Acta Universitatis Sapientiae

Social Analysis

Volume 8, 2018

Sapientia Hungarian University of Transylvania
Scientia Publishing House

Contents

Acta Universitatis Sapientiae

The scientific journal of Sapientia University publishes original papers and deep surveys in several areas of sciences written in English.
Information about the appropriate series can be found at the Internet address http://www.acta.sapientia.ro.

Acta Universitatis Sapientiae
Social Analysis

Sapientia University **Scientia Publishing House**

ISSN 2069-7449
http://www.acta.sapientia.ro

Instructions for authors

Acta Universitatis Sapientiae, Social Analysis publishes empirical and theoretical studies, research notes and commentaries, book and conference reviews in the field of regional sciences.

The focus of the journal is primarily oriented towards East-Central Europe and its regions. Empirical findings, policy analyses and critical essays aiming at describing the processes of social development, cultural reconfiguration and associated discourses taking place in this part of Europe are particularly welcome.

Acta Universitatis Sapientiae, Social Analysis is a peer-reviewed journal. All submitted manuscripts are reviewed by two anonymous referees. Contributors are expected to submit original manuscripts which reflect the results of their personal scientific work. Manuscripts sent to the journal should not be previously published in other journals and should not be considered for publication by other journals.

All papers are to be submitted in English, in A4 format, electronically (in .doc or .docx format) to the e-mail address of the journal: **acta-social@acta.sapientia.ro.**

Manuscripts should conform to the following guidelines:

The length of the papers should not exceed 7,000 words (respectively 3,000 in the case of commentaries and reviews) and manuscripts should be accompanied by a 200–250-word abstract, with 3-4 key words and with authors' affiliation. Tables and graphs, if any, should be prepared in black and white, should be titled, numbered, and integrated in the main text. References should follow the author–date system of the Chicago Manual of Style (http://library.osu.edu/help/research-strategies/cite-references/chicago-author-date). The list of references should appear at the end of the manuscripts.

Acta Universitatis Sapientiae, Social Analysis is published twice a year: in May and December.

Contact address and subscription:
Acta Universitatis Sapientiae, Social Analysis
RO 400112 Cluj-Napoca, Romania
Str. Matei Corvin nr. 4.
Email: acta-social@acta.sapientia.ro
nistorlaura@uni.sapientia.ro

Printed by Idea Printing House
Director: Péter NAGY

Acta Univ. Sapientiae, Social Analysis, **8** (2018) 5–21

DOI: 10.2478/aussoc-2018-0001

International Volunteers as Strangers in Szeklerland

Ágota SILLÓ
University of Debrecen, Hungary
agotasillo@gmail.com

Abstract. This paper focuses on volunteer tourism, which is approached as a new phenomenon in a Romanian minority region, i.e. Szeklerland. Volunteer tourism has developed very fast in last decades at international level and mostly in the developed societies. As an alternative tourism form, it is very popular among the youth and gap-year students. Volunteer tourism is a kind of international volunteering which offers opportunity for someone to volunteer and travel at the same time in a foreign country. Volunteer tourism makes possible the meeting and collaboration between local community and international volunteers. As a new phenomenon in the case of Szeklerland, volunteer tourism was started here by a foreign person, originated from England, who has established himself in Miercurea Ciuc, Harghita County, Romania. In this region, this event was regarded as a strange action; here, local volunteering is also a new phenomenon. The communist rule had a negative effect on the developing of volunteer culture in Eastern Europe. Therefore, in the 21st century in Romania, volunteering is still a rare phenomenon. On the other hand, the presence of foreign volunteers in Szeklerland is an unusual phenomenon. Volunteer tourists are those who meet with locals and thereby are more close to the local people to whom these people speak in foreign languages, have foreign looks and cultures. Due to their lack of English language skills, local people and organizations do not know how to connect with them. So, international volunteering or volunteer tourism is that phenomenon which allows to meet different foreign cultures, where the common ground could be a commonly spoken language, i.e. the English.

Keywords: volunteer tourism, motivations, international volunteers, Szeklerland

Introduction

The objective of this paper is to discuss a topic which is essentially a new phenomenon in Romania and in the Szeklerland region as well, i.e. volunteer tourism. Volunteer tourism, or "voluntourism" is a phenomenon which refers to volunteering abroad in a pre-packed excursion form. The participants usually pay a fee to an international or local organization, which will place them on projects based on the preferences of volunteer tourists. The theme of these volunteer tourist projects generally ranges from education to health and human rights and appear in the form of organized trips (Kass 2013).

At aggregate level, volunteer tourism is a phenomenon which, after some researchers, started in the 1950s with the activity of Voluntary Service Overseas. From those times, volunteer tourism passed over a developing process whose result is that "by the beginning of the XXI. century, voluntourism was an established industry, with hundreds of thousands of mostly eighteen to twenty-five year olds embarking on these constructed volunteer vacations" (Kass 2013: 26).

In the last few years in Szeklerland, foreign-looking and foreign-language-speaking people started to appear – they are international volunteers. Szeklerland, or the Szekler region is a Hungarian-inhabited region situated in eastern Transylvania (Harghita, Covasna, and Mureş counties), Romania. The development of volunteering in Romania has a different path than in western societies. In the developed societies, such as America or Western Europe, volunteering is an older activity than in post-communist countries such as Romania. The communist regime did not favor the incorporation of volunteering (Silló 2016). Nowadays, after the transition period, volunteering is still a missing link in Romania, wherefore in Szeklerland as well (Voicu & Voicu 2003b). This is also relevant for volunteer tourism.

The objective of this paper is to analyze and present through the case of an organization established by a foreign person in Miercurea Ciuc (Harghita County) the motivation of international volunteers and the reasons why they chose Romania as their placement.

Volunteer tourism trends

After the 1970s, the financial support of non-governmental organizations has decreased (Chen & Chen 2011). These organizations had to complete their financial framework, looking for international volunteers who could contribute (Otoo 2013) to the activities of such organizations both financially and physically. The attraction of foreign volunteers can be regarded as an innovative form of civic activism, which can also be considered a form of alternative tourism.

As an alternative tourism, volunteer tourism established itself as a significant phenomenon for decades, and it has gained various denominations such as "volunteer tourism" (Henderson 1981), "volunteer vacation" (McMillion et al. 2006), "mini-mission" (Brown & Morrison 2003), "pro-poor tourism" (Ashley et al. 2001, Hall 2007), "vacation volunteering", "altruistic tourism" (Singh 2002), "service-based vacation", "participatory environmental research tourism (PERT)" (Ellis 2003), or "voluntourism" (Chen & Chen 2011). In my paper, I opted for two terms: volunteer tourism and voluntourism because they best fit my topic of analysis.

In accordance with Verardi (2013), the conception of voluntourism is the interplacement of tourism with volunteering, which makes possible for individuals to learn about the world, about other cultures and to get involved in local short-term voluntary work. Brown (2005) explains volunteer tourism from the tour operators' perspective: voluntourism is a "type of tourism experience where a tour operator offers travelers an opportunity to participate in an optional excursion that has a volunteer component, as well as a cultural exchange with local people" (Brown 2005: 480). McGehee and Santos (2005) conceptualize volunteer tourism from the perspective of the volunteers. In another definition, volunteerism is "a specific type of sustained, planned, prosocial behavior that benefits strangers and occurs within an organizational setting" (Marta et al. 2006: 222).

A volunteer tourism excursion contains two main elements: tourism and volunteer services (Chen & Chen 2011). Volunteer tourists pay for a trip to a location chosen by them, where they have the opportunity to be engaged in a meaningful experience such as helping local communities, conserving environment, or supporting a research (Polus & Bidderb 2016). After Wearing (2001), volunteer tourism can be conceptualized as an alternative tourism and ecotourism. This kind of tourism has the potential to generate value changes and have positive influence both on volunteer tourists and the host community.

Volunteer tourism has its roots in Great Britain and Europe, from where it has spread all over Australia and the United States and is on its way to becoming popular in Asia and Africa as well (Wearing & McGehee 2013). The main international events which made volunteer tourism to become widespread were the September 11th incident and the Indonesian Tsunami. Nevertheless, for the increase in volunteer tourism, we may quote several other events as well such as the reduction of barriers to travel, the increased number of middle-class people, and their desire to experience unusual travel forms (Nestora et al. 2009, Otoo, 2013, Wearing & McGehee 2013). Thus, Verardi (2013) contends that this kind of volunteering is a good opportunity for young people to get to know the world, themselves, and their role in the world.

The importance of volunteer tourism has grown since the 1970s, but the greatest increase was reached during the late 20th century (Polus & Bidderb 2016). Data indicate that 1.6 million people have participated in volunteer tourism projects

worldwide, and they spent between £832 million and £1.3 billion per year (Wearing 2013). According to research on modern tourism, the modern tourist is attracted by heterogeneous spaces, where he/she can have a voice based on being, doing, touching, and seeing, and that is what volunteer tourism offers to them (Sin 2009).

Singh (2014) emphasized that volunteer tourism, like other forms of tourism, followed four phases of development. In the first phase, the negative impacts of voluntourism are emphasized. In the second phase of development, the accent is on exploring new host countries. In the third phase, studies investigate strategies in order to maximize positive impacts and to minimize negative impacts. The last phase of development emphasizes a multidisciplinary approach of voluntourism (Singh 2014).

Volunteer tourism is seen mostly as a form of "justice" or "goodwill" tourism, but there are also critics who question the effectiveness of volunteer tourism. Sin (2009) formulated the tensions and paradoxes in voluntourism. The author contends that in general volunteers are conscious toward some social issues, but after the volunteer tourist experience respondents are not necessarily able to be engaged with these social issues in future volunteering. This suggests that volunteer tourists are more passionate about traveling than are sensitive to social issues. Besides this, certain volunteer tourism programs may reinforce existing stereotypes (Sin 2009, Simpson 2004) and "may represent a form of neo-colonialism or imperialism, in which volunteer tourists inadvertently reinforce the power inequalities between developed and developing countries" (Raymond & Hall 2008: 531). Another tension discussed by Sin (2009) is that volunteer tourists tend to adopt a giving attitude, where the act of giving builds up the ego of the giver, making them feel superior to the receiver. Therefore, volunteer tourism always involves rich people to help poor people (Sin 2009). Raymond and Hall (2008) draw attention to the fact that volunteer tourism does not always result in cross-cultural understanding for the participants, and so it is the role of the sending organization to carefully manage the volunteer tourism programs (Raymond & Hall 2008). After Guttentag (2011), volunteer tourism may cause dependency on the part of the host community, which can get used to relying on external resources, ignoring the self-sustainable development (Guttentag 2011).

The general perception of voluntourism is that it increases global citizenship in host and guest communities, improves cultural understanding, and contributes to peace in the world. However, it is important to mention the critics of this phenomenon, who emphasize that the interactions with the host community are not a guarantee for mutual respect, understanding, and long-term relationship (Singh 2014). The benefits of volunteer tourism are unquestionable, but there are worries as well, which could be eliminated by the organization volunteer tourism trips by apolitical organizations (Sin 2009, Guttentag 2011).

The particularities of voluntourism in Szeklerland (Romania)

The practice of volunteering in Romania is a rather new phenomenon after December 1989. According to Romanian volunteer research (Voicu & Voicu 2003a), in 1999, 10% of the Romanians did voluntary work, in 2002, 8% of the Romanian people were involved in volunteering, while in 2007 14% was the rate of Romanian volunteers. With the exception of Russia and Ukraine, this is the lowest rate of volunteering among ex-communist countries.

After Voicu and Voicu (2009), there is a historical-social background which may explain the low rate of volunteering in Romania. Before 1945, the country was characterized as a mainly rural traditional country. In that time, volunteering at associations functioned in urban areas, and "the members of these associations were usually active in political parties, too…" (Voicu & Voicu 2003a: 155). But in the first period of communism these people were imprisoned. During the communist period, the associations were controlled by the state, and it was forbidden for the civil society to function. In addition, the state introduced the compulsory "voluntary work", which concerned everyone from students up to laborers. Other characteristics of the country are the low level of higher educated people and the poor social capital, which were obstacles to the development of volunteering. The social network usually developed just inside the kinship, and as a result the society became fragmented and the level of trust between groups was low. So, all those conditions which are necessary for the development of volunteering were missing in Romania before 1989 (Voicu & Voicu 2003a).

In Szeklerland, as part of Romania, the factors mentioned above were typical, too. It is also important to mention that not all Romanian tendencies about volunteering are relevant for Szeklerland. Historically, in this region, there was a feudal society where everyone had his own duty. The upper classes dealt with the main social issues, while the other members were only endurers of the measures taken. In the course of the history, in Szeklerland, almost all modernization endeavors were initiated from the central offices, often ignoring the local characteristics, which led to anti-modernization attitudes. Modernization was seen as an unauthorized intervention by the central power. These mechanisms were engrained so much in the Szekler people that, following the regime change, in the world of modernization and democracy, where citizens have the same rights, bottom-up initiatives did not start, and the proportion of civil organizations is still very low (Bárdi & Pál 2016).

In fact, in this region, the culture of volunteering is a new phenomenon, which started to develop after December 1989. In these circumstances, volunteer tourism is even a somewhat new social practice. Until now, there was no research about volunteering or volunteer tourism in this region, and not all the data

about Romanian volunteering are relevant for Szeklerland because of the above mentioned peculiarities.

The voluntourist profile

Volunteer tourists are that kind of people who invest their time, budget, and energy in a destination far from their home to acquire various forms of experiences (Chen & Chen 2011). Many studies (e.g. Barron & Knoll 2009, Brown & Morrison 2003) indicate that most of the volunteers are aged between 20 and 29 years. Volunteering is a more common activity among women. The explanation can be (e.g. Andreu et al. 2005) that they have a stronger motivation to travel, relax, explore, and socialize. The educational level is a main factor in the motivation to travel: for volunteer tourists with higher educational background, it is important to seek knowledge and to get to know new places and peoples (Otoo 2013).

The duration of volunteer projects may range from one week to over a year in length. Volunteer tourists who choose a project with over a year in duration are more altruistic than those who opt for a shorter time. Volunteer tourists who stay for a longer time in the host community tend to consider themselves volunteers and not tourists (Otoo 2013). The main factors which attract volunteer tourists to choose a destination are the culture and the people, which are followed by the volunteer opportunity, political climate, geography, and touristic attractions (Otoo 2013).

Countries which produce volunteer tourists are the same countries where the gap year has become popular such as Canada, the Unites States, Australia, New Zealand, and some Western European nations. For charity organizations and NGOs, the key target group is that of the gap-year volunteer tourists because they are young and are looking for novelty and authentic exotic places (Lyons et al. 2012).

Callanan and Thomas (2005) define three types of volunteer tourists based on six criteria (destination; duration of project; focus of experience, i.e. self-interest versus altruistic; qualifications; active versus passive participation; level of contribution to the local community): 1) shallow volunteer tourists are sensation-seeking volunteers who have mostly personal interests, 2) intermediate volunteer tourists, and 3) deep volunteer tourists, who tend to think more about the community (see also Wearing & McGehee 2013: 123).

Volunteer tourist motivation

In this chapter, my aim is to resume some of the results of the studies about volunteer motivations. "Motivations are the essential reasons for a particular traveling behavior and play a vital role in understanding the decision-making

process of tourists as well as assessing the subsequent satisfaction of tourists' expectation" (Otoo 2013: 2). The motivation of individual volunteer tourists is very complex, and it depends on demographic variables, but the most common motivations are the desire for authenticity, social integration, intense interaction with locals, enhanced cultural appreciation, and intercultural exchange (Kontogeorgopoulos 2017). Wearing et al. (2008) contend that individuals who practice volunteer tourism transform their leisure into self-exploration. Volunteer tourism is a leisure activity which helps individuals to have a meaningful experience and meaningful life, to discover and understand themselves, which is impossible to get in daily routine (Chen & Chen 2011).

Usually, volunteers are altruistically motivated, but there are also egoistic motives – so, volunteer tourists usually have a double motivation: they want to do something beneficial for the host community and also want to reach personal development (Polus & Bidderb 2016). In accordance with Wearing (2001), volunteer tourists' motivation includes altruism, travel, adventure, personal growth, cultural exchange, learning, professional development, etc. Others claim that volunteers travel because of four reasons: cultural immersion, altruism (to give back), camaraderie, and family (Brown 2005). After Caissie and Halpenny (2003), the focus is more on the self than on altruistic reasons, and the expectations of the trips also include relaxation and stimulation.

In the case of students, the motivations behind volunteer tourism are personal development and academic achievement (Chen & Chen 2011). Volunteer tourists use volunteer placement to improve their skills, which can be transferred to the labor market, others to get to know new cultures and acquire practical skills "during and after their university education" (Otoo 2013: 2). In the research of Wearing and McGehee (2013), the younger volunteer tourists' primary motivation is self-interest, while older volunteer tourists (aged between 40 and 70 years) are motivated by cultural immersion, seeking camaraderie, giving something back, and family bonding.

In the literature, there are many classifications of the volunteer tourists' motivational factors. Based on these, McGehee et al. (2009) identify three volunteer tourist types: 1) the Vanguards are young people – they form the most motivated group, are interested in skill-building, experience physically and mentally intense volunteer tourism; 2) the Pragmatists are made up of a middle-aged group, who are mostly motivated by the idea of developing a relationship with members of the host community; 3) the Questers are the oldest group – although they cannot name their motivation, it is getting close to altruism (see also Wearing and McGehee 2013: 122).

Rehberg (2005) uses also three categories in order to classify volunteer tourists based on their motivations: 1) the achievement of something positive: this volunteer tourist focuses more on the ethical values and consideration; 2) quest

for the new: this volunteer tourist focuses more on new experiences, culture, and friends; 3) quest for oneself: this volunteer tourist focuses more on self-serving goals and on career, their professional or academic field. In their research, Chen and Chen (2011) classified the international volunteer tourists' motivations into three categories: personal, interpersonal, and other factors. Personal factors are the authentic experience of the trip, interest in traveling, challenges, and stimulation. Interpersonal factors are desire to help, interaction with locals/ cultures, encouragement from others, and enhancing relationships.

Methodology

Similarly to previous voluntourism studies, I used a qualitative method to get an answer to the question why international volunteer tourists come to Szeklerland. As in Romania volunteering is a kind of new phenomenon in this region, we are in need to do explorative research. For this purpose, qualitative methods are particularly appropriate, and so I relied on interviewing in order to explore the phenomenon of international volunteering in Szeklerland. The study's aim is to investigate the key motivations of the participants who have joined international volunteer tourism trips in Romania.

To conduct the research, I contacted the Care2Travel association from Miercurea Ciuc because this is the association which receives the largest number of international volunteers in the region. I interviewed 11 international volunteers during the summer of 2016.

The Care2Travel association

The study unit of my analysis, i.e. Association Care2Travel, was set up in 2011. The main actor of this Association is a woman from England. She first came in Romania as a volunteer tourist in 2009. After many experiences as a volunteer and volunteer coordinator in Romania, she decided with two colleagues to set up a non-governmental organization in Harghita County in order to receive foreign volunteers. They identified two social problems they intended to tackle: an underdeveloped volunteering community in Transylvania and a struggling welfare state with many disadvantaged communities operating on the margins of society. The Association's aim is to support and promote responsible volunteering, break down barriers, and establish the environment where volunteering can get involved (see: www.care2travel.org).

Today, the Association promotes volunteering service combined with tourism services. Indeed, it is a host association in receiving foreign volunteers in Szeklerland and transferring them to volunteer placements in the region. The Association

offers individual and pair volunteering services such as English teaching (term-time only), after-school support (term-time only), childcare (available throughout the year), special needs care (available throughout the year), agriculture (available throughout the year), NGO support (available throughout the year), and 2-Day Volunteering Taster. It has also group volunteering services such as organizing and managing English summer camps with the local volunteers. The touristic activities offer exciting adventure tours, such as cycle tours, hiking tours, winter tours, or tailor-made tours, with the chance to explore Romania (see: www.care2travel.org).

The Association hosts approximately 200 volunteer tourists a year. July and August are usually the busiest months when the Association hosts between 10 and 20 individual volunteers per week. But there are programs for volunteer groups, too, when the association hosts groups; e.g. a group of 49 stayed for a week. The winter season, December–February, is quieter. In that period, the Association hosts between 2 and 6 volunteers per week (based on an interview with the Association's director).

The Care2Travel association has a 4-member permanent staff. The director and the volunteer coordinator of the Association select the volunteering activities after careful consideration and discussions with their local partners. They are continuously establishing new volunteer placements in the community. Placing volunteers depends on a variety of factors. The first step is when the volunteer chooses from the website the placement she/he is most interested in. After that, the director of the Association and the volunteer coordinator examine the motivations, the professional experiences, and the planned time of the volunteer and compare these with the volunteer placements. Finally, they place the volunteer where she/he can help the most. The aim is to make a good match (based on the director's interview), making use of all the information that the Association is given about the volunteer and with input from the local partners.

The Association has several international partners. The most significant one is from New Zealand, the International Volunteering Headquarters, which markets the placements of Care2Travel for individual volunteers all around the world. Other partners are the University of Hull (United Kingdom), the World Challenge (United Kingdom), and the International Volunteering Service Belgium, from where they receive student volunteers (based on interviews with the Director).

Research findings

The volunteer tourists' profiles

The international volunteers were randomly selected for the study. There were lists in every week with the name of the volunteer tourists who were volunteering

in Szeklerland in the period of the research, the summer of 2016. I also was in connection with the Association's director and volunteer coordinator, who helped me to meet the international volunteers. I interviewed only those who had already been volunteering for at least one week in Szeklerland.

Table 1. *Characteristics of the international volunteer tourists*

ID	Age	Gender	Country of origin	Occupation	Duration of stay
M1	21	Male	Pakistan (Pakistani)	Student	5 weeks
M2	30	Male	Singapore	Student	3 weeks
F1	38	Female	England	Nurse	2 weeks
F2	21	Female	England	Student	1 week
F3	22	Female	Australia	Gap year	2 weeks
F4	19	Female	Australia	Student	4 weeks
F5	24	Female	USA (Colorado)	Gap year	4 weeks
F6	54	Female	USA (Florida)	Teacher in primary school	4 weeks
F7	22	Female	Switzerland	Childrearing	4 weeks
F8	22	Female	Mauritius	Student	4 weeks
M3	25	Male	USA	Student	2 weeks

Source: author's own editing

As seen from the table above, the majority of the respondents came from developed countries such as the U.S.A., the U.K., Australia, Switzerland, or Singapore. Two of them were from developing countries such as Afghanistan and Mauritius. Some of them had already been international volunteers more than once, but for most of them this trip was the first international volunteer experience.

Socio-demographic characteristics

A detailed description of the volunteers' profile was crucial for the interpretation and understanding of the motivations for volunteering in Romania (Szeklerland). The international tourists who contributed to this study were three males and eight females, most of them being single. The age of the respondents ranged from 19 to 54 years, but the age around 20 years dominated the age category, and only one respondent was 54 years old. Most of the respondents were educated at the tertiary level or had been studying at a university; only one respondent had secondary-level education. Most of them came from a well-situated family in terms of social status such as ambassador's son, IT manager's daughter, doctor's daughter, lawyer's daughter, and only a few mentioned that her/his father was a mechanic, without qualification or was retired. Almost all of the respondents had siblings, only one was the single child in the family. All the international volunteers were first-time visitors to Romania.

Motivations for volunteering in Szeklerland

During participant interviews, the questions were divided into five main sections: definitions of volunteering, motivations, experiences, costs and benefits, and future plans. In this paper, I focus only on the motivations of international volunteers. Following the analysis of the interviews, the following themes emerged:

Increasing professional experience

One of the most frequently mentioned reasons which attract international volunteer tourists to join this trip was to get professional experiences which in the future can benefit them on the labor market.

> Just because I worked at human development field. A lot of people didn't study attachment, you know, child attachment, but with Romanian orphans it was much worse. So I thought that this would be a good place for me to learn about my field […], and when I go back, and I am applying for a job, people would understand what I was doing. It is easier to relate with my job. (F5)
> […], I said that I have only two more years to teach in America before I retire. I was thinking that maybe after retiring I would go to teach overseas in international school. I just decided that in my summer vacation which is June-July and a little bit of August, I would go to other countries to volunteer and get experience. So, when I want to have a job, I will have experience in different countries. (F6)

There was also a respondent who set up an organization and wanted to learn how to manage it; so, to acquire experiences, he applied for volunteering abroad. He explained that:

> We made our organization at home, in Pakistan. I have a vision in my mind. When I go back, I want to pursuit professionally, make a proper organization, then people can come and volunteer. For example, like Care2Travel. So, I want to do something in that line where I can learn those kind of skills. I was looking up and I saw IVHQ and NGO support program. This was the first line, the start. This is the program that I want to do […].(M1)

Interest in travel

Another frequent motivation of international volunteers was to experience the country. None of the participants had ever been in Romania before, wherefore

volunteering was an opportunity for them to embark on an adventure in an entirely foreign country.

> […] I can also experience the country. I heard good things about Romanian Carpathians. It is a really nice place to be in. (F5)
> Because it is a very pretty place. I want to explore it. And this is a different experience from the family trip. It is a typical country which is different with challenges. (F2)
> […] this would be a good chance to find out and also to do some travel. (F6)

Make a difference

Some interviewees expressed a desire to help, to make a difference. They expressed that there are happening sad things in the world, which are broadcasted through the media; so, certain well-off people feel the necessity to do something for the world.

> And I want to volunteer because I want to do something… I just felt sad about things happening in the world… and I can do something, too, I can go volunteering, so I tried volunteering. I thought whatever I can do will be a better practice than sitting in my apartment. (F7)
> I was after my exams and I would have five weeks' holiday, I really wanted to do something. I worked before, so I saved some money. I wanted to volunteer overseas. (F4)
> […] because I am quite privileged, and I thought it is good sometimes to do things and give back to the society in the way you are comfortable whit it. (F3)

Personal growth

In most of the cases, the major motivation for international volunteering was the gaining of professional experiences combined with the importance of personal development. Through volunteering, one can develop his/her personality, beliefs, and their skills.

> What really, really encouraged me was that I wanted to do something different during the holidays. As a law student… as I know every law student went for an internship, for a placement in a law firm and actually got [it] for a month, but I wanted to do something else because I strongly believe that volunteering makes you grow, just simply doing what is expected to do. (F8)

Interaction with locals/culture

Another frequently mentioned motivation of the volunteer tourists' trips is the desire for interaction with new cultures and communities (Wearing & McGehee 2013). Volunteer tourists want to be in interaction with local people and to get to know a new culture. For example, before coming in Romania, F1 met Romanian people in her country, which was a pleasant experience for her. Therefore, she wanted to get to know this nationality more closely.

> In England, there are many Romanian people, and I saw in children's home and also in the street homeless Romanians. All are especially nice, like very natural people, at least those with whom I talked. It is a nice nation. They are polite and friendly. Because I saw so many in London, I wanted to know why they want to come here from there. (F1)

Strengthen relations, identity

Some volunteer tourists use the opportunity of the volunteer tourism to strengthen their relationship with their families, relatives, or friends. In this research, one of the interviewees went on this volunteer trip to be with their friends who are also volunteering.

> Honestly he [my friend] chose Romania, and I just followed him. […] I told him "You just choose a place, and I [will] likely go there with you." Instead, we had chosen a place together, where he could go and where you don't waste your time. (M2)

Another participant wanted to combine the international volunteering trip with visiting their relatives who are living far from them and also to learn and practice their mother tongue, the Hungarian language, because at home she just learnt the English.

> Because they speak Hungarian. I want to know Hungarian. I have some relatives at Cluj-Napoca. I visited them, and they got me here, so they drew me here. It was good to see them as well […]. (F3)

Time and money

Most of the interviewees were on a university holiday, some of them were taking a break from school or work, and they wanted to use this period for something useful for themselves and for the society. Every participant had to pay for this

volunteering opportunity; so, even if they did not state it explicitly, all the interviewees had to have time and money to participate.

None of the interviewees had been in Romania before. For some of them, it was the first time to be in Eastern Europe, too. There were respondents who came to Romania accidentally, who did not plan on choosing Romania as a volunteer placement. For example, M1 wanted to go to Vietnam, but he could not get the visa, and so in the last minute the volunteer tourism organization recommended for him a placement in Romania, and he accepted the offer. Another volunteer tourist wanted to go to teach in an Eastern European country, and the only teaching offer during the summer of 2016 was in Romania. There were also volunteer tourists who chose Romania as a volunteer tourist placement because nowadays Romania seems to be a safe country to travel to. Only just a few of them had the desire to know the Romanian landscape and culture. Most of them had not heard about Romania before, but there were some participants who knew a little bit about the country, mostly in the sense of stereotypes such as Romania is a poor country, the beauty of the Romanian Carpathians, good universities at affordable prices, etc.

Discussion and conclusions

The aim of this study was to present the case of a non-governmental organization in Szeklerland, which receives and distributes international volunteers in different volunteer placements in Szeklerland. Additionally, I wanted to present the international volunteers' motivations for participating in this program and the reasons for choosing Romania as volunteer tourist placement, as much as Romania is an Eastern European post-communist country which is barely visible on the map of volunteering. Until 1989, volunteering had been a missing link in Eastern Europe. In the 2000s, too, volunteering continued to be a new phenomenon and a "missing link on the road to European integration" (Voicu and Voicu 2003b: 15).

During the 2000s, local volunteering in Szeklerland started to become visible, although it is still in an embryonic state. Cohorts born in the late 1980s, who were socialized in the transition period, are more open-minded towards volunteering (see Fényes 2015), but the phenomenon of international volunteering is still a new one to the society of Szeklerland. This can be captured through the fact that the very initiative to establish an international volunteer organization in Szeklerland came from a citizen of English nationality. Her organization offers volunteer tourism services and receives the largest number of international volunteers in the region.

As stated in the article, volunteer tourism is an emerging field of the tourism industry both in developing and developed societies (Wearing 2013). This activity is typically regarded as a practice of privileged Western people who visit

exotic third-world societies (Verardi 2013), and the beneficiaries of voluntourism are supposed to be both tourists and locals. The tourists satisfy their need to travel and to make something different during the holiday. This type of excursion guarantees authentic experiences in places where tourism is not so developed such as in protected rural areas or remote villages (Chen & Chen 2011).

Volunteer tourism is a new phenomenon in Szeklerland. Until now, only one organization has been offering volunteer tourism services, which is managed by an English woman who comes from a society where volunteering is at a developed level and where volunteer tourism has taken roots. This Association's aim is to manage a responsible volunteer tourism: it tries to realize projects which satisfy volunteer tourists' desires and is also beneficial for the local community. The research has revealed that this kind of trip is not a new phenomenon for volunteer tourists, while for the local people the presence of international volunteers is something new, and they are not yet ready to receive them. Volunteer tourism in Szeklerland is led by the Care2Travel association, which can influence the international voluntouristic behavior and can contribute to local people's open-mindedness towards international volunteers. For example, with partners from the UK, they attract several English students to the region and place them to help English teachers in teaching English for children.

References

Andreu, Luisa, Kozac, Metin, Avci, Nilgun, Cifter, Nurten. 2005. Market Segmentation by Motivations to Travel: British Tourists Visiting Turkey. *Journal of Travel and Tourism Marketing* 19(1): 1–14.

Ashley, Caroline, Roe, Dilys, Goodwin, Harold. 2001. *Pro-Poor Tourism Strategies: Making Tourism Work for the Poor*. Pro-Poor Tourism Report No. 1. Nottingham: Overseas Development Institute.

Barron, Paul, Knoll, Amanda. 2009. Towards an Understanding of Volunteer Motivations: A Case Study of Volunteers at Edinburgh's Fringe Sunday. In: J. Allen (ed.), *The International Event Management Summit: Conference Proceedings and Book of Abstracts.* Sydney: Australian Centre for Event Management and the University of Technology. 87–97.

Bárdi, Nándor, Pál, Judit. 2016. *Székelyföld története. III. kötet*. Székelyudvarhely: MTA BTK-EME-HRM.

Brown, Sally. 2005. Travelling with a Purpose: Understanding the Motives and Benefits of Volunteer Vacations. *Current Issues in Tourism* 8(6): 479–496.

Brown, Sally, Morrison, Alastair. M. 2003. Expanding Volunteer Vacation Participation: An Exploratory Study on the Mini-Mission Concept. *Tourism Recreation Research* 28(3): 73–82.

Caissie, Linda. T., Halpenny, Elizabeth. A. 2003. Volunteering for Nature: Motivations for Participating in a Biodiversity Conservation Volunteer Program. *World Leisure Journal* 45(2): 38–50.

Callanan, Michelle, Thomas, Sarah. 2005. Volunteer Tourism: Deconstructing Volunteer Activities within a Dynamic Environment. In: M. Novelli (ed.), *Niche Tourism: Contemporary Issues, Trends and Cases.* Oxford: Butterworth-Heinemann. 183–200.

Chen, Li-Ju, Chen, Joseph S. 2011. The Motivations and Expectations of International Volunteer Tourists: A Case Study of "Chinese Village Traditions". *Tourism Management* 32: 435–442.

Ellis, Claire. 2003. Participatory Environmental Research in Tourism: A Global View. *Tourism Recreation Research* 28(3): 45–55.

Fényes, Hajnalka. 2015. *Önkéntesség és új típusú önkéntesség a felsőoktatási hallgatók körében*. Debrecen: Debrecen University Press.

Guttentag, Daniel. 2011. Volunteer Tourism. As Good as It Seems? *Tourism Recreation Research* 36(1): 69-74.

Hall, Michael C. 2007. *Pro-Poor Tourism: Who Benefits*? NY: Channel View.

Kass, Jessye. 2013. *Voluntourism. Exploring Ethical Challenges and Critical Tensions within the Pay-to-Volunteer Industry.* (Senior Thesis). Waltham, MA: Brandeis University. (https://bir.brandeis.edu/bitstream/ handle/10192/25162/ KassThesis2013.pdf – last visit on: November 19, 2016).

Kontogeorgopoulos, Nick. 2017. Forays into the Backstage: Volunteer Tourism and the Pursuit of Object Authenticity. *Journal of Tourism and Cultural Change* 15(5): 1–21.

Lyons, Kevin, Hanle, Joanne, Wearing, Stephen, Neil, John. 2012. Gap Year Volunteer Tourism. Myths of Global Citizenship? *Annals of Tourism Research* 39(1): 361–378.

Marta, Elena, Guglielmetti, Chiara, Pozzi, Maura. 2006. Volunteerism during Young Adulthood: An Italian Investigation into Motivational Patterns. *Voluntas* 17(3): 221–232.

McGehee, Nancy G., Santos, Almeida, Carla. 2005. Social Change, Discourse, and Volunteer Tourism. *Annals of Tourism Research* 32(3): 760–779.

McGehee, Nancy. G., Lee, Seungwoo, Clemmons, David. 2009. *The Mystery of the Voluntourist: Utilizing Pearce and Lee's Travel Career Pattern Model to Examine Motivations, Typologies, and Preferences of Potential Voluntourists*. USA: Greater Western Chapter of the Travel and Tourism Research Association. March 17–20.

McMillion, Bill, Cutchins, Doug, Geissinger, Anne. 2006. *Volunteer Vacations* (9th ed.). Chicago: Chicago Review Press.

Otoo, Felix Elvis. 2013. Motivations of American Volunteer Tourists to Ghana. *African Journal of Hospitality, Tourism and Leisure* 2(4): 1–12.

Polus, Reni Cacillia, Bidderb, Christy. 2016. Volunteer Tourists' Motivation and Satisfaction: A Case of Batu Puteh Village Kinabatangan Borneo. *Procedia – Social and Behavioral Sciences* 224: 308–316.

Raymond, Eliza, Marguerite, Hall, C. Michael. 2008. The Development of Cross-Cultural (Mis)understanding through Volunteer Tourism. *Journal of Sustainable Tourism* 16(5): 530–543.

Rehberg, Walter. 2005. Altruistic Individualists: Motivations for International Volunteering among Young Adults in Switzerland. *Voluntas: International Journal of Voluntary and Nonprofit Organizations* 16(2): 109–122.

Simpson, Katt. 2004. 'Doing Development': The Gap Year, Volunteer-Tourists and a Popular Practice of Development. *Journal of International Development* 16(5): 681–692.

Sin, Harng Luh. 2009. Volunteer Tourism—"Involve Me and I Will Learn"? *Annals of Tourism Research* 36(3): 480–501.

Singh, Ranbir. 2014. Volunteer Tourism and Host Community. *International Journal of Scientific Research and Management (IJSRM)* 2(10): 1480–1487.

Singh, Tej Vir. 2002. Altruistic Tourism: Another Shade of Sustainable Tourism. The Case of Kanda Community. Tourism. *Tourism: An International Interdisciplinary Journal* 50(4): 361–370.

Silló, Ágota. 2016. The Development of Volunteering in Post-Communist Societies. A Review. *Acta Universitatis Sapientiae, Social Analysis* 6(1): 93–110.

Verardi, Cassandra. 2013. *Perception of Voluntourism*. Ottawa: Carleton University. (Thesis). (https://curve.carleton.ca/system/files/etd/9555f4e4-156e-471a-a60b-b8267f599005/etd_pdf/37fac09309ec38cf36a562712b9ff7a1/verardi-perceptionsofvoluntourism.pdf – last visit on: November 19, 2016).

Voicu, Mălina, Voicu, Bogdan. 2003a. Volunteering in Romania. A *Rara Avis*. In: P. Dekker, L. Halman (eds.), *The Values of Volunteering. Cross-Cultural Perspectives*. New York: Kluwer Academic/Plenum Publishers. 143–159.

2003b. Volunteering in Eastern Europe: One of the Missing Links? In: B. Voicu, H. Rusu (eds.), *Globalization, Integration, and Social Development in Central and Eastern Europe*. Sibiu: Psihomedia. 57–66.

Wearing, Stephen. 2001. *Volunteer Tourism: Experiences That Make a Difference*. Wallingford: CABI Publishing.

Wearing, Stephen, McGehee, Nancy Gard. 2013. Volunteer Tourism: A Review. *Tourism Management* 38: 120–130.

Acta Univ. Sapientiae, Social Analysis, **8** (2018) 23–39

DOI: 10.2478/aussoc-2018-0002

Evaluating the Level of Burnout among Healthcare Professionals

Kinga MAKKAI
Independent Researcher
Makkai.kinga.researcher@gmail.com

Abstract. The professional staff in human service institutions are often required to spend considerable time in intense involvement with other people. Frequently, the staff–client interaction is centered around the client's current problems (psychological, social, and/or physical) and is therefore charged with feelings of anger, embarrassment, fear, or despair. Solutions for these problems are not always obvious and easily obtained, thus adding ambiguity and frustration to the situation. For the helping professional who works continuously with people under such circumstances, the chronic stress can be emotionally draining and poses the risk of burnout. Extensive literature highlighted that healthcare professionals' work is relentlessly overloaded, emotionally overwhelming, escalating their private life, and thus favoring burnout development. In the present research, there was found a significant difference ($p < 0.001$) between the burnout level (Maslach HSS) of staff working in state hospitals and staff working in private hospitals. None of the other differences were significant: age ($p = 0.155$), gender ($p = 0.083$), work experience ($p = 0.480$), and job ($p = 0.015$).

Keywords: burnout, healthcare professional, medical staff, Romania

Introduction

In these last decades, the studies on the mental health of medical staff have become an important subject in international literature; however, there are few information regarding the level of burnout in medical staff. Their specific job requirements often consist in dealing with urgent situations in a high level of human risk. Researchers showed that burnout syndrome does not have immediate manifestations but appears as a gradual reaction of emotional breakdown due to the prolonged exposure to stress factors, which leads to an increase in dehumanization level and professional dissatisfaction (Leiter 1991).

Burnout is often defined by fatigue, demoralization, dissatisfaction, incapability, ageing, and decrease in motivation and in the joy of living. This is experienced

personally because of the working conditions and the expectation for a higher performance (Demerouti et al. 2011).

The term was introduced in the 1970s by psychologist Herbert Freudenberger, who in 1980 published *Burn Out: The High Cost of High Achievement. What It Is and How to Survive It*, in which he described this disorder (Freudenberger 1970).

The burnout syndrome is often described as having three dimensions: emotional exhaustion, depersonalization, and professional achievement. In emotional exhaustion, we perceive the emotion when the person feels emptied of emotional resources and becomes extremely vulnerable to stress agents. Depersonalization means that the person is distancing himself from other people, reduces personal achievements, and lives in a critical spirit (oriented towards others and himself equally), associated with a decrease in efficiency but also with negative thinking and evaluation (Demerouti et al. 2011).

Theoretical framework of the studied problem

The risks of burnout

Employees with a higher risk of burnout are likely to present more health problems such as anxiety, depression, sleeping disorders, memory loss, and neck pain (Peterson et al. 2008). In a study among 3,000 employees in Finland, Ahola (2007) reported a widespread depression, anxiety, and alcohol dependence among employees who suffered from burnout. Also, Hakanen and Schaufeli (2012) found among 2,000 dentists a positive correlation between burnout and emotions of depression and dissatisfaction with life. Also, regarding physical health, Kim et al. (2011) showed that social workers with higher levels of burnout reported more health-related problems through the research (3 years), i.e. insomnia, headaches, infections of the respiratory and the gastrointestinal system. Burnout syndrome is also an independent risk factor in infections such as the flu (Mohren et al. 2003), in type 2 diabetes (Melamed et al. 2006), and in cardiovascular diseases (Ahola 2007). In a 10-year research by Ahola et al. (2010), it was deducted that burnout, especially exhaustion, would be a risk of overall survival.

One of the most frequently quoted models of burnout, i.e. the *Job Demands –Recourses Model* (Demerouti et al. 2001), suggests that the working conditions are the main antecedents of the syndrome of burnout. The high job demands, which can be physical, emotional, cognitive, or organizational, are doubled by insufficient and inadequate resources, and this results in developing the syndrome. High workload is a result of job demands, which is the most powerful exhaustion predictor (Lee & Ashforth 1996). The increase of interest in burnout syndrome is because more and more people suffer from it in different professions.

Epidemiological data suggests the seriousness of this problem and the negative effects it has in the workplace and at home. This alone explains why there are this many studies of burnout in the last 40 years (Epp 2012). These days, employees are thinking and worrying more and more about their work life (Rebber 1985), where the work-related stress is a psychological stress, wherefore it results in compulsion and physical, mental, and social tension. The satisfaction in work is one of the most important factors of increased performance and provokes positive opinions about the individual's work, which stands in correlation with the salary, social value of the job, and the work (Rebber 1985).

The syndrome of burnout affects physical, academic, and social performance at the same time. It is a procedure when positive or negative reactions are given under stress. Burnout provokes aggressiveness, decrease in performance, quality, and competence in the job, wherefore it has effects not only on the individual but also on the people with whom s/he is in interaction with. Several studies describe that women are affected by more stress than men and cope with it in different ways (Witkin 2001). Others (e.g. Bakker et al. 2014) have classified unusual work conditions as important factors in work-related stress, which lead to anxiety and depression. Some (e.g. Ahola et al. 2010) argue that the high level of control and the low complexity of the job generate a decreased level of stress, and the employee feels valued.

Specialized literature talks about sociodemographic, vocational, and psychological variables which coexist with the syndrome of burnout. Important research questions include these variables' relevance and their relationship with the syndrome. This means we have to research the risk factors and protective factors which are related to different professions. The importance of these variables are recognized by all the researchers, but at the same time these produce the most conflicting results (Blegen 1993, Prins et al. 2007, Zagaro & Soeken 2007).

In consequence, exhausted employees can manifest one or more of the withdrawal behaviors (Hanish 1995), which can be lateness, absence, or turnover (Maslach et al. 2001). Employees which remain at work ill (presentism), have a lower performance (Cooper 1996) because they have to invest more time and energy in their work. Demerouti et al. (2009) found mutual relations between burnout, job demands, and presentism among nurses who work at hospitals.

The causes of burnout

The syndrome of burnout is one of the most popular subjects in occupational health. Studies show that employees who present higher levels of risk in developing the syndrome (for example, who are chronically tired and have a negative and critical opinion about work) manifest affected work performance and can develop serious health problems (Bakker et al. 2014). A prominent problem consists in the matter

that employees who present higher levels of burnout tend to remain in trouble. Furthermore, research shows that this syndrome can become stable for 5, 10, or even 15 years (Bakker et al. 2000, Hakanen et al 2011, Schaufeli et al 2011).

Which is the reason that burnout persists this long? Until now, the syndrome was not charged of being a continuous process (ten Brummelhuis et al. 2011). Previous studies suggest that the syndrome has structural causes in the professional environment, especially high job demands and low resources (Alarcon 2011, Demerouti et al. 2011, Lee & Ashforth 1996). Another study also indicates that individual factors, such as neurosis or perfectionism, play an important role in the development of burnout because these features predispose the employees to face the demands improperly (Swider & Zimmerman 2010). Despite this knowledge, we know very little about the individual roles in the process of developing the syndrome of burnout.

The causes of burnout are divided into two categories: situational and individual factors (Bakker et al. 2014). Situational factors include job demands and resources. Job demands lead to fatigue and psychological distancing from the job (Bakker et al. 2000). Ambiguity, conflict, stress, workload, and tension are among the most important job demands which lead to burnout (Alarcon 2011, Lee & Ashforth 1996). The resources are physical, psychological, social, and organizational aspects of work, which help in reaching a purpose, reduce job demands, and stimulate personal development through valuable work (Bakker & Demerouti 2007). The relationship between resources and burnout remains constantly negative (Demerouti et al. 2001).

A possible explanation for the negative relation between burnout and performance would be that tired employees cannot concentrate and therefore make more mistakes, whereas burnt-out employees do not want to help others (Swider & Zimmerman 2010) and do not receive any help themselves, which leads to a decrease in productivity (Bakker et al. 2014).

In the 21st century, burnout has been investigated from the individuals' perspective (Bergman & Lundh 2015, Bergman et al. 2003). In the context of burnout, this approach is capable of revealing the intra-individual heterogeneity of the syndrome and its development in time. More specifically, this means identifying different types of models of individual burnout and individual development trajectories. This approach also makes the distinction between burnout and other work-related well-being variables on an interpersonal level. However, person-oriented analytical methods are based on the heterogeneity of the population (Laursen & Hoff 2006).

Prevalence among health professionals

Professional staff in human service institutions are requested to spend time with other people with intense implication. Most often, the situation between the staff and the patient is concentrated on the current problems of the patient (psychological, social, or physical), wherefore they are loaded with emotions of anger, rage, embarrassment, fear, and despair. The solutions for these problems are not always obvious and easily obtained. Therefore, for the helping staff, who often work with patients under these circumstances, chronic stress can be overwhelming and raise the risk of burnout (Bria et al. 2012).

When the emotional resources are depleted, employees feel that they cannot give more of themselves (on a psychological level). Another aspect would be the evolution of negative, cynical attitudes and emotions towards the patients. These negative aspects are related to emotional exhaustion. These harsh and callous perceptions can lead to a phenomenon where the helping staff thinks that the patient deserves the problems that he is having (Ryan 1971).

More specifically, the syndrome of burnout is beginning to be considered as an occupational disease frequent among medical staff, for example, in Spain (Paris & Hoge 2012, Prins et al. 2007) but in other countries as well (Kiekkas et al. 2011, Soler et al. 2008). According to Schanafelt et al. (2012), medical staff have the highest levels of burnout. Recent studies show that affected doctors, nurses, and young professionals are predisposed to substance abuse (Mouston et al. 2010, Oreskovich et al. 2012), depression (Hakanen & Schaufeli 2012), insomnia (Vela Bueno et al. 2008), and a higher rate of suicidal thoughts (Shanafelt et al. 2011, Van der Heijden et al. 2008). The hospitals' performance is corrupted by burnout because of employee turnover (Leiter and Maslach 2009), absenteeism (Davey et al. 2009), and premature retirement (Linzer et al. 2001). Results indicate that the syndrome of burnout predicts suboptimal behaviors of care (Schanafelt et al. 2002) and serious medical errors (Schanafelt et al. 2010).

Studies show that burnout factors are high workload in little time (Pisanti 2011), taking care of demanding patients (Escriba-Aguitar et al. 2006), or large inequalities in the nurse–patient ratio (Gunnarsdottir et al. 2009). Also, cynicism is due to the lack of empowerment (Laschiger et al. 2013) and social support (Prins et al. 2007).

Extensive studies suggest that the work of medical staff is overloaded, emotionally overwhelming, and it escalates with family life, thus predicting burnout (de Jonge et al. 2008, Schanafelt et al. 2012, Schirom et al. 2010, Xantopoulou et al. 2007).

A systematic review of the risk factors among medical staff in Europe enumerates overload, emotional requirements, and negative work–life balance as prominent risk factors (Bria et al. 2012). Empirical studies established that quantitative (overload, extended hours of work) and qualitative (emotionally loaded situations,

work–home interference) requirements are important marks of burnout among health professionals and, consequently, contribute to the lowered quality of the health system (Bakker et al. 2004, LeBlanc et al. 2001, Prins et al. 2007, Schanafelt et al. 2010, Schirom & Nirel 2006). Medical staff in Romania reported high levels of burnout and negative work–life interference (Bria et al. 2013, Voicu 2006). Qualitative studies describe these levels as the consequence of the constant change of legislation, the scarcity of resources, poor system reputation, and high emigration rates of the workforce (Popa 2013, Spânu et al. 2012).

This disorder has serious repercussions on employees and the institutions where they work, but the effects can be more serious, while the medical staff suffers from burnout, wherefore they are not capable of providing quality services, and the whole health system suffers from this (Ortega & Lopez 2004).

The Romanian situation

For 25 years, the Romanian healthcare system was in constant transition and reform, without continuity and clear objectives. This is probably due to the insufficient funding and the frequent circuit of the ministries (Todorova et al. 2009, Vlădescu et al. 2008). The World Health Organization in 2009 declared that the Romanian healthcare system is among the most poorly financed ones in Europe, and it has a low priority regarding the distribution of resources among public sectors. In 2006, the GDP share of healthcare was 3.9%, less than half of the European average, i.e. 8.92%, and less than other countries', for example, Hungary's (8.3%). Although the salary in healthcare is less than the national average, in 2010, there was a 25% decrease in this sector. Furthermore, Romania is one of the European countries with the lowest density of medical staff, meaning 2 doctors and 4 nurses per 1,000 people, which indicates the overwhelming workload they are exposed to (Băban et al. 2005, Schafer et al. 2010, Bria et al. 2013).

Studies agree that emotional demands are the predictors of burnout, but only few investigate the role of cognitive demands (Bakker et al. 2011, de Jonge et al. 2010). Although the negative interaction between work and home was evaluated by some authors as a mediator between risk factors and burnout (Geurts et al. 1999), most of the literature indicate that it is a predictor of the syndrome (Bakker et al. 2004). Based on the demands–resources model, there were studies carried out among healthcare professionals, for example, doctors in the primordial prophylaxis (Schaufeli et al. 2011) or young doctors (Schaufeli et al 2009) but only a few in ambulance personnel (van der Ploeg & Kleber 2003). Studies show that ambulance personnel has a higher risk of developing physical and mental problems, although the results vary in different countries (Steurd et al. 2011). Ambulance personnel in Romania has medium to high levels of burnout according to one of the few studies treating this subject (Popa et al. 2010).

Purpose of the study, hypotheses, and methodology

Purpose of the study and hypotheses

The aim of the present study is to update the knowledge in the field of burnout among healthcare professionals and also to raise attention to this non-functional aspect of the healthcare system in Romania. Furthermore, the purposes include determination of an average level of burnout among healthcare professionals (doctors and nurses) and the differences in burnout between those who work in governmental hospitals and private ones, but also the differences in burnout depending on gender, age, and experience.

The study proposes the following hypotheses:

– Medical professionals who work at state hospitals have higher levels of burnout than the ones who work at private hospitals.

– Nurses have higher levels of burnout than doctors.

– The level of burnout increases with the time spent in the domain.

– Burnout levels do not correlate significantly with sex.

Methodology

The subjects of the research are doctors and nurses who work at state hospitals as well as private ones, all of them from Târgu-Mureş (Romania). In total, there are 60 subjects from which 15 doctors work at state hospitals, 15 at private hospitals, 15 nurses work at state hospitals, and 15 at private hospitals – in total, 12 men and 48 women, aged between 22 and 54 years old.

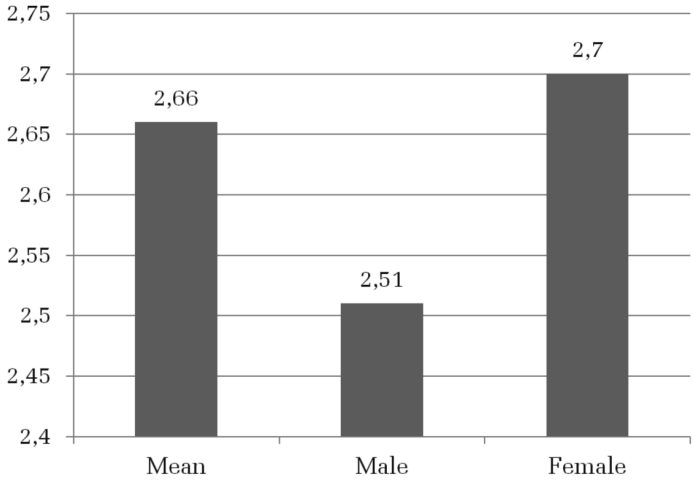
The sampling method was non-probabilistic and was based on voluntary participation. I went to several hospitals, advertised the research, and went back after a week to collect the questionnaires.

The questionnaire was based on the *Maslach Burnout Inventory – Human Services Survey* (MBI-HSS), which consists of three dimensions: emotional exhaustion, depersonalization, and personal accomplishment (Maslach et al. 1997). The emotional exhaustion subscale assesses feelings of being emotionally outworn by work. The depersonalization subscale measures an impersonal response toward patients. The personal accomplishment subscale assesses feelings of competence and achievement. In contrast to the previous two subscales, lower means on this sub-scale correspond with higher degrees of burnout, meaning that the values of this subscale had to be reversed in order to get the real data.

Other questions in the questionnaire investigated respondents' socio-demographic background, i.e. age, gender, occupation, and experience in the medical field. The collected data were then introduced into the SPSS statistics program and were analyzed as follows.

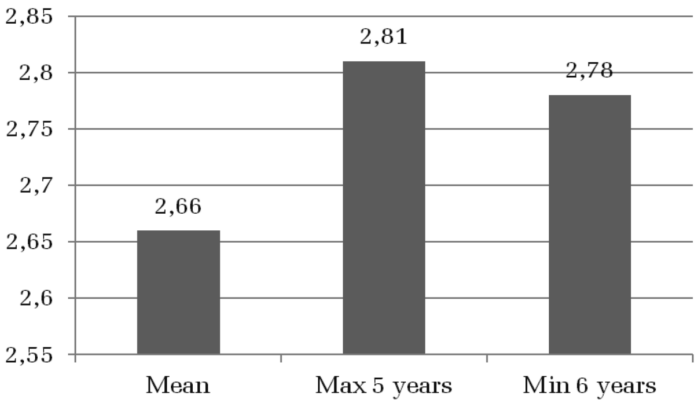
Research findings

Regarding gender, there were not found significant differences between the burnout levels of men (2.71 – 2.03 – 3.3) and women (2.25 – 2.33 – 3.59); p = 0.083. The numbers in the parentheses represent the burnout levels degraded to subscales. The first number represents emotional exhaustion, the second number depersonalization, and the third one personal accomplishment.



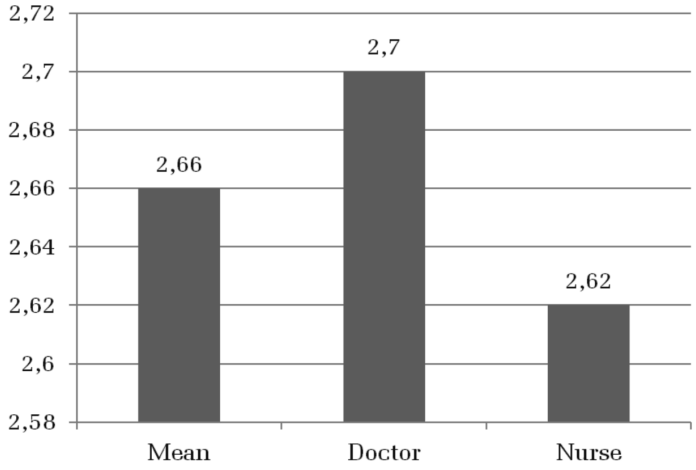
Graph 1. *Gender differences in burnout levels*

The subjects' experience in the field varies between 1 and 25 years, and this does not have any significant correlation with burnout. Those with maximum 5 years of experience have a satisfaction level of 2.81, whereas those with minimum 6 years have 2.78; p = 0.480.



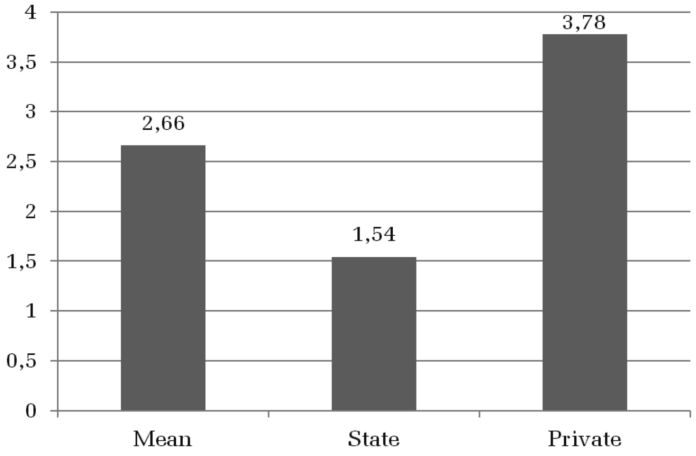
Graph 2. *Subjects' experiences in the field*

There was not found any correlation regarding the job either. Doctors have satisfaction levels of 3.4 – 2.06 – 3.54, whereas nurses 1.09 – 2.34 – 3.52; p = 0.015. The three numbers represent the subscales as well.

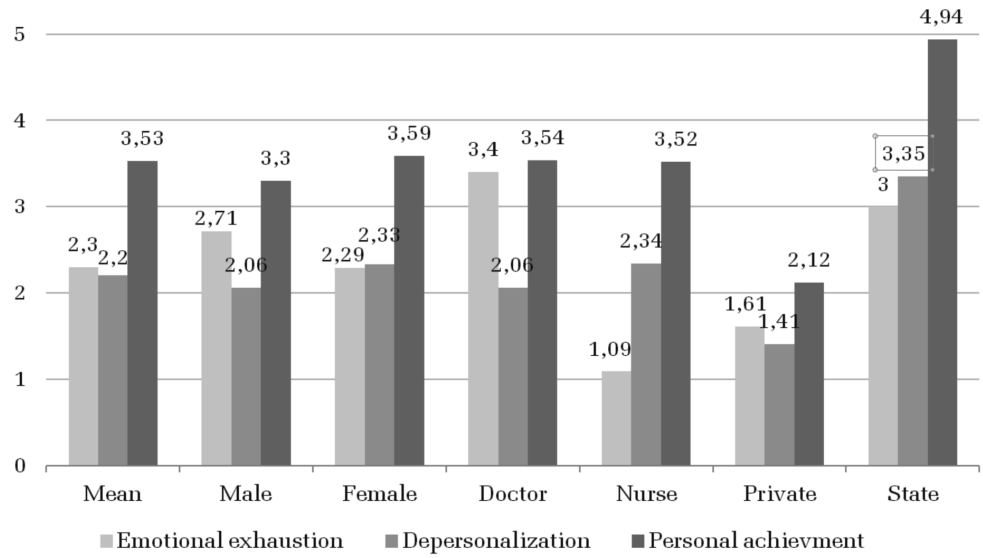


Graph 3. *Job differences*

However, there was found a significant (p < 0.001) association between the burnout levels of those who work at state hospitals (3 – 3.35 – 4.94) and those who work at private hospitals (1.61 – 1.41 – 2.12).



Graph 4. *Workplace differences*



Graph 5. *Summary of the results*

Although the present research did not find any differences regarding gender, experience in the field, or the position on the job (doctor or nurse), we did find a significant difference between workers in state and private hospitals, regardless of their jobs. State hospital workers have a much higher burnout level than the ones working in private hospitals. This is due to the very high workload. There is a great number of patients per doctor/nurse per day, every day. This is accentuated by the fact that this county's hospital is much in demand by patients from the whole country.

Conclusions, discussions, and suggestions for future research

The present results confirm the fact that the Romanian healthcare system is underbudgeted. This fact leads to serious consequences regarding the quality of the healthcare, including the medical staff's health. The Romanian healthcare system has long been confronted with a shortage of personnel and more recently with medical professionals' migration, mostly to western countries. Moreover, the medical professionals' migration was accentuated due to the underbudgeted system and by its slow reform (Popa 2013, Spânu et al. 2012). In line with other studies (Bria et al. 2013, Voicu 2006), we report high rates of burnout among Romanian healthcare professionals.

According to the job demands–resources model of burnout (Demerouti et al. 2001), high job demands combined with insufficient resources are predictive of burnout. In the present study, we tested the impact of different job demands (state and private hospitals) on medical professionals. In line with this model, I found significant differences between the two situations – the state-system doctors and nurses also show higher burnout rates than those in the private sphere.

Some previous research have found significant associations between gender and burnout: Plieger et al. (2015) say that in the male subscales the level of cynicism was higher. According to Maslach and Jackson (1981), females scored higher on emotional exhaustion, whereas males scored higher on depersonalization and personal achievement. We did not find significant derogations regarding gender.

In Maslach's research (1976), burnout is likely to occur within the first two years of one's career, but in the present research there is no evidence of correlation between experience and burnout.

Although I did not find any studies working with different workplace factors regarding burnout, I observed that there are significant differences not only in resources but also in job demands at state and private hospitals; so, I felt free to make the comparison, and it seems it was the only significant difference in this research, regarding burnout.

A more extensive and a deeper research into the differences between these categories' subscales should be carried out: for example, there is a difference between doctors' and nurses' emotional exhaustion. This would necessitate an extensive qualitative research, perhaps a series of interviews and observations.

Obviously, this study needs to be continued on extensive samples, more medical units in more cities, combining quantitative results with qualitative ones in order to be able to generalize the results at the level of the healthcare staff in this country.

All in all, this study confirms Demerouti's Job Demands–Resources model (Demerouti et al. 2001). This is why the most important aspect would be the improvement of the healthcare system in order to minimize the migration of healthcare professionals to more developed countries but also the patients' need to go to these countries in order to receive adequate and quality medical care.

References

Ahola, Kirsi, Hakanen, Jari. 2007. Job Strain, Burnout and Depressive Symptoms: A Prospective Study among Dentists. *Journal of Affective Disorders* 104: 103–110.

Ahola, Kirsi, Vänäänen, Ari, Koskinen, Aki, Kouvonen, Anne, Shirom, Arie. 2010. Burnout as a Predictor of All-Cause Mortality among Industrial Employees: A 10-year Prospective Register-Link Age Study. *Journal of Psychosomatic Research* 69: 51–57.

Alarcon, Gene M. 2011. A Meta-Analysis of Burnout with Job Demands, Resources and Attitudes. *Journal of Vocational Behaviour* 79: 549–562.

Băban, Adriana, Balázsi, Robert, Bradley, Janet, Rusu, Camelia, Szentágotai, Aurora, Tătaru, Raluca. 2005. *Psychosocial and Health System Dimensions of Cervical Screening in Romania.* Cluj-Napoca: Romanian Association of Health Psychology, Engender-Health.

Bakker, Arnold B., Demerouti, Evangelia. 2007. The Job Demands–Resources Model: State of the Art. *Journal and Managerial Psychology* 22: 309–328.

Bakker, Arnold B., Demerouti, Evangelia, Sanz-Vergel, Ana I. 2014. Burnout and Work-Engagement: The JD-R Approach. *Annual Review of Organizational Psychology and Organizational Behaviour* 1: 389–411.

Bakker, Arnold B., Demerouti, Evangelia, Verbeke, Wim 2004. Using the Job Demands–Resources Model to Predict Burnout Performance. *Human Resource Management* 43(1): 83–104.

Bakker, Arnold B., Schaufeli, Wilmar B., Demerouti, Evangelia, Janssen, Peter. P. M., Van der Hulst, Reneé, Brouwer, Janneke. 2000. Using Equity Theory to Examine the Difference between Burnout and Depression. *Anxiety, Stress & Coping: An International Journal* 13: 247–268.

Bakker, Arnold B., Schaufeli, Wilmar B., Sixma, Herman, Bosveld, Willem, Van Diedendonck, Dirk. 2000. Patient Demands, Lack of Reciprocity and Burnout: A Five-Year Longitudinal Study among General Practitioners. *Journal of Organizational Behaviour* 21: 425–441.

Bakker, Arnold B., Ten Brummelhuis, Lieke I., Prins, Jelle T., Van der Heijden, Frank M. M. A. 2011. Applying the Job Demands–Resources Model to the Work-Home Interface: A Study among Medical Residents and Their Partners. *Journal of Vocational Behaviour* 79: 170–180.

Bergman, Lars R., Lundh, Lars-Gunnar. 2015. Introduction: the Person-Oriented Approach. Roots and Roads to the Future. *Journal for Person-Oriented Research* 1: 1–6.

Bergman, Lars R., Magnusson, David, El-Khouri, Bassam M. 2003. *Studying Individual Development in an Interindividual Context: A Person-Oriented Approach.* Mahwah: Lawrence Erlhaum Associates.

Blegen, Mary A. 1993. Nurses' Job Satisfaction: A Meta-Analysis of Related Variables. *Nursing Research* 42: 36–44.

Bria, Mara, Băban, Adriana, Aucheica, Sorin, Dumitraşcu, Dan L. 2013. Burnout and Turnover Intentions among Romanian ambulance personnel. *Procedia – Social and Behavioral Sciences* 84: 801–805.

Bria, Mara, Băban, Adriana, Dumitraşcu, Dan L. 2012. Systematic Review of Burnout Risk Factors among European Healthcare Professionals. *Cognition, Brain, Behaviour. An Interdisciplinary Journal* 16: 423–452.

Cooper, Cary. 1996. Hot Under the Collar. *Times Higher Education Supplement* June 21.

Davey, Manfy M., Cummings, Greta, Newburn-Cook, Christine V., Lo, Eliza A. 2009. Predictors of Nurse Absenteeism in Hospitals: A Systematic Review. *Journal of Nursing Management* 17: 312–330.

de Jonge, Jan, LeBlanc, Pascale M., Peeters, Maria C. W., Noordam, Hanneke. 2008. Emotional Job Demands and the Role of Matching Job Resources: A Cross-Sectional Study among Health Care Workers. *International Journal of Nursing Studies* 45: 1460–1469.

de Jonge, Jan, van Vegchel, Natasja, Shimazu, Akihito, Schaufeli, Wilmar, Dormann, Christian. 2010. A Longitudinal Test of the Demand–Control Model Using Specific Job Demands and Specific Job Control. *International Journal of Behavioral Medicine* 17: 125–133.

Demerouti, Evangelia, Le Blanc, Pascale M., Bakker, Arnold B., Schaufeli, Wilmar B., Hox, Joop. 2009. Present but Sick: A Three-Wave Study on Job Demands, Presentism and Burnout. *Career Development International* 14: 50–68.

Demerouti, Evangelia, Nachreimer, Friedhelm, Bakker, Arnold, Schaufeli, Wilmar. 2001. The Job Demands–Recourses Model of Burnout. *Journal of Applied Psychology* 86 (3): 499–512.

Epp, Kirstin. 2012. Burnout in Critical Care Nurses: A Literature Review. *Dynamics* 23: 25–31.

Escriba Agüir, Vicenta, MartinüBaena, David, Perez Hoyos, Santiago. 2006. Psychosocial Work Environment and Burnout among Emergency Medical and Nursing Staff. *International Archives of Occupational and Environmental Health* 80: 127–133.

Geurts, Sabine A. E., Rutte, Christel, Peeters, Maria. 1999. Antecedents and Consequences of Work–Home Interference among Medical Residents. *Social Science and Medicine* 48 (9): 1135–1148.

Gunnarsdottir, Sigrun, Clarke, Sean P., Rafferty, Anne M., Nutbeam, Don. 2009. Front-Line Management, Staffing and Nurse Doctor Relationships as Predictors of Nurse and Patient Outcomes. A Survey of Icelandic Hospital Nurses. *International Journal of Nursing Studies* 46: 920–927.

Hakanen, Jari J., Bakker, Arnold B., Jokisaari, Markku. 2011. A 35-Year Follow-Up Study on Burnout among Finnish Employees. *Journal of Occupational Health Psychology* 16: 345–360.

Hakanen, Jari J., Schaufeli, Wilmar B. 2012. Do Burnout and Work Engagement Predict Depressive Symptoms and Life Satisfaction? Three-Wave, Seven-Year Perspective Study. *Journal of Affective Disorders* 141: 415–424.

Hanish, Kathy A. 1995. Behavioral Families and Multiple Causes: Matching the Complexity of Responses to the Complexity of Antecedents. *Current Directions in Psychological Science* 1: 156–162.

Kiekkas, Panagiotis, Spyratos, Fotis, Lampa, Efstathia, Aretha, Diamanto, Sakellaropoulos, George C. 2010. Level and Correlates of Burnout among Orthopaedic Nurses in Greece. *Orthopaedic Nursing* 29: 203–209.

Kim, Hansung, Ji, Juye, Kao, Dennis. 2011. Burnout and Physical Health among Social Workers: A Three-Year Longitudinal Study. *Social Work* 6: 258–268.

Lashiger, Heather K. S., Wong, Carol A., Grau, Ashley L. 2013. Authentic Leadership, Empowerment and Burnout: A Comparison in New Graduates and Experienced Nurses. *Journal of Nursing Management* 21: 541–552.

Laursen, Brett, Hoff, Erika. 2006. Person-Centered and Variable-Centered Approaches to Longitudinal Data. *Merril-Palmer Quarterly* 52: 377–389.

Le Blanc, Pascale M., Bakker, Arnold B., Peeters, Maria C. W., van Heesch, Nicolette C. A., Schaufeli, Wilmar B. 2001. Emotional Job Demands and Burnout among Oncology Care Providers. *Anxiety, Stress & Coping: An International Journal* 14: 243–263.

Lee, Raymond T., Ashforth, Blake E. 1996. A Meta-Analytic Examination of the Correlates of the Three Dimensions of Job Burnout. *Journal of Applied Psychology* 81: 123–136.

Leiter, Michael P., Maslach, Christina. 2009. Nurse Turnover: The Mediating Role of Burnout. *Journal of Nursing Management* 17: 331–339.

Maslach, Christina. 1976. Burned-Out. *Human Behaviour* 5(9): 16–22.

Maslach, Christina, Jackson, Susan, 1997. The Maslach Burnout Inventory Manual. Evaluating Stress: A Book of Resources. 191–218.

1981. The Measurement of Experienced Burnout. *Journal of Occupational Behaviour* 2: 99–113.

Maslach, Christina, Schaufeli, Wilmar B., Leiter, Michael P. 2001. Job Burnout. *Annual Review of Psychology* 52: 397–422.

Melamed, Samuel, Shirom, Arie, Toker, Sharon, Shapira, Itzhak. 2006. Burnout and Risk of Type 2 Diabetes: A Prospective Study of Apparently Healthy Employed Persons. *Psychosomatic Medicine* 68: 863–869.

Mohren, Danielle C. L., Swaen, Gerard H. M., Kant, Ijmert, Van Amelswoort, Ludo G. P. M., Borm, Paul J. A., Galama, Jochem. 2003. Common Infections and the

Role of Burnout in a Dutch Working Population. *Journal of Psychosomatic Research* 55: 201–208.

Moustou, Ioanna, Montgomery, Anthony, Panagoupoulou, Efharis, Benos, Alexis. 2010. Burnout Predicts Health Behaviours in Ambulance Workers. *The Open Occupational Health & Safety Journal* 2: 16–18.

Oreskovich, Michael R. et al. 2012. Prevalence of Alcohol Use Disorders among American Surgeons. *Archives of Surgery* 147: 168–174.

Ortega, Cristina, López, Francesca. 2004. El burnout o sindrome de estar quemado en los profesionales sanitarios: revisión y perspectivas. *International Journal of Clinical and Health Psychology* 4: 137–160.

Paris, Manuel, Hoge, Michael A. 2010. Burnout in the Mental Health Workforce: A Review. *The Journal of Behavioral Health Services & Research* 37: 519–528.

Peterson, Ulla, Demerouti, Evangelia, Bergström, Gunnar, Åsberg, Marie, Nygren, Åke. 2008. Work Characteristics and Sickness Absence in Burnout and Non-Burnout Groups: A Study of Swedish Health Care Workers. *International Journal of Stress Management.* 15: 153–172.

Pisanti, Renato, van der Doef, Margot, Maes, Stan, Lazzari, David, Bertini, Mario. 2011. Job Characteristics, Organizational Conditions, and Distress/Well-Being among Italian and Dutch Nurses: A Cross-Sectional Comparison. *International Journal of Nursing Studies* 48: 829–837.

Plieger, Thomas, Melchers, Martin, Montag, Christian, Meermann, R., Reuter, Martin 2015. Life Stress as Potential Risk Factor for Depression and Burnout. *Burnout Research* 2: 12–25.

Popa, Adela E. 2013. Hospital Decentralisation in Romania: Stakeholders' Perspectives in the News Print Media. *International Journal of Health Planning and Management* 29(1): 70–89.

Popa, Florian, Arafat, Raed, Purcărea, Victor L., Lală, Adrian, Popa-Valea, Ovidiu, Bobirnac, George. 2010. Occupational Burnout Levels in Emergency Medicine – A Stage 2 Nationwide Study and Analysis. *Journal of Medicine and Life* 3(4): 445–453.

Prins, Jelle T., Gazendam-Donofrio, Stacey M., Tubben, Ben J., Van der Heijden, Frank M. M. A., Van de Wiel, Harry B. M., Hoekstra-Weebers, Josette E. H. M. 2007. Burnout in Medical Residents: A Review. *Medical Education* 41: 788–800.

Reber, Arthur S. 1985. *Dictionary of Psychology*. New York: Penguin.

Schafer, Willemijn, Kroneman, Madelon, Boerma, Wienke, Van Der Berg, Michael, Westert, Gert., Deville, Walter, Van Ginneken, Ewout. 2010. The Netherlands. Health System Review. *Health Systems in Transition* 12: 1.

Schanafelt, Tait D. et al. 2012. Burnout and Satisfaction with Work-Life Balance among US Physicians Relative to the General US Population. *Archives of Internal Medicine* 172: 1377–1385.

2011. Special Report: Suicidal Ideations among American Surgeons. *Archives of Surgery* 146: 54–62.

2010. Burnout and Medical Errors among American Surgeons. *Annals of Surgery* 251: 995–1000

Schaufeli, Wilmar B., Bakker, Arnold B., van der Heijden, Frank M. M. A., Prins, Jelle T. 2009. Workaholism, Burnout and Well-Being among Junior Doctors: The Mediating Role of Role Conflict. *Work & Stress* 23(2): 155–172.

Schaufeli, Wilmar B., Bradley, Katharine A., Wipf, Joyce E., Back, Anthony L. 2002. Burnout and Self-Reported Patient Care in an Internal Medicine Residency Program. *Annals of Internal Medicine* 136: 358–367.

Schaufeli, Wilmar B., Maasen, Gerard H., Bakker, Arnold B., Sixma, Herman J. 2011. Stability and Change in Burnout. A Ten-Year Follow-Up Study among Primary Care Physicians. *Journal of Occupational and Organizational Psychology* 84: 248–267.

Schirom, Arie, Nirel, Nurit. 2006. Overload, Autonomy, and Burnout as Predictors of Physicians' Quality of Care. *Journal of Occupational Health Psychology* 11: 328–342.

Spânu, Florina, Băban, Adriana, Bria, Mara, Dumitraşcu, Dan L. 2012. What Happens to Health Professionals When the Ill Patient is the Healthcare System? [ORCAB Special Series]. *British Journal of Health Psychology* 8: 663–679.

Swider, Brian W., Zimmerman, Ryan D. 2010. Born to Burnout: A Meta-Analytic Model of Personality, Job Burnout and Work Outcomes. *Journal of Vocational Behaviour* 76(3): 487–506.

ten Brummelhuis, Lieke L., Ter Hoeven, Claartje L., Bakker, Arnold B., Peper, Bram. 2011. Breaking through the Loss Cycle of Burnout: The Role of Motivation. *Journal of Occupational and Organizational Psychology* 84: 268–287.

Todorova, Irina, Băban, Adriana, Alexandrova-Karamanova, Anna, Bradley, Janet. 2009. Inequalities in Cervical Cancer Screening in Eastern Europe: Perspectives from Bulgaria to Romania. *International Journal of Public Health* 54: 1–11.

Van der Heijden, Frank, Dillingh, Gea, Bakker, Arnold, Prins, Jelle. 2008. Suicidal Thoughts among Medical Residents with Burnout. *Archives of Suicide Research* 12: 344–346.

Van der Ploeg, Eleonore, Kleber, Rolf J. 2003. Acute and Chronic Job Stressors among Ambulance Personnel: Predictors of Health Symptoms. *Occupational & Environmental Medicine* 60(1): i40–i46.

Vela Bueno, Antonio et al. 2008. Insomnia and Sleep Quality among Primary Care Physicians with Low and High Burnout Levels. *Journal of Psychosomatic Research* 64: 435–442.

Vlădescu, Cristian, Scîntee, Gabriela, Olsavszky, Victor, Alin, Sara, Molodovsky, Philipa. 2008. Romania: Health System Review. *Health Systems in Transition* 10(3): 1–172.

Voicu, Bogdan. 2006. Work and Life Balance. In: I. Mărginean (ed.), *First European Quality of Life Survey: Quality of Life in Bulgaria and Romania.* Luxembourg: Office for Official Publications of the European Communities. 43–48.

Witkin, Stanley, Harrison, W. David. 2001. Whose Evidence and for What Purpose? *Social Work* 46(4): 293–296.

World Health Organization. 2009. *The European Health Report. Health and Health Systems.*

Xantopoulou, Despoina et al. 2007. When Do Job Demands Particularly Predict Burnout? The Moderating Role of Job Resources. *Journal of Managerial Psychology* 22: 766–786.

Zangaro, George A., Soeken, Karen L. 2007. A Meta-Analysis of Studies of Nurses' Job Satisfaction. *Research in Nursing & Health* 30: 445–458.

Acta Univ. Sapientiae, Social Analysis, **8** (2018) 41–54

DOI: 10.2478/aussoc-2018-0003

Receptivity to eHealth Services in the Hungarian Population of Mureş County, Romania

Katalin HARANGUS
Sapientia Hungarian University of Transylvania, Cluj-Napoca, Romania,
katalin@ms.sapientia.ro

Ágnes SÁNTHA
Sapientia Hungarian University of Transylvania, Cluj-Napoca, Romania
santhaagnes@ms.sapientia.ro

Abstract. One of the most dynamically evolving sectors of our days is eHealth. More and more applications, software, devices, etc. are launched that make healthcare segments accessible not only for professionals but for laics, too. This study examines to what extent the adult Hungarian population of Mureş County is ready to become eHealth participative, i.e. an active agent of its own healthcare attendance, in order to make use of the advantages offered by modern technologies that provide information and help understand our diseases, their prevention, and health maintenance. The probability of eHealth usage is approximated by the frequency of Internet usage. Social determinants of info-communication tool usage are assessed, controlling for covariates. Age has the strongest impact upon the frequency of Internet usage. The younger is the respondent, the more likely he/she is to be a frequent user, and, apart from this, only the educational level determines Internet use, higher education implying more frequent usage.

Keywords: eHealth, info-communication tool usage, digital inequalities

Introduction

The context in which patients consume health information has changed dramatically with the electronization of healthcare, that is, with the diffusion of the Internet, advances in telemedicine, and changes in media health coverage (Hesse et al. 2005). The term eHealth, often referred to as digital health, encompasses a wide range of activities and technologies directed at delivering healthcare. From the patient's side, these services entail the followings: getting information from providers and from websites, online discussion fora and apps, sharing experiences of health and illness, those with chronic illnesses engaging

in self-care, self-monitoring devices with digital biosensors, personal emergency response systems to alert professionals in case of emergency, patient education tools, etc. (Lupton 2018).

eHealth is one means of patient empowerment, of reducing the hierarchical distance between health services and the patients and determining the patient to become more responsible for his/her healthcare. The most popular way for empowerment is patient education, followed by enhancing the commodity of patients by reducing the complexity of daily tasks such as the patient–doctor communication (e.g. e-mail or instant messaging), online access to administrative services, and tele-diagnosis. Self-care is also increasingly contributing to patient empowerment (Calvillo et al. 2013).

This paper seeks to answer the questions as to what extent the Hungarian population of Mureş County, Romania, is empowered in this sense, how it is prepared to become an active part of its own healthcare provision in order to make use of those advantages offered by modern technologies that provide information and help understand their illnesses, the changes in their lifestyle, and in maintaining their health.

In order to create more efficient, transparent, and better-reacting public services, the European Union's leaders raised the political claim to disseminate information policies and raise awareness about them. In 1999, in the light of this endeavor, the European Union started within its action plan the program called "eEurope = Information Society for Everyone" and aimed to create the information society. Later on, in its program entitled "eEurope 2005 – Information Society for Everyone" the aim was to build broadband infrastructures to lay the foundations for the future information society. One of the four basic activities included in the priority action programs was the health system. This subprogram recommended three action types within e-health: developments regarding the electronic health card, creating health information networks, and spreading online health services. Later on, the program evolved into another project, the "i2010: European Information Society Growth and Development", wherein info-communication tool usage was identified as an important avenue in social integration and quality of life enhancement (COM 2005). Within the "Europe 2020" strategy (COM 2010a), one of the most important facets is the European Digital Plan, which contains several eHealth activities and aims (COM 2010b).

On the healthcare provider's side, in spite of general practitioners' positive attitude towards ITC use in healthcare, the use of computers and the Internet for patient consultation is still inadequate in Romania (Farcaş 2007), and integrated health services informational systems for patient monitoring are inexistent (Farcaş 2007, Sitar-Tăut et al. 2011). Most recently, a number of eHealth projects have been implemented in Romania; however, they mostly meet local needs and are inadequate for larger consumer populations, and thus remain at the level of pilot

projects (Banciu & Alexandru 2009). On the other hand, electronic health record keeping has evolved dramatically, personal health records (cards) were issued in 2014 (Imbrişcă & Neațu 2015) and uniformly used countrywide ever since.

Our study focuses on the patients' side, trying to track the receptivity of a population segment towards eHealth services in order to promote and maintain their health and to actively engage with health issues through web-based activities. Our findings originate from Mureş County, which has a specific place in the Romanian health service sector, being one of the few medical centers in the Central Region. Its state-owned and private hospitals are providing care for large population groups often arriving from far away within the country. Further, the town of Târgu Mureş is a teaching and training center with a medical university, being the only one in the country providing tertiary healthcare education programs in Hungarian language for ethnic minority Hungarians. Taken into consideration, this special situation of Mureş County's health service units, their patients' receptivity for technical innovation is even more interesting and important to study. However, our study was only carried out among Hungarian-speaking adults and solely in Mureş County, and so our results have a limited reach.

In order for modern info-communication tools and applications to become part of our everyday lives, the population should be eHealth literate, that is, it should have the necessary skills and devices to make use of these technologies. In this study, we are curious to find out which demographic variables impact on the frequency of Internet usage. Who represent those categories whose digital competences can be relied upon in future eHealth innovations?

A clear limitation of this study is that no typology of Internet usage can be created from existing data. The questionnaire only contained questions on the frequency of Internet usage; so, this measure is used as a proxy for the eventual eHealth service usage since frequent Internet usage increases the chance to engage in web-based patient activities.

Individuals' self-assessment of eHealth skills revealed a 62% of total Romanian population claiming to know how to navigate the Internet to find health information, further 33% tend to agree with the statement, and only 6% disagree. This dispersion puts Romania slightly above the middle rank among the 28 European countries (Vicente & Madden 2017).

To date, according to a review of international literature on eHealth literacy, lower age and higher education predict eHealth literacy, while higher education and being a female is associated with a high usage of Web 2.0 for retrieving health information. Women and teenagers with a chronic disease are more active in engaging and participating in health-enhancing behaviors online than the general population, and social media showed to be a promising tool for empowering patient engagement. However, so far, social media is being mostly used by patients with cancer to retrieve information (Cordoş et al. 2017).

Empirical evidence has shown that eHealth skills are primarily linked to socio-economic profiles, with younger and more educated population having better skills. Further and most importantly, eHealth skills are positively correlated with other abilities, such as computer and information skills (Vicente & Madden 2017), which justifies the approximation of eHealth literacy with ICT use as done in this paper. The recent study of Vicente and Madden (2017) assessed the individual's self-perceived and differentiated eHealth skills in the adult European population, asking about the ease to find, evaluate, and apply electronic health information to health problems. The analysis revealed that for a thorough study eHealth skills should rather be assessed separately than as one comprehensive skill as far as only one socio-demographic factor is statistically significant across all skills. The more frequently people seek health information online, the more likely they report themselves as high-skilled.

Based on the Health Information National Trends Survey, scholars found that as much as individuals perceived their communication with providers to be less patient-centered, they are more likely to engage in various types of online health activities (Hou & Shim 2010). Typical activities include using websites for healthy lifestyles, searching for healthcare providers, and seeking health information. Trust in online health information was also found to be a significant predictor for online health activities.

Secondary literature analysis concluded that among the multitude of eHealth services, web services and communication networks are the most used technologies, easing remote communication and access to health information and services. Besides them, both personal health record and electronic health record approaches share outstanding positions (Calvillo et al. 2013).

Data and methods

Our research was conducted on a representative sample of Mureş County's Hungarian population (N=383), the sample making up 0.19% of the total population of the respective county.[1] The primary aim of the research was to assess the state of health and the quality of life with the adapted version of the standardized questionnaire of Hungarostudy 2013. One block of questions (no 7) assessed the media usage and the extent of using different communication channels (personal, postal, chat, social media).

Our analysis reveals the electronic device usage of Mureş County's Hungarian population. In descriptive analysis, device usage was grouped in three categories, recoded from the original variables: frequent users, rare users, and no users (Fromann & Susánszky 2014). In the descriptive statistics, frequent usage is

1 Data was collected between September 2015 and March 2016.

mostly considered in the analysis as one can only expect from digitally literate people to benefit from eHealth services.

In the explanatory model (linear regression), the dependent variable is the initial ordinal variable for Internet use with nine (9) values: never uses Internet, uses Internet once a year, a few times a year, every 2–3 months, every month, every 2–3 weeks, once a week, more times a week, and daily.

We were curious to find out the socio-demographic profile of frequent users, that is, what increases Internet usage. Regression measures the impact of predictors on their own, adjusted to the effect of covariates. Our linear regression model includes scale, ordinal and nominal level predictors, that is, variables such as age, perceived socioeconomic status, highest level of education, gender, or partnership status (is living alone – is living with a partner). These latter dichotomous variables were recoded into values of 0 and 1, 0 always denoting the supposedly unfavorable situation, i.e. women, village, and living alone.

In regression analysis, we aimed to find the best fitting and most parsimonious causal model, using the variable selection procedure. Following Kleinbaum et al. (2007), the model was at first simplified, leaving out the non-significant interaction effects one by one. Thereafter, an automated variable selection algorithm was used. Apart from gender and age, the remaining variables were allowed to be sorted out by the algorithm. A stepwise selection was used, setting the threshold at 5% for inclusion and at 10% for exclusion. The final model was subjected to multicollinearity diagnostics, monitoring the VIF and Tolerance indicators.

Results

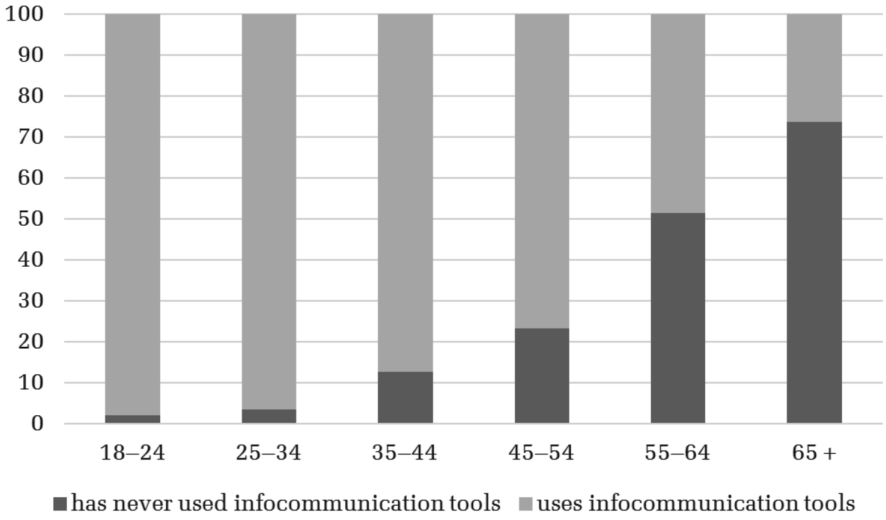
Descriptive results show that almost every respondent (92%) has his/her own mobile phone. The provision with info-communication tools is worse, with only 70% of respondents having a PC and Internet connection.

There was revealed a difference regarding residence within the population. 70% of town and city inhabitants use their PC and Internet regularly, whereas only 52% of village inhabitants do so. In much the same way, respondents living in larger settlements use PCs more often ($\chi^2 = 13.672$, $p = 0.001$) and communicate through the Internet on more occasions ($\chi^2 = 8.380$, $p = 0.015$) than do people living in smaller settlements.

Comparing the computer usage of the population of Mureş County and of Romania according to their residence, there is the same difference between town and village inhabitants. The proportion of users living in towns in Romania is 1.4 times higher, while in Mureş County this is 1.3 times higher than that of users living in villages (INS 2015).

When PC and Internet usage is assessed by age-groups, the rate of users decreases with age. When splitting the population into age-groups, we followed the standard division of the Romanian National Statistical Office (INS). Daily usage is dominant within the young generations, and the rate decreases with age ($r = –0.625$, $p < 0.01$). A similar correlation was revealed in the case of Internet usage, too ($r = –0.704$, $p < 0.01$).

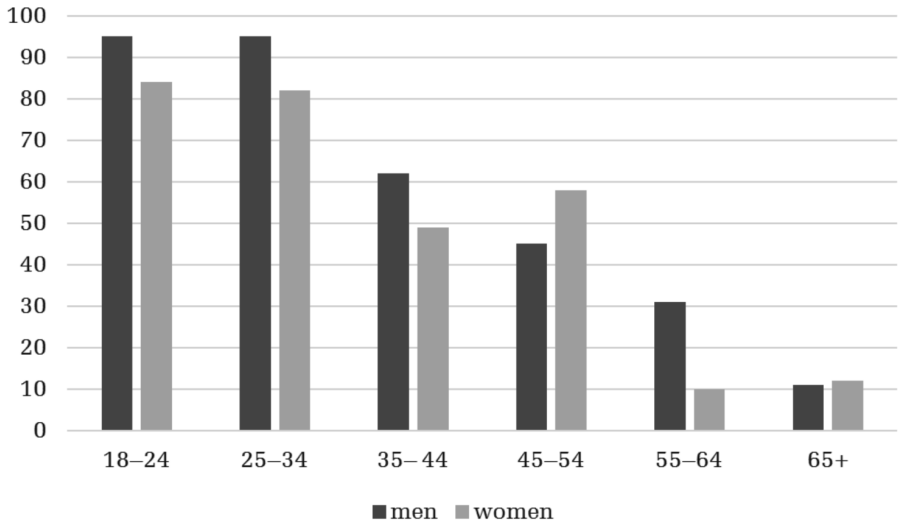
The most intensive info-communication tool usage (98.1%) is traced among the youngest adults (aged 18–24), the rate of users decreasing with age, until it is reduced to 26.3% among those aged 65 and above (*Graph 1*).



Graph 1. *PC and Internet usage by age-groups (%)*

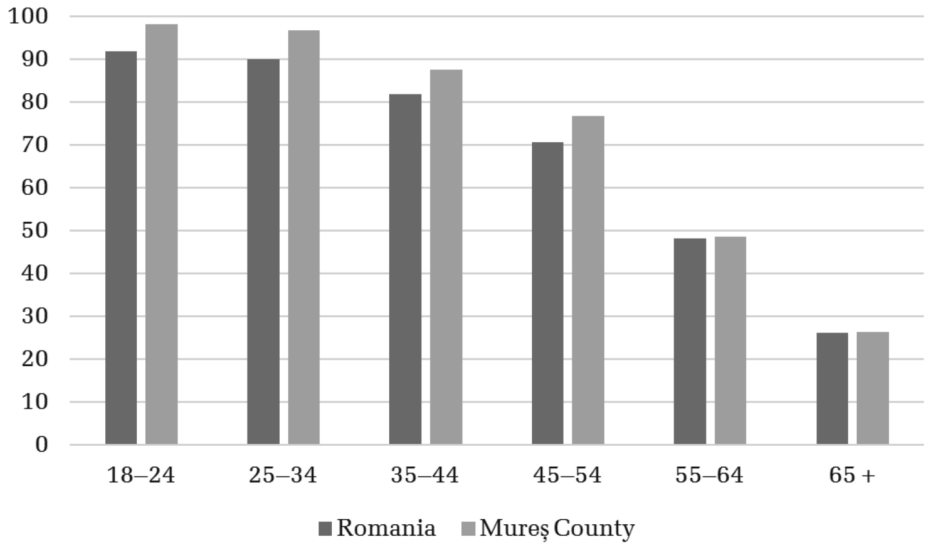
Data analysis by gender reveals no significant difference between men and women either in PC or in Internet usage. The proportion of male and female PC users who use computers daily or less frequently is almost the same: in our sample, 70.3% of men and 68.9% of women use a PC. To compare, the proportion of adult male PC users is slightly higher in Romania than that of the adult female users (72.1% and 68.2% respectively) (INS 2015).

However, in a three-dimensional analysis differentiated across gender and age-groups, the data show (*Graph 2*) that frequent PC usage is more typical for young men aged 18–34 than for women of the similar age-group (95% compared to 84%). In different age-groups, the proportion of genders differs: the advantage of men is higher in the age-groups 34–44 and 55–64 (62% vs. 49% and 31% vs. 10% ($\chi^2 = 2.331$, $p = 0.012$), whereas among those aged 45–54 ($\chi^2 = 4.008$, $p = 0.045$) and 65 and older the rate of digitally literate women is higher than that of men (45% vs. 58% and 11% vs. 12% respectively).



Graph 2. *Frequency of PC usage by gender and age-groups (%)*

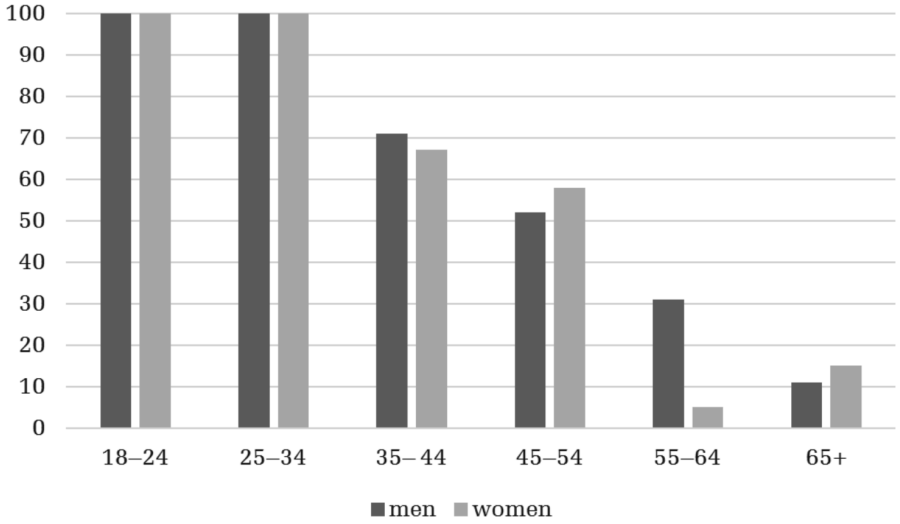
At national level, the proportion of PC users shows a decreasing trend according to age-group assessment. Young people aged 16–24 use PC the most (91.8%), and the proportion decreases with age. The proportion of usage among the age-group of 56–74 is only 26.1% (INS 2015). *Graph 3* below shows the PC usage of the Hungarian population of Romania and Mureş County by age-groups.



Graph 3. *Frequency of PC usage: Mureş County vs. Romania (%)*

Internet usage rates are similar to PC usage rates. Gender differences are only revealed in the older age-groups as young people's (18–34 years) daily Internet usage is almost as high as 100%.

There is a significant difference in the age-group of 55 to 64 ($\chi^2 = 4.667, p = 0.031$), 31% of men and 5% of women having claimed to be daily Internet users (*Graph 4*). Daily users are less numerous in the older generation, their rate decreasing by 20% with the advancement of age.



Graph 4. *Frequency of Internet usage by gender and age-groups (%)*

When analyzing the data for Romania, the proportions are similar. The proportion of Internet users in the adult population is 68.5%, whereas 65.7% of users use the device daily or almost daily. The proportion of men using the Internet is slightly higher than that of women: 74.8% vs. 72.1%. By age-groups, the proportion of Internet users also shows a decreasing tendency. The age-group of 16–34 uses the Internet intensively, while with the advancement of age this proportion is significantly reduced. The proportion of frequent users aged 55–74 is only 44%. There is a gender difference in the age-group of 35–44, where 57.7% of men use the Internet on a daily or almost on a daily basis compared to 61.6% of women of the same age (INS 2015).

Further, it can be stated that PC and Internet usage is significantly correlated with education level: the digitally most literate are also highly educated (r_{PC} = 0.588, $r_{internet}$ = 0.570); the correlation coefficients indicate strong relationships in both cases.

This trend is also characteristic at the national level. Only 67.6% of those graduating from trade schools or those who graduated only 8 classes or less are

PC and Internet users, whereas 83.9% of high school graduates, 85.7% of college graduates, and 85.7% of university graduates use PC and the Internet (INS 2015).

Descriptive results reveal that age and gender are significant predictors for Internet use, thus for possible eHealth service usage. Below, a linear regression model is being called upon to study the controlled effects of socio-demographic determinants upon the frequency of Internet usage and to assess their impact (*Table 1*).

Table 1. *The determinants of Internet usage*

Predictors of frequent Internet usage	Standardized β	t-value	p
Age	-0.579	-11.815	0.000
Highest level of education	0.219	4.485	0.000
Settlement type (village – town/city)	-0.093	-2.228	0.067
Perceived socio-economic status	0.045	1.057	0.291
Gender	-0.029	-0.698	0.486
Partnership status	-0.012	-0.300	0.765
Constant	9.879	5.038	0.000
Adjusted R^2 = 0.53, F = 55.53, p = 0.000			

Linear regression (N=383)

Taken altogether, the regression model is significant. Predictors explain 53% of the variance of Internet use frequency (adjusted $R^2 = 0.53$), which, according to our experience, is a rarely strong explanatory power in social sciences research. This means that the important social and demographic determinants of Internet use were identified, the frequent user profile can be drawn, and the differences in Internet use among different population groups are revealed.

Among the predicting variables, age has the most powerful impact (standardized b = -0.579). Age negatively correlates with the frequency of Internet usage, people are less likely to use the Internet with advancing age. Education level has the second strongest effect (standardized b = 0.219). With the increase of education level, the frequency of usage also increases, although, as previously revealed by descriptive statistics, the settlement type does not influence Internet usage. If all other predictors are being controlled for, town and city inhabitants do not use the Internet more often than the village population. Perceived socio-economic status in itself does not influence the frequency of Internet usage. Further, when adjusted to age and all other covariates, no gender difference was revealed by our data. By a similar socio-demographic profile, men are no oftener users than women, nor does partnership status influence Internet usage frequency.

Discussion

Our data mostly echo the results of neighboring countries, Hungary, for instance (Fromann & Susánszky 2014). Digital literacy is relatively high, and according to recent data it rapidly increases in Romania, by about 6% per year (INS 2015). Our descriptive data reveal an immense digital generation gap: the youngest age-group's usage is 70 times as intensive as that of the oldest age-groups. Linear regression statistics show that with advancing age the frequency of usage decreases. Both PC and Internet usage strongly correlate with age.

In the present, the rate of those young Transylvanian Hungarians aged 15–29 who never use the Internet is as low as 4% (Kiss & Barna 2013). Young people born and raised in a digital environment, i.e. the so-called digital natives, are often characterized in terms of the activity-passivity dimension: compared to older people, the so-called television generations, described as rather passive consumers of media content, "Net Geners" typically have an active attitude towards media content. Tapscott lists among the features of this generation scrutiny and speed, the search for immediate solutions (Tapscott 2009). With respect to health, this involves the fact that this generation is treating classic medical authority with a grain of salt, is checking up their health problems and disease symptoms on the Internet first (this can be done earlier than getting an appointment with the doctor), or at least supplements information obtained from the doctor with information from the Internet. As opposed to this behavior, older adults are rather distrustful towards health information obtained/obtainable from the Internet and also avoid Internet usage for such purposes (Zulman et al. 2011). Older respondents usually report comparatively fewer eHealth skills, have difficulty in navigating the Internet and determining information quality. Notwithstanding, they do not score low in all eHealth skills: they claim to be able to better understand health terminology (Vicente & Madden 2017).

Above all, the eHealth literacy of people aged 65 and above, the most populous target group of healthcare services, is rather low, and, at the same time, they distrust health information from the Internet, and this mistrust is also typical for educated old people as the relationship between age and mistrust does not disappear when controlled for the level of education. However, the age effect is slightly attenuated when controlled for experience with the Internet and technical difficulties encountered during its usage. Many adults of older age find the Internet confusing because it provides "too much information," and lack awareness about the source providing online health information. These respondents typically show lower willingness to search for health-related information on the Internet and manifest also lower rates of trust in such information (Zulman et al. 2011). In order to increase eHealth literacy and Internet usage for health-related purposes among older adults, it is recommended that websites' design and content features

clearly identify the source and credibility of information and minimize confusion. In this way, the utility of the Internet could increase as a health resource for the population.

Nevertheless, even if technology is there, it cannot be benefited from it if the population does not have the necessary information technology devices or the digital competences needed for the use of such technologies. The World Health Organization aims at enhancing equity in the eHealth literacy of the population since health gains among highly eHealth-literate people have created new inequalities in digital health information, and groups with low eHealth literacy are also at higher risk of poor health (Kickbusch et al. 2013).

Within the Transylvanian Hungarian population, PC and Internet usage increases with educational level. This result underscores the results of previous research with respect to PC usage (Márton 2012); however, this study is the first one to also assess a linear increase of Internet usage with education level. As for the eHealth skills of Europeans in general, the least educated experience difficulty in Internet navigation, determining information quality, and understanding health terminology. However, the ability to find reliable health-related information online does not differ by education level. This result draws attention once again upon the need to differentiate across eHealth skills in future research.

When controlled for other covariates, settlement type in itself does not influence the frequency of new media usage. Village inhabitants of a specific social stratum use the Internet with the same intensity than their fellow city-dwellers with a similar social background. Nor does gender in itself have impact upon the frequency of Internet usage. Nevertheless, as revealed by descriptive data, there are significantly less women among regular users in the active age-groups, which later, over 65, turns into its opposite. The reason of women's disadvantage is reflecting, most probably, the traditional gender role division of the Transylvanian Hungarian society, namely that care and household activities are predominantly done by women. In our region, women spend about three times more than men on doing household activities (INS 2013). The largest gender differences with respect to household and care activities appear in the age-groups of 25–44 and 45–64, exactly where the largest digital disadvantage of women is detected. In the European adult population, a gender gap was revealed for three eHealth skills. While women were less likely to know how to surf the Web for health information, they were more willing to report that they understand the terminology and know how to make use of the information found on the Internet (Vicente & Madden 2017).

To some extent, our results echo the findings of eHealth research in other countries, while, on the other hand, regional specificities are also being revealed. In the US, for instance, those with lower socio-economic status and older adults are less likely to engage in a number of eHealth activities compared to their

counterparts (Kontos et al. 2014). There, however, the gender gap in eHealth participation is unfavorable for men, whereas in our sample, by similar socio-economic conditions, no gender difference was assessed.

Conclusions

Traditional provider–patient healthcare is in some cases disentangled by modern info-communication solutions so that much time and energy can be saved both by doctor and patient with the use of these. However, in order for modern info-communication tools and, together with them, eHealth to become part of our everyday lives, population should own the skills and devices needed for their usage.

Within the eHealth reform process of the European Union, priority is given to the following patient-centered actions: to ensure the access of patients to health-related data stored electronically, receive consultation results in the shortest time to those concerned, and promote teleconsultation and electronic patient referral (Csákó 2015). All these priorities assume patients that are receptive to digital health services.

Our study aimed at identifying the receptivity to eHealth services within a specific population segment, that of Hungarians of Mureş County, Romania. We assessed the socio-demographic determinants of Internet users in order to approximate the groups of potential eHealth users in this population segment. According to a review of international studies, eHealth literacy is an attribute for relatively young and educated female populations (Cordoş et al. 2017). In our research, digital engagement was also typical of the young and educated; however – unlike in the recent eHealth literacy study on European adults –, no gender gap was revealed in this respect. Our results echo the recent European findings, according to which, on the whole, the most vulnerable groups with respect to eHealth literacy are the least educated and the eldest (Vicente & Madden 2017).

Enhancing eHealth could positively impact economy, labor market, and the quality of life in general. However, in implementing the reform, it is highly important that the population use info-communication tools and take advantage of it. Echoing the results of international surveys, our study clearly points out that Internet usage in our region strongly correlates with age and educational level: the younger and more educated a person, the more he/she takes advantage of info-communication tools. Social inequalities manifest themselves in digital inequalities, too.

Digital engagement of Transylvanian Hungarian adults differs across social groups. Providers of future eHealth services should acknowledge differential Internet usage in order to better address communication inequalities and health disparities.

References

Banciu, Doina, Alexandru, Adriana. 2009. *Innovative Research concerning eHealth Products and Services in Romania*. IEEE. DOI: 10.1109/WIRELESSVITAE.2009.5172425.

Calvillo, Jorge, Roman, Isabel, Roa, Laura. M. 2013. How Technology is Empowering Patients? A Literature Review. *Health Expectations* 18(5): 643–652.

COM. 2010a. *Europe 2020. A Strategy for Smart, Sustainable and Inclusive Growth*. Brussels: Commission of the European Communities.

2010b. *Digital Agenda for Europe*. Brussels: Commission of the European Communities.

2005. i2010: *A European Information Society for Growth and Employment*. Brussels: Commission of the European Communities.

Cordoş, Ariana-Anamaria, Bolboacă, Sorana D., Drugan, Cristina. 2017. Social Media Usage for Patients and Healthcare Consumers: A Literature Review *Publications 5*(2): 9.

Csákó, Beáta. 2015. E-health (E-egészségügy). *Infojegyzet* 62.

Farcaş, Dezideriu Dan. 2007. eHealth Strategy and Implementation Activities in Romania. Report in the framework of the eHealth ERA project. *eHealth ERA – Country Report Romania*.

Fromann, Richárd, Susánszky, Pál. 2014. Befolyásolják-e pszichológiai tényezők az Internethasználatot? *Magyar Coach Szemle* 3(1): 55–58.

Hesse, Bradford W., Nelson, David E., Kreps, Gary L, Croyle, Robert T., Arora, Neraj K., Rimer, Barbara K., Viswanath, Kasisomayajula. 2005. Trust and Sources of Health Information. The Impact of the Internet and Its Implications for Health Care Providers: Findings from the First Health Information National Trends Survey. *Archives of Internal Medicine* 165(22): 2618–2624.

Hou, Jiran, Shim, Minsun. 2010. The Role of Provider–Patient Communication and Trust in Online Sources in Internet Use for Health-Related Activities. *Journal of Health Communication* 15: 186–199.

Imbrişcă, Cosmin-Ionut, Neaţu, Alina-Maria. 2015. The Implementation of eHealth solutions. A Review of International Solutions and their Relevance for Romania. *International Journal for Economic Practices and Theories* 5(5): 487–494.

Kickbusch, Ilona, Pelikan, Jürgen M., Apfel, Franklin, Tsouros, Agis D. (eds.). 2013. *Health Literacy. The Solid Facts*. WHO Regional Office for Europe.

Kiss, Tamás, Barna, Gergő. 2013. *Erdélyi Magyar Fiatalok – Kutatásjelentés*. Cluj: Romanian Institute for Research on National Minorities.

Kleinbaum, David G., Kupper, Lawrence L., Nizam, Azhar, Muller, Keith E. 2007. *Applied Regression Analysis and Other Multivariable Methods*. Pacific Grove: Duxbury Press.

Kontos, Emily, Blake, Kelly D., Chou, Wen-Ying S., Prestin, Abby 2014. Predictors of eHealth Usage: Insights on The Digital Divide from the Health Information National Trends Survey 2012. *Journal of Medical Internet Research* 16(7): e172.

Lupton, Deborah. 2018. *Digital Health. Critical and Cross-Disciplinary Perspectives*. London: Routledge.

Márton, János. 2012. A médiafogyasztás és politikai aktivitás Erdélyben. In: V. Veress, A. Papp (eds.), *Politikai mintázatok. Erdélyi magyarok a Kárpát Panel vizsgálatai alapján*. Cluj: Romanian Institute for Research on National Minorities. 163–220.

Sitar-Tăut, Dan-Andrei, Sitar-Tăut, Adela V., Penciu, Oana-Maria, Mican, Daniel. 2011. Initiatives in the Romanian eHealth Landscape. *Informatica Economică* 15(2): 38–45.

Tapscott, Don. 2009. *Grown Up Digital: How the Net Generation Is Changing Your World*. McGraw Hill: New York-Chicago.

TFEU. 2012. Consolidated Versions of the Treaty on European Union and the Treaty on the Functioning of the European Union. *Official Journal* C 326/49.

Vicente, Maris R., Madden, Gary. 2017. Assessing eHealth Skills across Europeans. *Health Policy and Technology* 6(2): 161–168.

Zulman, Donna M., Kirch, Matthias, Zheng, Kai, An, Lawrence C. An. 2011. Trust in the Internet as a Health Resource among Older Adults: Analysis of Data from a Nationally Representative Survey. *Journal of Medical Internet Research* 13(1): e19.

Electronic resources

INS. 2013. http://www.insse.ro/cms/files/statistici/comunicate/com.../util.../utilizarea_timpului_r13.pdf

INS. 2015. Press release no 295/25.11.2015. http://www.insse.ro/cms/files/statistici/comunicate/com_anuale/tic/a15/tic_r2015.pdf

ACTA UNIV. SAPIENTIAE, SOCIAL ANALYSIS, **8** (2018) 55–74

DOI: 10.2478/aussoc-2018-0004

Health Education – Responsibility – Changing Attitude. A New Pedagogical and Methodological Concept of Peer Education

Helga Judit FEITH
Semmelweis University, Budapest, Hungary
feith@se-etk.hu

Ágnes LUKÁCS J.
Semmelweis University, Budapest, Hungary
lukacs.agnes@se-etk.hu

Edina GRADVOHL
Semmelweis University, Budapest, Hungary
gradvohle@se-etk.hu

Rita FÜZI
Department of Public Health, Government Office of the Capital City Budapest, Hungary
fuzi.rita@kmr.antsz.hu

Sarolta MÉSZÁROSNÉ DARVAY
Eötvös Lóránd University, Budapest, Hungary
darvay.sarolta@tok.elte.hu

Ilona BIHARINÉ KREKÓ
Eötvös Lóránd University, Budapest, Hungary
ikreko@gmail.com

András FALUS
Semmelweis University, EDUVITAL Foundation, Budapest, Hungary
falus.andras@med.semmelweis-univ.hu

Abstract. Health-related attitudes can be modified and supported most effectively at young ages. Young generations require more interpersonal and interactive pedagogical methods in programs engaged in health promotion, as well. The aim of the authors was to get an insight into a relatively novel pedagogical method, called peer education. This multilateral activity is focusing the procedure on attitudes, experience, and motivation of youngsters in connection with health promotion programs and community service work. In this article, the authors describe 1) the theory, origin, and principal influences of peer education compared to traditional teaching methods and 2) the new, efficiency-oriented and science-based methodology of health education program.

Keywords: peer education, health promotion, pedagogical method, measuring the effectiveness of health promotion program

Introduction

After more than 25 years of the transition, the health conditions of post-Soviet countries are still alarming. Among the East-Central European countries, Hungary's data on life expectancy, mortality, and morbidity is even worse (Bálint & Kovács 2015, Kovács & Tóth 2015). Besides the poor health conditions, health expenditure is low (i.e. 7%, OECD 2015) and effective health development programs are sporadically accessible. For this very reason, preventive and powerful health education initiatives are strikingly needed. Peer education could be one of the most potential and cost-effective health development methods improving the quality of health both at societal level and in a smaller social environment.

An increased need for effective health education programs was found by one of our former quantitative surveys among secondary school students (N=898) between the ages of 14 and 17 in 2015 (Feith et al. 2016). On the one hand, this study aimed to gain an insight into the attitudes and experience of youngsters in connection with health promotion programs. On the other, it wanted to examine the motivation and experience towards compulsory community service work.[1] Finally, its goal was to become acquainted with students' opinion about the special methodology of the planned health promotion program (authentic knowledge transfer, creativity, practice-oriented, multilateral interactions between younger generations).

According to the experience of 44.7% of the students, health promotion and prevention programs were not interactive at all (it was evaluated as simply boring), and there were no group tasks and games. 64.3% of them said that most of the programs were merely lectures; however, 71.1% claimed that these health and prevention programs still make sense. The majority of the participants would also support that a similar age-group could hold the health promotion and prevention programs for them. Most of them are interested in participating in programs through the community service work, where they would deal with younger children – preferably with kindergartners (52.7%) and with primary school students (47.9%) – with the help of university students, and interestingly, only every fifth person was clearly dismissive.

1 It is compulsory for secondary school students because it is needed for the secondary school graduation. Secondary school students must account for doing 50 hours of community service work. Many people identify community service work with voluntary work, whereas there is a difference between the two concepts in terms of motivation and internal impulse. Volunteering comes from a person's free will and internal motivation, while community service is compulsory and pedagogically initiated. Therefore, community service could hardly be regarded as a classic case of voluntary work because it is not an activity without interest but a criterion for secondary school graduation. Free choice, which is the basis of volunteering, is only realized in the act of choosing the activity in community service work. Both activities serve a common purpose and in both cases the goal is to strengthen sensitization and community commitment and support the participants in taking responsibility.

The reason why students would take part in this program was mostly the possibility of passing over useful knowledge with creative activities to the younger children. The rejection of participation was mostly due to the indiscipline of younger children and the inexperience in and the fear of responsibility. Furthermore, community service work would provide a good framework for organizing contemporary health care and prevention programs, as 82.8% of the participants thought when asked about compulsory community service work that "to help" is good. Therefore, building on this attitude of theirs is an additional opportunity to motivate them (Feith et al. 2016).

Our educational and research program is based on this preliminary study. This paper aims to provide a short literature review of peer education with a focus on its pros and cons and to present the methodology of a new health promotion concept.

Peer education

In the past fifty years, peer education has become a very popular pedagogical tool, especially in the field of health education; however, the term itself covers heterogeneous approaches and implementations. In the scientific literature, there is a lack of definitional clarity at least in three aspects: the notion of "peer", the aims and the methods being applied, and the form of "peer involvement" (Milburn 1995, Shiner 1999).

The term "peer" is primarily used with reference to adolescents or youth, and most of the existing programs are realized among this age-group. Although age could be one of the most important elements of defining peer, peer education reaches a wider audience. There are numerous initiatives among disadvantaged groups such as sex workers, LGBT persons, or patients suffering from the very same disease. To summarize, peer could be defined as members from the same social group such as age, ethnicity, gender, regular income, social status, or subcultural membership (Gould & Lomax 1993, Svenson et al. 1998, Shiner 1999, Turner & Shepherd 1999, Parkin & McKeganey 2000). Shared cultural background between peer educators and their target group has a significant influence on the effectiveness of peer education (Milburn 1995). Also, some of the studies suggest that in the case of adolescents peer educators should be 2–3 years older than their peers and underline that supervision is a crucial element for peer educators (Damon 1984, Adamchak 2006).

The scale of the applied methods in peer education is broad. It ranges from formal tutoring in a school to a very informal group discussion or a one-to-one counseling. Both the topic and the target group differentiate the methodology; nevertheless, the objective of peer education is always sharing information,

values, or attitudes related to a special subject (Gould & Lomax 1993, Sloane & Zimmer 1993, Shiner 1999, Turner & Shepherd 1999).

The role of peer educators also varies considerably in the process of peer education. According to Shiner (1999), there are two key dimensions at the level of involving peers: "peer delivery" refers to the amount of formal sessions delivered by the peer workers, while "peer development" refers to the extent to which the program focuses on peer educators' personal development. In the case of marginalized or disadvantaged groups, peer development should be highlighted, while peer delivery could be emphasized among peer educators with professional orientation (Shiner 1999).

Summarizing the different approaches, peer education could be defined as a process carried out within members of the same social group, with the purpose of educating each other by sharing information and attitudes in connection with a certain issue (Gould & Lomax 1993, Svenson et al. 1998, Shiner 1999, Turner & Shepherd 1999, Parkin & McKeganey 2000).

The rise of peer education

There have been many peer education initiatives in the course of the history. According to some authors, peer education can be traced back to the ancient times, to Aristotle and to Sparta (Wagner 1982, Turner & Shepherd 1999). The first relevant case of peer education about health issues was organized to prevent the Asian flu epidemic at the University of Nebraska, Lincoln in 1957 (Helm et al. 1972, Sloane & Zimmer 1993, Turner & Shepherd 1999). From the 1970s, as the perception of health-related issues changed by emphasizing the importance of lifestyle patterns and individual responsibility, the popularity of peer education has considerably increased. Several peer education programs have been initiated in the college campuses in the US (Sloane & Zimmer 1993). In the 1970s and 1980s, peer education projects focused on risk behavior such as smoking and substance misuse. In the past three decades, sexual education has become more significant in preventing sexually transmitted diseases, especially HIV (Gould 1993, Sloane & Zimmer 1993, Turner & Shepherd 1999, Parkin & McKeganey 2000).

Following the western countries, peer education became more prevalent in developing countries as well. Nowadays, most of the publications on peer education are about programs in African countries. In the case of developing countries, where the healthcare systems are less advanced, peer education can be a sufficient way of health education (Hart 1998, Parkin & McKeganey 2000).

The theory of peer education

It must be noted that in the case of peer education practice preceded theory. The process and virtue of peer education cannot be explained by a single theory although each of the connected approaches provides important elements for understanding it.

Damon (1984, 1989) summarized the theories of developmental psychology connected to peer tutoring, peer collaboration, and cooperative learning. Piaget (1965) highlights the socio-cognitive conflicts generated in peer discourse, Vygotsky (1978) spotlights the internalization of intellectual processes, and Sullivan (1953) emphasizes the co-construction of new ideas in the process of peer education (Damon 1984, 1989). In their review, Milburn (1995) and Turner and Shepherd (1999) draw attention to six theories altogether which are related to peer education.

One of the most-cited theories related to peer education is Bandura's Social Learning Theory. This psychological theory states that role modelling is the key element of peer education. The target group observes the behavior of peer educators and adopts it. The influence depends on role model credibility, which is strongly connected to peer educators' prestige in the group. Reinforcement is also an important component of the theory. Since peer educators spend more time and have more contacts with their peer group, the patterns of behavior can be reinforced (Bandura 1977, Kelly et al. 1991, Klein et al. 1994, Milburn 1995, Turner & Shepherd 1999).

Sarbin and Allen's (1968) theory stresses the importance of social roles and role expectations. According to Role Theory, peer educators conform to the expectations of the tutors, and, similarly, members of the target group will behave appropriately. This concept underlines similar cultural factors as important determinants of the success of peer education (Sarbin & Allen 1968, Turner & Shepherd 1999).

The most popular sociological theory describing peer education is the Differential Association Theory, which highlights the importance of social environment. According to Sutherland and Cressy's (1960) concept, individuals acquire all the habits in social situations. Although the theory was originally applied for crime and the transfer of bad habits, it assumes that good behavior could be learned through social relations, as well. It is important to emphasize that adapting habits works only in the case of a close network since individuals learn behaviors from people who are important and reliable for them. For that very reason, the relationship between peer educators and the target group determines the effectiveness of the process (Sutherland & Cressy 1960, Milburn 1995, Turner & Shepherd 1999).

Cohen (1955) emphasizes the integration of a cultural dimension to the Differential Association Theory. There are numerous subcultures in a society

which expect special norms, values, and behaviors from their members. The Subcultural Theory may provide important aspects in the case of peer education for special target groups (Cohen 1955, Turner & Shepherd 1999).

The Social Inoculation Theory also spotlights social factors in explaining the process of peer education. According to McGuire (1968), peer pressure is crucial in forming adolescents' behavior even if it could work both as a positive and a negative influence (McGuire 1968, Turner & Shepherd 1999).

The Communication of Innovation Theory (Rogers & Shoemaker 1971) or Diffusion of Innovation Theory (Rogers 1983) provides important aspects for peer education practice, as well. The rate of adopting innovations (or the content of a peer education project) in a community depends on many factors. Innovation spreads with a great efficacy when the source's and the receiver's attributes are similar. On the one hand, change agents or opinion leaders (or peer educators) should be similar to the target group; on the other hand, they should own a higher but not too superior status (Rogers & Shoemaker 1971, Rogers 1983, Turner & Shepherd 1999).

Pros and cons of peer education

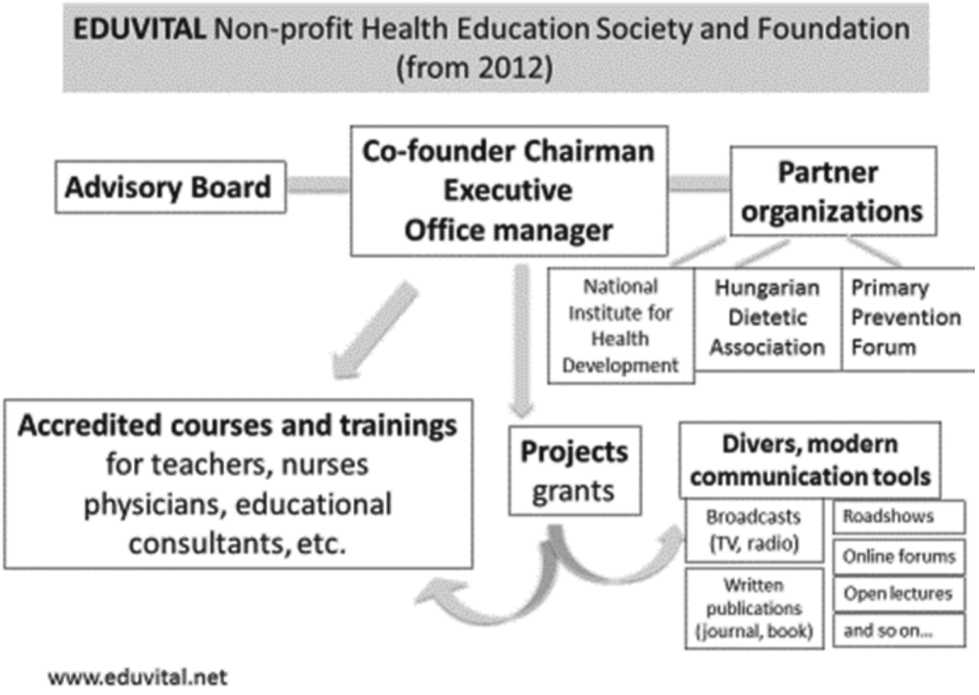
The popularity of peer education projects is based on its numerous advantages. First of all, according to the above-cited theories, the effectiveness of peer education can be explained by several psychological and sociological theories (Sloane & Zimmer 1993, Milburn 1995, Turner & Shepherd 1999). In addition, the methodology is beneficial for peer educators as well in the sense of prosocial behavior, self-esteem, and empowerment (Klein et al. 1994, Milburn 1995, Sawyer et al. 1997, Turner & Shepherd 1999, Parkin & McKeganey 2000). Peer education provides access to hardly reached populations, too (Turner & Shepherd 1999). Last but not least, peer education is considered a cost-saving method, especially in the field of health development (Sloane & Zimmer 1993, Milburn 1995, Hart 1998, Parkin & McKeganey 2000, Price 2009).

Even so, peer education has some weak points, as well. There are still definitional uncertainties about peer education, not just in terms of the applied methodologies but also in the interpretation of peer (Milburn 1995, Shiner 1999). The wide variations of peer education initiatives make the comparison of these programs almost impossible (Lindsey 1997, Shiner 1999, Mellanby et al. 2000). Furthermore, the real effectiveness of peer education projects is rarely measured in a valid and reliable way (Parkin & McKeganey 2000, Harden et al. 2001, Tolli 2012, Southgate & Aggleton 2016). Another concern what peer education programs face is controlling the motivation of peer educators though motives have a great influence on the process (Klein et al. 1994, Milburn 1995).

The EDUVITAL NET and the STAnD Program

The EDUVITAL Non-Profit Health Education Society (EDUVITAL NET, www.eduvital.net) was founded in 2012 with the aim to popularize modern and comprehensive knowledge on conscious lifestyle and healthy living. Therefore, the popularization of the so-called 4P strategy of systems medicine (preventive, predictive, personalized, and participatory medicine) aims at raising people's interest in modern harmonious lifestyle.

As shown in *Graph 1*, EDUVITAL NET is characterized by constructive cooperation and the teamwork of professionals.



Graph 1. *Operative structure of EDUVITAL Non-Profit Health Education Society (www.eduvital.net)*

With a multidisciplinary professional background, EDUVITAL NET provides complex, comprehensive, and reliable information on modern basic (epi)genetics, environmental awareness, nutrition, culture of movement, including the most important questions of school health, mental health, psychosomatic disorders, and healthy aging.

The health education program is primarily recommended to dedicated opinion formers who can influence the largest part of the society in their

everyday practice, such as pre-school and school teachers, school psychologists, healthcare professionals (e.g. family doctors, nurses, sociologists, social workers), representatives of non-governmental (minority and patient) organizations, to whom EDUVITAL NET offers modern, useful, and practical knowledge. A wide variety of materials is formulated to reach various age-groups from kindergarten age to early adulthood (3–20 years of age).

Moreover, one of the major aims of EDUVITAL is to work out and to adapt educational programs and pedagogical, teaching methods approved so far in other countries. The primary goal of the present activity is to harmonize the so-called "peer education model" (see later in details) with the more traditional frontal teaching models and renew them by the implementation and dissemination of more effective pedagogical solutions. In line with the international scientific trends and the grant announcement of the Hungarian Academy of Sciences, we felt motivated to prompt the project proposal of EDUVITAL NET.

The primary purpose of the STAnD Program (Study, Teach, Understand)[2] is supported by the EDUVITAL NET network. The primary aim of this program is to teach children attending kindergarten, primary and secondary school how to lead a healthy lifestyle and develop a health-conscious behavior with the help of a new methodology. Besides, in the long term, the program prepares the national and international introduction of this new pedagogical methodology. The most important aim of this conception is to involve the older generation of students into educating and shaping the attitudes of the younger ones, a process which is professionally tutored.

According to our view, which is underlined by theoretical concepts, international surveys, and implemented pedagogical practices (Sloane & Zimmer 1993, Turner & Shepherd 1999, Harden et al. 2001, Tolli 2012, Feith et al. 2016):

– in younger age-groups, children who are a few years older could become attractive personal "models" to follow for the younger ones (Damon 1984, Adamchak 2006);

– in health development work – beyond the openly apparent health-educational intention –, it is very important that a non-conscious, so-called latent impact also exists, in the case of which the responsibility of a person transferring the knowledge provides a leading behavioral pattern (Sutherland & Cressy 1960, Sarbin & Allen 1968, Bandura 1977, Klein et al. 1994).

The STAnD Program builds up its know-how of knowledge transfer in health science topics along a specific line of logic and methodology. The primary aim of the program is not only knowledge transfer but internalizing the knowledge and making it appear in a way that it could become exemplary, teachable, and likeable at the same time for youngsters. In line with this, the program pays special

2 The Hungarian version of this program is the "TANTUdSZ", the word is an acronym, which includes the beginning of the following words, in Hungarian: Study, Teach, Understand.

attention to the social-cultural factors characteristic of the target population, which precisely outline the necessary education and teaching methodology, a wise selection of which fundamentally determines the efficacy of teaching (Cohen 1955, Milburn 1995). In other words, modern and well-chosen prevention topics based on healthcare are insufficient by themselves; it is indispensable to complete them with the suitable pedagogical methodology, communicational technology and strategy as well as action plan. Thus, in order to realize an efficient health promotion – a health-education prevention program in addition to healthcare professionals –, we need experts who are professionals in practical pedagogical methodology and innovative education techniques and teaching methods.

The goals of the program are the following:

– to shape the lifestyle and health behavior of young people with the help of special educational methods that are suitable for their age, enjoyable and acceptable for them, and lack the overwhelming theoretical presentations with lower efficiency;

– to form an interaction between age-groups in public and higher education institutions and to strengthen the responsibility that older ones feel towards their smaller peers;

– to ensure real regional practice for senior students at higher education institutions in healthcare and pedagogy with the aim of building bridges between present and future healthcare professionals and those working in education both presently and in the future;

– to make a lively conversation and interactive cooperation between various higher education institutions of healthcare and teacher training;

– to create a socially useful opportunity in community service work needed for secondary school graduation for secondary school students in grades 9–11, which is valuable both from a health prevention and a pedagogical point of view;

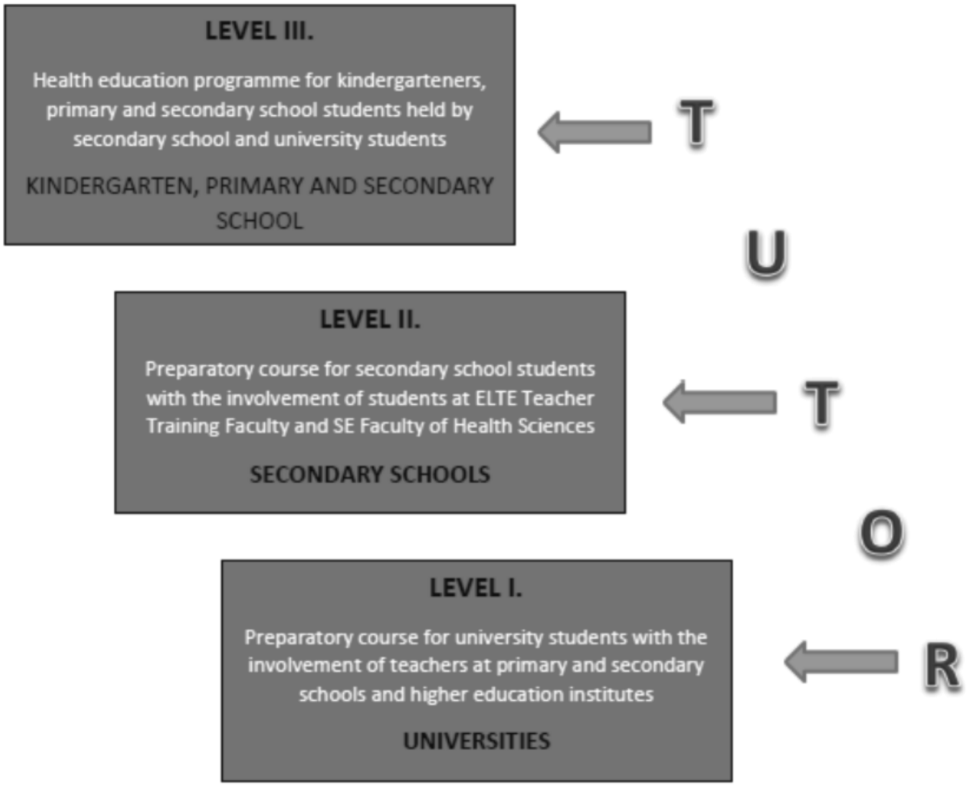
– to initiate and work out creative, innovative, and age-specific health education techniques and methodological recommendations as a result of the program;

– to make an impact assessment in connection with the efficiency of the program based on validated tests.

The STAnD Program can be divided into two branches: 1) an intensive higher education program for university students by teachers of health and pedagogy sciences (preparatory course) and 2) a health education program for children and young adults (aged 3–20 years) by students and peer educators under the supervision of tutors (peer education program).

The recruited students of the preparatory course are trained in up-to-date health, developmental psychology, and pedagogical knowledge, together with communication, conflict management, and project management skills. Two universities – one in the field of medicine and health sciences and one in the field of pedagogical sciences – may ideally organize an elective course.

The approaches to teaching can be categorized into teacher-centered and student-centered models. In the teacher-centered model, the teacher has a primary role, and the students (more or less) passively receive information via lectures. In this teaching method, student learning is measured by objectively scored tests and assessments. In the student-centered model, the teachers and students mutually have an active role, and the teacher only coaches and facilitates student learning. Formal and informal forms of assessment (e.g. projects, student portfolios, student presentation) measure the overall comprehension and acquisition of the material (Wright 2011).



Graph 2. *The structure of the STAnD program (Feith et al. 2015)*

We do not prefer teacher-centered methods in health education programs; so, our preparatory course applies active learning as a teaching method to involve students more directly in the learning process. We do support the priority of active learning, which is why we require the active participation of each student at all levels of the program. However, some students as well as teachers find it difficult to adapt to this learning and teaching technique because of their previous routine learning/teaching experience.

Students and peer educators who work together in teams with tutorial support are responsible to implement all interventions. The optimal team size is 4–6 higher education students (from institutions of teacher training and health sciences) with 2–3 secondary school students. Students and peer educators are permanently supported by tutors from universities, and they are expected to continue their work with formal tutorial support. They are unpaid volunteers, but they receive education credits for taking part in the teaching program.

Our peer education programs are based on different target education levels: kindergarten (3–6 years), elementary school (7–14 years), and secondary school (15–20 years).

The complex health education program is made up of three levels that are interdependently based on each other (*Graph 2*).

Level I

Level I is the preparatory phase, which is an extra training in healthcare and teacher-training higher education institutions, a practice-oriented course shared by the institutions, and it is organized for senior students. The basic goal of this training is to prepare the students in the program to be able to help secondary school students to conduct playful health education programs in the chosen health prevention topic (e.g. hand hygiene, fluid consumption, doing exercises) with constant professional support and supervision (e.g. school nurse and/or university or secondary school teacher). Students can also get mutual insight into the fields of one another beyond the practical knowledge suitable for their chosen future profession: teacher-training students into healthcare and healthcare students into pedagogical methodological studies.

The elective subject is not based on conveying theoretical knowledge that prefers frontal education methodology, but instead it builds on project-based education with a special methodology. In addition to innovative educational methods and cooperative learning techniques, the students' own ideas and proactive suggestion for realization receive special attention. We use a diverse range of active learning activities in our preparatory course: class discussion, demonstration, think-pair-share activity, collaborative learning group, student debate, small-group discussion, class game, technology-based learning (e.g. kahoot learning game), gallery walk, student presentations (e.g. pecha kucha presentations), and the project method.

In the STAnD Program, the process of working collaboratively happens in the teams of students and peer educators – so, making teams is a crucial point of our program. The members of the team have to cooperate, work together, and manage any possible conflicts between one another or the children they work with. Therefore, the initial course intends to build and develop successful

work teams with various group-building activities (e.g. icebreaker games) and special group-building project tasks, and it focuses on the competence, roles, and responsibilities of team members, the clear goals of the program, and the expectations on the part of the executive leadership.

The program gives an opportunity for students in higher education to gain a large number of ECTS[3] and professional practice in connection with their future work, under constant professional control.

Level II

The next level of the STAnD Program is the preparatory training in health prevention for secondary school students. Only those university students who have successfully finished the training of the preparation level can moderate this. It is necessary to have a multidisciplinary team consisting of healthcare students knowledgeable in the given health education topic and teacher training students who understand the educational methodology compatible with the team's health education goals and objectives. The program is run by constant professional tutorial support, in the presence of a so-called tutor. The aim of the preparatory course is to enable secondary school students to organize playful and creative programs for kindergarteners and primary school students together with the university students present in the health prevention topics determined collectively and accepted formerly.

Although the preparation for project work appears as the basic purpose, the program provides a fair opportunity for secondary school students to strengthen their theoretical knowledge connected to the topic of health prevention or make up for the lack of it (through the means of free conversation).

Participation in the preparatory training can be taken into account when considering the students' community service work, but it is also possible to finish all the compulsory lessons inside the framework of one program. Taking part in this program also enhances creativity, teamwork, and responsibility towards the younger ones.

Level III

Secondary school and university students organize playful age-specific health education programs that are based on a creative methodology in kindergartens and primary and secondary schools, under close professional supervision. The most important is that all three age-groups take part in this active prevention program planned and conducted by students.

3 European Credit Transfer and Accumulation System

As we have emphasized previously, the STAnD Program uses active learning as a teaching method, so the kindergarten- and school-based prevention programs are carried out by sportive, creative, and age-specific teaching methods. The activities help to show the fun side of learning, and so the most common activities are games. Furthermore, the use of simple science experiments is also a great way to introduce the importance of positive health behaviors to children and youngsters. Also, creative representations (e.g. recognizing objects with sense organs, drawing and painting, making models), drama activities, literature (e.g. listening or writing stories, poems about health issues), music (e.g. movement for music, singing songs), and classifications (e.g. exploring healthy and unhealthy habits, describing the characteristics of things) are used as teaching techniques.

The younger ones could freely ask any questions throughout the project work, and thus they could learn from the older students in an entertaining way that does not happen in the conventional educational framework. Since the older ones could appear as examples to follow for the smaller children, we suppose that this program could reach a positive effect, which could be beneficial for both younger and older age-groups.

The research methodology of the STAnD conception

As we have mentioned above, the effectiveness of peer education programs has not been evaluated systematically in a valid and reliable way in most programs (Parkin & McKeganey 2000, Tolli 2012, Southgate & Aggleton 2016).

The STAnD program intends to measure the expectations and satisfactions of students, peer educators, and tutors as well as the effectiveness of the training programs and the impact of the health promotion interventions. Due to the low number of previous scientific measurements and the difficulties of evidence-based health promotion programs, developing reliable and valid measurement instruments is a complicated and complex challenge in this field. In addition, difficulties are liable to occur in the measure system as well due to the wide range of the age-groups and the diverse socioeconomic statuses of the target groups.

Research methods and measurements across the STAnD vary by aims and target population. In the STAnD program, we use mixed research methods: a combination of quantitative research (structured questionnaires with closed-ended and some open-ended questions with comparative and non-comparative scaling techniques) and qualitative research methods (focus groups). The system of the quantitative research is presented in *Table 1*.

Table 1. *Types and dimensions of questionnaires in the STAnD health education program*

	EVALUATION OF…									
	…the demographic characteristics	…the motivation	… the future plans (career and family)	… the evaluation of the training program	…the attitude regarding health education	… the attitude regarding peer education	… the STAnD program	… the knowledge of prevention topics	… the attitudes	… the health behavior
Questionnaires of students										
– input	X	X	X		X	X			X	
– evaluation of training programs				X						
– output						X	X		X	
Questionnaires of tutors				X			X			
Questionnaires of school teachers					X	X	X			
Questionnaires of peer educators										
– input	X	X	X		X	X			X	
– output						X	X		X	
Questionnaires of target population										
– before intervention	X							X	X	X
– after intervention							X	X	X	X
– intervention in 4 months								X	X	X
Questionnaires of control groups										
– input	X							X	X	X
– after intervention in 4 months							X	X	X	X
Questionnaires of target population parents	X				X	X			X	X

The STAnD research measures: 1) to what extent our program has been implemented as planned, by measuring participants' satisfaction and quality assurance (process evaluation); 2) the immediate short-term effects and reach of our health education program (impact evaluation); and 3) long-term effects as to whether our program has achieved its goals (outcome evaluation).

Process evaluation

Before the STAnD program, the students and peer educators are asked about their previous peer education experience, their expectations and plans about the health education program, their attitudes and beliefs regarding the peer education method, and their motivation factors to join the course, by an anonym electronic questionnaire with the help of a free online survey software. Questions

also include demographic characteristics of the respondents and items related to the chosen profession, future career, and family plans.

Training and supervision of students and peer educators is an important factor in intervention effectiveness. Therefore, over the intensive higher education training, we measure the participants' (students' and tutors') satisfaction by anonym paper-based questionnaires lesson by lesson. Respondents are asked to evaluate different statements about the quality and effectiveness of the training program on a five-point Likert scale (strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree). Statements measure 1) to what degree participants react favorably/unfavorably to the training (useful, valuable topics; quality of training organization; recommendation of the course; etc.) and 2) to what degree participants acquire the intended knowledge, attitudes, skills, and confidence. After respondents have completed the questionnaire, each statement is analyzed separately per educational day and collectively (as a continuous progression of the training from the first lesson to the last one).

Following the STAnD program, the students and peer educators evaluate 1) what they learned during the training and the health education program and 2) which outcomes are the most directly linked to the training program (e.g. increased engagement with peer education and/or the level of knowledge; a lot of useful experience, information for the future profession). We also measure the significant changes in the students' and peer educators' attitudes and beliefs regarding the peer education method. Structured questionnaire and focus groups are used as research methods.

Impact evaluation

The immediate short-term effects and changes of the STAnD program can be detected with the help of questionnaires among the target population (3–20 years of age). Our questionnaires focus on the changes in the level of knowledge, health behavior, and attitude before and after the health education interventions in four different prevention topics: exercise and physical activity, healthy eating, mental health, and hygiene. We make experimental groups and control groups in every educational stage (from early childhood education to secondary education) to measure the effectiveness of preventive interventions. We pre-test the members of experimental and control groups prior to the intervention. Next, we manipulate the independent variables by using 4- or 8-lesson peer education programs in the experimental groups and not using any new teaching techniques for the control groups. After the intervention, we test again the members of experimental and control groups to compare the effectiveness of preventive interventions between the groups by sex, socioeconomic status, educational stage, prevention topic, and length of intervention.

Furthermore, since the educational program and the learning process are recorded by both the students and peers of the STAnD program, we are able to compare the effectiveness of the interventions in the different pedagogical methods.

In addition, the effectiveness of the STAnD program is also measured by the parent respondents via an anonym electronic questionnaire.

Teachers evaluate the quality of the program, but we also test their attitudes and beliefs about peer education programs.

In our questionnaires of the target population, we use some items of various validated (HBSC, WHO 2002; PISA, OECD 2015; EHIS 2014) and non-validated surveys (HHP Hungary 2015, HCS Hungary 2015) which we have filled in with our own questions and response scales. One of our important goals for the future is to validate our items.

Questions include demographic characteristics, self-perceived health status, health behavior, items related to the level of knowledge, health behavior, and attitude in the above-mentioned prevention topics, and the level of satisfaction with the STAnD program. Focus groups are also used as a qualitative research method at the primary and secondary educational stages among the child participants of the health education program.

Outcome evaluation

Our program also examines the long-term effects of the STAnD program – so, the members of the experimental and control groups are re-tested in four months. The aim of this survey is to detect whether the health education program has achieved its goals. We use the same items of questionnaires (without measuring the program satisfaction) to compare the results of the different times.

Conclusions

Modern and innovative health education is a complex pedagogical challenge as it involves numerous scientific fields (biology, health pedagogy, psychology, health sociology, information technology, etc.).

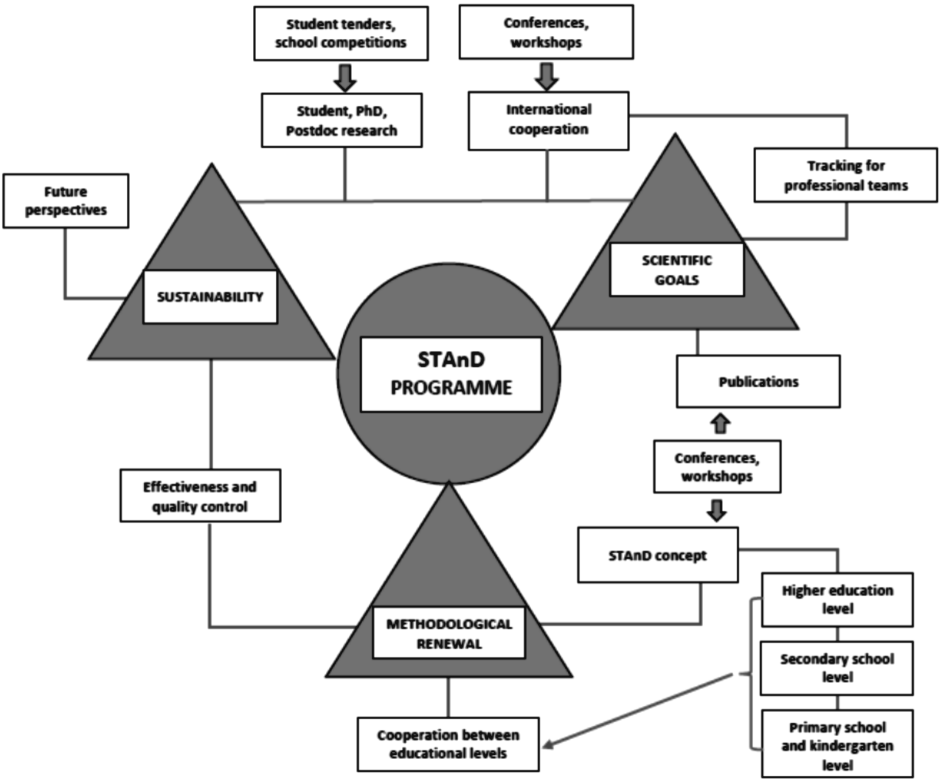
The primary goal of MTA-SE Health Promotion by Peer Education Research Group is to increase health consciousness and the sense of responsibility among the youth, to enhance the efficacy of school health programs with the detailed elaboration and launch of a new pedagogical methodology, the STAnD program, in Hungary and Romania (in Transylvania).

Our methodological conception is based on scientific evidence (Evidence-Based Education, EBE). The main point of our pedagogical approach is to involve

students and peer educators in children's and youngsters' (3–20 years of age) health education within the frame of a professional tutorial system.

The young educator participants can develop many skills upon the successful completion of the STAnD program. These are defined in terms of learning outcomes: cognitive skills (critical, reflective, creative thinking, etc.), methodological skills (time management, problem solving, decision making, education program planning and implementation, digital skills, etc.), and social skills (cooperation with peers and tutors, interpersonal communication with peers and younger children, teamwork, conflict management and negotiation, etc.).

The multidisciplinary STAnD is a really complex program, as shown by *Graph 3*. Sustainability, academic aims, and pedagogical reform of health education programs are the most important keywords.



Graph 3. *Highlighted targets and connections in the STAnD Program*

We believe that our health education program with the new efficiency-oriented and science-based methodology will contribute to raise health awareness, to provide better knowledge, and to alter the attitudes of younger generations.

References

Adamchak, Susan E. 2006. Youth Peer Education in Reproductive Health and HIV/AIDS: Progress, Process, and Programming for the Future. Family Health International, YouthNet Program, *Youth Issues Paper* 7.

Bálint, Lajos, Kovács, Katalin. 2015. Mortality. In: J. Monostori, P. Őri, Zs. Spéder (eds.), *Demographic Portrait of Hungary 2015.* Budapest: Hungarian Demographic Research Institute. 75–94.

Bandura, Albert. 1977. *Social Learning Theory*. NJ: Prentice-Hall: Englewood Cliffs.

Cohen, Albert K. 1955. *Delinquent Boys: The Culture of the Gang*. New York: Free Press.

Damon, William. 1984. Peer Education: The Untapped Potential. *Journal of Applied Developmental Psychology* 5: 331–343.

Damon, William. 1989. Critical Distinctions among Three Approaches to Peer Education. *International Journal of Education Research* 13: 9–19.

Feith, Helga J. et al. 2016. Tapasztalatok és motiváltság: magyar középiskolások véleménye az egészségvédő programokról. *Orvosi Hetilap* 157(2): 65–69.

Feith, Helga J., Melicher, Dóra, Falus, András. 2015. Utószó helyett a TANTUdSZ programról. In: Falus, A., Melicher D. (eds.), *Sokszínű egészségtudatosság. Értsd, csináld, szeresd!* Budapest: SpringMed Kiadó.

Gould, Jeffrey M., Lomax, Anne R. 1993. The Evolution of Peer Education: Where Do We Go from Here? *Journal of American College Health* 41(6): 235–240.

Harden, Angela, Oakley, Ann, Oliver, Sandy. 2001. Peer-Delivered Health Promotion for Young People: A Systematic Review of Different Study Designs. *Health Education Journal* 60 (4): 339–353.

Hart, Graham J. 1998. Peer Education and Community Based HIV Intervention for Homosexual Men: Peer Led, Evidence Based or Fashion Driven? *Sexually Transmitted Infection* 74: 87–94.

Helm, Carol J., Knipmeyer, Celeste, Martin, Mary R. 1972. Health Aides: Student Involvement in a University Health Center Program. *Journal of American College Health Association* 20: 246–251.

Kelly, Jeffrey. A. et al.1991. HIV Risk Behaviour Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis. *American Journal of Public Health* 81: 186–171.

Klein, Nicole Aydt, Sondag, K. Ann, Drolet, Judy C. 1994. Understanding Volunteer Peer Health Educators' Motivations: Applying Social Learning Theory. *Journal of American College Health* 43(3): 126–130.

Kovács, Katalin, Tóth, Gergely. 2015. Health Status. In: J. Monostori, P. Őri, Zs. Spéder (eds.), *Demographic Portrait of Hungary 2015.* Budapest: Hungarian Demographic Research Institute. 95–114.

Lindsey, Billie J. 1997. Peer Education: A Viewpoint and Critique. *Journal of American College Health* 45(4): 187–189.

Mellanby, Alex R., Rees, John B., Tripp, H. John. 2000. Peer-Led and Adult-Led School Health Education: A Critical Review of Available Comparative Research. *Health Education and Research* 15(5): 533–545.

Milburn, Kathryn. 1995. A Critical Review of Peer Education with Young People with Special Reference to Sexual Health. *Health Education Research* 10(4): 407–420.

McGuire, William. J. 1968. The Nature of Attitudes and Attitude Change. In: G. Lindzey, E. Aronson (eds.), *Handbook of Social Psychology*. Vol. 1. New York: Addison-Wesley, Reading. 136–314.

OECD 2015. Statistics on Health Expenditure and Financing. (http://stats.oecd.org/Index.aspx?DataSetCode=SHA – last visit on April 20, 2017).

Parkin, Steve, McKeganey, Neil. 2000. The Rise and Rise of Peer Education Approaches. *Drugs, Education Prevention and Policy* 7(3): 293–310.

Piaget, Jean. 1965. *The Moral Judgment of the Child.* New York: Free Press.

Rogers, Everett. M. 1983. *Diffusion of Innovations*. 3rd ed. New York: Free Press.

Sarbin, Theodore R., Allen, Vernon L. 1968. Role Theory. In: G. Lindzey, E. Aronson (eds.), *Handbook of Social Psychology*. Vol. 1. New York: Addison-Wesley, Reading. 488–567.

Sawyer, Robin G., Pinciaro, Paul, Bedwell, Diane. 1997. How Peer Education Changed Peer Sexuality Educators' Self-Esteem, Personal Development, and Sexual Behaviour. *Journal of American College Health* 45: 211–217.

Shiner, Michael. 1999. Defining Peer Education. *Journal of Adolescence* 22: 555–566.

Sloane, Beverlie Conant, Zimmer, Christine G. 1993. The Power of Peer Health Education. *Journal of American College Health* 41(6): 241–245.

Southgate, Eric, Aggleton, Peter. 2016. Peer Education: From Enduring Problematics to Pedagogical Potential. *Health Education Journal* 76(1): 1–12.

Sullivan, Harry S. 1953. *The Interpersonal Theory of Psychiatry*. New York: Norton.

Sutherland, Edwin Hardin, Cressy, Donald Ray. 1960. *Principles of Criminology.* Philadelphia: Lippincott.

Svenson, Gary R. 1998. *European Guidelines for Youth AIDS Peer Education.* Lund: Department of Community Medicine, Lund University.

Tolli, Marina V. 2012. Effectiveness of Peer Education Interventions for HIV Prevention, Adolescent Pregnancy Prevention and Sexual Health Promotion for Young People: A Systematic Review of European Studies. *Health Education Research* 27(5): 904–913.

Turner, Gillian, Shepherd, Jonathan. 1999. A Method in Search of a Theory: Peer Education and Health Promotion. *Health Education Research* 14(2): 235–247.

Vygotsky, Lev. S. 1978. *Mind in Society.* Cambridge: Harvard University Press.
Wagner, Lilya. 1982. *Peer Teaching: Historical Perspectives*. Westport, CT: Greenwood Press.
Wright, Gloria Brown. 2011. Student-Centered Learning in Higher Education. *International Journal of Teaching and Learning in Higher Education* 23(3): 92–97.

Referred surveys

European Health Interview Survey (EHIS), 2014
Health Behavior in School-Aged Children (HBSC, WHO), 2002
Health Communication Survey (HCS), National Institute for Health Development, Hungary, 2015
Holistic Health Promotion (HHP), National Institute for Health Development, Hungary, 2015
Program for International Student Assessment, PISA, OECD, 2015

Ethical approval

Our research is morally acceptable and we follow the World Medical Association's Declaration of Helsinki and requirements of all applicable local and international standards. The Hungarian Medical Research Council Research Ethics Committee has approved this research (No 18241-2/2017/EKU).

Conflicts of interest/funding

This study was funded by the Content Pedagogy Research Program of the Hungarian Academy of Sciences.

Acta Univ. Sapientiae, Social Analysis, **8** (2018) 75–89

DOI: 10.2478/aussoc-2018-0005

The Ethical Dimension of Professional Integrity in the Hungarian Child Protection System

Ernő BOGÁCS
National Office for Rehabilitation and Social Affairs, Budapest, Hungary
bogacs.erno@szgyf.gov.hu

Andrea RÁCZ
Eötvös Loránd University, Budapest, Hungary
raczandrea@tatk.elte.hu

Abstract. Following a discussion about ethics and social work, in this article, we will present the main results of three researches conducted in the past few years on the Hungarian child protection system. These studies highlight the professional gaps, the prejudiced beliefs related to the primary (children) and secondary (parents) client systems of child protection, the value crisis in professional mentalities, and the crisis of the profession in general. We argue that a change in mentalities and professional treatment in the operational practice requires a thorough reconsideration of the ethical dimensions of child protection to the extent of developing and introducing their own code of ethics. As the helping profession is actively involved in the transformation of the welfare state, in parallel with restructuring welfare conditions, we should reconsider how the scarce methodological framework for practice at the national level can cope with problems and how it can emancipate the clients and serve their well-being. The research results indicate that the direction of development is to create an activating and mobilizing helper system that can preserve the core values of the profession as well as adapt to social changes and reflect on the expectations of the public policy thereof.

Keywords: ethics, values, value crisis, child protection, professional integrity

Introduction

This study starts with a discussion about why social work needs ethics. Following this discussion, we present the main results of three researches conducted in recent years on the Hungarian child protection system. These studies highlight the professional gaps, the prejudiced beliefs related to the primary (children)

and secondary (parents) client systems of child protection, the value crisis in professional mentalities, and the crisis of the profession in general. We argue that a change in mentalities and professional treatment in the operational practice really requires the reconsideration of the ethical dimensions of child protection to the extent of developing and introducing their own code of ethics.

Social work and ethics

To examine the relationship between social work and ethics, one first needs to find an answer to the question: why do we need ethics in social work? Gardner et al. (2008: 42) claim that, essentially, the recognition of any field of knowledge as a profession calls for the existence of an ethical dimension in addition to knowledge and skills. This ensures that the expertise is not used for selfish ends and against public interest. It is an appealing approach, particularly in relation to social work, as it could become (one of) the profession(s) of professions since all three conditions are so poignant (especially the ethical).

Obviously, many fields of knowledge would debate this approach, not only those that require some sophistication to justify the ethical dimension (e.g. military industry) but also those areas that appear to be ethically neutral. Furthermore, "ethical" professions such as medicine and social work may violate the ethical dimension in their practical implementation. It is important to mention this because the professions cited above may be considered to be less ethical or ethically neutral for reasons related to their implementation or practice. Speculative thinking, of course, can reveal the existence of an ethical dimension in any profession. However, it cannot be overlooked that the requirement of public interest may be appealing, but it is also controversial. Why is ethical what is socially useful? And, anyway, what does one mean by public interest? The opening question – how does social work relate to ethics – can be answered simply. That is, social work can only be considered as a profession if it has an ethical dimension. Public opinion certainly supports this attractive wording because if there is one profession which is undoubtedly viewed as in need of an ethical dimension that is social work. Nevertheless, the more critical-minded may ask: why is something that serves public interest considered ethical? What does ethics have to do with social interest and, ultimately, what is ethics?

If we take social work in a broad perspective and in historical context – at least in the Christian cultural sphere –, it can be clearly identified with the physical and mental doings of mercy. Although salvation is divine grace, that is, unattainable as a gift, faith without deeds is dead. Accordingly, in the early days of Christianity, helping other people was a natural element, an essential manifestation of the morality of living in order to please God. It is important to note that the morality

of life perceived in this sense did not only serve individual salvation but also the building of the Body of Christ as the community of believers (the Church), pointing to the existence of important social aspects. Helping in this period was a way of being, wherefore it was more of a spontaneous than an organized activity. Even when it stopped being perceived as a way of living, helping others did not become institutionalized, even if it manifested in organized ways in different activities of the religious communities and religious orders and continued to be implemented in the deeds of faith as an attribute of moral life. Social work has developed from this practice. First, in the 19th century, it was strongly linked to the renewal of early Christian communities' ancient traditions when some charismatic figures attempted to respond to the problems of the new social class (the proletariat). Later, social work became a state intervention (Müller 1992: 11).

In a conceptual approach, social work is viewed not as social science but a profession, and its socially constitutive and retaining roles are less pronounced. Social work is "the paid professional activity that aims to assist people in overcoming serious difficulties in their lives by providing care, protection, or counseling or through social support, advocacy and community development work" (Martin & Pierson 2011: 493). The ethical element is, however, deductible as long as helping to overcome difficulties is an ethical category.

The question of what counts as an ethical category and ultimately what is ethics still remains. In an etymological approach, it is relatively easy to interpret the concept of ethics. In terms of content, some uncertainties could be identified (Vossenkuhl 2007: 37), and it is much more difficult to extract the concept, at least if we seek a short, summarizing definition. For example, commonsensically, ethics is used as a synonym for morality (Nyíri 2003: 13, Vossenkuhl 2007: 37), which, although incorrectly, may be considered acceptable, as the present study will also refer to this discourse. Nevertheless, it is the analyses in this paper that require the separation of ethics from other related concepts, especially that of morality.

Ethics, strictly speaking, is strongly linked to philosophy as a science; a sort of moral philosophy as long as it is interpreted in Heller's (1994) approach. One may even conclude that ethics is a philosophical discourse reflecting on morality. Its central concept and subject is morality. Any attempt to describe the essence of ethics will inevitably conflict with morality. According to dictionaries, morality is the totality of socially approved rules and their implementation to manage moral conduct and to help us assess it. Besides the discourse of dictionaries, Heller (1994) makes a similar statement on morality so as to highlight individual attitude, calling it morality. This is an important statement because morality – contrary to ethics – is not a theoretical construction but a certain individual's quality of behavior that is bound to a specific time and space and often to another individual or individuals. It is the nature of a specific action or failure. Still, we are left with a few questions: what are the criteria according to which a behavior

can be classified as correct or moral? What or who qualifies as a standard and rule for correctness? Where does the prestige of such norm or rule derive from?

Value pluralism

In the metaphysical, transcendent worldview, the answer to the previous questions is very simple: transcendence as the foundation of all correct or moral behavior. It was a satisfactory explanation and a validity criterion for the majority of the society until the Enlightenment, and it still is for a certain social stratum. After the 17th century, however, this authority ceased to be distinct and general. More actors demanded independence in their actions, or, better yet, authority was demanded for more actors. If we accept valuableness as an alternative to correctness, value as a synonym for correct, we can state that along the described process of the history of ideas, values have become diversified, their hierarchy has changed, and the essential element of morality has become malleable. Value pluralism has gained ground with a positive effect. For example, it has enabled the unfolding of the interpretive side of ethics, which is good news for philosophers. It is less gratifying for people of action who find difficulty even in applying the rules and norms of correct and incorrect to a particular case. Once authoritative norms and rules are questioned, they become void, while new norms and rules appear which are vindicating authority. This can be a liberating phenomenon for some and may lead to uncertainty for others. However, the undoubtedly liberating experience of value pluralism and relevant eligibility also brings side effects, i.e. the loss of certainty.

The uncertainty in the choice of correct norms and rules (Vossenkuhl 2007: 46) adds up to the uncertainty in the application of those norms and rules. The difficulties of putting in practice the rule of helping people (what counts as suffering, how can "real" help be provided) begs the questions: is applying the rule of helping the suffering also a valid rule for the right conduct? Is helping the suffering the correct behavior? It may seem to be nothing but navel gazing, but the point is real: value pluralism involves the possibility of a value crisis. It should be noted that this may be an essential moment of moral development as well as that of an ethical regression. These considerations do not strive to argue for the necessity or possibility of a single moral authority but instead wish to raise awareness of the potential uncertainty resulting from value pluralism and its consequences. The existence of a declared exclusive highest value, wherefrom all other values can be derived, is grounded in faith and belief. All other modes of reasoning place the knowledge or construction of values into people, which implicitly supports value pluralism. Consistently thinking further, these methods of argument are based on unprovable premises; hence, certain moral perceptions ultimately derive from rationally unprovable fundamental beliefs, that is, they

are based on belief, or choice dependent on the degree of proof. It also applies to those reasoning modes that declare the existence of exclusively proclaimed values and intend to prove these statements with the help of rational arguments.

Value pluralism and social work

In respect of social work, all of this is important because, as a result of the empirical and historical fact of value pluralism, moral considerations that constitute one set of conditions for social work may vary depending on current politics and social policy, professional expectations, and personal beliefs. Social workers possess no highest value or value system recognized by all, wherefrom correct behavior could be inferred and applied to specific cases. Social work may require professional ethics in this context. The dilemma is twofold: 1) What is the value to pursue? 2) Is the behavior in accordance with the rules or norms determined by the value? Accordingly, the function of social work ethics is twofold: 1) to determine the behavioral rules and norms of correct social work; 2) to prepare the application options for behavioral rules and norms (facilitating the application of norms) (Márfai 2017: 16).

Professional ethics

Despite the argument outlined above, which describes the difficulty of the definition of ethical values demanding general and exclusive validity, there is a constant endeavor to develop and declare such an ethics. As for the modern era, it is sufficient to mention human rights or children's rights as recorded in international agreements. The values contained therein are legally binding, so the social workers as citizens and as paid employees, on the other hand, must take these into account in their work. The suggestion is understandable: why should there be a specific professional code of ethics for social work when social work is directly or indirectly regulated by human rights, the constitution and specific legislation, methodological recommendations, standards, technical programs, and job descriptions of the individual states. Ethics, human rights, etc. focus on the same subject in different approaches: to define and describe value (Beran 2007: 83–93). They may be interpreted as ethics. Human rights serve as the first function of ethics in social work, while the governing legislation and the other regulations as the second function. The reasons for a separate professional ethics of social work are as follows: the first is general (human rights, the constitution), while the other (legislation, standards) is concrete. In order to facilitate a professional's decision, an optimal level of generalization and deduction may justify the preparation of professional ethics. On the one hand, human rights or constitutions are too general, and they may not necessarily coincide with a

certain social worker's moral convictions. A set of intermediate deduction of norms and rules is required that can both directly and identifiably apply to social work but also facilitate the relationship with the "unique person" through their profession (social work) by its identified specific subject (social work values) (Heller 1996: 17).

Relative to the question of why a social worker needs ethical guidance, it may be worth investigating whose interests these morally impeccable actions serve: the social worker's or the client's. Not only the orientation of social work appears to be at the center of this issue but also its ethical dimension. This ethical dimension is no longer equated with the correct behavioral norms. This is the application phase. The standards and rules of acceptable conduct are known and partly accepted, but because of their rivalry or interpretation their application requires decision making. Although it seems obvious, the client's interest is questionable, and not only because of a different definition of needs or as part of a thinking process (see Krémer 2009: 207–208). Müller (1992) is of the opinion that at the beginning of the development of social work the objective was not to help the individual but to implement a certain social interest. We have seen that the concept of social work is not necessarily linked to the social element in a constitutive sense, while in relation to ethics it emerges again and again. Why is this condition so stubborn? Is it because the individual cannot exist without society, wherefore she/he should be protected? In fact, the individual is usually forced into communal existence simply because she/he is not alone. Thus, people are organized into communities in some way to survive. This fact may lead to the conclusion that humans are essentially social beings, and satisfying their needs and developing their talents require social existence; but this is as verifiable or deniable a theory as that of a person who basically seeks love and power. However, based on these facts, that is, that the individual shares a living space with several other individuals and that people get organized into smaller or larger communities in order to ensure mutual survival, it is a fundamentally appropriate argument for the social aspects of ethics to gain emphasis.

Community life produces a variety of organizational forms depending on the number of individuals and the complexity of interactions among them. One of these is the state. The state has diverse tasks to organize and manage society for the individual's survival, and one of its priorities is to cater for the social needs of individuals and communities (Torma 2016: 5). Reverting to the historical contemplations, evidently, the state has been taking over more and more functions in this field after the Enlightenment (Müller 1992). The question is why this is regarded as important by the people in power. According to a harsh opinion, it was to maintain the people's capability for labor and offspring in the industrial reserve army (Müller 1992: 9). After the universal suffrage has been adopted, it may be assumed that the state's gaining ground in the social field is due to

political reasons. Today, when productive work and work in general have been transformed, maintaining the industrial reserve army poses no interest (machines make human labor unnecessary in areas without some expertise); yet, the reserve army becomes indispensable in other contexts, namely as a *voter reserve army*, which could be redefined as a useful base in the endeavor to acquire and hold power. This approach may seem rather cynical – so, we assume that politics is a profession, which means it has an ethical dimension. Moreover, the actors of this profession keep public interest in mind, and they are no more self-serving like the representatives of journalism. However, the relativity of ethics may question traditional values in this case as well, especially social values, given that they are tied to social interest that the state should represent. This can create a situation that brings the social worker to a crossroad: social value or the client's interest, social interest or his/her own values. The state intervention – in spite of its public interest – may thus give rise to situations that are incompatible with the interests of individuals in need of assistance or a social worker's values. The social worker may need ethical support in this situation.

Social interest and client interest

The intention to suppress the personal nature of social work relates to social expectations to enforce a formalized helping management (Pierson & Thomas 2011: 496, Parrot 2010: 2). One element of this intention is the development and application of policies, protocols, standards, and indicators used in the world of business to promote efficiency and measurability. Another step would transform the social worker into a mediator of ready services (administrator). The ethical dimension of this activity does not even arise when demand and service overlap. A decision-making situation occurs when the appropriate services are not able to cover the demand or the amount of services is limited (Parrot 2010: 4–5). The administrator feature as a social or professional requirement in this case conflicts with the classic helper attitude in the tension to find the right norm of conduct. Only a moral decision can ease the tension. In the above, choosing standards of good conduct presents a typical challenge for the social worker. More often, the application of the interiorized or adopted rules poses difficulties in individual cases (even in establishing ranking). Here, it is not the value systems that compete with each other. Adapting the approved values and rules to life situations may require support.

The conflict of society and his/her own values, social interests and client's interests, competing values and loyalty are all moral decision, and this requires guidance. Social work may need "ethics" in this sense.

The issue of professional integrity in the research of child protection

Historically, especially in the second half of the 20th century, social work went through several changes in terms of organizational context, and the wider context of socio-economic and political environment. Asquith et al. (2005), however, highlight that the most important principles and values on which social work is based on have been able to remain constant even though they are very vulnerable in practice. Sárkány (2011) claims that the profession of social work is both a value-driven science and a profession, where navigation relies on the values of the client system and the society's current system of values. What appears as a fundamental dilemma in social work is the question of the dual mandate, on the one hand, as the representation of society and the given institution seeking legally and economically profitable solutions, while, on the other hand, as the representation of the client in need of help. The social worker, therefore, mediates between client and society while functioning as a social subsystem. This means the coexistence of the helping-supporting and the standard promoting-controlling functions (Pataki 2008, Sárkány 2011). Sárkány (2011) raises the interpretational possibility of the triple mandate following Staub-Bernasconi, that is, the existence of an independent profession requires scientific methodology and ethics as well. The protection of human rights and social justice are fundamental as two ethical standards as well as requirements to be enforced. In this sense, social work is also a profession of human rights, whose central task is to protect rights and support interests. The preservation of fundamental values is important because it can contribute to the professionalization of the vocation, to the delimitation of its own framework in relation to other vocations. Concerning theories dealing with professionalization, vocations can be classified into two types: 1) how vocation trends develop; 2) what characteristics certain vocations have, including what features a given vocation has, what activities it performs in the public interest, how it develops self-interest, and what it identifies with (Nagy 2009: 87). Within this second group, the so-called social function-oriented trends are important to us, which belong to Durkheim, Parsons, and start from social needs that a particular profession responds to. This is a kind of mission since it is in the service of the common good founded on the social division of labor as well as shared responsibility and solidarity (Nagy 2009: 92).

However, the people in social work training and the professionals themselves assume the low prestige of the vocation (Fónai et al. 1996, Grand 2011, Papp & Rácz 2015). The volatility of the values of the profession is indicated in the example that students typically do not take on political appearances, advocacy activities, decision preparation work and do not consider important tasks that aim to change the functioning of society and social policy (Nagy 2011: 110).

Primarily, this requires not intellect or high qualifications, but capabilities and skills. Society's image of the profession does not promote the clarification of the boundaries of the profession – not only because they know little about it but as people's views on social work and child protection are significantly influenced by the associated scandals, especially those related to children. Several such events took place in our country in the previous years. We should emphasize the importance of ethics in social work as it provides principles and values for social workers, a kind of moral code set, and in this sense it can be used as a synonym for ethics and value. However, ethics is often used as the totality of regulations and standards that govern the conduct of professionals, that is, typically related to the regulation and monitoring of professional activities. The international discourse emphasizes more and more that the code of ethics is a document that governs conduct, while the helping profession's core values appear to be less important; hence, the legislation has become more important than the promotion of values in the practical operation (Al Asquith et al. 2005). Excessive bureaucracy, increasing administrative burdens for the profession clearly lead to value conflicts for the helpers. Zastrow draws attention to the fact that the bureaucratic systems are impersonal, neutral; the client functions as an actor in the system. In fact, the system is a tool of power, a totality of rules and roles, neither good nor bad, but amoral. Knopf Zastrow explains that democracy, humanism, and respect for uniqueness give drive to the helper, the relation is based on volunteerism, while the bureaucratic system is hierarchical, value deficient, and emotionally neutral (Zastrow 1995: 43). Often, the solution to this dilemma is that the social worker personalizes bureaucracy by constructing an enemy picture, but since the system is amoral, it is meaningless to attribute personal qualities to it – we should treat it as a structure.

In connection with the voluntary and obligatory clients, the question arises how to motivate the client. According to the stereotypical view, the voluntary client is actually the well-behaving client who is conscientious, requests and accepts help, is motivated, open to cooperation, able to make decisions freely, and the cooperation is less burdened with certain ethical dilemmas. This is the opposite of the obligatory client, who is identified with the image of the unmotivated client (Pataki 2008: 6–7). According to Lorenz (2008: 98), the success of the intervention largely depends on the social-political context it is implemented in: "If the political program imposes a punitive approach, which aims to separate the deserving from the undeserving, then users will refuse even the friendliest approach, and what is more, they will regard a 'friendly police-social worker' with much more suspicion, and the loss of confidence will be even more destructive when the mask of helpfulness peels off".

Dominelli also draws attention to the fact that in many cases the compulsory cooperation is realized with individuals who come from a social stratum where freedom is in fact limited (qtd by Pataki 2008: 10). Thus, public policy often

forces individuals to build up obligatory relations with social services and social workers. In this perspective, social relations are thus reflected in the relationship between the social worker and client, and the social workers themselves can be considered as the delegates of the dominant groups (Pataki 2008: 10).

The following is a brief description of the main findings of three researches on child protection, which intend to reveal the professional mentalities in child protection, reflecting on the dysfunctional operation of the child protection system as well. In fact, the tangible professional crisis in child protection derives from the undefined nature of the profession as to what extent it is pedagogy or social work in nature. We believe that competencies of social work type and the core values of the profession may provide an important frame of reference for child protection personnel.

The state as good parent?

In 2014, the University of Debrecen conducted a research built on quantitative and qualitative methods, which was designed to explore the principles and technical concepts generally related to corporate parental and care-taking responsibilities that define practical work among child protection professionals (Rácz 2014). The research drew attention to a number of dysfunctional operations; the followings will highlight those that strain the integrity of the professional framework.

During the placement procedure in child protection care, when the most appropriate place is determined for children in the care system according to their needs, all the interviewed experts claim that typically the available places determine the proposal of a committee of experts, rather than children's real needs. Decisions motivated by financial reasons override a child's personal interests, which appear not only in the selection of a place for appropriate support capacity but in the case of choosing between foster or institutional care forms, since it is a fundamental statement that foster care is significantly cheaper, and the experts handle it as a high priority argument in the decision-making process. When examining foster and institutional care, the experts take it as the most important starting point that the two subsystems should not be contrasted with each other even when comparing their operating characteristics or assessing their efficiency, that is, they are complementary care forms of services to substitute a family. It is a wrong idea that either form of care should have over-dominance although they agree that the application of certain guidelines, setting priorities (for example, the guiding principle of placing the under 12 age-group to foster care) are necessary, but their practical application should reflect the actual real-life situations more accurately than the current practice does. They believe that the profession should formulate the advantages

and disadvantages arising from the peculiarities of the two forms and should be able to use these as means.

Unfortunately, in many cases, the child protection system works through ad-hoc decision-making processes with clear underfunding in the background. In the early 2000s, the conversion process started, that is, the replacement of large institutions – as turning point in reorganizing the system – was a process without sufficient funds. As compared to mass placement, the institutions of the apartment home structure typically operate in small settlements without advanced infrastructure, which poses new challenges to children and professionals alike, and in the absence of appropriate training the professionals were not able to provide adequate support for children in their trust.

It is a serious problem in child protection that professional, substantive changes are mostly private initiatives, thanks to a dedicated expert. There is no quality control in the specialist care of the current system. In addition, professional regulations would be vitally important because they would determine what professionals should know and, simultaneously, what a particular institution or care can provide for children or parents.

Indicators and evaluation models in the child protection system

The Rubeus Association's 2015 research consisted of two parts: 1) the definition of service field indicators and specifications in the child protection system; 2) preparing evaluation models that record the requirements for child care in the provided services (e.g. children's home care, disabled care, foster care), and record results as requirements are met at the level of the actors of the system (e.g. child, parent, tutor, guardian, foster parent), and in the broadest sense the specific child care services and their relationship with other social subsystems (e.g. education, health). The test of evaluation models often exposed weaknesses, professional misconduct, or even ethical misconduct. We may interpret these for all three actor fields:

1) Level of professionals

Focusing on the strengths is often ignored; the professionals can better identify the negatives, which, however, make professional work more difficult. It is a problem that certain child protection positions are full of tensions; for example, the co-operation between foster care advisor – child protection guardians –, children's homes or foster care staff. It is important to clarify the individual competence boundaries, the responsibilities as well as how and by what professional tools and methods the professionals can mobilize to ensure the basic goals of child protection. During the assessment of the nature and content of professional work, the question arises as to whether the care assistants (e.g. foster care counsellor, child welfare guardian) perform a helping or a controlling type of work.

2) Level of biological family

Based on the results of the research, actually, the information on children are often different, arbitrary for the members of the target group (children and parents) and professionals in these cases. The biological parent is lost in the administration, often feels threatened and blamed, while the system does not provide an adequate support. The entire system of child protection lacks the service level of assistances that aim at strengthening parental competencies.

3) Level of clients

The road to specialized care as well as the way out of there, even if planned, is not interpreted for the different actors. Young people's vision of future is uncertain; thus, they are under-motivated and unfocused, they drift with events, and they are passive players in shaping their own destiny. In children and young adults, there appear some cases of "adopted impotence", which in all cases relates to the conservation of the conditions they face when entering child protection care, that is, unsolved traumas, disorder in family relations, and in general their meagre network of connections.

The research draws attention to the important role of ethics in addition to the legislative framework, protocols, and standards, which can solve dilemmas encountered in practical operation and find the right treatments (Rubeus Association 2016).

Social professional image and self-reflections

The University of Debrecen undertook another research between 2014 and 2015, titled *The Political and Sociological Use of Narratives of Victimhood in Europe and Hungary*, which covers four thematic areas – social, child protection, health, and legal areas – and investigates experts' opinions on the profession, the experts themselves, and the clients. The social and child protection areas were based on Papp and Rácz's (2015) evaluation study of an analysis of semi-structured interviews with twenty professionals. The helpers came from different areas such as family assistance, child welfare, school social work, children's homes, or homeless services. The results of the research bring attention to the fact that over the last 20–30 years social and child protection professionals' pervasive role has become endangered before clarification, and co-operation is based on fear in many cases, the fundamental values of the profession are violated in practice, and authoritarianism has become the basis for cooperation with the clients representing the power.

The main results of the research showed that the expectations are enormous for the professionals on the part of the maintainer, operator, local leader as well as the clients. Professionals experience fear on a daily basis: they are afraid that they make wrong decisions that may turn the client's life into tragedy, while

the leaders give no professional guidance in these matters, although they should have a key role in that the helpers have space to consider each case, to question guidelines; in general, to have the intention to respond to the individual problem areas and to formulate new methods and procedures for particular problem areas. The interviewed social and child protection experts unanimously agreed that it is crucial for professionals to assess their limits because not every case of failure is their fault. Professionals believe that to cooperate with clients and representatives of power is conflict-ridden, often including local leaders, not only the decision makers. They cannot fulfill their role as helpers in such a vulnerable position, and when they fail they perceive it as if they are themselves the victims of the system. As long as the helping framework, the expectations are not clear, social workers and child protection professionals will only take on a the role of martyr in the spirit of moral superiority.

Summary

Lorenz (2008) points out that social work is actively involved in the transformation of the welfare state and the restructuring of welfare conditions; therefore, it should be assessed whether the available methodological framework is sufficient to manage the problems and, more broadly, "to promote the social conditions to viability in the context of globalization" (Lorenz 2008: 97). The direction of development is the establishment and strengthening of an activating and motivating social work and child protection, which are based on the most important core values of helping and, at the same time, adapt to social changes and public policy expectations (Montana 2008). The methodology must be renewed by giving more space to the issues of human autonomy and action and freedom of choice.

The situation is given: either the social and child protection professions will become the servants of public policy and politics without criticism or a competent action plan must be prepared to reflect on the conditions in the marginalized groups of society. In Lorenz's words, "the basic trust emerges as a dialectical interaction between self-confidence and trust towards the social environment (...)". The children and their parents need not a repressive stability but a contractual framework that reduces the unpredictability of life with the support of a reliable, accountable, and effective helping system. "What would be useful to learn from the market – as opposed to the planned economy that has clearly failed – is the process by which the unpredictability can be reduced" (Lorenz 2008: 99–100).

In our study, we have argued against converting the helping professions into an instrument of power to recruit and regulate the electoral army reserves.

However, the identification and the implementation of the rules of good conduct require the existence of ethics for the helper. The conflict between society and personal values, social interests and the interests of the client (in the case of a child, even against the parents), competing values and issues of loyalty all require moral decisions, which need a platform. Helpers should actually enjoy their profession: by providing challenges, different management strategies for each client, opportunities to develop knowledge, applied methods and self-knowledge, and by offering space to deploy new services when new needs arise (Zastrow 1995: 50).

References

Asquith, Steward, Clark, Chris, Waterhouse, Lorraine. 2005. *The Role of the Social Worker in the 21st Century – A Literature Review.* Scottish Executive. (http://www.gov.scot/resource/doc/47121/0020821.pdf).

Beran, Ferenc. 2007. *Etika.* Budapest: Gondolat Kiadó.

Fónai, Mihály, Kiss, János, Fábián, Gergely. 1996. Szociális munkás szakos hallgatók pályaképének néhány eleme. *Esély* 1: 114–134.

Gardner, Howad, Csíkszentmihályi, Mihály, Damon, William. 2008. *Jó munka.* Budapest: Lexecon Kiadó.

Heller, Ágnes. 1996. Morálfilozófia. Budapest: Cserépfalvi Kiadó.
1994. *Általános etika.* Budapest: Cserépfalvi Kiadó.

Hexendorf, Edit, Farkas, Vilmos, S. Hámori, Antónia, Pusztai, Ferenc, P. Hidvégi, Andrea, Kubínyi, László. 1976. *A magyar nyelv történeti-etimológiai szótára 1.* (ed. Kiss Lajos). Budapest: Akadémiai Kiadó.

International Federation of Social Work (IFSW). 2014. A szociális munka globális definíciója. *Esély* 6: 96–100.

Juhász, József, Kovalovszky, Miklós, O. Nagy, Gábor, Szőke, István. 1972. *Magyar értelmező kéziszótár A–Zs.* Budapest: Akadémiai Kiadó.

Kecskés, Pál. 2003. *Az erkölcsi élet alapjai.* Budapest: Jel Kiadó.

Krémer, Balázs. 2009. *Bevezetés a szociálpolitikába.* Budapest: Napvilág Kiadó.

Lorenz, Walter. 2008. A szociális munka és az új társadalmi rend: a szolidaritást gyengítő neoliberalizmus elutasítása. *Esély* 1: 91–101.

Márfai Molnár, László. 2017. *Túlélés és megértés. Alkalmazott etika és esztétika.* Budapest: L'Harmattan Kiadó.

Müller, C. Wolfgang. 1992. *Hogyan vált a segítségnyújtás hivatássá?* Budapest: T-Twins.

Nagy, Krisztina. 2011. „Bizonytalanok" és „próbálkozók". A szociális képzések hallgatóinak karaktertípusai és a képzés jelentősége a szakmai szocializációban. *Esély* 1: 100–116.

2009. Professzionalizáció- és professzió-elméletek a segítő hivatások tükrében. *Esély* 2: 85–105.

Nyíri, Tamás. 2003. *Alapvető etika.* Budapest: Szent István Társulat.

Papp, Eszter, Rácz, Andrea. 2015. Vigyázat! Emberek! Szociális és gyermekvédelmi szakemberek szakmaképének vizsgálata. *Metszetek* 3: 45–61. (http://metszetek.unideb.hu/files/metszetek%202015_3%20racz%2045-61_0.pdf).

Parrot, Lester. 2010. *Values and Ethics in Social Work.* Exeter: Learning Matters.

Pataki, Éva. 2008. *Kontroll és segítő funkció a szociális munkában. A kötelezett kliensekkel való munka elméleti és gyakorlati kérdései.* (Study Report) (http://szm.sze.hu/downloadmanager/download/nohtml/1/id/3035/m/4169).

Pierson, John, Thomas, Martin. 2011. *Dictionary of Social Work.* Berkshire: Open University Press, McGraw-Hill House.

Rácz, A. (ed.). 2016. Indikátorok és evaluációs modellek a gyermekvédelmi szakellátásban. Budapest: Rubeus Egyesület (in press).

2014. Jó szülő-e az állam? – fejlesztési igények a gyermekvédelmi szakellátás professzionalizációjáért. In: A. Rácz (ed.), *Jó szülő-e az állam? – A corporate parenting terminus gyakorlatban való megjelenése*. Budapest: Rubeus Egyesület. 215–245. (http://rubeus.hu/wp-content/uploads/2014/05/CPnemzetkozi_2014_final.pdf).

Sárkány, P. 2011. A szociális munka mint alkalmazott etika. *Szociális Szemle* 1–2: 7–18.

Torma, András (n.d.). *A közigazgatás funkciói és feladatai.* (http://www.jogikar.uni-miskolc.hu/projectSetup/files/koi/kozig1/a-kozigazgatas-funkcioi-es-feladatai-igazgatasszervezo.pdf).

Vossenkuhl, Wilhelm. 2007. A jó lehetősége. Etika a 21. században. *Iskolakultúra* 3: 37–50.

Zastrow, Charles. 1995. Mit tegyünk, hogy a szociális munka élvezetes hivatás legyen? (part. 2). *Esély* 5: 42–59.

Acta Univ. Sapientiae, Social Analysis, **8** (2018) 91–106

DOI: 10.2478/aussoc-2018-0006

Human Resources in Romanian Child Protection Social Services. A Regional Analysis

Zoltán ELEKES
Szent István University, Gödöllő, Hungary
elekes.zoltan@hotmail.com

Abstract. Efficiency and cost effectiveness of human resources implied in social services in general and in child protections services specifically is a taboo subject in Romanian social policy. On the following pages, I will make a general analysis of human resources included in the Romanian social services sector, starting from the topic of territorial coverage with professionalized social workers. After a regional- and county-level analysis of this, linked to the social and economic situation of the regions, I look at the specific field of child protection to see if there exists any cost effectiveness in the volume of human resources implied in these services. In the final part of my study, I will make considerations about the quality of the personnel within child protection services.

Keywords: child protection, human resources, regional analysis

Introduction

The quality and quantity of human resources implied in social services is the most important element of this activity. If in the case of industrial, or even agricultural production the technology and technical equipment play a more and more important role or in the case of other services where procedures are essential to assure a constant quality, then in the case of social services the quality is assured notably by the human relationship built between professionals and beneficiaries. On the other hand, the costs connected with human resources constitute the biggest part of the functioning costs of social services, and there are very limited possibilities to reduce these costs. Just as an example: the 2016 total budget of child protection services of Harghita County's (Romania) Child Protection and Social Assistance Department was 25 million RON (5.5 million euros). Human resources were budgeted with almost 19,000,000 RON (4.2 million euros) and the functioning costs (including food, energy, etc.) with 6 million RON (1.5 million euros). This means that 75% of the social service budget is used to cover the costs

of human resources. Even if this is a singular data, the situation is similar, with some deviances, in the case of other social services, too.

There are very few researches and systematic studies on the role, situation, and efficiency of human resources in the social services. The existing rules which establish the necessary number of employees in different services start from the the required minimum number of employees but do not speak of the efficiency criteria. Generally, the efficiency of human resources is a taboo subject in Romanian social policy, starting out from the very general reason that assisted persons in social services usually need complete and 24 hours/day services, seven days/week. At the same time, there are very rare discussions about the quality, motivation, competences, and qualifications of these employees. In the last few years, the majority of public debates were about the demotivating salaries of the personnel working in social services. Surely, the very low wages in social assistance have contributed to a stagnation or, in the worst cases, to a deterioration of quality, motivation, and qualification of employees in the last 15 years, but the newest measures promise a normalization of salary levels in this field. Maybe, there is time now to start discussing subjects of quality and efficiency in terms of human resources in the Romanian child protection system. The following study tries to have a contribution to this debate, using the data which can be obtained from official reports, statistics, and studies made in the past few years by different institutions or individuals.

Professional social workers and other categories in the social services system

The Romanian Law of Social Assistance (Law 292/2011) – the basic law of the field is relatively weak in references to human resources implied in social assistance activity. Even if it contains a separate chapter dedicated to this topic, from the overall 146 articles of the law, only 7 refer strictly to the question of human resources. The above mentioned articles contain more general aspects, and there are no specific regulations in order to clarify or refine the case of human resources. The main profession in social assistance is considered to be that of the social worker. In fact, professional social workers represent a minority within the totality of employees. There are several other professions included, most frequently psychologists, educators, carers, medical assistants, and physicians. Some of these professions are regulated by special laws, and there are special professional bodies which control, protect, and promote these professions.

The National College of Social Workers of Romania (NCSWR) is created based on the Law 466/2004, and it is the most important professional body in the field of social assistance. There were 6,625 registered social workers members of the

college nationwide on 28 January 2017. Even if this appears to be a big number, the real need of the social assistance system is much greater. According to the study of the World Bank (Stănculescu et al. 2016), there was a need of 11,000 qualified social workers in the primary and specialized services in Romania. In a study made by Florin Lazăr in 2015, he estimated that 35,000 people finished their university studies of social work in the last 20 years (Lazăr 2015). If we are looking at the coverage of the general population by qualified social workers, taking into consideration the above mentioned data and the Romanian census data (the last one in 2011), we can calculate a number of 3,000 people/1 social assistant on the national level. If we accept the general idea in social legislation that one social worker can work efficiently in the same time with 25 cases (families or individuals), we can conclude that only around 1% of the population is covered by specialists in this field.

Eurostat statistics (Eurostat 2016) show that almost 40% of the Romanian population is at risk of poverty and social exclusion and almost 25% is living in severe material deprivation. The situation becomes even more complicated if we make a regional and county-by-county comparison. There are important regional differences concerning the share of population at risk of poverty. Generally, the Southern and Eastern part of Romania seems to have bigger problems; the highest poverty rates are in the South-Eastern region (53.4%) and in the North-Eastern region 48.9%, but also in the South-Western region the rate is higher than the national average. The regions of the capital city of Bucharest and the Central, North-Western and Western regions in the Transylvanian part of Romania have lower rates of poverty than the national average.

Even if, logically, more social problems mean a higher need for social workers, the figures calculated by myself showed a different reality. The lowest number of social workers are present in two of the most poverty-stricken regions (South-Eastern, Southern, South-Western), and, at the same time, the regions with lower poverty rate managed to attract more specialists in this field. The sole exception to this rule appears to be the North-Eastern region, well known for its huge social problems but also having the second best coverage with affiliated social workers (*Table 1*).

Table 1. *Poverty risk of population and social worker density across Romanian development regions*

Region	Population rate at risk of poverty	Population for one affiliated social worker
North-East	48.9%	2,444
South-East	53.4%	4,257
South	40.9%	4,908
South-West	45.6%	3,946

Region	Population rate at risk of poverty	Population for one affiliated social worker
West	37.5%	2,487
North-West	30.9%	2,443
Central	32.8%	2,571
Bucharest	30.3%	3,200
National	40.3%	3,037

Source of data: calculated by the author based on the 2011 national census data, Romanian Social Workers College data, and World Bank poverty data

The differences are even higher if we calculate this ratio county by county. The worst situation is in Gorj County, where there is one social worker per 12,200 inhabitants, and Giurgiu with 10,050 inhabitants/one social worker. But there is a very poor ratio in the case of Teleorman (7,127) and Galați (7,054) too.

The problems of coverage by social workers of the Romanian population shows another important disparity: the coverage in rural areas is much weaker than in the case of cities.

Table 2. *Rates of affiliated social workers by specific county groups*

High risk of poverty counties	Population for one affiliated social worker
Călăraşi	5,897
Teleorman	7,172
Suceava	5,52
Vrancea	2,597
Botoşani	1,664
Vaslui	1,883
Low risk of poverty counties	**Population for one affiliated social worker**
Bucharest – Ilfov	3,2
Cluj	2,867
Argeş	2,944
Braşov	4,324
Hunedoara	3,348

Source: calculated by the author based on 2011 national census data, Romanian Social Workers College data, and World Bank poverty data

The Romanian social assistance system is built on three levels. The central/governmental level is responsible mainly for strategies, legislation, social policy, and financing of the system, while the middle/county level is the host of the specialized (in most of the cases, residential) social services. These include a big part of child protection facilities (children's homes, family-type homes, employed foster parents network, family placement, and adoption procedures) and specialized services for people with disabilities (residential centers, protected

homes, rehabilitation centers). The main trend in the European and Romanian social policies in the last decades was the prevention of institutionalization and the strengthening of local communitarian services, the so-called primary services network. These services are in the responsibility of the third level, i.e. the local authorities (to create, administrate by themselves or by NGOs), and their most important role is to urge the individuals, families, or communities to find solutions for their social problems as close as possible to the family and community to avoid extreme social exclusion situations when the institutionalization looks to be the sole solution. From this point of view, the role of the local (villages, cities) level is essential in the efficient functioning of the national social assistance system. I have showed above the situation of coverage with professional social workers on national, regional, and county level, without taking into consideration the types of services they provide.

At the same time, in order to have a more appropriate image, it is very important to analyze the situation of human resources implied on local level in social services and charitable activities. The World Bank's Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015–2020 of Romania (Stănculescu et al. 2016) based on a survey made in more than 3,000 localities showed that almost half (47%) of the smallest villages of Romania do not have even one specific job for social work duties in their organizational structures. On average, in the case of rural localities, 34% of these have no specialized job for social work. This figure is 4% in the case of urban localities. 40% of the communes (rural localities) have only one job for social work and only 6% have 3 or more jobs in this field. In the case of urban localities, 67% of these have 3 or more jobs for social work and 20% have two jobs. If in rural localities or small cities the employees of public social services (SPAS – Romanian abbreviation) are mostly implied in administrative work for social benefits, in the bigger cities, the SPAS has social services in its administration such as soup kitchens, day-care centers for different vulnerable groups, shelters for homeless people, elderly homes, etc. The World Bank (Stănculescu et al. 2016) estimates that 2,300–3,600 new employees are needed in these local structures (preferably qualified social workers) in order to have a minimally necessary coverage of the population (especially in rural areas with social services and benefits).

Another important issue is the quality and qualification of the existing workforce in the SPAS. Research shows that only a quarter of the 4,800 employees in social departments of communes and small cities (with up to 50,000 inhabitants) are professional social workers even if three-quarters of them have university degrees – most of them in other fields (Stănculescu et al. 2016). Professional trainings, qualification courses reach very rarely this category of employees because there is not any organized and financially sustained adult education system for these professionals. These conditions are not helping employees to form a larger and

more comprehensive view about the social welfare system, the social problems, and community needs and to take a more active role in the creation of necessary new social services.

The number of employees in the social welfare system generally and at the local authority level specifically is not a publicly known data. The data series of the Romanian National Institute of Statistics do not contain specific data about the total number of employees in the social assistance sector because the domain is evidenced together with the health sector. On the other hand, regarding social protection, there are data only about the number of employees in public residential institutions for people with disabilities, which number represents a small part of the total employees of the sector. Thus, in order to approximate the number of total employees in social welfare, we have to put together all the data that we can obtain from different sources.

Going back to the number of employees at the local authorities' social services (SPAS), we know form the study of the World Bank (Stănculescu et al. 2016) that roughly 4,800 people are employed in communes and small cities. Considering that there are 40 cities with more than 50,000 inhabitants plus Bucharest, which are not included in this census, we can conclude that there are not more than 6,000 total employees in the SPAS nationwide. The above mentioned data about the employees in public residential care institutions for people with disabilities show that 12,414 people worked in these institutions at the end of 2015, most of them (7,347) in rehabilitation centers for people with disabilities. Even if this is a big number compared to that of the employees of the SPAS, it does not contain all types of residential institutions and is much lower than required by legislation. Due to HG (governmental order) no 867/2015, which establishes the list of accepted social services and their organizational rules, the residential institutions for adult people with disabilities must have at least one employee/one assisted person.

If we take into consideration the official report of the Ministry of Labor and Social Justice, a total number of 17,844 people were living in residential institutions at the end of 2015. This means that these institutions are also understaffed. According to the data of the Ministry of Labor and Social Justice (database of Ministry of Labor 2018), 342 elderly homes were operated in 2018 with 15,283 places. As far as there are no official data about the number of employees in these institutions, we can make a general estimation based on the above mentioned HG, which establishes the assisted persons/employees rate at 1.5 in this system but also based on the information we have from elderly homes that up to 10,000 people can work in there.

The biggest employer in the Romanian social assistance system is the special child protection system, in which 32,708 employees were active on 30 September 2016 (Ministry of Labor 2016). This is more than five times bigger than the number

of employees in communitarian services of the local authorities. These numbers show that the Romanian social assistance system is overturned with very few, small, and weak primary, communitarian services, and at least eight times more people work in public residential services.

At the policy level and even at the social legislation level, the European Union and Romania agree that the preventive communitarian services must have the main role in the social assistance system, while specialized residential services must act only in exceptional situations when communitarian services cannot provide enough for that specific case. If we discuss about primary communitarian services, we have to mention that local authorities are not the sole service providers on the local level. Non-governmental organizations take a more and more important role in this field, in many cases co-operating with authorities by using public funds. From the starting point of the Romanian revolutionary social changes, NGOs took a very important role especially in the field of social services. If at the start, in the early 1990s, they activated mostly in the distribution of external donations (direct social benefits) for different disadvantaged categories (institutionalized children, elderly or disabled persons, poor families), they gradually started to develop constant social services first of all based on the experience and financial support of their Western partner organization. This process also meant the start of the professionalization of the organizations and a base of staff expansion, too.

According to a study published in 2010 by the Foundation for Civil Society Development about the NGO sector in Romania in 2008, of 21,319 active organizations, 1,543 NGOs had a social assistance profile (Lambru & Vameşu 2010). If we also add to these the organizations which have a non-specific profile, we can estimate that between 7% and 10% of the Romanian NGOs are active in social services. These NGOs hired almost 10% of the employees of the NGO sector in Romania. The sector has in 2008 a total number of 89,450 employees; so, we can estimate that less than 9,000 people were hired in NGOs with a social assistance profile. Unfortunately, there are no data on how much of these employees worked in residential or communitarian services, but an important data is that almost a quarter of the organizations assured residential services. If we agree that residential services generally need more employees than communitarian ones, we may conclude that there are not more than 5,000 people in the communitarian services of NGOs in Romania.

Normally, the idea of voluntarism is also worth speaking about. Even if voluntarism in social services does not refer to working solely in NGOs but also in public institutions, the experience in Romania shows that public institutions generally do not have a systematic approach to this topic, while in many NGOs voluntary workers are considered an important resource in the context of constant underfinancing of their services. According to the same study (Lambru & Vameşu 2010), 3.7% of Romanian citizens declared that they had performed voluntary

activities in NGOs. Even if this number is 10 times lower than in case of the western European countries, where voluntarism is considered to be part of a normal life in many families/communities, we cannot be sure that the respondents' statement regarding this question reflects the Romanian reality or a desirable behavior for them. Volunteer-hosting or volunteer-intermediating organizations and institutions maintain that volunteers cannot replace employees in social services, but they can complete and improve their work. Social services, where the constant or regular presence of the staff is needed, cannot base their activity on the limited time or wavering willingness of the volunteers. On the other hand, volunteers usually bring fresh energy, motivation, and new ideas in the social service sector, especially in the case of residential services where beneficiaries could enjoy the new faces and the new connections with the external world.

Human resources in the child protection system

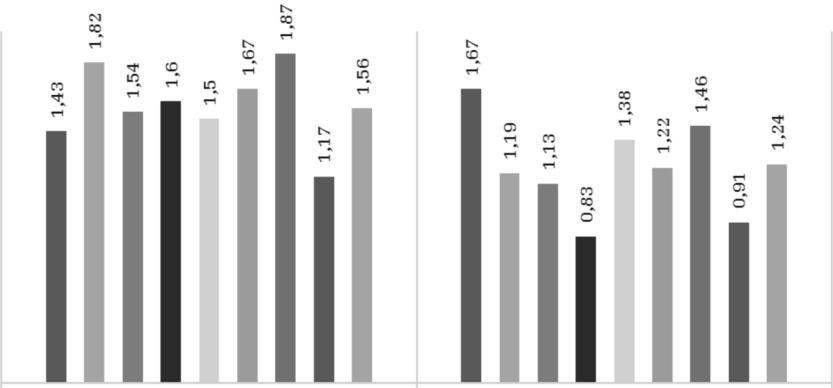
According to all of my estimations, the biggest employer in the Romanian social service sector seems to be the child protection system, especially the residential and employed foster parents (AMP) network of County Departments for Social Assistance and child protection (DGASPC). According to the statistics of the Romanian child protection and adoption authority (Ministry of Labor 2016), a total number of 32,708 employees were working in these structures on 30 September 2016. More than one third of them (12,470) worked in placement centers (family-type houses or regular centers) and almost the same number (11,937) in the employed foster parents network. 4,470 employees are considered to be the own staffs of the departments; these include case managers, administration, in many cases probably the adoption services, etc. The remaining 3,830 employees are in other services of these county departments, but all these people are involved in the child protection activity.

As these statistics contain data only about the employees of public service providers, we have to take into consideration that more than 3,800 children are assisted in private placement centers (administrated by NGOs and churches), which means that a plus of estimated 2,000 employees are involved in these activities. If we make a first calculation on the two main protection forms, the assisted children/employee rate is appreciatively 1.56 children at one foster parent at the national level. At the same time, in the case of placement centers, the rate is 1.24 (see *Graph 1*). At first sight, the maternal foster parents network (AMP) seems to be more cost-effective than placement centers (PC). If we go down with our calculations on NUTS II or NUTS III levels (regions and counties), we can see that the situation looks very different from region to region, from county to county (*Table 3*).

Table 3. *Children and employees across development regions in the Romanian child protection system*

Region	Number of children in AMP	Number of employees in AMP	Children in public PC	Number of employees in public PC
North-East	5,354	3,738	3,183	1,900
South-East	2,638	1,449	2,281	1,908
South	2,299	1,488	2,079	1,835
South-West	1,795	1,115	1,207	1,446
West	1,979	1,321	1,115	804
North-West	2,092	1,252	1,831	1,496
Center	1,765	941	2,565	1,751
Bucharest	742	633	1,217	1,33
National	18,709	11,937	15,478	12,47

Source of data: Statistics of Ministry of Labor and Social Justice on Children Rights Protection (2016)



	Children/ employee in AMP	Children/ employee in public PC
North-East	1,43	1,67
South-East	1,82	1,19
South	1,54	1,13
South-West	1,6	0,83
West	1,5	1,38
North-West	1,67	1,22
Central	1,87	1,46
Bucharest	1,17	0,91
National	1,56	1,24

Source of data: Statistics of Ministry of Labour and Social Justice on Children Rights Protection 2016

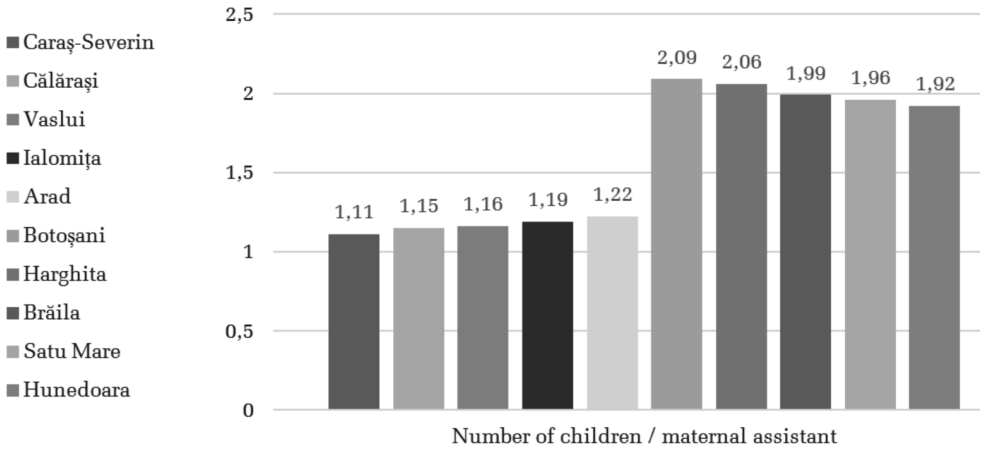
Graph 1. *Assisted children/employees rates across the development regions*

Based on these calculations, it is visible that the Bucharest region has the most cost-inefficient system from this point of view. I can identify two kinds of explanation for this situation. On the one hand, the Bucharest local administration, which sustains the child protection system of the capital city, is by far the richest local administration from the country; so, they are not strongly interested in cost efficiency. On the other hand, it is relatively hard to find workforce for the very low salary levels applicable in this system, and for this reason the employers are also more tolerant towards the employees (they accept, for example, one child for a foster parent).

We cannot have the same explanation if we are looking at the data of other regions. The North-East region, the poorest in Romania, has, after Bucharest, the lowest rate of children/maternal assistant, below the national average, especially in Vaslui County, where 1,480 maternal assistants are hired to take care of 1,723 children. The rate in this case is 1.16. The Central Region, with a general rate of 1.87 children/one employed foster parent, has a relatively good economic situation, having the third lowest rate of poverty after Bucharest and the North-West region, while with a similar rate (1.82) the South-East region has the highest poverty rate in Romania.

In the case of placement centers, we can see two regions with a ratio of assisted children/employees less than one. Bucharest and the South-West regions are in this situation, again a rich and a relatively poor region. The highest ratio in this field is in the North-West region, but, as we will see, the results are affected by some (in my opinion non-realistic) data of the two counties. If we do not take into consideration this region, we will find the highest ratio in the Central and Western regions.

If we want to have a more detailed approach of the situation of human resources involved in child protection activities, we can analyze the situation on the county level (*Graph 2*). In fact, this level is responsible for managing the special protection system for children. The observable differences are even higher on this level than they were in the case of regions. The lowest rate of children/employed foster parents is in Caraş Severin County (1.11), but very low rates are in Călăraşi, Vaslui, Ialomiţa, and Arad counties as well. Three of these counties are among the counties with the lowest GDP/capita (Vaslui has the lowest level in Romania), while Caraş Severin and Arad are among the well-situated counties in the GDP/capita ranking. At the same time, among the counties with the highest ratio of children/employee in the foster parents network, we can find four counties which are in the middle of the GDP/capita ranking and one which has the second lowest rate of GDP/capita (Botoşani).



Source of data: Statistics of Ministry of Labor and Social Justice on Children Rights Protection 2016

Graph 2. *Assisted children/employee rate in Romanian employed foster parents network by county*

If we make the same calculus in the case of placement centers, we see that the statistical data of the Romanian child protection and adoption authority probably does not reflect reality in all of the cases. In the case of a few counties, the assisted children/employee rate is very high (9 in the case of Vaslui, 5.39 in the case of Suceava, or 4 in the case of Alba). This ratio does not meet the minimum standards asked by the specific legislation and surely does not cover the necessities of placement centers. We can just suppose that despite the statistics on children in public residential institutions some of the counties also introduced children in their statistical reports, who are placed in subcontracted centers administrated by NGOs, and in this way they could benefit by the allocated fund from VAT also for these children. Otherwise, NGOs get only allowances for material costs (food, energy, clothes, etc.) but nothing for salaries.

The county-level analysis of this sector has its limits. Taking out the extreme values, we can see again an important variation also in the case of the remained counties. In the case of counties from the South-West region (Oltenia), all five counties have more employees than children in placement centers, the lowest rate being registered in Olt County (0.76 – on average, four employees for three children) and the highest in Dolj (0.87). Bucharest city has a ratio below the national average (0.89) in this case too. Iaşi, Covasna, and Harghita counties are on the opposite side, having a ratio between 1.60 and 1.73 children/employees. Again, there is no visible relation between economic status and the functioning efficiency of the child protection placement centers.

What possible explanations exist for the above described situation? It is hard to believe that different social policies could be the background of this variation – even if at county level and local level the elaboration and implementation of social service development strategies is a legal obligation and in the last years there appeared new county-level strategies (some of them through a large consultation, while others just to fulfill this obligation); however, there were no visible changes in the public social service network in the last 10 years. The system was set up in the first half of the first decade of the third millennium and is functioning relatively with the same services and employment structure. The number of employees in the placement centers slowly decreased (from 15,262 in 2007 to 12,572 in 2017) in the same time with the decreasing number of assisted children (from 20,532 in 2007 to 15,335 in 2017) (Statistics of Ministry of Labor 2007–2017). The number of employed foster parents follows the same trend; after a maximum of 15,225 in 2007, it decreased year by year to 11,781 in 2017. The number of assisted children in foster families also decreased from 20,194 in 2007 to 18,673 in 2017.

If we calculate the employer/assisted children ratio for these numbers, we can see two different trends. If in the case of placement centers the evolution of the ratio shows less cost efficiency in 2017 (1.21 assisted children/employee) than in 2007 (1.34), in the foster families system the trend is in the opposite sense (in 2007, there was an average of 1.32 children/employed foster parent, while in 2017 this number was 1.58). Even with this positive evolution, the gap between the counties remains, mostly because the financing system of the government does not stimulate counties to take steps in the direction of improving cost efficiency. In the last 10 years, due to the national budget laws, almost 90% of the running costs of the child protection services were covered by national budget through VAT redistribution to the counties based on the standard costs of the services and the number of assisted children in these. An interesting characteristic is that there are different standards for a child who is alone with an employed foster parent and for two or more children in a family. In these conditions, the counties who have more foster parents with only one child have received bigger amounts of funding year by year in comparison with counties which tried to keep two or more children in a foster family. The situation looks different at the moment, in 2017, when, due to the growing employment costs and the same allocations, the national budget covers a smaller part of the functioning budget of the services.

The quality of human resources included in child protection services

In order to get a picture of the cost effectiveness of child protection services, it is important to have the results of the calculus made above. Even if these data were collected by the National Authority of Children's Rights Protection, the Authority did not start to analyze or discuss about the cost differences of the same services in different counties. It is very hard to calculate or show the real efficiency of these services (e.g. how many lives have become better because of child protection services, how many people changed their course of life and became tax-paying citizens, for example) because in the child protection system there are assisted children, youths with different backgrounds and different results in their social integration, dragging along their own dramas into the new, adult life.

A possible but not a sure and complete way to approach this question of efficiency is to find out more about the quality of human resources included in the social services. At first sight, we can see that the legislation does not tell too much about and does not give too much answer to the working conditions in child protection institutions or for maternal assistants. The educator job is not defined in the child protection law but only in the occupations' classification. According to this classification, the specialized educator job can be assimilated with the educational activities in child protection institutions, and so it needs a secondary-level education. Based on the legal salary grid, educators can have secondary-level studies but also higher-education-level studies, their salaries being different in these cases. Governmental Act no 679/2003, which establishes the applicable rules for recruiting professional maternal assistants, is even more relaxed. There are no study conditions for this profession; so, theoretically, even with primary studies, it is possible to be employed in taking care of abandoned children. Some counties apply their own rules, trying to select the potential candidates. In Harghita County, for example, at least 10 classes are required, but there are some exceptions even to this rule. The majority of the employed maternal assistants have secondary-level education, and there are some people with university degrees as well. One condition is linked to the qualification of the maternal assistant: to follow at least a 60-hour training organized by the counties' Child Protection and Social Assistance Departments or by an accredited organization, based on an analytical program accepted by the National Child Protection Authority. The training is followed by an examination regarding the material studied here, and finally the counties' Child Protection Commission gives a three-year accreditation for the person to practice as maternal assistant.

If we take a look at the qualifications of the educators in the specific case of Harghita County, we can see that only 43 of the 237 educators working in the placement centers of the County Department have higher education degrees,

while 194 have a secondary-education level. At the same time, there are again 39 people who work directly with children, but they are employed as night-time workers or cooking, cleaning personnel in the majority of the cases because they have no secondary-level degrees. 35 of these people have general-level studies or professional school degrees. In the case of educators, there are not any previous professional conditions to hire them; generally, they do not benefit from a previous training, and they have to learn the job during the work. Even the tutoring of the newcomers by the older educators is almost impossible because they usually work alone during their 8–12 working hours in a group of 6–10 children.

An important step in the professionalization of the employees in child protection institutions was the introduction of the new quality standards for residential centers. Due to these standards, all the employees of these centers have to participate annually in at least 42 hours of training. Starting from the behavioral problems of the youths, training of the personnel became an urgent need in the placement centers. Because of the lack of adequate training materials and specialized, experienced trainers in this specific issue, the Harghita County Child Protection Department participated in several EU-financed learning projects in which there were elaborated and piloted training materials in subjects such as: preventing youth violence, communication and cooperation in the foster parents–biological parents–social assistant relationship, supported employment for disadvantaged youths, agricultural and entrepreneurial basic knowledge for disadvantaged youths, behavioral problems and disorders, prevention and intervention of burn-out, learning difficulties and learning motivation, or crisis intervention in placement centers.

The elaboration of the training materials was preceded by research and needs analyses in the participating countries' child protection systems. The experience of Romanian, Hungarian, Croatian, Austrian, Italian, German, Danish, Swedish, French, English, Irish, Slovakian, and Polish partners was used in this work. The resulted materials were used at county level, but they were disseminated also on national level. In spite of all these efforts, the lack of specialized education of the employees working in the child protection system remains a serious problem on county and on national level as well.

Conclusions

I started this study by showing that human resources can be considered the most important resource needed in social assistance in general and in social services in particular. This importance seems to be overlooked by the responsible institutions and people who have shaped the Romanian social assistance system in the last 25 years. In the case of primary-communitarian services, the lack of human resources

is an evidence, and it is an urgent problem: in order to understand this, we have to look at the very low number of qualified social workers hired in these services.

In the case of specialized services, the quantity of human resources included is relatively high, but there remains the question of efficiency. The legal standards are relaxed, they establish the required minimum number of employees, not the maximum, and they are relatively generous too, the highest number of employees in the Romanian social sector being in specialized services.

Due to the central allocation system for financing these services, there could not be shown any relation between the ratio of employees/beneficiary and the socio-economic situation of different regions and counties. What is evident is that there are important differences in this ratio among regions and counties, starting from a 1 to 1 beneficiary–employee ratio to ratios exceeding 2 to 1 in various child protection services. But quantity is not equivalent to the quality of human resources included in the work with the beneficiaries. In child protection, we find very relaxed regulations regarding study and qualification requirements. Even if the new quality standards applicable for the services ask for at least 42 hours of training/year, the majority of educators and maternal assistants have only secondary-school-level education, without too much specific knowledge necessary for a good-quality work.

References

Dărăbuş, Ştefan, Pop, Lidia, Milligan, Claire. 2012. *Auditul serviciilor sociale pentru copii din România*. Baia Mare: Editura HHC România.

Lambru, Mihaela, Vameşu, Ancuța. 2010. România 2010. Sectorul neguvernamental – profil, tendințe, provocări. Bucharest (http://www.fdsc.ro/library/conferinta%20vio%207%20oct/Romania%202010_Sectorul%20neguvernamental1.pdf).

Lazăr, Florin. 2015. Asistență socială fără asistenți sociali? Bucharest: Editura Tritonic.

Lazăr, Florin, Dégi, László Csaba, Iovu, Mihai Bogdan. 2016. *Renaşterea unei profesii sau despre cum este să fii asistent social în România?* Bucharest: Editura Tritonic.

Stănculescu, Manuela Sofia, Grigoraş, Vlad, Teşliuc, Emil, Pop, Voichița (eds.). 2016. *România: Copiii din sistemul de protecție a copilului.* Bucharest: The World Bank, Ministerul Muncii, Familiei, Protecției Sociale şi Persoanelor Vârstnice, UNICEF.

Teşliuc, Emil, Grigoraş, Vlad, Stănculescu, Manuela Sofia (eds.). 2015. *World Bank's Background Study for the National Strategy on Social Inclusion and Poverty Reduction 2015–2020 of Romania*.

Electronic resources

Budget of Harghita Counties' Child Protection and Social Assistance Department (http://www.dgaspchr.ro/_f/File/buget/2016/Buget_pe_anul_2016_copii_.pdf)
People at Risk of Poverty and Social Exclusion – Eurostat Statistics explained (http://ec.europa.eu/eurostat/statistics-explained/index.php/People_at_risk_of_poverty_or_social_exclusion)
Statistics of Ministry of Labor and Social Justice about Protection of Disabled Persons (http://www.mmuncii.ro/j33/images/buletin_statistic/dizabilitatian_2015.pdf)
Statistics of Ministry of Labor and Social Justice about Children Rights Protection (http://www.mmuncii.ro/j33/images/buletin_statistic/copil_III2016.pdf)
Statistics of Romanian Child Protection Authority 2007–2017
http://www.copii.ro/statistica-pe-ani/
Database on Ministry of Labor and Social Justice about Elderly Homes
http://www.mmuncii.ro/j33/images/Documente/Familie/2018/Camine_persoane_varstnice-26-06-2018.pdf

Acta Univ. Sapientiae, Social Analysis, **8** (2018) 109–112

DOI: 10.2478/aussoc-2018-0007

Deborah Lupton: Digital Health. Critical and Cross-Disciplinary Perspectives

London–New York: Routledge, 2018

Ágnes SÁNTHA
Sapientia Hungarian University of Transylvania, Cluj-Napoca, Romania
santhaagnes@ms.sapientia.ro

Deborah Lupton's brand new volume, titled *Digital Health. Critical and Cross-Disciplinary Perspectives*, is the second in the *Critical Approaches to Health* series of Routledge. The volume fills a gap in social sciences in particular but in the scholarly literature of medical and information technological sciences as well. To date, this is the first systematic analysis of the large field of digital health, its manifestations, and impact on social life.

Digital health encompasses a range of technologies serving the interest of patients, healthcare providers, and entrepreneurs. "The term 'digital health' refers to a wide range of technologies directed at delivering healthcare, providing information to lay people and helping them share their experiences of health and illness, training and educating healthcare professionals, helping people with chronic illnesses to engage in self-care and encouraging others to engage in activities to promote their health and wellbeing and avoid illness" (Lupton 2028: 1). The realm of health and medicine has become a digitized domain of everyday living and is often either welcome or condemned as a subversive transformation of healthcare in our times. This dichotomy of welcoming and condemning new technology is present from the very beginning till the very end of the analysis.

Besides acknowledging its huge potential, Lupton investigates the social, cultural, and political underpinnings of digital health. She writes a critical approach to digital health as she reveals how this is enmeshed within broader social relations and structures, showing more general considerations of power, interest, and benefit served by new technologies which function (also) to sustain structures of disadvantage and marginalization.

The author discusses several topics originating in this wide-ranging field. Three major aspects, however, are clearly marked out: first, the problems related to data protection, to the surveillance of individuals facing the invisible power; second, the persistent or even increasing social inequalities due to information

technology in healthcare and disease prevention; and third the alleged transformation of medical professions as a result of the emerging and spreading digital technologies.

New technologies generate streams of digital data about human bodies. Online searching for health and medical information on the Internet is probably the simplest and most popular digital practice, gaining popularity in spite of the doubts on the accuracy of information. Telemedicine as a remote healthcare consultation is emerging as a time-, energy-, and cost-saving alternative to the classic doctor–patient setting. Digitized patient self-care and self-monitoring in chronic diseases, sensors, robotic care providers, and medical apps support patients in their daily self-care. Persuasive computing and gamification as ways of addiction preventions or motivators for lifestyle change also contribute to patient empowerment. This kind of empowerment and cost efficiency are seen as positive outcomes of digital health technologies. Through this constant dataveillance of the body, the concept of the "digitally engaged patient" entails a shift of responsibility from care providers to individuals.

Precisely within the context of the new EU data protection regulations, big data and cloud computing systems raise questions about data privacy and storage. Digital media technologies have expanded the active creation and sharing of content, including that of personal information; and this carries considerable risks. Data has been largely commoditized, measuring and quantifying has become the supreme value, more powerful than other means of collecting information, often neglecting individual needs and qualitative aspects. Here, Lupton takes up the concept of surveillance. For Foucault, power is not only repressive but has a productive nature, his terms biopolitics and biopower suggesting practices of managing, regulating, and monitoring human bodies. Instead of coercion and violence to ensure discipline, there are more subtle forms of power that encourage citizens to conform to expectations and norms. Digital surveillance in our days is similar to the Foucaultian concept of biopolitics, it often entails self-surveillance as a technology of the self, which, in turn, monitors human bodies from the power side. This raises concerns about privacy, information ethics, and the misuse of personal data as digital health data are primary resources for commercialization and commodification through big enterprises, with the aim of developing new products and services.

Dataveillance strategies reinforce existing social inequalities. Geographical location, state of health, and socioeconomic status influence digital technology use. Within Europe, in some countries, searching for medical information on the Internet is a widely used activity, while in others only a minority is benefiting from it. The contrasts between the most and the least developed regions in the world are even more striking. People with disabilities are sometimes, indeed, helped and empowered in their communication by the new digital technologies

(Caron & Light 2015, Dobransky & Hargittai 2016), but to the most part the disabled are rather locked out from their use. Gender differences in digital device usage start in early childhood. Women are disadvantaged in the male-dominated world of information technology, the more so in developing countries. Girls and women are also more exposed to cyberbullying than men, and other social minorities also suffer several forms of online harassment. Self-tracking devices can be empowering in the case of the elderly, helping them achieve mobility at old age; however, they might substitute human care and interaction and, as such, sustain their isolation.

Datasets used by data brokers generate information on the customers' lifestyle choices, which result in chances for some and exclusion for others, specifically for those who are disadvantaged in the first place. Besides the privacy concerns raised by too much online visibility, invisibility is also dangerous. It exacerbates the disadvantages of invisible social groups in the process of decision making based on digital data, their needs remain unidentified, and thus they are left out of eventual resource allocation (Lerman 2013).

One of the most valuable chapters of the book is the last one, discussing the aspects of digital technologies in medical professions, most notably the reluctance of health professionals to the expansion of digital health devices. Digital health was and still is perceived as a threat from the health practitioners' side as it undermines the high prestige of medical profession and the asymmetry of the doctor–patient relationship.

Thanks to new technologies, health surveillance practices have evolved considerably and communication with patients and colleagues have become easier for doctors. However, the professionals' resistance is obvious for at least four reasons introduced by the author. First, digital technologies starting with the simplest one, online information searching, are being perceived as a challenge to the prestige and autonomy of medical professions, being incompatible with the existing paternalistic, pedagogical, and often repressive orientation towards patients. Second, medical profession loses control over medical knowledge itself, the profession being alarmed at the often misused lay medical treatments online. Third, doctors are often being defamed by online comments to the medical service patients receive, which are the hardest to refute. Fourth, the online public sphere offers the possibility for public debate such as for the public expression of opposing views to the public health policy decisions.

From the patients' view, telemedical technologies are welcome because they are convenient, cost-saving, reduce waiting hours, the time and effort spent on patient face-to-face consultation, yet the quality of care is perceived as lower compared to the classic healthcare setting (Andreassen et al. 2006). With all its possibilities, complete trust in these services has not yet been achieved. The example shows that in spite of the troublesome new phenomena disquieting

doctors and challenging their power, medical profession still seems to hold its position. Patients who search for medical information online clearly claim that they need doctors' real-time advice even on Internet sites and express their need for the customization of information available online. This supports the argument that biomedicalization, medical knowledge and authority – even if challenged by new digital technologies – remain dominant within the new setting. No need for doctors to worry about losing their prestige.

It is not enough to read Deborah Luptons' book only once. The author reports on every mentionable study in the field, mostly from the Western world and Australia, her home country, without neglecting, however, the specific issue of digital health in developing countries. Thanks to its huge empirical material, the series of examples, and evidence standing behind every thesis she formulates, this book needs to be invoked over and over again.

References

Andreassen, Hege K., Tronsden, Marianne, Kummervold, Per Egil, Gammon, Deede et al. 2006. Patients Who Use E-Mediated Communication with Their Doctor: New Constructions of Trust in the Patient–Doctor Relationship. *Qualitative Health Research* 16(2): 238–248.

Caron, Jessica, Light, Janice. 2015. "My World Has Expanded Even Though I'm Stuck at Home": Experiences of Individuals with Amyotrophic Lateral Sclerosis Who Use Augmentative and Alternative Communication and Social Media. *American Journal of Speech-Language Pathology* 24(4): 680–695.

Dobransky, Kerry, Hargittai, Eszter. 2016. Unrealized Potential: Exploring the Digital Disability Divide. *Poetics* 58: 18–28.

Lerman, Jonas. 2013. Big Data and Its Exclusions. *Stanford Law Review Online* (available at: https://www.stanfordlawreview.org/online/privacy-and-big-data-big-data-and-its-exclusions).