).

As shown above, in the international conventions, healthcare is considered as a right, and three key dimensions of this right appear predominant: **adequacy**, **quality**, and **access**. The situation is however more complex when looking at how the right to healthcare has been translated into EU policies and activities. To start with, healthcare was included, in 2005, among the strands of the *Open Method of Coordination (OMC) for social protection and social inclusion* (together with the fight against poverty and social exclusion and pensions). Two policy paradigms coexisted in the social OMC. On the one hand, social policy was seen as a '**productive factor**', contributing to economic growth and employment. Furthermore, particular attention is devoted to the need to preserve the sustainability and enhance the efficiency of social protection systems, in order to ensure that the systems are both viable and financially sustainable in the long term. On the other hand, social protection is treated as a '**citizenship paradigm**' (fundamental right) with the emphasis placed on '*access*' to social protection rather than the 'sustainability' of social protection systems'. The approach to healthcare in the Social OMC appears closer to the citizenship paradigm, at least at the discursive level. Indeed, in the *Nice Common Objectives* (which underpin the Social OMC), the Member States were asked to 'put in place policies which aim to provide access for all to healthcare appropriate to their situation, including situations of dependency'. The coexistence of the two paradigms is particularly evident in the Common Objectives of the Social OMC (2006), which call (Objective 1) for '[…] adequate, accessible and financially sustainable, adaptable and efficient social protection systems […].

This said, a more '**economically-oriented**' EU approach to healthcare had already emerged in the 1990s. Healthcare was progressively made subject to the EU internal market rules, and controlling public expenditure on health has long been a theme in EU coordination of macroeconomic policies.

The three approaches to healthcare developed simultaneously in the Social OMC. In the *Council Conclusions on Common Values and Principles in European Union Health Systems* (Council, 2006) – which built on discussions taking place in the context of the Social OMC – besides the principles of **universality**, **access to good quality care**, **equity** and **solidarity**, **financial sustainability** is also seen as a 'fundamental feature' of healthcare systems. An exemplification of this is the understanding of 'preventive care', depicted as '[…] an integral part of Member States' strategy to reduce the economic burden on the national healthcare systems, as prevention significantly contributes to cost reduction in healthcare and therefore to financial sustainability by avoiding disease and therefore follow-up costs' (Council, 2006). **Patient involvement** is a further principle stressed in the Council Conclusion.

The need to preserve both **access to high quality healthcare** and an **efficient use of resources** characterizes the 'social investment approach' as understood in the Commission Social Investment Package (SIP) (European Commission, 2013a). This said, in this document – as well as in the Commission Staff Working Document 'Investing in Health' accompanying the SIP (European Commission, 2013b) – a population with a good health status is mainly seen as a productive factor. As the Staff Working Document makes clear, besides being 'a value in itself', health '[…] is also a precondition for economic prosperity [insofar as] people's health influences economic outcomes in terms of productivity, labour supply, human capital and public spending'' (European Commission, 2013b:1). Health expenditure is recognized as 'growth-friendly expenditure'. Consequently, the Commission '[…] recommends reforming health systems to ensure their cost-effectiveness and sustainability and assessing their performances against the twin aims of providing access to high-quality healthcare and using public resources more efficiently'. Interestingly enough, in the most important EU initiative in the social domain undertaken in the most recent period – the *European Pillar of Social Rights* (EPSR) – a more marked rights-based approach to healthcare emerges. Indeed, the Recommendation on the EPSR (European Commission, 2017) simply and clearly states (Principle 16 – 'Healthcare') that '*Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality*'.

As it emerges from the review of key documents above, three approaches to healthcare coexist (and compete) in EU discourses and initiatives: 1) *healthcare as a human right* (with an emphasis on access, quality and affordability); 2) *healthcare as a cost*, with an emphasis on fiscal sustainability; and 3) *healthcare as a productive factor*, promoting the health status of citizens and thus improving their employment prospects, with an emphasis on efficiency and preventive actions. The latter approach is prevalent in the Commission understanding of social investment. A further element relevant to the healthcare sector and characterizing the SIP is the emphasis on the **involvement of private for profit and third sector actors** in the funding, provision and delivery of social policy.

Healthcare systems within the European Union differ widely, and a great deal of public money is involved in this sector. Therefore, Member States have always watched jealously to keep the

competence on healthcare within their national borders. Article 168, 7° of the Treaty on the functioning of the EU states that *'Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care.'*

4. Implementing this international framework

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.

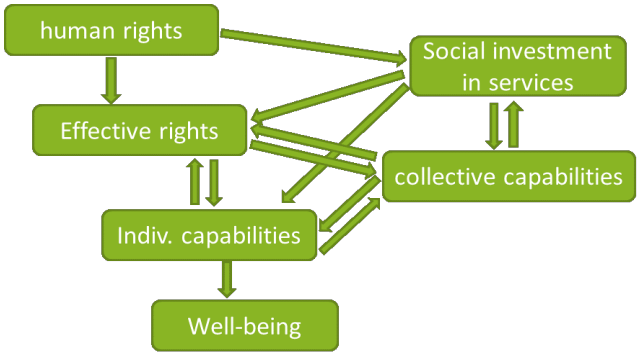
It should be noted that the health status of a population does not only depend on the efficacy of healthcare systems. Policies that address the socio-economic determinants of health, including quality of housing and working conditions can have a more important impact on population health than clinical 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.

Measuring these health and health care aspects is very often measured in terms of public expenditures, health outcomes and achievements. 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 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, our model builds on human rights and capabilities as building blocks for the wellbeing of individuals. We learned from previous discussions that (formal) human rights (e.g. right to work, right to social protection) are values, social norms which do not automatically result in improved wellbeing. For the implementation of such rights (mainly in the field of economic, social and cultural rights), different types of policy measures need to be implemented: legislation, organisation of (public) services, subsidies, social transfers, inspection, judicial enforcement... Although some legal measures may establish effective rights (e.g. a guaranteed access to basic services), most policies necessitate additional 'social investment' in individual and collective capabilities through public or subsidised service provision (e.g. health care…) and the transfer of power and resources – either directly to individuals / households (e.g. social benefits), or to companies and civil society organisations (e.g. subsidies to housing companies, water distribution, health care providers).

In our Macaresti case study at the local level, we will examine closely all stakeholders involved and all links in the model, from the viewpoint of vulnerable groups. In the end conclusions will be drawn concerning wow social investments can be shaped and how they effectively contribute to the implementation of basic rights.

The starting point is a general overview of health care trends in Romania, as a context for the local analysis.

5. General trends in health care Romania

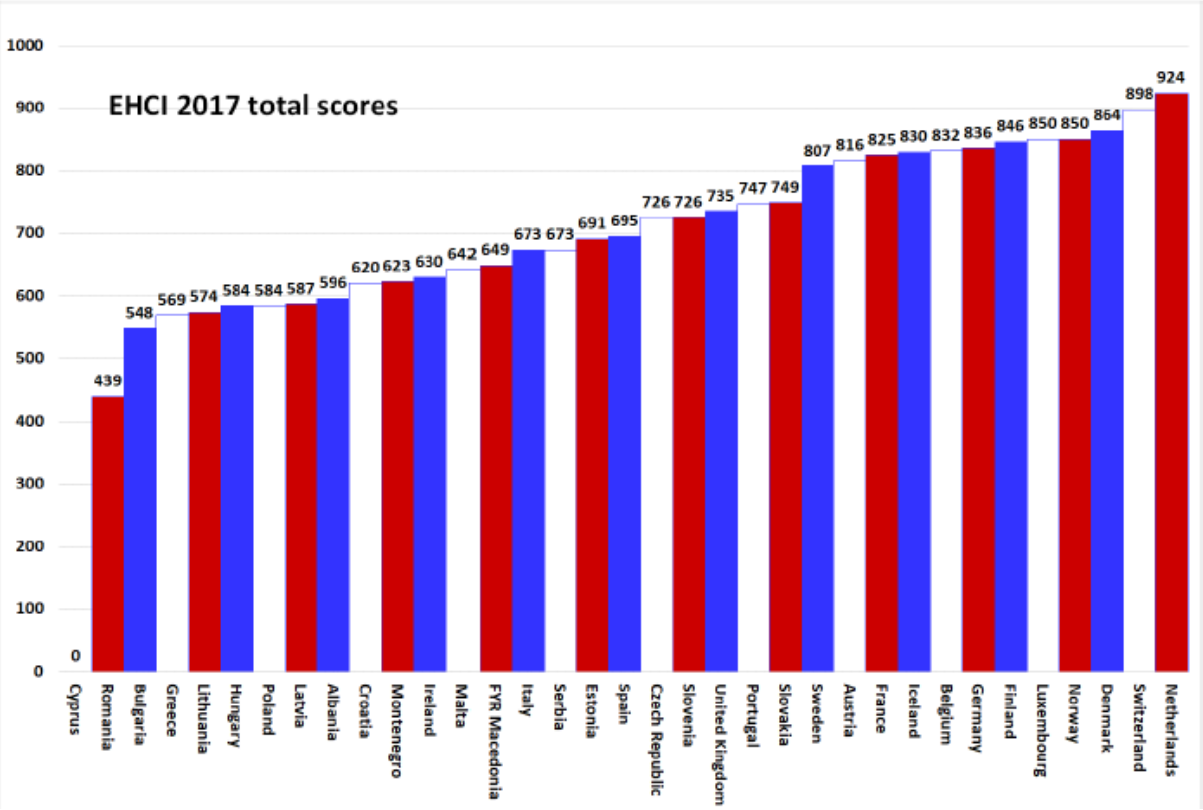
The Romanian health care system has been in a perpetual state of reform since the collapse of the communist regime in 1989, with around 26 ministers of health since then. In 1990, the Romanian government embarked on a fundamental, albeit slow-paced, health care reform, shifting the health system towards a more decentralized and pluralistic social health insurance system, with contractual relationships between health insurance houses as purchasers and health care providers. The main legislative acts were introduced between 1995 and 2002. In 2006, these were replaced by the aforementioned Law 95/2006, which is still in place today and harmonized the national legislation with the *acquis communautaire* (body of common rights and obligations).

In 2012, a new health law was proposed, following numerous studies that had shown poor performance of the health system, plus mounting pressure from the general public and health professionals. The proposal envisaged replacing the system of controlled resource allocation with regulated competition at both the health insurer and service provider levels (after the Dutch model), introducing the 'money follows the insured' principle, and modifying the structure and functioning of service providers to enable service integration, improved continuity and quality, while also ensuring cost efficiency. The proposal was rejected amidst protests and calls for the resignation of the president. The most recent reforms focused mainly on introducing cost-saving measures.

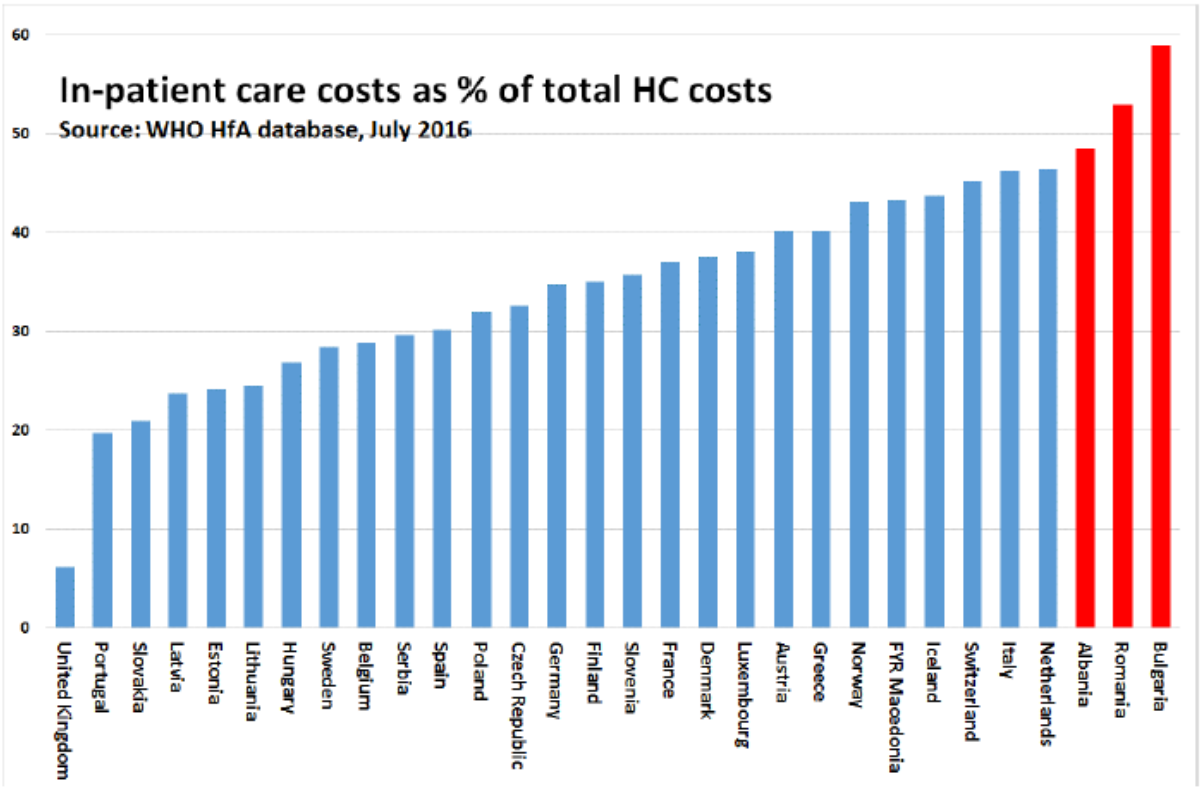
The National Health Strategy 2014–2020, which contains strategic objectives in the areas of public health and health care services as well as system-wide measures, is seen to be the main document guiding current and future health care reforms. It is the first Strategy with an allocated budget. However, there are no clear, detailed plans for the specific objectives included in the Strategy and its implementation is dependent on the political will. However, it is expected that such plans will be developed in the future, as this is the condition for accessing EU structural funds, with the existence of the Strategy itself also being a condition of accessing such funds. On big challenge remains a focus on shifting care from hospitals into the community, with community services being among the least developed care settings.

Despite its over 27 years of continuous efforts to reform the health care system, Romania is facing serious problems in meeting population health care needs, mainly due to chronic underfunding of public health care units, shortage of medical personnel, lack of general practitioner in rural areas. The economic crisis has deepened these problems, making the access to health care more difficult for disadvantaged or vulnerable groups of population. Poor health status of the population, the demographic aging, the large share of socio-economic dependent population and the high level of chronic diseases incidence all lead to increased health care need therefore healthcare costs. Health care activity is mostly based on the public sector and is financed from public funds. Geographical distribution of medical personnel reveals major disparities among regions and in particular between urban and rural areas: less than 20% of the physicians (5.592 from 52.541 in 2012) are practicing in rural areas, 66% of the medical personnel being concentrated in 6 large cities while 5% of the rural communities have no doctor. Over 15.000 health professionals (30% of total) have left Romania since 2007 and about 40% of the medical graduates (2.500) are emigrating every year.

Recently (January 2018), the Euro Health Consumer Index (ECHI) 2017 was published. The EHCI, started in 2005, is the leading comparison for assessing the performance of national healthcare systems in 35 countries. The EHCI analyses national healthcare on 46 indicators, looking into areas such as Patient Rights and Information, Access to Care, Treatment Outcomes, Range and Reach of Services, Prevention and use of Pharmaceuticals. Romania is putted at the last place of this index, this for the second time in a row.



The low result can be assigned to an antiquated healthcare structure. For example: Romania is suffering a high and costly ratio of in-patient care over out-patient care.



The objective of this East Flanders funded report is to examine the Prisacani population (potential) needs for care and outlines certain particularities for this region. There is an applied dimension towards a focus on community care attached to the paper which may be of use to the local policy makers and planners.

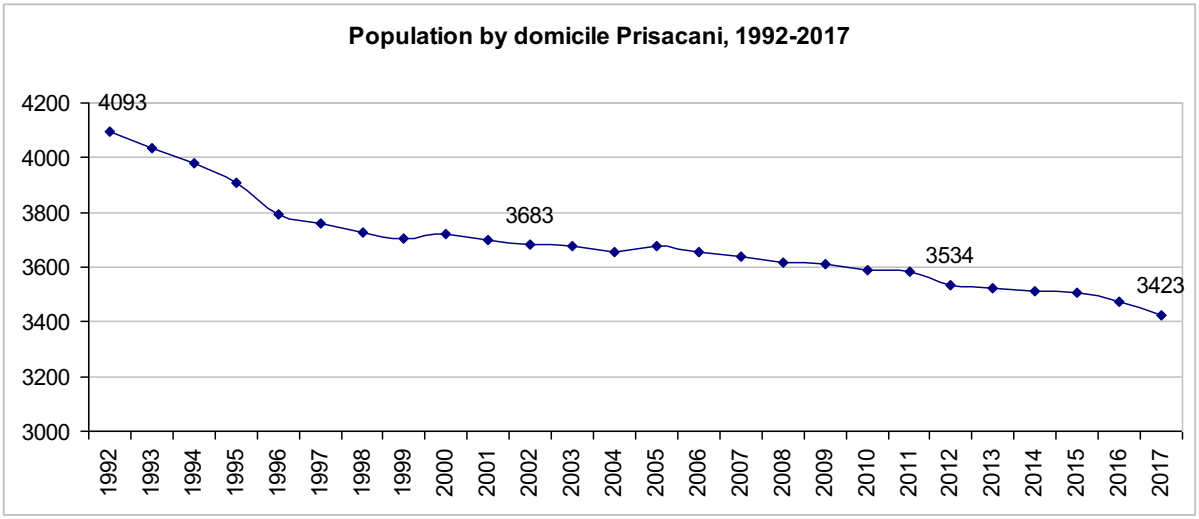
Two large groups have been considered in particular: the aged population over 65 years (starting from the premise that many of them need permanent assistance) but also economically dependent population, with limited financial resources that do not contribute to the health insurance system or are uninsured. Vulnerable populations are social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality.

6. Needs assessment Macaresti (Prisacani)

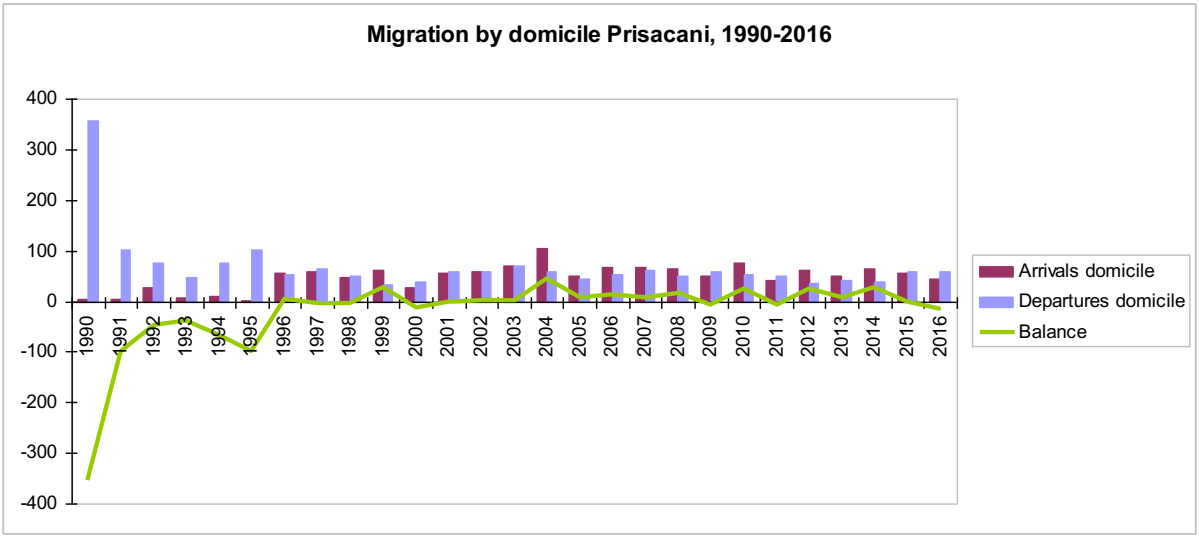
A diversity of indicators can be used to get an insight in the health status of a population and possible risks or needs that a community will have to face.

6.1. Trends in the Prisacani population

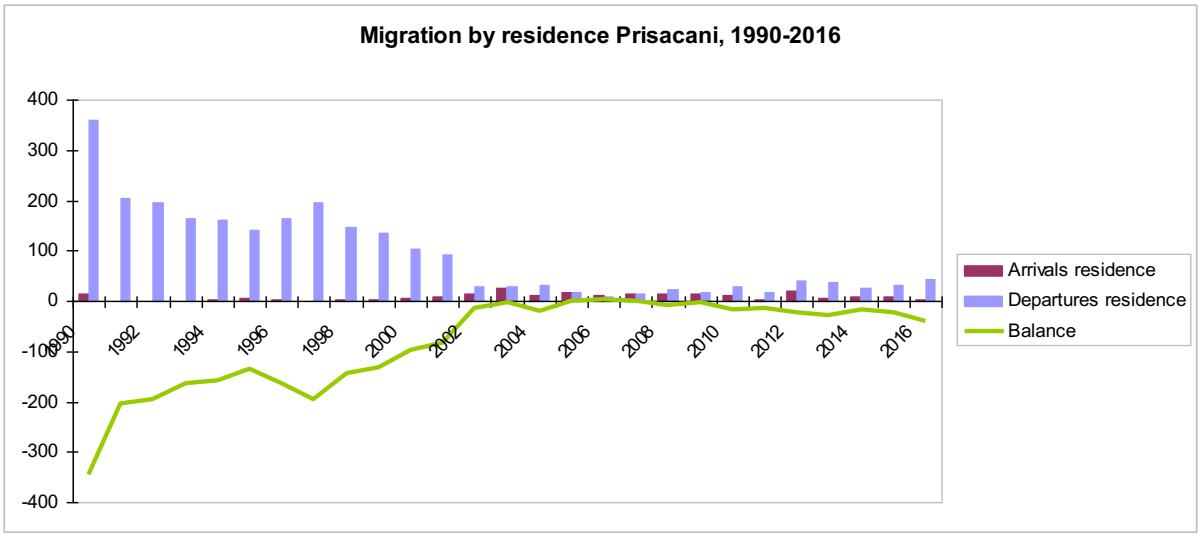
A strong decline can be seen in the period 1992 – 2002. 380 less registered in the administration or almost a decline of -10%. The next 10 years the population one again declined with -7%. So in two decades almost 1/5 less people were registered in Prisacani.



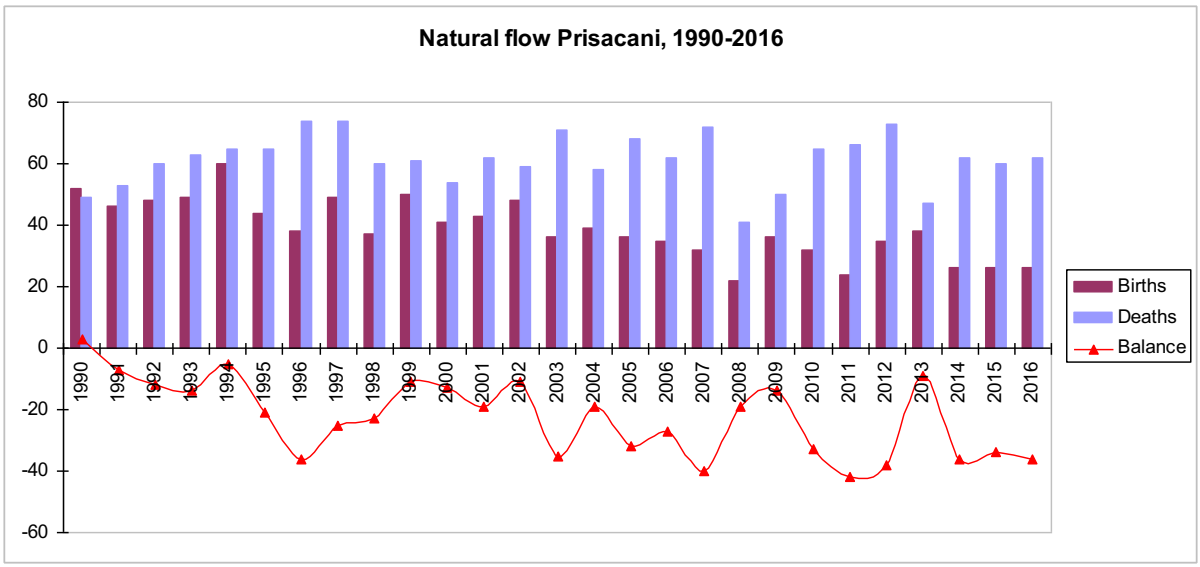
Where is this decline coming from? For some regions emigration can be the explanation. But when the data about migration are being analysed on 2 levels: migration by domicile and residence, the result is an interesting trend for Prisacani. Until 2002 a strong emigration can be seen, but since then a more balanced in and out can be seen.



In migration by domicile in some years an even positive balance can be seen. Migration by residence is more complex phenomenon. People keep there domicile in the commune but live for a certain time outside of the town. This is typical for labour migration: seasonal workers for example.



Important is to add the natural flow. And here a trend can be seen a high negative balance in natural flow. The last 6 years every year a negative of between 30 and 40 persons can be seen. The low amount births is one reason, but even more important: the high death rate 17-20 pro thousand is having a big impact.



For this report a mixed table is made in order to have a combined insight into migration and nature flow. This table is made of 2 main pillars:

- The following of age groups in intervals of 5 years. In other words people in 2007 who were at that time 20 years old are supposed to be appear in 2012 in the group of 25 years old persons.
- The amount of persons in the same age group compared in 2007 and 2017.

Age	2007	2012	2017	Difference interval 2007-2012	Difference interval 2012-2017	Difference same age group 2007-2017
0-4	210	159	143			-67
5-9	251	206	163	-4		-88
10-14	232	253	210	2	4	-22
15-19	226	221	249	-11	-4	23
20-24	211	221	212	-5	-9	1
25-29	281	213	222	2	1	-59
30-34	301	281	208	0	-5	-93
35-39	275	291	283	-10	2	8
40-44	141	278	293	3	2	152
45-49	166	137	279	-4	1	113
50-54	176	165	143	-1	6	-33
55-59	197	185	168	9	3	-29
60-64	192	182	176	-15	-9	-16
65-69	219	172	163	-20	-19	-56
70-74	201	193	141	-26	-31	-60
75-79	179	158	164	-43	-29	-15
80-84	120	132	105	-47	-53	-15
85+	62	87	101	-33	-31	39

From the 192 of those of age 60-64 in 2007, only remained 141 of age 70-74 in 2017. Or a decline of -26%. For the group 70-74 in 2007 so 80-85 in 2017, this means even a decline of almost 50%. For other age categories a stable trend can be seen. Taken into account this data, the assumption is affirmed of a high mortality rate among the 65+ population. A same indication can be seen in the next table, in which a growing mortality pro 1.000 is reflected.

Deaths 2007	41		Deaths 2016	62
Population 2007	3.591		Population 2016	3.472
Mortality rate 2007 pro 1.000	11,4		Mortality rate 2016 pro 1.000	17,9

Another phenomenon is the decline in amount of persons from the same age at 2 different periods in time: 2007 and 2017. But there's an exception: for the age groups 40-44 and 45-49. This age group is doubling his amount in comparison to 10 years ago. This means a stronger influx of these age groups between 2007 and 2017. Probably caused by the dual citizenship: Romania-Republic of Moldova. In September 2007, Romania resumed its policy of granting or restoring Romanian citizenship to Moldavians who requested it. In 2009, Romania granted 36.000 more citizenships and expects to increase the number up to 10.000 per month. As a border commune there's a probability that Moldavians cross the border to be registered in Prisacani. This assumption needs to be tested with other border communes.

6.2. Need for home care among elderly

People of all ages may become dependent on home care. However, the risks of dependency for children, young people and adults of working age are low compared to the risks for people at the

upper end of the age spectrum. In old age, people often become frail and develop multi-morbidity conditions, which cause them to need both medical care and social care on a continuing basis.

It is estimated that in the EU countries, on average, 2% of the entire population of a community needs home care services. Caritas studies show that **over 20% of Romania's elderly population (65+)** need home care. Currently, only 6% of the elderly population benefit from these services, that is, 0.23% of the total population. This means that the home care needs of more than 19% of the population are not being met in Romania. Citizens in Harghita county, where Caritas covers the whole county, monthly are covered on a proportion of 1,11% from the population with long term home care services.

In a time interval of 10 years the share of the older population in Prisacani remains almost the same. Around 1/5th of the population is 65+. In 2017 674 persons were aged 65+. **This means a potential group of <u>135 persons</u> in need of home care in Prisacani**.

To have more (indirect) but reliable indications of the need for home care, some studies are used; In some cases multi problems for 1 person need to be filtered, but besides this a good insight can be developed.

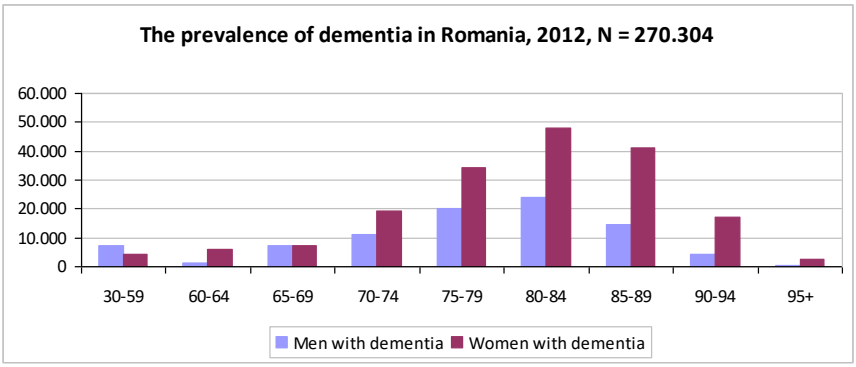
Recently the County of Iasi published an overview of persons with a disability in every commune.

Amount of non-institutionalized people with a handicap, Prisacani, 2017										
Adults					Children					Total
Very severe	Severe	Medium	Light	Total	Very severe	Severe	Medium	Light	Total	
55	69	11	3	138	4	1	6	0	11	149

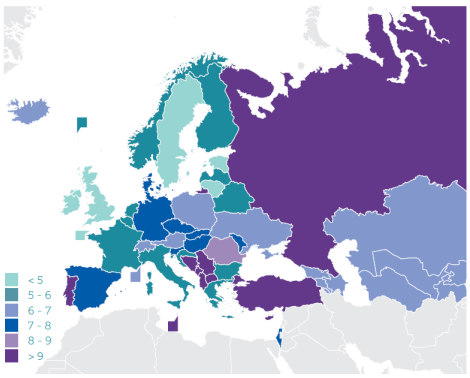
Among this group home care (medical and social) are for sure a need to be fulfilled. The same can be seen for other diseases, such as diabetes and Alzheimer.

The pattern of disease is changing. Some diseases such as Alzheimer's disease and dementia are becoming more prevalent in an ageing population. There is also greater awareness and understanding of such conditions and how effective treatments and support may be offered within a home setting by using a range of home care services.

Alzheimer Europe estimates the number of people with dementia in Romania in 2012 as being 270.304. This represents 1.26% of the total population. The number of people with dementia as a percentage of the population is somewhat lower than the EU average of 1,55%.



More people are living with the consequences of diabetes, heart diseases, respiratory diseases, stroke and cancer: these could be effectively and efficiently taken care of at home with appropriate and targeted support.

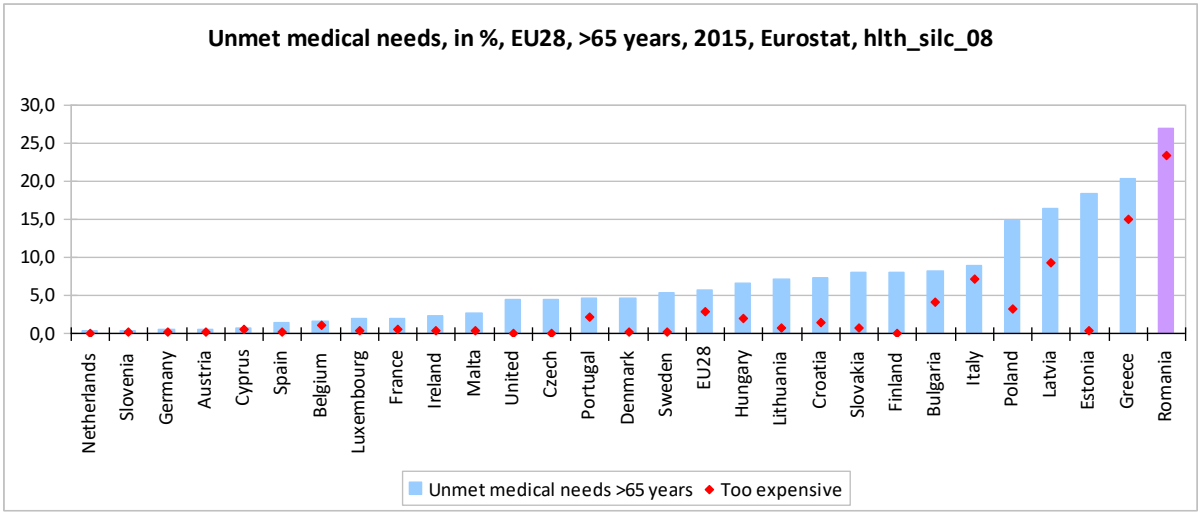


There were over **1.5 million** cases of **diabetes** in Romania in **2015**.

Total adult population : 14.623.000
Total diagnosed diabetes in adults: 1.544.100
Prevalence of diabetes in adults : 10,6 %
Total diagnosed diabetes in adults: 670.200
Rural area: 8,32 %
Urban area: 12,42%

Some persons will suffer from multiple health problems, but taken into account the data above concerning disabilities, Alzheimer and diabetes another 5 to 10% of the population can be in need for home care. In total for Prisacani a number of 200 to 250 persons are estimated to need home care.

In Romania, a large number of elderly people **can not afford to go to a doctor**, especially in rural areas: in 2010, 72,7% of pensioners did not afford to visit a specialist and 80,1% could not go to the dentist. One of the main reasons for unmet medical needs is because off too expensive.



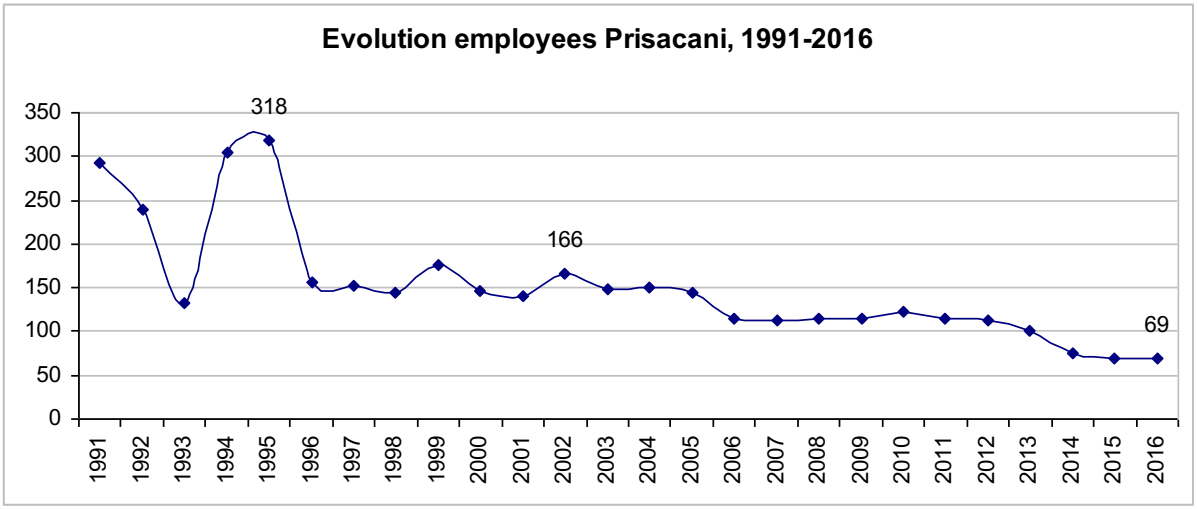
6.3. Need for a solidarity / community based approach

The main focus of the previous chapter was the assessment of the health status. This gives an idea on the care needs, other indicators are referring to the health determinants. Some of these factors are being described below. In the context of a 'healthy community' it is important for community workers to have an overview on this also. Preventing to become ill or being insured against health costs are an integrated part of the development of a healthy community with an involved population.

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. Employment is also an important condition to be insured. According to the provisions of Law 95/2006, the social health insurance system is compulsory for all citizens, as well as for foreign residents in Romania, and opting out is not possible. The main criterion for entitlement is proof of contribution payment or of status that allows coverage without contribution. Although social health insurance is compulsory, in 2014 only 86% of the population was covered, with the proportion higher among those living in urban areas, at 94,9%, compared to rural areas at 75,8%. The **uninsured are: people working in agriculture** or those not officially employed in the private sector and self-employed or unemployed who are not registered for unemployment or social security benefits. The uninsured can only access a minimum benefits package, which is strictly enforced. This package covers emergency care, treatment of communicable diseases and care during pregnancy. The Social Insurance House published detailed information concerning the amount of insured persons and the categories of insured.

Insured persons Romania	**2016**		
Total permanent resident population	22.214.995		
Total usual resident population	19.760.314		
Total insured persons	17.130.940	77	Procent of total permanent resident population
Employees (stable salary)	6.023.987	35	Procent of total insured
Partners connected to employee	735.107	4	Procent of total insured
Children	3.652.015	21	Procent of total insured
Persons with social benefit	400.442	2	Procent of total insured
Pensioners (all categories)	4.397.879	26	Procent of total insured
Others	1.921.510	11	Procent of total insured

To transmit this towards the local situation, some indicators are brought together. The first one gives the evolution of the amount of employees for Prisacani.



A strong decrease can be seen in the mid 90's. At this moment only 69 persons do have a stable monthly salary from a job. This means that on an active population (20-64 of age) of 2005 persons, that only 3,5% have a stable job.

The amount of unemployed with a social benefit decreased from 47 in 2010 to 11 in 2016. This decline doesn't automatically mean an increase in employment but rather a shift to another kind of social benefit.

Besides the unemployment, people can apply for social financial support to the commune. In the county of Iasi this amount is high in comparison to other counties. But for Prisacani is a rather low amount of people a beneficiary. In 2016 for example only 9 persons benefited, which represents a monthly cost of less than 4.000 lei.

This leads to the assumption that most people living in Prisacani are depending on agriculture. Contemporary Romania is to a large extent a rural state. 93,7% of the Romanian territory is rural and hosts 47% of the Romanian citizens. Although 40% of the labour force is employed in activities located in rural areas, this amounts in 2013 to the GDP for only 6.4%. Romania counts around 3,9 million agricultural holdings, of which around 74% are smaller than 2ha and 18% between 2 and 5ha. Around 70,4% of these farms have an income of less than 2.000 euro a year.

The situation in Prisacani confirms this trend. Data for Prisacani are mostly based on the agriculture census of 2010. In total, Prisacani counts 5.992ha of which 72% or 4.326ha can be used for agricultural purposes. Out of this 4.326ha almost 4.078ha is effectively used as agricultural surface: so 94% of agriculture grounds and 68% of the total Prisacani surface. In total there are 1.184 agricultural holdings, of which 1.180 are effectively using agricultural ground. This means an average surface of 3,46ha for each agricultural holding (County Iasi average is 2,59).

	<1ha	0,1-0,3ha	0,3-0,5ha	0,5-1ha	1-2ha	2-5ha	5-10ha	10-20ha	20-30ha	30-50ha	>100ha	Total
Total holdings	21	117	162	212	309	301	42	4	4	1	7	1.180
% of total	1,78	9,92	13,73	17,97	26,19	25,51	3,56	0,34	0,34	0,08	0,59	100

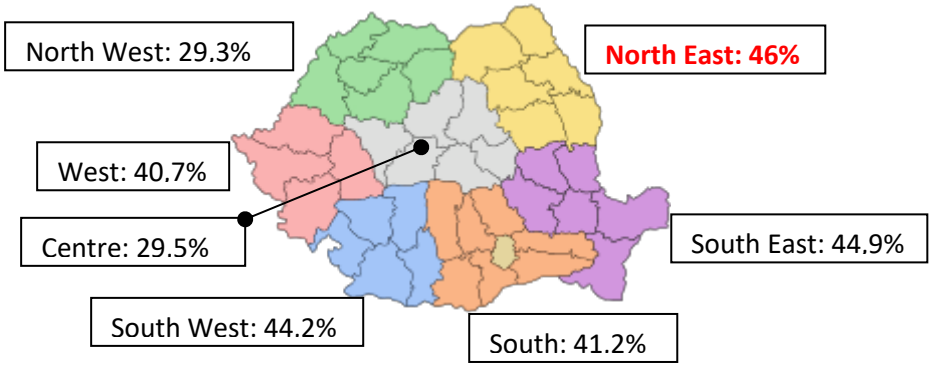
In Prisacani 95% of the agriculture holdings are having less than 5ha agricultural ground. In total there are 2.423 holdings of which 35 with juridical personality and 2.388 as individual or family. The latest are 'involved', referring to 'working in agriculture without having a juridical entity: mostly working for their own'. A further distinction can be age groups of persons involved in agriculture.

Age	15-24	25-34	35-44	45-54	55-64	Over 65	Total
Total persons	182	280	453	339	430	739	2423
% of total	7,51	11,56	18,70	13,99	17,75	30,50	100

This table shows an ageing group of persons involved in agriculture: 1/3 of the agricultural population is more than 65 years old. In general 75% of the active population aged between 15 and 64 years old is depending on agriculture. This self-sustaining agriculture is proving also the vulnerability of people.

When comparing the poverty rate of the different regions in Romania; the Nort East region is classified as the most poor region of Romania (see graph below).

Overview poverty rate Romania (38,8%) and Regional poverty, 2016, Eurostat, tgs00107



It has to be mentioned that even on the regional level a diversity of poverty rates can be seen. Although the data are outdated (2008), they still illustrate the big gap between poor and richer communes. For the county of Iasi this means:

Commune	**Poverty rate in %**	**Extreme poverty rate in %**
Lowest rate – Tomesti	17,3	2,9
Prisacani	50,0	7,3
Highest rate – Voinesti	68,9	12,2

The Local Human Development Index is building further on this. The index of local human development measures the total capital of localities, looking in particular at four dimensions: human capital, health capital, vital capital, and material capital. Single indicators are used to measure each of the first three stocks. Material capital is assessed as a factor score of three specific indicators that focus on living standards: dwelling space, private cars to 1000 residents, and distribution of gas for household consumption in the particular territorial unit. The aggregation of the four measures of the dimensions of community capital is achieved by another factor score. One of the key advantages of LHDI is that it allows for comparison of very different localities, urban or rural, small or large. The LHDI is similar to the Human Development Index (HDI) used by United Nations Development Programme (UNDP). The factor score aggregating the four LHDI indicators for the four forms of community capital is converted to take a variation from about zero to about 100. For the county of Iasi this means:

Commune	**Calculation 2002**	**Calculation 2011**
Lowest rate – Focuri	34,1	34,6
Prisacani	35,1	42,2
Highest rate – Tomesti	61,7	77,5

On the level of villages (sat) no complete actual data are available. The Atlas of Rural Development of 2016 takes only into account the most marginalized villages. Interesting is to see that for Prisacani the village of Macaresti is mentioned as having a population of 633 persons of which around 20% live in a marginalized /deprived situation.

Low employment, relative low salaries, a low amount of social benefits, a low degree of people with a monthly salary and a growing number of retired people is putting a higher pressure on the active population which is at the same time migrating to find a job abroad. The remaining population is highly vulnerable: persons who are at risk of poverty or severely materially deprived or living in households with very low work intensity. A more detailed description of the multi-dimensional perspective on vulnerability can be found in the social map of Macaresti written by Roger Cockhuyt, where data are provided concerning housing, water supply, education and infrastructure.

It's clear that cooperation among the population is needed, by collaborating on a solidarity base improvements can be designed together with available medical staff.

In Prisacani there is a dispensar, a pharmacy and a dental office. The medical services are provided by 3 family doctors and 3 health professionals (nurses)

7. A community based - integrated - mutual health care

It is widely recognized that social networks and loneliness have effects on health. Social relationships affect mental health, health behaviour, physical health, and mortality risk. Sociologists have played a central role in establishing the link between social relationships and health outcomes, identifying explanations for this link, and discovering social variation at the population level. Studies show that social relationships have short and long term effects on health, for better and for worse, and that these effects emerge in childhood and cascade throughout life to foster cumulative advantage or disadvantage in health. Thus, a policy focus on social ties may prove to be a cost-effective strategy for enhancing health and well-being at the population level. Social ties may be unique in their ability to affect a wide range of health outcomes and to influence health throughout the entire life course. Moreover, interventions and policies that strengthen and support individuals' social ties have the potential to enhance the health of others connected to those individuals.

A further implementation and extension of the East Flanders County (BE) funded project will be based on the functioning principles which have proven their value in the The Open Network for community development organizations (TON). In this context a reference is made to the case study of Asociatia de Ajutor Mutual Slatina-Timis (ADAMS). Slatina-Timis is a rural community situated in the East part of the Caras-Severin county, 66 km from Resita the county capital city. Since 1989, Slatina-Timis twinned with the town of Geel in Flanders (Belgium). Within this close partnership, a number of community development projects have been implemented. Amongst them ADAMS In this NGO community members can voluntarily opt to become members by paying a small fee to the health center and which is used for more and better health services. ADAMS association is governed through the decisions of its General Assembly (all ADAMS-members are part of the GA and thus elect the board) and its Board meetings. In this way, community members have a voice over the services that they need and are able to influence decisions on the directions where services should be developed. This NGO became the manager of the Healthcare Center of the community, hired the medical staff – a family doctor, nurses, a dentist, accountant, cleaning personnel, and is operated by a general manager. Financially it complemented several sources of income coming from both Romanian public funds (Health Insurance) as well as from Belgian partners (Flemish Government, twinning partner, Belgian mutualities). ADAMS comprised within its community health center family doctors services, nursing services, dental services, social pharmacy services (providing drugs at smaller prices to ADAM members), MEDIOTEQUE (providing wheel-chairs, crutches, bed pans, walking frames, hospital beds, etc. to members in need at a very low cost), revalidation space, home care, contact with second line healthcare (specialists and hospitals), prevention and health promotion and diets. ADAMS also acts as an advocate for patients and members regarding patient rights, provides information as a service and is in close collaboration with national an regional bodies. The positive outcomes can be read in a case study that can be found on
http://en.calameo.com/read/0026087002a032857c853

Also in other localities these kind of working is developed such as Moldovita (Suceava, with focus on health care centre) and Bunesti (Brasov), Batar (Bihor), Dumitresti (Vrancea), Cotnari (Iasi), Armenis

(Caras-Severin) and Berbesti (Valcea) (all of them focusing on home care and/or medical renting services).

The main principles in the development of such a mutual – community based health care system are:

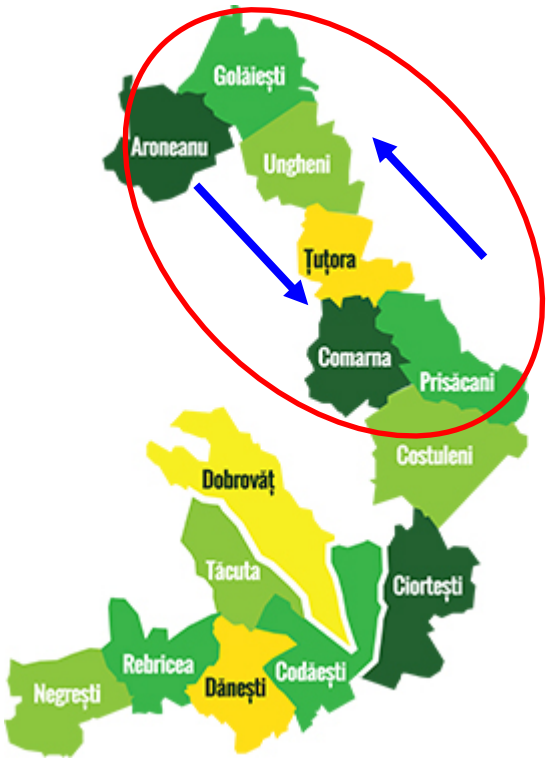
- Community involvement and participation
- Focus on the "Healthy Community"
- Democratic member organization, with transparent decision making
- Independence of politics, religion, philosophy
- Proactive approach of eligible beneficiaries (proactive assessment of eligibility criteria and registering of eligible persons on the list of beneficiaries)
- Beneficiary centered offer of services: beneficiaries as active contributors to the care process not as passive recipients of services
- Socially accountable financial contribution for all members
- Cooperation with public health care services
- Development of a provider network/ close collaboration with existing local health care providers (hospitals, family doctors, pharmacists, community nurses , social assistant)
- Provision of learning services for families and relatives, neighbors and volunteers

This above developed proposal is also n line with a 2016 study about the commune environment planning conducted by 'Search Green Management'. In recommendation 5 the study focuses on the development of medical centre but with a reference to community development:
"*Propunerile pentru dezvoltarea serviciilor de sănătate şi asistenţă socială a populaţiei comunei Prisăcani sunt următoarele:*

- *Construire Dispensar policlinic;*
- *Reabilitare Dispensar Măcărești;*
- *Dotarea şi echiparea cabinetelor medicale cu echipemente medicale moderne care să poată acţiona în cazuri de urgenţe;*
- *Promovarea şi derularea unor campanii de educare / informare a populaţiei cu privire la beneficiile consultaţiilor regulate, efectuarea analizelor medicale, informarea cu privire la anumite boli, comportamentul adecvat pentru prevenţie;*
- *Asigurarea condiţiilor de igienă şi educaţie pentru sănătate în şcolile şi grădiniţele din comună;*
- *Implementarea unui sistem de îngrijire la domiciliu pentru persoanele dezavantajate (persoane în vârstă sau cu dizabilităţi)*"

The question here is if it is possible for a relative small commune with a modest budget to create this medical centre and services. In the answer a regional / inter-local solution can be considered. Smaller communities working together, each from their own needs and experiences. For the development of this project – organization, **a close collaboration with the GAL Stefan Cel Mare is needed**. Based on talks with the mayor from Prisacani and Aroneanu (developing a day centre with home care integrated), the scaling of the project can be done in the region between both communes.

	Inhabitants 2011
Aroneanu	3.402
Golaiesti	3.732
Ungheni	4.173
Tutora	2.067
Comarna	4.732
Prisacani	3.254
TOTAL	21.360



The 3 main pillars of work (strengthening the capacity of existing medical services) are:

- Home care and medical renting service
- Volunteering (Local Health Council, Home visits, Civil society)
- Educational programs (about life skills)

with 2 physical points: 1 in Aroneanu and 1 in Prisacani.

8. First steps towards implementation

The first steps to develop an interlocal - community based – mutual health care service are:

- First stakeholder meeting before the summer of 2018 with focus on an intentional agreement
    - In preparation of this meeting a first round of 1 on 1 talks will be organized
    - For the stakeholder meeting the following are invited
        - Mayors
        - Representative GAL Stefan Cel Mare
        - Representative GAL Meetjesland (BE)
        - Representative TON
        - Representative ADR-Vlaanderen (BE)
        - Family doctors in the region

CMI DR. NACONECINII ANGELICA	Aroneanu
CMI DR. COTEA CULITA	Comarna
CMI DR. DIMOV IONELA NICOLA	Golăeşti
CMI DR. RADU MADLENA	Ungheni
CMI DR. VERDES FELICIA	Ţuţora
CMI DR. DRAGAN ELENA	Prisăcani
CMI DR. GAFENCU IRINA MIRELA	Prisăcani

- The extension of this social mapping to the communes Comarna, Tutora, Ungheni, Golaiesti and Aroneanu (summer of 2018)
- Second stakeholder meeting with a focus on the business model (budget, actions, employees) in the second half of 2018
- After agreement starting the implementation 2019-2020