Before I left the UK, I check the weather and noticed that Romania was 16 degrees, however snow was forecast. I left the UK amid a second wave of snow – I found that I took the snow to Romania with me!

My exchange was located in Bucharest, in southern Romania, which is the country’s capital and commercial centre. According to the 2011 census, there are approximately 1.9 million inhabitants live within the city limits, with a further number in the surrounding urban areas increasing the total population to 2.27 million. Bucharest is the sixth-largest city in the European Union and economically, Bucharest is the most prosperous city in Romania. It boasts one of the main industrial centres and transportation hubs of Eastern Europe. The city has big convention facilities, educational institutes, cultural venues, traditional “shopping arcades”, and recreational areas.

Exchange

I was invited to shadow Dr Ileana Efrim, an inspirational family doctor who serves a population of 1600 patient. The clinic was set up by the department for transport to maintain the health of it transport workers. After the revolution, there was a move to a health insurance system and Ileana came to the clinic and bought out the outgoing retiring family doctor.

Figure 1 – Outside the building where Ileana practices
Primary Care in Romania

Health care in Romania is public, and is paid for by mandatory social health insurance contributions. Children under 18, students, the unemployed and low income people do not have to make contributions. There is also a private health care system where people pay for health care. GPs are gatekeepers for the public system only.

Each person should be registered with a family doctor. The state distributes funding and each area of medicine has an allocation – which is not always known to them. Half of the funding is from the registration of each patient to the doctor and halve is generated from each consultation. Each patient has a health card which must be presented on each consultation. Most GP practices in Romania have one GP working with a nurse. The nurse usually undertakes administration activities and is often considered a doctor’s assistant.

Public health care is free for those insured (85% of people), but as there is limited funding people sometimes end up having to pay for services that should be free like blood tests, X-rays or scans. Ileana informed me that for each service, a specific allocation of money is given. For example, phlebotomy may be given a certain amount of funding. Each blood test costs a certain amount. Once the funding is used, the service will not do any further blood tests until the next round of funding is given. This means that patients may have a considerable wait for routine investigations.

Figure 2 – The clinic is set on the first floor of the building
Training

At medical school, there is an obligation to undertake a six years of training and then have to pass a national MCQ exam, and then they are able to pick specialties based on results. The family medicine training program is very different to in the UK. Trainees start their 4 year GP training straight out of medical school, and the first 6 months of GP training are spent working at a GP practice, mostly shadowing/doing basic procedures such as blood pressure. Following this all trainees do rotations in medicine, paediatrics, surgery, obstetrics & gynaecology, oncology, dermatology, psychiatry, neurology, diabetes, infectious diseases, epidemiology and management and bioethics. After this they do 18 months in a GP practice.

Family practice is not usually ranked high on doctors preferences. This is mainly due to the low rate of pay compare to hospital specialists, bureaucratic issues and a lack of funding. The state diverts funding to hospital medicine.

Family doctor training was three years until this year. From January onwards, it will be four years. This will be comprised of six months in family practice, two years in hospitals and the last component in family practice.

Public expectation of primary care

The public has an expectation that secondary care provides miracles while family doctors are rated much lower down. However patient care is very much driven by the patient and the patient has responsibility for their own care. For example, if a patient needs a referral, they are given the paper to then identify an appropriate place to access the service.

The role of the GP

Each family doctor usually rents a room, which may vary from an apartment to a single room. Each family doctor must have a five hour clinic and offered two hours of home visits for each session. Appointment is 15 minutes long and a Family doctor can see between one and 20 patients per session. Patients would often come knowing exactly what they wanted from the consultation. As there are no reception or administration staff, the consultation is usually very busy, with nurses, doctors and patients walking in and out of the consultation room while the consultation is taking place.

Each consultation is documented through the insurance card. Each prescription can be issued for a maximum of three months and the cost depends upon the medication. It is well recognised that if a patient is prescribed a medication from the hospital, it should be continued from hospital. However if the hospital does not provide it – which often happens – the family doctor must provide it and is also liable to foot the bill!

There is a state proposed computer system however in this clinic a separate more popular system is being used. It is more user-friendly and it links with the state
computer system. Patient data is monitored by the Ministry of health and ultimately the Ministry of finance. The Ministry of finance sends funds to the Ministry of health to disseminate funding between vaccinations, cancer, diabetes program, transplant and secondary and family practice. There is an issue of transparency with how much funding is sent provided. Each family practitioner has half of their funding payment by the number of patients registered to them and separately by each consultation the patient has.

Interestingly, as the former dictator had diabetes, he promoted diabetes as a speciality of diabetes and metabolic diseases. All patients with diabetes are referred in to the specialist system. Any family practitioner cannot prescribe medicines for diabetes.

I was surprised to learn that there were no local/national antibiotic protocols. There is also a limit of the number of medications a family doctor can prescribe through the health insurance of seven. If a patient needs any more, one has to be stopped first! Many patients would come in wanting blood tests or specialty referrals. A large proportion of the patients we saw came in with the results of blood tests/scans that had been done privately and they wanted a diagnosis and treatment.

Many patients attended for sick leave. A family practitioner can only sign a sick note for a maximum of 30 days. If a patient has more than 30 days off in the last 48 months, then they must be referred to an occupational specialist Doctor Who can then sign a sick note for up to 90 days. If a patient requires more than 90 days off work, they are referred to a special commission which can sign patients off for between 90 and 120 days. There are some exceptions which include MI, stroke, and TB which have one year automatically and cancer has two years leave.

Patients would often attend very frequently – several times in the same week to update the doctor on tests that had been performed. Due to this the GP knew the patients/families very well, which created a very good doctor-patient relationship, but one that was more paternalistic than in the UK. GPs were also responsible for much of antenatal care and child health checks.

Other services

There are no district nurses, no provision for palliative care and no hospices. There is a limited homecare service. I asked Ileana about palliative care and she informed me that most people die in hospital. Most people attend hospital due to issues with poorly controlled pain. We received a telephone call during clinic from a patient’s husband to inform Ileana that the patient had died. There is no equivalent for the two week wait.

Changing times
Ileana and other colleagues, have formed a consortium of family doctor in Bucharest who are trying to change practice. They are gathering momentum to encourage family doctors to work collaboratively with the possibility of a practice manager under a business enterprise. However this will require a culture change. There is also an active and dynamic educational program in Romania where local, national and international colleagues attend and learn and work together.

Figure 3 – In Caru’cu Bere with Ileana and Laura enjoying a Romanian dinner

Conclusion

This exchange was a great experience to learn and share primary care practice. Romania has a great strength in their continuity of care in primary care in Romania compared to the UK. Consultations can be more effective as the doctor already understands the patient – in terms of a deep understanding of their medical condition, social background and health-care belief. This is often lost in UK primary care, as patients rarely see the same doctor. I also learned about homeopathic treatment which are not used in the UK but are commonly used in Romania such as IV calcium for fainting in young females, use of honey for sinusitis and the use of immune-stimulants to prevent respiratory tract infections.

I’m inspired to consider alternatives mechanisms of practice, consider alternative therapies if they have evidence base and take a more understanding view of European patients coming to see me in the UK. Thank you to Ileana, Laura and
Raluca! I really enjoyed my experience and would definitely recommend it to others in the future.