

Article

Multidimensional Approach on Sustainability of Ageing in Romanian Residential Care Centres for Elders

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Abstract: Residential care centres for elders (RCCEs) in Romania have rapidly developed over the last two decades. In the absence of coherent policies regarding elderly people, RCCEs are mainly the result of businesses arising from an acceleration of the ageing process in Romania. This study uses a multidimensional approach to investigate issues related to the sustainability of ageing in RCCEs in Romania. Specifically, it aims to analyse whether the grouping of RCCEs is following the distribution of elderly Romanian population likely to require such amenities, and whether the characteristics and services of these facilities were appropriate for their users in line with World Health Organization's Agenda of Ageing. The research relies on a combination of quantitative methods by Geographical Information System (GIS) spatial analysis, and qualitative methods by interviews. The results show that remote rural areas have clusters with high shares of aged population, while the distribution of the RCCEs prevails in large cities, being partly adapted to socio-spatial requirements, and the general trends of the demographic ageing process. These findings are in contrast with the dominant perception of RCCE beneficiaries, who want to be closer to their domiciles, as they are more oriented towards family values, emotionally affected by separation from their relatives, consider themselves socially and spatially segregated groups in care centres, although aware of the need for long-term institutional care. The study reveals the necessity for optimising health policies for elders, by improving the socio-spatial management of such services and building age-friendly environments in long-term care in consent with WHO calls.

Keywords: multidimensional approach; sustainability; ageing; residential care centres for elders; perception; Romania; care policies; GIS

1. Introduction

Demographic ageing is a particularly complex process, with multiple economic, social, and societal effects, and a major concern for researchers and international organizations in the field [1]. Demographic ageing, first reported at the beginning of the 20th century by Alfred Sauvy (1928), became more visible between 1960 and 1970. This process is prevalent in many countries of the world, as demographic projections show that the share of elderly population aged ≥ 65 years continue to increase, tripling by 2050 (22% of the world population). During this period, the total population is expected to increase by only one-third, while child population less than five years old are projected to decrease slightly (5%) [2].

Such an instance would globally trigger, on the one hand, an increase in pathological conditions, the incidence of diseases related to ageing or a high risk for developing other chronic diseases

and, on the other hand, a considerable pressure on specialised social and healthcare services in residential care centres for elders (RCCEs). From this point of view, healthcare providers would require community-based approaches to prevent and manage natural declines in older age population (mobility loss, nutrition, vision, hearing, cognition and mood) [1]. Ageing does not represent a burden, per se, and it can also represent an opportunity to be explored [3]. Therefore, since 1990, in response to global trends in ageing, The World Health Organization (WHO) called for a paradigm shift towards a positive concept of ageing, defining healthy and active ageing as a process that “allows people to realize their potential for physical, social, and mental well-being throughout the life-course” [4].

In 2016, WHO adopted the Global Strategy and Action Plan on Ageing and Health (GSAPAH), relying on five strategic objectives among which the development of age-friendly environments, alignment of the health systems to the needs of older people, the development of sustainable and equitable systems of long-term care, and also defined ten priorities for a Decade of Action on Healthy Ageing (DAHA), in line with sustainable development goals (SDG) [5]. Thereupon, EU and national governments must focus on healthy ageing through policies and programs in consent with DAHA and SDG [5,6].

The demographic ageing process in Romania started later than in Western European countries, i.e., after the 1990s, with the repeal of the 770/1966 Decree, which marked the end of the pro-natalist policy and the liberalization of family planning. Later on, it was accelerated by the migration of workforce, increasing marital age, and lower fertility [7–11]. Currently, the age pyramid of Romania’s population shows an increase in the share of people aged ≥ 65 years (EP). This increase is only sustained by a slight improvement of the life expectancy, while adult and young population groups declined as a result of migration and lower birth rates. At the same time, the dependency ratio has been growing steadily, generating specific socioeconomic issues [12], which need to be addressed by the Ministry of Labor and Social Justice of Romania (MLSJ) through improved policies.

Romanian society is traditionally oriented towards the elderly care within the family. Specifically, a series of policies for the elderly were adopted, the first ones since as early as the 13th century, when “bolnițele” (the infirmaries) were built around monasteries [13]. Regarding the most recent legislative measures, these continuously changed following the frequent fluctuation of ministers and governments and primarily targeted management-related issues of social assistance for elderly people (e.g., Law no. 17/2000, republished in 2007).

Among the most important legislative measures for the elderly population, we list the Government Decision (GD) No 212/2011 [14] entitled the “Development of the national network of homes for the elderly, the Law 197/2012 [15] and GD No 118/2014 [16] through which social services for elders were licensed, and opened both for public and private entities. These include residential care and assistance centres for EP (residential care centres for the elderly/RCCSs, Respiro centres/crisis centres, and protected house); day care centres for elderly people (day care and recovery centres, day care centres and leisure); residential care and care centres for medical-social assistance (RC medical-social, RC of palliative care); care services at home (care units at home). Recently, the MLSJ drew “The national strategy for promoting active ageing and protection of the elderly for 2015–2020”, which emphasizes a better orientation of the health system, the social assistance system, and the social insurance budget for elders, setting up a connection with the scientific research in the field.

In the context of science-policy interdependence, population ageing has been approached by international and/or national scientific research, which aimed to understand its complexity from well-established demographic, social, and economic perspectives and, also, novel perspectives derived from psychology and medicine. The use of such a combined and novel approach in the study of population ageing in Romania would most likely lead to an improvement of national social policy.

A wide array of studies on the ageing process present the spatiotemporal image of life-courses, accessibility, mobility, segregation, and socio-cultural environment [17–24], as well as its effects on the labour force market [25]. Research on the psychological particularities of elders, the perception of and the attitude towards the elderly people, are crucial; their significant variations in time and

space have to be considered, such as cultural norms, socioeconomic development, changes in family behaviour either towards keeping values of the traditional society [9] or adopting by elders of a permanent help-seeking behaviour, which may increase their dependency [26]. This stage of life, often characterized as “a social death” [27], is marked by irreversible biological, psychical, and social changes, but with different ways of manifestation from person to person, and expresses itself through specific needs [6,25]. In this respect, it is essential to diagnose the social problems of the elderly population [8,26,27], the vulnerability factors affecting the elders’ health, promotion of active ageing, and sustainability of residential care for elders. Healthcare services in Romania generally failed to keep up with this demographic and perception-related shift. Healthcare services for older age people receive less investment, and are of lower quality, compared to services provided to adult population [28,29]. As people age, they are progressively more likely to live with co-morbidities, disability, and frailty. In general, older people living in residential care centres have a high prevalence of multi-morbidity, frailty, and functional dependency, as shown by many clinical studies [30–32]. Poverty and social exclusion limit the participation of the elderly to the public, social, and cultural life, considerably diminishing the access to health services and to specific care procedures, as well as to a decent life [33–35]. Further intervention plans and measures of social assistance, directed at supporting the aged people [11,36,37], are also crucial. Moreover, the care policy for elders requires reconsidering the role of research in the social support network, represented by all the connections created around a person [38], by the neighbourhood [39], and by family ties, to ensure successful rebuilding of a life of harmony in elder institutions [40,41]. On the other hand, the social-economic transformations of the last decades in Romania demand, more than ever, a proper design of care services for the elderly. The extension of schooling period, the professional mobility, the difficult insertion on the labour market, and the massive emigration, justify the low involvement of the descendants in supporting the elders [42]. In the absence of this support, the elders’ institutionalisation has become an alternative for life lived at home [43–45]. As such, a deeper knowledge of the social perception of both elders and their families/acquaintances on issues such as institutionalization in RCCEs, effects of physical and emotional distance from family, dominant states of mind, and others, becomes necessary in the process of constructing sustainable ageing policies.

The interaction between research and policies in the field has marked significant evolutions both in terms of concepts about ageing and the way of action through international campaigns to prevent early ageing, especially in active populations [46], thus, why Romania should adopt the Western European concept of ageing-in-place [40] or the WHO’s Global Strategy, with regard to active old age.

In these circumstances, in Romania, the complex relationship between the spatial arrangement of social assistance services/residential care centres and demographic ageing has not been explored yet. Furthermore, research is also needed on the institutional framework, regulating the functioning of such centres at the national level, i.e., whether they comply with guidelines of international organizations, including the WHO, and whether they are responsive and sustainable to the challenges posed by demographic change. Thirdly, the perception of beneficiaries of residential care centres on the services received has not been widely explored. From this perspective, the paper aims to

- (i) determine whether the distribution of RCCEs follows the distribution of the elderly Romanian population likely to require such facilities, and,
- (ii) assess whether the characteristics and services of RCCEs were appropriate for their users in light of WHO guidelines.

To meet the proposed objectives, we used GIS spatial analysis for mapping the location of residential centres and the distribution of elderly population, to find patterns in their spatial arrangement and assess whether their distribution is adapted to the demographic ageing trends. Surveys were complementarily used to assess the perception of institutionalized elders (direct beneficiaries) and indirect beneficiaries on the characteristics of the centres and their services, given the

multitude of institutional, social, demographic, and economic challenges that occurred in different regions of the country.

2. Material and Methods

The study employs a multidimensional approach, by combining a spatial dimension with a social dimension. The spatial dimension is related to the distribution of aged population and RCCEs, whereas the social dimension refers to the perception of the direct and indirect beneficiaries on the characteristics of the care centres and their services in the light of WHO's calls. Thus, the authors investigated the social dimension through the quality of essential services (medical assistance, accommodation, food, and cleanliness), active ageing, and/or creation of a friendly environment (e.g., access to activities/entertainments for an active life), perception of social distance (e.g., new relationships/interactions as a result of changing residence).

The research design is based on GIS spatial analysis and two surveys. The first survey uses the naturalistic inquiry [47,48] and was applied to direct beneficiaries of RCCEs; the second survey is semi-structured and was applied online to a group of indirect beneficiaries, snowball sampled [49].

The GIS outputs were prepared in ArcView 10.1, and employed data on population structure by age group for the year 2016, provided by the National Institute of Statistics (NIS) via TEMPO online database (<http://statistici.insse.ro/shop/?lang=en>). The data was computed as the percentage of elderly population (>65 years) in the total population at the commune level (polygon, shape file); the GIS outputs also included data provided by the MLSJ, regarding the number and location of residential centres for the elders (point shape file). We should note that all these centres are either public or run by NGOs, because those operating as trading companies are not in the official statistics. To highlight the spatial pattern in the distribution of elderly care centres in relation to the distribution of aged population, we used Hot Spot Analysis tool, which calculates the Getis-Ord G_i^* as explained by ESRI [50] according to the formulae

$$G_i^* = \frac{\sum_{j=1}^n w_{i,j} x_j - \bar{X} \sum_{j=1}^n w_{i,j}}{S \sqrt{\frac{[n \sum_{j=1}^n w_{i,j}^2 - (\sum_{j=1}^n w_{i,j})^2]}{n-1}}} \quad (1)$$

where x_j is the attribute value for feature j (polygons); $w_{i,j}$ is the spatial weight between the feature i and j ; n is equal to the total number of features, and:

$$\bar{X} = \frac{\sum_{j=1}^n x_j}{n} \quad (2)$$

$$S = \sqrt{\frac{\sum_{j=1}^n x_j^2}{n} - (\bar{X})^2} \quad (3)$$

G_i^* statistics is a Z score. This allowed us to obtain a Z score in the dataset clusters by determining the statistical significance as hot spots (positive Z scores) and cold spots (negative Z scores) [50]. We then mapped the resulting hot and cold spots, with three levels of confidence: 90%, 95% and 99% (focusing on higher than the upper limit of a 95% confidence interval) which helped to identify spatial patterns in the distribution of aged population and RCCEs (Figure 1).

Naturalistic inquiry applied to institutionalised elders and semi-structured interviews of indirect beneficiaries, further enabled us to capture information with a low degree of manipulation and control or constraints [51]. These were complemented with information about ageing, elderly living in residential centres, observation, and documentation on care policies.

The sampling for the naturalistic inquiry was carried out on the basis of responses and approvals received during 30 days (December 2015, January 2016) from 6 RCCEs out of 30. Of these, two are

public (one in the rural area, one in the urban area), and four private (one urban and three rural). Only three of them allowed us to mention their names.

To get information about the perception of the centres' residents, we used an in-depth interview, mainly due to the sensitivity of the issue approached. In this way, we capture real and profound viewpoints, which otherwise would have been lost in front of a perfect stranger. The sample group was formed by choosing the odd numbered participants from lists comprising 8 to 10 seniors; these lists were provided by the institutions (RCCEs that agreed to be part of this study) and included only residents able to take part in an interview. During the interviews, the nurse or the psychologist were present in the anteroom, in order to provide medical/clinical help if necessary. We chose four seniors per RCCE, firstly, because some care centres had only a few institutionalized elders and, secondly, to prevent redundancy in answers through post-interview communication between community members. The interview was applied to 24 subjects. However, because of the incoherence of testimonies due to precarious mental health status (confirmed later on by the RCCE staff), we only considered 20 of them. According to the ethics of research, the participants voluntarily permitted us to interview them, and we encoded additional information as follows: gender (M/F), age (as it is) [52], and education (noted with letters: p—primarily, g—gymnasium, l—college, f—faculty). We also obtained permission from all relevant authorities or institutions: MLSJ, owners, directors of some private or non-governmental residential centres for elderly people. To subsequently increase the reliability of data, we applied a semi-structured interview to a third party, to 20 indirect beneficiaries working with RCCEs. The sampling was carried out using the snowball technique in the academic environment of Bucharest and Stefan cel Mare Suceava Universities (geographers, sociologists, psychologists) who had private or professional long-term experience related to RCCEs. The sampling further included reporters and volunteer students or other colleagues, who were previously familiar with conditions in the centres included in the study. (Table 1) The data collected were processed using SPSS v.17, and Microsoft Excel 2010.

Table 1. Sociodemographic profile of the respondents.

Variable		Residents		Indirect Beneficiaries	
Gender (%)	F	65		75	
	M	35		25	
Age (%)	<25	-		10	
	26–65	15		90	
	66–79	35		-	
	≥80	50		-	
Education (%)	Primary	5	Position	Sociologist	30
	Gymnasia	20		Geographer	35
	Vocational	20		Psychologist	5
	Lyceum	20		Volunteer	25
	Academics	35		Reporter	5
Marital status (%)	Widow	75	Connection within RCCE	Member	20
	Divorced	5		Friend	35
	Single	20		Other	45
Children (%)	No	25	Professional Experience	<5 years	15
	1	25		5–14 years	10
	2	25		15–24 years	65
	≥3	25		>25 years	10
RCCE (%)	Rural	50		65	
	Urban	50		45	
RCCE (%)	Private	60		60	
	Public	30		30	
	NGO	10		10	
Distance RCCE–Residence (%)	Same county	40		60	
	Same settlement	15		15	
	Other counties	45		15	

3. Results and Discussion

3.1. Ageing in Romania

The analysis of the Romanian population by large age groups over the past quarter-century reveals a significant trend of demographic ageing, a phenomenon that impacts many people and which is of equal interest for the elders, for their families, and for the entire Romanian society. After 1990, Romania suffered a genuine demographic shock, caused by the magnitude and harshness of political, economic, and social changes that affected all the former communist countries. The transition from a centralised to a market economy was difficult; however, the western European model, based on family planning, low fertility, and delay of marriage, was quite easily adopted. In addition, industrial restructuring, rising unemployment rates, and the need for the population to improve their living conditions led to an unprecedented migratory exodus [53,54]. This has had a significant impact on the Romanian population, mirrored by the drop in the number of inhabitants, and an increase of demographic ageing.

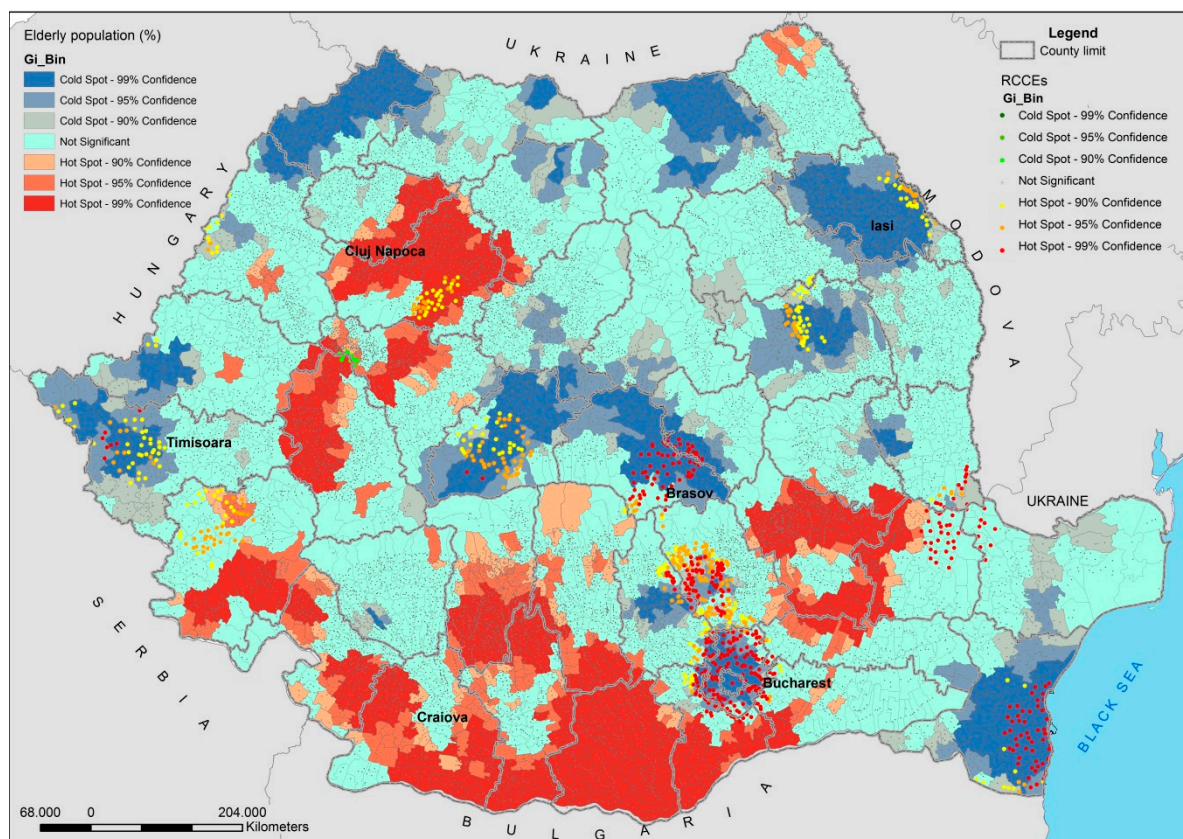


Figure 1. Clusters map of the elderly population in Romania (2016) and the number of accommodated people in public and NGO residential centres (2016). Hot Spot Analysis in ArcView, 10.3.1. Data sources: ([55]; MLSJ, 2014, 2016).

Numerically, the younger generation cohort decreased by 2.7 million in 2016 compared to 1992, while the number of aged people grew by one million in the same period (34.9%). Also suggestive is the significant increase in the share of the elders in the total population, from 10.9% in 1992 to 15.6% in 2016 [55]. In Romania, the demographic ageing index, (expressed as the number of persons 65 years old and over, per 1000 young people aged between 0 and 19 years), amounted to 786.6‰ in 2016, compared with 351.9‰ in 1992 [55].

We also noticed a significant increase of “the eldest of the elders”, i.e., the persons aged 80 years and over, whose share in the elderly population grew from 17.7% in 1992 to 24.2% in 2016. Thus,

the average Romanian family begins to have four generations, a feature that is a genuine opportunity, due to the intergenerational transfer of experience and knowledge. At the same time, this also requires structural changes at the economic level, the development of infrastructure, better health services, and specific nursing facilities for the “oldest” people.

3.2. The Romanian Context of the RCCEs' Supply and Demand

The RCCEs are the most widespread and demanded social assistance services for elders (45%) among all seven previously identified in Romania (MLSJ, 2017).

The RCCEs accommodate, receive and care for dependent and semi-dependent (sometimes even non-dependent) elders, after a medical and social examination, with the explicit consent of the person concerned. While the social care centres and the recovery and rehabilitation centres provide specialized long-term care and health services by specialists, as many of them developed from former small hospitals, RCCEs are primarily focused on accommodation and care, and, secondarily, on essential health services. These institutions are regulated by Law 17/2000 [56], Law 47/2006 [57], Law 292/2011 [58], and Law 192/2012 [15]. In Romania, the RCCEs operate as public services under the coordination of local and county authorities or as private entities (NGOs, religious cults recognised by law, individuals authorised by law, and companies in certain conditions stipulated by regulation, [16]), separately or in partnership with the state. In December 2015, according to NIS, there were 194 RCCEs in operation, administered privately, and 118 public, of which 74 were subordinated to the local councils and 44 to the Counties' Councils through the Direction of Social Assistance and Children Protection (MLSJ). The number of accommodation places is small: 7778 in the home cares administered by various foundations and 7693 in the public centres (INS, 2017). Although media presents the supply of social services to the elders as insufficient, in reality, in 2016, the degree of occupation was of 83% for the centres administered by NGOs and 85% for the public nursing homes. These facts are confirmed by statistics, which showed a large number of pending requests in 2015, respectively 18% of the total institutionalized persons, but less in 2016 (6%). This situation resulted from the bureaucratic operations or petitioner's options for some specific centres. Moreover, the data is scarce, as most private RCCEs function as NGOs, due to the simplicity of management. The MLSJ accredits some of them, but does not license them, while other private entities work outside the law (former boarding houses) receiving financial support from other sources than the state, or only from the beneficiaries. Furthermore, there are also residential centres managed by trading companies, that are not present in the official statistics, but only in various forms of advertising (for instance, www.camine-batrani.ro).

The licensed RCCEs are usually equipped (logistics, staff) according to the minimal standards or higher, established by conventional norms and verified by the specialized public agencies of the MLSJ. While the public RCCEs are equipped at satisfactory standards, many private centres provide considerably better facilities, thus explaining why more people opt for their services.

The admission of a person in public RCCEs and several private centres dependent on public funding is under the supervision of the Community Assistance Directorate (CAD), as they receive subsidies from local budgets. The CAD analyses the documents of applicants, which could refer to pension evidence, clinical evaluation/medical certificate, the CAD's survey, and the Identity Card to attest that the subject lives in the RCCE area/county: the information is used in prioritisation or ranking of their admittance when accommodation places are in high demand. The CAD also requests some legal and financial proof of their family support. At the same time, priority is given to those who cannot take care of themselves. The private RCCEs that do not depend on state subsidies have more permissive admittance criteria concerning residence, but have higher monthly costs (over 1000 €). In this respect, because the average pension in Romania is around 200 €, and given that the elders are allowed to contribute up to 60% of the amount of the pension to their care in RCCEs, the rest of the monthly expenditures calculated per resident (about 500 €) should be paid either by the family (if its revenue per member is over 150 €/month) or by the state.

The residence criterion shows significant geographical entropy cumulated with the very low level of pensions in Romania [34], thus proving that the social assistance program of the elderly in specialised centres is unbalanced. This can also explain both the large number of people waiting for the institutionalization and the occupancy rate of RCCEs.

3.3. Spatial Dimension of RCCEs and Ageing in Romania

Results show that the RCCEs have a diverse spatial pattern (Figure 1). Their distribution in small cities and rural settlements is the result of the centralised communist policies and the current preference for an attractive and unpolluted environment. Such desirable conditions are nowadays offered by the settlements lying on the outskirts of the tourist areas (Prahova Valley, North Bucovina, The Black Sea, etc.) or of the large urban centres, which also happen to be the leading suppliers of senior people (Bucharest, Sibiu, Brasov, Cluj-Napoca, etc.).

In 2016, the rural–urban distribution of the RCCEs relative to the population reveals an apparent disproportion: 23% of the units operate in the rural environment (concentrating 55% of the institutionalized elderly people in the country), while 77% are found in the urban settlements [55]. As a rule, the centres located in the urban areas benefit from high-level equipment and a large pool of qualified personnel, while those located in the rural areas provide a non-stressful environment and the opportunity of jobs for the locals.

The causes of this entropic distribution are the long distances between family residence and elderly care centres, the shift from urban to rural areas and vice versa, and the scarcity of such institutions in or near the large areas with a significant share of the elderly population.

The distribution of the elderly population resulting from our analysis clearly shows two broad areas of high demographic ageing: the rural area of the Romanian Plain, comprising the southern part of the country, the Western Carpathians, located in the central-western part of the country, followed by Northern Moldova, in the northeastern part of the country (Figure 1).

Clustering by the G_i^* statistic has statistically significant positive Z scores in Cluj-Napoca area, where the spatial distribution both for elders and care centres converges. In other areas, high values for elders do not coincide with the concentration of the care centres, as shown by the opposite clustering values of the Z score. This instance could be explained by incorrectly applied or lack of policy of long-care services in most regions of Romania (Figure 1).

3.4. Social Perception of Direct vs. Indirect Beneficiaries on Living in RCCEs

To capture the social dimensions of the environment created within the RCCEs, otherwise unexplored in Romanian research, we tested the perception of two sample groups. The first sample (S_1) includes the RCCEs' residents (direct beneficiaries) capable of interacting with the interviewers, and the second consisted of a group of indirect beneficiaries (people with family members institutionalized in RCCEs, or very familiar to living conditions in RCCEs by their professional expertise) (S_2) (Table 1).

The first social dimension refers to the *quality of essential services* (medical assistance, accommodation, food, and cleanliness). All RCCEs included in the study fulfil the minimum criteria of services/logistics [13], however, regarding the perception of the two sample groups on care services provided, we found that S_1 considers them as “very good” while S_2 was just “good”. Moreover, NGO RCCEs are very highly appreciated, followed by private RCCEs, whereas the lowest ratings were given to public centres, with one-point Likert scale difference between the two groups (Figures 2 and 3).

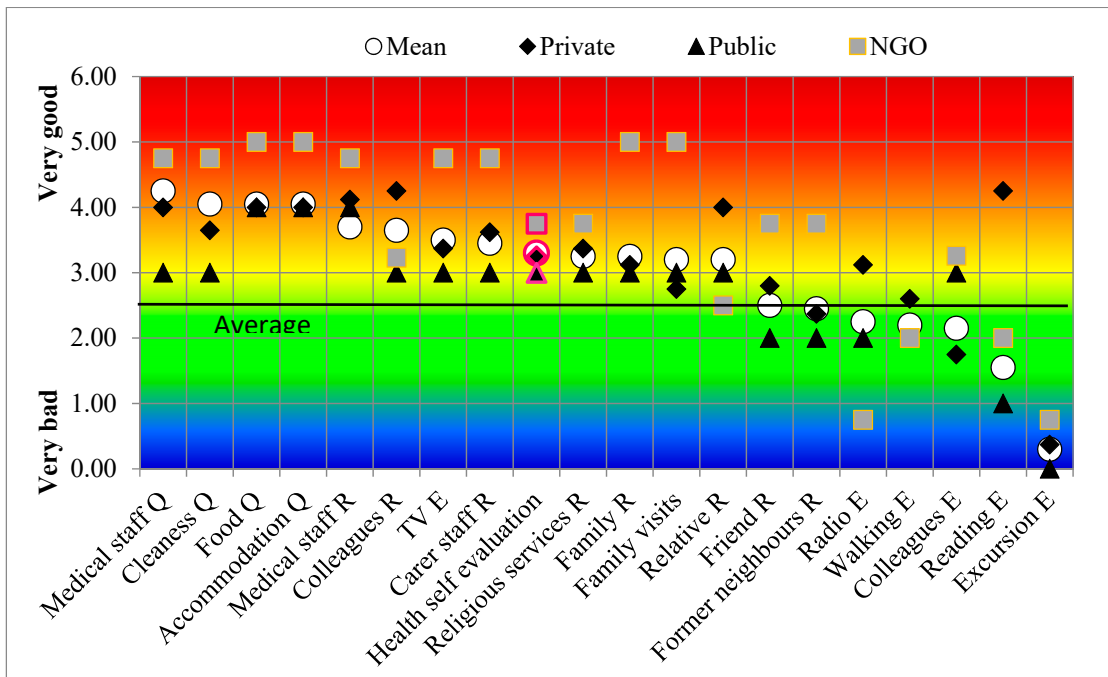


Figure 2. Perception of the RCCEs' beneficiaries regarding the quality of services (Q); relationships/interactions (R), and activities/entertainments (E). Processed after SPSS descriptive output.

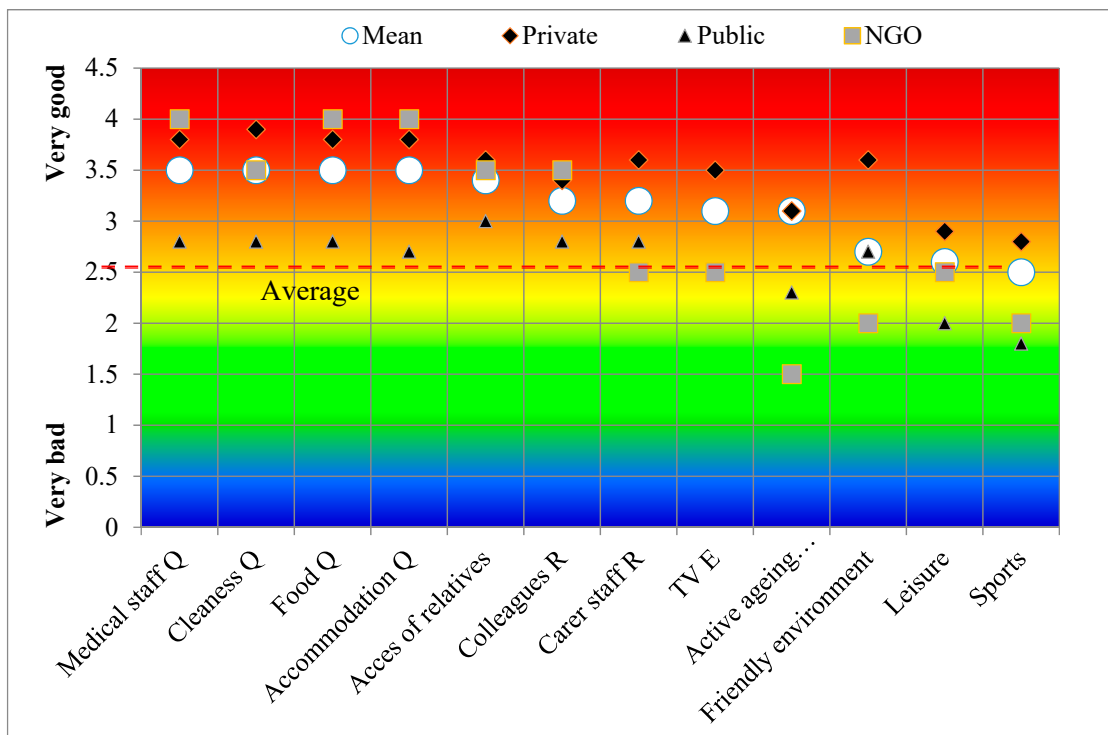


Figure 3. Perception of the RCCEs' indirect beneficiaries regarding the quality of services (Q), relationships/interactions (R), and activities/entertainments (E). Processed after SPSS descriptive output.

One can conclude that the services offered in centres managed by NGO are “good” and “very good”, as a result of their specific commitment and fundraising know-how; these are followed by private businesses, developed mainly using private resources, but with the highest costs amid all categories of RCCEs; opposite to RCCEs managed by NGOs and private entities, there are public

units, which appear to conduct a “laissez-faire”-type management, a disinterest in accessing funds, and which are generally based on the government financing.

Programs adopting solutions for *active ageing and/or creating a friendly environment* belong to the second social dimension. Although there is a clear difference in the preference for activities or the use of a leisure facility among residents of the centres (S_1), there is none in S_2 . In order to obtain an overall picture on the perception of both direct and indirect RCCEs' beneficiaries, we rated their opinions according to their testimonies or discussions. In both groups, there was dissatisfaction regarding the poor development of leisure activities, as well as the inability of RCCEs to build a friendly environment that would favour active ageing to some extent, except watching TV habits (Figures 2 and 3).

The social distance's perception is the third dimension. The decision for changing the family residence for an elderly residential centre is made under the provisions of the law. The survey on group S_1 allowed us to identify several factors which influenced this decision: elders' own option, according to their health status, care needs, family circumstances, income, and educational and cultural background, while indirect beneficiaries (Figure 3) consider that each case is different and would require a good balance of all factors. Most people prefer the centres closest to at least one family member, followed by those located nearby their homes, and lastly, those in quiet areas, with leisure facilities. This preference could be correlated with the fear of social exclusion/distance. Usually, the waiting time between option and accommodation lasts up to or even more than one year, and contributes to a relocation of the elders from one county to another, from urban to rural areas, and, less frequently, from rural to urban environments, thus increasing the geographical distance perceived as a factor for social isolation.

When changing the residential environment, people usually develop two types of social relationships: with family members and with the staff of the care centres. Most people consider that they have “good” relationships with the first-degree relatives (weekly or monthly visits), a few are satisfied with only phone calls as their children live abroad (“*I am looking forward to seeing her, she calls me every two days from Italy*” (F80g), and, incidentally, see the relationship “unsatisfactory”, because of the conflicts that probably led to their institutionalization (M71v). For those without children, the relatives, either living closer or farther from RCCEs, are their main moral support, although they rarely meet: “*I am feeling better, because I have moral support*” (F68l; F81f) or “*I get in touch with them to learn what happens outside and I am offered warmth*” (F71f). They firstly need emotional support and only secondly, material inputs, “*she helps me morally and financially*” (M79g); “*at least to do that, because I have always helped them as I could*” (M76g); “*I feel good, but I weep, thinking that I have reached a certain age*” (F86l), or “*when they visit me, I do not feel abandoned and alone*” (F83f).

With advancing age, the relationships with friends and former neighbours begin to fade, either because of the lack of communication or because many of them passed away. It is worth noting that no respondent considers his or her roommates and the people inside centres as friends (Figures 2 and 3).

Sometimes, although the elderly people have a family, they find support in religion: “*faith in God gives me a good feeling*” (F84p), rating the religious services occasionally performed inside the institutions, at main ecumenical events as “satisfactory” or “good”.

The social environment is profoundly changed in this new community, as they have to interact with new people embodied by the institution staff in charge with sanitation, food preparation, or medical assistance. The staff becomes their daily support, for which they are very appreciated. The relationships with the staff are seen as “very good” and “good”, irrespective of the institution type (Figure 2).

However, the social environment experiences a lack of active ageing programs. Based on their testimonies, the residents have a rather passive life, watching TV shows, few of them listen to the radio or, less frequently, read newspapers and books, solve crosswords, or keep a diary. Their hobbies are rarely encouraged. Occasionally, in the public care centres, artistic programs supported by the local authorities (town halls, schools) or by the NGOs are organised, while the physical health programs (focusing on massage and walking outdoor near the centres) are insufficient.

All of these factors drive the residents into a deep negative state of mind, and contribute to a general perception that they are a socially disadvantaged group:

- loneliness (“*The family is missing, even if the condition here are very good*”, M79g);
- inutility (“*social death*”, F71f; “*you cannot find your purpose*”, F83f);
- helplessness (“*unfortunately old age cannot be cured*”; F68l; “*ugly, especially when dementia problems occur*”, F90f; “*I would rather die any moment*”, M77g; “*a torment for my family*”, M89f);
- home nostalgia (“*home is one thing and being here is another*”, M80v; “*there is no place like home*”, F64l; “*we should never go away from home, we should die at home*, F81f).

As a result, the indirect beneficiaries claim that appropriate levers should be created to foster elderly care centres, be it provided by public or private organizations, or even by NGOs, to sustain long-term care functioning (financing support, the training programs for employees, improving legal mechanisms between family and RCCEs residents). They have further highlighted the need to develop and to maintain an adequate and specialised workforce, within an integrated, supportive, and comprehensive long-term approach [59,60].

Due to medical issues and physical frailty status of residents, the management of these RCCEs has a great responsibility for creating a sustainable environment that enables and enhances active ageing and residents’ quality of life. All actors involved in the organisational structure of RCCEs need to focus on specific issues and social determinants of active ageing: cultural, behavioural, physical, and social determinants.

3.5. Potential Directions of Action to Improve the Sustainability of Ageing in RCCEs

Results showed a high concentration of RCCEs around cities and a deficiency in remote rural areas, where an elderly population prevails. Results also showed a discrepancy in the perception of the quality of services provided by the RCCEs, between the direct beneficiaries of such services and indirect beneficiaries. While the first situation could be tentatively attributed to less income/more physical space per family in the rural areas, the second issue might be related to the feeling of isolation of the institutionalised elders, emerging from a considerable physical distance from home. Additional research in the areas we delimited is, therefore, needed to properly identify the causes of such discrepancies, and the best measures to be taken to meet them towards a more sustainable ageing process.

Based on the informational input derived from interviews, specific directions of action can be highlighted, to improve the dominant state of mind for RCCEs’ direct and indirect beneficiaries.

That is, RCCEs should provide a familiar and welcoming atmosphere. The social environment is seen as social support to the residents, creating opportunities for new activities or daily communication. However, in our cases, it seems that less attention is paid to recreation (leisure, trips, hiking, birthday events, etc.), which is in contrast to the wishes of the residents. It is crucial to provide them with opportunities to engage and participate in different meaningful activities [61]. A holistic and integrated approach to develop such activities needs to be achieved.

The quality of the services offered by residential centres should be improved through better health programs meant to reduce the length of inactive old age or to cut down the number of people who turn to specific social services. Likewise, better programs, with respect to health procedures, leisure activities, and cultural events (organising performances, subtitling for deaf people in as many TV programs as possible, etc.) are needed. In this regard, adopting policies, measures, and good practices from other countries experienced in this field, which have already proven their efficiency, could be useful.

On the other hand, as many people are tied to their homes and families, a new orientation towards the home care services by creating an age-friendly environment should be primarily considered. This new orientation could solve the entropic spreading of RCCEs in Romania, avoid polluted areas [62], improve emotional living, and generate jobs for local communities.

Regarding the status of policy efforts for meaningful change regarding the sustainability of ageing in RCCEs, these should firstly consider the changing character of the nation's population. Our results highlight the urgency that the government should take steps to improve the conditions reported here, to offer the right to social sustainability [63]. Current public subsidies and resources are inadequate; however, to address these gaps, a top-bottom approach can be employed. This could be achieved by creating calls for European structural funds as Human Capital Operational Program (POCU), and, and Regional Operational Program (POR), paralleled by a bottom-up approach, through local initiatives. POCU (Human Capital Operational Program), Axis 4. OS 4.4 *Reducing the number of persons from vulnerable groups by providing social/medical/socio-professional/vocational training services tailored to specific needs* has only one recently launched call, i.e., "Grandparents of the Community", aimed to diversify care services for the elderly. It will not solve the lack of RCCEs in vulnerable rural regions such as Oltenia, Moldova, and Bărăgan (Eastern Romanian Plain), because such costs are not eligible. POR (Regional Operational Program), Axis 8.3. *Social infrastructure-integrated, community-based socio-medical centres* can be used as an alternative/complementary solution, because costs for both social and medical services are eligible, and are accessible by local public authorities, providers of social services under public and private law accredited according to the law, as well as partnerships. In our opinion, given growing demand for better located and higher quality RCCEs, the solution will most likely imply a bottom-up approach. That is, through local initiatives, local public authorities, and private investors will be able, through their own funds, to stimulate the construction of RCCEs in the areas presently not covered and/or where the demand is higher than the supply.

4. Conclusions

The ageing of the Romanian population rapidly increased, producing significant changes in the age pyramid as a consequence of a low birth rate, high external migration, and new reproductive behaviour.

The economic changes and the needs of daily care of ill and old people explain the increasing demand for social care. Thus, in Romania, under the provision of laws and regulations, different types of elder care services were developed, but among them, the elderly care centres (state-owned, privately owned, and managed by NGOs) prevail as an adaptation to market demand. However, from a territorial standpoint, the distribution of the RCCEs in relation with the map of aged population is slightly entropic, both spatially and in terms of accommodation capacity, which results in a high concentration around cities and a deficiency in remote rural areas, where elderly population prevails.

The quality of services in these centres is considered as being good, but the institutionalised people complain about the social isolation (distance), which inevitably leads to the deterioration of self-image and self-esteem, to disorientation and to a loss of landmarks. In Romania, institutionalisation continues to be regarded with fear, being experienced as a final emotional separation from the family. Changing home—an intimate space par excellence—with a standard, public space, is accompanied both by institutional constraints, which require the acceptance of the community at the expense of individuality, and physical constraints, derived from the constant decay of the body and mental anguish [46]. In this regard, the Romanian long-care policies should be oriented toward building an age-friendly environment for elders, in consent with WHO calls for a positive concept of ageing, encouraging active and healthy ageing by optimising health, stimulating inclusion, and enabling well-being in older age. Moreover, the social support network for the elderly must be continuously adapted to the demands of the society, while the residential structures need to be permanently planned from a temporal and spatial perspective, so that they cope with ageing dynamics and the distribution of the clusters of senior people. It is advisable that residential centres create a "family atmosphere", to diversify their health programs (medical procedures, sports, and leisure activities), and to offer cultural facilities meant to foster the adjustment to the new life.

Demographic ageing is an additional burden for the frail economic system of Romania, requiring both collective and individual responses, and contextual interpretations. At a collective level,

the authorities should find ways to properly manage the changing demographic structure, and the increase in life expectancy is associated with a higher demand for elderly care and spatial disparities in eldercare supply. This needs to consider Romania's specificities, to use the added values of the private sector and NGOs, to focus more on quality of services. At the individual level it is necessary to promote good and strong relationships between generations and to empower the elderly population in finding a new social role in the Romanian society.

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