HOW DO ROMANIAN PATIENTS PERCEIVE AND EXPERIENCE PUBLIC AND PRIVATE REHABILITATION SERVICES?

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https://doi.org/10.35189/dpeskj.2020.59.3.8

Abstract. *The quality of medical and rehabilitation services is a constant topic of debate. Health service quality is defined as the degree and direction of discrepancy between patients' perceptions and expectations. The present study is a conclusive direct investigation that aims, among other things, to record the differences between private and public rehabilitation systems, and compare the results obtained from questionnaires applied to patients. The main hypothesis from which we started this research was that there were differences in terms of patient-physiotherapist relationship and quality of services between public and private rehabilitation systems. This research was carried out using the following methods: bibliographic study method, observation method, questionnaire method, mathematical and statistical processing method, and graphical method. The study was conducted over a period of ten months (June 2018 - April 2019) in seven private rehabilitation institutions and two public rehabilitation institutions in Târgu Mureș, Romania, on a total of 260 patients. Data analysis revealed statistically significant quality gaps between rehabilitation services offered by private versus public institutions. Following the investigation, interpretation, and analysis of recorded results, we can say that the hypothesis has been confirmed. Public rehabilitation institutions failed to meet patients' expectations in all major areas of service quality.*

Keywords: *physiotherapy, rehabilitation, public health.*

Introduction

Physiotherapy is an essential part of medical services, being used by a significant number of people (McFadden et al., 2016). When talking about the public health system in Romania, we can say that a low number of physiotherapists are found especially in clinical departments (Staes & Badache, 2015); however, an encouraging number of physiotherapists work in special outpatient departments. The Romanian health system also includes private rehabilitation institutions where procedures are incurred by various private health insurance companies, patients, or the Romanian National Health Insurance House. Moreover, if we refer to physiotherapy at home, there are a series of collaborations between the National Health Insurance House and private rehabilitation companies or individually authorised physiotherapists (Casa Națională de Asigurări de Sănătate [National Health Insurance House], 2020).

Whether it is a private or public rehabilitation institution, therapeutic objectives as well as staff training, and commitment to the patient's needs and health issues are the same (McKinnon et al., 2019). Both private and public rehabilitation institutions should respect the patient's confidentiality and autonomy, provide prompt services and qualitative facilities in order to meet the expectations of the population and achieve high-quality standards.

At the moment, there are two major currents worldwide. On the one hand, the ethicists, who consider private institutions as a tick insect of the public health system, blaming them

for creating unfair competition. On the other hand, those who encourage excessive liberalism, idealising private institutions and considering them as the only real alternative to the public system.

In Romania, a system has been created in which sources of finance are both public and private, in order to offer equal chances and correct distribution of service payment. The Romanian health system is a modified version of the Bismarck model, which also includes influences of Semasko and Beveridge models (Bârliba & Sinițchi, 2008).

The reality presented in previous studies has shown that the Romanian health system is characterised by low funding and inefficient use of resources, with the lowest gross domestic product (GDP) per capita invested in healthcare in the European Union (OECD/European Observatory on Health Systems and Policies, 2017). According to the 2020 World Health Systems ranking of the World Health Organization, the Romanian health system is ranked 99 (Tandon et al., 2000). The Word Health Organization no longer produces such a rating due to the complexity of the task.

Public and private rehabilitation institutions have come to coexist to such an extent that it is difficult to draw a fine line between them. The National Health Insurance House partially supports the procedures in private rehabilitation institutions, and some physiotherapists work in both public and private institutions. The private system is considered a complementary system that has a limited field of activity, but its main role is to decongest the public system by treating a certain number of people. The choice of the rehabilitation institution is influenced by the recommendations of the physician, friends, and colleagues (Hintz et al., 2019), but also by prejudices, background, and financial possibilities.

The quality of medical and rehabilitation services is a constant topic of debate (Fatima et al., 2017; Pai & Chary, 2013; Mehdizadeh et al., 2015). Health service quality is defined as the "degree and direction of discrepancy between consumers' perceptions and expectations" (Parasuraman et al., 1988, p. 17). Good overall healthcare outcomes are only achieved when patient satisfaction is taken into account (Kansra & Jha, 2016; Al Fraihi & Latif, 2016). Patient satisfaction consists of two important dimensions (procedural and personal) and includes two aspects (cognitive processes and emotional reactions to the elements of the institutional structure) (Popa et al., 2017; Rossettini et al., 2020). While the procedural dimension refers to treatment or the anticipation of patient's needs, the personal dimension involves elements such as the physical aspect of cleanness, maintenance, and relationship with the medical staff (Handayani et al., 2015). The cognitive process refers to aspects such as understanding the information provided by the medical staff, while emotional reactions refer to employees, materials, environment, financial resources (Zarei et al., 2014; Persai et al., 2014; Ezegwui et al., 2014).

Gap-analyser models were used in several studies for assessing hospital service quality (Purcărea et al., 2013; Torabipour et al., 2016; Chakravarty, 2011; Aghamolaei et al., 2014). Similar studies were conducted in Romania, where it has been found that patient satisfaction is among the lowest in Europe (Jankauskienė & Jankauskaitė, 2011). Factors that increase frustration in Romanian patients are: quality, cleanness and maintenance of the environment, equipment, technology, communication with staff, and empathy (Agheorghiesei & Copoeru, 2013; Popa, 2017).

The role of physiotherapists in today's society is well known due to their training and experience, elements that impose the responsibility of complying with international standards of conduct and behaviour. The physiotherapist's principles and values are set out in the working Code of Ethics. Beneficiaries of these services can consult this code to know exactly what to expect from the physiotherapist and their professional practices. The World Confederation for Physical Therapy (2017) also indicates that the therapist's roles are as follows: disability prophylaxis; implementation of treatments and procedures to restore the integrity of different body parts involved in performing motor actions; maximising different functions; disability reduction; improving the quality of life of people with functional disabilities due to various causes, impairments, restrictions or limitations, and many others.

In addition to the physiotherapist's main role of treating and implementing kinetic programmes, they are assigned many other tasks such as: developing, promoting, and implementing various movement-based wellness and health awareness programmes (Dankel et al., 2016; Landridge, 2019); teaching and interacting with intern students or volunteers; managing various situations that may arise in rehabilitation institutions; supporting public health programmes; supporting patients and the national health system.

For the proper functioning of all rehabilitation institutions, a series of requirements have been formulated to guide the entire rehabilitation process. These requirements play a key role in preventing possible critical and unpleasant situations.

A personal clinical file should be prepared, which contains information about the patient, the objectives, assessments, means, and methods used in each physiotherapy session, etc. (Olawale et al., 2015). This individual file has to meet the following requirements: to be created at the first appointment with the patient (during anamnesis); accurately reflect clinical findings; contain information on general health status; contain values that record the progress of the rehabilitation programme; be sufficiently concise, legible and dated, in the event that the patient is taken over by another specialist; be kept in a safe place, in accordance with the legislation on the privacy and security of personal data. Any change in the rehabilitation process is recorded in the individual plan so that the file remains useful and relevant. The access of other medical staff to the individual file will be allowed only with the patient's consent.

The file should also contain data about the patient's history and health status (physical, psychological, and social). If these documents do not exist, the physiotherapist asks the patient or family specific questions in order to gather the information necessary to outline an appropriate rehabilitation plan. After talking about the medical history, the patient will be physically and functionally examined (Samsson & Larsson, 2015). All measurable data are recorded.

The anamnesis informs the physiotherapist about the aspects that bother the patient (Papadakis & McPhee, 2016). By listening, being open, and creating an atmosphere of trust, the physiotherapist gets a general idea about the patient's physical and psychological condition. This anamnesis has a major role and cannot be done by completing a questionnaire, through computer programs or through a third person, because it is a fundamental part of building the physiotherapist-patient relationship.

Assessment in physiotherapy includes observation, the use of specific assessment techniques and tools, specific tests, palpation, manipulation, and also standardised

measurements (Braun et al., 2018; Lahelle et al., 2020). The conclusion of all these examinations should be explained to the patient.

It is recommended to ensure privacy when performing the initial evaluation, and all the assessments should be performed away from other patients or strangers (Hudon et al., 2015).

Not a single physiotherapeutic procedure or examination can be performed without obtaining informed consent (Chima, 2015; Roman et al., 2019). The physiotherapist is required to mention all treatment options, their benefits, risks and possible side effects, and to answer all the questions asked by the patient or family, clarifying all the necessary aspects and mentioning that, at any time of the rehabilitation programme, they can refuse procedures or exercises (Fenety et al., 2009; Aderibigbe & Chima, 2019). If the patient refuses recommended treatment, this will be mentioned in the patient's personal file, together with the reasons, if any. In rehabilitation institutions where intern students or volunteers are present, patients are informed that they have the right to refuse to be observed or treated by them. Physiotherapists should not abuse their professional position to influence patients in making the right decision (Lamont et al., 2019).

In short, patients are provided with relevant information about all the therapeutic procedures. All information should be adapted to the patient's age, emotional state, and cognitive ability, and should not influence their decisions in giving informed consent. The entire patient information process is recorded, signed, and dated.

The physiotherapist should ensure that the patient is fully involved in any decision-making process regarding the treatment plan. The physiotherapist should take into account the patient's goals and aspirations, involving them in the decision-making process when possible (Stevens et al., 2017).

All the patient's needs, social, cultural, and religious contexts will be taken into account due to their strong impact on the rehabilitation process.

Moreover, physiotherapists should be transparent and honest in their financial agreements with patients, clearly providing their fees (in private rehabilitation institutions) and vehemently refusing various gifts or extra money from patients.

The physiotherapist will refer patients to another specialist in the medical field when considering that their health condition requires further investigations or when, for various reasons, they do not respond to the physiotherapeutic treatment. These recommendations can be done in writing or orally.

An integrated part of physiotherapy is the interaction between therapist, patient, and patient's family, which has the main role of developing a mutual understanding of the beneficiary's needs; this interaction has a positive influence on the rehabilitation programme (Miciak et al., 2019). Members of the medical interdisciplinary team should also interact with each other, setting together goals and strategies for implementing treatments and interventions. Moreover, physiotherapists should interact with administration and governance structures in order to inform, develop, and implement various policies necessary for the health system.

Whether it is about different pathologies or physical disabilities, when patients access physiotherapy services, they are most often deeply affected, scared and sceptical about the procedures to be performed (Hojat, 2016). This is the reason why the first meeting between the two (patient-physiotherapist) aims to create the premises for a collaboration based on trust

and respect. For this, the patient should meet a warm person, with an attitude characterised by gentleness, understanding, and positivity, which influences the patient's openness to communicate various personal aspects without feeling embarrassed (Voinescu et al., 2009).

Talking about the same aspect mentioned above, we emphasise the well-known idea that no two patients are alike. Individual requirements and means of intervention need to be adapted, therefore the physiotherapist should possess specific skills. That is why we believe that physiotherapy is a field similar to education, where knowledge is not enough if it is not accompanied by commitment to the patient.

We also believe that this patient-physiotherapist relationship profoundly influences the course and results of the rehabilitation programme.

Just like in the general medical field, introspection in the therapist-patient relationship should be an attribute of the former and clearly cultivated with care by the latter (Pașca, 2012). This relationship is undoubtedly found in the rehabilitation programme.

The main hypothesis from which we started this research was that there were differences in terms of patient-physiotherapist relationship and quality of services between public and private rehabilitation systems in Târgu Mureș, Romania.

Methodology

The present study is a conclusive direct investigation that aims to record the differences between private and public rehabilitation systems and compare the results obtained from questionnaires applied to patients.

This research was carried out using the following methods: bibliographic study method, observation method, questionnaire method, mathematical and statistical processing method, and graphical method.

The study was conducted over a period of ten months (June 2018 - April 2019) in seven private rehabilitation institutions and two public rehabilitation institutions in Târgu Mureș, Romania, on a total of 260 patients.

For confidentiality reasons and in order not to affect the image of all rehabilitation institutions included in this research, their names will remain anonymous. All subjects were informed about the purpose of this research and expressed their agreement regarding the use of personal data, with the preservation of anonymity.

Data about age, gender, and number of physiotherapy (PT) sessions are found in Table 1.

Table 1. *Participating subjects and their distribution by age, gender, and number of physiotherapy sessions*

	Number of subjects	Mean age (M.U. = years)	Number of PT sessions performed (M.U. = no.)	Women (M.U. = no.)	Men (M.U. = no.)
Private rehabilitation institutions	130	42.3	43.1	80 ↓ 61.54%	50 ↓ 38.46%
Public rehabilitation institutions	130	54.4	7.9	72 ↓ 55.39%	58 ↓ 44.61%

The study was conducted with the help of a questionnaire addressed to patients, which included 20 items, each of them with three response options. According to the response given to each item, they were classified into three groups according to their nature, namely: negative responses, neutral responses, and positive responses.

Results

All aspects covered by the 20 items and the distribution of recorded responses are shown in Table 2.

Table 2. *Distribution of responses*

No.	Item	Negative responses			Neutral responses			Positive responses		
		Ppriv %	Ppubl %	Δ R_{Ppriv-} R_{Ppubl}	Ppriv %	Ppubl %	Δ R_{Ppriv-} R_{Ppubl}	Ppriv %	Ppubl %	Δ R_{Ppriv-} R_{Ppubl}
1.	Services are qualitative	3.85	27.69	-23.84	28.46	33.08	-4.62	67.69	39.23	28.46
2.	Physiotherapists perform anamnesis and initial evaluation	10.77	33.85	-23.08	26.15	33.85	-7.70	63.08	32.31	30.77
3.	Anamnesis and initial interview are performed in an intimate environment	27.69	70.77	-43.08	32.31	15.38	16.93	31.54	13.85	17.69
4.	Patients are informed about the possibility of refusing any exercise or procedure	28.46	59.23	-30.77	10.00	10.77	-0.77	61.54	30.00	31.54
5.	Patient consent is required when students are present	33.08	64.62	-31.54	19.23	13.85	5.38	47.69	21.54	26.15
6.	Objectives and procedures are well explained	0.77	24.62	-23.85	17.69	15.38	2.31	81.54	60.00	21.54
7.	Physiotherapists have good communication skills	3.85	23.08	-19.23	16.92	6.15	10.77	79.23	70.77	8.46
8.	Only one physiotherapist treats and monitors one patient	15.38	66.15	-50.77	37.69	11.54	26.15	46.92	22.31	24.61
9.	Physiotherapists have a positive attitude	0.00	0.00	0.00	3.85	17.69	-13.84	96.15	82.31	13.84
10.	Interest in continuing the kinetic programme at home	6.15	36.15	-30.00	14.62	0.00	14.62	79.23	63.85	15.38
11.	The clinic is advisable to a family member	2.31	30.77	-28.46	7.69	13.85	-6.16	90.00	54.62	35.38
12.	An interdisciplinary team exists	16.92	21.54	-4.62	25.38	22.31	3.07	57.69	56.15	1.54
13.	Exercises are correctly demonstrated	0.00	12.31	-12.31	6.92	15.38	-8.46	93.08	72.31	20.77
14.	Public rehabilitation services are as good as private ones	74.62	22.31	52.31	16.15	24.62	-8.47	9.23	53.08	-43.85
15.	Patients have personal files that contain regular assessments	18.46	36.92	-18.46	20.77	13.85	6.92	60.77	49.23	11.54
16.	Chocolate and flowers have a good influence on physiotherapists	2.31	8.46	-6.15	9.23	15.38	-6.15	88.46	76.15	12.31
17.	Time of a session is limited	8.46	21.54	-13.08	16.15	16.15	0.00	75.38	62.31	13.07
18.	Latest treatments are available	5.38	53.08	-47.70	20.77	33.08	-12.31	73.85	13.85	60.00
19.	Healthcare environment is aesthetic	4.62	57.69	-53.07	11.54	33.85	-22.31	83.85	8.46	75.39
20.	Services are affordable for patients	44.62	3.08	41.54	19.23	16.92	2.31	36.15	80.00	-43.85
	Mean	15.39	33.69	-18.31	18.04	18.15	-0.12	66.15	48.12	18.04

Legend: Ppriv = Patients from private rehabilitation institutions / Ppubl = Patients from public rehabilitation institutions/ R_{Ppriv} = Responses of patients from private rehabilitation institutions / R_{Ppubl} = Responses of patients from public rehabilitation institutions / Δ = difference

After processing the statistical significance of the differences between patients' negative responses to the 20-item questionnaire and calculating the t-test using the GraphPad Prism 8 for Windows, the comparative analysis shows the following:

At a probability threshold of $P < 0.05$, the difference between the two rows of data is statistically significant, the calculated t-value being 2.865 and that of $R^2 = 0.1777$, with a 95% confidence interval ranging between 5.374 and 31.24, a homogeneity of variance of 1.02404, Shapiro-Wilk Test (W) = 0.884395, Cohen's d = 0.207873 (Table 3).

Table 3. *Comparative analysis of the negative responses of patients from public and private rehabilitation institutions*

Statistical indicators	Values
Significantly different? (P < 0.05)	Yes
P-value	0.0067
t, df	t = 2.865 df = 38
Mean of column A	15.39
Mean of column B	33.69
Difference between means	18.31 ± 6.389
95% confidence interval	5.374 to 31.24
R-squared	0.1777
F-ratio	1.02404
W	0.884395
Cohen's d	0.207873

After processing the statistical significance of the differences between patients' positive responses to the 20-item questionnaire and calculating the t-test using the GraphPad Prism 8 for Windows, the comparative analysis shows the following:

At a probability threshold of $P < 0.05$, the difference between the two rows of data is statistically significant, the calculated t-value being 2.447 and that of $R^2 = 0.1361$, with a 95% confidence interval ranging between -32.96 and -3.112, a homogeneity of variance of 0.33235, Shapiro-Wilk Test (W) = 0.940355, Cohen's d = 0.793769 (Table 4).

Table 4. *Comparative analysis of the positive responses of patients from public and private rehabilitation institutions*

Statistical indicators	Values
Significantly different? (P < 0.05)	Yes
P-value	0.0192
t, df	t = 2.447 df = 38
Mean of column A	66.15
Mean of column B	48.12
Difference between means	-18.04 ± 7.372
95% confidence interval	-32.96 to -3.112
R-squared	0.1361
F ratio	0.33235
W	0.940355
Cohen's d	0.793769

Conclusion

Following the investigation, interpretation, and analysis of recorded results, we can say that the hypothesis has been confirmed, and data analysis has revealed statistically significant differences between rehabilitation services offered by private versus public institutions. Public rehabilitation institutions failed to meet patients' expectations in all major areas of service quality.

Although private and public systems have come to coexist to such an extent that it is difficult to draw a line between them, the population's prejudices about the quality of public institutions remain unchanged. Aspects such as the quality of services, availability of latest treatments, obtaining informed consent, respecting the patient's privacy, conducting an anamnesis and initial interview in optimal conditions, etc., were identified as being poorly applied in public rehabilitation services, thus leading to the conclusion that certain aspects of the daily practice mentioned in the National Occupational Standards are not applied.

We believe that it is absolutely necessary to provide physiotherapy services at the highest standards of education and work practice, and we hope that this research will be considered as an alarm signal.

The area of action of physiotherapy is not limited to treating the patient but also includes other factors that we have tried to integrate in this study. We strongly believe that increasing the financial budget may not be the revolutionary solution to all problems that are faced in Romanian rehabilitation institutions. Aspects such as staff absenteeism, improper patient care, and long waiting times will not be fixed by an increased budget. Also, we support the inclusion of specific courses aimed at communication and networking techniques in the educational programme of bachelor's or master's degree studies.

For the future, we hope that there will be no differences between the quality of services offered by public and private rehabilitation institutions. This can only be achieved if the two components of the health system are on equal terms regarding the investment of interest and money from the government, because a strong health system is achieved by stimulating competition and excluding commercial rivalry.

Acknowledgments

Our thanks go to the management staff of both public and private rehabilitation institutions of Târgu Mureș, Romania, to the physiotherapists and all the subjects for their support in conducting this research.

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