LEGAL ELEMENTS OF CONTINUITY OF THE MEDICAL AND SOCIAL SERVICES FOR THE ELDERLY POPULATION

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Abstract: *In an aging society, quality and continuity of health and social care are equally important. Continuity of elderly care covers two types of services: medical and social. In rural field, primary health services are provided by family doctors, in private practice, who have contracts with the health insurance house. Social services are offered by providers of social services, public and private, which have contractual relationship with local government authorities. In the medical field, continuity is regulated only for the providers who are in contract with the health insurance fund. In social services, continuity is not expressly regulated; there are provisions for the quality conditions that must be fulfilled by the home care providers and by the residential centres for the elderly.*

INTRODUCTION

Haggerty JL & al (1,2) consider that „although continuity of care is understood differently across health disciplines, an interdisciplinary review of concepts and measures of continuity of care found in all disciplines would recognize three types of continuity":

- Relational continuity is the therapeutic relationship between a patient and one or more clinicians that bridges episodes of care and provides coherence through clinicians' growing comprehensive knowledge of the patient;
- Informational continuity ensures connectedness and coherence by the uptake of information on past events;
- Management continuity refers to consistent and coherent management by different clinicians through coordinated and timely delivery of complementary services."

The issue of elderly population in Romania has the complex implications, interdisciplinary, bringing together the social, medical and economic fields. Like in most European Union (EU) countries, in Romania, the elderly population is growing, now standing at 16.14% of the entire population.(3) 55.2% of the elderly population lives in rural areas and it constitutes a vulnerable population group with many risks. In rural field, primary health services are provided by family doctors, in private practice, which have contract with health insurance house. Family doctors coordinate and integrate health care provided to patients by themselves or by other providers of health services. Their role is to ensure the access to their patients in the health system at different levels of proficiency that is appropriate to the needs of patient care. To identify and respond as appropriate social needs of the elderly and particular conditions in which they are located, social services are organized in local communities. Local authorities are those who have the responsibility to identify and assess the needs of the elderly, organization, planning and ensuring funding social services. Social service providers, which can be public and private, have responsibility for the provision of services in compliance with quality standards.

PURPOSE

The purpose of this study is to analyse the Romanian legal provisions in terms of medical and social dimensions of continuity of services provided to the elderly.

METHODS

The approach consisted of a comparative study of normative acts regulating the organization and functioning of health units, the contractual relationship between providers and payers of health care services, organization and functioning of social and care services of the elderly. Comparison criterion: the existence of provisions that relate to the three types of continuity: relational, informational and management continuity. The main regulations analysed: Law no. 95/2006.(4) on healthcare reform, Law no. 46/2003 (5,6) Patient Rights, Law no. 263/2004 (7,8) governing to ensure the continuity of primary care of local communities, framework contracts (9) and its implementing rules concerning the conditions of medical assistance in social health insurance system, Law no. 292/2011 (10) of the social assistance, Law no. 17/2000 (11) on social assistance for the elderly, Law no. 197/2012 (12) on quality assurance in social services, Government Decision no. 886/2000 (13) approving the national needs assessment grille of older people, Government Decision no. 23/2010 (14) on cost standards for social services, Order of the Ministry of Health no. 318/2003 (15) on the organization and operation of home care, Order of the Ministry of Labour, Social Solidarity and Family no. 246/2006 (16) on specific quality standards for home care services and for the elderly residential centres.

RESULTS

In the medical field, continuity is regulated only for the providers who are contract with the health insurance fund. In social services, continuity is not expressly regulated; there are provisions for the quality conditions that must be fulfil by the home care providers and by the residential centres for the elderly. The results of the analysis of legislation in the two areas, medical and social, depending on the dimensions of continuity are:

Table no. 1. Elements of continuity

Medical field	Social field
Relational continuity	
- Patient care based on	- The rights code of

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cooperation and partnership between various public and private health care units; - The right of patients to community services available after discharge; - Direct doctor-patient communication, especially at the family doctor level.	beneficiaries of the care services - Providing information and personal counselling supplied by the care services providers - Facilitate the development of relations between the beneficiaries and community members.
Informational continuity	
- Compulsory medical letter as a means of informing the family doctor about diagnosis, investigations, treatments performed and recommended by other health care providers; - The existence of an electronic patient record data (electronic patient file); - Existence of the practice guidelines.	- Mandatory existence of the service contract, recording and archiving the data beneficiaries; - Develop and implement procedures for assessing beneficiary, its admission, award or termination of care services, - Existence of quality standards for care services; - Communication of the established procedures to the public social service.
Continuity Management	
- Patient's right to benefit from continue medical treatment to improve his condition or to cure; - Existence of the integrated ambulatory at the hospital level; - The existence of permanent centres at the level of family medicine.	- Supporting the beneficiary to have access to a family doctor or to other specialist doctor as well as procurement of medical devices; - Provide ongoing cooperation with the family doctor; - Provide functional autonomy recovery program.

DISCUSSIONS

In Romania, the aging population have the following consequences:

- Social, relating to the reduction in revenue with retirement, risk of losing financial independence, difficulties in ensuring adequate social protection;
- Medico-social, aimed at increasing complex care needs according to specific morbidity for elderly, requiring granting increased number of medical and social services and, sometimes, assisting in social care institutions;
- Economic, creating problems difficult to solve on ensuring minimum social and economic protection of the elderly.

Currently, the existing legislation to ensure continuity of medical and social services is addressed separately on two medical and social fields, without a common strategy, integrative. In the future, Romania will have to adapt their policies for elderly population with European Commission recommendations concerning:

- Modernizing social protection for the development of health care and long term care quality, accessible and sustainable;
- Supporting national strategies for health care and care for the elderly, in order to increase social protection.

CONCLUSIONS

In Romania, health and social services are provided by different suppliers, as follows:

- Medical services - private providers (family doctors) who are in contract with Health Insurance House;
- Social services - public and private providers that contract with the local administration authorities.

Public policies and regulations are made separately by two central authorities: Ministry of Health and Ministry of Labour, Family, and Social Protection. Continuity of health care is regulated in part, only for insured persons and only in terms of health care providers who enter into contract with health insurance funds. Continuity of social care for older people receives regulation that empowers local authorities and providers of care. In the future, for the Romanian elderly population, there will be necessary to elaborate legislation that to target the organization of decentralized and integrated medical and social services at Community level, in relation with the needs of the population.

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