Working Paper No.23
3 May 2004

ENGLISH ONLY

STATISTICAL COMMISSION and UN ECONOMIC COMMISSION FOR EUROPE

STATISTICAL OFFICE OF THE EUROPEAN COMMUNITIES (EUROSTAT)

CONFERENCE OF EUROPEAN STATISTICIANS

WORLD HEALTH ORGANIZATION (WHO)

Joint UNECE/WHO/Eurostat Meeting
on the Measurement of Health Status
(Geneva, 24-26 May 2004)

Session 3 – Supporting paper

DATA SOURCES ON ROMANIAN HEALTH STATISTICS

Submitted by National Institute of Statistics, Romania [*]

1. INTRODUCTION

The health status of the population is a direct or indirect consequence of the lifestyle, of the living standard in all its aspects: the living conditions, the quality of life and labour, the income and consumption levels, the social environment. The living standard influences the health status of the population by providing adequate conditions enabling the preservation of a health status unaltered by disease or other problems that may impair "physical and mental wellness", on the one hand, and access to medical care services, on the other. At the same time, the resources and organisation of the medical assistance system as well as its network of sanitary units and the number and territorial distribution of its specialised personnel have a decisive influence on the health condition of the population materialised in the offer of medical services. Both the living standard and the system's capacity to provide health care are determined by the level of social development, by the general economic and social conditions. Consequently, we may conclude that health is a notion as complex as it is difficult to define. According to the definition adopted by the World Health Organisation, health does not only mean the absence of disease or of the handicap, but a good physical, mental, and social condition. Health is a complex concept conditioned by biological factors (genetic, reproductive, ageing), environment factors (physical,

[*] Paper prepared by PhD. Student Georgeta Marinela Istrate, Direction of Social Services Statistics and Dr. Anca Magdalena Coricovac, Ministry of Health.

chemical, social), behavioural factors (lifestyle), and, last but not least, the health services. The health status is difficult to define and measure. Consequently, as in the case of other complex concepts, characterising health requires the use of a wide range of statistical indicators defined within the general framework of the system of social indicators. The health indicators are part of the social indicators system because the health condition determines the welfare of the population, its living standard in general, being in turn influenced by them.

2. MAIN INDICATORS FOR MEASURING THE HEALTH STATUS OF POPULATION

The health status of the population is therefore the result of a complex of social, economic, and sanitary factors generated by the economic and social system. Under the circumstances, the health condition of the population must be approached from a twofold perspective: as an important aspect of the living standard, an important factor of human and social development, but also as the resultant of living conditions, of the social development. Within this context, the health indicators will be developed as an integral part of the system of social indicators to be used for the evaluation and the characterisation of phenomena in all social fields.

The health indicators system can be developed for various domains according to the object of analysis. A minimal system of indicators necessary to evaluate and analyse medical assistance and the health status of the population should include three categories of indicators: indicators for population access to medical assistance, indicators for the health status of population, indicators for vital balance.

2.1 Indicators for population access to medical assistance

These indicators are defined to evaluate of the supply of medical services and to characterise the access of population to such services and to medicines. The most important indicators are the following:

- Number of persons per medical doctor or number of medical doctors per 1 000 inhabitants;
- Number of persons per one ancillary medical person;
- Number of medical doctors and ancillary medical stuff;
- Number of medical units by unit category (dispensaries, polyclinics, health centres, consulting rooms, hospitals, pharmacies);
- Number of hospital beds (per 1 000 inhabitants) and total of the number of hospital beds by specialities;
- Average distance to the nearest medical doctor or to the nearest medical care unit (km);
- Share of public health expenditure in GDP.

2.2 Indicators for the health status of population:

- Perceived (declared) versus ascertained (diagnosed) health status;
- Use of medical services and medicines;
- Lifestyle;
- Share of population with good and very good health condition;
- Prevalence rate by disease/disability category, expressed in number of persons affected per 100 inhabitants, measuring the individual morbidity rate (chronic conditions and infirmities, temporary disability);

- Number of persons suffering from tuberculosis;
- Number of HIV - infected persons or suffering from AIDS;
- Average duration of incapacity of work (days);
- Specific mortality rate, by cause of death (number of persons deceased per 100 000 inhabitants);
- Share of population by using a medical apparatus;
- Prevalence rate of long-term physical disability (number of cases per 100 persons);
- Share of population who have suffered household accidents (percentage);
- Average number of visits per year to the family doctor/specialist/dentists (number of consultations per year per inhabitant);
- Average hospitalisation duration (days per person per year);
- Share of population who have used medicines (to alleviate disease symptoms, to prevent illness, or to improve their health condition);
- Share of population who smoke on a daily basis and distribution of this population according to the number of cigarettes smoked per day (percentage);
- Share of population who have never smoked (percentage);
- Share of population who drink alcoholic beverages frequently (percentage of people who drink alcoholic beverages at least three times a week);
- Average quantity of alcoholic beverages drunk per week, by types of drinks (litres per week);
- Share of population who practise physical activities to reduce the risk of falling ill and maintain a good health status (percentage).

2.3 Indicators for vital balance are the following:

- Birth rate (live-born per 1 000 inhabitants);
- General mortality rate (number of deaths per 1 000 inhabitants);
- Infant mortality rate (number of 0 – 1-year-old babies deceased per 1 000 live-born babies);
- Maternal mortality rate (per 100 000 new-borns);
- Natural growth of the population (difference between the number of live-born babies and the number of deceased persons);
- Average duration of active life (years), representing the period of time when a person maintains his/her work capacity and is able to stay part of the active population. It can be calculated based on the information regarding the actual duration of active life (collected for surveys and censuses) or based on the legal duration of the active life (established by law);
- Average life span – life expectancy at birth (years);
- Share of population with 5-year olds and older who have no chance to survive up to the age of 60.

Availability of the indicators in the three categories defined above is determined by the statistic system's capacity to collect the primary information required for their calculation, so that expanding or reducing the range of indicators depends on the availability of data sources, on the analysis requirements, and on the objects of the survey, of the report to be prepared. The detailing degree of the indicators according to geographic and territorial (residence area – urban/rural – counties, regions) or demographic (sex, age group) characteristics is determined based on the analysis requirements such as to provide coherence and comparability of data. It is also necessary

to bear in mind the need to ensure international comparability, which raises special problems related to the harmonisation of the statistic instrument as regards the three basic pillars:

a) the concepts and definitions used;
b) the methods for collecting information;
c) the methods for calculation, classification, and grouping of the indicators.

3. DATA SOURCES ON HEALTH STATISTICS

The main actors in collecting information and supplying health indicators are: the national official statistics system managed by the National Institute of Statistics, and the health statistics departmental system managed by the Health Ministry. The data sources enabling the creation of databases are:

3.1.Administrative data sources
3.2.Statistical data sources:
3.2.1.Unspecialised data sources;
3.2.2.Specialised data sources;

3.1. Administrative data sources:

3.1.1.General Practitioners Data;
3.1.2.Hospitals Admission Data;
3.1.3.Outpatient (Ambulatory Care) Data.

3.1.1. Data from general practitioners

Generally, the whole population is registered with a general practitioner. Data on General Practice activity derive from the compulsory data collection containing diseases codified according to the International Classification Diseases (ICD10).
According to the actual knowledge and experience diagnosis related data collected through general practitioners are widely considered as approaching best the description of the status of health this is because general practitioners are the main or first point of entry of patient in the health care system.
General Practitioners records include information on consultations, diagnoses, prescriptions, treatment and test results. They may also include records of hospitalisation and references and notifications of death.

3.1.2. Hospital registers

All hospitals through the country register data on cases of diseases and on number of out of hospital patients. The data registered are transmitted to the local (county) Statistical Office of Public Health Direction and to the Centre for Health Statistics and Medical Documentation in the framework of Health Ministry, where are centralised and analysed in order to send morbidity information to the National Institute of Statistics and other national and international users.

3.1.3. Outpatient (Ambulatory care) data

National outpatient registers exist for the following chronic conditions:

- Cancer
- Communicable diseases (HIV/AIDS, tuberculosis, derma-venereal diseases)
- Mental health disorders
- Diabetes

Cancer registry: There is a specific system for register the cancer cases, organised by National Cancer Registration Office – with departments in each district. These Cancer Registration offices

are based in hospital through the country. General practitioners, hospital clinicians and pathologists to the respective registries send notifications of cases. For coding diseases, it uses ICD classifying types of cancer. The registry should be a link for the causes of death statistics to allow the calculation of indicators, for instance, the calculation of cancer survival rates. Data collection on cancer is reported by National Cancer Registration Office to Centre for Health Statistics and Medical Documentation that transmitted to WHO ("Health for All").

Communicable diseases:
HIV/SID A: All cases are registered by specialists from National Communicable Diseases Institute " Prof. Dr. Matei Bals) in Bucharest. Data collected are transmitted to the National Institute of Statistics and to the Public Health Direction in framework of the Ministry of Health. The National Communicable Diseases Institute collaborates with the European Centre for the epidemiological Monitoring of AIDS in Paris, France.
Tuberculosis: There is a network of special dispensaries in each district;
The specialists certifies and registers the case of tuberculosis and monitoring all the patients registered with tuberculosis; all data registered are transmitted to the local Statistical Office of Public Health Direction, than to the Centre for Health Statistics and Medical Documentation and National Institute of Statistics (INS). The individual declaration forms are sent to the Pneumonlogy Institute – Bucharest in order to evaluate the activity in this field.
Derma-venereal diseases: Syphilis and other sexually transmitted diseases are registered in specific national network of derma-venereal dispensaries. If appear a new case the specialist (epidemiologist) who identify disease must inform immediately the county's Direction of Public Health. The information is transmitted to all the similar Direction of Public Health through the country in order to identify the potential contagious sources and source of contact. Periodically, the amount of data is reported to National Derma-venereal Centre and to the Centre for Health Statistics and Medical Documentation.
Diabetes: For diabetes, information is obtained from specific medical dispensaries where patients are registered and monitored. There is a clear evidence for the insulin-dependent patients.
Mental health disorders: For mental health there are specific medical clinics where the patients are registered and monitored. A specific legislation for very dangerous patient with psychiatric disorder is in force;
The cases which are suspected that could be occupational disease and they are sent to the occupational physicians who can establish if the case must registered such a occupational diseases or not.

3.2. Statistical data sources:

3.2.1. Unspecialised data sources

- Demographic statistics (birth/death certificates, births, deaths, and marriages register documents);
- Population and housing censuses;
- Selective household surveys aimed at evaluating the living conditions of the population, that include modules referring to the health status as perceived by the people (Integrated Household Survey; Living Conditions Survey; Family Budget Survey; Time Use Survey, etc.).

The unspecialised statistical data sources provide less information as far as building the health indicators is concerned, but the advantage is that this information is correlated with social and economic characteristics (economic activity, professional status, occupation, income, consumption of medical services, medicinal drugs, food) that can influence but also explain the

health condition of the surveyed persons. The most important in this category are the household surveys included in the Romanian national statistic system. They are carried out by the National Institute of Statistics on an annual basis or at longer intervals and have become permanent instruments for evaluating the living conditions of the population.

Between 1995 – 2000, the Integrated Household Survey represented the main multifunctional statistic survey conducted by the National Institute of Statistics, supplying the multiple information needed to characterise the living conditions of the population, to measure poverty, to identify the poverty factors and profile, and to characterise the health status of the population (household members' estimations on their own health condition), the consumption of medical services, and the household health expenditure.

Since then, the multiple information on the living conditions of the population has been supplied through a system of selective household surveys conducted at various intervals, providing correlated and coherent information on the health status of the population.

The Integrated Household Survey is a survey based on a questionnaire containing an extremely great number of variables, has turned out to be a much too complex and difficult survey both for the personnel involved in carrying it out (surveyors, statisticians) and for the people. Consequently, a system of selective household surveys harmonised with the similar surveys in the European Union countries has been designed, comprising:

- Family Budget Survey – representing the central pillar of the household survey system;
- Living Conditions Survey;
- Time Use Survey.

Family Budget Survey provides detailed information on the household consumption income and expenditure enabling a deeper analysis of people's economic and social situation.

The collected information also enables:

- Identification of the disadvantaged households and persons or of the discouraged ones, in order to elaborate adequate social protection programs;
- Analysis of the impact of implementing various social programs, of the economic effects of transition in general upon the economic and social situation of the people;
- Identification of medical consumption and the factors that can influence it, the frequency of health problems as perceived and declared by the people, the amount of health expenditure of the population, etc.

As in the case of the Integrated Household Survey, the set of instruments for the family budget survey is formed of the household questionnaires and diary, the reference period is the calendar month, and the survey sample is the same as the one used for the household survey. The Family Budget Survey uses the health module of the Integrated Household Survey so the collected information is perfectly comparable, providing continuity of the data series related to the health condition of the population, the consumption of medicinal drugs and medical services, and the household health expenditure.

Living Conditions Survey is another selective household survey including a health module as well. The main objective of the survey is to produce coherent information describing the living conditions of the population in Romania and, at the same time, enabling the outlining of poverty, the study of social phenomena and of the existing social disparities, based on its complex type of approach. The individual information gathered reveals the interconnection among and the complementarily of various aspects of life such as the health condition, the education, the incomes, the living conditions, occupation, the work conditions, the social relations, the associative life, etc. They also enable us to obtain subjective data on the extent to which the population is satisfied with certain services, namely if people request the services of the police, of the medical doctors in sanitary units, if they are content with the convenience provided by their dwellings and the environment they are located in. The data are collected by means of two types of questionnaires: The household questionnaire, and the individual questionnaire.

The data are recorded in the two questionnaires (the household and the individual ones) by interview, with a two-week reference period.
The health module included in the questionnaire records information related to the health status perceived by the population, it tracks chronic diseases and the health problems in the last 12 months and the way in which they affected daily activities, hospitalisation periods, request for services provided by certain medical doctors (family doctor, specialist, dentist), smoking and the consumption of alcohol, the people's attitude towards optional health insurance.
Time Use Survey also including a health module is mainly focused on supplying comparable information on the extent of household persons' engagement in productive activities, their participation in associative, cultural and sports activities, as well as time use and allocation for various activities.
The information gathered reveals the following aspects:

- Living conditions: Structure and convenience of household-occupied dwellings, household equipment with dwelling annexes
- Household equipment with durable goods
- Nature and extent of household persons' engagement in activities producing money or in kind income: Wage labour, self-employed activities carried out individually or with wage earners
- Assistance received from persons inside/outside the household and service provided to persons inside/outside the household
- Level of education and schooling
- General health status of the population
- Time allotted to cover the distance to/from work
- Participation in associative life, in cultural, sports, and other activities
- Household incomes: From wage labour, independent activities, agricultural or non-agricultural activities, from social protection sources (pensions, unemployment benefits, child allowances, etc.), from financial and real estate assets, etc.

Based on the results of the survey, specialised studies can be conducted in the following domains:

- Flexible individualised programs to improve public transport, cultural and spare time activities, time use policymaking, etc.
- Work time measurement in order to evaluate underground economy;
- Satellite accounts (for household production);
- Activities specific to special groups: Elderly, youths, disabled persons;
- Participation in cultural, artistic, and sports events, in associative life, in providing assistance for other people (child care, chronically-ill people, etc.)
- Measurement of women's "double" activities as employees and housewives and evaluation of their involvement in paid and unpaid work.

Population and Housing Censuses are exhaustive information sources on the population and the living conditions. They supply detailed information on population distribution by various demographic, social, and economic characteristics, to build important life statistics indicators. Censuses supply basic information for the calculation of the demographic, health, education, and labour indicators. Population censuses also supply the statistical data necessary to build sampling bases for the design of samples for selective household surveys.

3.2.2. Specialised statistical data sources:

- Health Examination Survey (HES);
- Health Interview Survey (HIS).

Health Examination Survey (HES)

Five **specialised, objective surveys** were carried out in Romania by Centre for Health Statistics and Medical Documentation in the last decades on the health condition of the population in 1959, 1964, 1983, 1989, and 1997. All surveys used similar sampling methods – the 3-layer typical selection: area, residence area (urban/rural), and localities.

Technically, they were based on complex medical examinations carried out by commissions formed of specialised medical doctors: internal medicine, obstetrics – gynaecology, podiatry, stomatology, but also the other specialities, if necessary: neurology, psychiatry, surgery, dermatology, etc.

The object of the last three surveys on the health condition of the population (1983, 1989, 1997) was to estimate the comparable prevalence indices for 99 diseases in order to establish the morbidity level and trend in the respective cases between 1983 – 1997.

Morbidity was first surveyed in households, both as number of diseased persons and by main groups of diseases. The prevalence indices by sex, large age groups, residence areas (urban/rural), some occupation category, level of education of the surveyed people, etc., were also included in the survey for all the diagnosed cases. The examination surveys supply multiple and objective information on the health condition of the population but have the disadvantage that this information is not correlated with the characteristics of other factors that influence the state of health (incomes, consumption, living environment, etc.).

The last HES was done on a representative sample of 11600 persons, which have been investigated on the survey occasion. There have been used also some other parameters, for the establishing of the requested number of persons in order to make the sample more reliable (by country, counties, sex and groups of ages – under 15 years, 15-59 years and over 60 years old).

The results of the last HES are analysed on the following classes of indicators:

- morbidity inside the households;
- morbidity by contingents;
- morbidity prevalence;
- number of diseases persons by country and diseases.

Health examination survey provides the results of clinical examination and can be considered a powerful source of morbidity data; the HES results can be compared with information from other sources.

Health Interview Survey (HIS)

In Romania, National Institute of Statistics carried out in 2000 Health Interview Survey (HIS), called SAN.

The health survey is an efficient and flexible source of information regarding the health status of the population. The survey assures the necessary information to evaluate the health status of the population, as well as to have evidence upon individual morbidity (chronic conditions) of the medical services and medicine consumption. In the same time, HIS offers the possibility of emphasising the link between the health status of the population and some demographic factors (sex, age, marital status, educational level) or behaviour factors that have a direct impact upon health (consumption of tobacco, alcoholic drinks, carrying out of physical or sport activity).

The data resulted are comparable at international level, the survey being a standard in point of methodology and organisation, of concepts, definitions and classifications used, as well as of sampling plan.

The target population of the survey was all the person with permanent residence in Romania, members of the selected households. Data collection method was the face to face interview. For the persons under 15 years the data ware given by an adult person from the household.

The health survey (SAN) was carried out between 24th of July and 6th of August 2000 and the survey was done on a random sample of 9018 dwellings, representative at national level, using a two stage sampling plan. Non-response rate was 8,2%.
Information regarding data morbidity collected by HIS carried out in 2000 is about the following diseases: hypertension, asthma, stroke and effects of stroke and myocardium infarct or angina pectoris, other heart chronic diseases, diabetes, malign tumour (including leukaemia), allergies, arthrosis and arthritis, osteoporosis, migraines, Parkinson, Alzheimer, epilepsy and others.
An advantage of surveys is that they can collect a wide range of information about respondents. Data on health-related behaviour such as smoking, alcohol consumption are also available. Surveys also offer the opportunity to obtain more information that can be compared with information from other sources external to the survey.
Health Interview Survey (HIS) will be reviewed according with the recent recommendations of Eurostat in order to harmonisation with Eur opean system of health survey. National Institute of Statistics is going to organise in 2006 a new health survey that include all the European developments and recommendation.
The survey is an efficient and flexible source of information on the health status of the population, such information being crucial in the elaboration of social protection policies (it shows the exact number of temporarily or long-term disabled persons, of persons suffering from chronic diseases) as well as public health policies (allotment of resources and adoption of various prophylactic measures).
The main advantages of the selective household surveys are the following:

- The estimations provided are required in the study of some important aspects of the social life and therefore of the health status of the population in relation with the factors that influence it. The errors affecting these estimations can be controlled with mathematical means.
- They use independent random samples to avoid overburdening households with requests for information, which has a positive influence on the quality of the results
- They meet various information requests in several domains
- They are harmonised in point of definitions, classifications, nomenclatures, and sampling methods and their results can be used to conduct complex surveys.

4. A BRIEF DESCRIPTION OF THE 2000 – HEALTH INTERVIEW SURVEY RESULTS

4.1. The Perceived Health Condition

The health condition of a person may be outlined not only by its objective dimension, through all the diseases that he or she suffers, but also by the subjective dimension in which the person may express his or her opinion regarding his or her general health condition. This opinion is not necessarily based on the number of diseases they suffer from, but merely on their general disposition.

Among the total of population, 72,2% considers that their health condition is good or very good. This opinion depends mostly on the person's age. Men declare a good and very good health condition in a bigger percentage than women, the difference being of 8,3 percentage points. This difference is almost non-existent between 0 and 14 years old, but as they grow up the discrepancy between sexes deepens, the bigger difference being between 65 and 74 years old (11,6 percentage points).

According to the education level, the best health condition is declared by persons who graduated the high school (about 80%), followed by persons that graduated a post-high school and a faculty (about 75%), while the persons with a lower level of education declare in a smaller percentage a good and very good health condition (63-69% of them).

4.2. Individual morbidity

The health condition of a person may be affected in a higher or lower level by a disease or a wound. These diseases may last longer or shorter (acute diseases) or it may affect a person for a longer period of time (at least 3 month), which requires a continuous or periodical treatment (chronic conditions).

- The declared chronic diseases and infirmities

Almost 1 among 4 Romanians suffers from a chronic disease, a bigger percentage being among women, a.i. of 28,0% comparing to 20,3% which is registered among men. Nevertheless, at most of the chronic diseases, the prevailing rate is bigger with women than with men. Also, the persons living in the rural areas suffer in a lower percentage from a chronic condition than those living in an urban area (22,6% against 25,6%), for most of the chronic diseases the prevailing rate being inferior in the rural areas.

The differences presented above are more evident if we watch the structure of the population who suffers of chronic diseases after the declared chronic diseases. Thus, women declare in a bigger percentage chronic diseases than men, the difference being of 8,8 percentage points. The bigger the age, the bigger the possibility for a person to suffer from a chronic disease. The most frequent chronic diseases are hypertension (almost 30% of the total number of persons suffer from a chronic diseases) the heart chronic disease (21,4%) and lumbar-sciatic (13,4%). The hypertension and other heart diseases are to be found mainly in north-west regions, in Centre and in Bucharest.

An important aspect is to know in what measure the chronic diseases affect the population in performing the daily activities. Thus, a quarter of the persons suffering from chronic diseases declared that they are seriously limited in their daily activities by these chronic diseases, the rest of the persons declaring that they are not at all affected (58,6%) or only at a smaller level 16,5%). According to infirmities, the structure of the population shows that 2,7% of the persons has an infirmity. A higher percentage is found at groups of older people : 4,0% between 55 and 64 years old, 5,4% between 65 and 74 years old and 10,7% at 75 years old and more. More than half of the persons with an infirmity (57,0%) declare that they are seriously limited in performing the daily activities by their infirmity, while only 9,0 declare they are not at all limited in their daily activities.

- Temporary incapacity

Different health problems, serious or less serious, may determine the limitation or temporary incapacity of performing an activity in a way considered normal for a healthy person. During a period of two weeks that preceded the interview, a quarter of the total population suffered from health problems. Women are more subject to this problem than men (30,4%, with 10,4 percentage points than men) as well as the urban population (27,2%, with 4,2 percentage points more than in the rural areas).

The structure per categories of diseases that population suffered from shows a higher share of breathing apparatus (22,6%), circulatory apparatus (20,6%), and of the nervous system

(19,4%). On age groups, the higher prevailing pertain to the circulatory apparatus, starting with the age of 55 years old, while at the other ages the diseases of breathing apparatus prevails. During the mentioned period, 7,7% of the population are persons that have interrupted or have given up the usual activities because of a disease or a wound, 63,5% of them being forced to stay in bed at least one day. The most affected were the women (9,4% of them), and the rural population (8,8% of them). However, men experience an average period of time of temporary incapacity higher than women, as well as a longer period of time of staying in bed.

Thus the average period of time of temporary incapacity within the two weeks that preceded the interview was of 8,0 days (8,6 days men and 7,7 days women). At the same time, it has been ascertainedthat the percentage of the persons with temporary incapacity, as well as the average number of limited days, grows together with the age.

- Medical Devices used by the population

Using a medical device is linked mostly to the age. Thus, as people grow older, more and more persons have to resort to such devices. As a share within the population of 1 year and more, only 23,3% of them use medical devices, the most frequent being the spectacles (glasses) and contact lens (19,4% of the population of 1 year and more). It is noticeable that men share that wear glasses is lower with 7,6 percentage points than women. More than that, the rural population use less seeing correction devices than those from the urban areas (13,7% comparing to 24,2%). Another medical device more frequently used, specific to older persons, is the set of plates (artificial teeth). Thus, 1 of 4 persons of 75 years and more uses a set of plates (artificial teeth).

- Long-term physical incapacity

Long-term physical incapacity is defined as a long-term limitation of most of the activities of the daily life. The instrument of its assessing (the method "Activities of day by day life" – ADL) is addressed to the problems of mobility, personal care and communication. Among the population of 15 years and more, 5,8% are persons with long-term physical incapacity. Women have a higher share 6,7%, and men 4,8%. The incapacity is a phenomenon that mostly may be encountered at older ages. Thus, at 75 years old and more, 1 of 3 persons suffers from incapacity. Per sexes, the differences are more obvious while the age grows: 365,7 women of 75 years and more among 1000 suffers from incapacity, while the percentage of men is of 280,7 among 1000. The same, according to residence, the bigger difference is to be observed at 75 years and more (296,9 persons among 1000 in urban areas and 357,1 persons among 1000 in rural areas).

Among different forms of incapacity, the problems of locomotion nature highly prevail, 36,8 persons among 1000. The next in hierarchy is the problems of personal care, 25,0 persons among 1000. What prevails less is the immobility and communication problems (15,2 persons among 1000).

Among the total of immobilised persons, 48,0% are immobilised in their houses, 41,7% in bed, and the rest of 10,3% in chair.

4.3. Medical services and medicine consumption

- Consulting the family doctor

Knowing the dimension and the profile of medical services and medicine consumption offers an indirect information about the general health condition of the population. The results of the survey shows that most of the population (91,1%) has already chosen the family doctor; concerning those who haven't yet in-listed on the list of a family doctor. The persons who needed

the doctor went to him/her, during the mentioned period, at an average of four times. Women appeal to the family doctor more frequently than men (4,2 visits comparing to 3,8). Considering the age groups, the percentage of going to the family doctor increase together with the age, excepting for the persons between 0 and 14 years.
Between the persons who went to the family doctor, at the last visit, 36,5% received a dispatch. Most of them were send to a specialist (almost 80,0%) or to a laboratory for medical analysis and examinations (24,6%). Out of the total number, 10,1% were sent to a hospital to be hospitalised.

- Consulting a specialist doctor

In the period of 12 months that preceded the interview, the specialist doctors examined 18,7% of the population [1)]. Women requested examination from a specialist doctor in a higher rate than men (21,7% comparing to 15,6%), as well as the persons living in the urban area (22,3% comparing to 14,4% which is the share in the rural area). The age also is an important factor to request an examination by a specialist doctor. Thus, if only 10,7% of the young people of 15-24 years visited the doctor, the persons of 55 years and more the percentage is higher,26-29%. Considering the specialisation of the doctor who was consulted in the last period, it has been ascertained that the most applied for were the cardiologists (16,8% of the persons who went to the specialist doctor within the last 12 months previous to the interview). About half of the persons of 55 years old and more went to a cardiologist and an internist (31,3%, and 17,2%). In most of the cases (82,6%), people went to a specialist doctor who belonged to a public medical service.

- Consulting a dentist

During 12 months (period before the interview), 15,2% of the population of 3 years and more went to the dentist. The women, with a share of 16,7%, rise above men with 3 percentage points. It is to be observed that the persons with a high level of education went more to the dentist than those less educated. Thus, for the graduate of a university, of a college or a technical school, the share is of 30,4%, and 28,6%; for those who graduated from gymnasium and primary school, or did not graduate from any school, the share is only of 11-12%.

- Alternative medicine

During the last 12 months previous to the interview, 1,7% of the population appealed to treatment of alternative medicine (2,0% women and 1,3% men).

- Hospitalisation

The survey permitted to emphasise other aspects of the requests of medical service as hospitalisation. The hospitalisation of one day were counted (without staying in the hospital), and also those for at least one night. Out of the total of population, 1,3% was hospitalised for one day (1,2% of the men and 1,4% of the women). Per age groups, excepting for 0-14 years, there is a slight rising of the share of hospitalised persons, so that at the groups of 65 to 74 years and 75 years and more the share is of 1,9%.

Most of the persons were hospitalised (according to the motif of the last hospitalising) for disease of the circulatory apparatus (17,1%), of the digestive apparatus (15,9%), of the breathing and genital-urinary apparatus (both with 10,5%).

[1)] Excluding the examinations during hospitalization

- Medication consumption

In the two weeks preceding the interview, 26,4% of the population used medication. Most of the persons took medication following a prescription or recommendation of a doctor (68,2%) or of their own initiative (28,7%).
Beginning with 15 years old, the percentage of persons using medication in the respective group of age increases together with that, from 10,4% at the age 15-24 years to almost 62% with people of 75 years and more. Women use more medication than men.

4.4. Life Style

The distribution according to the BMI shows the fact that, in Romania, 33,9% of the population of the 18 years and more is overweight (38,5% men and 29,7% women) and 8,7% is obese (7,8% men and 9,6% women).

- Tobacco consumption

Smoking and alcohol consumption, unhealthy nourishment, inadequate organising of time, physical inactivity, and others, represent a major factor of behaviour risk. Smoking is the main cause for pulmonary cancer, ischemical cardeopathy, chronic bronchitis, and emphysema. Smoking during pregnancy reduces children's weight at birth, and exposing to cigarette smoke increases the risk of pulmonary cancer, and of other respiratory illness for the non-smoking people.

Almost 21,0% of the population of 15 years and more smoke daily, while 59,5% of the mentioned population have never smoked. A percentage of 4,0% of the person that do not smoke any more, even though in the past they used to smoke daily.
If in the group of age 25-54 years old, the biggest share of daily smokers (29,3% of the total population of that age), to the next age groups there are many more persons that have given up smoking (7-8% of those who used to smoke in the past).

The share of male smokers in the entire population of 15 years old and more is nearly 3 times bigger than the corresponding for women (32,3% comparing to 10,1%).

Also, it is to be noted that woman of 55 years old and more have a high rate of non-smokers in the entire female population; within the group of age of 75 years old and more the percentage is 92,5%.

As an average, a daily smoker smokes 15,0 cigarettes per day, the highest value being in the group of age 55-64 years old, respectively, 16.6 cigarettes.

- Alcohol consumption

A moderate alcohol consumption may be profitable for health. Opposite to that, the excessive consumption of alcohol may lead to diseases as cirrhosis, some forms of cancer, hypertension, and accidents, especially traffic ones. According to the inquiry results, 50,6% of the population of 15 years old and over has drunk alcohol within the 6 months previous to the interview. Out of them, more than 1/5 drank frequently (at least 3 times per week) such drinks. As expected, men drink alcohol more than women (68,2% comparing to 34,2%). As in the case of tobacco consumption, most of the alcohol drinkers are men between 25-54 years old (79,3%).

- Physical activity

It is well known the fact that the physical activity represents an important factor which influences significantly the health condition. The constant physical activity stimulates health, reducing the risk of heart diseases, colon cancer, arterial high blood pressure, diabetes, obesity, osteoporosis and depression.

Sedentariness characterises more than 2/3 of the population of 6 years old and more (68,6%). Taking into account the residential criteria, the share of the sedentary persons in the corresponding population is almost equal to (68,6-68,7%), but considering the sexes, the situation is different. Thus, the sedentary women share exceeds with almost 14 percentage points that of sedentary men. The biggest difference between men and women is registered at the group of age 15-24 years old, this being of 22,8 percentage points. Young people of 15-24 years old are registered as performing intensively a physical activity (3,0%) and medium (6,1%). As the age increases, the share of persons that carry on an intense, medium or easy physical activity decreases.

*****