
HEALTHCARE QUALITY - A MANAGERIAL APPROACH

PENTESCU Alma

Lucian Blaga University of Sibiu, Romania

Abstract:

Healthcare quality has been defined in different ways, depending on the dimension that the authors had in mind. Furthermore, if initially healthcare quality was defined and assessed from the specialists' and researchers' point of view, nowadays the importance of patient and the public opinion preferences and perspective has been recognized. Thus, the first step in assessing the quality of these services involves defining what is meant by "quality". Along these lines, this paper presents the results of a qualitative research, conducted on a sample of 16 managers, quality managers and CEOs of several clinics and hospitals, both public and private (for-profit), from Bucharest.

Key words: *quality, healthcare services, qualitative research, semi-structured interview, managers*

1. Meaning of healthcare quality and its components

According to Avedis Donabedian (1980 in Legido-Quigley, McKee, Nolte, Gliens, 2008, p.2), healthcare quality is *"the kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts"*.

The Institute of Medicine (IOM) of the United States of America defines the quality of care as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge... How care is provided should reflect appropriate use of the most current knowledge about scientific, clinical, technical, interpersonal, cognitive and organizational elements of healthcare"* (Lohr, 1990, p.21).

Other definitions worth mentioning are those of the Department of Health of the United Kingdom (1997), according to whom healthcare quality means *"doing the right things (what), to the right people (to whom), at the right time (when), and doing things right first time"*, respectively of the Council of Europe (1998), which defines quality of care as *"the degree to which the treatment dispensed increases the patient's chances of achieving the desired results and diminishes the chances of undesirable*

results, having regard to the current state of knowledge” (Legido-Quigley, McKee, Nolte, Glions, 2008, p.2).

All these definitions aim the patients' welfare (achieving the desired results in terms of their health status), emphasizing either the costs, the current state of knowledge or the responsiveness of health systems to people's expectations.

Based on the research conducted in this field, Donabedian highlighted the **dual nature of healthcare quality**, which has a **technical side** (the existing science and technology) and an **interpersonal side** (the application of the existing science and technology in actual practice). Also, according to the National Commission for Accreditation of Hospitals - CoNAS (2010, pp.5-7), the quality of care has three dimensions:

- **professional quality:** *the product/service meets all the conditions set by top professionals from the medical field (practice standards). Usually, the professional quality of care takes into account skills, compliance with clinical protocols and guidelines, the use of infection control measures, information and advice, and the integration of healthcare services;*
- **patient's expectations regarding a specific service:** *in this case, quality is illustrated from the consumer's point of view (its satisfaction). In most cases, patients do not have the necessary knowledge in order to assess the provider's skills, but, taking into account how they feel and how they were treated, they assess the quality of care in terms of how well it met their expectations;*
- **total quality management:** *is the most efficient and productive way of using resources within the limits set by authorities/buyers (efficiency).*

As regards the **components of healthcare quality**, Avedis Donabedian (2003, p.6), has identified the following seven attributes:

- **“efficacy** *(the ability of the science and technology of healthcare to bring about improvements in health when used under the most favourable circumstances);*
- **effectiveness** *(the degree to which improvements in health now attainable are, in fact, attained, comparing the actual performance with the performance that the existing science and technology could be expected to achieve);*
- **efficiency** *(the ability to lower the cost of care without diminishing attainable improvements in health);*
- **optimality** *(the balancing of improvements in health against the cost of such improvements);*
- **acceptability** *(conformity to the wishes, desires, and expectations of patients and members of their families; acceptability is comprised of the following five parts: accessibility, the patient-practitioner relationship, the amenities of care, patient preferences regarding the effects, risks, and cost of care, and what patients consider to be fair and equitable);*

- **legitimacy** (conformity to social preferences, as expressed in ethical principles, values, norms, laws, and regulations);
- **equity** (conformity to a principle that determines what is just and fair in the distribution of healthcare and of its benefits among the members of a population)".

Similarly, Elizabeth Ransom, Maulik Joshi, David Nash and Scott Ransom (2008, p.5) believe that high quality healthcare services should be:

- **“safe:** care should be as safe for patients in healthcare facilities as in their homes;
- **effective:** the science and evidence behind healthcare should be applied and serve as the standard in the delivery of healthcare services;
- **efficient:** care and service should be cost effective, and waste should be removed from the system;
- **timely:** patients should experience no waits or delays in receiving care and service;
- **patient centered:** the system of care should revolve around the patient, respect his/her preferences, and put him/her in control;
- **equitable:** unequal treatment should be a fact of the past and disparities in care should be eradicated”.

For this purpose, safe care may be measured in terms of the percentage of overall mortality rates or patients experiencing adverse events or harm, while effective care may be measured by how well evidenced-based practices are followed, for example: the percentage of time diabetic patients receive all recommended care at each doctor visit; the percentage of hospital-acquired infections; the percentage of patients who develop bedsores while in the nursing home. Efficient care may be measured by analyzing the costs of care by patient, by organization and/or by community, whereas timely care may be measured by waits and delays in receiving needed care, service, and test results. Patient-centered measures may include patient or family satisfaction with care and service, while equitable care may be measured by examining differences in quality measures (such as measures of effectiveness and safety) by race, gender, income, or other demographic and socio-economic factors (Ransom, Joshi, Nash, Ransom, 2008, pp.5-6).

Going back to the meaning of healthcare quality, it is worth mentioning that different stakeholders (physicians, patients, managers, payers, and the society) define quality of care differently. Therefore, considering all components listed above, the relevant attributes in the definition of healthcare quality are: the technical performance, the management of interpersonal relationships, the amenities of care, the accessibility, the responsiveness to patient preferences, the equity, efficiency and cost-effectiveness.

Thus, physicians tend to define quality of care in terms of technical performance, emphasizing the need to keep up with the latest findings in order to provide quality services. On the other hand, managers are generally concerned with the quality of the non-clinical aspects of care over which they have most control,

especially the amenities and access to care. Moreover, unlike the physicians and patients, managers pay special attention to the equity, efficiency, and cost-effectiveness of these services.

Third-party payers tend to assess quality of care in terms of costs, inefficient care being regarded as poor-quality care. Therefore, they are more likely to opt for providing optimal care, rather than to provide the maximum possible care. In contrast, physicians consider themselves as duty-bound to do everything possible to help their patients, including expensive interventions even when such measures have a small probability of benefiting the patient (Ransom, Joshi, Nash, Ransom, 2008).

Finally, patients assess the quality of care on the basis of the aspects they are able to evaluate: the interpersonal aspects of care and the amenities of care.

2. Steps in providing quality healthcare services

In order to provide quality healthcare services, Donabedian (2003, p.46) suggests a model based on three components: *structure - process - outcome*.

Structure refers to *the characteristics of the individuals who provide the healthcare services* (number of employees, their education and qualifications) as well as *the conditions under which care is provided* (facilities and equipments, the means of supervision and performance evaluation, the methods of paying for care, etc.). Thus, a suitably qualified personnel, which works under proper conditions, favours the provision of quality service, but without guaranteeing it. For this reason, these elements are useful in detecting errors.

Process means *“the activities that constitute healthcare, including diagnosis, treatment, rehabilitation, prevention and patient education, usually carried out by professionals, but also including the patient and his/her family”*. The quality of the process is influenced by the therapeutic decisions taken (are these the appropriate ones?!) and by the promptitude with which they were taken.

Outcome embodies *“the changes (desirable or undesirable) that can be attributed to healthcare, including changes in the health status, changes in the knowledge acquired by patients and their family members that may influence future care, changes in the behaviour of patients and their families, patient’s satisfaction with the care received and its outcomes”*.

Structure, process and outcomes are not attributes of quality, but the information one can obtain. Along these lines, structure (the way in which the healthcare system is set up) has a major influence on the behaviour of the people involved and, as a consequence, on the quality of the healthcare services provided. As regards the process of care giving, because it takes place in “real-time”, it offers immediate clues about the quality of the services provided, these information being rather easily obtained. What matters most is the effect of the healthcare services on the patient’s health and well-being, although outcomes may be consequences attributable to antecedent care. This means that, before using certain outcomes as a quality indicator, one must correct the differences between patients in terms of

exogenous characteristics of the process of care giving, procedure known as "case-mix adjustment". One also needs to choose how to measure outcomes; for example: "*partial, diagnosis specific*" or "*inclusive, generic*" (Donabedian, 2003, p.54).

As for the **monitoring of the quality of care**, information is a vital resource. Thus, the use of incomplete or intentionally distorted information will create a false picture of the quality of the services provided.

In healthcare, the necessary information can be obtained from *medical records, surveys (of patients/physicians), financial records, statistical reports, direct observations and through simulations* (Donabedian, 2003, p.78).

The **medical records**, kept by physicians for each patient under their care, are a widely used source of information. Unfortunately, they are often incomplete, inaccurate and sometimes hard to interpret. The completeness of medical records varies by the type of healthcare unit in which services are provided (if a single physician has to provide services and complete the documentation, completeness will decrease). Additionally, there is no information about the patient - practitioner relationship (an important component of the quality of care), but only aspects of the technical care, such as the anamnesis, test results, prescribed drugs, interventional procedures, and the findings on physical examination.

Surveys may be conducted among patients and members of their families, physicians or members of a community. Thus, one could use questionnaires (sent by mail, email or face-to-face) or interviews (by telephone or face-to-face). The information obtained can be entirely new or can be a confirmation or additional information of the data from the medical record.

Surveys of patients and family members are useful to see how satisfied they are with the provided services. Furthermore, these opinions can suggest how to improve those services. What matters most is when they are conducted. For example, opinions obtained while the patient is awaiting care may be distorted by the patient's unwillingness to offend. For this reason, it is desirable to obtain information in a more neutral setting, but not too late, so that details begin to fade. In all cases, confidentiality and anonymity are compulsory.

When the purpose of the survey is to monitor the quality of the provided healthcare services it is important to allow physicians (or the medical staff) to explain the care they have given or failed to give, for a rational explanation of their behaviour. In addition, physicians can be questioned not just about the care they themselves have provided, but about the quality of the services provided within an organization, about the working conditions (in terms of the availability of the necessary resources as well as in terms of organizational aspects) and about their satisfactions and dissatisfactions. Along these lines, it is worth mentioning that their satisfaction is an important attribute of *structure*, the environment influencing how well they perform (Donabedian, 2003, p. 86).

Direct observations can be used to obtain information about how safe and hygienic that healthcare unit is, whether or not it meets standards, whether or not the needed equipment is available and kept in good repair, about how medical records/

information about the patients are kept, and about service provision (observing the interaction with the patient, what was done, and how well). The quality of care may be rated using qualitative terms (such as "exceptional," "good," "satisfactory," "not satisfactory") or quantitative terms (a number between 1 and 100). Furthermore, the evaluation committee may give recommendations, respectively may videotape instead of writing down the relevant details.

If all evaluation methods described above assess the quality of the provided healthcare services, **simulations** may be used in order to assess the ability to perform well. Thus, to see how well healthcare services can be provided under certain circumstances, one could use an actual patient (observing the process of care giving) or a computer programmed to respond to the clinical activities undertaken by the physician. In either case, the physician knows that this is a test and therefore can be expected to try to excel. Hence, in order to be as close as possible to a real situation, one might evaluate the physician with *prior consent, but without knowledge of when the test is conducted or what it is to be* (Donabedian, 2003, p.89).

Similarly, the Romanian experts in healthcare management (Școala Națională de Sănătate Publică și Management Sanitar, 2006, p.209) consider that the quality of care may be assessed by observing the process of care giving (by experts, technique called *peer review*), by assessing patient satisfaction, using the anonymous patient technique (the evaluator play for one day the role of patient), by reviewing the existing data, by surveys among the medical staff and patients (conducted at the discharge from hospital).

To sum up, after establishing the methods of collecting information and the ones for quality assessment, one must decide when the monitoring is to take place. Along these lines, the quality of the provided healthcare services can be assessed using a prospective or *anticipatory monitoring, a concurrent monitoring or a retrospective monitoring* (Donabedian, 2003, p. 92). The most frequently used method is the retrospective monitoring, although one can not intervene. In contrast, concurrent monitoring allows one to intervene, and if needed, to interrupt care or alter its course. However, when errors in care are discovered and their causes are understood, retrospective monitoring is useful for suggesting ways of improvement. In conclusion, when monitoring the quality of care one should assess the healthcare provider's performance in reference to the existing standards.

3. Research methodology

Given the importance of providing quality healthcare services as well as the world-wide pursuit of improving these services, the aim of this research is to gain a better understanding of managers' perception on the importance of - and means of providing quality healthcare services.

Along these lines, the identified **decision problem** consists in a detailed knowledge of managers' (of several public and private -for-profit- clinics and hospital from Bucharest) interest in - and the measures taken to provide quality healthcare

services. Thus, the ***purpose of this research*** is to study the perception of the managing staff of several clinics and hospitals towards the quality of care.

In accordance with the above mentioned purpose, following ***objectives were set***:

- ***O1***: to study how interested managers are in providing quality healthcare services;
- ***O2***: to identify the main problems encountered, on a daily basis, in their attempt to provide good quality healthcare services;
- ***O3***: to study the meaning they attribute to the concept of healthcare quality and its components;
- ***O4***: to identify if there are documents which acknowledge the quality of the provided healthcare services;
- ***O5***: to identifying the methods through which they monitor the quality of the provided healthcare services.

The ***investigation method*** chosen was the individual interview. The main selection criteria, was the interviewees' ability to take decisions with regard to quality assuring and monitoring.

Thus, based on an interview guide structured on three discussion topics, we have conducted 16 semi-structured interviews with the managers, quality managers and CEOs of the following clinics and hospitals (from Bucharest): „Carol Davila” Nephrology Hospital, „Prof. Dr. Alexandru Obregia” Children’s Hospital, „Prof. Dr. Theodor Burghela” Urology Hospital, „Sfânta Maria” hospital, the Emergency University Hospital, „Floreasca” Emergency Hospital, the Ophthalmology Emergency Hospital, „Dr. Victor Babeş” clinic, „Filantropia” Hospital of Obstetrics and Gynecology, „Dr. Victor Babeş” Infectious and Tropical Diseases Hospital, „MedLife” healthcare network, „Romar” clinics and „Regina Maria” healthcare network.

4. Data analysis and research results

Content analysis of the data showed the following. As regards the first discussion topic, ***the interest shown in providing quality healthcare services***, all the respondents were concerned with the quality of the provided services.

Concerning ***the problems they encounter daily***, in their attempt to offer good quality services, most of the respondents (more than a third) mentioned money. Thus, managers of the public healthcare units say that the funding is not sufficient for offering quality services constantly. What they mean by this is either money for the necessary resources (varying from supplies essential to the medical act – syringes, infusion sets, disinfectants – to service and spare parts for different medical equipment), or investments and funding from national programs. Along this lines, due to insufficient funding healthcare institutions lack necessary equipment, don't have enough medicine and medical supplies, can't financially reward those that work better, being obvious that it is extremely hard to follow an ideal (specific quality standards) when you do not have the necessary resources. In this context, one of the interviewed CEOs stated the

following: *“Medicine progresses every year, bringing about new and expensive diagnostic tools, tests and treatments, with which funding doesn't keep up”*. Likewise, not only the CEOs/managers of the public healthcare units, but also one CEO of several private clinics, claimed having funding issues.

Another issue, related to those of funding, regards **the equipment and facilities of the hospitals**. Accordingly, these are either overcrowded (the CEO of a public hospital claimed: *“The hospital is overcrowded, being poorly planned from the beginning. It was thought up more like a hotel, developed in height and with very few auxiliary spaces”*), or lack the necessary equipment (*“Major investments, which can't be covered by the hospital, are needed. For example: investments for the operating rooms, buying MRI or an angiography machines and so forth”*).

The managing staff of both public and private healthcare units, state another problem which refers to **the work force**. So, the existing staff is either insufficient, or insufficiently motivated (especially in the public sector). As regards the private healthcare institutions, these face recruitment difficulties on the one hand (the new generation of doctors being, on many levels, different from the previous ones and well-known doctors being hard to find), and on the other hand losing good doctors because of their migration abroad.

Furthermore, **the specific legislation** seems to be a problem that affects the public as well as the private healthcare units. The uncertainty towards the future legislative changes and the size of the healthcare designated budget make long term strategy planning and decision making harder: *“State contracting doesn't have a normal degree of credibility. We don't know the laws [...] we don't know if they are going to be the same in five years; we don't know the budget; we don't know anything”*.

If public healthcare units referred mainly to exogenous issues, the managing staff of the private institutions also revealed some **management difficulties**. Thus, these problems emerge from *patients' exigency, from their ability to pay for some/part of the services and from the difficulty of maintaining them and gaining their loyalty*. Also, in the same context as the before mentioned difficulty, another problem is the *competition, respectively market positioning and setting oneself apart from the main competitors*. Nonetheless, *the lack of compliance with the existing procedures or the excessive need for procedures* is another difficulty that the CEOs/managers of the private healthcare units face.

As to the second discussion topic, **defining the concept of healthcare “quality”**, the meanings attributed to the quality of care targeted either the technical side of a healthcare service (the actual medical act), or included the aspects which are important to the patient (the patient - practitioner relationship, accessibility, and so on):

- *“In a hospital, when you talk about the quality of care, you start with the organization, the structure, the circuits and you go as deep as the quality of the bedding and the bed making, the food serving, important being also the behaviour of the staff”*;

- *“The quality of healthcare services is a dynamic process. It depends on the perception of the interviewed person, but also on the social context and the system organization”;*
- *“When we talk about the quality of the healthcare services provided in this hospital, we think about the result obtained by the patient (the diagnosis, the blood test)”;*
- *“The quality of care refers to the synergy between the doctor and the patient. How the patient is greeted by the doctor, how the discussion is started. [...] There is a personal and a professional quality, if you will. The way one interacts, the way one diagnoses, through specific means of course, how one explains the diagnosis and the treatment, how he or she follows up. [...] In fact, the key of quality medical services is this personal and professional relationship”;*
- *“Generally speaking, quality is perceived as a premium service. Whether it concerns a doctor, a hotel or something else, the provided service is on an advanced level. In fact, the quality of a medical act means doing everything that needs to be done in order to assure a patient's safety and the need to obtain repeatable and reproducible results. And, like in any other domain, quality means applying procedures and standards [...]. If you search for the definition of the medical act on the WHO website, you will see that it means [...] doing what needs to be done, acting according to good practice guidelines; for the right patient (which means that you correctly selected the patient), at the right time (which means acting when the patient needs it).*

Likewise, while defining the quality of care, a part of the interviewed CEOs/managers referred to the existing standards (procedures, guidelines, protocols), while others thought about the degree of patient satisfaction:

- *“In my opinion, while talking about the quality of healthcare services we need to refer to the quality standards of different procedures, of different standardized medical acts and to see to what degree these quality points are being met; depending on the resemblance to the ideal we can say whether the quality factor has or has not been respected”;*
- *“Patients consider if a service is of good or very good quality based on their general perception, taking into account the facilities that the hospital is offering, in terms of the professional training of doctors and nurses, of the equipment and accommodation of the hospital”;*
- *“The quality of care is being customized through patient response. This is the only scale. If they are returning it means that the service was of good quality”.*

Thus, summarizing the previously presented meanings of quality, the quality of healthcare services can be defined from the angle of the professional and personal quality of the physician and from the patient - practitioner relationship.

The main components of the quality of care named by the interviewed CEOs/managers can be organized, in accordance to the dual nature of service quality (Donabedian, 2003), in:

- elements that appertain to the technical side of the service (associated with the existing knowledge and technology): *professional expertise, the medical act itself (the doctors' performance), diagnostic and therapeutic recommendations, the ability of correctly and promptly diagnosing and treating, technical issues, infrastructure;*
- elements that appertain to the interpersonal side of the service (referring to the application of the existing knowledge and technology in actual practice): *accessibility, a good patient - practitioner relationship, the attitude of the staff, the interaction with the patient, communication.*

Moreover, these aspects can also be found in the documentation created by the National Commission for Accreditation of Hospitals (2010, pp.4-5), according to which the quality principles of healthcare services are: expertise, accessibility, efficacy, efficiency, interpersonal relationships, continuity, safety, physical infrastructure and comfort, the ability to choose.

From a different point of view, the quality of care can also be analysed by relying on the factors that influence it. Therefore, some *"important and conditional factors of the quality of healthcare services are the portion of the GDP designated to healthcare services, the training of the medical staff, the number of inhabitants appointed to a hospital bed or a doctor"*.

Also, according to some of the CEOs/managers interviewed, quality is closely linked with patient satisfaction (*"quality is the main element in patient satisfaction"*), requiring a *"focus on the needs of patients, in an attempt to personalize the service to the type of patient targeted"*.

Finally, it is worth mentioning the statement that *"quality [...] is connected to what the patient (or who pays for the service) can afford"*.

Regarding the question **"What do you think your patients understand by the quality of the healthcare services provided in this hospital/clinic?"** almost all CEOs/managers interviewed listed factors not related to the medical act itself, since patients are subjective, their opinions can vary according to age, social class, personality, etc. Furthermore, they think that patients also appreciate the quality of service they received based on timeliness and the quality - price ratio.

To sum up, the CEOs/managers of the above mentioned healthcare units believe that most patients define the quality of care based on **the medical staff's behaviour and communication**. In addition, patients can appreciate different aspects at different stages of the service. For example: *"in the case of telephone appointments, the patient will pay attention at how quickly these are made; when coming to the clinic, he will pay attention to the reception staff; during blood harvesting, for example, the behaviour of nurses is important, and overall, waiting time is also a crucial factor "*.

Regarding the third topic of discussion, **quality management**, we found that in all healthcare units (in the sample) procedures, guidelines and protocols were being used. Also, almost all hospitals (in the sample) meet the CoNAS quality standards (those of the National Commission for Accreditation of Hospitals). Following the healthcare reform and the classification of hospitals in terms of their expertise

(Ministerul Sănătății, 2011), hospitals in Romania must be accredited by the National Commission for Accreditation of Hospitals by the year 2015, because starting this year hospitals which are not accredited will no longer receive funding from the National Health Insurance House (Agerpres, 2014). Thus, some of the hospitals that were part of the sample have already been accredited, the others are still waiting for the accreditation visit (CoNAS standards already implemented or under implementation). Executives of one single hospital have said that *"because of objective reasons, there is no system of quality management (and control), but it is under implementation (will probably be ready in 2-3 years)"*.

In addition to compliance with the CoNAS standards, some public hospitals and all private (for-profit) hospitals (in the sample) are ISO certified. In addition, some laboratories within them are RENAR accredited.

Unlike public healthcare facilities, the private (for-profit) hospitals (in the sample) started with ISO certification, subsequently starting (some even completed) the accreditation process for CoNAS, and two major healthcare networks are also seeking to implement the JCI (Joint Commission International) standards.

As regards the ***ways in which procedures, guidelines, protocols, standards are being communicated to employees*** (which ensures their adoption by employees), most CEOs/managers (almost half) use direct hierarchical communication. Also, more than a quarter of respondents use trainings. In addition, these procedures exist at any job (there is a folder which contains procedures for each department). Finally, some CEOs/managers are communicating these procedures in writing to their employees, and others are organizing meetings (*"health boards"*) once a month.

On the question ***"How do you measure if the set procedures, guidelines, and quality standards are kept?"***, the responses were quite different. Thus, a quarter of the respondents said they use hierarchical control. Other CEOs/managers periodically assess compliance (one eighth quarterly and another eighth annually: *"Compliance is checked randomly. Once a year, an audit committee verifies compliance with the quality standards based on feedback from patients"*).

Also, almost a quarter of respondents use indicators and an eighth verify if standards are being met, or not, based on patient feedback: *"To assess the quality standards, health services should be evaluated in accordance with the European standards. [...] Quality standards are assessed by survey of discharged patients, when they are asked to assess the healthcare services they received"*.

In addition, as reported by interviewees, the main ***key performance indicators*** used are:

- *indicators of healthcare service use*: number of inpatient hospital stay, length of stay, bed utilization rate, the number of patients discharged from surgical wards;
- *efficiency indicators*: average cost / bacteriological examination, average cost / radiological examination, bed costs, cost of medicine;

- *quality indicators*: hospital mortality rate, the proportion of patients who died 24 hours after admission, the proportion of patients who died at 48 hours after surgery, the rate of nosocomial (hospital-acquired) infections, the index of concordance between the diagnosis at admission and the discharge diagnosis;
- *outcome indicators*: the percent of patients with postoperative infections, the percentage of adults with hypertension under control, re-socialization percentage of patients with mental illness;
- *satisfaction indicators*: number of complaints from the total number of feedback received; medical complaints versus administrative and operational complaints.

As regards the **correspondence between the existing accreditation standards and the requirements for quality and patient safety**, the CEOs/managers interviewed have expressed their unanimous consent. Although some of them consider that some standards are slightly exaggerated or that they require some over-documentation, they consider that the existing standards are logical and consistent.

Asked what would be the two **changes they would make if they had all the resources they need and wouldn't be constrained in any way**, two CEOs/managers said they want more freedom in the use of funds and staff.

Furthermore, by expressing it in one form or another, some CEOs/managers want a bigger budget to be able to *fully retrofit and to restructure the hospital in terms of appearance* (a hospital in the public sector), *to ensure a better salary for employees, to be more vocal in terms of promotion or to be able to invest more in training and team development* (units in the private -for-profit- sector).

Also, some want a change from an administrative point of view, respectively *more time to implement quality standards (for their understanding and implementation of procedures)*, and others want *to change the public perception in what regards the medical staff*.

Finally it should be noted that there are CEOs/managers who do not want any change: *"I would not make any changes, what I wanted to change I already changed"*. All in all, the desired changes relate either to legislative issues or to financing the healthcare unit.

5. Conclusions

In conclusion, all the CEOs/managers interviewed are concerned about the quality of the provided services. Also, if staff-related problems affect both public healthcare facilities as well as private (for-profit) ones, financing issues are prevailing in the public units, while private (for-profit) hospitals face problems in attracting and retaining patients.

Also, certain thinking patterns were noticed, which allowed a systematization of the answers. Thus, as regards the meaning assigned to the concept of healthcare

services' quality, it can be defined in terms of the professional and personal quality of the physician or in terms of the patient - practitioner relationship.

From the perspective of quality management, all healthcare units in the sample are using procedures, guidelines, protocols and most of these units are in the process of CoNAS accreditation. Unlike the public healthcare facilities, the private (for-profit) hospitals are trying to approach quality standards from abroad, these being ISO certified and CoNAS accredited (or in the process of being accredited). Also, two major healthcare networks seek accreditation in accordance with the JCI standards.

Compliance to procedures, guidelines, protocols and standards by employees is ensured through direct hierarchical communication and through training programs. Also, the main ways by which the quality of the provided healthcare services is monitored can be grouped as follows:

- from the professionals' perspective: indicators;
- from the patient's perspective: satisfaction studies.

From the patient's perspective, the most important elements of the service are the communication with the physician and the amenities of care, analysing hospital benefits and the quality of care by those elements they are facing directly. Furthermore, the desired changes (by the managers of the healthcare units that participated in the research) are related to legislative issues or to financing the healthcare unit, which coincides with the problems they encounter daily.

As regards the **limitations of this research**, its implementation has highlighted the complexity of the investigated phenomenon. Thus, a more detailed understanding requires more resources, both financial and human. Therefore, a research team would probably succeed to obtain more information or a more detailed description of the investigated phenomenon. However, this research has managed to capture some aspects that can be used as a basis for future research.

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