Health Equity Pilot Project (HEPP)

Summary of HEPP Coaching Workshop

Romania 29 March 2018

Contents

Report on the Health Equity Pilot Project Workshop - Bucharest, Romania, 29 March 2018

1. Workshop objectives

The objectives of the workshop were to:

1) To share the learning from the HEPP project on how to address health inequalities in relation to nutrition, physical activity and alcohol consumption

2) To facilitate the opportunity for public health professionals in Romania to learn from each others work focusing on addressing disadvantaged communities and vulnerable groups

3) To explore the opportunity for community approaches to addressing health inequalities.

2. Process

The workshop was co-produced in terms of content with HEPP and the General Director of the Romanian Institute of Public Health, with consultation with the State Secretary for Health.

The agreed workshop methodology was to:

- Establish the importance of this work by having the Secretary of State for Health open the workshop
- Set the context for the workshop in terms of the ECs commitment to addressing health inequalities and the Health Equity Pilot Project
- Establish that the workshop was interactive and not didactic
- Identify that while the workshop was not a decision making forum, that it was seeking to identify potential actions to take forward to address health inequalities
- Elaborate the principles and concepts of socio-economic health inequalities as developed in the Commission on the Social Determinants of Health
- Identify what is known about health related inequalities in the behaviours under review (nutrition, physical activity and alcohol consumption)
- Identify the context for action on behaviour related health inequalities in Romania
- Identify opportunities and barriers to action on health inequalities (with a focus on behaviours)

- Share the evidence base for effective action to address health inequalities resulting from poor diet and nutrition, low physical activity, and harmful alcohol consumption
- Consider potential future actions

The programme is attached as annex 1.

The participants list is attached as annex 2.

3. The context of Health Inequalities in Romania

Romania has a social health insurance system ensuring universal health coverage to a basic package of services; however vulnerable groups are not well catered for especially in processes that can lead them out of social exclusion/vulnerability. The gaps in health status between urban and rural, and by income, education and geography are little addressed.

In particular there are few links made between health and social care, and from community nurses to GPs so that the response to the multi-dimensional needs of vulnerable individuals, families and communities are sometimes fractured.

There were steep differences in health status between those in the least educated groups between regions, while there was little difference in health status between regions for the well-educated groups. The National Institute of Public Health was seeking to offer support and advice to reduce those differences.

There are significant health inequalities particularly in rural areas where in many cases there is a poor local infrastructure with weak local government structures. There is also a portion of the urban population who experience health inequalities.

Outside of the large cities local authorities, especially in marginalized areas are not able to raise funds for local activities. This means that there is a complete reliance on national funding.

Although national funding for heath services has increased over the years there has not been an increase in funding either to public health prevention measures or to family doctor provision. It is probable that this has tended to drive patients to go to hospital services.

External collaborations with external funders and international and local NGOs, has allowed the Institute to develop a substantial programme for community intervention mainly in communities with the Roma population in 6 counties and 45 communities of the country, which has included the training of 45 community teams (community nurse and Roma health mediator) who are working as health workers at a local level.

The project by enhancing local collaborations with mayors aims to develop integration between local family doctors, community nurses and social workers to develop service models that focus on prevention. These are currently pilots. Findings from the work, which include evidence of impact and case studies which includes good practice models have been produced. These have been shared with other local authorities.

This workshop was identified as a valuable event to bring the various strands of project work into discussion with one another.

4. What does the data tell us about health inequalities in Romania?

The Secretary of State's presentation highlighted the importance given to a health in all policies approach linking agriculture, health education, screening and the role of the family doctor, and community health interventions.

She presented the health profiles of the population. There are approximately 19 million people in Romania, with about 50% living in rural areas. There are 42 counties, and about 11,000 family doctors - approximately one doctor for 2000 people. Romania has a strong public health protection tradition.

Romania is one the poorest country in the European Union, with 37.4% of the adult population, and 46.8% of children in Romania, at risk of poverty. Social support is reported to be poor by 26% of the population (cf. EU average 15.5%), with very low health care expenditure (at around 5% of GDP), and with sizeable unmet health needs, which are considerably greater among the poorest.

At regional level, the north west has a marginalised rural population of about 11.3% (almost twice the Romanian average of 6.2%) mainly non-Roma, the central regions have about 8% marginalised rural population who are mainly Roma, whereas other marginalised rural communities are mixed (Roma/non-Roma). Marginalisation refers to education below 8th grade, no formal work, and poor housing (e.g. no electricity or over-crowded).

Health mediators work with Roma communities, and Community Nurses work with non-Roma.

According to national legislation community care is provided by community nurses and health mediators employed by local authorities and working on direct technical coordination of County Public Health Directorates. About 1,200 community nurses and 420 health mediators are presently employed. They work in mayoralties and communities and links and referral to GPs is sometimes difficult and the response to the multi-dimensional needs of vulnerable individuals, families and communities is fractured.

Despite these figures Romania reports very good perceived health in SILC (yet has the 4th worst life expectancy in the EC, and particularly high infant mortality). It may be that this is in part about the optimistic approach of personal health status.

The causes of mortality are approximately:

1. 60% cardio-vascular disease
2. 20% cancer
3. 3% chronic respiratory disease
4. 1% diabetes
5. 10* other NCDs
6. 4% injury
7. 4% communicable, perinatal

Behaviours:

The following are recognised in Romania as key drivers of ill-health

1. High blood pressure
2. Overweight (though adult obesity is lowest in Europe)
3. Low fruit and veg
4. Tobacco use
5. Alcohol consumption
6. Cholesterol
7. Physical Inactivity

Behaviours in more detail

Obesity, the lowest in EU is higher in urban areas, among men, and among lower socio-economic groups.

Fruit consumption, and separately vegetable consumption are the lowest in the EU 28 for both men and women.

Average salt intake is about twice the recommended daily average, and amongst the highest in the EU 28.

Overall alcohol consumption is declining, yet Romania has binge drinking levels comparable with the Nordic countries which are the highest in the EU, with

drinkers starting at an increasingly young age. It is about 8th worst in the EU in terms of the proportion of 15 year olds consuming alcohol on a weekly basis.

Adolescents achieving the WHO recommendations for physical activity drop from 32% in 11 year old males, to 16% in 15 year old males, and from 20% at 11 to 7% at 15 year old for females.

Romania is part of the Health Behaviour of School Age Children, the Global Adult Tobacco Survey, Obesity Surveillance Initiative, Global Youth Tobacco survey, as well as other local surveys.

5. Other Points

5.1 Addressing multiple needs at community level

There are several pilot projects aiming to develop the community care at local level. One project, carried out with Swiss funds, developed a joined up approach of community nurses, home care nurses and local GPs which functions at local level to meet the actual needs. It involves both capacity building to enable joint work across disciplines, and empowerment from within the system to permit the breakdown of vertical structures and the development of horizontal ones – which can then react appropriately to the needs of individuals, families and communities.

However the regulatory process has been rendered somewhat unworkable as each level has continued to demand accreditation rights to ensure appropriate standards are met.

If the joint working can be made effective, there are opportunities to scale up using World Bank or Norwegian funding.

5.2 Unicef

The Unicef interventions are centred mainly in the north-east of Romania, especially in Bacău county. UNICEF is providing a package of services in schools. They have found a disconnect between the central level, and what happens in practice at municipal level. It is even difficult to get a real picture of numbers of people in a municipality. It is thought that the area of Bacau has about 40,000 households and 70,000 vulnerable children with poor housing and education. 1% lacked identity papers, and 3% had no family doctor. The needs are greater than the ability to provide services.

Insufficient numbers of community nurses and social workers are available for the scale of need. 75% of time is meant to be on outreach work, for community nurses and social workers though this is rarely achieved.

Positively, where the work has started to make an improvement, mayors who have supported a focus on vulnerable children have been re-elected as they have shown that change and improvement is possible.

The work will struggle to be sustainable as the salaries are not affordable from the taxes that can be collected (particularly as unemployment is high) as the local tax base is too low. Salaries need to be provided centrally.

There is an argument that the budget for health care is low, but has doubled in recent years without, it was stated by one discussant, any increase in results. There is no investment in prevention.

In the rural areas the first contact with the health service is still to call an ambulance rather than visit a doctor. It was noted that 1 month of community nurse salary is equivalent to 6 hospital bed days, however it is hard to identify how to switch the budget either from the insurance fund or from the Ministry of Health. Public health savings are not cashable by the health system.

5.3 Project Addressing Vulnerable Groups (Roma)

The National Institute of Public Health Project on community health intervention with focus on Roma population (RO 19 03) funded by Norwegian grants focuses on health promotion by increasing the health understanding (knowledge) of vulnerable groups through the work of the health mediator and community nurse. The main pillar of the project was to recognise the importance of working with the whole community and building trust. The work took place in both the home and the school setting and had a focus on smoking, nutrition, and appropriate use of medicines. The most complex was sexual health education.

The work also focused on treatment and prevention in TB, diabetes, and hypertension.

The first challenge is to encourage an understanding of good health as an asset, and secondly of recognising the role of the health care system as opposed to self prescribing.

The communities in which the work took place have started to recognise the importance for children of breakfast and avoiding very long journeys for water to fetch water, as well as improvements in weaning practices; greater acceptance of vaccinations, and oral health; importance of reducing risky behaviours and birth control; and seeing the benefits of positive health.

It is found to be more effective to enable individuals to identify the possibilities for health improvement rather than tell people the negative consequences of their actions (show not tell!). Generally sensitivity was needed in working with Roma so that they weren't talked down to, their culture was respected, and they were not belittled by the process. There were some stigmas, and taboos which needed to be respected.

Examples of changes are:

- a significant decrease in cigarette consumption, from about 17 cigarettes / day - to 14 cigarettes / day
- an increase in the proportion of those who want to quit smoking from 34% to 45% post-intervention
- significantly increased the proportion of those who consider that smoking is harmful to health, from 25% at the time of the initial assessment to 62% at the time of the final assessment
- in terms of breakfast, 70.8% of the Roma participating in the study say they eat in the morning each day, compared with 61.8% at the time of the initial assessment
- however the Roma declared that they eat daily vegetables at 66.5% at the initial evaluation and 23% at the final evaluation as the price of vegetables has become unaffordable.

5.4 Challenges for public health

It is recognised that there is a major challenge for public health as:

- It tends to be systematically underfunded, exclusively through the MoH budget
- Sustainability of plot projects, funded with international programmes
- There is a need to complement work with National Health Insurance House
- The National Institute need to navigate a complex political world.

There are also specific problems to Romania. For example the market for alcohol includes considerable home production, so that MUP/Pricing may not be so effective, as it may lead to more home production of alcohol.

Hypertension and salt were mentioned as particularly important, and HEPP shared papers on best buys, and the UK experience, and made links to World Action on Salt and Health.

6. Summary of learning and areas where action could be taken

The learning is specific to the situation in Romania, however they may have general applicability in other member states. The context of under-resourced action on public health generally, high levels of poverty and poor education, provide challenges for Romania.

Health Inequalities

Romania is the one of the poorest countries in the European Union. 37.4% of the adult population at risk of poverty in poverty, and 46.8% for children. Social support is reported to be poor by 26% of the population (cf. EU average 15.5%), with very low health care expenditure (at around 5% of GDP), and has sizeable unmet health needs, which are considerably greater among the poorest.

Romania therefore has substantial health inequalities in relation to other Member States, which can be addressed by improving the economic and social development of Romania, and ensuring that improvements are spread across the population.

There are significant health inequalities particularly in rural areas where in many cases there is a poor local infrastructure with weak local government structures. There is also a large urban population who experience health inequalities. In the case of Bucharest, this population is often the rural poor who have migrated to and live on the outskirts of the city.

There are significant health inequalities and challenges to work for the Roma population. Many of the Roma population experience poverty and deprivation, and are not readily reached by 'mainstream' programmes. Poverty makes, for example, affording a healthy diet more difficult.

Health Service

The national legislation provide the right to basic package of health services, and public health programmes whether or not people have contributed to the state insurance scheme. However the public are not always aware of their rights, which means that sometimes these services are not used by those who most need them. Further, some communities such as the Roma are skeptical of the efficacy of GP interventions, consequently there is a resultant pressure on emergency services.

Funding Streams

It has proved difficult for public health and health promotion to engage with the National Health Insurance service who are responsible for funding health services. One of the challenges is presenting them with evidence that a focus on health prevention will in the medium term, contribute to reducing or holding back health service costs. This may be an area to explore.

Outside of the large cities local authority Mayors lack the ability to raise money. This means that there is a complete reliance on national funding.

Although national funding for heath services has increased over the years there has not been an increase in funding either to public health prevention measures or to family doctor provision. This has tended to encourage the use of hospital services.

Data

A further challenge is quality of national data for marginalized, ethnic minorities and vulnerable population. While there are some national data sets significant areas are either opaque (for example no ethnic minority data is collected systematically due to discrimination issues) or contradictory (for example in questionnaires on self reported heath individuals often report that their health is generally good or that they consume low levels of alcohol whereas the reverse is the case). The health surveillance of the NIPH initiated in the 45 localities should be further implemented.

Discussion - enabling change

The workshop concluded with a discussion on what factors facilitate change with regard to health inequalities and nutrition and alcohol. Consideration was given to the relationship between evidence based interventions such as reformulation in particular and what actions could be taken to motivate the private sector to take action.

It was noted that generally speaking the private sector was reluctant to act. The English Department of Health Responsibility Deal was discussed which was an attempt to create a voluntary partnership with the private sector. In discussion on the relative lack of success of this programme it was noted that a policy intent by the Government at the time that they were not in favour of regulation may have weakened the potential for this scheme to make an impact. This was contrasted with the current UK Government plans to enact a "sugar tax" which appears to have led to number of private sector companies jumping before

enactment to reduce sugar content of some brands, and the effective salt reduction strategy.

The conclusion of the discussion was that a strong commitment by governments to legislate in the medium term could be a useful mechanism to motivate private sector change in the short term.

Consideration was also given to the role of European Commission with a view expressed that it would be helpful if clearer statement could be made of the benefits of government action on prevention as against health care. It would be useful to have a strong statement from EC encouraging investment in prevention strategies.

Relationship with Private Sector

One of the issues that was raised, which is particularly pressing in countries such as Romania where there is limited government funding for public health, is the role of the private sector in sponsoring health initiatives. The discussion focused on whether private sector funding, for example sponsorship of local NGO projects from food companies, might compromise a public health institute's ability to challenge that sector.

Potential Actions

Family doctors preventive advice, which is compulsory as part of basic package, should be further strengthened (but might require further funding).

Prevention is the way forward but the question is how to incentivise the system? It is suggested that economic modelling of the potential savings to the health care system might be useful.

Hypertension and salt were mentioned as particularly important, and HEPP shared papers on best buys, and the UK experience, and made links to World Action on Salt and Health.

Annex 1: Agenda

HEPP Coaching Workshop
Bucharest, March 29th, 2018

		Prezentator	Ora
Welcome	MoH Representative	SS Dr. Corina Silvia Pop	9.30
Introducing the workshop scope and topics	HEPP representative(s) will describe the purpose of the workshop and the pilot project, the main concepts to be introduced (e.g. social determinants, life course, social gradient, multiple disadvantage, regressive interventions) and behaviour change theories	HEPP representative(s)	9.35

Local Context	• Romanian context (existing health strategies, national health programs, projects approaching health inequalities having international funding)
	• Health inequalities in Romania and health determinants
	• Examples of good practice:
	  • Health inequalities in vulnerable groups – project RO 19.03
	  • Health inequalities approach in Swiss funded project
	  • Social approach of vulnerable groups (SASTIPEN projects)
		MoH representative
		
		Dr. Alexandra Cucu
		
		Adriana Galan, Project Manager
		Dr. Florentina Furtunescu
		
		George Radulescu, SASTIPEN
			10.15

Formal Responses	• Formal Responses from key Ministries to presentations
	  • M of Education,
	  • M of Regional Development and Public Administration,
	  • M of Labour and Social Justice,
	  • National Agency of Roma
	
	Each response to be structured as follows:
	
	• What the local context presentations made us think about
	• What is the responsibility of our Ministry with regard to health inequalities and lifestyle
	• Areas for future collaboration
		Each representative to have up to 5 minutes	11.15

Lunch			12.00
Evidences for successful interventions at international level	• Nutrition and inequalities: behaviours, harms and effective interventions • Physical activity and inequalities: behaviours, harms and effective interventions • Alcohol and inequalities: behaviours, harms and effective interventions	HEPP representative(s)	13.00

		Prezentator	Ora
Domains, future interventions and responsibilities	Identify fields of collaboration, responsibilities and expected outcomes on medium- and long term horizon	HEPP representative	14.30
Conclusions and closure		HEPP representative MoH representative	15.30

Annex 2: Participants

Family Name	First Name	Institute	Function
Pop	Corina	Romania Government	Secretary of State for Health
Fortenescu	Florantina	National Institute for Public Health	Director General
Galan	Adriana	National Institute for Public Health	Programme Manager
Cucu	Alexandra	National Institute for Public Health	Director, CHEPS
Sandu	Mariana	SASTIPEL (Roma focused NGO)	Coordinator
Moldoveanu	Irina	ANSVSA (National Veterinary Agency)	Official
Petrescu	Eduard	UNICEF	Project Specialist
Butu	Cassandra	WHO	Public Health Official
		WTP?	
		ANR	Expert ANR
Balau	Cristian	National Institute for Public Health	Psychologist
Popa	Cezar	National Institute for Public Health	Referrant
Ursu	Ciprian	National Institute for Public Health	Medic
Dima	Claudia	National Institute for Public Health	Medic
Cioran	Livia	National Institute for Public Health	Medic
Galan	Stefan	National Institute for Public Health	Psychologist
Radulescu	Silviu	National Institute for Public Health	Primary Medic
Georgescu0	Daniela	National Institute for Public Health	Economist
Jancu	Olivia	PFA	Translator
Gamsu	Mark	HEPP	Facilitator
Goldblatt	Peter	HEPP	Inequalities Lead
Brookes	Chris	HEPP	Programme Manager