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Perceptions Concerning Social and Healthcare Services among Romanian Older Persons

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Abstract: Social exclusion, especially social exclusion in old age, represents an area of interest at European level, in the context of demographic transformations. At national level, studies and research on social exclusion in old age are scarce, although the older population is more likely to be at risk of social exclusion. The article presents the results of a quantitative research methodology based on a questionnaire applied to older people of age 65 years and over. The research was conducted during November - December 2021 and the survey was representative at national level with a margin of error of ±3.5%. The aim of this article is to analyse the perceptions of older persons regarding the access and quality of social and healthcare services accessed, and thus, to gain a better understanding on how these types of services could contribute to social inclusion. Data interpretation was made using techniques of descriptive statistical analysis. Results emphasize that access to social and healthcare services are essential in old age. Perceptions of older persons highlight the need for structural changes at national level, so that social and healthcare services could make a real contribution to reducing social exclusion.

Keywords: *Social exclusion; older persons; social services; healthcare services.*

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1. Introduction

Social exclusion in old age represents an area of interest at European level in the context of demographic transformations. At national level, studies and research on social exclusion in old age are scarce, although the older population is more likely to be at risk of social exclusion. Social exclusion in old age tends to be evaluated form from an economic, legal, social perspective, but the process of social exclusion should be analysed and understand considering also the individual perception. As previous studies highlight (Scharf and Keating, 2012), social exclusion is more difficult to quantify when referring to the older persons compared to other groups such as families or children and it could be amplified as the state of health deteriorates (Walsh et al., 2017).

The first part of the paper presents the concepts of social services, healthcare services and social exclusion through limited access to services, the second part describes the methodology used to measure the perceptions of older persons regarding the availability and quality of social and healthcare services, and the last part discusses the results and draws conclusions.

2. Social services, healthcare services and social exclusion

Social exclusion is a complex phenomenon (Levitas et al., 2007). It involves on one side, social resources consisting in the political, educational and civic rights and opportunities (Bruce & Yearley, 2006), or in the resources, rights, goods, services, relationships and activities that the majority of the individuals in the society have access to (Levitas et al., 2007), or in the ideas, attitudes and behaviours that the society consider as normal (Walsh et al., 2017), and on the other side, a group of individuals deprived – in various degrees - of these social resources. But social exclusion is a dynamic process that involves agency (Walsh et al, 2021), meaning that people can "migrate" closer or farther from these social resources during their life and this "migration" process is influenced by their own actions and by the actions of others.

According to Levitas et al. (2007), social exclusion is also a multi-dimensional process. Kneale (2012), based on the work of Barnes et al. (2006), identified seven domains of social exclusion: exclusion from financial services, exclusion from decent housing and public transport, exclusion from civic activities and access to information, exclusion from local amenities, exclusion from common consumer goods, exclusion from cultural activities, and exclusion from social relationships. Scharf & Bartlam (2008)

identified three dimensions of social exclusion in elderly people: exclusion from material resources, exclusion from social relations and exclusion from services. According to the systematic literature review developed by Van Regenmortel et al. (2016), the theoretical framework on social exclusion incorporates sixteen dimensions: financial resources, material resources, social relations/social isolation, participation in civic activities, health, psychological wellbeing, access to health services, exclusion from basic services and information, neighbourhood exclusion, ageing, transport, housing, employment labour market, self-reported social exclusion, self-dependence, and ostracism. Macleod et al. (2019) propose a seven domains model for social exclusion in later life: service provision and access, civic participation, social relations and resources, economic, financial and material resources, health and well-being and discrimination. Based on the previous literature (Scharf et al., 2005; Scharf & Bartlam, 2008; Jehoel-Gijsbers and Vrooman, 2008; Barnes et al., 2006; Kneale, 2012; Van Regenmortel et al. 2016; Walsh et al., 2012; Macleod et al., 2019), Walsh et al (2021) grouped the indicators of social exclusion in later life in six main categories: economic exclusion, including material deprivation, exclusion from financial products and lack of participation on the labour market; institutional exclusion, consisting in access to basic services like health and social care and information, to social rights, to housing, mobility and transportation; exclusion from meaningful relations, either being intergenerational relationships or other social relations, perception of loneliness and isolation; socio-political exclusion, like the participation to civic activities; territorial exclusion, consisting in the lack of connection with a safe and secure neighbourhood; symbolic/identity exclusion, related to normative integration, ageism and ostracism.

According to many authors (Barnes et al., 2006; Scarf and Bartlam, 2008; Kneale, 2012, Macleod et al., 2019; Walsh et al., 2019; Walsh et al., 2021), the access to social and health services is one of the components of social inclusion, especially in later life. Barnes et al. (2006) and Kneale (2012) made reference to the access to local amenities, that is composed of three sub-domains, one of them being local health care and services. Scharf & Bartlam (2008) mentioned the exclusion from services, that includes all essential services, especially health and social care. In their systematic review, Van Regenmortel et al. (2016) identified that 9 of the 26 eligible articles included the exclusion from basic services or information as dimension of social of social exclusion in later life, and 3 of the eligible papers included the exclusion from health services as dimension of social exclusion in later

life. Macleod et al. (2019) made reference to service provision and access. Walsh et al (2021) identified in the previous literature the access to basic services like health and social care and information as components of social exclusion in later life. Thus, we can conclude that the access to health and social services and the access to basic services are key component of social inclusion.

Studies in CEE (Hrast et al., 2013) revealed that older adults are significantly more exposed to social exclusion comparative to other age categories.

In Romania, social services for older adults are regulated by law and consist in: services relating mainly to personal care, prevention of social marginalization and support for social reintegration, legal and administrative advice, support for the payment of current services and obligations, care of the home and household, help with housekeeping, food preparation; socio-medical services, mainly for personal hygiene, rehabilitation of physical and mental abilities, adaptation of the home to the needs of the elderly and training in economic, social and cultural activities, as well as temporary care in day centers, night shelters or other specialized centers; and medical services, in the form of consultations and medical care, that are provided based on the legal regulations on social health insurance. By location and duration, social services can be classified as: temporary or permanent home care; temporary or permanent residential care; and day care, nursing clubs, temporary care homes, apartments and social housing, and the like (Law no. 17/2000). In terms of social service providers, they can be either public or private providers, and the financing of social services for the elderly is ensured on the principle of sharing the responsibility between the central and the local public administration (Law no. 17/2000).

Researches regarding access of Romanian older adults to basic services are scars. Hrast et al. (2013) identified that slightly more than 30% of older people in Romania had bad access to health care in 2007, percentage similar to the other CEE countries. Through qualitative research developed in 2019 in Romania, Ghenţa and Bobârnat (2021) identified a series of measures for enhancing social inclusion in later life, some of them making specific reference to health and social care.

3. Data and method

In order to highlight the importance of social and medical services for the social inclusion of the elderly in society, in this article we use a data base from a face-to-face questionnaire survey designed to assess the

perception of older people about the effectiveness of measures to reduce social exclusion among this category of the population in Romania.

3.1. Objectives

Our analysis took into account the influence of some indicators on the degree of social inclusion of older people, indicators that come from the area of health and social services: availability of social and healthcare service for older persons within the community; degree of satisfaction with differed types of healthcare services accessed during the last 12 months, and degree of satisfaction with differed types of social services accessed during the last 12 months.

Objectives of the paper are:

• To get an insight into the availability of social and healthcare services within the community from the perspective of older persons

• To assess the quality of social and healthcare services based on the satisfaction of beneficiaries with the services received.

3.2. Sample

The target population was represented by Romanian un-institutionalized people aged 65 and over, the total volume of the sample being 802 elderly persons. A stratified random probabilistic sample was used, with a sampling error of ± 3.5% for the national sample. The sample design started from the distribution in the basic population of the target group was taken into account, the persons aged 65 and over, according to Rumanian development regions and place of residence. The sample was stratified according to 8 Romanian development regions, locality type (large urban, medium-small and rural) and residential area (see Table 1). In selecting the number of localities, the allocation of at least 7 interviews per locality / sampling point was taken into account.

Table 1. Sample structure

Romanian development regions	Target population (%)	Sample (%)	Sample (N)
Bucharest- Ilfov	10.2	10.2	82
Centre	11.9	12.1	97
North East	15.8	16.0	128
North West	12.3	12.2	98
South	17.2	17.1	137
South East	12.9	12.8	103
South West	10.5	10.3	83

West	9.2	9.2	74
TOTAL	**100**	**100**	**802**
Urban	54.8	55.1	442
Rural	44.2	44.9	360
TOTAL	**100**	**100**	**802**

Source: Authors' own conception

The selection of localities as primary sampling point was made randomly in each county included in the sample (depending on the type of locality - large urban / small-medium and rural), and in each locality, polling stations were randomly selected (as starting point for household selection). For the selection of households, the random route method was used based on a statistical step of 3 starting from the starting address (address of the polling station).

The subject of the sociological survey was the 65+ year old householder who celebrated his birthday closest to the date of the interview, where there were several 65+ year old in the household. If in a household, selected according to statistical step, there were no people aged 65+, that household was abandoned and went to the neighboring household, until finding a household with people aged 65+, and later, after conducting his interview applied the statistical step again to select the next household.

3.3. Data collection

The face-to-face survey was conducted on the basis of a questionnaire prepared by authors which was first pretested among 29 respondents from the target group. The questionnaire was applied using the CAPI method (face-to-face interviews assisted by the operator and completed on the tablet). The application used was VoxCo (interview platform that also allows the application of questionnaires offline). This platform allows the recording of interview sequences as well as GPS coordinates to verify the quality of data collection. In this regard, respondents were asked, at the beginning of the interview, to agree on the quality control of data collection and processing of opinions.

The data collection took place between November 11-27, 2021. The rate of refusal to participate in the survey (respondents who refused to provide information and answer the questionnaire) was around 25%, mainly due to fears about COVID-19, mainly in urban areas (large urban areas).

4. Results

Data regarding availability and quality of services are analyzed based on age, gender, residence area, income, and educational level using IBM SPSS 20. For multiple response questions, the denominator was the number of responses.

4.1. Perception with regard to the availability of social and healthcare services

Over a half of the respondents consider that social and healthcare services available within the community they are living in, are adequate in number. Still, one fifth of 65+ older persons appreciate that there are not enough healthcare and social services according to their needs (Figure 1).

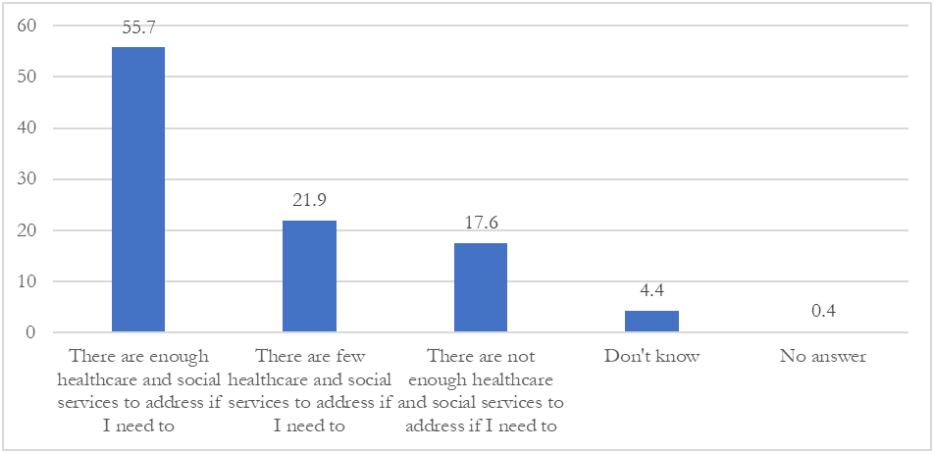


Figure 1. The availability of social the availability of social and healthcare services
Source: Authors' own conception

17.2% of women and 18% of men have a negative perception regarding the availability of social and healthcare services. Older persons living in rural areas are in a larger extent less satisfied with the availability of social and healthcare services, compared to respondents living in urban areas (18.3% compared to 17%). They also consider that there are fewer healthcare and social services in rural areas (23.1% compared to 21% in case of respondents from urban area). 19.1% of older persons 65-74 years old, respectively 14.4% of persons aged 75-84 years old are unsatisfied with the availability of social and health services. Most of the unsatisfied older persons are pensioners (96.5%) and only 2.1% have other sources of income

(dividends, interest rate, rents, leases etc.). In terms of available income, almost a fifth (17.8%) of older respondents with incomes below the average old-age pension (third trimester of 2021) consider that there are not enough social and healthcare services to address, compared to 16.5% of those with incomes over the average old-age pension. Based on the level of education, respondents with a medium level of education (high school, vocational school) have a negative appreciation regarding the availability of services: 19.4% compared to 17.1% in case of those with no/low education or 11.6% in case of those with a high level of education (graduate and post-graduate studies).

4.2 Satisfaction regarding different types of healthcare services accessed during the last 12 months

During the previous 12 months before the survey, most of the older persons received healthcare services provided by a family doctor (44%) or by a specialist physician (28.6%). 12.4% received dentistry care and 8.3% were in need of hospital healthcare. A small percentage (6.5%) received ambulatory healthcare and 0.5% received other types of healthcare services (e.g. physical therapy). The types of healthcare services accessed were influenced by the decisions taken at national level in the field of health, which limited / restricted access to certain components of the health system, but also by the fear of COVID-19 infection in clinics and hospitals. For all the types of healthcare services, the level of satisfaction is high. The highest dissatisfaction occurred in case of family doctors or hospital healthcare services (Figure 2).

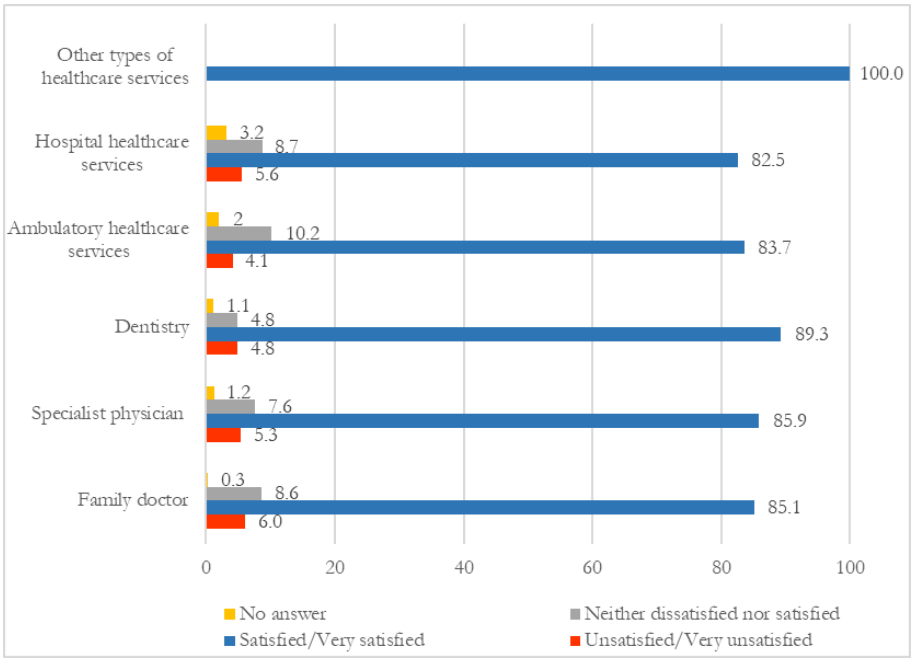


Figure 2. Satisfaction regarding different types of healthcare services during the last 12 months
Source: Authors' own conception

With regard to healthcare services provided by family doctors:

• 3.2% of men and 8% of women were unsatisfied/very unsatisfied;

• 5.4% of older persons from urban area and 6.8% of those from rural area were unsatisfied/very unsatisfied;

• Older persons aged 75-84 years were in a larger extent unsatisfied/very unsatisfied with the healthcare provided by family doctors (9.7% compared to 4.8% in case of older persons aged 65-74 years or 3.7% in case of older persons aged 85+).

• 7.4% of those with an income over the average old-age pension were unsatisfied/very unsatisfied with the healthcare provided by family doctors, compared to 5.8% in case of those with an income below the average old-age pension.

• The percentage of those unsatisfied/very unsatisfied with the healthcare provided by family doctors is almost 10% in case of older persons with a low level of education, and around a half of this value in case of the rest of the respondents.

With regard to hospital healthcare services, the dissatisfaction may be explained by the health decisions taken to fight against COVID-19

infection which limited access to chronic patients in hospital units and narrowed the type of healthcare provided:

• 3.2% of men and 7.8% of women were unsatisfied/very unsatisfied;

• 6.8% of older persons from urban area and 3.8% of those from rural area were unsatisfied/very unsatisfied;

• Older persons aged 85+ years were the most unsatisfied/very unsatisfied with the healthcare provided by hospitals (25% compared to 4.8% in case of older persons aged 65-74 years or 5.1% in case of older persons aged 75-84 years).

• 5.7% of those with an income below the average old-age pension were unsatisfied/very unsatisfied with the healthcare provided by hospitals, compared to 2.9% in case of those with an income over the average old-age pension.

• The percentage of those unsatisfied/very unsatisfied with the healthcare provided by hospitals is 9.1% in case of older persons with a low level of education, and around a half of this value (4.2%) in case of the respondents with a medium level of education.

4.3 Satisfaction regarding different types of social services accessed during the last 12 months

Only 4.9% of the older respondents received different types of social services during the last 12 months before the survey. Among these, most accessed social services were home care services and social canteen: over a third (32%) received home care and another 30% received free meals at the social canteen. 16% requested the services of the social ambulance, 10% received residential long-term care services, 6% received social services within the day care centers, 2% received residential social services and 4% other types of social services.

Referring only to the beneficiaries who received social services, almost 40% of women's responses regarded home care services compared to 26.9% in case of men's responses. 33.3% of older persons' responses from urban area compared to 30% of those from rural area emphasized the need for home care during the year before the survey. 33.3% of the options made by those with an income over the average old-age pension regarded home care services and another 23.8% of responses regarded free meals at the social canteens.

As people grow older, they are more and more likely to be in need of long-term care services: 28.6% of the responses of people aged 65-74 years, 31.6% people's responses aged 75-84 years and 40% of the responses of

people aged 85+, mentioned the home care services. At the same time, 52.6% of the responses of older persons aged 75-84 years regarded free meals at the social canteen, and only 9.5% of those aged 65-74 years old. A third of the responses of persons aged 85+ regarded free meals.

Over a half of the options made by the respondents highly educated named the home care services, compared to 20% in case of those with low/no education.

For all the types of social and socio-medical services, the level of satisfaction is high (Figure 3).

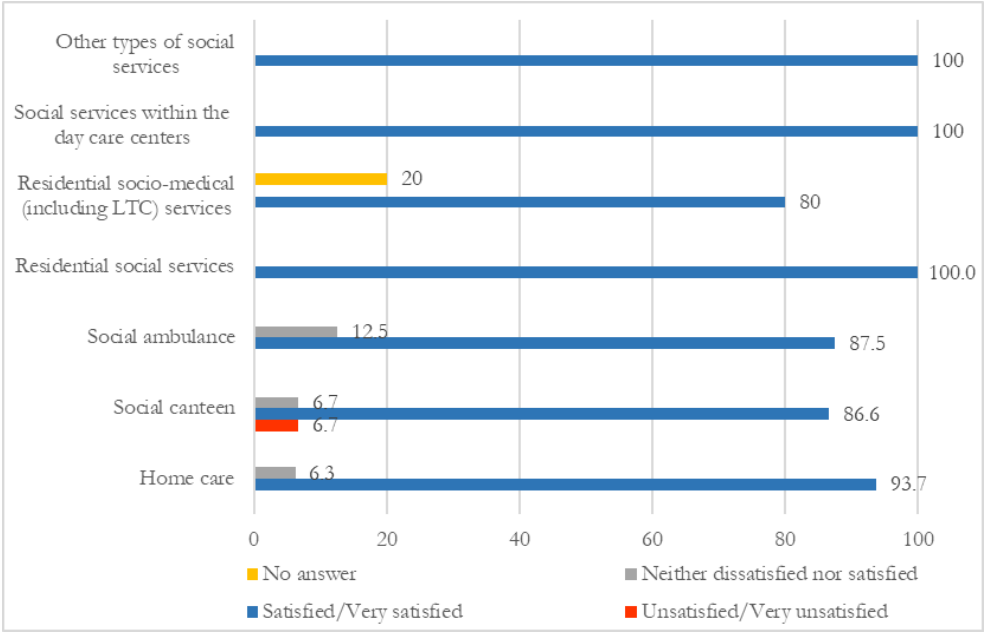


Figure 3. Satisfaction regarding different types of social services during the last 12 months

Source: Authors' own conception

With regard to home care services:

• All the older females were satisfied/very satisfied with regard to the that received home care, compared to 85.7% of older men.

• All the older persons from urban were satisfied/very satisfied with the services, compared to 83.3% of older persons from rural area.

• All the respondents aged 75+ years were satisfied and very satisfied with the services, while 16.7% of those of age 65-74 years old were undecided.

With regard to social canteens:

• 87.5% of men and 85.7% of women were satisfied and very satisfied with the services they received. 14.3% of women were very unsatisfied.

• All the older persons from urban area were satisfied and very satisfied with regard the services, compared to 80% in case of older persons from rural area.

• All the respondents aged 65-74 years and 85+ years old were satisfied and very satisfied with the social services they received, compared to 80% in case of older persons aged 75-84 years. 10% of the older persons 75-84 years were very unsatisfied.

Only 61.5% of respondents received social and socio-medical services with the help of local public authority during the year before the survey.

5. Discussions and conclusions

Given the nature of the sample used in the research (probabilistic, stratified), the results obtained are nationally representative for the older population (aged 65+). However, the period of implementation of the face-to-face questionnaire survey can be nominated as a limit of this research, period marked by the COVID 19 pandemic measures which restricted the access of the older persons mainly to medical services.

The study presents the perspective of older persons with regard to access and quality of social and healthcare services. A series of studies emphasize multiple factors (socioeconomic, characteristics of dwelling, access to transport etc.) as determinants of access to health services (Szeman & Patyan, 2017). In our study we try to understand the perception regarding availability of healthcare and social services based on age, gender, residence area, income and educational level. As the results are quite high in terms of limited or not enough social and healthcare services within the community, we may consider that there is an insufficient access to health and social services, especially in rural areas and for persons aged 65-74 years old. Also, deprived respondents (those with income below the average old-age pension) were more likely to have less access to social and healthcare services, based on their perceptions with regard to availability of services. Low income can influence access to health and social services as other studies reported that a lower income decreases the possibility for people to focus on health and care (Precupețu & Pop, 2017). The respondents with a medium level of education (high school, vocational school) expressed the most negative opinion regarding the availability of services. Precupețu &

Pop (2017), Szeman & Patyan (2017) also point to multiple individual factors (gender, income, health status, presence of disability, living arrangements, and ethnicity/race etc.) that may constitute barriers to access to health and social services. Family doctors, specialist physicians, and dentists were the most accessed types of healthcare during the last 12 month before the survey. The residence area had an influence on the level of satisfaction with regard to healthcare services. The general appreciation with regard to healthcare services is positive and other studies pointed to similar results (Ghenţa et al., 2019). For services provided by family doctors, the older persons from rural area express more misappreciation compared to those from urban area, while in case of hospital care older persons from urban area are more dissatisfied with the quality of services compared to those from rural area. With regard to social services studies of Carrino & Orso (2015) demonstrated that the level of education is a determinant of formal care utilization, as highly educated older persons 65+ are more likely to receive home-care. In this regard, the results of our study is in line with previous results. Studies and research (Ghenţa et al., 2021) conducted at national level in the field of older persons and quality of life in relation to socio-medical services reported high levels of satisfaction with regard to services delivered.

Further research on indicators related to limited access to social and healthcare services among Romanian older persons could deepen the understanding of the phenomenon and may lead to potential solutions to improve the access and the quality of such services.

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