THE YEARBOOK OF THE „GH.ZANE" INSTITUTE OF ECONOMIC RESEARCH
VOL. 21, ISSUE 1, 41-49, 2012

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EMERGENCES IN THE MANAGEMENT OF HEALTH SERVICES FROM ROMANIA - CO-PRODUCTION AND "HEALTH IN ALL" COLLABORATION IN THE TREATMENT AND REHABILITATION OF PERSONS WITH SUBSTANCES ADDICTION

Abstract.

In the last period one can notice a high incidence of substance abuse (substance addiction) cases both in Romania and in other countries, becoming a problem to the modern society. Persons with substance abuse require long and expensive medical treatments, which are not always effective and do not guarantee the success. The new tools specific to the New Public Management and already functional in the US and Western countries must be implemented also in providing the social and medical services in Romania: co-production in public service and "health in all" collaboration. This article provides a brief overview of the importance of these new tools in the health system and points out the possibility of the adoption of the co-production through virtual communities of students process on the post-treatment services for people with substance addiction from our country.

Keywords: substance addiction, health service co-production, "health in all" collaboration, virtual community of students

1. Current challenges for the health systems

In the last period one can notice a high incidence of substance abuse cases both in Romania and in other countries, becoming a problem to the modern society (acc. EMCDDA, 2010 statistics; the National Report on Drug Situation in Romania, 2010; Svikis, et.al., 1997).

Economic and social crises (notably poverty and lack of education) are „push" factors that generate and sustain substance abuse (alcohol, cigarettes, illegal drugs, ethnobotanicals, medicinal substances, inhalants, etc.). Moreover, under the effect of globalisation, the Internet and social networks, it becomes a dangerous phenomenon of „imitation", which gets bigger and bigger especially among young people and affects economically, socially and even politically all the countries. New types of businesses (such as the „dreams" stores) carried out even in online version (difficult to be controlled) have fed more and more the trend of young people to abuse substances, either due to the lack of values and education, either due to the state of confusion when facing the lack of perspectives, either because of their rebellious age and desire to have a state of „well-being" (Simionov, 2010).

Under the National Programme „Education for Health in Romanian School", the consumption of toxic substances (alcohol, drugs, and tobacco) is frequently among young people, (students), with adverse consequences on school performance (greater absenteeism, school dropout) and with an increase in juvenile delinquency.

Indeed, a very serious phenomenon is the abuse of substances among street children and young people (according to the study conducted in 2003 by the Organization *Save the Children*). Almost 70% of the children and youths say they are inhaling toxic substances daily (the so called „*aurolaci*" – the persons who are inhaling a chemical product named Aurolac);

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13% of the street children say they are addicted to hard drugs; 95% of them declaring they have consumed or used to consume alcoholic beverages; 90% of them are smoking.

The economic and social costs with these substance abuse persons are high and they burden the public budget (Zarkin, 2004; Solberg and al., 2008). For example, in the U.S.A. the total costs arising from substance abuse amount to $ 240 billion. Studies show that every man, woman and child pays nearly $ 1,000 a year to cover the costs for the health care of people who are substance abuse, for the law enforcement, for car accidents due to substance abuse, for the criminality cases and for the lost productivity. The total social and health care costs incurred as a result of the use of illegal drugs, tobacco and alcohol addiction reach to at least $ 240 billion, i.e. 4% of GDP, more than America spends on education (schools) and housing (GlobalChange, 2010).

Persons with substance abuse require long and expensive medical treatments, which are not always effective and do not guarantee the success (Miller, 1992). Substance abuse generates poverty, broken families, violence (Buss, al., 1995), theft, suicide, car accidents (those who drink alcohol or take drugs), trafficking in human beings (street children), mortality, etc. A person who consumes drugs is more likely to steal or make a crime in order to get money; a student who consumes ethnobotanicals will have a poorer academic performance and thus the State resources invested in training are lost; it is almost certain that in families with such problems will occur births of children with malformations and infantile mortality, etc. The costs of reintegration in society are also important. Individuals who are substance addicted are often stigmatised, discriminated, abused and marginalized, finally getting to personality disorders. Frequently, they no longer complete their studies and remain without qualification, are viewed with distrust, find very hard a job, and commit suicide, etc.

This is the beginning of a vicious circle (people find their refuge in substance abuse again). We face a reiteration of addiction behaviour and the treatments have only a short-term role because they do not eliminate the cause and the hospitals do not monitor the patient on long-term (failing to trace his route toward recovery). In addition, migration from one country to another may worsen this phenomenon, by „imitating" these behaviours or may affect the structure of health services expenditure, by the transfer from one country to another.

The few studies conducted on this problematic (the National Programme „Education for Health in Romanian School", the European Project: *Surveys in Schools on the Consumption of Alcohol and Other Drugs*, ESPAD, 2007; The Presidential Commission's Report for the Analysis and Development of Public Health Policy in Romania, 2008), indicate the need for urgent to build a system for quality assessment. It is an alarm signal for the whole society, both nationally and internationally.

However, these studies are still at the stage of *diagnosis* and do not offer solutions. There are associations of support and rehabilitation centres (for example, Blue Cross Romania – headquarters in Sibiu, Association of Anonymous Alcoholics in Iasi, etc.) which try to deal with these people, but their treatment involves interdisciplinary skills and thus the efforts remain insufficient and resultless.

The new tools specific to the New Public Management and already functional in the US and Western countries must be implemented also in providing the social and medical services in Romania: co-production in public service and "health in all" collaboration.

2. Medical policies supported by co-production in health care

Social pressures and scarcity of resources (human and financial), increasing demands for improving health services financed from public funds, explain *the need for reconstruction of the whole system of medical and social services,* rethinking of the system on new conceptual basis and strengthening the role of ethics within it and, consequently, development of certain

health policies, adapted and really efficient and effective. Indirectly, it is about the need for a greater increase in attention to the quality of life by improving health status.

According to Ellen Kuhlmann (2006), "the common purpose is that of improving the quality of service and safety for patients and the public in general". Health system lies in the face of new challenges, while health policies have the mission to reactivate the public interest to attend this improvement.

Thus, we can speak about the necessity of *co-production in health care concept* which requires dialogue and negotiation between the first line staff and the users of health service (www.communitycare.co.uk, 2009).

Co-production in public service meets the deficiencies of the classic administrative system.

Since the 1970s in the USA and the mid-1980s in Europe (after a decline in attention at the beginning of the Decade), co-production in public services flips the classic administrative system (the well known one sense decision-making, by top-down, in which the main role was played by professionals and managers). The new model involves negotiation between multiple policies, planning, policy formulation, decision-making and service providing by calling. It is an approach based on stakeholder networks, targeting many different purposes, and involves aspects of public governance (Bovaird, 2007). The latter involves three main pillars of support: Accountability, Transparency and Participation (Eeckloo and et. al., 2007). The knowledge, expertise and skills of professionals give them power over others and implicitly it attracts responsibility. The information available to them gives them an advantage over those who consult them and therefore they have the responsibility to use this knowledge in an accountable manner (Wade, 2000).

Co-production means the achievement of public services with the help of the community and its users. They make available their resources, expertise and availability to provide legitimacy, alongside/together with the expert/professional providers of service (Hyde & Davies, 2004). It brings together individuals, organizations and communities in collaborative effort to identify new models and innovative services in order to improve civil service (Ottmann et.al. 2011).

Advantages of co-production reside both in improving the quality of public service and in streamlining costs and reducing the budget (Rjur, 1981), as well as improvement of civic spirit, strengthening the social capital and democracy (Vamstad, 2004 quotation Ottmann et.al., 2011).

Making a broad foray into literature and synthesizing the views of many authors with concerns in the area, Tony Bovaird (2007) exemplifies many categories of co-production (total or partial) in the public service:

- professionals invites users and community members to participate in the design and planning of public service, but the first provides the service (for example: users' committees that provide feedback on public service);
- professionals establish the planning coordinates and design of public service, but the users and community members are those who are in charge for providing such service: expert patients who are users or who have used the service and now are providing advice to other patients; training programmes for mothers, who in turn become trainers for other mothers;
- the user and professional cooperate entirely: cooperation between communities and professionals in planning and design of the service, resting on its volunteers in providing such service and collection of funds (e.g., religion-based social services, using professionals that are managed by community representatives, with the help of volunteers);
- total involvement of users-community: meaning involvement in activities for the locals, recourse to professionals being made only where it is needed (i.e. local associations for leisure), but without involving processes of formal planning and design;

- involvement of users-community in providing public services planned and designed by professionals (family who take care of people with disabilities or who provide home care services, volunteers trained by professionals to provide moral support to people with suicidal tendencies, recycling programs for and with the help of the community);
- partial involvement of users and community members in the planning and design of public service (i.e. services contracted by local community groups, but under a contract of public agencies – the renovation of heritage buildings, etc.);
- offering traditional services organised by the Community (children's clubs, cooperatives, etc.).

In the medical field, co-production requires an active partnership between professionals and the community, each of them offering substantial contributions in relation to the resources provided (Chiarella, 2010). Co-production recognizes the client (patient) as an important resource, for which the value could not be easily created and supplied unless the patient contributes actively to the service which is intended to him (Alford, 1998, quoted by Barry Welsh, 2010). Co-production illustrates especially how the stakeholders (which are external to the provider organisation) become partners in a network and assume own accountability in the public service. In other words, "public institutions and Government acknowledge to a greater extent the contribution to the community of non-paid people and the relationship between these activities, the welfare and public services".

Edgar Cahn (quoted by David Boyle, et.al. 2006) highlights the importance of the networks involvement (networks consisting of the families of the public service users and people from their vicinity).

Cahn defines public service co-production according to the following values: *active* (every human being can bring its contribution to the well-being of both as a constructor and as a contributor); *redefining work* (including everything that is necessary in order to: raise healthy children, keep families together, strengthening a healthy and an active community, expressing concern to vulnerable persons, support to Justice system recovery and further functioning democracy), *reciprocity* (replacement of the generous actions undertaken in one-way direction, by two-way transactions with reciprocal character, between individuals, between individuals and community, between individuals and institutions, between institutions, between institutions and community, between communities); *social networks* (creating a social infrastructure that individuals need to relate each other, which requires continuous investments in the share capital, winning the trust, generating the feeling of reciprocity and civic engagement).

Meijer (2011) mentions two types of added value which are gained in public service through the process of co-production with the support of citizens (community): *a substitution value*, the citizens undertake the efforts that the State institutions should make; *and an additional value*, through the new knowledge and emotional support of the citizens, in addition to what the public official could provide.

Examples of good practices in the field of co-production in the service of rehabilitation in terms of drug addiction are found in all countries. For example, in India there are networks of rehab centers managed by voluntary organizations, and programmes of treatment with the support of the community, in order to get the addicted person closer to family and community, and at the same time to earn a better support and cooperation from the latter. Besides these initiatives of the community one can mention the regularly organization rehab campuses (in the venues where addicted people live), with the labour support of voluntary organizations, and the organizational and financial support of local leaders and social organisations. Moreover, there are also the therapeutic communities built on the principle of self-treatment through joint work and companionship, which ensures mutual beneficial social

relations. Self-help programs are also provided and by the Anonymous Alcoholics groups (The Hindustan Times, 2008).

3. Co-production in providing the service and "health in all" collaboration based on ethical values

Co-production in health care to persons who are substance abuse (addiction) requires the integration of all stakeholders involved in the formulation and implementation of public policies: central and local authorities; health system (doctors, psychologists and psychotherapists); rehabilitation centres; education system (teachers, trainers, educators, student communities); religious institutions (priests); institutions with regulatory, monitoring and control role (the National Anti-Drug Agency, Police, Justice); social care institutions; private companies (entrepreneurs who deliver alcohol, tobacco, ethno-botanical substances, but also employers who face such problems from the own addicted employees); distributors of pharmaceutical products; NGOs and associations with prevention and post treatment role; international bodies; Community (family, friends, colleagues); virtual communities; the media.

Hiring for *"health in all" collaboration* becomes a "categorical imperative" and, consequently, new strategic roles emerge for the agencies, institutions and specialists in the field of health (Kickbusch, 2003).

Referring to the rehabilitation services, Latter et.al. (2000) consider that multi-professional assessment and the establishment of the objective (mutual) is the central process. The authors highlight several demands in this respect: empowerment in interaction, two-way communication, respect and partnership; joint decision-making and improvement of mutual understanding; individualization in information and education; emphasis on consistent and cooperation and not only on compliance.

A "health in all" collaboration (see Borrell & Malmusi, 2010; Colins & Koplan, 2009; Greaves & Bialystok, 2011; Puska, 2007; Uusitalo et.al. 2007) has multi-player and multi-professional coordinates and its base of operation should be: the philosophy and principles of the ethics of care and the assumed responsibility; avoidance of careless; understanding of causes that lead to the abuse of substances and identification of preventing and stopping solutions for these behaviours. Collaborative management relies on co-production in health care and it focuses on *awareness and voluntary assumption of ethical values and norms* shared in common. "As long as the emphasis is on the safety or on the improve, on the whole, of the health care system, the importance of recognising the health care system as a *moral undertaking* in which all professionals can practice safely, responsible and ethically constitute the central objective" (Storch & Kenny, 2007).

This implies: *ethics towards people who are substance abuse (and their family)* – promotion of values geared towards helping others, who need special consideration, our support, skills and resources; *institutional ethics* - meeting with the responsibility the mission of each institutional actor; the quality of health services, organizational learning and continuous improvement; accountability in the allocation and use of resources; *professional ethics* - compliance with professional ethics, continuous learning and improvement of skills; *ethics towards the company/social responsibility* – responsible saving of resources by actual preventing/treating and reintegration into society of substance abuse persons; indirect education of population (change of mentality/elimination of prejudice, suppression of discrimination and marginalization behaviours) by demonstrating the possibilities of prevention and suppression; active involvement of the community in health services; e*thics of collaboration* – which are the ethical values and norms that support this model? to what extent is this model of governance centred on the needs of the patient? how effective are the

resources consumed?; how much are the patient rights observed?; what is the role of professional ethics? how much is the medical personnel protected, is it supported to be trained continuously and not to be exposed to risks,? how much do we want more and better?.

4. Co-production in health care by using virtual communities for problems regarding substances addiction

Co-production in public service is studied by Meijer (2011) in an exploratory study about the benefits of the new media, which, in his opinion, "facilitates contact between colleagues and offers the possibility of creating the joint virtual communities". Meijer says that the benefits of these virtual communities materialize in the exchange of information and socio-emotional support offered by participants in the community.

In health, virtual communities take three essential features (Camerini, 2010): they are based on a real physics community and their members log in for a therapeutic purpose; they are used to overcome barriers and large geographical distances; they are structured hierarchically because the leaders of discussions are professionals from the health care system.

Another study carried out in 2011 on a questionnaire-basis (Agheorghiesei et.al. 2011) among ninety-four (94) students from five master Studies at the University Alexandru Ioan Cuza of Iasi, Romania brought attention to the possibility of using virtual communities in providing after-care service (post-treatment) for addicted people (alcohol, tobacco, ethno-botanical substances, high-risk drugs).

The results of the study show that a proportion of 37.2% of the students would be willing in some degree to participate in a virtual community for supporting addicted persons. Master Students would guide these people towards experts (59.6%), would offer their moral support (34%), would share common experiences (25.5%) and would post video spots to raise awareness of these persons, so as to stop this behaviour of addiction. Among the reasons which would determine them to collaborate in a virtual community are as follows: intervention for a friend, solidarity with human suffering, pro support education, as well as professional ethics. The condition of their participation in these communities would be: guidance from an expert (70,2%), proper knowledge in this problematic (58.5%), training (44.7%). Creation of networks based on recommendation is appreciated by them as a necessary element in the formation of these support groups.

Despite the many opinions that claim that the benefits of virtual communities have not yet been fully revealed, the virtual communities of students could be used in the process of co-production in the after-care services for young addicted persons, mostly students.

The need expressed by students (according to the survey conducted among them) to be led by an expert and to be trained to participate in this kind of communities would rally the best on the category in which professionals (the experts - a doctor or a psychologist) establish the coordinates of planning and design of the public service, but the users and community members (students) are those in charge for providing such service, at the same, one can take into account the co-production in which the user and professional shall fully cooperate, the expert (a psychologist, a doctor) and the community (students) participating together both in the design and in providing counselling and guidance service (Bovaird, 2007).

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