

MEDICAL ACT BETWEEN FUNDING AND PATIENT NEEDS – ANALYSIS FROM THE PERSPECTIVE OF PHYSICIANS WITHIN THE CITY OF IAȘI

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Abstract

The necessity of empirical research in the field of medical services provision is highlighted both by the numerous modifications within the legislative framework (through which the medical system is organized and functions) and by the dysfunctions within its existence. The study proposes to identify those factors that may influence the quality of the medical act. The identified factors are present on the level of university training, of lifelong learning, of specializations and professional developments, on the level of the organization and functioning of the medical system. We also present the solutions identified by the physicians. The study is based on the analysis of 12 interviews conducted with physicians within public and private institutions in Iași. The topics of discussion were centred on the following aspects: medical system evaluation (comparison with European medical systems, but also between the public and the private system), relationships within the system (collaboration between institutions, collaboration with the family physician), work relationships, assessment of relationship system with/ between colleagues and professional recognition. This paper brings to attention the difficulties pointed out by physicians within the exercise of their profession, in their relationship with both institutions and patients. The main aspects pointed out are related to insufficient funding (reflected in the amount of equipments and drugs, in the infrastructure), to insufficient hospital staff, oversteering, university training and lifelong learning (that do not benefit from a unitary and integrating approach) and to the permanent change of the legislative framework that regulates the exercise of the medical profession.

Keywords: medical system, funding, training, specialization, private system, public system

Résumé

La nécessité de faire des recherches empiriques dans le domaine du fournissement des services médicaux est soulignée autant par les nombreuses modifications dans le cadre

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législatif (à travers lequel le système médical est organisé et fonctionne) et par les dysfonctions dans son existence. L'étude se propose d'identifier les facteurs qui peuvent influencer la qualité de l'acte médical. Les facteurs identifiés sont présents au niveau des études universitaires, de l'éducation permanente, des spécialisations et des cours de développement professionnel, au niveau de l'organisation et du fonctionnement du système médical. Nous présentons aussi les solutions identifiées par les médecins. L'étude est basée sur l'analyse de 12 interviews avec des médecins qui travaillent dans des institutions publiques and privées de Iași. Les thèmes de discussion ont visé les aspects suivants : l'évaluation du système médical (comparaison avec les systèmes médicaux européens, mais aussi entre le système public et celui privé), les relations dans le cadre du système (collaboration entre les institutions, collaboration avec les médecins de famille), relations au travail, l'évaluation du système des relations avec/ entre les collègues et la reconnaissance professionnelle. Cet article souligne les difficultés identifiées par les médecins dans l'exercice de leur profession, dans leur relation avec les institutions et les patients. Les aspects principaux mentionnés par eux sont relatifs aux fonds insuffisants (qui se reflètent dans la quantité des équipements et des médicaments, dans l'infrastructure), aux personnel médical insuffisant, au niveau trop élevé du stress, aux études universitaire et à l'éducation permanente (qui ne sont pas intégrées dans une approche unitaire) et aux changements continus du cadre législatif qui réglemente l'exercice de la profession médicale.

Mots-clés: système médical, financement, formation, spécialisation, système privé, système public

Rezumat

Necesitatea cercetărilor empirice în domeniul acordării serviciilor medicale este evidențiată atât de numeroasele modificări care au fost impuse de realizarea cadrului normativ (prin care se organizează și funcționează sistemul medical) cât și de disfuncționalitățile apărute în funcționarea acestuia. Studiul își propune să identifice acei factori care pot influența calitatea actului medical. Factorii identificați se regăsesc la nivelul formării universitare, la nivelul formării continue, specializărilor și perfecționărilor, la nivelul nivelului organizării și funcționării sistemului medical. De asemenea sunt prezentate soluțiile pe care medicii le identifică. Studiul se bazează pe analiza a 12 interviuri realizate cu medici din instituții de stat și private din Iași. Temele de discuție au fost axate pe următoarele aspecte: evaluarea sistemului medical, (comparația cu sisteme medicale europene, dar și dintre sistem public și sistem privat), relații în cadrul sistemului (colaborarea între instituții, colaborarea cu medicul de familie), relațiile de muncă, evaluarea sistemului de relații cu/ între colegi, recunoașterea profesională. Lucrarea aduce în atenție dificultățile identificate, în exercitarea profesiei, de către medici, atât în relația cu instituțiile cât și în relația cu pacienții. Principalele aspecte identificate sunt legate de finanțarea insuficientă ce se reflectă în dotarea cu aparatură și medicamente, infrastructură, numărul redus al personalului din spitale, suprasolicitarea, formarea universitară și formarea continuă care nu sunt abordate unitar și integrator și schimbarea în permanență a cadrului normativ ce reglementează exercitarea actului medical.

Cuvinte cheie: sistem medical, finanțare, formare, specializare, sistem privat, sistem de stat

1. Evaluation of the healthcare system in Romania – quantitative analysis

Starting with 2008, a Report of the Presidential Commission for the analysis and elaboration of policies in the field of public health in Romania (www.presidency.ro/static/ordine) proposed a series of measures and solutions for overcoming the difficulties within the medical system. The main problems pointed out are those related to costs and to the quality of services. From the point of view of costs, the most frequent debate topics refer to insufficient funds and inefficient spending of funds. The scientific literature presents these aspects as general issues in the evaluation of medical systems, including in developed democracies. The study of Calnan M.W. and Sanford, E. (2004) – that sought to measure the level of general trust in the medical system of England and Wales by using a questionnaire elaborated and applied in Germany and the Netherlands – found the lowest scores on the level of satisfaction in relation to how the health service was run and financed, waiting times, certain professional skills of physicians, as well as the implication of cost cutting for patients.

The data within the Special Eurobarometer “Patient safety and quality of care” (EC 2014), 71% of the respondents report that the overall quality of healthcare (in their country) is good, one percent higher than within the 2009 study. Respondents in Romania ascribe a good score to the quality of medical services (only 25%), significantly below the European average, along with Greece (26%) and Bulgaria (29%). In the same study, concerning healthcare quality in their country compared to other Member States, Romania is at the bottom: 78% (the European average is 34%) believe that medical services are worse. The criteria considered within service evaluation concerned the following: healthcare providers who are well trained, treatment that works, modern medical equipment, respect of a patient’s dignity, access to medical services (accessibility and proximity), no waiting lists for being seen and treated, free choice of doctor and type of hospital, and a welcoming and friendly environment. Taking into account these criteria, we conclude that respondents in Romania ascribed scores higher than the European mean concerning respect of a patient’s dignity (29%, compared to the EU average of 25%) and free choice of a doctor (28% compared to 19%), but also significantly comparable scores concerning the quality of medical personnel and equipments, as well as treatment that works, which suggests that the discontent is related mostly to causes pertaining to the system (funding, organization), rather than to the interaction/ relationship with the healthcare providers. Furthermore, the study published by IRES (2014) shows that the medical profession ranks on top of professions that the population ascribes high and very high degrees of trust, alongside the teaching and military professions. The assessment of perceived quality of health system (according to GHS 2011) shows that Romania, alongside Egypt, Colombia, Ukraine, Poland, and Greece, scored the lowest; the main causes are bad management and improper financing. In this study, the directions based on which they assessed perceived quality of services are the following: belief that the

health system ensures the best quality for all categories of population (especial the vulnerable ones) and that medical research will evolve in such a way as to provide solutions for solving medical problems. The same study found that the Romanian patients' participation to decision making in the treatment plan is the lowest in Europe, which ranges the therapeutic relationship within the paternalistic paradigm.

2. Design of the study. Method, sample, data collections instruments

Our research ranges within the spectrum of qualitative studies, considering that it involved the use of semi-structured interview. We chose this research technique because it was able to cover the aspects of the research, by providing information, from the perspective of physicians, regarding the types of relationships determined between physicians and patients, as well as between patients and the institutional setting, in the context on a long-term interaction due to chronic diseases.

The data collection period was November 2014 – March 2015. The interviews were conducted face to face, based on an appointment set between the interviewee and the researcher, in physicians' offices. The duration of the interviews varied between 60 and 90 minutes. After signing the informed consent form, the interviews were recorded and then transcribed verbatim and submitted to a thematic analysis. The sampling is theoretical, because the selection criterion was for the physician to have mainly chronic patients. We interviewed 12 persons – general practitioners and specialists within both the public system and the private system (with contracts with CASS or working exclusively in the private field). From among them, 9 had contacts with the medical systems of other countries through training courses, scholarships or participation to studies. The mean age of the respondents is 36; four of them are general practitioners and eight are specialists. Their accumulated service (including the residency) ranges between 6 and 14 years. Four of the physicians work exclusively in the public system; three of them work both in the public system and in the private system, while five physicians work only in the private system.

The topics of discussion were centred on the following aspects: medical system evaluation, (comparison with other medical systems, comparison between public and private system), relationships within the system, assessment of relationship system with/ between the colleagues, professional recognition and evaluation of the relationship with the patients.

3. Physician in Romania. Evaluation of healthcare system from the perspective of physicians in Iași

Starting from the topics of discussion and from the interview analysis, we pinpointed the following factors that influence the quality of the medical act: aspects related to work conditions (comprising the time and place of work, job satisfaction and motivation, training and development, material endowment and

funding), aspects related to the relationships established within the system and reflected in the relationship with the colleagues, the relationship with the family physician, the relationship with other institutions (health insurance fund, pharmacies, College of Physicians) and aspects that reflect the relationship with the patients (patient's information level, patient's involvement and awareness, patient's path in the system, patient's possibility of choosing the physician, type of services accessed and the possibility of requesting a second opinion).

4. Factors identified on the level of university training

Training during the academic years has generally received positive appraisals, but physicians also mentioned aspects that may be improved, related especially to university curricula. An unanimous opinion was expressed on the need of introducing courses that focus explicitly on communication with patients, on the development of practical skills, on instructions regarding the specific way of working within the system: prescriptions, computer system, situations when prescriptions are entirely or partially subsidized, types of drugs (nationwide lists), maximum number of drugs prescribed within a month and patient's path in the system.

“You study a lot ...there is too much focus on science and none on the integration within the system; we did not learn a thing about private practice systems or outpatient systems until we had our own private practice, when we discovered that there is a Tax Registration Number, that there are referrals, that the patient has to sign, that they have the right to consults, that they have the right to two more consults, that we could prescribe a treatment,...we had no idea about any of this before opening a private practice... so who should teach us all this?! Nobody told us there was such a thing as outpatient care; we were forced to discover it because we found no positions in the hospital. We were like newborns; we had not studied any psychiatry, any medicine. For me, what I do in my private practice was a whole new field to study...90% of it was acquired after graduating from all types of specialized education. So, basically, you end up with 10% of the information, which you have to update later, anyway, depending on lists of subsidized or non-subsidised pharmaceuticals, and not everything that the patient represents, what it means discussing to a patient about a certain specialization”. (I.9., 38, specialist, psychiatry, private)

Physicians consider that they had an incomplete training, both during school and in regard to the relationship with the patient, because the training is not included in an integrated perspective, which comprises the relations between patients and all their particularities (socio-economic status, roles) and their social environment, but it focuses on disease and on the treatment specific to it.

“Maybe, besides all of the other information taught in medical school, it would have been good to include some other hours, to let us actually practice. This is the patient they only teach you the disease and the proper treatment to give, but knowing how to follow the patient, learning if he, for instance, has a wife, if my diagnostic has some

social or legal implications, if he is a man, being careful not to produce dysfunctions of some sort, well, nobody teaches you things like that! When you're with the patient, face to face, who is like you father, you start to really think about what to do and you look up all possible dimensions. So, they do not really teach you anything on the socio-human-medical integration of the patient, they simply don't!" (I.9 38, specialist, psychiatry, private)

On the other hand, because no more positions became available in the public system in the period 2009-2011, for the physicians who finalized their residency, the possible alternatives became either changing their specialization and becoming medical representatives, or applying for jobs abroad and in the private system.

"No positions were available in the public system, because they were blocked for 2-3 years, by Ministry order, meaning that it was a choice, but ...forced, determined by a context..." (38, specialist psychiatry, private)

Human resource management in the healthcare sector is considered poor, taking into account that – compared to the other European countries – the number of physicians and auxiliary medical personnel in Romania is lower than the European mean. An issue that physicians identified is the lack of concordance between the number of jobs made available through residency exams and the real number of physicians demanded on the workforce market, which intensifies the personnel deficit in specializations such as oncology, geriatrics and emergency medicine. It is also worth noting the insufficient number of specialized staff, mainly for preventive and medical-social sectors, for public health and for healthcare management. Respondents also reported the small number of personnel with nurse college degrees and of auxiliary personnel, as well as a preference of the medical staff for urban settings and hospitals, which leaves the rural environment in need from the point of view of the access to healthcare services.

"Physicians leave because there is no horizon of expectations. I'll graduate from medical school, I'll have a specialty, but I don't know what will happen with me. There are physicians who have a job during their residency but give up on it afterwards, precisely because it would be almost impossible for them to work under those circumstances... because, in general, such are all the jobs available. Very hard work conditions, in areas where there is high deficit of staff. They [physicians] leave for several reasons. They leave because often not those who deserve it are included in the system, but those who manage to enter one way or another. There are also persons who simply choose to leave... because they are structured this way; they want to discover and learn new things and wages are incomparable but, first of all, they leave because of uncertainty, because you graduate from school here and there is no correlation between the necessary [number of doctors] and the need, or if there is, it is highly miscalculated, between the necessary number of physicians in terms of specialty and the number of physicians trained for that specialty, which leads to a real problem on the work market. Because the private system cannot take them all" (I.1, 37, general practitioner, psychiatry, private)

Taking into account these dysfunctionalities, it is worth highlighting the consolidation of medical services provided in the private system or of services provided by private healthcare institutions, which have contracts with the National Health Insurance Fund; actually, they have become a viable alternative to the public healthcare system.

5. Factors identified on the level of training, specialization and improvement

In the current conditions, the medical system fails to ensure a formal lifelong learning and development framework; the access – though not conditioned – is made more difficult by the overloading of medical personnel within the public system (they have to use their leave days for such trainings courses) and by the lack of financial means necessary for paying the participation fees to such scientific events.

“On principle, the institution you work for should encourage the physicians. The College of Physicians – our governing institution – forces us to have a medical activity, comprising a certain number of points granted annually, but the institution should support us at least by granting us leave days, not to mention by paying the congress fee, because the institution has a lot to gain, on principle, if the physician improves himself, right?” (I.2, 36, specialist, neurology, public)

The lack of any type of encouragements for choosing a medical career and for young specialists, the poor organization of the lifelong and post-university learning process for physicians, as well as the low level of wages are among other negative aspects reported by physicians.

“The instruction level depends on the budget of each physician, on his financial means. Because, if I do not have the money to attend the National Rheumatology Congress, I will simply not attend it. What does money mean? It means a lot: lodging, meals, transport and when you get there you need more ...you see a book... you think ‘I’m not going to see it next year for sure, I have to buy it now’. Yes, the instruction level depends on the budget of each physician. And on time. Because, for such physicians as myself, time never seems to be enough” (I.5, 35, specialist, rheumatology, private)

All these aspects highlight dysfunctions on the level of planning and training process of medical personnel, aspects related to several institutions that do not benefit from coherent coordinated policies in the field.

“Training – you do that by seeing and by doing, in the sense that, every time you attend to a patient, you become more experienced. This is not education, it is training. Education, meaning access to new techniques and other such things... that is much more sporadic and as soon as you manage to have a little time... and that is very rare... I think now of conferences, symposia, courses.... if you want to go to a training course... you go ... but it will be on your leave days and on your money” (I.6, 37, specialist, nuclear medicine, public)

Training / development courses (especially abroad) are sporadic; they are usually the initiative of hospitals, which invested in new equipments, but there they are not part of a strategy of the Ministry or of the employer. There is no preoccupation for the development or specialization of physicians considering the development of new techniques and technologies specific to the medical field.

“Everywhere in the world, the hospital you work for, the State contribute, meaning that they actually pay the physicians their courses, training. In the Romanian system, there is no such thing and this is why pharmaceutical companies are sponsors for all kinds of conferences, congresses and for physicians’ access to them, to new things. This is also related to bureaucracy.... For re-accreditation, the College of Physicians requires a certain number of lifelong learning points from the physician, which is more or less relevant, because these points can be easily purchased at a fair price. You simply pay for courses or for participation to congresses. I can give multiple examples in this sense, where investments were made in equipments but there was no one qualified to use them, and then we talk of exceptions.... of people who are sent – including abroad – for professional development, for actually learning how to use those equipments, but there is no coherent program, there is no custom for the manager – for this should be included in the management of a hospital – to invest in the medical staff, they don’t do things like that” (I.1, 37, general practitioner, psychiatry, private)

6. Factors identified on the level of the organization and functioning of the medical system

A category of factors – identified by physicians – refer to the organization and functioning of the medical system and they reflect in incertitude related to the job, after completing the studies (residency specialty), and to wages.

The assessment of the public healthcare system brings to attention negative aspects related to personnel deficits, outdated or insufficient equipments, frequent legislative changes (concerning medication and which raise the possibility of projecting long-term strategies) and to insufficient funding. At the same time, physicians also identify positive aspects such as physicians’ availability and flexibility in the relationship with the patients, patients’ possibility of choosing their physician, of requesting a second opinion.

“Considering that I came back from abroad, [I can tell you] patients get an appointment sooner in Romania than abroad, I’m talking here about serious illnesses for which they obtained an appointment in six months [abroad]. I saw not one, but several patients, thoroughly investigated abroad, but the patients were put on hold. With a load of papers containing investigations, they waited to receive a treatment, but appointments take a lot of time. They do not have access to follow-up and treatment as we do. In our country, most physicians show availability. We do not have access to all investigations, like most rheumatologic investigations, because [patients] have to pay” (I.5, 35, specialist, rheumatology, private)

“Even in terms of physician’s attitude toward the patients, maybe things are even better here; there are physicians who are more involved in the relationship with the patient and more familiar, more open; I cannot say there are many of them, but there are some who even give their own money to patients for buying medication” (I.4, 29, specialist, neurology, private)

Negative aspects in the organization of (especially public) medical institutions were reported, concerning space ergonomics (lack of adequate spaces for patients to change, common spaces such as toilets, waiting rooms, halls with questionable conditions, high number of patients and even periods when there are two patients in one bed).

“Old people usually do not protest, they do as they are told, reason for which the management of the institution does not feel the need to change anything, but it is offensive to tell a patient to go and change just around the corner, while I try to cover them [for privacy]” (I.4, 29, specialist, neurology, private)

The distribution of sections within a hospital – that makes it hard to transport a patient from one section to another – is a situation reported mainly concerning patients that cannot move. The inexistence of certain specialties in hospitals and the collaboration between hospitals when a patient is transferred from one institution to another are aspects that influence both the medical condition of the patient and the budgets of medical institutions. The solution provided by the physicians is to reorganize the hospital spaces in such a way as to facilitate patient access (especially for those unable to move) to the services they need, as well as creating jobs and hiring physicians for specialties currently lacking in hospitals but very much needed, such as cardiology.

“People are admitted to the neurosurgery hospital – with a neurology and neurosurgery section, but no cardiologist – and there are cases pertaining to cardiology, but which can also entail neurological damage. In a hospital with no cardiologists, the patient must pay for such an investigation – done outside the hospital – though he is hospitalized in a public clinic in Romania. I find that astonishing ... not to mention that it is extraordinarily difficult to transport a neurological patient; there are costs and numerous problems for a patient who is already in bad shape, because any change may worsen his state ... and that only because of poor management. Even at St. Spiridon, which comprises I don’t even know how many buildings. Normally, a normal hospital, in the current acceptance of the term, such as hospitals abroad ... at the underground level, there is radiology and all emergencies get to the ER and then to MRI, and only afterwards upstairs, to other sections. I believe that such a thing should exist in a regional university hospital ... if the patient has to go to neuro, he goes to neuro, if the cardiologist is around, he may come for a consult. You should not take your patient, call for an ambulance I don’t know how many times, because ambulances also have to go in the territory, to get patients ..., and, during all this period, the patient must wait, and if his state becomes worse, costs will be higher. So [the system] is poorly designed and a lot of money gets wasted, only due to the way in which patients are transported” (I.7, 34, specialist, family medicine, nuclear medicine, public)

Another aspect with negative effects on both patients and the management of system funds was identified in terms of patient's transfer from one hospital to another. There is a current custom of repeating a patient's lab works upon the admission to the hospital, though they had been previously done that very same day.

“Sometimes you go... with a certain pathology. You go to the endocrinologist who orders lab works, an ultrasound, all paid from the hospital budget, because the patient has a hospital admission paper. Sometimes he needs surgery right away; some other times, lab works are repeated right after your consult. Lab works again, ultrasound again; I don't believe that is OK. I think this is a way of wasting money, such procedures. Certain things should be repeated, but if an ultrasound showed something, it is useless to repeat it several times within a short timeframe” (I.7, 34, specialist, family medicine, nuclear medicine, public)

The explanation for such facts is related strictly to the way in which the National Health Insurance Fund reimburses services for medical institutions, irrespective of their organization forms. Another faulty aspect is represented by the protocol to follow when a patient's diagnostic involves investigations from several physicians. Though the legal path of a patient seeking to access the free healthcare services involves an appointment to the family physician, a referral to the specialist, then an appointment to and a consult by the specialist and the repeating of this cycle as many times as necessary, the physicians prefer and say it is in their own interest and in the patient's interest to send him/her to a physician they know and with whom they have previously collaborated. They posit that, this way, they show the patient that they care, that they are interested; waiting time is cut short, the patient no longer “wanders” in the system; at the same time, through the direct physician-physician contact, the diagnostic is set more rapidly and more accurately. The physicians within both public and private institutions admit these practices as adjustments to patient needs, considering the conditions imposed by the system. From this perspective, they acknowledge the benefits of the private system (with or without contracts with the National Health Insurance Fund) compared to the public system. Furthermore, the physicians we interviewed admit that, if themselves or a loved one ever had a medical problem, they would rather use the private system, to the detriment of the public one.

“A hospital admission paper is easier reimbursed by the [National Health Insurance] Fund if it is as complete as possible. Period. There is no way around it. It is time – and resource – consuming, but not as much as you get back from the Fund. An empty paper costs x lei, a paper with works necessary for that pathology costs an extra amount. So you need that extra amount” (I.3, 36, specialist, radiology, public)

Another problem identified is access to basic healthcare services; from this perspective, Romania ranks among the last, in aspects such as the number of physicians, pharmacists or nurses compared to the population. Disparities

concerning health status and the access to healthcare services differ by regions and zones in Romania, and they are closely connected with the level of economic development. The most striking gap is encountered in the rural setting, where the number of medical personnel, in general, and especially of physicians, is significantly lower than in the urban setting; this is also apparent for various medical institutions, pharmacies, hospitals and healthcare centres. The physical distance between the practice of the family physician and that of the specialist was reported by physicians as an impediment in the accessing of primary medicine services. Among the solutions provided by them, it is worth noting family medicine practices near or within clinics, ambulatory care or hospitals; they posit that such an organization would be beneficial mainly for patients, but also for physicians.

“There are drugs that represent the golden standard; they are the best and guidelines tell me I should start with those, but I cannot prescribe them to a granny who lives 4 km away from the healthcare centre. Because there is no infrastructure, meaning there is great distance between the patient and the nearest healthcare centre or first aid point, and because the village does not have trained nurses for their treatment, while pharmacists have limited time [to spend with each customer], patients often need an aspirin, but they cannot get it. And the distance between villages is also great; you cannot walk from one to another; if there were even a well-trained nurse with a basic emergency kit, they would not be forced to use solutions such as putting a walnut leaf on the back” (I.5, 35, specialist, rheumatology, private)

Given that a great part of the Romanian population lives in rural areas, – where functional hospitals are practically inexistent – there are major issues in terms of accessing basic healthcare services.

The fragmentation of healthcare correlated with limited access to medical services is another issue identified by physicians. The model involving the specialization of services and the absence of interdisciplinary teams also leads to the non-inclusion of patients within an integrated approach. The solution identified by physicians is a philosophy comprising the integration of healthcare services that ensure healthcare continuity. A major problem reported by respondents is that of persons admitted to hospitals with no ID, to relatives or with relatives with no financial means for transporting the patient home upon discharge or when such patients exceed the legal number of days for hospitalization.

“There was this patient admitted to neurology and the family was not coming to get her..., there was no ambulance ready to take her home..., so I asked my colleagues: what does the social security system do? They replied there was no immediate solution. If we called someone in her locality, police must come to identify her, though she does have an admission to hospital paper, then, after the police, some other authority must arrive... all that takes months. Meanwhile, she is in an emergency hospital, occupying a bed, because the family lacks resources or will to come and get her. There should be something that acts as a mediator, for these chronic patients to be transported. A colleague told me that, for another patient who came in the same manner, he went and obtained an ID and a handicap pension. But this is not in a physician’s job description...”

Take Socola, for instance; some of the patients have been in Socola since their birth. The hospital becomes a shelter, which is another way in which the system wastes money... I believe we are overwhelmed” (I.7, 34, family medicine, nuclear medicine, public)

Furthermore, the access to drugs, especially for disadvantaged categories, is still a major issue for patients. Subsidized drugs are over within the first days of the month, which has actually become a normal thing. *“Though you pay you National Insurance Fund fees... past the 5th day there are no more funds”* (I.3., 36, specialist, radiology, public); this also occurs in numerous hospitals.

“In our country, you are forced to obtain positive outcomes for a patient with minimum and sometimes with zero resources, or other times with resources you obtain God knows how... there are poor patients to whom you prescribe certain drugs, but if the hospital does not have them, you cannot give them to the patients, because you cannot pay for all of them, which means you cannot have the same results as your colleagues abroad. Your patients do not always benefit from the best treatment for reasons that often have nothing to do with the physician’s training. You prescribe [the drug]. You know it is the best, it will help, but... and I believe this is a common situation... but you prescribe antibiotics based on the drugs available in pharmacies, because you know that continuity in treatment is compulsory” (I.7, 34, specialist, family medicine, nuclear medicine, public)

In developed countries, individuals access public healthcare services more than twice a year for preventive purposes, (Kruk *et al.* 2011) and they expect from the healthcare system not only to provide medical services, but to provide them in a supportive environment, based on respect created by the government. Very few prevention programs proved to actually be effective. Whereas for pathologies such as cervical and breast cancer, free screening programs were heavily advertised, physicians posit that these services are more likely characteristic to persons who access private healthcare systems or to persons who had cases of such conditions in their family (fear as stimulus of prevention).

“If these preventive services were also included in primary school syllabus, I would understand. If children were taught to wash their hands, there would be a lower rate of pathology. I don’t go for lab works because I know I have to wait in line; I know I have to take advantage of the fact that I am a physician, which is not quite OK. The preventive system would actually have a role, reason for which trust would be higher. It would reduce the number of patients, the loading of diagnostics with chronic diseases not identified in time, not assessed in due time; it would also reduce the costs, and maybe there would be money left for other things, too. There are lines for screening for cancer, for mammography and, to my surprise, there are many women who live in rural areas, but they come because they had someone in their family with cancer... however, the good thing is they do come. There are also people who pay ... they don’t come within free programs” (I. 6, 36, specialist, nuclear medicine, public)

Among possible solutions identified by physicians, we mentioned the introducing (as early as in primary school) of healthcare education hours, a better collaboration

with family physicians and an efficient use of communication channels: media, social networks. When talking about messages provided by the media and transmitted via TV channels, physicians criticize the fact that certain celebrities advertise drugs; in their opinion, such information provided by the media may interfere with medical prescriptions, in the sense that patients prefer to use the advertised drug to the detriment of the one prescribed by the physician. The brochures within the practices of family physicians or within hospitals are considered adequate, but not sufficient. In terms of prevention and a healthy lifestyle, physicians ascribe an important role to the patient. The informing process must be conducted by involving the patients and by making them responsible; physicians do not believe that this is the direct responsibility of the Ministry of Health.

“You cannot force people; such an education starts in early childhood. Teaching the child to exercise, to do sports and to know the basics of healthy diet... it is hard to say... who [is responsible] ... to point the finger toward one institution, the ministry or... this also starts from us, the people, from the way we have been raised, educated to be healthy. We work a lot and we say we don’t have time for sport and we run after money all day long, which is a difficult process” (I.2, 36, specialist, neurology, public)

A fundamental component of prevention programs, of integrated services provisions, of health status monitoring – especially for chronic patients – is represented by the institution of family physicians. The importance of family physicians becomes even greater considering that the Romanian healthcare system is still based on hospital assistance as main intervention method; Romania is still among the countries with the highest hospitalization rates in the EU and one of the highest in the world.

Primary medical assistance is only weakly connected with hospital assistance. The healthcare system still fails to solve efficiently the major health issues of Romanians, because it focuses on curative assistance (especially on hospital assistance), to the detriment of outpatient care and primary assistance.

“Well, this interface between patient trust in the medical system and in the hospital is often represented by the family physician. All things should start from here. Western medical systems, within civilized countries, focus on primary medicine, they put it like this: primary medicine and the family physician make the first and the most important selection between going to a hospital where the patient is, ultimately, a consumer of all types of resources ... and treating a conditions in the smaller healthcare centre, meaning the family physician must decide whether the condition can be treated in an outpatient regime” (I.2, 36, specialist, neurology, public)

Family medicine is not granted the due importance, and the relationship of family physicians with the patients is influenced by the great number of recorded patients.

“What does the system tell me? You consult [the patient] and you send him to the family physician. During a simple consult, I cannot write to the family physician the

diagnostic and the treatment, because I do not have all the data. So, if the system tells me to consult a patient every six months, in my capacity of specialist, this does not help. For the family physician, such diseases are serious and they cannot treat them every month.... chronic diseases should be followed exclusively by specialists, in the current context... certain pathologies are approachable by virtually any specialty, but there are others that exceed their expertise. When I see a patient, I know he has a certain treatment and I know what I have to monitor in his case. When family physicians have 20 patients waiting, all with different pathologies, they forget this aspect. I am persuaded that they forget” (I.5, 35, specialist, rheumatology, private)

Another aspect hard to manage by physicians is bureaucracy and the anxiety entailed by alterations of legislative acts that regulate the organization and functioning of the system.

“How do we ultimately treat a patient? Based on what principles?! Set by who?! By the Court of Accounts, by the National Health Insurance Fund, by who, we need to know! There are various stages and controls and platforms and policies for each of them, and both us and the patient must obey all of them” (I.9, 38, specialist, psychiatry, private)

Irrespective of their workplace, – public system or private system, hospital, ambulatory, clinic, private practice – physicians underline that more than half of the time allotted to a consult is reserved to paperwork: prescriptions, medical letters and referrals, daily activity registry, periodical reports, etc. The only differences identified depend on the type of consult and on its purpose: initial consult or follow-up consult.

“There are many [complaints]. I believe that the greatest obstacle is represented by paperwork and by all the justifications we have to give; if physicians were allowed to do their jobs and if they did not have to fill in so many papers, they would think more about the case; each case is different and they would have more time to research each case, they would have more time for the public, for taking to the patient. But, [under these circumstances] sometimes you ponder: talk to the patient, write a letter, a referral, or complete the registry? This is the most traumatising aspect. Hence, we are no longer physicians, robots who must fill in papers because, if we have a control, that is all they ask. I would call all my patients during such a control and I would throw all the papers in a drawer” (I.5, 35, specialist, rheumatology, private)

7. Conclusions

Managerial limitations – both legislative and professional – accompanied by insufficient funding lead to frequent situations when the exercise of medical acts is made more difficult by the lack of equipments or drugs.

The digitized system and the creation of health cards, though meant to facilitate and to help the job of physicians, often only make it harder. Making them more effective is one of the solutions proposed by physicians, because this would avoid the situations when patients cannot benefit from subsidized drugs for a specific

disease only because those drugs are not included on lists A or B, or because they exceeded the number of drugs purchasable in a cumulated and simultaneous manner throughout a month. This way, physicians or institutions would be able to avoid potential sanctions.

Effective funding and fund management are still serious issues of the Romanian medical system. Decentralization and closure of hospitals failed to lead to a reduction of costs or to directing the money toward other institutions. On the contrary, it widened the gap between institutions that provide medical services, thus augmenting inequalities.

The law that regulates the organization and functioning of the medical system stipulates (Chap. 1, Art. 41 (1) that primary medical assistance should provide basic medical services to a designated population and it should ensure the continuity of the medical act, irrespective of the absence or presence of a disease, by integrating the physical, psychological and social aspects of the health status and by focusing on prevention, acute and chronic disease care, home care and medical care activities on the level of the community. At the same time, the law defines community medical assistance as the set of activities and healthcare services organized on the level of primary medical assistance, for the solving of medical-social problems, especially for the vulnerable population, in order to prevent diseases and to maintain population's health in their own environment. The community medical assistance team comprises a community nurse, a healthcare mediator, a midwife, a social worker, a physical therapist and persons with other professions, depending on the needs of that community. While the legal framework allows them to work together, primary assistance (the institution of family physicians) functions almost separately from the other healthcare services, which leads to discontinuities in the follow-up of patients' health status.

In this sense, a host of health system objectives are worth mentioning, as follows: access to the system, healthy behaviours, continuity and quality of care, improvement of lifestyle, and monitoring of health status. Any medical system aiming to be effective must take into account reaching objectives such as increased access to healthcare services and to their effective use (Russel 2005), satisfaction with and loyalty to the physician (Safran *et al.* 1998), self-monitoring of the health status (Wang *et al.* 2007), the patient's desire of recommending the physician to other persons and adherence to treatment (Hall *et al.* 2002). Professional norms, the quality of relationships between the categories of personnel within medical institutions and the way in which they reflect upon the patient are factors that can influence the relationship of trust (Gilbert 2005). A deep understanding of the factors that determine the creation of a relationship of trust in institutions will contribute to the improvement of medical services provided by institutions; it could also reduce disparities within the medical system and increase the degree of individuals' responsibility for their own health status (Cojocaru *et al.* 2013).

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