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"CAROL DAVILA" din BUCUREȘTI**



**"CAROL DAVILA" UNIVERSITY OF MEDICINE AND PHARMACY
BUCHAREST
DOCTORAL SCHOOL
MEDICAL FIELD**

**ASSESSING THE QUALITY AND PERFORMANCE OF
HEALTH SERVICES PROVIDED IN MEDICAL
PRACTICES**

DOCTORAL THESIS ABSTRACT

Doctoral supervisor:

ARMEAN PETRU, University Professor PhD

Doctoral student:

DR. COJOACA MARIAN EMANUEL

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**Universitatea de Medicină și Farmacie „Carol Davila” din București Strada Dionisie Lupu nr. 37
București, Sector 2, 020021 România, Cod fiscal: 4192910 Cont: RO57TREZ70220F330500XXXX, Banca:
TREZORERIE sect. 2 +40.21 318.0719; +40.21 318.0721; +40.21 318.0722**

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INTRODUCTION

The quality of health care and the performance of health systems are becoming topics of increasing relevance internationally, on the background of increasing interest in health as a fundamental value and as a premise for sustainable development, but also in conjunction with unprecedented global challenges, including the aging of the population, economic problems, but also the recent COVID-19 pandemic and the increasingly frequent and resounding armed conflicts, including in Europe.

In this increasingly problematic context, it is becoming more and more important for all states of the world to direct their available resources for health as effectively as possible and to ensure its best protection.

Romania is the EU state with the lowest expenditure on health per capita and per year, and also with the most unfavourable health status indicators.

All these aspects led me to approach in my research the particularly challenging topic of quality measurement in primary health care, with the intention of making a modest contribution to the future transformation of this field in which I believe very much and to which I have dedicated a good part of my professional life.

I thank my mentors for their guidance and openness, and I thank my family, who have constantly supported me in this endeavour that I consider particularly important for my professional life.

I. GENERAL PART

CHAPTER 1. HEALTH SYSTEMS - ROLES AND FUNCTIONS

1.1. Healthcare systems - conceptual framework

According to the Constitution of the World Health Organization, the state of health is characterized by a complete physical, mental and social well-being and not merely the absence of disease or disability [1].

The right to health is one of the fundamental rights and ensuring it as adequately as possible remains an important challenge for all countries in the world. On the other hand, securing the right to health is becoming an increasingly complex challenge because health is a public asset, to which all people have access, but health care can be very expensive and some people (often the sickest) come from disadvantaged socio-economic groups and cannot afford it.

Internationally, health has been recognized for decades as a key prerequisite for sustainable development and today the world's states have committed themselves to sustainable development goals and targets through the 2030 Agenda for Sustainable Development, which, among its seventeen goals, includes Goal 3 - "Ensure healthy lives and promote well-being for all people of all ages" [2].

According to the World Health Organization, within the political and institutional framework of each country, **a healthcare system is the set of all public and private organizations, institutions and resources whose primary purpose is to improve, maintain or restore health**, encompassing both personal and population services, as well as activities to influence policies and actions of other sectors to address the social, environmental and economic determinants of health [3].

1.2. Principles of healthcare systems operation

The literature provides numerous examples of principles on which the functioning of health systems should ideally be based. The most common of these are given below.

1. **Principle of equity.** This principle refers to the fact that all people should have an equal opportunity to reach their health potential. This can be seen from several perspectives [6-9].

ption, obligations on physical activity levels, etc.).

2. **The principle of universal health coverage.** This principle implies that the health system should be organized in such a way that all people get the health services they need without suffering financial hardship when they pay for them [10-12]. For a community or a state to achieve universal health coverage, it must have a strong, efficient and well-managed health system.

3. **Quality principle.** This principle requires that health services are safe, people-centred, timely, equitable, integrated and efficient. High quality care improves health results and reduces waste, and is an integral part of a sustainable health system.

4. A principle closely related to quality of care is **patient safety**, i.e. the prevention of any unintended or unexpected errors, or any adverse reactions, during the provision of health care, in essence doing no harm to patients [19, 20].

5. Also related to the quality of health care is the **ethical approach** to care, implicitly the patient's **informed consent**, i.e. the right to decide whether to consent to health care services after receiving full and accurate information tailored to his/her level of understanding [22- 25].

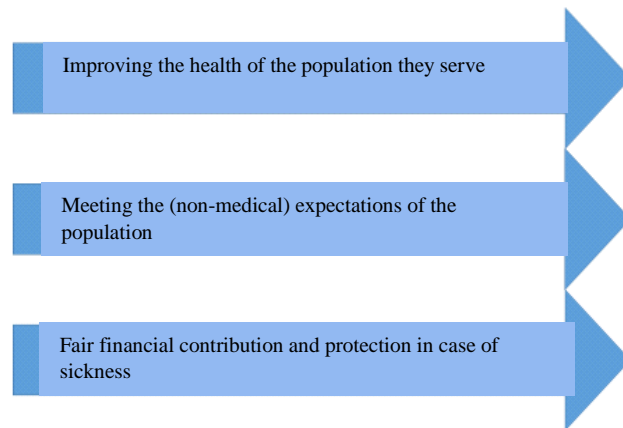
6. **The principle of solidarity**, with somewhat variable meanings, implies, in a narrow sense, that every individual, regardless of income or social situation, should receive the same services from the same health care providers and with the same clinical results.

7. **The efficiency principle** - health systems should be directed towards the care that is most needed and brings the greatest value to the most people [3, 28].

1.3. Purposes and functions of healthcare systems

The World Health Organization's 2000 report, which strategically conceptualized health systems as "assemblages of elements that interact with each other to contribute to the health of individuals in communities," emphasized that they have three main purposes (Fig. 1.1):

Fig. 1.1 Purposes of healthcare systems



Source: World Health Organization, *The world health report 2000: Health Systems: Improving Performance*. Geneva, 2000

1.4. Elements of health systems structure

The macrostructure of health systems refers to the key sectors/parts that make up the health system, and can be summarized as follows:

- 1) Who makes the rules/takes decisions (Parliament, Government, relevant ministry, other national authorities). The regulatory element is generally represented by the legislative power of the state concerned.
- 2) Who benefits from the health system - patients, civil society, through representatives, patients' organizations, civil society organizations advocating for health-related or health-adjacent rights.
- 3) Who pays for the operation of the health system, i.e. the authorities/entities that ensure the allocation and use of existing funding.
- 4) Who provides the functions in the health system - in particular the service providing function, i.e. the professionals and the entities in which they are organized.

1.5. Current challenges for health systems

1. Demographic change, represented by the ageing of the global population

2. Developments in consumer expectations.

3. Economic transformations and general progress in medical technologies and products.

4. New threats to public health. In the last decade the world has been confronted with terrorist threats, widespread migration for security and economic reasons [47], the COVID-19 pandemic that has killed nearly 7 million people [48], or high-profile armed conflicts, perhaps most surprisingly the conflict in Ukraine, with profound implications for public health [49, 50].

CHAPTER 2. QUALITY AND PERFORMANCE OF HEALTH CARE

There are several aspects to consider and analyse regarding the quality and performance of health care.

2.1. Conceptual framework on quality of health care

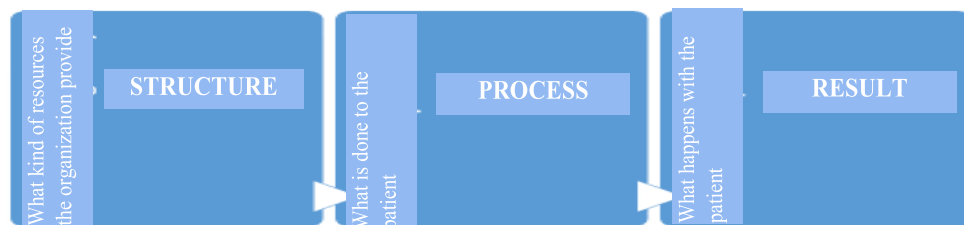
The concept of quality health care is gaining increasing visibility, both internationally and in the European Union, amid growing diversity of medical practice, variations in practice and awareness of patient safety issues.

2.2. Several **dimensions of the quality of medical care** have been described, such as [58]: effectiveness, safety of care, patient-centeredness (ability to respond to patient needs), efficiency, equity, timely provision of medical services, professional competence, acceptability, relevance, continuity of care.

2.3. Quality measurement at structure-process-result level

Avedis Donabedian approached quality analysis in an organization at structure, process and result level by likening the organization to a system [59] (Fig. 2.1).

Fig. 2.1. Framework for improving the quality of health services



2.4. Against the background of the general interest in the quality of health services, the OECD has drawn attention to the fact that the measurement of the quality of health care is an essential complement to the measurement of universal health service coverage and that states should have resources specifically dedicated to this purpose and use a mixture of population-based indicators and service-based indicators [60].

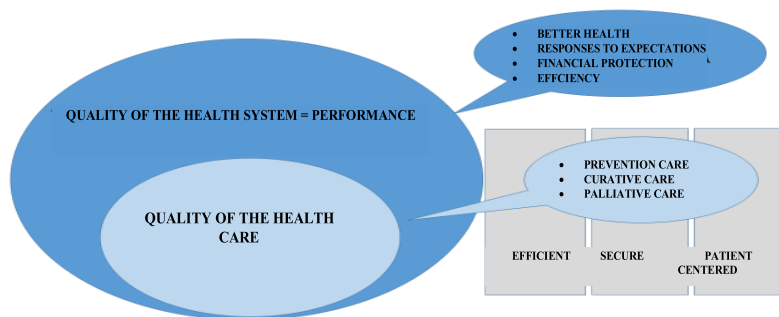
Thus, emphasis was placed on **documents and strategic approaches regarding the quality of health care in primary healthcare.**

2.5. From quality to performance in health care

In terms of performance, the WHO supports the concept of health systems performance assessment (HSPA), which is "a country-specific process of monitoring, evaluating, communicating and reviewing the extent to which high-level health system goals are achieved, based on health system strategies" [65].

At the conceptual level, quality has been divided into [52] (Fig. 2.2):

Fig. 2.2. Relationship between quality and performance in health systems



Source: WHO, Busse, 2019 (adapted)

2.6. There are several developments and trends in measuring the performance of health systems. An important promoter of conceptual and technical development for health systems performance analysis has been the OECD, who proposed a framework for measuring the performance of health systems, with 70 indicators, which was widely used for international comparisons, initially for OECD countries and later for EU members in the "Health at a Glance" publication series (Health at a Glance). The OECD carried out, through a Delphi survey, a minor revision of this framework and an analysis of the indicators used, resulting in a revised framework with 57 indicators, which is still in use today.

At the level of the European Union, there were also concerns regarding the quality of medical services, after the Maastricht Treaty, which granted public health powers. It started with the European Core Health Indicators (ECHI) project and the inclusion in Eurostat of some indicators (expenses, resources, activities, consultations, preventive services, etc.) [73, 74]

II. PERSONAL CONTRIBUTIONS

CHAPTER 3. ASSESSING THE CARE PROVIDED BY MEDICAL PRACTICES IN TERMS OF QUALITY AND PERFORMANCE

3.1. Study hypotheses

This research consisted of an exploratory analysis of the mechanisms for evaluating the quality and performance of the services provided at the level of primary health care practices in Romania, in comparison with international models, with the intention of identifying mechanisms and indicators that provide a more complete picture of the quality and performance of health services at this level.

We considered the following working hypotheses:

- 1) In Romania, primary health care practices have a clearly regulated organizational and operational framework that ensures the quality and performance of the health services provided;
- 2) There are indicators for measuring the quality and performance of health services in international practice that can be used in Romania;
- 3) Primary health care professionals are aware of the importance of quality of care and value it;
- 4) Patients in Romania have a favourable perception of the quality of health care in primary health care.

3.2. Research purpose and objectives. General research methodology

The main purpose of the work was to analyse the framework of organization and functioning of medical practices in order to establish mechanisms for evaluating the quality and performance of services provided at the level of primary health care practices in Romania and to analyze international models in this field. Another purpose is to establish indicators that will provide a more complete picture of the quality and performance of health care at the level of medical practices.

For this research we have set the following objectives:

- Analysis of the general framework for the organization and functioning of medical practices and the quality assurance mechanisms governing them;
- Analysis of models and indicators for measuring the quality of primary health care in international practice;
- Analysis of professionals' views on quality in primary health care;
- Analysis of patients' views on quality in primary health care;
- Defining a set of indicators to measure the quality of services in the primary health care practice.

In order to achieve **objective 1** - "Analysis of the general framework for the organization and operation of medical offices and the quality assurance mechanisms that govern them" - the critical analysis of specialized literature, quantitative data analysis and qualitative research methods were used - criteria-based analysis.

In order to achieve **objective 2** - "Analysis of models and indicators for measuring the quality of primary medical care in international practice" - a qualitative analysis was carried out, starting from the quality indicators in primary care of the OECD, which were analysed after a self-designed grid.

For **objective 3** - "Analysis of the opinion of healthcare professionals regarding quality in primary healthcare" - an analysis of quantitative data, collected on the basis of a self-designed questionnaire, was carried out.

For **objective 4** - "Analysis of patients' opinion regarding quality in primary healthcare" - an analysis was carried out on quantitative data, based on a self-designed questionnaire - the questionnaire for patients.

For **objective 5** - "Defining a set of indicators to measure the quality of the activity of the primary healthcare office" - a qualitative approach was used to synthesize the results obtained in objectives 1-4.

CHAPTER 4. RESULTS AND DISCUSSIONS

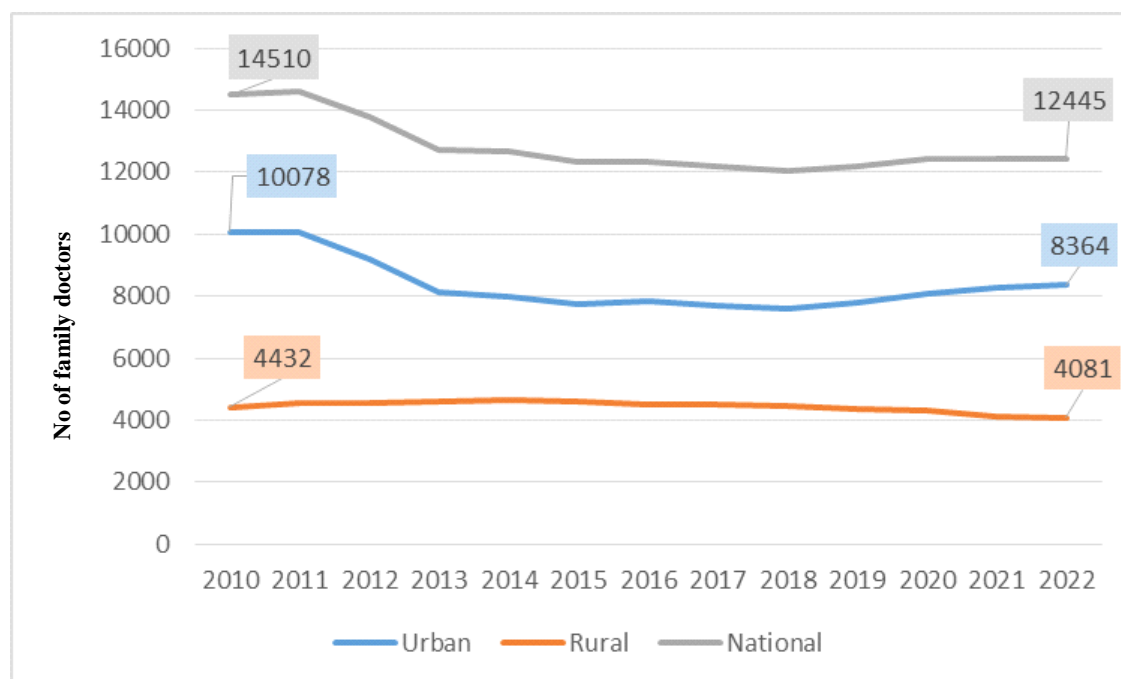
In this research, two studies were carried out, according to subchapter 4.3 – “Analysis of healthcare professionals regarding quality in primary healthcare” and subchapter 4.4 – “Analysis of patients” opinions regarding quality in primary healthcare’.

Study 1 included a number of 224 doctors from 36 counties and the Municipality of Bucharest, and study 2, a number of 177 patients, coming from the list of 15 general practitioners (family doctors) in Bucharest.

Some of the results and conclusions of the studies are briefly presented below.

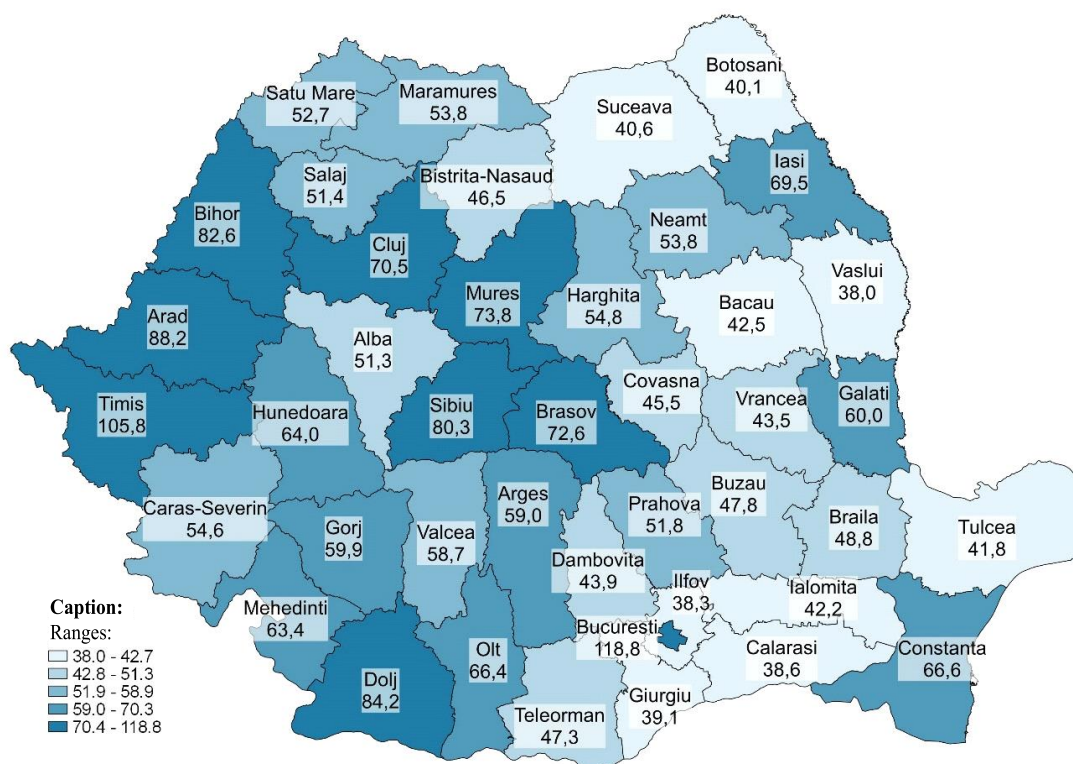
Accelerated decrease in the number of doctors raises the issue of medium-term (3-5 years) professional coverage. When correlated with the average age of medical professionals, this analysis could point to an even more unfavourable situation, in the sense that the average age is expected to be high and the health care system to face a significant wave of retirements based on "age" in the next 5-10 years. Details of the annual evolution of the number of doctors are shown in Fig. 4.4.

Fig. 4.4. Evolution of the number of family doctors between 2010 and 2022, nationally and by residence area



Another important issue, beyond the dramatic decline in the number of professionals, is how they are spread geographically, given that both effectiveness of care and equity of access require equal opportunity, or equal efforts to access. To this end, we have calculated the coverage of family doctors per 100,000 inhabitants (Fig. 4.5).

Fig. 4.5. Family doctor coverage per 100,000 inhabitants, Romania, 2022



It is found that, although we are talking only about family doctors, the coverage characteristics are in line with the general characteristics for medical staff, respectively:

- a. university centres with medical universities/faculties and the counties in their vicinity are best covered;
- b. the NE region (except for Iasi and Neamt counties), the SE and partly the South are visibly more deficient in terms of coverage.

The analysis of coverage by residence confirms these conclusions and reveals, in addition, the more pronounced deficit for rural areas (Fig. 4.6 and Fig. 4.7.).

Fig. 4.6. Family doctor coverage per 100,000 inhabitants, urban, 2022

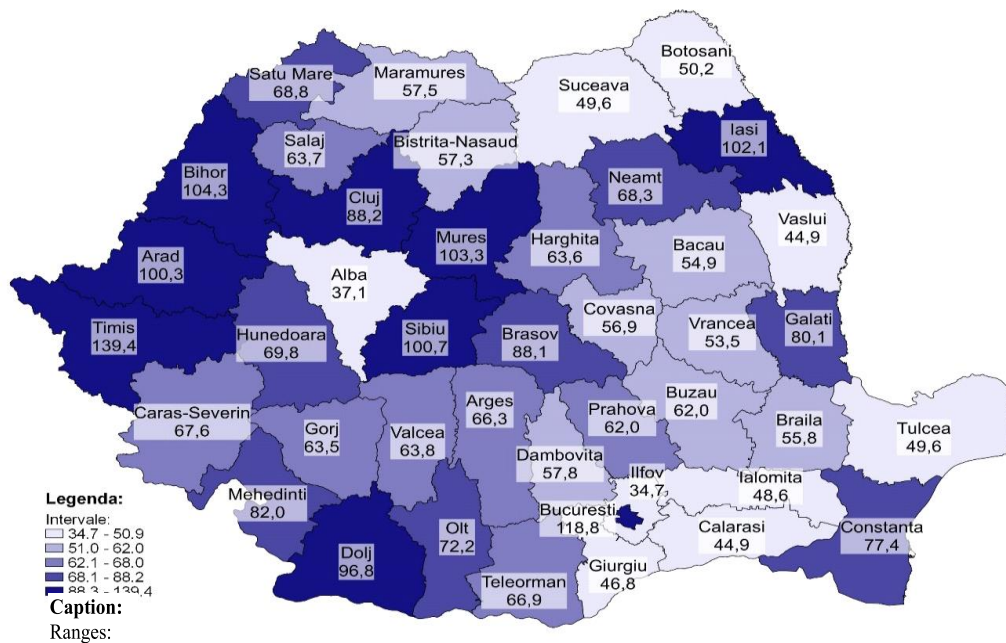
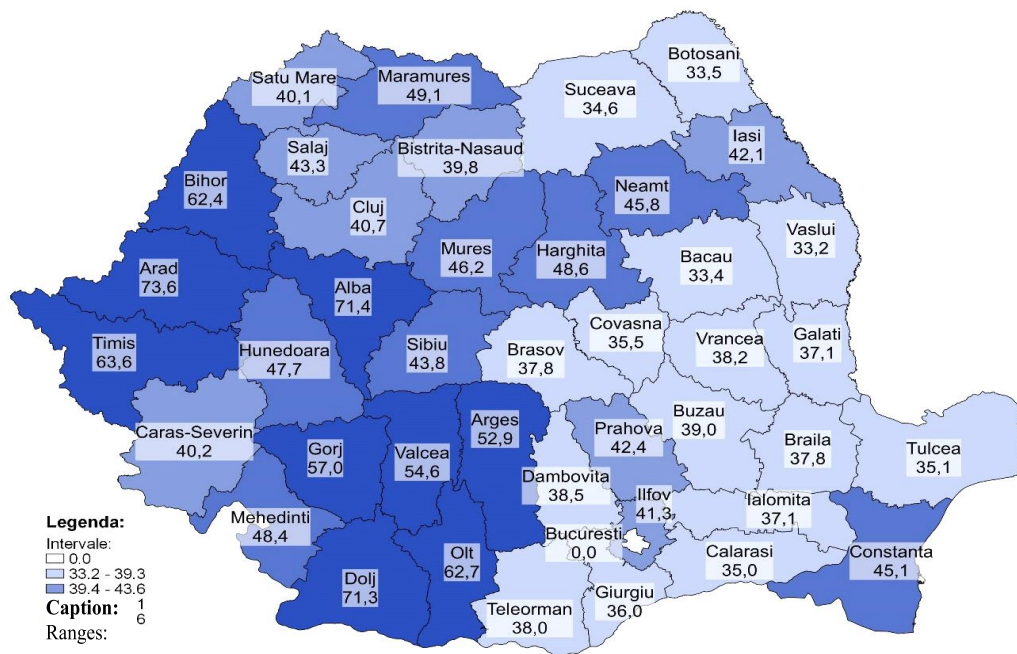


Fig. 4.7. Family doctors coverage per 100,000 inhabitants, rural, 2022



CHAPTER 5. CONCLUSIONS AND PERSONAL CONTRIBUTIONS

5.1. Conclusions

1. The analysis of the organization and functioning of medical practices revealed a clearly defined regulatory framework and an uneven and decreasing territorial coverage, while the professional path of a family doctor before becoming a specialist requires at least 10 years of university and postgraduate studies.
2. From the exercise of identifying the quality criteria used in primary health care, it was revealed that the Romanian legislation includes a significant number of provisions related to the quality of health care (authorization, evaluation, accreditation, implementation and reporting of services provided in the basic service package). These legislative provisions take the form of clear requirements that can be assessed as met/not met and that can be classified in the quality dimensions of the OECD model (effectiveness, safety, response to expectations).
3. The ANMCS standards use organizational management, clinical management and ethics and patient rights as reference levels, this classification is in line with the principles of health systems operation and performance evaluation.
4. The authorities' requirements are not currently accompanied by indicators to measure quality. This stage, of developing indicators, will be necessary in the future in order to be able to really measure the quality of health services.
5. The basic package of services follows the lifelong approach, with separate provision for services needed at different stages of life, but the extent to which these services are taken up by those eligible is not apparent from publicly available data. Moreover, some flagship primary health care services (e.g. vaccination service, screening services for cervical, colon and breast cancers) are not included in the analysis of the activity of family doctors.
6. Current official data sources provide rather limited information on the processes at primary care level. The analysis carried out confirms the first research hypothesis, i.e. that in Romania primary health care practices have a clearly regulated organizational and operational framework aimed at ensuring the quality and performance of the health services provided, but this framework is mainly materialized through regulatory requirements and to a lesser extent through concrete indicators. Even when indicators are followed, or benchmarks are set (e.g.

max. 3 ultrasound scans/hour) it seems that the aim is rather to control costs. Indicators referring to health results are not routinely used.

7. In terms of international models, the OECD has refined the WHO model for analysing health system performance and developed a set of indicators to measure the quality of health services that have been in use for about 10 years.

8. The analysis of OECD indicators according to the criteria "feasibility", "importance of the problem", "comparability" revealed that all indicators are of high importance, but only two are currently routinely used in Romania. Some indicators can be implemented in the short term without additional efforts, while others could be implemented in the medium term, provided comparability is improved. For some of the indicators, it would be possible to collect data and calculate indicators either through surveys or by introducing new population programs and new variables in the current information system (for screening programs). There are, however, a number of important indicators whose implementation is problematic. In an optimistic scenario, these could be implemented in the medium to long term, with substantial data interoperability efforts.

9. Professionals' views on quality in primary health care were analysed using a self-created questionnaire, which took some questions from OECD instruments and had as areas of investigation professionals' views on the quality and safety of health care services provided, views on communication with patients, views on the importance of quality and professional training in this field. Most of the responding family doctors were at least satisfied with the quality of the health care they provide in their practices and considered that this quality is mainly supported by professional training and experience, communication with patients and the existence of medical practice guidelines, but is also limited by the infrastructure and equipment of the practices, the information system and legislation.

10. Family doctors had a favourable opinion of patient satisfaction, with almost two thirds of them saying that their patients were at least satisfied with the services they received.

11. Regarding the possibility of improving the quality of the services provided, almost 80% of doctors answered in the affirmative and listed the IT system, legislation and the infrastructure and equipment of the practices as the most important.

12. Two thirds of doctors were able to specify quality indicators that are not routinely reported, indicating a personal concern for measuring quality indicators, even if these are not formally required by the authorities.

13. In terms of the safety of health services, more than three quarters of the doctors surveyed considered that they provide very safe or safe services to their patients. However, most doctors either did not answer or answered negatively to questions about possible reporting of medical errors or medication errors during care, which reveals that this aspect is less developed in usual practice.

14. Only a third of doctors believe they spend enough time with the patient, while almost a third were somewhat confident. As for providing explanations that are easy for patients to understand, 63% of doctors are sure they do this, and as for involving the patient in the therapeutic act, only 28% of doctors responded they were sure. This result supports the need for training programs in patient partnership and shared-decision.

15. Regarding the view on quality training, we found that doctors grant a very high importance to the quality of health care and almost half of the doctors consider that they have a "generally good" training in this area, but most of them expressed their willingness to follow another training program on the quality of health services.

16. The patients interviewed were selected by circumstantial selection through family doctors. The gender distribution was in favour of women (66.1%) and patients were predominantly elderly.

17. Almost 50% of the patients interviewed in our study had at least a good opinion of their own health, a proportion lower than the proportion typical of the Romanian population in Eurostat (50% compared to 73.3% in Eurostat), a fact derived from the way of conjuncture selection of patients (patients who presented themselves to the family doctor, possibly for a health condition), a selection mode that also generated a distribution by age group deeply shifted to the right (elderly patients predominate).

18. In terms of access to consultation most patients had been to their family doctor 1-3 months ago, got same-day or same-week appointments or presented unscheduled for consultation.

19. Waiting time for appointments was a problem for 42.6% of patients (although most patients either came directly or were scheduled within a week), and waiting time to be picked up for appointments was a problem for 28.8% of patients.

20. In terms of patients' views on communication with doctors, 25% of patients were certain or somewhat certain that doctors do not spend enough time with them in consultations, 29% were certain or somewhat certain that doctors do not explain things in a way they understand, and 22% were certain or somewhat certain that doctors do not involve them enough in care and treatment decisions.

21. Based on the results obtained from the patients interviewed, there is a higher proportion of lower patient satisfaction with their experience of health care compared to the average patient in the 9 OECD reporting countries (Netherlands, Estonia, Portugal, Luxembourg, Germany, France, Slovenia, Poland, Sweden).

22. Patients in Romania were somewhat sure/assured that doctors spend enough time with them in a slightly lower proportion than the average of the 9 countries.

23. Comparisons between patients' and doctors' views on communication issues and views on quality were significantly different. Overall, doctors tended to be very satisfied on all four variables to a greater extent than patients.

The OECD has proposed a framework for measuring the performance of health systems, with a focus on quality, the lifelong approach and primary health care, and publishes annually a set of indicators on quality in primary health care, which have been analysed in terms of feasibility, relevance and comparability, based on current data sources in Romania, and it was found that these indicators could be partially or fully taken up in three stages.

In a context where Romania has a clearly defined package of basic services in primary health care, reflecting the lifelong approach, and where exploratory studies of professionals and patients conducted through this research revealed the interest of these parties in quality assurance, including the collection of questions from OECD instruments, it is important for the country to improve its health information and informatics system, especially in the context of the commitment to OECD access. The Access Memorandum includes targets on health system performance and quality of health services.

5.2. Personal contributions

Numerous sources in the literature confirm that primary health care is the foundation of an effective, efficient and responsive health system. To achieve this, further analysis is needed to ensure comparability, and the purpose of this research was simply to explore the use of an international tool in Romanian patients, this being, to our knowledge, the first research of its kind in Romania to date. Although patient satisfaction questionnaires are routinely used at hospital level or in private health care provider organizations, they are not commonly used in outpatient services and family doctors.

Therefore, based on the results described above, this research was able to define a set of indicators for measuring quality in primary health care in Romania.

We have shown that it may be possible to initiate this approach in the context of European funding from the National Recovery and Resilience Program and the Health Program respectively.

5.3. Research limitations

A limitation that needs to be expressed is that this research has combined quantitative and qualitative methods of analysing the quality of health services which may generate subjective responses leading to results that are not in line with reality.

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