

# INTERGENERATIONAL SOLIDARITY IN ROMANIAN SOCIAL AND HEALTH CARE POLICIES

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**Rezumat:** Pornim de la premisa că solidaritatea intergenerațională este garantul progresului economic și social, dar și al cooperării dinamice între diferite grupuri de vârstă, chemate să joace un rol activ în societate. Una dintre întrebările ce suscită interesul este focalizată pe modul în care solidaritatea intergenerațională va fi afectată de provocările demografice, pe fondul crizei economice și al presiunii fiscale exercitată asupra populației contribuabile la sistemele de asigurări. Prin articolul de față ne propunem o analiză critică a efectelor pe care evoluțiile politicilor publice îl au asupra solidarității intergeneraționale, cu focalizare asupra politicilor sanitare și de protecție socială din România. Materialele de studiu utilizate sunt constituite din documente europene și naționale cu privire la protecția socială, acordând atenție semnificativă principiului solidarității, ce ghidează domeniile sanitar și al protecției sociale din România. O analiză aparte este făcută pentru excepțiile pozitive de asigurare socială și a sănătății. Principalul dezavantaj al organizării celor două sisteme pe baza principiului solidarității este generat de dezechilibrul între generații și de cel dintre populația activă și cea inactivă. Principalul avantaj îl constituie ajutorul oferit persoanelor și grupurilor vulnerabile. Actualizările politicilor sociale și sanitare vor putea constitui noi puncte de analiză, în lucrări viitoare.

**Cuvinte cheie:** solidaritate intergenerațională, politici sociale, politici sanitare, protecție socială, persoane vulnerabile, principiul solidarității.

**Abstract:** We start from the premise that intergenerational solidarity is the guarantee for economic and social progress, as well as for the dynamic cooperation between the different age groups called to pay an active role in society. One of the questions that rise interest focuses on the way in which intergenerational solidarity is going to be affected by the demographic challenges, taking into account the economic crisis and the fiscal pressure put on the insurance systems taxpayers. In this article we would like to make a critical analysis of the effects the public policies evolution has on intergenerational solidarity, focusing on the Romanian health care and social protection policies. The

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study documents used encompass European and national documents referring to social protection, with a special focus on the solidarity principle that guides the Romanian health care and social protection systems. A special analysis is dedicated to positive exceptions of social and health care security. The main disadvantage of organizing the two systems on the solidarity principle is generated by the imbalance between generations and between the active and inactive population. The main advantage is represented by the aid offered to vulnerable people and groups. The update of social and health care policies could represent new analysis subjects in future papers.

**Keywords:** intergenerational solidarity, social policies, health care policies, social protection, vulnerable people, solidarity principle.

**Resume:** Nous partons de la prémisse que la solidarité intergénérationnelle est le garant du progrès économique et social, mais aussi la coopération dynamique entre les différents groupes d'âge, appelés à jouer un rôle actif dans la société. Une des questions que soulève l'intérêt se concentre sur la façon dont la solidarité intergénérationnelle seront touchés par les défis démographiques, la crise économique et la pression fiscale exercée sur la population de contribuer aux régimes d'assurance. A travers cet article nous proposons une analyse critique des effets de l'évolution des politiques publiques ont sur la solidarité intergénérationnelle, en se concentrant sur les politiques sanitaires et sociales en Roumanie. Matériel pédagogique utilisé est constitué de documents européens et nationaux sur la protection sociale, en accordant une attention importante au principe de solidarité, qui guide la protection sanitaire et sociale en Roumanie. Une analyse distincte est faite pour les exceptions positif d'assurance sociale et de santé. Le principal inconvénient de l'organisation des deux systèmes est basée sur le principe de solidarité par le déséquilibre entre la production et celle entre actifs et inactifs. Le principal avantage est le soutien pour les personnes et les groupes vulnérables. Mises à jour de politiques sanitaires et sociales peut constituer de nouveaux points de l'analyse dans les travaux futurs.

**Mots clés:** solidarité entre les générations, la politique sociale, santé, protection sociale des personnes vulnérables, le principe de solidarité.

We start from the premise that age perspectives are social constructions, based on less objectives criteria, which vary from one culture to another. We use the age class concept in order to determine groups of people having the same age, which due to these characteristics have different sets of life chances and similar social rights and obligations. The roles and norms given by the society to the different age groups create both barriers and favorable opportunities. Then, one group's interests can coagulate against those of other groups (Payne, 2006).

For those deciding the social policy as well as for practitioners (social workers, doctors, etc.) it is important to acknowledge that the process of awarding a dependency status based on age represents a social construct and not a biological one. There is no essential relation between the chronological age and the need or

dependency. Moreover, if we think about transfers, the transfers going from the active generation towards the inactive population, we can add aspects that are usually ignored- descendant flows, usually financial (donations, inheritances, financial aids), from the elderly (considered inactive) towards their adult children and grandchildren (some people call them “financial returns”) (Masson, 2007: 290-314).

The ageing of population and the changing of family models are global realities. The challenges brought by these evolutions to the social protection schemes are present and often lead to divergent opinions, which oscillate between the fiscal burden created by the inactive population and its need for social protection and the fact that the same population, considered to be inactive and dependant, can become a real resource for the future. If at the level of public policy the child investment is focused on education, in the case of the elderly the focus is on the pension, health care and social protection systems.

Consonant with Marshall (1970), the central and clear objective of social policies is to ensure the welfare of the entire collectivity. A good life quality is actually an inherent condition of the welfare. Referring to life quality, Andrei Roth said: “If we take into account the value of human life- and not only that of a favored group of individuals, but of the majority, namely of all individuals that make up the society- then life quality is linked to all issues related to the way society is organized and functions, to everything that affects- hides or eases, shadows or highlights, or embellishes, degrades or ennobles- peoples life” (Roth, 2002:111). Relevant for the standard of living is the way incomes are allotted in order to satisfy different needs: the exigency to spend most incomes in order to satisfy primary needs indicates a low standard of living. In the market economy, the unequal income distribution is a natural phenomenon. The transfer mechanisms (social protection) are intended for the protection of that part of the population that is in a deprivation situation - different degrees of poverty. The negative consequences of poverty on the life quality of different affected social categories and individuals are evident and in the same time they reflect upon the entire society (Roth, 2002:119–124). „Taking into account these aspects, we can see that the optimization of the social protection system- no matter the shape it is going to take- is important not only for its charity aspect, but is also for the best interest of the society as a whole and of all its components” (*ibid*, p 124). In the simplest case of a trans-generational configuration the active generation is meant to take care of their children’s needs (education, upkeep), but also of their elderly parents (contributions to the insurance systems) (Masson, 2007:290). The intergenerational solidarity becomes the guarantee of the economic and social progress, as well as of the dynamic cooperation between the different age groups called to play an active role in society. One of the important research questions focuses on the way in which intergenerational solidarity is going to be affected by the demographic

challenges, taking into account the economic crisis and the fiscal pressure put on the insurance systems taxpayers.

The demographic problems represent a challenge both for the social protection systems and for the health care systems. The White Paper *Together for Health: A Strategic Approach for the EU 2008-2013* (COM (2007) 630 final) represents a strategic response to the various problems, threatens and opportunities of the health care and connected systems (Vlădescu, Bușoi, 2011:72-73).

In this article we would like to make a critical analysis of the effects the public policies evolution has on intergenerational solidarity, focusing on the health care and social protection systems, two components of the Romanian social protection system that have been constantly reformed during the last years. The study documents used encompass European and national documents referring to health care and social protection, with a special focus on the solidarity principle that guides the two fields and on the positive exceptions of social and health care security.

## **1. The advance of solidarity in the European documents**

*The Europe 2020 Strategy for Economic Growth* focuses on three priorities (smart, sustainable and inclusive economy), which support each other and which are able to help the Member States obtain a high employment rate, economic productivity and social cohesion. The principles that guided the draft of this strategy are represented by the policies that combine the economic growth based on competitiveness with the increase of cohesion based on the solidarity value—namely a type of governance based on social solidarity values.

2012 is the year for *Active Ageing and Solidarity between Generations*. Active ageing is promoted in three ways: participation on the labor market, the active role older people have in society and the advance for an independent way of life. The aim is to raise awareness of the contribution that older people make to the development of our society, as well as of the different means to encourage their contribution. The Union's initiative seeks to encourage policymakers (at all levels) and stakeholders to take action with the aim of creating better opportunities for active ageing and strengthening solidarity between generations (Eurostat, 2012). Moreover, this year is supposed to encourage healthy and independent ageing by using preventive approaches in health care (Eurobarometer, 2012).

One of the European institutions' main concerns, with a long term effect on wellbeing, is the development of general interest social services. Even though there is no general definition in the Union's documents, we can include in this category: on one hand, the compulsory and complementary social security systems, organized in different ways and that cover the social risks of life, and on the other hand, the services provided directly to the individual. The last type of services

mentioned is said to play an important role in increasing social cohesion, in facilitating social inclusion and in guaranteeing the fundamental rights. In this category we can include: social care, employment and professional training services, social housing, long term care services etc. (COM (2007) 725). The need for a sustainable development of general interest social services is argued in several European documents: COM(2007) 725 Communication from the Commission “Services of general interest, including social services of general interest: a new European commitment” 224 (2007), Recommendation of the Council of Europe “Ensuring territorial continuity of social services in rural regions”, COM (2010)2020 Communication from the Commission “Europe 2020: A strategy for smart, sustainable and inclusive growth”, the Biennial Report on social services of general interest SEC(2008)2179 and SEC(2010)1284), the Commission Recommendation of 3 October 2008 on the active inclusion of people excluded from the labour market (C(2008)5737), the Report “A Voluntary European Quality Framework for Social Services” (The Social Protection Committee 2010) and, last but not least, the Report on the future of social services of general interest adopted by the Committee on Employment and Social Affairs of the European Parliament (2009/2222(INI) (the De Rossa Report).

Summarizing the European documents, we can see that the Member States are encouraged to develop national policies for social security and integrated approach structures, to concentrate on employment measures, on facilitating the transition from one workplace to another, on supporting the access on the labour market of those unemployed, on increasing the chances for a good development of training and learning competences. The above mentioned documents restate and support the importance of the social services of general interest. The social services of general interest actually transform the fundamental social rights, although they depend upon public financing in order to ensure equal access, no matter the wealth or income; they contribute to non-discrimination, equal opportunities, health care, improving living conditions, by actively involving the individuals in the society. Thus, the social services providers can contribute to social inclusion, to the social cohesion of local communities and to the solidarity between generations.

In *The Biennial Report on social services of general interest* (2011) it is stated that social and health care services represent 5% of the economic results and provide employment for 21 million people. The same report mentions that the social service of general interest are under pressure due to the economic and financial crisis and that they are under a lot of stress due to the governmental austerity programs. The social service of general interest should not be jeopardized because of the economic crisis, as this could have long term negative effects on employment, the EU economic growth, the increase of tax incomes and gender equality (De Rossa Report, 2011).

One of the important strategic documents for the older population is the *International Plan of Action on Ageing* (2002) and the *Political Declaration* that followed, through which it is stated the right of older persons to a healthy and secure life and to an active participation in the economic, social, cultural and political life. The final goal is to empower the older persons in order for them to be able to actively (and really) take part in the life of the families and communities they belong to. The priorities mentioned and recommended in the *Plan of Action* are the following: older persons and development, advancing health and well-being into old age, and ensuring enabling supportive environments for older persons (Șoitu, Rebeleanu, 2011). It is one of the reference documents that advocates for the active participation of the older people in society.

Right from the beginning, the *Treaty upon the European Union* fights against social exclusion and discrimination, promotes equal opportunities between genders, the rule of law and social protection, as well as the solidarity between generations. The same document points out that the promotion of active ageing needs a multidimensional approach and a long term engagement from all generations.

Through the *Open Coordination Method* (COM (2003) 261) and the *Concerted strategy for modernising social protection* (COM (1999)347), the Commission wanted to create at the level of the Member States a coherent, efficient and broad framework, focused on objectives like: shaping the labor market so that it could offer income for social protection; ensuring sustainable pension systems; promoting social inclusion and ensuring the quality of health care systems.

## **2. Solidarity and the health insurance system in Romania**

The increasing number of older people and of chronic diseases in Europe make the promotion of active ageing in good health an important task, by assuring the access to adequate and high quality health care services, to long term and social services, as well as the development of initiatives that promote the prevention of the health risks associated to the ageing process. Ageing in good health can help increase the number of older people that participate in the labor market, it may allow them to remain socially active for a longer period of time, and it can improve their life quality and limit the pressure on the health care, social security and pension systems (Decision 940/2011).

Although a healthy life is naturally an increasingly important issue, people's focus on the health care's scale and costs draws their attention only to some of the basic needs (e.g. food). In a study made in 194 countries (Backman et.al. 2008) and published by *The Lancet*, Romania is among the countries that are not committed to offer universal access to health care services. One of the synthetic

health condition indicators is life expectancy at birth. It is known that in our country the life expectancy at birth is lower than at the level of the Union and that the decision makers of the health care policy make efforts in order to increase life expectancy, and especially the expectancy for healthy years. The latest indicator is essential for guaranteeing individual autonomy even at an old age. The access to health care services, in a universal way and in compliance with the need for health care and not based on the amount of contributions, is in fact the essence of a functional social solidarity.

The universal provision of health care services is stipulated in law 95/2006, but only for the insured. The legislator makes a difference between the insured who pay their contribution and those who don't pay. The persons belonging to the following categories are considered to be insured without them paying a contribution, but the contribution is paid from other sources (state budget, local budget, social security budget, unemployment budget): they are on leave due to temporary work incapacity (because of a work accident or an occupational disease); they are on maternity leave until the child turns 2, or 3 in the case of disabled children; they serve a confining sentence or are hold in custody; they take unemployment relief; they are returned or expelled, or they are the victims of human trafficking and their identity needs to be established; people who are part of a family that benefits from social aid; the retired, up to the pension revenues that are under the income tax threshold. Without enumerating the categories that benefit from health insurance based on a compulsory contribution, art. 213, paragraph 4 from Law 95/2006 allows the following interpretation: all categories that are not mentioned as being insured without a contribution payment have to pay for the social health insurance. In other words, the employees and the natural persons that make taxable incomes on the Romanian territory have the obligation to pay the contribution. In this category were also included the retired who receive pensions bigger than 740 lei, those who receive unemployment benefits and social aid, and those who work based on a temporary work agreement.

We have to mention that even though the social health insurance was introduced in Romania in 1997, in 1992 a Governmental Ordinance established a new way of financing health, also regulating the creation of the special health fund. The special health fund was meant for the price compensation of the drugs bought by the population. Also the incomes of the health care facilities were included in this special fund. The natural and legal persons' contribution to the special health fund is regulated differently, based on the gross incomes is they were not included in a social security system. We have to remember that the retired, the unemployed and those unable to produce income as well as the family members they supported (children, husband, wife, pupils, students) did not have to pay a contribution (Rebeleanu, 2010:141-158).

The *solidarity principle*, based on which the social health insurance functions in our country, has its origin in a globally wide spread system- that of redistributive insurance. Social solidarity is related to the fact that individuals have to commonly assume and share some social risks, regardless of their nature (Baldwin, 1990). The social solidarity principles have a universal nature, based on the equality principle, the equality of individuals facing a need, and in this context, dependency loses its stigmatizing character and the association with a specific social group. The borne interdependency, as a social solidarity effect, makes the benefits to be distributed based on the needs and the costs (contributions) based on the possibilities (Pop, 2002:740-741). As far as the Romanian health insurance system is concerned, the horizontal transfer works as a redistributive mechanism.

The main disadvantage of a system organized on the solidarity principle is generated by the unbalance between generations, namely when a small number of active people have to economically support the inactive population<sup>4</sup>. Such a report could hinder the equity principle. Equity in health care services means equal access to the available health services for equal needs, equal use of services for equal needs and equal care quality for everybody (Whitehead, 1991). Many definitions of health equity mention the importance of creating equal opportunities for health and the reduction of the existing health differences. Margaret Whitehead thinks that there are seven action principles that could promote health and health care equity: improving the life and labour conditions, facilitating people's access to a healthy lifestyle, decentralizing the decision-making process and encouraging people's involvement in the decision-making process, evaluating the health impact through multisectoral actions, keeping the health equity issues on the governments global agendas, ensuring high quality and accessible health care services and basing equity policies on proper research, monitoring and evaluation (Whitehead, 1992:429-45). These are thought to be fundamental principles for the development of equity based health policies.

Equity in accessing the health care services is an additional argument for explaining the health equity as a proper redistributive mechanism, one tailored to the health need, regardless of the person's capacity to pay the contribution, if we strictly refer to the social health insurance. Because, though it is the nucleus of the public health insurance system, solidarity is limited in the case of private or optional insurances. In order to maintain solidarity in the context of insurers' competition, in the case of the private health insurance (described in the public discourse as inherent for the future of the Romanian health system) risk assurance strategies are recommended, which should attract all the categories the decision-makers have to keep in mind: the compulsory affiliation for most categories, with

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<sup>4</sup> The economic inactive population is considered to be represented by those aged 0-15 and over 65.



the possibility to adjust the contribution amount to the revenues so that even those with low and modest revenues could be included, contracting all volunteer suppliers so that equal access to suppliers is ensured, the benefit package clearly defined (Dixon, Pfaff, Hermesse, 2002:170-186).

The fact that the Law 95/2006 mentions the principle of compulsory contribution payment makes the individual indirectly responsible for his access to health services in case of illness. Moreover, Law nr.220 of 2 December 2011 introduces the co-payment, defined as the insured's contribution to the health system, collected separately from the one paid from the unique national health insurance fund. The document restrains the category of insured persons exempted from the co-payment costs: children under 18, young people between 18 and 26 years if they are registered as students, but no longer than 3 months, until the beginning of the academic year, if they don't have work revenues, patients with diseases included in the national health programs if they don't have work revenues, pension or revenues from other resources, the retired with revenues under 740 lei/month. The document also mentions the possibility that all costs generated by co-payment could be covered by the complementary health insurance.

Law 95, title X, states that the eligibility of the affiliation to the private system is conditioned by one requirement: the compulsory affiliation to the public health insurance system. This aspect can be interpreted in two ways: there is the decision-makers concern to guarantee access to minimum health services, included in the basic package covered by the unique national health insurance fund, without discrimination and in compliance with the equal chance principle; this aspect is found in different wordings and in the definition of the welfare state and in the right of all citizens to have access to a comprehensive social security system (The Universal Declaration of Human Rights 1948); it also restates the health concept of public and undesirable public good (by maintaining the obligation to belong to the public health insurance system). On the other hand, it is possible to maintain the initial inequalities related to the health services access; considering the evolutions in the Romanian society the affiliation to a private system is more accessible only for some categories, (those with an average or big income), residents in urban areas. The persons with incomes from transfers and who were anyway disadvantaged also in the public health insurance system as far as the health services access was concerned (older population, Roma, people on minimum income, families with many children, the enumeration not being limitative) could not afford the option of a private insurance. For those who could afford the double health insurance option, the compulsory and the optional one, there is the alternative that they use the services covered by the private insurance, thus conserving or increasing the resources for the public fund. Concerning this last aspect two question might rise. To what extent the horizontal transfer could be more functional for the Romanian health insurances? Is it possible that the

compulsory insurance to the public system, when a person has the financial possibility to affiliate to a private health insurance company, could contribute to the decrees of social solidarity?

### 3. Social care reform in Romania

In March 2011 the new *National strategy for the reform of the social care system* was published. The document becomes a landmark for all modifications from the following years, modifications related to the organization and operation of the national social care system.

The social care reform is designed in compliance with Romania's task to adopt the fundamental principles of the European Union- fighting social exclusion, promoting social justice and the fundamental rights.

Through this document is restated the role of the Labor, Family and Social Protection Ministry in elaborating the public policies in this field, in administrating and coordinating the national social care system, in promoting the rights of children, family, lonely people, older persons, disabled persons and of any person in need, as well as in financially and technically supporting the social care programs meant for them. The purpose of this strategy is to create a social care system based on the principles of social justice, with a focus on the advance of social inclusion through active measures. According to the new strategy, social care represents the panoply of institutions and measures, through which the state acts in order to prevent, limit or discard the temporary/permanent effects of the situations that could generate the social marginalization or exclusion of individuals, families, groups or communities. The state intervention takes place through the local and central authorities, the local communities and the civil society. The social care system remains non-contributively, receiving financial support from the state and local budgets and it is thought as "a final security net meant to ensure the protection of the least favoured groups" (p.3).

In the *Strategy* it is stated that Romania has engaged to fight against poverty and social exclusion, both by promoting sustainable economic growth and employment, and by ensuring modern and efficient social care. An efficient social protection represents "a construction made up of employment, health, housing, education and social care" (p.33). The main problems of the social care system are mentioned: an efficient use of the available funds, organizational problems concerning human resources, as well as the access to social care services, problems of the covering capacity, as well as problems related to the absence of distinct monitoring of the social care services expenditures. Starting from these problems mentioned in the document, the following objectives were elaborated in the strategy: improving equity, increasing the social participation of those benefiting from social services and activities, making more efficient the use of social care

system funds, along with improving the functioning of the social care system, increasing the analysis, prognosis, strategic planning, monitoring and evaluation capacities, and last but not least, improving the quality of the system's human resources.

The objective of stimulating an active involvement of the beneficiaries in the assurance of their own wellbeing targets, on one hand, to increase the participation in professional trainings of the minimum revenue beneficiaries, but also to maintain the restrictions for social aid for those who can work or who can participate in the available social activation programs, considered to be relevant by the responsible social worker (family planning, health education, second chance programs, etc.- actually, measures that foster equal changes for those in deprived situations). Extrapolating, the active measures meant for promoting social inclusion should be targeted not only for the active age, but also for the older persons of those with disabilities. The Government's intention to promote social inclusion can be put into practice at the community level by stimulating volunteering activities among the elderly, as well as by facilitating the older people's access on the labour market, even after they retired (with restrictions concerning the pension and salary cumulating), especially that by involving older people in paid activities helps them stay active even when they grow old. The possibility to undertake paid activities even after retirement is considered by the Romanians to be a very important aspect.

The international survey report *Population Policy Acceptance* (Dorbritz et al., 2005) shows that this is the most desired measure by the older people in Romania. 38.4% of those interviewed think that the possibility to work after retirement is the most important measure intended for older people, while measures like the development of health services, the development of homecare services or the increase of the number of locations where older people could socialize were not so often mentioned (Mureşan et al. 2009).

Besides the family policies, the Strategy for the reform of the social care system (2011) highlights the need for adequate policies for disabled and older persons, without mentioning the specific direction towards which the measures should be directed.

The new *Social care law* (Law 292/2011) issued on 20 December 2011 keeps the definition of the national social care system as 'an assembly of institutions, measures, actions through which the state, with the help of the public central and local administrations and of the civil society, acts in order to prevent, limit or discard the temporary/permanent effects of the situations that could generate the social marginalization or exclusion of persons, families, groups or communities' (art.2, al.1). The law stipulates the primacy of social services over social security benefits. The social care aim is to help the beneficiaries enter the labor market and to prevent and limit any type of dependency to state or

community aid. The responsibility of the individual, of the family and of the community is highlighted as essential for the wellbeing of the citizens.

Both social services destined for disabled and older people oblige the local public administration authorities to organize and finance/co-finance these services. The eligibility criteria are not excluded in order to provide free services, and there is also the obligation to pay a monthly support contribution for the beneficiaries in the residential centres, based on the supported person's income or that of his/hers legal provider. Concerning the social care of older people, the law stipulates that social care measures are complementary to the social insurance benefits in order to cover the ageing and health risks (we notice the use of the "social benefits" phrase in relation to the contributively component of the social protection system). The obligation of the family to care for and support the older person is laid down. The range of social care services and benefits is laid down in order to avoid institutionalization. Moreover, se notice the introduction of the consultative role of the older people's associations in the decision-making process regarding the development of social services for older people.

Actually, through the modifications taking place in the social care system we tend to believe that in fact family solidarity and its role in supporting the elderly is sustained, namely an informal system, which is unorganized and unsupported yet.

In 2006 the public discourse brought up the introduction of a benefit ("a dependency benefit") whose owner would be the evaluated older person, who fell within a dependency level. In order to be eligible, the revenue per family member should not have been bigger than the average monthly state social insurance or peasant pension. The benefit's financing was envisaged to be done from the state budget, while in 5 years, starting with the 1<sup>st</sup> of January 2007, was going to be supported by the compulsory long term care insurance, which had to be regulated by a special law. The introduction of the dependency benefit was going to be done by modifying Law 17/2000. None of the above mentioned intentions was accomplished. There are European countries (Germany, France) where the dependency insurance is compulsory and represents an insurance against the dependency risk. This insurance guarantees a financial support for people who need long term care and prevents a long illness or dependency to become a financial risk.

The recommendation of the Council of the European Union no. 92/442/CEE and that of the Council of Ministers no. R(94)14 suggest a series of measures that target, among others, the diversification of the benefits for fighting and preventing the social marginalization risk and the improvement of measures related to the prevention of the dependency situation. The Council of Europe's recommendation R(98)9 stresses the necessity for a public opinion awareness regarding the importance of the dependency situation, mentioning the urgent

character of the political and legislative measures that address dependency. The present Romanian regulation framework only partially complies with these international regulations: the defining aspects of dependency and caring for the dependant person are clearly protected and mentioned, but there is not yet a legal framework for the insurance of the social dependency risk. This could be one of the priorities of the present authorities for the improvement of the older persons' social protection system. Indirectly, it is a way of making the "active" individual responsible and determining him to invest in his future individual insured welfare, by contracting a dependency insurance.

Solidarity is a reference principle for the social care system. The public-private partnership in the social services offer is considered to be essential, while volunteering is an important resource of the system. If we take into account the fact that active participation, dignity and autonomy are values promoted also by the new social care regulations, we cannot overlook the fact that older people are little used as a resource. The present volunteering regulations allow and encourage the undertake of volunteering activities. Volunteering is a very useful resource and has a clear advantage regarding the possibility of social service providers to spare financial resources and time. Although there are not many references to the volunteering personnel, we believe that once mentioned and legally recognized the possibility to work as a volunteer, besides the employed staff, represents an opportunity that should be harnessed by the organizations at its just value. The young people's involvement in activities meant for older people represents a gain for both sides- there can be a dialogue between generations, favorable for all those involved. Older people, even if they need care and support, represent a valuable resource due to their experience, accomplishments and knowledge that could be genuine models for young people. Besides their status of service beneficiaries, we believe that the involvement of older people in volunteering activities could guarantee their active participation in the social, cultural and economic life of the communities, increasing their self-esteem and the feeling of social utility for this population category. The percentage of older people and old adults involved in such activities or affiliated to non-profit organizations is extremely low. The potential of this category is big and the Romanian volunteering market is under development. There is the possibility to diversify it so that it could offer enough opportunities also for the older people category (Rebeleanu, Nicoară 2011).

## **Conclusions**

The recent European documents stress the importance of preventive actions like a healthy lifestyle or an active and healthy ageing, these being financial solutions.

The national health and social care legislation is based on the solidarity principle. If in the case of the health care system, solidarity could be jeopardized by

the future private health insurance regulations (a change that still has several uncertainties in the public discourse), in the field of social care, social solidarity tends to become more evident at the level of local communities.

Old age borders and characteristics are socially determined. Even if at an older age dependency is associated to a reduced functional capacity, the relation between the functional incapacity and dependency is not an even one. An older person's dependency depends upon his/her own financial means, on the provisioned social security aid and on the entire range of adjustments that can decrease dependency.

It is important for any social policy measure to recognize the importance of the informal care in Romania and also of the main threats. We should take into account the fact that stock of the main care providers- women from the extended family that don't have a full time job- could decrease in time (fertility reduction, which will result in a decreased number of descendants, or as a result of measures that will increase the number of employees among these categories) (Mureșan et al, 2009). Another problem might appear if a large part of the population changes its orientation and gives up the practice of caring themselves for the elderly and decide to ask for specialized services. This change is possible in several ways: change of the value system (people no longer believe that the best way to take care of older people is at home), new pressures on the family members that will free them from such burden or the attraction the new services (public or private) will have on the family members. Subsidiarity in care supply is an aspect that should not be neglected by the decision-makers.

The social inclusion measures promoted through employment should be extended also to the older people category. Maintaining older people on the labor market would increase the number of insurance funds' taxpayers. Moreover, due to Romania's option for early retirement (right after 1990), in our country we can not say that older person and retired are the same thing. Involving older people in volunteering activities would help them stay active, would increase their self-esteem and the sense of social utility; but in our country the involvement is extremely low and restricted especially to religious organizations or churches.

Certainly, a social protection configuration, which guarantees the security of individuals, is required, but one that assures the intergenerational solidarity: as Anne-Marie Guillemard also said, ageing and longevity could represent an opportunity for any developed society. Older people in Romania don't need only health care, long term care, pensions, etc., but also the right to be active participants and contribute to the development of the society they live in.

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