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HEALTH DISPARITIES AMONG PEOPLE WITH SUBSTANCE DEPENDENCE IN ROMANIA

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Abstract. Introduction: Health disparities, health inequalities or health inequities are terms frequently used as synonyms, but with different content or meaning. **Methodology:** We have tried first to tackle the definitions problem and than through a secondary analysis of national published data to assess health disparities within the marginalized populations of Substance dependent people. **Discussions:** Analyzing health inequities in populations with potentially important impact on public health can offer targets for the actual health reform project in order to improve gaps between Romania and the other UE countries;
Keywords: substance abuse, health disparities, inequity

Background

The health status of a population is determined by two factors: access to health and second to the access to health services. Access to health depends to a large extent on external factors of the health system as follows: 10% social conditions; 8% medical conditions; 7% climatic conditions; 15% hereditary factors and 60% lifestyle. Health disparities appear mainly due the access to care and for at least four reasons: a) ethnic, b) racial, c) economic - including the direct costs supported by the population (co-payments for treatment and hospitalization costs) and indirect (transport cost, waiting times) -, and d) geographical – either uneven location of care facilities, or uneven quality of services of the same type .[1]

There are some important indicators used to measure community health. Some of them there are health disparities, inequalities and inequities. The information provided by measuring community health indicators helps in decision making process and in implementation of different interventions aimed to reduce preventable diseases and death among community members. [2]

The health of a population, together with education and income, reflects the level of human development. There are several composite indicators measuring human development, among them, the most common used are: the Human Development Index (HDI), the Inequality-Adjusted Human Development Index (IHDI), the Gender Inequality Index (GII), the Multidimensional Poverty Index (MPI), Health and Activities Limitation Index (HALex), Health Related Quality of Life (HRQL) and the degree of satisfaction with medical staff and to the quality of health care.[2]

There are different terms used to for uneven access to medical care. For example in US the most common term is health disparities, while the rest of the world are preferred terms like *health inequality* and *health inequity*.[3-9]

According with the US Department of Health and Human Services *health disparities* are defined by the "differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation". [10]

Another way to measure health disparities is to determine the differences between different groups (egg sexual minorities) in regard with morbidity, mortality, incidence or prevalence for diseases or risk factors with negative impact on health [7] or to

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measure the differences in this indicators between a specific group and general population [8].

In the 2011 CDC Report on Health Disparities and Inequalities,[2] Thomas R. Frieden the CDC director tried to differentiate the terms as follows (quotations):

Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes. [11]

Health inequalities, which is sometimes used interchangeably with the term health disparities, is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity) .[12]

Health inequities are a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair .[13]

In Romania all four types of inequities in access to care are present, causing inequities in health status of different population groups, of communities in different geographical areas and in economically disadvantaged groups. These disparities are shown by the lower values of the main indicators of health and quality of life status, but also by the low level information on health risk factors and safety or the health care system and the basic package of services in Romania. Factors influencing the degree of accessibility of populations to health services are generally represented by: the poverty, unemployment, occupation, place of residence, medical insurance in social health insurance system and coverage with medical personnel.

In Romania the Health System had major problems after the end of communist regime in ensuring adequate health care for all the people. In March this year the College of Physicians in Romania through the voice of its President Prof. dr. Vasile Astarastoae issued a document entitled „Inequities of the Romanian health system" [14] in which it is shown the alarming state of health and health utilities, placing the population at risk. Romania occupies the last place in the European Union with 687 EURO per capita total health expenditures [15], even the total expenditure on health per capita increased 2.7 times between 1998-2008 (Fig. 1).

According to the report, after the age of 65, healthy years expectancy is 16.5 years for women and 13.6 for men. Infant mortality in Romania (11 per 1,000 live births) and maternal mortality (maternal deaths per 100,000 living new born 13.52) are the highest in the European Union. We have elevated rates of mortality under the age of 65 years due to causes that can be avoided through effective action based on evidence of public health, such as ischemic heart disease, breast cancer, cervical cancer, lung cancer, pneumonia, mortality related to alcohol abuse, suicide, transport accidents and AIDS. Cancer mortality rate for women is the highest in Europe (128 per 100,000) as the one for cervical cancer is highest in the region, being four times higher than the EU average (3.32). Ischemic heart disease mortality rate before age 65 is also among the highest in the European Union. Mortality rate of acute respiratory diseases, pneumonia and influenza in children under 5 years was reduced by half in 2000-2008 (from 143.53 to 76.22) but is almost 15 times higher than EU average (5.18 in 2008).

Although we have surveillance systems for communicable diseases, tuberculosis and sexually transmitted diseases are public health problem in Romania. The incidence of tuberculosis in Romania is the largest in the region - 101.02 cases per 100,000 inhabitants (EU average is 14.09 cases per 100,000). The incidence of syphilis is 18.67 cases per 100,000 inhabitants, five times higher than the EU average (3.7 per 100,000).

We have 2.2 doctors per 1,000 inhabitants (dentists were included), 50% less than average, second lowest with Poland. Regarding nurses coverage we have 5.5 nurses per 1,000 inhabitants .[1] As for advanced medical equipment, we are on last place in the EU in the covering with MRI and CT facilities. We are in the last places in the EU in terms of access to prosthetic joint prosthesis with 46 per 100,000 inhabitants, three times less than the EU average (153 hip prosthesis) and we are in last place in Europe in terms of access to medical care at home but in compensation we are the first regarding the access to psychiatric hospitals. [16]

In the last Human Development Report, published on 4 November 2010 [17], Romania ranked position 50 from 169 countries with a Human Development Index of 0.767. Romania was ranked alongside Bulgaria (rank 58) Serbia (rank 60) and Ukraine (rank 69), in the second quarter corresponding to „high human development", the other EU countries are ranked in the first quarter of HDI with „very high human development". According to IHDI, which takes into account the disparities related to health, education and income in 139 countries, from 2009, Romania recorded a loss of 12.1 percentage points [15]. As in most of the EU countries, the low participation of women in politics, (only 9.8% for Romania), is the promoter of gender inequality. In terms of civic and community welfare, according to the 2010 Report, Denmark (83%) is seen as the safest EU membership, while Lithuania (29%) with Latvia (44%), Slovakia (47%) and Romania (51%) have the lowest perception regarding the safety of citizens.

Roma people in Romania, one of the disadvan-

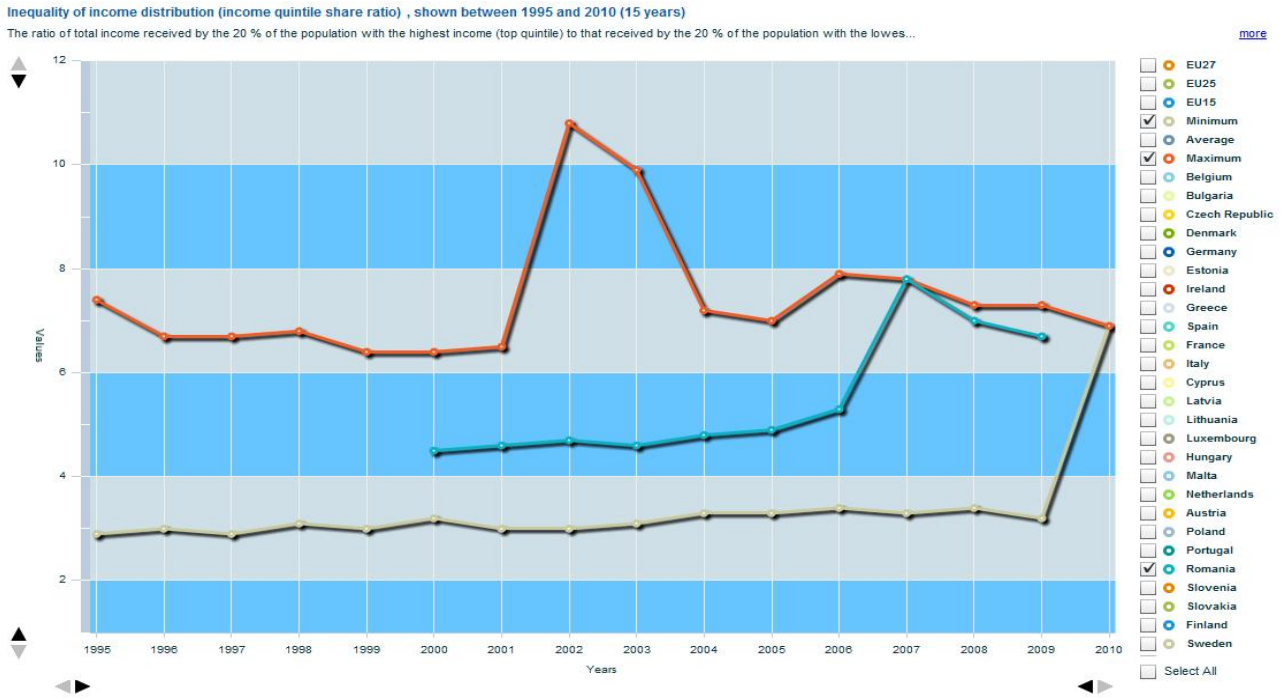

Figure 1. Inequality of income distribution comparation between Romania and maximum and minimum averages for UE between 1995 and 2010 (Source : EC Eurostat 2010)

taged groups are far below the national average in terms of living standards and national income. Income represents one third from the Romanian national average and their infant mortality rate is three times higher.[1]

Health disparities among addicted people

Most of the substance dependent people struggle with more than one stigmatization, because at the "dependency" disparity they add either the "HIV" one, the "sex worker" one, the "MSM" one and so on [18]. The national data on people living with addiction are gathered by the National Agency Against Drugs (ANA) who fortunately after a one year "hiccup" was reestablished as a direct governmental unit. The ANA report issued in November 2010 [19] was based on data collected in all its 41 departmental centers, in the substitution centers, but also through 4 pilot studies developed in 2009 by UNICEF and UNODC in collaboration with NGO's like Romanian Association Against AIDS (ARAS) or Romanian Angel Appeal.

Unlike 2009, in the first six months of 2010, there is a uniformity of distribution of emergency cases due to drug use recorded in the medical units, as follows: 26.4% of the Bucharest-Ilfov, 25, 18.3% % North West, South East 18.5%, 11.9% South. (Fig 2)

Till 2009 the IDU population was clustered mainly in Bucharest with main drug of use heroin (97%), with a frequency of at least 2-3 times a day (75%). In the last injection, more than one in ten respondents (13%) said that he borrowed used injection equipment (needles/syringes) and others, and 14.9% of IDUs reported current using syringes previously used by another person. In 2010 the arrival on the market of the new "legal drugs" or "ethnobotanical drugs" a mixture of methamphetamines, mephedrone, synthetic cannabinoids and Methylenedioxypyrovalerone (*MDPV*) has drastically changed the situation with an increase by 20 times in the number of drug users (ANA estimation 250.000 and 750.000 by CIADO) almost half of them injecting the „stimulants". They are now disspersed in all the country with only one specialized center in each of the 41 counties.[19]

The data regarding the prevalence of drug-related infectious diseases show stabilization for HBV and HCV infection but at values above the European average. This is explained by sharing injecting equipment in a high percentage and low health and social services addressability. Analyzing HBV infection regarding gender: 85% were male and 14.8% females (0.2% unidentified). Regarding age groups, the highest prevalence for VHB among IDUs has been in those aged more than 34 years (17.4%), followed by those aged between 25 and 34 years (10%). The lowest prevalence was in those younger than 25 years (9.6%). The HCV prevalence was 71.2% with higher prevalence among males (77,5%) than women (387,1%). Also HCV prevalence was higher by about 10 percent in patients readmitted to treatment (75.7%) compared with patients admitted for the first time in treatment (65.7%).[19]

Figure 2. Distribution of Drug induced Emergencies at EU regions in Romania
(Source: National Agency Against Drugs, National report on Drug Situation – 2010)

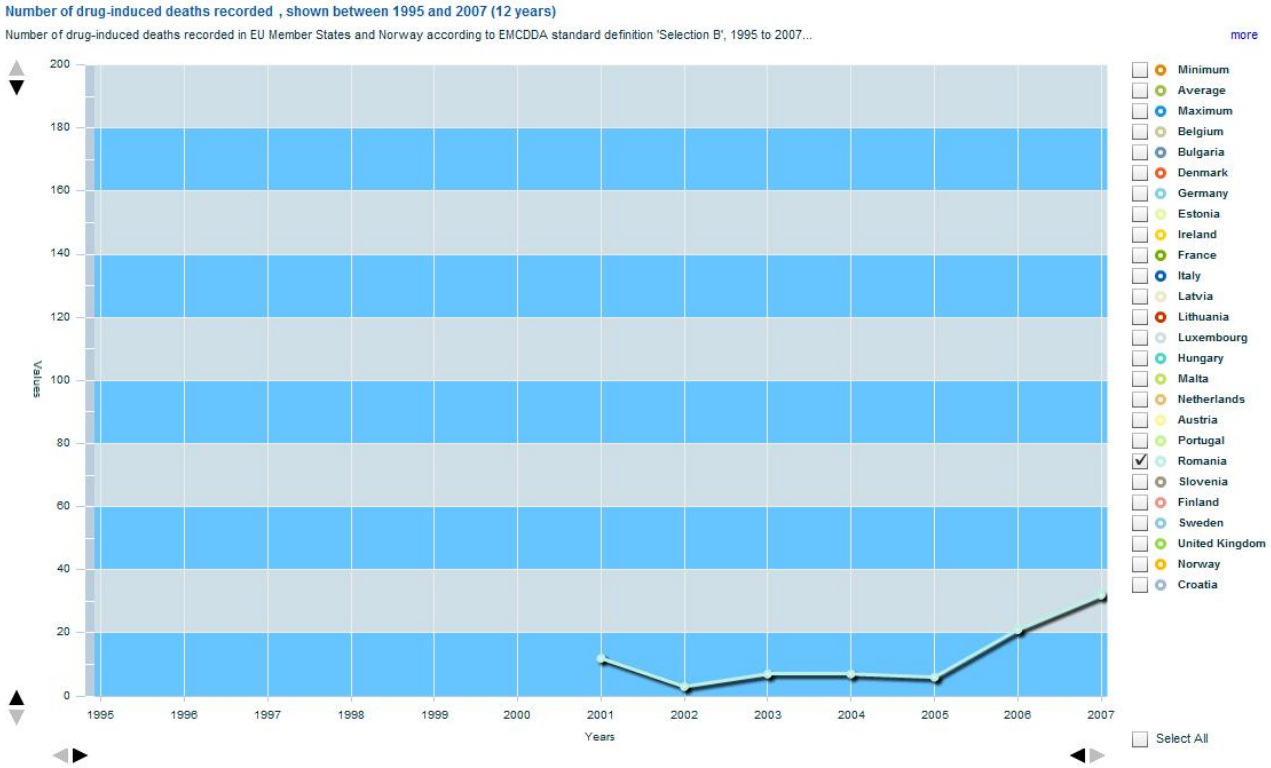

Figure 2. Number of drug-induced deaths recorded, shown between 1995-2007
(Source : EC Eurostat 2010)

Available data on HIV/AIDS for 2009 and 2010 reveal a significant increase to around 3.3% positive cases among the tested IDU's with an equalization among genders. Also, HIV prevalence was higher among patients admitted for the first time in treatment because of drug use (4.8%) compared with patients readmitted to treatment (1.8%).

Unfortunately there are no data available for other diseases such as syphilis, tuberculosis and sexually transmitted infections among IDU's.

Analyzing the drug related deaths, even we have lower numbers than the EU average since 2005 we see a constantly increasing trend (Fig. 3).

Regarding the level of education among addicted people most have secondary education (39.9%) and high school (34.4%) completed with only a small percentage with a high educational level (3, 5%) and 22.2% with less than primary education (9% are illiterates). Approximate 20% of the IDU's using outreach services have no identity papers. [19]

In terms of marital status, more than half of the subjects interviewed were married (53.9%), 42.4% were in a marriage or cohabiting relationship, with responsibility for their own family (11.8% - married, 30.6% - cohabiting), and the remaining 3.2% were other marital statuses (2.9% divorced, widowed - 0.3%). [19]

In terms of socio-professional status of IDU interviewed approximately 50% of them are unemployed; around 30% are employed on fixed-term contract or permanent employment, and 11.37% are working illegally. [19]

The main ways of obtaining revenue in the last 12 months among injecting drug users interviewed were getting money from your partner/parents or relatives (53.55%), the provision of remunerated activities (45.77%) practice of sexual relations (2.04%), selling drugs (5.25%) and other methods (19.25%). 91% of the IDU's declared they were sexually active in the last 12 month, with 73% having a steady partner, 40% of them stating that his partner is also IDU. [19]

Conclusions

The great challenges present in the Romanian Health System have induced significant health disparities for all population and especially in the marginalized groups such as people with addictions. The majority of drug dependent people struggle with more than one stigmatization, being part also from other unwelcomed groups as MSM, sex workers, roma and so on. The arrival of the new "legal drugs" has challenged more the unequal distribution of specialized centers within the country. It is useful to learn from other experience in smoothing health disparities than reinventing the wheel [20]. In concordance with the EU recommendations Romania should drastically increase the health expenditures in order to cover the gap between Romanian health services and the UE average health services.

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