IS QUALITY OF ROMANIAN MEDICAL SERVICES A REALITY OR A DESIRE?

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ABSTRACT

All medical services should be offered at a very high quality level and at very accessible prices so that everything is done for the best of the whole people community and not according to the commercial interests. If we do not do so we take the risk that the whole society and economy pay the price by having weak and not healthy work force, able to deliver medium quality jobs. The paper presents Romanian, American and some other payment and compensation systems and ways for the medical personnel to be rewarded for the fact that they help patients by offering consults, treatments and interventions, operations and put effort for people's health and overall "state economy's health".

KEYWORDS: *Healthcare, Services, Motivation, Management, Quality*

As patient, you are often in the situation of thinking how close to our expectations will the physician we address meet our health need. We think if he/she is motivated enough to solve our problem at the level we expect. Expectation is also subjective. There are patients that understand that solving the problem means the pain goes away for the moment and hope it will not come again later, there are patients for which solving means total vanish of the pain and symptoms and regaining the previous health status and there are a third type of patients for which an adequate qualitative level of medical services means total recovery and prevention of disease appearance on the future.

Into the Romanian system, the patient is paying medical services by the monthly contribution to the health insurance fund (from which the state pays the public physicians), paying other self-willing contributions but also by suffering of some possible in-hospital complications caused by the poor quality of the medical process itself. Into this last case, the patient is paying with his/her own health, and this is the deepest harm possible and the hardest to quantify. The patient is also the one who pays with his time for medical services of poor quality, be it the fact that he/she has to loose the time in order to find out that it's case to address to some other specialists (more competent, more willing/ more attentive), be it he/she has to wait for hours in order to get into the cabinet, even if a scheduling or even appointment has been previously done.

It's in the direction of improving the situation and also in the idea of diminishing such unpleasant cases the fact that the actual strategic planning of Health Ministry contains into the financial part the idea of paying salaries according to the type of individual work contract; paying the residents decently and helping physicians to have a second specialization.

Financing the residents at a higher level would motivate Romanian young physicians that nowadays are more tempted to go to the United Kingdom, Belgium, Italy or some other countries in order to get a decent salary of 1200 -1500 EUR per month and not 400-800 EUR as here. The young residents are also unsatisfied by the way they are treated " or even totally neglected when it comes to rewards, because otherwise, when it comes about work we are the first to be asked to help but payment is always forgotten of is simply

mocking from system side", as declared by Mihaela C., a young resident in Obstetrics-Gynecology within Spitalul Universitar Bucureşti.

What could really matter in the way of increasing the quality of medical services is rewarding personnel according to quantifiable quality criteria. In this idea, physicians and the rest of medical personnel would be motivated to offer not only qualitative medical services in order to obtain big incomes but also are interested for more activity and participation in different events. Using some performance indicators to reflect the quality of the medical interventions can help into this evaluation and should be a priority which could bring a true improvement. The most relevant performance indicators that could be used are: number of solved cases on medical specialties related groups and among them on diagnostic related groups, as reported to the complexity of the medical intervention; number of nozocomial infections (contacted into the hospital); and time effectively waited by patients.

As a new way of medical personnel rewarding we could adopt the American idea from the Radford Community Hospital of having in each medical unit a fund of money which to be given to the medical personnel if patients are pleased by the services or to be given to the patients if they are not pleased by the medical and complementary services provided into the respective medical environment. This could motivate the personnel in order to increase the quality of their work by increasing the interest and the dedication knowing that this effort will be highly appreciated. The idea could be even spread to the whole personnel working in such a unit, even if we speak about cleaning ladies or doorman. This is important since being ill affects the overall sensibility of some persons and patients could be bothered even by the fact that the cleaning lady bumped with the mop into the ill person's bed when sweeping around.

The Romanian system has now also a deeper accent on primary medical care, as also into the majority of European countries. A comparison of 10 countries from West Europe revealed higher satisfaction levels of patients for health systems that are based on a strong primary care system and with controlled influence of expenses on the health care. The Euro barometer survey of citizens out of 15 European Union Member countries shows that Denmark (which has a very strong primary care system with 24-hours out of 24, 7-days a week access to primary care) has the highest public satisfaction rate for health care, attributed to the value placed on the accessibility of primary care delivered by general practitioners. Patient satisfaction with primary care and general practitioners is strongly influenced by the mode of care delivery, style of the physician, availability of out-of-schedule-hours, continuity of care and provision of usual screening.

The low level of physicians salaries (as compared to the western European countries) makes it not possible for the moment to have "non-stop" availability of the physicians belonging to the primary care system but this is desirable for the future.

Compared to the specialists, primary care physicians are more likely to provide continuous and comprehensive care, which means improved health outcomes. Easy access to primary care doctors and their "gate" function brought benefits like less hospitalization, less specialist reference, less emergency guards, less probability of being subject to inappropriate health interventions and therefore smaller costs. When approaching directly the specialists it is possible that health care costs increase. There are also studies analyzing what happens in case of substitution of selected services (example for hypertension and asthma) from secondary to primary care showed this shift to be more cost-effective. In other cases such as depression treatment, shifting from the primary care physicians towards the specialists meant more effective but more costly medical services.

The "pay with your time" aspect is valid in United States and Canada also. Even pregnant women that have scheduling are not taken for consultation right in time. They have to wait several minutes or even hours before entering to the physician's cabinet. The predominant pay model in physician reward system has traditionally been based on obtaining individual productivity. A recently released issue by the "American Center for

Studying Health System Change" confirms once more the dominance of incentives based on productivity aspect (7 out of 10 doctors are paid in this way) but also notes an increase in compensation based in part on quality measures (about 24 % of physicians in 2007, raising with 4 percentage points as compared to 2005 level), which is the prove that there is a movement for improving healthcare quality and value.

A very good aspect is the one that into the western part of the United States, California more precisely health plans offer bonuses for physicians with high scores on preventive care (for example administration of childhood immunizations). The six clinical preventive measures refer to screening for breast cancer, cervical cancer and coronary heart disease; gauge treatment for asthma and diabetes, and monitor the provision of childhood immunizations. The scorecard for payment of physicians taking into account these aspects will also weigh patient satisfaction and use of new information technologies.

Reward and payment processes link together many different parts and persons into the health care industry. Patients, physicians, health plans and insurers are all connected through various financial transactions. Founders of health care include public and private partners such as employers and the state authority into this domain that may offer direct subsidies to certain providers (for example to public hospitals) or for certain services (for example immunizations). Many companies offer into the salary package also health plans or insurances for the employer and his/her family. In some cases, purchasers and providers could also be directly linked through contracting approaches under which employer's contract directly with a provider group to benefit for care. The advantages of having a budgetary approach are that it provides an incentive to control costs and produce care efficiently and can also encourage innovation in cost-reducing technologies, lower-cost and investment in health promotion and disease prevention. The approach can also make costs more predictable for the founder. More than that, it can provide flexibility to providers regarding decision about how to spend the budgeted amount and coordinate care with other providers encompassed by the budget. Disadvantages include the potential for risk selection in order to avoid patients who might be high-cost users of medical care, and the possibility to provide insufficient or reduced quality of services to minimize costs and stay within budget. More than that, there exists also the possibility for conflicting incentives if physicians and hospitals are paid under separate risk pools, which could encourage a physician to admit a patient to the hospital (or refer the patient to a specialist) to reduce his or her own costs. Therefore equilibrium should be kept also between private and public health systems in order to obtain best results out of the system.

Also into the United States, there is possible to have e-mail consults with physicians. It is a preferred way for American people since it saves time (10 minutes to compose and send an email versus an hour or more to drive, wait, enter, consult and drive back); it saves gas and money, it saves physician's visit money; means less money spent from the Insurance funds. The problem appears for the physicians when totalizing revenues because overall, they are smaller. This is because adopting e-mail patient consults really drop physicians' earnings (and especially the primary care sector) if the patient visits are replaced by e-mail communication for more than 11% of the total number of patients. Still, a lot of physicians think that offering e-mail consults is advantageous from the marketing tools point of view, since most Americans with Internet knowledge desire this facility. Benefits that physicians could appreciate are: time saved over reduced phone calls, space gained for patients who really need to see the doctor; reduced revenue losses which would have been for scheduled patients that would finally not show up to the cabinet; and reduced malpractice threat with e-mail consults that are better documented communications than face-to-face visits.

The physician's reward system for this type of consults is charging patients for an upfront annual free for a "Direct Physician e-mail consult service", like the GreenField clinic at Portland, OR does. Email communication with your physician, with or without a related face-to-face encounter. This is an appropriate way to communicate when you have

just a little time, when you prefer written answers, when you want to share information with family. This is limited to 15 email consultations per year, which are defined as in-depth e-mail conversations with the physician, separate from the e-mail related to scheduling appointments, or e-mail conversations with the respective person's health coordinator. Another possibility is for patients to pay for each e-mail online - like Medem System does. The third option is negotiating with the insurance companies for reimbursing e-mail consults. Into the present, only few insurance companies compensate the e-mail consults. Physicians should price them at an adequate level so that it means also saving for patient.

Coming back to our national medical system, we should take into the account the fact that the appearance of the Romanian private medical system offered the patients the possibility to choose between this and the public one even though quality medical services can be offered in both public and private health system. Into the present, Romanian patient's perception is altered when making the comparison between public and private systems due to the fact that people tend to get away from everything that means "past" and public system has been dominant in the past. So be, even if both systems can offer qualitative services, into the mind of lots of people there is the idea that they can receive good medical services only at high prices and therefore only into the private system (clinics or cabinets). Another reason for which certain persons are willing to choose the private system is the fact that their status or image "requires" such a thing, they want to show that they belong to high class. But it is also about the way the two systems are managed. Until 2005, Romanian Health Ministry had only physicians as ministers. In 2005 was elected a person whose studies in management were indeed needed since this is a skill that should not miss for persons into this position. This change could also change, in time, the perception of Romanians regarding the public system. If this will be better managed by a "manager" in specialization than by a physician that has a management position, it will be for sure a gained point in people's mind and not only. In our country we have undertaken health care reforms, with a recent emphasis on decentralization, reform of health insurance schemes, and a more efficient use of health resources. The many changes in the health care system are reflected in health care resource statistics, with the number of hospital beds declining (as into the majority of east and central European countries).

The main idea is that all medical services should be done at a highly qualitative level and accessible prices so that everything should be done for the best of community, having a social and not commercial goal. Otherwise we risk that the whole society "pays" the price by having work force with poor health status that can offer work at a not very high qualitative level, which cannot have a high productivity and cannot either have notable performances.

Another important idea is that everything has to be thought on a long run and not for short term. This thing is valid for the whole system as well as for each physician and hospital taken separately. On short term patients can choose to receive treatments in clinics or physicians that valuate the financial aspect in the way that they have very high prices for their services (consultations, interventions, treatments). This price level is more likely to be chosen by population interested into "image" as mentioned before, or just simple people that prefer to pay a high price thinking that quality level is directly proportional with price. The problem that appears here is a management one. High prices not sustained by long term strategies, long run plans and quality could mean a single aspect namely the commercial one that is valid only on short term. Because of this bad management, long run could mean that the patient will not come back because he suffered when instead he should have enjoyed the recovery, because the treatment or intervention had no positive effect of simply because maybe there is no one to come back anymore …. Complications, wrong or unsuccessful treatment or intervention could mean life itself. On the opposite side, long term approach and a good management means that reward of physicians is not only the outcome that they immediately obtain for the services they offered, but also future incomes

of the patients that will become real "loyal customers", the health status of the respective patients and also ethic rewards.

In many cases the ethic rewards are even more valuable than the money since it means long term thanksgiving coming from patients. This thanksgiving could be direct (many thanks addressed to the physician, appraisals etc.), indirect (praying for health of the physicians that solved their problems) or multiplied (recommending the physician to some other persons, since the respective patient is very satisfied with the health services received from the physician that treated or surged him/her and therefore speaking favorable about the physician). Later on, the fact that also other patients (that heard good things about one physician) go to receive treatment or have a surgery done at the respective physician represents both a moral and material reward.

In order to solve this situation, National Health Insurance House has elaborated a law project according to which starting 1st of January 2009 physicians to be able to give prescriptions only within a certain amount of money, amount establish on a monthly basis and that cannot be overrun. The system is similar to the one that existed four years ago but this is a risky measure since the patients could be revolted because in this way they will face the situation when not in pharmacies but at physician the funds will be over one day so the maximum limit for compensated medicines other than for the ones comprised into the national health programs will be a floating problem from pharmacies into the cabinets now. Theano Mihail, pediatric and family doctor at Titan polyclinic in Bucharest asks in this idea "What shall I do if a mother comes with a sick baby and my maximum limit of the fund is over? Should I send her home ? Or should I prescribe her medicines that she should buy? In this case, what for is she paying medical insurance?". The physician explained that no physician can preview how many patients are going to get sick in the next month. "I can have 10 patients in one day but there can be as well 40. The ones that will be sick at the beginning of the month will have more changes to get the compensated or free medicines. What about the rest of them? Applying this system will mean social revolt", declared dr. Mihail Theano.

Management in this case was thought more oriented on the financial side since physicians are not allowed to prescribe medicines over the maximum limit of the monthly fund per cabinet, not respecting these meaning penalties, but making economies meaning possibility to invest into medical devices for the cabinets. Therefore, changes have been, are done and will be more. They are the engine towards development, this being true also into the medical field. Anyhow, no matter how big is the attention and effort done for having a developed health system and adapted to population needs, there are a lot of controversies and a lot of intentions that sometimes are divergent but the overall idea should be to do everything it takes to assure that the system offers qualitative services both into the public and private medical system and no matter the way the medical personnel is paid or rewarded, be it even for the fact that once upon a time it was a vow ….. All medical services should have a good management and should be offered at a very high quality level and at very accessible prices (for the private system) or within the insurance plan (for public one) so that everything is done for the best of the whole people community and not according to the commercial interests. If we do not do so we take the risk that the whole society and economy pay the price by having weak and not healthy work force, able to deliver medium quality jobs.

As a conclusion, in order to obtain a system that can appropriately reward quality care, payment methods should provide: the possibility to align financial incentives with the implementation of care processes based on best practices in domain and the achievement of better patient outcomes (important improvements in quality are most likely to be obtained when providers are highly motivated and rewarded for carefully designing and fine-tuning care processes to achieve increasingly higher levels of environmental protection, health safety, effectiveness, patient-centered, timeliness, efficiency, and social equity); reduce fragmentation of care (payment methods should not put barrier to the ability of providers'

regarding coordination of the care for patients across settings and along time); fair payment for good clinical management of the types of patients in evidence (physicians should be adequately compensated for taking good care of all types of patients; the risk of random incidence of disease in the population should reside with a larger risk pool, no matter it is about large groups of providers, health plans, or insurance companies); the opportunity for providers to share in the idea of quality improvement (rewards should be located close to the level at which the reengineering and process redesign needed to improve quality are likely to take place); the opportunity for patients to recognize quality differences in health care and direct their decisions accordingly (people need to have good information on quality and the ability to use that information as they see fit to meet their needs, even have access to the physician's grades as appreciated through the performance system).

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