

QUALITY OF ROMANIAN MEDICAL SERVICES – WAYS TO MANAGING TOWARDS IMPROVEMENT

Barbu Maria-Magdalena

Academy of Economic Studies, Bucharest Faculty of Management Str. Floare Roșie, nr. 7, bl. 51, sc. C, apt. 114, cod postal 062261, sector 6, București, România mariamagdalenapnb@gmail.com 0729600325

Health of people means everything since on it depends the well being of persons, families, companies, countries. All medical services should be accessible and offered at a very high level of quality which to allow and ensure future proper health status and people in good condition as active work force. If we do not do so we take the risk that the whole society and economy pay the price by having weak, not healthy work force, able to deliver only poor and medium results. This is the reason for which we should do our best to manage as good as possible for higher quality and continuous improvement. The paper presents Romanian payment and compensation system in comparison with some other countries' systems and ways to improving quality by assuring proper reward of medical personnel who help patients by offering consults, treatments, surgeries and put effort for people's health and overall "state economy's health".

Key words: Quality, Health Services, Motivation, Management, Active Life

The article's JEL code: L89.

Quality of Romanian and other European health systems

In Romania, 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 București.

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 nosocomial infections (contracted into the hospital); and time effectively waited by patients.

For sure that smaller rate of nosocomial infections will meet patient's expectations and patients will be glad to wait only some minutes or not wait at all. Successfully managing the quality indicator's aspects will positively influence relationship with patients and will also help in meeting their expectations.

A quality aspect is also the continuous availability of medical services (24 hours a day, 7 days a week). The problem here is that the low level of Romanian physicians' salaries makes it not possible for the moment to have the "non-stop" availability of the physicians belonging to the primary care system but this is desirable for the future. 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.

American and Canadian approach

Whether primary care system should be enforced even more or not is a management question. In the medical system of the United States, gate-keeping exercised by primary care preventing direct patient access to specialist care led to patient dissatisfaction. The health insurance system in the United States works fine as long as the person is healthy. Only people who have medical affections have problems since each contributor pays twice as much as people in other wealthy countries and apart of them there are 16 % population (47 million people out of 281,43 million people) without insurance. Americans can go to the doctor, pay directly and then send the bill to the insurance company for reimbursement. In most of the cases, the insurance company sends a form letter rejecting the claim. From this point on, only very ambitious people fight and send back a letter to the insurance companies to ask for clarification and after more steps (physician has to fill in a special form and send it to the insurance company which to confirm to the contributor the ok for the reimbursement or if the respective affection is not covered for reimbursement) get the money back. This is what happens into the private healthcare system. In comparison, with the private insurance, the public Medicare plan has predictable costs and benefits. The person can go basically to any doctor, and Medicare reimburses the doctor directly, protecting him/her from paying upfront and if the claim is denied, the respective doctor is financially liable unless. Nowadays, the lack of transparency means insurance companies can take advantage out of the patients by denying their claims. In exchange, insurers should be forced to disclose the treatments they cover and under what circumstances, as well as their full plan of fees. They should be limited regarding the ability to change the terms of their coverage, and they should be public responsible for the conditions under which they deny claims.

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.

Although the United States spends more per capita on health care than any other nation, numerous reports highlight deficiencies in the quality of care. Pay for performance is one approach under consideration as a way to garner greater value from the more than \$1.9 trillion spent annually on U.S. health care. A number of health plans and other private payers have initiated P4P programs, and the Centers for Medicare and Medicaid Services (CMS) has several

demonstration projects underway to investigate whether P4P can be incorporated into Medicare. Congress in December 2006 passed Medicare legislation to pay a 1.5 percent bonus to physicians who report on quality measures in 2007. As physician practices contain quality and value into their measurement and reward systems, it is important also that they begin to have a deeper look at compensation in a more strategic approach. The researched done by Minnesota Physician Magazine physicians have been asked to develop and implement better compensation programs which to reinforce their practices' missions, values and key objectives.

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 fee 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 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 value 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.

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.

Moral reward and better managing health system

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.

Sometimes, the quality of medical services cannot reflect the effort of only good willing physicians or of the contributors since the health system of our country cannot totally and in each case return the benefits they are entitled to receive according to the amounts the contributed with to the health fund. Not even compensated medicines or free ones cannot be the way of returning the amounts to the contributors every time because if the monthly maximum fund plan has been eliminated for all pharmacies, now the medicines distributors problem appeared they being unsatisfied by the exchange rate used for calculations and prices when making the expense account with National Health Insurance House, this having as a result stopping the delivery of medicines to the pharmacies and even complete lack of some essential drugs for diabetic affection or some other affections. The result was that two third of the medicines for which physicians have written compensated or free prescriptions have been taken by patients with money, proving once more that the system doesn't work proper. Here, the moral reward can come from the patients from the physician for a successful treatment but will not come from patients to the whole system because is not the case. Future management of the health system should solve this problem in order to allow fluidity and positive trends be something regular into the system and not only happening.

In order to solve the unpleasant and blockage situations similar to the ones mentioned above, 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. 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).

References:

1. Barton, L.P- „Understanding the U.S. Health Services System”, 3rd edition, Health Administration Press, Chicago, 2006;
2. Chicu, V., Curocichin, Gh., Friptuleac, Gr- Curs de promovare a sănătății. Chișinău, 2006, Davies, J.K.- Quality, Evidence and Effectiveness in Health Promotion, Taylor & Francis Publishing House, London, 2007;
3. Leebow, W., Scott, G- „Service Quality Improvement: The Customer Satisfaction Strategy for Health Care”, American Hospital Publishing, iUniverse, Nevada, 2007;
4. Moldoveanu, G., Dobrin, C- „Managementul calității în sectorul public”, Editura ASE, București, 2003;
5. Plumb, I., Androniceanu, A., Abăluță, O.- „Managementul serviciilor publice” – ed. a II-a, Editura ASE, București, 2005;
6. Thornicroft, G- “International Outcome Measures in Mental Health; Quality of Life, Needs, Service Satisfaction, Costs and Impact on Carers.”, The Royal College of Psychiatrists, London, 2007;
7. Vlădescu C. (coord.)- „Sănătate publică și management sanitar. Sisteme de sănătate”, Editura CPSS, București, 2004;
8. Watson, D., Broemling, A- “A result-based logic model for Primary Health Care. Laying an evidence-based foundation to guide performance measurement, monitoring and evaluation. University of British Columbia, Centre for Health Services and Policy Research, Columbia, 2004;
9. Wright, J., King, R- „We All Fall Down: Goldratt's Theory of Constraints for Healthcare Systems”, North River Press, Great Barrington, Massachusetts, 2006;
10. Stan, S- „Serviciile și rolul lor în țările dezvoltate cu economie de piață”, Editura A.S.E., București, 1998;
11. Starfield, B- „Primary care. Balancing health needs, services and technology.” New York, Oxford University Press, 1998;