THE ACADEMY OF ECONOMIC STUDIES IN BUCHAREST
C.S.U.D.
Doctoral School - BUSINESS ADMINISTRATION

RESEARCHES ON THE POSSIBILITIES TO CONTINUOUSLY
IMPROVE THE QUALITY OF HEALTH CARE IN ROMANIA IN
TERMS OF CUSTOMER ORIENTATION

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București
2016
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**Key words:** HEALTH CARE SERVICES, HEALTH REFORM, QUALITY, QUALITY ASSESSMENT, MANAGEMENT OF TOTAL QUALITY, EXCELLENCE, PATIENT RIGHTS, PATIENT SATISFACTION, STAFF SATISFACTION.
Introduction

The quality of health care was a constant concern in human history, the evolution of this concept was influenced by both the evolution of the concept of "quality" in the general sense, and society, and the evolution of medicine and science of healthcare as an interdisciplinary area of application of science, technology and mathematics in delivering services that lead to improved health status of the patients.

With the increasing complexity of medical care and the development of science and technology, the concept of "quality health care" become increasingly difficult to define and assess. The complexity of quality health care services derives from multiple different perspectives from which it is viewed and evaluated (authorities, patients, specialists), from the plurality of parameters and dimensions of its interconnections.

The quality of health care has increasingly become a central concept, whose role and place are growing, regardless of the degree of development of a country, the maturity of the health system or the resources allocated to this sector, as long as the results are difficult to predict or achieve at the desired level and there are variations in health care standards from one organization to another, from one environment to another or from one period of time to another.

Today, we hear more and more about a management of the culture of organizational quality, with the expected beneficial effects on the performance of health care, the medical effectiveness and efficiency in fund management.

Conducting research and summaries of thesis chapters

The doctoral research paper with the title „RESEARCHES ON THE POSSIBILITIES TO CONTINUOUSLY IMPROVE THE QUALITY OF HEALTH CARE IN ROMANIA IN TERMS OF CUSTOMER ORIENTATION" performed in the Doctoral School of Business Administration, Academy of Economic Studies in Bucharest, under the direction of Mrs. professor Roxana Sârbu, PhD, aimed at identifying opportunities for improving the quality of health care services from the perspective of patients and professionals in the system, managers, doctors and nurses, to increase efficiency and effectiveness of the entire system.
As specified secondary endpoints related to research one must remark the assessment of healthcare system in Romania, in its evolution, ways of defining and assessing the quality of health care services and the use of quality management systems in customer orientation of these services.

Doctoral research was multidisciplinary, involving, in addition to in-depth economic knowledge, a number of scientific and research skills in the areas involved or associated with medicine, law or psychology.

PhD thesis contains an introduction and is structured on six chapters, followed by conclusions from the research, references, appendices and a list of tables and figures in the body of existing work and is carried on 385 pages. They were found 238 references, most of the past 10 years, resulting in 377 bibliographic references as footnotes. Findings by the author are shown graphically in 165 figures, for systematization of data being used 29 tables. During doctoral research the author has published 3 scientific papers in international journals (listed BDI), presented papers at 6 international conferences, including two ISI Proceedings.

Chapter 1 is titled **Overview of the medical services in the Romanian Principalities, from the beginning until the first half of the twentieth century** and comprises three subchapters, namely: **Historical Landmarks of health services; Elements of organizing health services; The emergence and evolution of medical education.**

In our country, the first forms of patients care are registered in the monasteries, as a result of the power and wealth held, assumed the task of giving assistance, under various forms, of those in need. Ursea (2009, p. 248) states that the first monastery hospitals were mentioned in documents in Transylvania, as early as the eleventh century, and run either as infirmaries for monks or as places for laity care, care being provided by monks trained in Monte Cassino in Italy, or Germany¹. Among the first such settlements can be mentioned: - Mănăștur hospital in Cluj (1061); hospital in Sibiu (1292); poor hospital from Bistrița (1295); Asylum hospital from Cluj "Saint Elizabeth " (end of XIII century and beginning of XIV century)².

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Since the XIV century, in some Romanian and Moldovan monastery in the country „infirmaries" were developed, the first being documented in the Romanian Country in 1524 to Sănmăndreni and the second at Argeș monastery. Later, Stephen the Great built in Moldova in 1487, a hospital in Pătrăuți, intended for caring the soldiers.

Until the appearance of the first hospitals, medical services were provided by foreign doctors who care for the various rulers or nobles of the time.

Due to the lack of local doctors, Constantin Brâncoveanu tried to organize a civil healthcare system financially supported by the ruler and military, funded from the treasury.

In Transylvania, under the influence of health reforms from Austria, since 1752, appears obligation to employ some officials MDs at county level and since 1755 the control of diplomas and medical practice is set.

The first hospital in the country is open to Bucharest Romanian - Colțea Hospital (1704), followed by asylums Holy Friday, all in Bucharest, and that from Târgoviște, called unfit hospitals. It will follow St. Pantelimon Hospital (1735-1752) and St. Vissarion Hospital of Bucharest (1735), a small hospital in Craiova in 1737 and St. Spiridon Hospital in 1757 from Iasi. In 1813 the Hospital Philanthropy is built and then in 1859 the Central Military Hospital, in 1886 Grigore Alexandrescu Hospital and Rescue Society from Bucharest appears in 1906.

Despite the shortcomings, Bucharest hospitals resemble to those of more developed countries, as Iorga shows (1939, p. 273) that quotes in his paper History of Bucharest the French philanthropist Appert. When he visited Bucharest in 1853, he believed that hospitals "are generally just as good as those, analogous of a large number of cities in Germany and certainly much better than most hospitals from Hungary and rich Hamburg". Iorga also (1939, p. 281) cites favorable opinion of another traveler through Bucharest in the middle of the nineteenth century regarding the hospitals from that times "they are not in any way under the institutes similar in the US and even surpass through their novelty and good organization.

Doctors who have made available to poor patients their lives and knowledge in sec. XIX giving them free consultations are important names of Romanian medicine, among which we can mention only from the Colțea Clinic: Daniel Danielopolu, Eugen Felix Jacob

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Iacobovici, Constantin Leonte, Gheorghe Marinescu and many others. Following inspections made to the great foundations in Bucharest (Colțea, Pantelimon and Filantropia) and the irregularities that were found, Kiselef decides, on April 2, 1832, to unify them under a common management; thus Eforia Civil Hospitals from Bucharest appears, they operated over 100 years.

Laws of 1864 promote decentralization and establish subordination of county and municipal health authorities to the local authorities, which must ensure functioning from their budgets.

After the Great Union, Romanian medical education encounters a development on multiple levels, and in 1869 in the University, the Faculty of Medicine from Bucharest shall be established, the first in the country of its kind and along with Faculty of Dentistry and Pharmacy today comprise University Medicine and Pharmacy „Carol Davila" Bucharest.

Many graduates are sent abroad, where they complete PhD and they return home with new knowledge in the field of physiology, pathologists, and anesthesia, antiseptic and medical techniques that have contributed to the development of Romanian medical system\(^5\). Participation in the War of Independence of many teachers and students from the Faculty of Medicine, as volunteers within the military medical service, helped also by experience, to develop knowledge in this field.

Romania's first modern sanitary regulation is adopted in 1874 and subordinates public health administration to Ministry of Internal Affairs. Its principles will remain in force until 1910 and will regulate the health service as a service of the state.

An important role in healthcare was played by Social Insurances, introduced by the Law that ensured trades, credit and workers insurances since 1912, considered to be the source of Romanian social security system. Since 1923 the first laws on the organization and functioning of social care were developed and starting that year until 1943 social security issues have been regulated by the Ministry of Public Health, Labor and Social Care.

In 1919 the Faculty of Medicine from Cluj is reorganized, in 1945 Faculty of Medicine from Timisoara and in 1948 the Institute of Medicine and Pharmacy in Târgu Mureș is established.

In 1930 Health and social care law appears, this law brings social and organizational innovations, requiring the establishment of sanitary nets (made within a county with a population exceeding 100,000 inhabitants) led by a doctor hygienist. Health and social protection law has undergone a series of changes in 1934, 1935 and 1936.

Besides Eforia Civil Hospitals from Bucharest, in 1938, according to Ursea (2009, p. 306), in the country functioned a number of other establishments and clinics, which together had a larger number of hospitals than those funded from State budget:

- Brâncovenesti Settlements ensured quality medical care in 480 beds, the activity developed in two clinics held in the Faculty of Medicine: Surgical Clinic and Internal medicine and balneology Clinic and two dispensaries from Dabuleni and Cervenia;

- St. Spiridon parish clerk of Iasi had 600 beds, 12 university clinics and services for consultations in hospitals in Iasi Hospitals: Central Hospital, Pascanu Cantacuzino Hospital, and the Institute of obstetrics and gynecology and seven hospitals in: Roman, Harlau, Tg. Frumos, Botosani, Focsani, Galati and Tg. Bacesti.

- University Clinics of Cluj which has over 1,000 beds funded by the Ministry of Public Instruction.

A series of epidemics break out in the period immediately following the war, epidemics which the health system is not ready to face hovering well below needs. According to Ursea (2009, pp. 313-314) in Romania, of the 58 existing counties, 34 had no health services for children, 26 had no maternity services, 36 counties had dermato-venereal services and overall there were only 148 pediatricians, under 50 infectious disease specialists and dozens of hygienists. As a result, the amounts paid to health system begin to be increasingly higher, reaching in 1946 to 6.42% of the total budget, compared to 1.7% in 1945.

Chapter 2, The evolution of the Romanian medical system between the second half of the twentieth century and nowadays continuous research presented in the first chapter and is structured in three main areas, namely: Romanian medical system between the end of World War II and 1989; Romanian Paradigm of medical system between 1990 and the present; Reforms in the health and reflection of the Romanian health system coverage and quality of its official reports.

According to Ursea (2009, p. 313), after the war, Romania's health state was extremely poor, of recurring fever and typhus occurred during the war and continued in 1944-1945, but
also because of low living standards of the population, cultural level and low degree of hygiene (75% of the population lived in rural areas) and because of a shortage of trained medical personnel (in 1944, the medical staff was formed by only 148 doctors, 50 specialists in infectious diseases and dozens of hygienists)\(^6\).

Since 23 August 1944 economic and social life of Romania is reorganized by other principles, socialist, along with a new type of political regime in power, implemented and led politically by a single party, a fact reflected in the health services system.

Following investigations, Ursea (2009, p. 314) notes that between 1944 to 1946 the medical priority was the eradication of epidemics caused by war which perpetuated after its termination, respectively relapsing fever and exanthematic typhus, by running several health national campaigns (Argeș, Dâmbovița, Northern Transylvania), to which assisting children in devastated areas by drought, particularly in Moldova is added.

In 1946 Parhon Institute is opened, specialized in endocrinology, whose target was to combat goitre, whose incidence was very high in some areas of the country.

In November 1948 appears the *Decree 302 for the nationalization of private health institutions*: hospitals, clinics, home health, maternities, etc., which are not owned by the state, either as individual institutions, companies or associations of any kind\(^7\).

The years 1948-1950 were the years of reconstruction and organization of the health care system on new bases imposed by social relations, socialist, health being the central problem of state, its organization principles being reported in the 1948 Constitution. If in 1948 nationalization of hospitals, asylums and pharmaceutical production was held, in 1949 the pharmacies were nationalized. The last stage of crossing state ownership of the material base of the health system was that abolishing private medical practices. Also in 1949 was abolished Eforia Hospitals, the components hospitals became state hospitals, under the Ministry of Health subordination, which were ascribed to a number of clinics and Tot în 1949 a fost desființată și *Eforia Spitalelor*, spitalele componente devenind spitale de stat, în subordinea Ministerului Sănătății, cărora li s-au arondat o serie de policlinici și dispensaries.


Since then, the state policy was to create a system of hospital care and ambulatory led by the Ministry of Health, based on annual and five-year plans.

Ursea (2009, pp. 314-315), within his exceptional works the "Medical encyclopaedia of Romanian origins to the present" presents the main first objectives of the 1949 annual plan in public health:

- Restoring hospitals and improving their operation;
- Increasing the number of hospital beds;
- Establishment of 50 dispensaries and medical districts in rural areas;
- Improving the protection activities of mothers and children;
- Combating infectious diseases: malaria, pellagra, typhus\(^8\);
- Increasing the number of health stations with 600;
- Establishment of 337 school infirmaries etc.\(^9\)

By 1950, the socialist planning is conducted not only annually but also to five years time. The first three Five-Year Plans, 1951-1965 followed, in the first place, broadening the material base of healthcare, implementation preventive and anti-epidemic measures, hygiene and safety of the workers, all aimed at increasing the quality and medical efficiency (Ursea, 2009, p. 315). Specific to this period is opening special units seeking ownership of primary care jobs.

The principle that faces and governing healthcare is prevention, applied through dispensaries, in which the main activity was preventive, detection, registration, medical assistance and active pursuit of those at high risk of disease, people with special physiological state (pregnant, dystrophy, etc.) and people with various diseases (Ursea, 2009, p. 315)\(^10\).

In 1951 anti-epidemic sanitary network is created, it is properly equipped for epidemiological investigations, hygiene and operative intervention at country level, with a role in prevention and control of infectious diseases.

In rural areas "the unified hospital" appears organizational and administrative unit built at the local level, which in addition to the hospital with specialized wards, has an outpatient

\(^8\) Monitorul Oficial of Romania (Part I A), no. 28/4 February 1948, pp. 898–899.
\(^10\) Ibidem.
clinic with specialized services, urban constituency dispensaries and business and factory dispensaries.

At the end of 1957, a new health organization makes sanitary districts to be separated from polyclinics and to be in the field, also being served by a staff of general physicians, as Daschievici stated (2004, p. 309)\textsuperscript{11}.

Another new concept appears a type designed county hospital with a capacity of 700 beds, which provide hospital care at all the county level. The first such type of hospital was built in Bucharest, District 3, the current St. Ioan Hospital, designed as a general hospital (internal medicine, surgery, obstetrics and gynecology and pediatrics), with stationary and ambulatory in a special building.

The next stage, that of modernization and improvement of the health care system took place between 1965-1980.

Because of inadequate funding, the proposed objectives were not fully achieved until 1989. However, investment in health care units led to development of the material system by building many clinics, especially in small urban areas sizes, with no healthcare and hospitals.

In 1978 occurs \textit{Law. 3 on the health insurance reform} which introduces a continuous medical and hospital reform initiated in 1951, when it was held their unification and their territorial organization. It provides the establishment in each county a \textit{medical dispensary} and in larger municipalities \textit{specialized cabinets} subordinated to the county Health Department or Health Department of Bucharest. In urban areas \textit{clinics or dispensaries} are organized, depending on the population. Also this law provides the establishment of medical clinics or dispensaries polyclinics in enterprises and educational institutions, depending on the number of staff or pupils/students and their duties is also provided. \textit{Hospitals} are also organized in the subordination of the county and Bucharest sanitary or Directions under the Ministry of Health.

Unfortunately, since 1981, following the judgment of policy makers to liquidate foreign debt of Romania, savings from health budgets have made a series of indicators that reflect the health of the people to know significant discounts.

In parallel higher and secondary medical education developed. Medical institutes have been established in Timișoara, Târgu Mureș and Craiova and developed existing ones.

As a result, in late 1989, in Romania there were 41,918 doctors with an average of 552 inhabitants/doctor and 135,664 healthcare workers average, with an average of 171 population/health personnel average, ranking in terms of these indicators the category of countries with a system of health protection at a high level. (Ursea, 2009, p. 324).

Overall system in the period 1939-1989 the total number of doctors has increased by 4 times, but in the structure were recorded higher increases specializations in which Romania was poor: - baby care pediatricians - 6 times, infectious diseases - 15 times, radiology - 6.5 times, dentistry - 4.5 times, balneology, over 10 times. It should also be noted that the number of consultations and treatments per capita rose from 2.85 in 1950 to 4.16 in 1960, 6.96 in 1970 and 9.6 in 1989, and the number of vaccination and revaccination increased in 1970 nearly 3 times compared to 1950 and in 1989, over 6 times. A spectacular increase was registered in the number of live births in hospitals which increased from 6.5 % in 1950, 88.3 percent of live births in 1969.

Ursea (2009, p. 326) notes that between 1980-1989 the funds allocated for the modernization of Romanian medical system is insufficient for the material and technical basis which was sufficiently developed, equipping medical facilities with modern equipment and technique decreases and as a result, a number of indicators population health condition are dropping.

In parallel, an increased attention to scientific research is given, through integration with education and medical practice. In the schedule of the teachers, one third is allocated to research.

With all the shortcomings of Romanian health system as a result of the investments, especially in rural areas and developing the system of medical education, life expectancy of the population has grown at an average of 63.17 years in 1956 to 69.42 years, in 1989, remaining still a gap between urban than rural life expectancy of 1.62 years.

Since December 1989, Romania has experienced, both economically and socially, a major transformation by moving from a political planned socialist system, where public ownership was dominant toward a democratic society organized on principles of the market economy, based on private property.
According to the *National Strategy for Public Health* (2004, p. 11), political changes, government and lack of coherent strategy and clear objectives have made real health reform to take place only after the '90s, among the main objectives of enrolling the following\textsuperscript{12}:

- Introducing a social health insurance system;
- Effectiveness and quality of medical care as basic payment services;
- A high population access to health services;
- Focus increased outpatient care;
- Improving the quality of medical services;
- Decentralization of the healthcare system by increasing the role of local authorities, professional associations, financing institutions and communities.

Exceeding efficiency of hospitals criterion rather than the interests of patients and powerful entrepreneurial orientation of the system, a number of indicators of the development level of the health system and the degree of population health deteriorated, especially during the financial crisis crossed by Romania between 2009-2011.

Thus, if until 1989 we witnessed an increase in the number of health facilities, aiming at a closer medical act toward the patient, by setting up clinics and health constituencies, while increasing the number of hospital beds (between 1938 and 1989 the average rate the annual growth was 12\% ) in the period 1990 to 2013 witness a considerable reduction in the number of hospital beds, with 36.86\%, from 207,001 to 130,708, at an average annual rate of 1.53\%, a slight increase between 2000 and 2001 hospital beds for the various specializations knowing a differential evolution.

In parallel between 1990 and 2013 were recorded changes in the form of ownership of sanitary units: if in 1995 there were 412 hospitals, all public property, for private practice there were no available data, in 2013, the number publicly owned hospitals reached 134,365 and in private practice 134.

However, in the European Commission and the OECD report *Health at a Glance*. *Europe 2014* in 2012, Romania with 6.5 hospital beds per 1,000 inhabitants was above the European average of 5.2 hospital beds per 1,000 populations reported.

The increased personnel expenses, but also to equip medical facilities with modern equipment, and other investments in the health sector, in absolute terms between 1990 and 2013, with some fluctuations (reduction in 2009 and 2012), spending of the state budget related to this area have experienced a significant real growth.

However, the percentage of GDP allocated to health is well below the European average throughout the period 1990-2012, placing us in 2012 to last place in the EU with 5.12% of GDP, compared to 9.61% of GDP European average and far away to the Netherlands, which holds first place with 12.44% of GDP.

Even if we are the last place in Europe in this regard, it is noteworthy the budgetary efforts made between 1995 and 2012 when the annual average amount per capita for health registered, with small fluctuations, an upward trend, knowing an increase of 4.76 times higher than the European average of these expenses, which increased by 2.34 times, a trend that continued in 2013 and 2014.

However, despite all the shortcomings of the system, the latest report of the European Commission and OECD - Health at a Glance. Europe 2014 places Romania, through the indicators analyzed in a favorable position compared to E.U.media-28:

- In terms of self-assessment of health, Romanians are above the European average: 70% of Romanian believe that their health is very good or good, 20% average and 10% poor and very poor, Romania hovering in this viewpoint 12th place out of 28 European countries.

- In terms of self-assessment of long-term health problems, existing or expected, Romania ranks second in Europe, only 19.8% of the population aged 16 have reported a condition of chronic disease or expecting such a condition, compared with the European average of 31.1% and with Finland, where more than 46% of the population expect such a condition;

- The penultimate place in Europe (2011) cases of measles (19 cases per 100,000 population), followed by France with 23 only cases per 100,000 inhabitants;

- No. 5, with less than one case of pertussis per 100,000 (2011), in comparison with the Netherlands, of 33 cases, Estonia, 36 cases and Norway 90 cases per 100,000 population;

- 12th in Europe with two hepatitis B cases per 100,000 inhabitants (2011) compared to 10 cases in the Netherlands, 14 cases in the UK and Sweden and 16 cases per 100,000 in Norway;
- 7th place in the EU in the incidence of HIV, with 2.3 new cases of illness per 100,000 population (2012), below the EU average 6.3 cases and the incidence of AIDS the same place, with 1.4 cases per 100,000 inhabitants (2012), but above the European average of 1.1 cases;

- 2nd place in 2013 with a rate of 4.0% in cases of diabetes in adults between 20 and 79 years, compared with the European average of 6.0%, the highest level being in Portugal - 9.6%;

- First place in type 1 diabetes in children aged 0 to 14, with 5.4 cases per 100,000 inhabitants (2013), compared with a European average of 18.4 cases, the highest being found in Finland - 57.6 cases of children suffering from type 1 diabetes per 100,000 population;

- 5th place in patients with Alzheimer's in 2012 for the population over 60 years - 6.2% compared to the European average of 7.0%, the highest level being found in Italy - 7.7%;

- 3rd in new cancer cases diagnosed and below the European average, with 50 new cases of breast cancer per 100,000 women, compared to the European average of 74 cases (the last hovering Belgium, 112 in November cases) and the same place the number of new cases of prostate cancer, 24 cases per 100,000 men, compared to the European average of 70 new cases (last place is held by France with 127 new cases of prostate cancer per 100,000 men).

The end of 2014 marks the adoption of the National Health Strategy from 2014 to 2020 - Health for Prosperity, which aims not only to resolve nonconformities identified at the system level, reducing inequalities in health, optimizing the use of resources on the basis of cost-effectiveness, but also promoting management quality performance in order to pass from mere goal, declarative qualities of a health, the reality level of perception, attitude and behavior (p. 5).

In our opinion, for the first time in an official document, the quality orientation of health services and continuous quality improvement is in a central place, being in the mission of the Ministry of Health, as values of vision for the future and also as strategic intervention area ("Strategic intervention area 2: health services - Ensuring equitable access of all citizens, especially the vulnerable groups to health services quality and cost-effective") (p. 26), which stresses the need for structural reforms.
In early 2015 the Government issued Emergency Ordinance no. 11 amending and supplementing Law no. 95/2006 on health reform\(^\text{13}\) that introduces the art. 175, which states that is compulsory in the organizational structure of hospitals to have a quality management structure, in order to initiate the evaluation process for hospital accreditation. At the same time, accreditation as a "process of validating compliance characteristics of health services" will be given by the National Quality Management in Health, established by reorganization of National Commission of Accreditation of Hospitals.

In conclusion, although there were special financial efforts from the Romanian state in health, the results are not as expected and maybe that's why the latest regulations in this field such as the 2014-2020 National Health Strategy focuses on the quality and management of its health services.

After studying the historical evolution of the Romanian health system, Chapter 3 - *Highlights in defining and assessing the quality of health care*, we intended to study the definition and scope of the concept of service quality health care and the assessment methods of their quality. In turn, this chapter is structured in three subchapters, namely: *Features defining the concept of quality in health care services; Dimensions of quality health care services; Methods and criteria for assessing the quality of health care.*

In the first part of this chapter we have analyzed and defined a number of terms and concepts specific to the medical field, namely: *health systems, public health, public health assistance, health promotion, health protection, health-care mentenance, health care services, medical health and health services.*

In 1990, the US Institute of Medicine has made an analysis of specialized literature and identified over 100 definitions and parameters of quality of health care, depending on which has developed a definition based on eight dimensions, identified by most of the authors: *"the extent to which health services for individuals and populations increase the probability of desired health outcomes and are consistent with the achieved level of professional knowledge"* (Legido-Quigley, McKee, and Glina Nolte (2008, p. 3).

In the quality of health care services, the oldest definition identified is that of Lee and Jones (1933, p. 6) and which Donabedian consider to be probably more known "*good nursing"*\(^\text{13}\) Romania’s Government, 2015. *Emergency Ordinance no. 11 amending and supplementing Law no. 95/2006 on Health Reform.* In: Monitorul Oficial of Romania (Part I) no. 84/January 30, 2015. Bucharest.
care is the type of medicine practiced and taught by recognized leaders of the medical profession at a time, or in social, cultural and professional development data at a community or population group. According to these authors, the concept of good health care (quality) is based on eight "elements of faith": 1. limiting the practice of physicians based on rational medical science; 2. prevention as a core element; 3. Intelligent cooperation between scientific medicine and public practitioners and profane public; 4. treating the individual as a whole (as an individual within a family, in a certain environment); 5. maintain a close and continue personal relationship between doctor and patient; 6. coordination with social welfare work; 7. coordination of all types of medical services; 8. applying all the necessary modern services and doctors scientific needs of all people (Lee and Jones, 1933, pp. 6-10).

Donabedian, considering that the quality evaluation should start from a conceptual and operational definition of quality of care, affirm that "health care is a remarkable concept difficult to define" (Donabedian, 2005, p. 692). Considering the definition of Lee and Jones, above mentioned, Donabedian believes that some of the eight elements of faith are treated as attributes or properties of processes of care, and others as goals or objectives of the process, but in his opinion it seems that the criteria to which is defined quality are nothing but value judgment applied to various aspects, properties, components or dimensions of health care process, concluding "quality can be almost anything anyone wants to be, although typically it is a reflection of the values and goals of the current health care system and society as a whole, a part of which it is "(Donabedian, 2005, p. 692).

Also Donabedian (1990) believes that there are "seven attributes define quality of health care: 1. Effectiveness: ability of care at their best level of improving health; 2. Effectiveness: the extent that tangible improvements in health are achieved; 3. Efficiency: the ability to obtain the highest possible health improvement at the lowest cost; 4. optimal level: the best balance between costs and benefits; 5. acceptability: compliance with patient preferences regarding accessibility, patient-practitioner relationship, kindness, effect and cost of care; 6. legitimacy: according to social preferences relating to the foregoing; 7. fairness: fairness in the distribution of care and their effect on health. Logically, health professionals

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should take into account patient preferences and social preferences in the evaluation and quality assurance. When these two are not in agreement, the doctor must reconcile "16.

Another definition given by Donabedian to quality of health care is provided by the National Hospital Accreditation (CNAS) (2010, p. 4): "that treatment that is expected to maximize the size of the welfare of patients, taking into consideration the balance of gains and losses expected which occur at all stages of health care "(Donabedian, 2003)17 and also Donabedian (2003) believes that quality means" doing what needs to be done in the best possible way at the right time, for the suitable person and the best result possible with the resources available. "

Recently a new trend has emerged on the definition of terms psychological factor. According to Reid Sanders (2011, p. 151), according to this new vision, quality health care depends on the environment/atmosphere in which they operate, so some service health care of average quality, but provided staff friendly, sympathetic, compassionate and friendly can lead to shape an image among clients of high quality service18.

In conclusion, we can say that there is no unitary or exhaustive definition of quality of health care, the view from which it was viewed over time vary not only depending on the specialization of the author, but also by the progress of medicine and theory of quality itself.

The literature shows a variety of approaches to the measurement of various aspects of quality. One of the most comprehensive works on quality health care is that of Donabedian who, in his numerous works, since 1965, in addition to defining the quality and identification of the multiple facets and dimensions of quality health care, has been working continually and methods on quality assessment. Thus, in his view, expressed in the works since 1980, 1982, 1986 and 1988, the quality of health care is determined by the interaction between the three dimensions of it, namely: structure, process and outcome, and that is in fact the conceptual quality health care, considering that a good structure increase the likelihood of a smooth running of a process which, in turn, increase the likelihood of achieving a good result.

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Starting from his statement Mosely and Wolinski (1986) who argue that the result is a function of five variables: patient, physician, illness, organization and treatment, lately taking increasingly more extensive comparative studies of effectiveness, focusing on specific procedures defining the population or changes in the system, in which the evaluation is carried out based on measurement results\textsuperscript{19}.

After establishing the method of quality assessment, the next step is to determine the sources of data, which may include: records of insurance companies for reimbursements to physicians, clinical records, records of pharmacies, laboratories or supervision of patients, each regarding quality in terms of another size, depending on the intended purpose of use of the information.

In the complex process of assessment of services for health care, when determining the valuation method, the components to be evaluated and data sources, another important aspect is determining the evaluator who can be patient, specialist or an independent third party in who depends the method of measurement.

In theory, the patient is the one who can correctly assess the health status and quality of care received. However, some patients may be influenced in their responses by how the questions are asked, others can not appreciate objective medical act as a result of too much subjectivity and others can not appreciate the quality of service received just due to disorders suffering.

In other opinions, clinicians are those who can objectively assess the health improvement of patients, but less objective when assessing patients' interpersonal relationships with professional and administrative personnel, facilities, waiting times etc. dimensions of service quality components health care.

A third category of evaluators is that of an independent third-party, but often involves significant costs and making a series opposition or manipulation techniques from those evaluated. However, in this case we rely on standards, criteria and indicators defined, in which it can achieve a fair and objective evaluation.

After clarifying the dimensions of quality of health care and its evaluation methods, next chapter, Chapter 4, was designed to \textit{Management of the quality of health care services} in

which we analyzed in the three subsections, *the specific elements of the management system health care services quality, peculiarities of total quality management in this area, considering factors and critics favoring its implementation and excellence in health care*.

According to Varkey (2010, p 2), the foundation of management in health care quality were laid in 1914, the American surgeon Ernest Codman, introduced the idea that doctors and hospitals must assume responsibility for the results of care to patients. For this, he proposed registration of a series of data (number of patients, diagnosis made before the operation, the number of team members performing operations, procedures and results) on small charts, which later will be collected and analyzed through the results of operations on patients. Based on this idea, the next seventy years, a period considered to be the quality control or quality assurance, efforts have focused on poor results and deviations from standards, to the detriment of highlighting positive aspects and their contribution to quality of care²⁰.

Since we can not speak of a total quality management system at the outset, its implementation came naturally and gradually by understanding of benefits, involvement, commitment and operation through continuous improvement of activity under the auspices of a quality management system implemented, we considered necessary to present for begining the characteristics of a quality management system, governed by the international standards ISO 9000, system-specific health care - SR EN 15224: Services health care systems of quality management Basic requirements EN ISO 9001:2008. Basically, SR EN 15224 contains specific interpretations of the requirements of SR EN ISO 9001:2008 for health care services, clarifications and additions, such as the management of clinical risk in planning, operation and control of processes, and a Practical guide for implementation in health care organizations.

The literature reunits multiple studies on the benefits of management systems of quality health care services, including: establishing a policy and develop procedures that lead to reducing premature mortality and improving quality of life for patients; controlling costs, with profit generation; viability and sustainability of the organization etc., except that the earlier positive effects can not be obtained than in the existence of adequate staff numbers and training of a professional management and provision of modern equipment of the latest generation.

Moreover, as demonstrated Haj, Lamrini and Rais (2013, pp. 17-30)\textsuperscript{21} between Donabedian's model, specific for health care institutions, with its three components: structure, process and results and the model developed by family ISO 9000 there is perfect compatibility.

Implementing a quality management system in health care services is supported by many facets of quality of medical care in which none is inferior to another: the quality of the staff's attitude, equipment, facilities, safety, security etc. all of which can be classified into: the quality of administration and management; quality and quality of health care professionals. Through such a quality management system we ensures an orientation for the future, we can anticipate changes, such as patient expectations, new opportunities, developing technologies to diagnose, and social expectations generally aimed at creating long term relationships with suppliers, employees, doctors, nurses and public and private communities. The success of an organization of health care depends largely on the knowledge, skills, motivation and autonomy of its employees, and as long as through a total quality management emphasis on teamwork and continuous improvement, including projects results and conducted by Quality Circles, the effect will be higher than usual management.

For outstanding results - excellence in health care in the US Malcolm Baldrige Award is given for which there are specific evaluation criteria and which was established in 1999 and at European level there is European Award for Health, established in 2007.

*European Health Award (European Health Award - EHA)* was established with the public recognition of the efforts and initiatives to improve public health or health care in Europe. The purpose of awarding this prize is to promote cross-border cooperation and sustainable development initiatives, innovative and transferable on the main problems of the system, namely: disparities in health status, access to health services and providing treatment at European level.

Unlike the European Health Award, *Malcolm Baldrige Award for American health care* has evaluation and selection criteria more rigorous and detailed and, like the other prizes in quality/excellence, are subject to continuous improvement. Changing the criteria is determined by changing the values and concepts that govern fundamental principles of excellence, who know optical changes from one period to another, thus generating November revisions.

Chapter 5 - Research on the degree of satisfaction with the quality of health care in Romania from the perspective of patients and professionals in the system, we presented three research that we conducted to identify the degree of patient satisfaction and professionals in the quality of health care services in Romania, as opportunities for improving the quality and performance of these services.

In this regard, in the first chapter we presented the results of a pilot study on the awareness of patients' rights, which was primarily aimed at gathering preliminary information of the survey on satisfaction of patients and building plan questions, the questionnaire it will be administered at the same research.

The study was conducted in December 2014 by statistic survey, by distributing questionnaires (100) among patients admitted to the one of the largest university emergency hospitals in Bucharest, yielding a response rate of 62%. It was elected such a hospital and not a hospital specialised for a certain condition, to ensure a better representation of patients affected by different diseases, due to the large number of patients, including those coming to the emergency, and also, to ensure representativeness of the backgrounds of patients in university hospitals were there are treated patients from both urban and rural areas.

The questionnaire included 11 questions: questions of identification (gender, age, education, residence), objective questions (number of visits to the family doctor and hospitalizations), questions of content (knowledge of the existence and content of specific rights of patients, how they learned of their existence) and questions of fenomena perception (so far as it considers that patients' rights are respected within the system).

The conclusion of this pilot study is that Romanian patients do not know their rights, actually, except a very small proportion of 11.29%, most of them confusing them with the rights of policyholders and, however, the perception of compliance their is below 50%. Following the findings of this pilot study, we considered necessary to introduce into the feedback questionnaire on patient satisfaction, a question on knowledge of their rights as patients.

In the second chapter we presented the results of a survey on the satisfaction of patients from hospitals on quality of care received.

In conducting this research we started from the conclusions of an analysis tracking the interests of policyholders regarding the quality of medical services provided, presented in the
activity of CNAS in 2013, according to which there are elements that can create doubts concerning the degree of objectivity and sincerity information provided patients that may affect the study findings, including:

- On some questionnaires was put stamp prescriber;
- Some questionnaires were signed by the patient, although they must remain anonymous;
- There were no negative responses regarding the attitude of the official physician or the health insurance fund;
- There were no recorded cases of patients dissatisfied, and the percentage of patients who were "very satisfied" is very high, which raised questions on honesty and fairness responses ("patients tried to be kind, have rated superficially medical attitudes / officer, were afraid of possible repercussions if less favorable assessments, hurried, etc." - p. 120)

Therefore, we considered necessary to carry out independent research among patients, to whom the purpose of research was explained, to achieve a picture of the real situation of their level of satisfaction with the health care they receive, to enhance quality thereof.

The research was performed from 16th of March until 26th of April 2015, at the County Hospital X. The selection of the patients group was done using regular selection means after non probabilistic methods. The collection of data was performed through a questionnaire with 13 questions; the selected group had 1,415 patients. First a univariate analysis was performed, then this analysis was completed in order to see the all the aspects that interrelated themselves in the patient’s answer, so a bivariate analysis was performed, the correction coefficient that we used was Spearman, because the analyzed data is limited and present a deviation from the normal distribution curve.

After the biovariate analyssis we found some powerful and evasifunctional direct links between some variable that were investigated. This should be discussed first:

- Information about how medical examination will occur and how will be performed the collection of the samples (0,999);
- The risks of an surgical procedure/recommended treatment and the consequences of an possible refusal/stops of the medical act that was recommended by the MD (0,999);
- Request for services from a favorite MD and the grasping if its services (0,999);
- Lighting of the rooms /spaces from the hospital and the temperature from the hospital (0.999).

There are also in the same category:
- The case of an MD that handles each case at a time, puts interest in treating every patient (0.979);
- The request in hospitalization period of a different medical option from a different MD, regarding the diagnosis of treating MD and its receipt (0.969);
- Confirmation of the fact that the MD that handles each case understands the problems of each patient (0.915) and so he applies unique treatments, for each patient;
- The nurses that grant the respect and attention due to a patient, fully respecting the hours of administration of treatment recommended by a doctor (0.912) and an interest in treating each patient (0.910).

All connections are statistically significant at a probability level of 99% (sig = 0.01). There are a number of direct connections, of high intensity between the variables that are part of the same level of questions analyzed: statements about the doctors and nurses who interacted directly with patients. The intensity of the links varies from 0.515 to 0.979, with a statistical significance level of 99% (sig = 0.01). If the extent to which patients are informed and / or receive information from medical personnel who have interacted with, the intensity of links ranging from 0.746 to 0.999, with a statistical significance level of 99% (sig = 0.01).

For services that patients benefited during admissions and administration and / or providing medical treatment, intensity bonds ranges from 0.449 to 0.999, with a statistical significance level of 99% (sig = 0.01). But here there are some reverse links, high intensity and medium to low intensity, with the following explanation:
- Patients who requested and received another medical opinion during hospitalization, received from the hospital the full medications needed (-0.594);
- In patients who have requested another medical opinion regarding the diagnosis of the treating physician during hospitalization, medications needed was provided largely by the resources of the hospital and to a lesser extent by their own cost (bought drugs simple painkillers, bandages etc.) (-0.575);
- Patients who have requested the services of a physician of choice and those who have received the services of a physician of choice during hospitalization have largely secured through their own cost medications needed (bought expensive drugs) and received a lesser extent the support of hospital resources (-0.263);
- Patients who were admitted through the emergency room during hospitalization have assured full cost of their medications needed (-0.209).

We can say that hospitals do not have buffer stocks of drugs to prevent emergencies, in which case patients are obliged to provide necessary medication alone. On the other hand, the County Hospital X ensures particularly hospitalization for chronic and acute cases and emergencies being diverted immediately after stabilizing the patients to specialized hospitals; patients seeking the services of a favorite doctor (in a manner similar to resort to the services of a private clinic where the patient chooses the preferred doctor) are willing to pay more for the recommended treatment, which usually is made with more expensive drugs; that some patients ask for the opinion of another physician in the same medical department of the hospital does not lead to change of medication, and this is ensured largely by the hospital (doctors know which medicines are available and recommend the same regimen).

Conditions encountered in the hospital influenced the comfort felt by the patients during hospitalization in direct connection at a medium and poor intensity. The intensity of links ranging from 0.104 to 0.999, with a statistical significance level of 99% (sig = 0.01) and 95% (sig = 0.05).

There are also reverse link, all mild and poor:
- the program of receiving visits to hospital affects inverse proportion the functionality of toilets (-0.446);
- Conditions of accommodation are influenced inverse proportion by temperature and light of the hospital spaces (-0.060);
- Functioning of the toilets is inverse proportion affected by temperature and light hospita spaces (-0.057).

There is no consensus on the definition of client health care services in the literature, being seen often as a combination of patient, family, doctor and financier, each having their expectations that the organization of care health needs to know and understand, which only achieved through the good relations and appropriate communication.
Knowledge of staff satisfaction, regardless of its role in the overall health care services is essential to quality improving. This idea is presented by many authors, including Deming, who favors a management style where there is favorable climate for dialogue and no fear in an organization.

Staff satisfaction is reflected directly in the attitude towards patients, the compassion shown them by respect for them and their families, to the desires of their empathy and emotional support provided by the information provided, all leading thus to an increase not only the quality of healthcare and reduce costs, but also to an increase in patient satisfaction.

Therefore, in parallel with research on patient satisfaction with hospital X, we performed the same period 16.03-26.04.2015, and research on satisfaction of physicians and nurses, and technical staff and auxiliary in the same county hospital. For facilitating the analysis and interpretation of results, the questionnaire applied to the staff of the hospital had a unique structure and consisted of 21 questions - Annex 7.

I got response from 134 physicians without management functions within the hospital, 257 workers with secondary education and 20 workers, technical staff and auxiliary staff.

Switching to a bivariate analysis of data in order to highlight those issues that interrelate to each other we complete the image of the reasons that underlie to the investigated medical personnel’s satisfaction. As in the previous research, the correlation coefficient used was Spearman, whereas the analyzed data are limited and present some deviation from the normal distribution.

- The relationship and communication that employees have with heads and hospital management is influenced directly and with high intensity by:
  - Material supplies equipment, machinery, tools, etc., necessary for the activity (0.814);
  - Working conditions in the hospital (0.810);
  - Collaboration between departments (0.806);
  - Arranging and cleaning of common areas (dressing room, dining room, toilets, showers, recovery rooms, etc.) (0.745);
    - Awareness about workplace risks (0.745).

Also a direct influence, but of medium intensity is presented upon the communication that employees have with heads and hospital management, the knowledge by employees of their prospects for professional development (0.400) and the staff motivation presents a direct
link of low intensity (0.242). All these connections are statistically significant at a probability level of 99% (sig = 0.01).

The employees associate received information about the risks of employment, directly and with very high intensity, the cleanliness of common areas (dressing room, dining room, toilets, showers, etc. spaces recovery) (0.999) equipment level material with equipment, appliances, tools, etc., necessary for the activity (0.906) and working conditions in hospital (0.900). Also directly, but with great intensity, they link workplace risks with collaboration between departments within the organization (0.897) and how to communicate with bosses and / or hospital management (0.745). Directly with a medium intensity, workplace risks are correlated with their prospects for professional development of employees (0.360) and with a lower intensity by personal motivation (0.270).

Employees appreciate working conditions within the hospital directly and with a very high intensity level with equipment supplied material, equipment, tools, etc., necessary for the activity (0.983), collaboration between departments within the organization (0.976) and arranging and cleaning of common areas (dressing room, dining room, toilets, showers, etc. spaces recovery) (0.900). Directly, with a high intensity influence employees perceive the risks associated employment relationship in communicating with bosses and / or hospital management (0.810). And directly with a medium intensity workplace risks related to their professional development perspective (0.398) and personal motivation (0.314).

Arranging and cleaning of common areas (dressing room, dining room, toilets, showers, recovery rooms, etc.) are appreciated by hospital employees that depend directly and with very high intensity level by the equipment supplied material, equipment, tools, etc., needed for the activity (0.906), directly and with a high intensity of collaboration between departments within the organization (0.897) and the relationship of communication with bosses and / or hospital management (0.745) and directly with medium intensity, with their own professional development perspective (0.360). Personal motivation or satisfaction taken in the workplace affects planning and cleanliness of common areas directly, but with a low intensity (0.270).

The collaboration between the departments of the hospital is seen by employees as being correlated directly with a high intensity of the relationship that communicates with bosses and / or hospital management (0.806) and directly with a medium intensity, with their
own perspectives professional development (0.373) and the degree of personal motivation or satisfaction taken in the workplace (0.300).

Employees believe that the degree of personal motivation or satisfaction taken in the workplace is directly correlated with an average intensity of the extent to which knowledge promotion policy within the hospital (0.372) and directly with low-intensity relationship they are communicating with bosses and / or hospital management (0.242), as well as their own professional development perspective (0.221).

Following investigations, we could make a number of proposals to further improve the quality of health care, who may remember the following:

a. introduction of a cost management of quality level at medical facility financed with public funds, which will benefit a focus on the poor quality of care and reducing overall health costs as a result of leverage;

b. for more efficient spending of budgetary amounts allocated to the health sector, we believe that the necessary measures should be the priority funding of research institutes and make investments in construction and modernization of Romanian organizations producing drugs in order to reduce costs of treating various disorders;

c. the development, at the ministry level of guides containing measures of basic hygiene, preventive measures contacting of contagious diseases and to maintain a degree corresponding health effects and symptoms of the most common diseases, to be both distributed for free to schools, hospitals, family doctors etc.;

d. management of health care organizations must pay more attention to business planning, long-term, taking into account both the risks and the potential opportunities, building on trends on the European and international level;

e. the organization management of health care should promote, support training and ensure coordination of multidisciplinary teams integrated, replacing traditional relationship doctor-patient, starting with the reality that the chances of improving the quality of the activity occurring between functions departments and teams, rather than within a single;

f. development of electronic filing of all data from the department by creating an integrated network at the hospital level to allow quick and easy access to the electronic patient record. Obtaining an accurate, meaningful at the right time is an important means to boost employment and sense of responsibility of staff and increasing their job satisfaction;
g. the organization of quarterly analyzes of management, with the participation of a representative of the Ministry of Health, one of the Ministry of Finance, but also an organization for the defense of patients' rights and / or Officer for patients' rights, in which to present the main problems that faced the Hospital, both in financial, administrative, medical, and patients, focusing on complaints registered in order to identify optimal solutions etc.