



Royal College of
General Practitioners

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Participant report

Dr Radhika Khanna – Romania – 30/06/2019 to 13/07/2019

I was thrilled to be able to visit Bucharest in the sunny month of July for a 2 week exchange.

I was keen to visit Romania to further my knowledge of primary care in another European country. I was particularly interested in visiting Eastern Europe a region where I was aware that the additional burden of infectious disease control, including that of TB, was a challenge to primary care and public health. Romania has one of the highest incidences of TB in Europe with 72 cases found per 100,000 people with a country being deemed to have high incidence if it has rates exceeding 40 cases per 100,000 people. There were 14,000 cases recorded in 2017.

I visited Bucharest, which is the capital of Romania and is situated in the southeast of the country. It is the largest city of Romania and is the cultural, industrial and financial centre of the country. It is a busy, bustling city and is the 6th largest city in the European Union. As per data from the 2011 census there are 1,883,425 people who live within the city limits.

I was lucky to visit 2 different practices in Bucharest during my stay one inner city and the other located in the suburbs. My objectives were centred around learning about primary care provisions in Romania, exploring differences and any challenges the health care system has to face.

The Romanian healthcare system is a universal healthcare system which finances primary, secondary and tertiary care. As of 2015 each Romanian citizen can access healthcare on presentation of a health card – which is read at the point of contact with a health professional using a chip and pin device. Health cards are distributed to those who have health insurance, which is ordinarily paid for through insurance contributions from patients' salaries. Some citizens are insured without paying contributions; these include children under 18 years of age, individuals under 26 years who are in higher education, war veterans, disabled people without income and pregnant women. I found there were some difficulties with the health cards it often took a few times for cards to be read and some patients, in what seemed like administrative errors, did not receive health cards which made accessing health facilities trickier.

Health insurance covers medical services such as consultations, prescriptions and basic hospital care. As in the UK patients requiring secondary care services need a referral by their GP. This referral takes the form of a paper document that the patient takes to make an appointment with a secondary care service themselves. The outcome of the consultation or clinic letter is given to the patient directly in the majority of cases.





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The clinic letter is then handed by the patient to the GP for actioning. In way of investigations such as ECGs patients often have to pay for these themselves due to a lack of funding. There are also limits on the number of medications covered by health insurance.

I visited both a single handed GP and a GP based in a poly clinic, both had a nurse who carried out administrative, included appointment booking, as well as clinical duties. Neither practice had a practice manager and the role of fulfilling national audits and ordering supplies rested on the GP and nurse. I noted however that there was remarkably less administrative work to do than in the UK with more time spent seeing patients. Nurses carried out childhood immunisations.

I found that the GP and nurse often knew patients and their families, who were often registered together at the same practice, very well. I noted that older patients preferred a more didactic doctor led consultation. Patients only saw their own GP unless they were on leave, in which case the GP made arrangements prior with a colleague to cover their patients in emergencies. As patients often held copies of results and clinic outcomes they often had appointments with the GP to update them on their condition. In the suburban practice I visited, patients would often knock on the consultation door rather than calling prior to speak to the GP, more often than not these patients had a specific outcome to the consultation (for example a medication request or sick note). I found that community services such as district nurse and palliative care are not publically funded, and that there are no set rapid referral pathways for cancer diagnosis.

I learnt about the challenges of delivering a health care system when faced with high rates of emigration. I was surprised to hear, that after Syria, Romania has one of the highest rates of emigration in the world in part due to young people seeking higher salaries and opportunities abroad. In terms of healthcare a mass exodus of health care professionals has greatly affected the quality of care given to patients. In rural parts of the country health care provisions, for example thrombolysis practitioners and facilities for stroke, are scarce.

Cardiovascular disease and cancer account for the majority of deaths in Romania with deaths from the former accounting for 951.3 deaths per 100,000 inhabitants in 2014 which is a rate 2.5 higher than the EU average. I learnt that Romania has the highest incidence of cervical cancer in the WHO European Region in part due to low coverage with no more than 10% of the target population benefitting from screening. I did not see any smears being performed whilst in consultation as most are done by gynaecologists. In addition the HPV vaccine in most cases is required to be paid for privately.

High rates of not only TB but MDR (multi drug resistant) TB pose a risk to public health. The WHO in 2016 reported that 5.6% of TB cases were pulmonary MDR-TB and of these nearly a third were XDR (extensively drug resistant) TB cases. Similarly to the





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UK Romanian GPs refer patients with presumed TB on the basis of history onto hospital TB services, with laboratory findings confirming diagnosis. Secondary care services manage TB treatment. It appears community TB management is not so well structured with prolonged hospital stays consequently reported, which may or may not be necessary. However external funding from overseas donors helps NGOs to run facilities, some of which focus on treating drug resistant TB forms. These facilities may also provide psychologists, to support patients' mental health whilst they are treated for extended periods. From my discussion with health professionals with an under funded and in rural areas with scarce healthcare coverage - ensuring patients are compliant with long treatment regimes is a challenge. In 2014 15% of MDR cases notified were lost to follow up. Furthermore in the areas I visited contact tracing was complex to ensure, which makes managing TB spread all the more difficult.

I had a wonderful 2 weeks in Romania and was fortunate to be hosted by incredibly friendly host GPs. I enjoyed learning about a different health care system and the experience has made me reflect on my own practice and the health care system I work within in the UK. I felt there was a strong doctor patient relationship in the consultations I witnessed which perhaps we do not achieve in the UK, with patients often seeing different doctors rather than one familiar face. I feel both the Romanian and the UK health systems have problems with communication to overcome. In my own practice although we do receive clinic letters from hospitals directly, as opposed to via patients, there are often delays in processing scanned documents which often means patients hand in their own copies of clinic letters for actioning. With an objective in finding out about more about TB in Romania I was interested to learn more about the barriers to effective management, which as an infectious disease consequently greatly affect TB control.

I would highly recommend an exchange to Romania to colleagues – I visited during a heatwave but I'm sure a visit in winter would be just as delightful!

