Chapter 10

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HEALTH CARE ANALYSIS IN ROMANIA WITH QUALITY ASPECT

Abstract: Paper shows analysis health care in Romania with quality aspect. It was showed that the Romanian health care system is in a process of rapid transformation.

Key words: health care, quality, Romania

10.1. Introduction to the health care situation in Romania

Romania is an East European country with a 238,391 sq. km (12th largest in Europe) area and 3,190.3 km border. According to the January 1992 census Romania have 22,788,993 inhabitants with a density around 95.7 inhabitants per sq. km.

Talking about the recent history of the health care system we underline that there were four decades, from 1949 to 1989 with a Semashko health care system. In 1989 began a big reform with a very important moment in 1995 when the very centralized and tax-based health care system had transformed into a decentralized and pluralistic social health insurance system, with contractual relationship between the health care providers and the insurance houses.

Until the Social Health Insurance Law (Legea 145/1997), the health system was centrally coordinated by the Ministry of Health through 41 District Health Directories and Bucharest Health Directory. The health system itself was in fact a network of hospitals, polyclinics, dispensaries

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and other units. There were a number of hospitals, health institutes and national centers of high specialization under the direct supervision of the Ministry of Health. Also other ministries had their own networks, like Transportation Ministry, National Defense Ministry, Internal Affairs Ministry, Ministry of Labor and Social Protection and Romanian Intelligence Service. This network provided health services to the employees of those ministries.

Primary care was organized until 1997 in the form of medical dispensaries, with general practitioners with free practice rights. They did not need training through a residency program. Every dispensary was coordinated by the nearest hospital. Doctors were employed by the same hospital and the staff and all other expenses were paid by the hospital. The patients were assigned to those dispensaries by a territorial base, with no possibility of changing it. Every dispensary had at least 5 nurses, each with their own specialization (pregnancy and infant care, hygiene, pediatric, etc.).

The beginning of the healthcare reform in Romania meant the reorganization of health services and a new financing system. After adopting the Social Health Insurance Law (nr. 145/1997) the new system was based on a Bismarck type system. 1998 was a transitional year and in 1999 the system was changed. The payment would come from the National Health Insurance House (NHIH) through 42 District Health Insurance Houses (DHIH) and that meant that the way primary care was organized should be changed. Doctors were to be no longer employees but self-employed and working under a yearly contract with a District Health Insurance House. This contract was written by the Ministry of Health and NHIH and was not negotiable by individual doctors. This stays true to this day. Until 2001 the Romanian College of Physicians was a negotiator for this contract but the Government changed that to a status of consulting.

Primary care was organized as permited by law (Emergency Government Ordonance nr. 124/1998) in individual practice, associated practice, civil medical societies and limited responsability societies. Most

of the GPs chose individual practice. They employed nurses and paid for all the expenses of the practice. Doctors had to fulfill the contract with the DHIH but they were subordinated also to the District Health Directory (DHD) for coordination and control. Also the DHD's were the owners of the buildings in which GP worked. A new GP office or a change in an old one (like retiring of a GP) was made through DHD and a GP had to sustain an exam at the local DHD to enter in the system.

Until 2001 the Social Health Insurance Law no. 145/1997 was modified three times, by OUG 30/1998, OUG 72/1998 and OUG 180/2000.

The Social Health Insurance Law nr. 145/1997 was replaced with OUG 150/2002. The new law allowed a better control for the government but stipulated some more rights for the patients. The status of GPs was not modified by the law but the Romanian College of Physicians got only a consultative role.

Following this new policy, the Ministry of Health was able to radically modify the GP contract. The GPs no longer had their own income separated from the money they received to pay for the expenses of the practice. The penalties for the contract also increased.

In 2006 a new law for the health system was issued, Law no. 95/2006. This new law had, for the first time, a special chapter for primary care. It recognized the liberal character of a GP and introduced the notion of the GP practice – now the GP was the owner of his own business and could sell it or buy it. A new practice could be open if the GP had all the credentials (free practice right, specialty training, office space, sanitary authorization, etc.). However the new law didn't recognize the right for GPs to negotiate the contract or minimal financing for primary care.

10.2. Hospitals divided in Romania

Hospitals in Romania are divided following (ROSAK-SZYROCKA J. NASTA R., TIRAU 2012):

1. ***First class – maximum performance*** **-** The highest class include hospitals which have 34 sections of different kinds. Basically, a first class institution should have all the specialties covered. In addition, might have guard lines and clinics in all these 34 sections, with skillful doctors. First class institution might have a minimum medical equipment: digital radiology, computed tomography, magnetic resonance and to conduct scientific research. The number of patients from other counties should be higher or equal with 30%, and readmissions and patients transfer will be in the smaller proportions.
2. ***Second class – the best county hospitals*** **-** The institution from this class might have in their own structure 21 sections and labs, including general surgery and infectious diseases. Guard lines will cover every department and specialty doctors might assure the healthcare 24 h/day in 11 departments. The most performing equipment requested for the second class are: computer-tomography and magnetic resonance device. Institution is required to conduct scientific research and hospitalized patients from other counties at least 5%.
3. ***Third class – the most county hospitals*** **-** The third class institutions have 21 sections, from anesthesia and intensive care to oncology and general surgery. The specialty doctors will be present non-stop only in 10 from all 21 sections. A third class hospital will have a computer-tomography. The institutions doesn't have conditions for hospitalized patients from other counties.
4. ***Fourth class – Municipal units*** **-** The fourth class includes especially municipal hospitals which have 7 sections required, including anesthesia, intensive care and general surgery. Gynecology have at least a maternity. The institution have only 2 guard lines. Shouldn't miss the ultrasound and radiology equipment.

5. ***Fifth class – Chronic hospitals*** **-** The last category includes hospital for chronic diseases, mostly in rural areas. In these are hospitalized patients having some chronically diseases of some kind like: neurology, psychiatry and rehabilitation. The equipment is just for treating patients with those diseases.

In the Figure 10.1 it was showed number of hospital with taking into consideration classes.

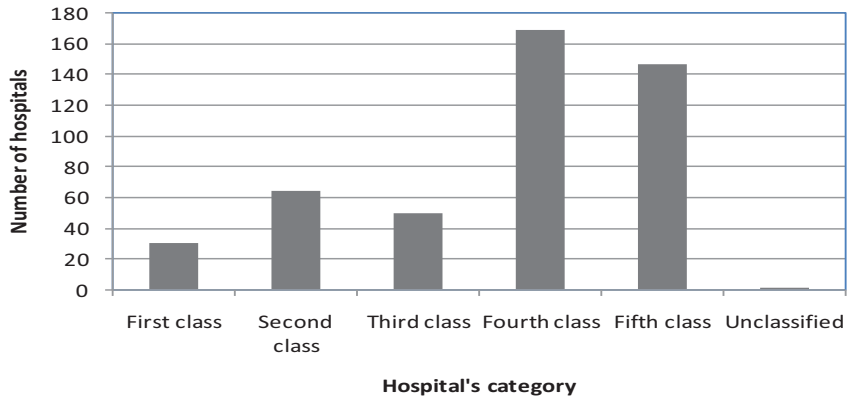

Fig. 10.1. Number of hospital with taking into consideration classes.

Source: Own study

It can be seen from the Figure 10.1 that the highest number of hospitals in Romania occurs in case of fourth class –municipal units 169 hospitals after then there is fifth class – chronic hospitals are posing 147 hospitals.

10.3. Health care quality analysis in Romania

Quality of care is not regulated by a specific act. Law 95/2006, which regulates the entire health system, has some references to quality for sectors of care, such as hospitals, laboratories and primary care facilities.

All the sectors need quality improvement, and the institutional framework is regarded as an essential step towards better quality of health care. The most advanced in this regard are the laboratories, where more and more laboratories are achieving accreditation under the International Organization for Standardization. Challenges to quality of care occur at at least two levels. The first is infrastructure, where the need for improvement is obvious and where disparities between regions and counties are huge and visible. The most obvious is hospitals. The disparities can be found sometimes in the same hospital. The second level is policy-making, which has room for much improvement and is recognized by the government as a priority. A stronger policy could lead to essential changes in the managerial and organizational culture towards quality improvement. This represents one the main challenges of current and future health care policies. In Romania, the hospitals must have some quality certificates to function according to the law as following:

- ISO 9001,
- ISO 14001,
- OHSAS 18001,
- ISO 27001.

The most important quality certificate is ISO 9001 with his additional guidance documents.

ISO 9001 is a fundamental quality management system standard that requires an organization to identify, define, document, implement (follow), monitor/measure, and continually improve the effectiveness of its processes. It is a self-directed system that requires the organization to identify and address all imposed requirements; as well as improve its organizational performance by modifying systemic issues.

ISO IWA 1:2009 is a document which provides additional guidance on the requirements of SR EN ISO 9001, *"Systems quality management. Requirements* "considering both efficiency and effectiveness of a system quality management and, therefore, the potential to improve the performance of an organization. In compared to SR EN ISO 9001, the

objectives of "customer satisfaction" and "product quality" are extended to include stakeholder satisfaction and organizational performance.

The document is intended to help health-care organizations to implement and improving a quality management system that focuses on prevention of errors and undesirable outcomes, reducing variation and waste, i.e. activities which do not surplus value.

This document was developed with the following objectives:

- Improve the quality and safety of health services provided to complete accreditation or accreditation to help.
- Ensure process improvements to increase the value added to the organization and customer.
- Improve the image of the organization to increase customer confidence and provide a tool to analyze the quality.
- Maintain consistency with the overall approach of other sector-specific documents for eg EN ISO 13485 for medical devices EN ISO 15189 for laboratories medical.
- To minimize or reduce the difficulties faced by health care organizations.

At European level there are two papers on this topic that can be used with IWA 1 which standards were adopted Romanian translation method:

- SR CEN / TS 15224:2007 Health Services. Quality management systems. Guide use of EN ISO 9001:2000.
- SR CEN / TR 15592:2007 Health Services. Quality management systems. Guide use of EN ISO 9004:2000 in order to improve the performance of services health.

The principal centers that cares about hospitals and their quality in Romania are National Commission for Hospital Accreditation (CONAS) and AJA Registrars Romania. National Commission for Hospital Accreditation is the leading collegiate body and consists of 7 members, representatives of the Presidential Administration, Government, Romanian Academy, College in Romania, Order of Nurses and Midwives in Romania. Members of the National Commission on Accreditation of Hospitals are appointed for a period of four years, by the Prime Minister,

at the suggestion of the institution or professional organization of which the person nominated (WWW.HOPE.BE).

Members of the National Commission on Accreditation of Hospitals shall meet in regular monthly meetings and extraordinary meetings whenever necessary, convened and led by the President or, in his absence, by the Vice President. Coordination Council decisions shall be taken by simple majority.

At the meetings of the National Commission for Accreditation of Hospitals may participate general, but with guest status without voting, and invited representatives of the evaluation committee for accreditation of hospitals to provide information on the assessment of hospitals.

The vision of CONAS is to focus on quality of care, efficiency and performance and their mission is to coordinate a standardized evaluation process quality of services provided by hospitals in order to improve the health of the Romanians.

AJA Registrars Romania is the another organization responsible for quality in Romanian hospitals. It has a separate division, AJA Medical which was created in order to provide medical facilities in Romania and training certification services according to international standards and applicable European regulations in order to increase the level of performance in health services and thus increase patient trust and satisfaction. The Objectives of AJA Medical are:

1. Developing standards of excellence dedicated medical facilities with a focus on patient safety and the application of risk management health services
2. Develop training programs dedicated to the health sector in order awareness of the importance of applying integrated management systems and European requirements to fulfill the objectives and participation in continuous improvement.
3. Building partnerships with public entities / private (domestic / international) in the medical field in order to develop new products with teams of technical experts.

10.4. Health care quality analysis with taking into consideration EHCI ranking 2012

The European Health Consumer Index (EHCI) is already a standard ranking, comparing health care systems in Europe (*WWW.HEALTHPOWER HOUSE.COM,*).

In 2012, based on 42 indicators assessed 34 public health care systems in Europe, taking into account five key areas for consumers:

- patients' rights and access to information,
- waiting times for treatment,
- treatment outcomes,
- prevention / scope and extent of services offered and
- the availability of drugs.

EHCI ranking is developed on the basis of public statistics, questionnaires completed by patients and an independent study, conducted by the authors of the ranking - the research institute Health Consumer Powerhouse (HCP), based in Sweden. The number of points reached by countries was showed in the Figure 10.2.

Analyzing the data contained in Figure 2 we see that the best rated was health care in the Netherlands, which received 872 ranking points. A little further down, the Denmark and Iceland, who won, respectively, 822 and 799 points. The lowest rated level of health care was in Serbia, which received only 451 points. Also, low-rated level of health care was in Bulgaria and Romania. They gained 455 and 459 points. From Figure 1 we can see that Poland is now competing for the place with Latvia and Hungary.

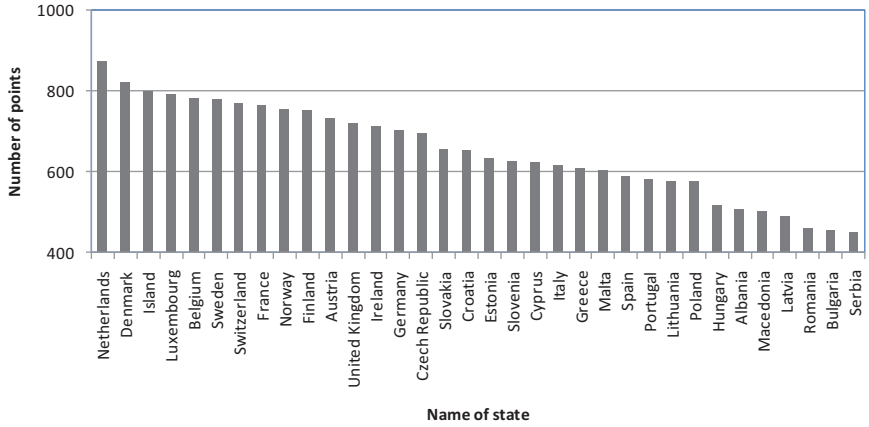

Fig. 10.2. The number of points obtained by countries in the EHCI ranking in 2012.

Source: www.healthpowerhouse.com

10.5. Summary

Results of examinations and their analysis showed that it is very hard to care about the quality in Romania because in 2010 only 3.6% of GDP was spent on healthcare. The total insurance resources decreased by 18% because of unemployment. The Romanian health care system is in a process of rapid transformation. In this context, one of the main problem arising is that which is related to authority and coordination of the whole process of change. Thus, there are new entities with important roles in the health care area, but with few management and administrative skills, alongside the "old ones" which did not adjust their structure and function to the new reality. The health insurance system in Romania, therefore, needs to anticipate and be prepared for similar kinds of developments.

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