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PATIENTS' PERCEPTIONS REGARDING THE AVAILABILITY OF PRIMARY CARE SERVICES IN ROMANIA - A PILOT SURVEY AMONG USERS OF PRIMARY CARE SERVICES IN BRASOV COUNTY

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Abstract: *In Romania, users' perceptions about availability of services in primary care have not been explored since 2009, when a national report was produced, and little is therefore known about the subject. The study aims to identify perceptions of primary healthcare service users regarding the availability of services in primary care. This research is a pen-and-paper self-administered survey applied to an opportunity sample of people, addressing family doctor's practices, from 17 selected settlements of Brasov county. Overall, the analysis of population's perceptions on the primary care system in Brasov County shows a high degree of satisfaction among the patients despite a narrow spectrum of services offered by family doctors.*

Key words: *Health Services Needs and Demand; Perception; Primary Health Care; Romania.*

1. Introduction

There is a consensus that patients' centeredness should be the core of the Healthcare system and Governments are looking for solutions to embed patients' perspectives and needs in Healthcare planning [9]. Primary care, through its privileged front line position, is essential in this equation [4].

People live longer lives and expect from their doctors', especially from primary

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care providers, advice for healthy lifestyles and for chronic care. In a study exploring preventive advice, a significant number of patients declared not having had any discussion about these concerns with their primary care doctor [1]. Advice about smoking cessation, of importance for the health of patients with chronic respiratory diseases, is also often neglected [11].

The needs of patients with chronic conditions require a redesign of medical services in a proactive, preventive, and holistic manner [2].

Due to a high survival rate, oncology patients are being considered more and more to be chronic patients and consequently expect more emotional support and information from their doctors [5], [8].

Romania's position in this equation, especially in relation to primary care, is a challenging topic to address.

In 2017, the European Observatory on Health System and Policies published a national report on Romania, showing that while Romanians claim to have good health, mortality figures are still remarkably high, being amongst the first in Europe for most preventable diseases. The underfinancing of the healthcare system is one of the main causes identified by the authors of the report, as well as the inefficient use of resources. Healthcare planning in Romania is merely top-down in nature and is not correlated with the health needs of the population. Romania is reporting a high grade of unmet healthcare needs in the population related to cost, distance and waiting times, especially for the low-income group [17].

A study published in 2011 by public health specialists from the National School of Public Health and Management Bucharest (NSPHM), acknowledged the increasing demand of health services from Romania's population, especially for cardiology, oncology and medico-social services [13]. Under the coordination of the Ministry of Health (MH), the NSPHM has also performed a health services needs assessment, considering demographic and morbidity data, on a national and regional level [10]. From the perspective of primary care, the analyses focused on the deficit of health care providers but didn't provide any insight on patients' views.

Despite evidence showing that the involvement of patients in decision making can contribute to changes in the healthcare system, in Romania their opinions are rarely consulted. In 2009 a World Health Organisation (WHO) led survey elicited Romanian patients' perspectives on primary care, at a national level, seeking for accessibility and continuity of care issues [7]. At that time, the level of contentment with availability of services was high.

Therefore, under the framework of an Health Needs Assessment (HNA) project run in Brasov county, which aimed to map health services needs at all levels of care, we performed a sub-analysis of the perception of the population on the availability of primary care services.

The findings allowed us to explore the perception of the population about the availability of services in primary care and to identify to what degree system barriers have altered the use of medical services in primary care, trust in GPs and ultimately the GPs' roles themselves in the community.

2. Objectives

Identifying perceptions of primary healthcare service users about availability

of services in primary care in the actual context of health services delivery.

3. Material and Methods

The research consisted of a survey conducted in the context of a Health services needs assessment project, commissioned by County Council of Brasov, with the objective to map the need of medical services in the county. A subset of questions was dedicated to identifying the perception of population addressing primary care services on their availability.

The study was approved by the Ethics Committee of Transylvania University according to its ethic code.

3.1. Participants and settings

Brasov County accounts for 635,084 inhabitants (census from the County Statistical Department at 01.01.2019). A sample of 1285 responders was calculated as representative, with a statistical error of 3.32% for p =95%.

Participants to the survey were randomly selected from 17 settlements of County Brasov, that represent the variety of urban and rural population. The settlements were chosen according to the size of the population and the geographical positioning, deprivation scores, distribution of healthcare facilities, to cover all specific populations and the diversity of healthcare needs.

Sample distribution Table 1

Settlement	Size	Number of questionnaires
Brasov	Municipality 289.000 inabitants	400
Sacele	Over 20.000 inhabitants	100
Codlea	over 20.000 inhabitants	100
Rasnov	10.000 – 19.000 inhabitants	80
Victoria	under 10.000 inhabitants	65
Rupea	under 10.000 inhabitants	65
Bran	Rural over 5.000 inhabitants	55
Hoghiz	Rural over 5.000 inhabitants	55
Tarlungeni	Rural over 5.000 inhabitants	55
Teliu	Rural 3.000 -4.999 inhabitants	45
Vama Buzaului	Rural 3.000 -4.999 Inhabitants	45
Poiana Marului	Rural 3.000 -4.999 inhabitants	45
Recea	Rural 3.000 -4.999 inhabitants	45
Homorod	Rural between 1.500 – 3.000 inhabitants	35
Parau	Rural between 1.500 – 3.000 inhabitants	35
Ormenis	Rural between 1.500 – 3.000 inhabitants	35
Dragus sau Ticus	Rural under 1.500 inhabitants	25
TOTAL		1285

Eligible participants to the study were all adults, consenting to respond to the questionnaire. Potential participants were approached in family doctors' (GP's) offices in all selected settlements. Between 1-10 practices were approached, depending on the size of the settlement.

Survey operators were instructed to invite every adult patient entering the practice within a certain time frame of

that day, to participate in the study. No selection or discriminatory criteria were applied. The operators were present in the family doctor's office 1-3 days in different time frames in the day to offer the possibility for various categories of potential respondents to take part in the study (like working people, elderly, housewives). The questionnaire was self-administered but supervised by an operator who intervened only in case of difficulties in understanding the question or in cases of illiteracy. The participant invitation process continued until the required number of completed surveys for the size of each settlement was reached.

The study was conducted between June – September 2018.

3.2. Variable and data collection

The questionnaire contains twenty-one items that were grouped into 4 categories: demographic data, access to primary care services, processes, availability of procedures and outcomes in health.

Questions had pre-formulated answers that prefigured the recognised normative aspect of care. A total of 877 questionnaires were returned and validated. Incomplete questionnaires were not included.

We explored the following aspects related to access: waiting time until appointment, opening hours, access by telephone, availability of GPs in the community, presence of a second family doctor in the community, and availability of out-of-hours services (OOH) led by GPs.

The process attributes include continuity of care, information on medication, information on prevention, time spent at consultations, range of diseases that can be addressed, availability of preventive services (Pap smear), flu vaccination, medical procedures available (blood draw/electrocardiogram), GPs' knowledge of patients' history, and facilitation of access to secondary or tertiary care.

Outcomes of care attributes include health problems not resolved after GP encounters and being more informed about health problems after visiting GPs.

We have also explored patterns of use of services related to family medicine, such as the number of visits to the GP per year and the constancy in being registered with GPs.

The questionnaire was piloted on 15 adults from different environment to validate the questions.

3.3. Data analysis

For this article only frequency analyses were performed. Correlations that can establish a mapping of needs through the county, or between health status, economic status and service utilizations are considered only for local use.

4. Results

The demographic characteristics of the participants to the study are summarised in Table 2. It should be noted that the population over 65 is higher (18.2%) than the county average (15.8%), as published by the County Statistical Department. The gender distribution favours women (67.2% female and 32.8% male). The level of education is as follows: 11.6% have a basic education level (8 classes and under), 61.1% have graduated from high school or a professional school, and 27.2% have a university background. This distribution covers the broad spectrum of education in the community.

In terms of visits to the GP, 15.6% of patients visited their GP once in the past 12 months, 19.8% visited the GP 12 times,

and only 3.9% visited the GP more than 12 times.

Demographic data of the sample Table 2

DATA	CATEGORY			
Age distribution (%)	**18-30 years old**	**31-50 years old**	**51-65 years old**	**Over 65 years old**
	19.7	39	22.4	18.9
Gender distribution (%)	Female		Male	
	67.2		32.8	
Level of education (%)	Primary school	Professional school	High school	University and higher
	11.6	13.7	47.4	27.2
Residence (%)	Urban		Rural	
	48		52	
Years with same GP	Less than 10 years		More than 10 years	
	46.4%		53.6%	
Number of visits to GP in the past 12 months (%)	One visit	More than one, less than 12	12 visits	More than 12
	15.6	60,7	19.8	3.9

In Table 3 we present the summary of data related to the access to GP's office. Results show that opening hours are appreciated by the population as offering good opportunities to reach the GP, 91.1% being satisfied with it. Practices can be easily accessed by phone in 90.5% of cases.

Continuity of care represented through the presence of OOH services is low, only 58.7% stating they have access to it but access to another GP in the area is mentioned as satisfactory by 72.4% of the participants.

Good coverage with GP's is confirmed by the percentage of the participants to the study stating that they have a GP in the neighbourhood (97.4%).

26.6% of the participants stated that they can reach a same day visit to the GP and cumulatively 53.9% same or next day.

Access to the GP's office Table 3

Questions	**Yes (%)**	**No (%)**
In the past 6 months, did you feel the need to be seen by an GP and you couldn't reach him or her?	11.4	88.6
In the place where you live, do the opening hours of the GP allow you to access services whenever you need them?	91.1	8.8
In the place where you live, is there an out-of-hours centre?	58.7	41.1
In the place where you live, is the GP's office is easy to access by telephone?	90.5	9.5
In the place where you live, if your GP is not present, is there any other GP you can visit?	72.4	27.6
Do you have a GP where you live?	97.4	2.6
How long do you have to wait for an appointment for the GP?		
26.6%: same day	53.9%: 1 day	12.1%: 2 days	7.4%: more than 2 days

Table 4 provides a summary of the perception of the participants about the process of care. The data indicate that GPs are recognised as treasurers of the medical information of the patient (over 90% of respondents perceived their GP as knowledgeable about their medical history). Over 80% of participants felt their GP spent sufficient time on the consult, that they could address any medical issue with their GP, and that they could get referrals to secondary and tertiary care from their GP.

Processes of care in the GP's office Table 4

Questions	**Yes (%)**	**No (%)**
Does your GP know your disease history?	93.8	6.2
Does your GP know your medication history?	93.5	6.5
Did you receive clear information from your GP regarding your illness?	88.8	11.2
Did you receive clear information regarding ways to prevent illnesses?	87.7	11.2
Is your GP spending enough time with you?	86.8	13.2
At the GP, can you address any medical problems?	87.6	12.4
In the GP's office, can you get referrals for appointments for secondary or tertiary care?	82.1	17.9

Table 5 outlines information relating to the perceived result of the process of care. 88.2% of the participants felt that their health status improved after the visit to the GP, 91.9% affirming that they have understood how to take their medication after physician's advice, and 87.4% felt informed regarding prevention.

Outcomes of care in the GP's office Table 5

Questions	**Yes (%)**	**No (%)**
After the consultation with your GP, did you feel that your health had improved?	88.2	11.8
After the consultation with your GP, did you feel more informed on preventative measures?	87.4	12.6
After the consultation with your GP, did you understand how to take your medication?	91.9	8.1

Table 6 summarizes on the availability of procedures. Access to Pap smear testing is reported as limited in GP's offices, with only 46.2% availability. Flu vaccination is offered in 94.4% of cases, pregnancy monitoring in 85.6% of cases. Blood draw and electrocardiogram are showing low scores (36.9% and 44% respectively).

Procedures in the GP's office Table 6

Questions	**Yes (%)**	**No (%)**
In the place where you live, do you have access to intravenous injections or infusions?	92.4	7.6
In the place where you live, do you have access to the flu vaccine?	94.4	5.6
In the place where you live, do you have access to pregnancy monitoring?	85.6	14.4
Is your GP doing well-child monitoring?	90.7	9.3
In the place where you live, do you have access to Pap smear services in the GP's office?	46.2	53.8
In the place where you live, do you have access to blood draw services in the GP's office?	63.1	36.9
In the place where you live, do you have access to an electrocardiogram?	56	44

5. Discussion

Our study summarises participants' perspective on the availability and provision of primary care services in a pilot county.

One of the first discussion points is **access** to primary care. In Brasov County only 2.6% of patients declared that they do not have a GP in the area where they live. The result is in concordance with the reduced number of settlements without a GP in the studied area (Data from Brasov Health Insurance House at 31/07/2019). Brasov county, being highly urbanised and offering good employment opportunities, is a region of choice for GPs.

In other regions of Romania, the problem of coverage with GPs is of a different magnitude. In 2015, reports from National Health Insurance House (NHIH) cited by authors of the Health System review published in 2016, [3] showed that all over Romania, 300 communities did not have a GP.

Despite the financial stimulants and the construction of modern facilities in remote regions, the problem of attracting and retaining of GP's only improved slightly. Overall, the deficit of GPs is congruent with the general downward trends of the healthcare workforce in Romania, a phenomenon also encountered in other eastern European countries which results from the migration of doctors to Western countries, aging of GPs, and insufficient motivation for a carrier choice. Although data on the outflow of doctors in Romania are not accurate, official data on diploma verification applications in 2007 were showing that 10% of doctors had the intention to leave the country [15].

In Romania, under the framework of the National Health Insurance System (NHIS), 92.5% of the population is registered with an GP but registration is not a guarantee for good access. Patients' ability to choose their GP has led to a phenomenon of patient migration toward preferred doctors and consequently GP's have lost their catchment areas, having their patients spread all over the County. While a 2009 report identified 70.8% of patients having to travel less than 20 minutes to their GP, it is likely this situation has changed, and therefore needs to be re-examined.

Reaching the GP is also discussed in terms of opening hours and telephone

contact. The compulsory working hours of GP's in Romania are 25-35 hours per week in the practice, and another 10 hours a week for home visits. Working time is correlated with the size of the patient list. Practices with over 2200 of registered patients, can offer increased office access (1-2 extra hours a day). Services provided outside working hours are not paid to the provider. Fee for service can be charged for extra hours but is seldom solicited by GPs. Another characteristic of the working time is the work in shifts (morning and afternoon), especially in urban settlements, due to the small dimension of the premises and sharing of the same office by 2 doctors. This type of opening hours is leaving patients without access to their GP for 24h, fact that is encouraging the use of emergency services for conditions that could have been treated at the GP. Despite these facts, 91.2% of respondents of our study stated that the operating hours of GPs offices allow them to access the practice easily.

Furthermore, when asked if in general, reaching their GP was a problem (in the past 6 months), 88.6% of respondents indicated not having had any problems, and only 11.6% answered that they encountered problems.

Comparing opening hours of other European countries and the UK [14], we can remark that opening hours vary widely across countries, the majority having longer opening hours than Romania, ranging from 7 to 12h/day. Only Hungary and Lithuania are reporting lower times (2 to 6 hours a day).

The results of our study showed that only 26.6% of people could receive a same-day appointment with their GP. The pattern of access has changed since the beginning of the health insurance system. While the regional WHO office reported in 2009 that 92.8% of people could schedule a same-day appointment with their GP, today this has dropped to a quarter.

Nevertheless, our study shows that next-day appointments are possible in 53.9% of cases.

When asked if there was an alternative doctor to see if their GP was missing, 27.6% of participants affirmed that there was no other doctor to replace their GP in the community, meaning that continuity of care cannot be ensured otherwise than in out-of-hours (OOH) centres. However, OOH centres in their neighbourhood could only be accessed in 58.6% of cases.

Access to GPs' offices by telephone is available in 90.5% of practices. This pattern of access by appointment is compulsory in the Health insurance system. Easy phone access is a quality criterion in the evaluation of practice. Telephone consultations are not recognised as a type of consultation [12].

Our study indicated that patients prefer long-term relationships with their GPs, even though they have the option of choosing and consequently changing their doctor. About half of the patients are registered with their GP for more than 10 years (53.6%) but more than 90% have been registered for more than 1 year. Romanian patients perceive that GPs are meant to be close to the family and prefer to see the same doctor every time. This type of preferred relationship is impeding availability of access to healthcare services only to the working hours of the doctor. Accessing another GP has only been recently possible in the contractual framework of the health insurance, and only upon notification of the absence of the current doctor.

The average number of visits to the GP in the past 12 months in our study was 11.25, with most respondents (19.8%) having visited their GP on 12 occasions. The highest frequency is registered in the over-65 years old group. In contrast, a European database [6] (Eurostat, Healthcare activities statistics-consultations) shows an average of 5.7 contacts with the GP, and a national report from 2009 shows 7.7 visits per years. The increase in the number of visits is due to the contract framework of the National Health Insurance House (NHIH), which specifies the gatekeeping role of the GP. Conversely, the system organisation results in GP access limitations; A GP's contract with the NHIH limits the number of daily consultations (20 or 24, based on the number of patients registered in the patient list) and only 5- or 6 opening hours a day. However, despite these limitations, which could cause waiting lists, there is no significant waiting time to see a GP, only 7.4% of the patients having to wait more than 2 days to reach their GP. It can be explained by the fact that GPs cover extra patients every day, thus reducing the length of the consultations that are normally set to 15 minutes per patient.

Although a same day visit was only possible in 26.6% of cases people do not consider this feature to be a barrier to access. In our opinion, it is probably linked to the lack of another perspective. If alternative model practices, with more time availability, could be an option, perhaps the patient's opinions would have been more varied.

A possible option to cover the reduced consultation time at GP office is access to continuity of care through **OOH services and or other health resources** (ambulatory subspecialty care, private medical services). It is necessary considering that in 27.6% of cases, the GP is the only health resource in the community.

Access to OOH services is a problem due to the lack of coverage in the whole territory of the county. It is a result of the fact that OOH is a service organised by GPs at their sole discretion, without rigorous planning of the service by the District Health Authorities.

In terms of the **process of care**, respondents have shown that they consider GPs a reliable health resource. GPs who know their history and medications can inform and educate them regarding their disease. This result shows that even though there is a reduced variety of services that GPs can provide (in the situations of the restrictive contractual framework), patients are still counting on their GPs. The potential of this relationship is important, and GPs are to be encouraged to practice at their full potential, broadening the spectrum of services that they deliver to patients, adapting it to the needs of the population and responding to the needs of public health [16].

The results of our study show that most of the responders are satisfied with the results of care.

Health education and medical advice is recognised to be valuable in 88.8% of cases concerning diseases and 87.7% of cases for preventative measures.

A total of 52.3% of patients suffered from a chronic disease, and 91.9% of them affirmed that they understood the medical advice of their GP on how to take medication.

We also explored some of the **procedures relevant to public health**,

such as pregnancy monitoring and well-child and cervical cancer screening. Access to these services is appreciated by patients, yet data from the NHIH show a reduced number of reported services, such as pregnancy monitoring (0.98% of all services/year/2016) and well-child (2.26 % of all services provided by GP/year/2016). Underreporting is one of the causes, as well as a lack of education among the population accessing these services can be a cause.

Cervical cancer screening was included temporarily (5 years) in a payment scheme, during a cervical cancer screening organized by the Ministry of Health between 2012-2017. During the program, GPs had the opportunity to screen for Pap smears in their offices or to refer patients to a gynaecologist. Not many GP's chose to do Pap smears in their offices.

Point-of-care testing, such as lab tests and electrocardiograms (EKGs), is not recognised as an offered service in the family doctor's office.

6. Conclusions

Overall, the analysis of population's perceptions on the primary care system in County Brasov is showing an unexpectedly high degree of satisfaction among the patients considering access, process of care and outcomes of care.

Results are surprising if we consider all the normative barriers in the provision of medical services in primary care that are set by the government, such as the limited number of consultations, reduced opening hours and barriers in medication prescription.

In our opinion, high satisfaction rates of patients using primary care services, despite evidence that some important conditions of access and service delivery are missing, is due to the population's belief that the competences of this speciality are limited by its nature, and this is how it is supposed to be. The fact that a medical resource is relatively easily available encompasses the barriers to access due to limitations in the spectrum of services that is offered. These limitations are disturbing for GPs who feel unable to practice their profession.

7. Limitation of the Study

This analysis was performed to describe the perception of healthcare users about availability of services in primary care in a specific county of Romania. Generalisability is therefore limited in terms of specific results, but, since some regulatory policies are generally applicable some conclusions about perception of the population can be drawn.

Also, the results of the study represent in their majority the opinion of service users that might have better perceptions than non-users about the availability of services.

List of Abbreviations

GP: general practitioner/family doctor
NHIS: National Health Insurance System
NHIH: National Health Insurance House
DHIH: District Health Insurance House
HNA: health needs assessment
OOH: out-of-hours services
MH: Ministry of Health
NSPHM: National School of Public Health and Management Bucharest
WHO: World Health Organisation.

Declarations

Ethics approval and consent to participate

The study was approved by the Ethics Committee of Transylvania University. The consent of the patients to participate in the study was verbal and assumed through the completion of the questionnaire. The questionnaire has a heading section that explains the reasons for the study and that the study is anonymous. The questionnaire was approved by the Ethics Committee of Transylvania University according to its ethic code. It is also in the principles of the European Code of Conduct for Research integrity, Core practices Committee on Publication Ethics COPE.

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Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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