The Romanian health care system in transition from the users' perspective
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1.1 Transitions in health care: the European perspective

In the 1980s, most West European countries were considering major changes in health care. The growing costs of health care gave rise to the idea that the delivery of services could be made more effective. The market mechanism was seen as the ideal way to stimulate this effectiveness [1]. Do such changes affect the quality and accessibility of care [2] and what are the opinions of the patients about these reforms? These aspects of the changes, however, are not often studied.

There were several reasons for the changes made to the health care arrangements in West European countries. The main reason was the political wish to control costs in health care and to make health care delivery more transparent. It was believed that the introduction of a market mechanism would result in a better (more efficient and controlled) health care system. But a redefinition of the role of the state was also at stake. In the 1950s, the state slowly came to be seen as the first (and later, even the only) body responsible for health care delivery and quality of care in countries like the Netherlands and Germany. In the UK, the state took the central role immediately on the introduction of the National Health Service.

Although the medical profession continued to play an important role in the service delivery arrangements, other players also began to appear. Besides the state, health insurance companies became more important as cost controllers and, in the 1990s, the patients perspective was also seen as a serious aspect in rearranging health care.

These developments were present in most West European countries. Although each system differed considerably in its factual organization of health care, the ideas/elements mentioned above were introduced to some extent in most West European countries during the early 1990s.

At that same time, in Central and East European countries, health care systems also started to change from centrally directed systems into health-insurance-based systems (usually following the Bismarck model), sometimes accompanied by more incentives for privatization, such as family medicine in Slovenia, Croatia and Romania or hospital budgeting in Slovakia. It is perhaps possible to say that partly stimulated by the World Bank the ideas of a


[32] Castelein, S., Kwaliteit van zorg en tevredenheid met de gezondheidszorg vanuit het perspectief van de patiënt, gemeten bij de huisarts, tandarts, en medisch specialist (Quality of care and satisfaction with care from the patient's perspective measured at the general practitioner, the dentist and the medical specialist) Groningen 1999 (Master Thesis)

market mechanism (privatization of doctors practices, for-profit insurance, co-payment by patients), which were being proposed in the West European health care reforms as possible solutions to deal with Western problems, were being introduced as best solutions in Central and East European health care systems. However, these systems came from quite different backgrounds and had experienced quite different steering mechanisms.

In fact, by imposing Western solutions the changes in health care took on a European dimension. This dimension was based on the views of international advisers and financiers. The role of the consumer was, and is, another issue in most Central and East European countries. The consumers role has been very limited so far.

1.2 European consumers of health care services

In Western countries, consumer involvement in health care has become increasingly important [3-5]. The reasons are many and varied, such as the political and economic rights of citizens as payers. According to Boote [3], this involvement is an ethical obligation, facilitating a more democratic and open provision of service delivery [6,7] and is complementary to the clinicians perspective in providing a more holistic interpretation of health and useful insight into illness [8]. Therefore, the consumer's perspective is part of (local) health services development and planning, of monitoring service quality and of health research in Western countries.

This involvement takes different forms, from policy commitment to the programs implemented. In the UK, there is government commitment in this respect [9]; in the Netherlands, the existence of quality assurance and improvement of programs from the patient perspective takes the people's view into account [10]. Public consultation in the policy-making process with respect to health care takes many forms. For example, when setting priorities, questionnaires are used in Sweden, the Netherlands and the UK, and public meetings and focus groups are also used in some regions of the UK [11-14].

The strategy of involving consumers addresses both the health care providers and the users. On the one hand, health care professionals are trained in communication and closer partnerships skills for this purpose, and on the other hand, the users of the health care services receive training to ensure that they have the knowledge, skills and support to enable them to exert influence [3]. In the UK, partnerships between consumers and professionals, or professional bodies, were formed [3,15].

The switch from the "compliant, trusting, uncomplaining" patient [16] to the questioning consumer [3] has resulted in a heterogeneity of users; there are not
only consumers but also consumer groups and consumer advocates [17,18].

According to Boote [3], the health care users involvement in research goes beyond the role of passive suppliers of opinions, towards an active partnership with researchers. The empowerment of consumers within the research process is increasing from the level of consultation, through collaboration, towards consumer control.

But what about the involvement of health care service users in the Romanian health care system?

**1.3 Romanian patients / users of health care services**

The involvement of users in the development and planning of health services, monitoring service quality and in health research shows a different picture of patient status in the Romanian health care system. Because of this difference and the lack of consumerism in the Romanian health care system, the term user and not consumer is preferred in this thesis. User stands for the Cochrane definition of consumer, i.e. "someone who uses, is affected by, or who is entitled to or compelled to use, a health-related service" [19], and it is preferred for its neutrality and lack of connection with consumerism.

Regarding the involvement of users in health research, the project on which this thesis is based was the first, up to 2000, to ask for the people's opinions on health care. With respect to monitoring quality of care, only physicians within health insurance funds perform this role. Despite the high percentage of monthly income paid for health insurance, Romanian users of health services have no control over the value received for the money paid.

Furthermore, since 1989, the health care system in Romania has been "in reform"; it is shifting from an integrated, centralized, state-owned and state-controlled tax-based system to a more decentralized and pluralistic health insurance system. Health reforms are often seen as a good opportunity to involve users in planning and developing more democratic health services, but this seems not to be the case in Romania.

Consumer empowerment is considered to be a critical component of health system reforms in other countries, according to Segal [20]. It can contribute to efficiency in two ways: firstly, by ensuring the market is driven by the (well-informed) preferences of consumers and, secondly, by its potential to result in a more cost-effective approach to patient care.

Orientation towards a market system is mentioned in policy documents, but the empowerment of users, as a target of the health care reforms, is definitely missing in Romania. Although patient satisfaction is seen as an objective of health care system reforms [21], in 10 years of change, users have not been asked their opinions.
Additionally, seen as beneficiaries but not as key actors in reform, users did not attend the periodic meetings with the Romanian reform team, as the primary and secondary health care doctors did [22]. Therefore, there is no feedback on the changes from the lay people. As in the old times of the communist regime, the population was only informed by mass media campaigns. But even this program of information was not evaluated in order to assess its efficiency. There is not much data available concerning the peoples opinion of the health care system and its reform what they think, believe, appreciate and how satisfied they are with health care services.

But, for the people, topics related to health are very important. In a national survey carried out by the Foundation for an Open Society in 1998, 28% of the respondents stated that they are most afraid of illness. In fact, in the lay peoples "agenda", amongst prices, war, unemployment, delinquency and illness, illness takes first place. The importance of illness may be partly explained by the fact that people are afraid of running into problems when they need health services [23].

The aim of this thesis is to try to bridge the gap between political intentions and reality; it stimulates the producers of health, i.e., the users of health care services [24], to play their role in health care policy. The thesis starts with a description of the legislative changes and their affect on the accessibility and equity of health care services. Then, the utility of an instrument measuring the status of the health service from the peoples point of view is proved. Opinions about changes, satisfaction with the health care system and health care providers, and expectations and experiences regarding physicians form the main core of the thesis.

1.4 The objectives and research questions

The questions already raised include: What do the consumers of the health care system think about the changes in the health care system? Do they experience these changes as progress or as drawbacks? Will the changes increase the accessibility of the health care system in their opinion? Do they experience better quality of care? Such questions are the subject of this study.

International literature shows that the opinions and satisfaction of patients can be considered as important indicators of whether the changes in health care are successful and beneficial or not, i.e., whether they are performing well [25,26].

Objectives

The objectives of this study are to analyze the quality of care from the user perspective, to measure user satisfaction with the health care system and its
professionals, to describe the opinions of patients concerning the health care reforms in their country, and to find out peoples priorities regarding the quality aspects of health care and their experiences with health care providers. As indicated before, such information has thus far been lacking in Romania. With this data, policy-makers acquire new material to evaluate their activities regarding health care reforms and may find new insights into how the transition is affecting patients.

Three concepts are central in this study: opinions on changes, satisfaction and expectations. Opinions on changes describe how people think about issues such as information, accessibility and quality in 2000 as compared to 10 years before. Satisfaction with health care indicates how people appreciate the services as they are actually delivered. Satisfaction does not guarantee that the service is delivering quality. Expectations reveal what patients consider as important to receive. Expectations and actual experiences may indicate the quality of the service [10,27,28].

**Research questions**

The following questions will be studied:

1. What are patients opinions about the recent changes in their health care system?
2. How satisfied are patients with the health care system in general and with health care professionals?
3. What do people expect from health care providers?
4. How many people do not get what they consider as most important for them regarding health care provider services?

To understand the context of the four research questions, it is important to describe in more detail the health care delivery system in Romania as well as the recent reforms. This description will be dealt with in a separate chapter.

To measure expectations, opinions, health status, etc., it is necessary that reliable and validated instruments are available. As may be expected since this approach is new such instruments are not all validated in Romania. Therefore, an additional research question is:

5. What are the psychometric qualities of two instruments, i.e., QUality Of care Through the patients Eyes (QUOTE), and functional health status measured by MOS-20?

**1.5 Methodology of the study**

A questionnaire was developed to answer the research questions. The research population was defined as the adult citizens of a country, i.e., 18
years of age and older. The sampling was based on the population of GP practices randomly selected in a specific region. A region was selected for practical reasons. It was too costly (in time, personnel, money) to execute a national study.

The selected region was Dolj in the south-west of Romania. The total number of inhabitants in the district was 741,800 in 2002 [29]. The capital Craiova (310000 inhabitants) is the fifth largest of Romania’s 41 cities [32]. Craiova is the main urban center of the Dolj region with an important set of social, economic and cultural functions for the whole south-west area (29,200 sq km) of Romania [31]. The Dolj region may be seen as an example of several regions in Romania, i.e., a large city with industries and a rural area with towns and small villages.

Situated about 200 km from Bucharest, the Dolj region has developed industries in the auto, textile, petrochemical and food processing sectors, mainly concentrated in Craiova. Nowadays, throughout Romania, due to the structural changes undertaken to create a market-driven economy, many people have lost their jobs and have gone back to the agricultural domain. In the Dolj district, the loss of employment has continued, especially in the industrial giants in Craiova [31]. In 1996, there were 154,000 employees in industry and in 2001 only 127,000 [29]. As a result of the layoffs, especially in industry, the unemployment rate is high, i.e. 11.2% at the end of 2001 [29].

The percentages of males and females in the Dolj district are 48.7% and 51.2% respectively; for Romania, these percentages are 48.9% and 51.1% respectively [29].

The average income level in the Dolj district is 2,958,155 as compared to 3,019,424 for Romania as a whole [29].

The Dolj population has an average standard of living, due to the balance between agricultural occupations and some factories that are still working (machine construction, textile and a few in food processing). Of the 127,000 people in employment at the end of 2001, 5,800 were in agriculture, 1,200 in sylviculture, forestry and hunting, 44,000 in industry, 1,600 in mining and quarrying, 35,000 in manufacturing, 7,100 in electric and thermal energy, gas and water, and 8,100 in construction [29].

The average life expectancy in Dolj during 1999-2001 was 71 years of age; 71.1 years is the life expectancy for Romania as a whole. With respect to other indices of human development, i.e., infant mortality, Dolj has relatively good scores because it benefits from good medical support (according to the Ramboll Report [31]). At the end of 2001, Dolj had the following medical units: 13 hospitals, 3 polyclinics, 19 medical clinics, 8 health centers, 205 surgeries, 20 pharmacies, and 11 hospital specialist ambulatories [29].

In general, it may be stated that the Dolj region is not different from the
average in Romania concerning socio-demographic and socio-economic structure.

In the Dolj region of Romania, 10 GPs (6 urban, 4 rural) were selected at random and, for each GP, 100 potential patients of 18 years of age and over. These 1,000 people were asked to cooperate in completing questionnaires. The interviews were executed by trained interviewers. The interviewers were students of sociology who were specially trained to conduct these interviews as part of their training. The students were trained to become familiar with the questionnaire and with the interview situation, as well as in how to introduce the interview and how to execute it. The training was given by an experienced social scientist (Claudia Bara). The students were supervised during the interview period with regular checking of the quality of the interview.

The sample consisted of 1,000 randomly selected persons. The response rate was 68%. After verifying the questionnaires for completeness of data, checking with some respondents, eliminating providers, the final number of questionnaires used in this study came to 619, of which 61% came from urban areas and 39% from rural areas. The average age was 46 years, with 44% men and 56% women.

**Instruments**

To answer the research questions, it is important that reliable instruments are available which have been used before in other research and/or are validated internationally. This is especially important since this type of research is relatively new in Romania. The use of new instruments may be risky if they have not been tested elsewhere, so several international instruments were used.

Quality of care from the consumers perspective was measured with the QUOTE [10]. This instrument is internationally validated, but this is the first time it was used in Romania. The questions about satisfaction were based on a Dutch study done in 1999. In this study, nine specific questions were asked [32]. Medical variables were investigated using the MOS-20 [33], also an internationally validated instrument.

For some aspects, new questions had to be formulated since the research dealt with some specific, recent changes. Knowledge and opinions about the changes in the health care system were measured by items that had been formulated specifically for this research. As a phenomenon characteristic of East European countries, under-the-table payment is described by some specific items.
1.6 Outline of the thesis

The next chapter will describe the reforms that have taken place in the health care system in Romania during the last decade, starting with a short description of the situation before the revolution (Chapter 2). The content, socio-economic and political context of health care reforms and their affect on user accessibility will be presented.

The psychometric qualities of the short form (20 items) of the Medical Outcome Study Short Form (MOS-20) are analyzed next (Chapter 3). This is the first validation of a scale that assesses functional health and well-being in the Romanian context. For a country in transition, there can be no doubt about the utility of this scale for measuring health status from the people's point of view.

The opinions that people hold about the changes in health care as compared to ten years before are described in detail and opinions are correlated with background variables (Chapter 4). In order to obtain an assessment of 10 years of change, the opinions of various groups of people are presented. Then, satisfaction with the Romanian health care system and its professionals is analyzed. A model to predict satisfaction with the health care system is proposed and tested (Chapter 5). Here special attention is paid to under-the-table payments as one of the predictors.

The next question to be dealt with is the aspects of health care that people consider to be the most important. The QUOTE instrument is used for this purpose. The instrument is analyzed on its scalability (some psychometric characteristics) and expectations of the health care providers are also described (Chapter 6). Various groups of people with different expectations of health care providers are described and the possible discrepancies between what people consider important and whether they receive it are presented (Chapter 7).

The thesis will end by summarizing the main findings and by discussing the consequences for health care reforms (Chapter 8).

References:

Introduction


