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SOFTSKILLS IN PEDIATRICS

**PEDIATRIC HEALTH SURVEY IN FIVE EUROPEAN COUNTRIES:
ROMANIA, HUNGARY, ITALY, SPAIN, GERMANY**

Research conducted within the Erasmus+ Strategic Partnership
Project: *Softis-Ped - Softskills for Children's Health*

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Foreword

Softskills in Pedatrics is the result of a pediatric health survey conducted in five European countries: Romania, Hungary, Italy, Spain, and Germany through the Erasmus+ Strategic Partnership Project: Softis-Ped - Softskills for Children's Health Project Number: 2016-1-RO01-KA203-02463, funded by the European Commission.

The aim of the current project is to identify the most important soft skills for paediatricians, match them with the best teaching methods and strategies, and elaborate guidelines and materials for training the trainers to use these methods and develop future paediatricians' soft skills. As such, the current study will accomplish the first part of the project aims, i.e. to identify the soft skill needs in the partner countries in terms of communication, hospital environment, transparency of communication, time management and intercultural issues

The survey findings will eventually conduct to enhancement of paediatric education and services by improving communication with child patients and their families, communication within the medical team and communication across cultures.



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CHAPTER 1

INTRODUCTION

PEDIATRIC HEALTH SURVEY IN FIVE EUROPEAN COUNTRIES: ROMANIA, HUNGARY, ITALY, SPAIN, GERMANY

ABSTRACT

The current chapter presents an overview of the medical health system in general and of the pediatric public and private health system in particular in five European countries who are members of the project Softskills for Children's Healths: Romania, Hungary, Italy, Spain, and Germany, with statistics pertaining to health insurance and education, i.e. syllabus and envisaged competences in paediatric undergraduate, graduate and continuing medical education.

I. PEDIATRIC HEALTH SYSTEM IN ROMANIA

1.1. The Romanian Health System

In 1999 Romania started to implement the Bismark system of social health insurance, like most EU Member States (Germany, Austria, Belgium, France, Luxembourg, the Netherlands) characterized by collection of health insurance premiums into a single fund, called the National Fund for health insurance (NFHI) consisting of:

- revenue from compulsory contributions for health insurance, supplemented by subsidies from the state budget,
- amounts from other sources (donations, sponsorships, bank interest, property exploitation of health insurance houses),
- amounts transferred from the revenues of the Ministry of Health.

Since 2014, the clawback was introduced, requiring pharmaceutical market players to contribute to the public health system with an amount determined on the basis of the turnover obtained on public NFHI funding in order to allow health insurance bodies to partially recover granted amounts in a reimbursement system.



The defining elements of the health insurance system in Romania are:

- NFHI administration is carried out by the National Health Insurance House;
- insured parties undertake to pay a contribution according to the taxable income;
- insurance contribution is fixed as a percentage on the income and not by individual risks of insured persons;
- all insured persons benefit from a similar package of basic services on contract basis;
- NFHI does not exclude the existence of private insurance.

In 2015 the health insurance scheme covered 87% of the population, a percentage that corresponds to 17,191,563 persons registered on family physicians' lists, of the total 19,759,96 registered inhabitants according to data released by the National Statistics Institute on 31 December 2015.

Employees represent the largest category of insured people, i.e. 34.04%, followed by pensioners and children, i.e. 26.82% and 22.24% (Fig. 1).

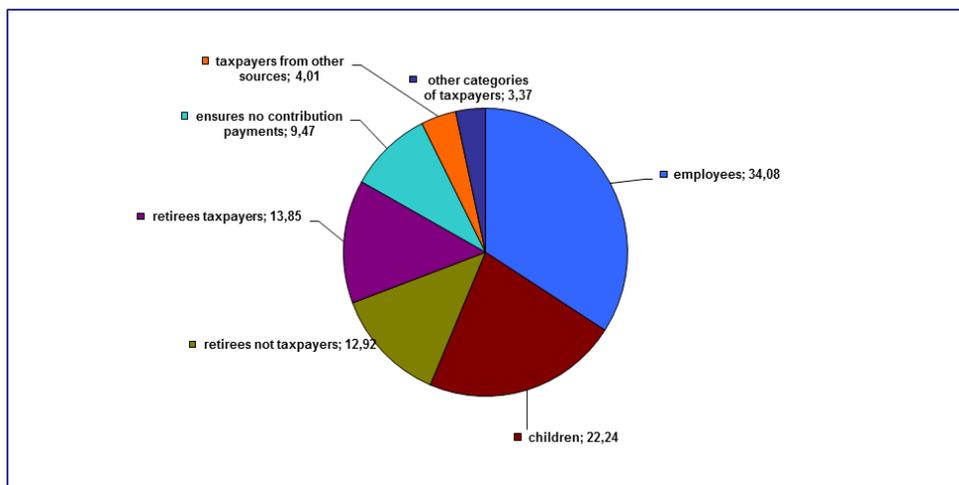


Fig. 1. Structure of insured categories of Romanians including children

With reference to expenses, NIHF provided funding for about 68% of the health services, while the Ministry of Health allocated 11%, the rest of funding being provided by patients (Fig. 2).

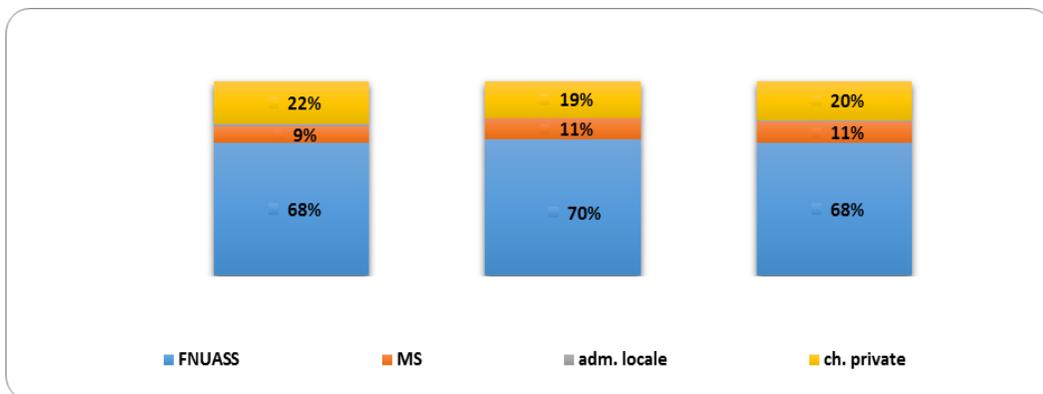


Fig. nr. 2. Health-related expenses according to source (% of total)

Source: CNAS, M.F.P., Mind Research & Rating

The approved budget credits in 2015 versus payments from the National Fund for Health Insurance is presented below (Table I):

Table I Budgetary expenses for 2015

	Budget (thousand EURO)	Payments (thousand EURO)	Performance
Total expenses of which:	5,211,440	5,196,873	99,72%
1. Health expenses:	4,884,720	4,870,203	99,70%
Pharmaceutical products, sanitary materials and medical devices	2,056,135	2,053,905	99,89%
Outpatient medical services	660,370	657,578	99,58%
Pre-hospital emergency and sanitary transport	7,908	7,866	99,47%
Medical services in hospitals (bed units)	1,997,890	1,996,484	99,93%
Home care	12,803	12,736	99,48%
Medical services according to international documents	92,106	92,106	100,00%
Payments in previous years, recuperated in the current year	0	5,443	-
Fund administration expenses	57,507	54,926	95,51%
2. Social security expenses	326,720	326,670	99,98%

The data above demonstrate a hypertrophy of the **hospital care** which has one of the highest rates of health care expenses (40.99%) within the health insurance



system. In contrast, outpatient services represent 13.50% of the total cost of health expenditure, of which 50% (1,503,342 thousand RON) are the primary medical care costs, the rest are clinical, laboratory, dental medicine outpatient care and recovery.

Optimization of this imbalance requires urgent action to ensure greater coverage of the health needs of the population with services from the system base, i.e. community support services, assistance services provided by the family physician and the outpatient clinic. These services must be capable of responding to the main needs related to acute episodes of illness and monitoring of patients with major chronic diseases (diabetes, hypertension, Chronic Obstructive Pulmonary Disease), so that hospital services should be resorted to only in circumstances requiring advanced complexity services.

This view, supported by the implementation since 2014 of a new package of health services, aiming to apply conditions related to evidence-based medicine and provision of cost-effective services at the bottom of the system, is the top challenge of the social health insurance system in Romania.

1.1.1. Public Pediatric Services

Public pediatric health services in Romania are free. Thus, children and young people up to the age of 26, if they are enrolled in the education system (i.e. pupils, students or apprentices) and if they have no income, benefit from free hospital admission and therapy. Young people aged up to 26 who come from the child protection system, have no income from employment or do not benefit from social security, are exempt from payment of health insurance contribution.

Insured mothers of children up to the age of 2 or of a child with handicap up to the age of 3 and mothers raising a handicapped child aged 3-7 years, benefit from paid leave from the state budget or state social insurance budget.

There are also **national health programs** which are directly coordinated by the Ministry of Health. Some of them are addressed to the *Mother and child* and provide special funds for screening, drug therapy and dietary management of conditions such as phenylketonuria, hypothyroidism, prevention, diagnosis and treatment of malabsorption syndromes, chronic hepatitis, cystic fibrosis, asthma, congenital or acquired immunodeficiency, dystrophy treatment, surfactant therapy, etc. In addition, there are programs coordinated by the National House of Health that provide prophylactic curative treatment of haemophilia in children, malignancies (including immunophenotyping for diagnosis of acute leukemia in children, etc.).

1.1.2. Demographic data in Romania

The number of live births in 2015 was 187,372 (185,006 with residency in Romania and 2,366 abroad) versus 185,322 live births in 2014 marking a sharp decline compared to 1989 when there were 369,544 live births. The **number of deaths** in 2015 was 260,997 deaths (254,791 deaths in 2014), a more pronounced increase compared to 1989 (247,306 deaths). The **main causes of death** in 2015 were represented by:



cardiovascular diseases (153,849 deaths), cancer (51,288 deaths), respiratory diseases (14,992 deaths), digestive (14,374 deaths) and accidents (9,730 deaths).

The number of **deaths of patients under 1 year** fell to 1,493 deaths in 2015 compared to 1,634 deaths in 2014. In 1989 the number of deaths of patients < 1 year was 9,940.

Abortions were 378,3 cases per 1,000 live births versus 400,6 cases/1000 live births in 2014, with 0.4 abortions for a live birth. In 1989 there were 0.5 abortions/a live birth (522.5% live births).

The **number of maternal deaths** from complications of pregnancy, delivery and post-partum was 28 in 2015 compared to 24 maternal deaths in 2014, whereas the total days of sick leave for the care of sick children was 24,802 days/2015.

1.2. Pediatric Education – University of Tirgu Mures

The University of Medicine and Pharmacy of Tirgu Mureş has a total number of 5,500 students in full-time undergraduate and Master programmes plus doctoral students and residents, of which about 50 residents in Paediatrics (10 per year in a 5 year-rotation programme), and about 500 teaching staff of which 51 PhD coordinators including Pediatrics. Over 60 postgraduate courses take place every year, with 4 (in 2016) in pediatrics and neonatology. The University works in cooperation with Mures Clinical Emergency Hospital (over 3,500 beds), most doctors having both academic and clinical appointments. This medical-educational tandem facilitates students' acquisition of practical skills during practical instruction and clinical internships while anchoring and substantiating medical research.

The international dimension of the university is given by the General Medicine and Dental Medicine programmes offering full-time tuition in English with students coming to study from European (Italy, Belgium, Germany, France, England, Greece) and world countries (Africa, Asia, USA).

Pediatrics [6] is taught to all undergraduate students in Medicine and Dental Medicine during the 5th (penultimate) year and Puericulture in the 4th year of their formal medical education according to an internationally benchmarked curriculum. These students can also choose to enrol in the optional course in Neonatology whereas Nursing students study the Pediatrics-related course: Mother and Newborn care. Every year, about 70 undergraduate medical students in different stages of their medical education perform summer practice in the Pediatrics Clinic I of Tirgu Mures Clinical Hospital. **These students form part of the target group** of the current project.

Department M4 of the University of Medicine and Pharmacy Tirgu Mures (clinical medical sciences) includes 4 Paediatric Disciplines with a total of **24 teaching staff which** will represent part of the target group of the project: Pediatrics I (7 teaching staff: 1 professor, 3 lecturers, 3 assistant professors), Pediatrics II (7 teachers: 1 associate professor, 3 lecturers, 3 assistant professors), Pediatrics III (6 teachers: 1 professor, 1 associate professor, 2 lecturers, 2 assistant professors), Pediatrics IV (4 teachers: 1 associate professor, 1 lecturer, 2 assistant professors). The teaching staff are involved in Pediatrics lectures, practical applications and clinical stages and have published course-books, workbooks and online resources that are made available through the university virtual learning platform



About 10 new graduates pursue residency in pediatrics, with a total of about 50 residents (also project target group), rotating in the pediatrics scheme. The teaching staff have basic training, PhD and post-doctoral studies, professional skills and competences in paediatrics, are published authors of books, course-books and research papers and have presentations at international and national scientific events. They are members of national and international societies of paediatrics as well as organizers of workshops and international symposia (e.g. the 11th National Congress of Paediatrics with international participation, Sept.25-28, 2013).

Undergraduate and resident students are provided with a comprehensive, theoretical but also practical, patient-centered medical education. Within this context, formation of life-long soft-skills that the project proposes would represent the added value for providing excellent paediatric care, maintaining productive relationships with parents, and enhancing patient and physician satisfaction.

1.2.1. Undergraduate pediatric education – the case of the University of Medicine and Pharmacy of Tirgu Mures

Paediatrics is taught in years 4-6 through three main subjects:

Puericulture – 4th year (14 hours course + 15 hours internship)

Syllabus:

- Introduction in childcare. Growth and Development
- The newborn: Newborn at term. The postmature newborn. The newborn with low weight at birth (SGA - small for gestational age).
- The newborn with large weight for the gestational age (LGA - large for gestational age - macrosoma). The premature newborn
- Immunizations. The immunization schedule for children in Romania. Nutrition principles.
- Infant and toddler's nutrition
- Nutrition with milk formulas. The premature infant's nutrition.
- Nutrition of small children, pre-school children and teenagers. Acute diarrheal disease (ADD) in infants and toddlers.
- **Specific skills acquired**
 - Taking patient history, performing complete clinical examination of the newborn and child
 - Carrying out maneuvers for infant and toddler care (bathing, swaddling, immunizations, etc.)
 - Establishing an adequate food scheme according to age
 - Making a baby diversification scheme
 - Establishing child psychomotor development stages
 - Calculation of anthropometric parameters
- *Transversal competences:*
 - Acquire oral and written communication skills with both mother and 12pediatric patient
 - Carry out a project, by performing responsibly tasks specific for a team role



- Execution of projects under coordination, for solving specific pediatric problems, with correct assessment of the workload, available resources, time and risk required to complete the task, in conditions of applying the rules of conduct and professional ethics in the field, as well as rules of safety and health at work.

Paediatrics – 5th year (42 hours course + 105 hours internship)

Syllabus

- Fever in children. Sepsis. Infant respiratory pathology: diseases of the upper airways;
- Respiratory pathology: cough in children; baby otomastoiditis; epiglottitis and laryngeal croup in children; acute bronchiolitis;
- Respiratory pathology: bacterial pneumonia; interstitial pneumonia; pneumopathies treatment; asthma;
- Cardiovascular Pathology: congenital heart diseases; endocardiomyopathies; pericarditis; heart failure;
- Diseases of the digestive tract: Specific aspects of acute infectious diarrheal disease in children. Non-infectious acute diarrheal disease, acute dehydration syndrome, recurrent abdominal pain, malabsorption syndrome (celiac disease, cystic fibrosis, food intolerances), gastroesophageal reflux, gastritis and ulcers in children;
- Deficiency diseases: rickets, iron deficiency anemia; protein-energy malnutrition;
- Vascular collagen diseases: juvenile rheumatoid arthritis; Kawasaki disease in children;
- Renal and urinary disorders: urinary tract infections, acute diffuse glomerulonephritis; nephrotic syndrome;
- Bleeding diatheses: Schönlein-Henoch purpura; immune thrombocytopenic purpura; haemophilia;
- Pediatric Oncology: leukemia; abdominal masses (Wilms tumor, neuroblastoma); Hodgkin and non-Hodgkin lymphoma;
- Pathology of the nervous system: convulsions; child epilepsy, intracranial hypertension syndrome in children;
- Metabolism and nutrition diseases: diabetes mellitus. Headaches in children.

Acquired abilities:

- History taking, performing full clinical examination of a pediatric patient;
- Carrying out basic maneuvers for child diagnosis;
- Formulating a positive and differential diagnosis in pediatrics;
- Establishing an individualized pediatric therapy;
- Pediatric case presentation;
- Planning adequate complementary examinations in pediatric pathology
- Acquiring oral and written communication skills with both mother and pediatric patient;
- Carrying out a project, performing specific tasks responsibly in a team role;
- Execution of projects under coordination for solving specific pediatric problems, with correct assessment of the workload, available resources, time and risk



required to complete the task, in conditions of applying the rules of conduct and professional ethics in the field, as well as rules of safety and health at work.

Neonatology – 6th year (14 hours course + 15 hours internship)

Syllabus

- History of Neonatology. The importance of Neonatology in modern medicine. The role of technology in Neonatology. Neonatal screening.
- Physiological adaptation to extrauterine life. The algorithm of neonatal resuscitation. Initial steps of neonatal resuscitation. Positive pressure ventilation. Chest compressions. Intubation. Medication. Special situations. Ethical Issues. Post resuscitation monitoring.
- Perinatal asphyxia and fetal distress. Hypoxic-ischemic encephalopathy, stadialisation, therapeutic principles. Obstetrical trauma. Intracranial haemorrhage. Neonatal seizures.
- Respiratory distress in the neonatal period. Respiratory distress syndrome (RDS), Transient neonatal tachypnea (TTN), Meconium aspiration syndrome (MAS). Congenital pneumonia.
- Neonatal jaundice. Physiological and pathological jaundice. Isoimmunization, hemolytic jaundice in Rh and ABO system. Therapeutic principles in neonatal jaundice.
- Perinatal infections. TORCH syndrome. Neonatal group B streptococcal infections. Septicemia and meningitis.
- Oxygen - drug or toxic? Monitoring. Modalities of oxygen administration. Chronic pulmonary disease. Retinopathy of prematurity.

Acquired abilities and competences:

- Identifying the need for initiating neonatal resuscitation.
- Designing and implementing an appropriate therapeutic plan after newborn assessment.
- Accurate evaluation of the disease risk or the context of illness appearance in a category of high-risk neonates, followed by selection and application of appropriate prophylaxis.
- Tackling health/disease problems in terms of particularities of prematurity, directly related to these special conditions.
- Initiation and development of scientific research and/or training in neonatology.
- Fulfillment in terms of efficiency and effectiveness of managerial tasks required by the organization of neonatal intensive care.

Paediatric Semiology – 4th, 5th, 6th year (14 hours course)

Syllabus

- Cough, dyspnea; wheezing; cyanosis; stridor; hemoptysis;
- Anorexia; vomiting; diarrhea; hepatomegaly; splenomegaly; jaundice; constipation;
- Dysuria; hematuria; proteinuria; urinary frequency; Anuria;



- Anemic syndrome; Lymphoproliferative syndrome; hemorrhagic syndrome;
- Acute fever; prolonged febrile syndrome; fever and rash;
- Assessment of pain in children; myalgia; arthralgia; chest pain; recurrent abdominal pain; back pain; headache; weeping baby;
- Tumoral masses in children.

Our university began an extensive process of student-centered and competence-based curriculum reform for the students' better integration in health services. To this purpose, emphasis is on teaching integrated courses, CBL (case based learning), TBL (team based learning), as well as courses in communication skills. Evaluation is both summative and formative.

1.2.2. Residency in paediatrics

The aim of paediatrics residency programme is to form highly competent paediatricians by exposure to a large spectrum of child patients (from infants to teenagers) and diverse medical, psychological and surgical conditions, in order to form their cognitive and technical skills for progressively independent paediatric practice.

The curriculum is based on a number of 200 hours/year (lectures, seminars, case presentations) plus 40-50 hours of individual study. Training is quantified in credits (CFU), 1 credit = 25 hours of training. Of the total amount of time, teaching covers 20-30%, the remaining 70-80%, being dedicated to practical activities and individual study. Training is monitored in the log-book, together with credits for stage assessments, activity in research programs, participation in scientific meetings and continuing education.

Programme tracks:

1. General Paediatrics – 2 years and 1 month –Child and adolescent Psychiatry - 3 months, Diabetes: 2 months, Peumology: 2 months, Paediatric neurology: 3 months, Paediatric Oncology-hematology: 3 months, General Echo: 3 months, Genetics: 2 months 2 weeks., Dermatology: 2 months.
2. Neonatology – 6 months, infectious diseases: 6 months, Paediatric surgery and othopedy: 2 months
3. Bioetics : ½ month (20 hours) for practical activities and individual study [7].

1.2.3 Continuing Medical Education

Continuing medical education includes graduate courses, participation in workshops, national and international congresses, summer schools organized under the patronage of the Romanian Society of Pediatrics (2 editions/year, duration of one week and 40 hours of lectures and practical activities according to a rotation scheme of pathologies), physicians receiving credits of continuing medical education.

The University of Medicine and Pharmacy has organized the following post-graduate courses in the field of paediatrics in the last 3 years:



1. Paediatric syndromes – Renal, haematologic and neonatal pathology;
2. Paediatric syndromes – Digestive and respiratory pathology;
3. Updates in paediatric pathology;
4. Updates in child nutrition;
5. Pediatric emergencies.

1.3. Pediatric Services

Statistics on the health care units in Romania at the end of 2014 show the existence of the following:

- 367 public hospitals,
- 10 Polyclinics,
- 187 dispensaries,
- 330 outpatient hospital-integrated clinics
- 2 TB sanatoriums
- 2 preventoria
- 7,758 public and private pharmacies

The number of hospital beds at the end of 2015 was: 125,482. Of these, there were

- 7,491 beds for pediatrics,
- 366 pediatric TBC pneumology
- 1,077 pediatric surgery,
- 279 pediatric recovery,
- 45 chronic paediatrics
- 3,230 neonatology
- 879 premature neonatology [5].

1.3.1 Private Paediatric Services

In Romania, private pediatric services began to develop especially after 2000. Private practices, pediatric clinics and private hospitals were founded, especially in traditional university centers like Bucharest (with the most significant growth), Cluj Napoca, Timisoara, Craiova, Iasi, Targu Mures, but also in other cities (Brasov, Sibiu, Constanta, etc.). There is no clear official update of the number of private pediatric units, the number of pediatric beds or consultations and outcomes, in Romania.

To conclude, increase of the quality of health care is a primary objective of healthcare providers and is reflected in the increase of patient satisfaction with the received healthcare services, while identifying and meeting their needs, demands, and expectations from the health system. Quality medical education and training likely to optimize paediatric health practice is just one aspect that is expected to contribute to meeting these desiderata.

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II. PEDIATRIC HEALTH SYSTEM IN HUNGARY

2.1. The National Health System

Hungary has a tradition of health services dating back to the 19th century. The first public health act was passed in 1876, and social security and social insurance systems have a long history in Hungary. From 1948, the mixed-economy health care system was restructured to a centralized state model, in line with other sectors of the economy. The health care legislation adopted in 1972 confirmed that access to health services was a right linked to citizenship and promised comprehensive coverage free of charge at the point of use. However, since the system was underfunded it was unable to meet the level of demand. [1]

In the past century the Hungarian health system was characterised by the dominance of hospitals and thus by an overdeveloped hospital structure. The primary care was characterised by low prestige and lack of uniform training. Due to strong interests inside and outside the profession, the health policy has not dared significantly modify this situation. Any kind of reform is also hindered by the underfinanced nature of the health care system.

Because of outstandingly bad infant mortality rates in the 60's (46‰!) paediatric practices caring for the population under 14 were dynamically set up. By the 90's this network was completely developed in towns and partially in rural areas. This high quality system was described by a Dutch PHARE study as unnecessarily overdeveloped. Anyhow, our infant mortality rate has been improved to 5.62‰ by 2008. [2] Since then the paediatric primary care system of children is operating in parallel with that of the adults'.

Development of modern primary care and its background institutions were carried out only at the beginning of the 90's. However, it covered almost exclusively the adult GP care, because of detected grave shortcomings in this field, while primary paediatric care and its results were found satisfactory. Earlier patients were allocated to the local providers, according to the place of residence, were allowed to visit only the official GP (panel doctor, district physician), who was employed by the municipalities or the local (state owned) hospitals. Since the new regulations in 1992, patients can choose their family doctors or primary care paediatricians, and GPs were allowed to leave the employee status and to form their own enterprises. Today there are about 6,700 primary care physicians (PCP) in Hungary for a population of 10 million. The 1,498 paediatricians are working mostly in big cities, caring for children only, 1600 GPs are treating population of all ages in mixed practices and the rest of the PCPs treat only adults. The average number of children belonging to a primary care paediatrician's office is approximately 800. In smaller areas paediatricians have 4-500 children to care for, while in the most populated areas the physician can treat up to 1,500 patients.

74% of children under 14 and 46% of adolescents under 19 years of age are treated by paediatricians. All the other children and adolescents are cared for in "mixed" practices by family physicians, located primarily in rural and sparsely populated regions. That means that in Hungary - similarly to other European countries - paediatricians and family physicians provide medical care for children and adolescents. The National Health Insurance does not finance GP's medical care for children under 14 in case there is also a paediatrician practice operating in the locality.



Therefore, in towns 100% of children under 14 receive paediatrician care. The age group of 15-18 can freely decide between paediatrician and GP service in the whole country.

The primary care paediatrician profession is on the edge of disappearing: if a paediatrician office is closed the children living in the area will be moved to the mixed practices and treated by family doctors. In 2016, Hungarian primary care paediatricians' average age was 59 years, 46 percent of practitioners were older than 60 years and 140 doctors had already celebrated their seventieth birthday. Nine paediatricians were older than 80 years. However, there are no other doctors who would take their places in the office. From the 1498 Hungarian primary care paediatric practices, 500 are occupied by doctors aged between 50 and 60 years. The lack of upcoming generations in paediatrics may lead to the extinction of the profession.

In the last years, at least 100 paediatric practices were closed down. In 2012 there were 1,527 practices whose number fell to 1498 by 2016. In the capital, the situation is much better and there are many paediatricians working in Budapest where even a ten percent decline in the number of doctors wouldn't cause a considerable holdup in children's medical care. In areas left without local paediatric service parents must choose between taking the children to another area's paediatric office, or accepting the local GP's care.

At the beginning of the last decade the government intention of eliminating the paediatric primary care system arose. This intention was reduced but it is still a hard problem that the lack of quality development leads to the atrophy of the paediatric primary care system.

Paediatricians study paediatric care for 5 years. In contrast, family doctors participate in a four month long paediatric training, or more exactly, a two months theory training completed by a six week practice in paediatrics. This is clearly not enough to provide the same quality medical care as paediatricians. According to the research of Bunuel Alvarez [3] specialised physicians can provide higher quality preventive health care. Their role is crucial in children's treatment, therefore it is important to maintain paediatrician offices.

The basic financing of paediatric medical services is influenced by several multipliers: first, it depends on the capitation, the number of patients living in the paediatrician's working area (the multiplier is higher when the population is lower). Second, there is a multiplier depending on the type of settlement (lower in big cities, higher in remote areas). There are other multipliers depending from professional qualification of the paediatrician, age of the patients (the younger the patient is, the higher the multiplier). Many primary care paediatricians also work part time as occupational health physician, or provide other type of medical services to increase their low income. Besides the basic financing, paediatricians receive pay for performance as well. The amount depends on the number of patients who are living outside the paediatrician's working area and have chosen the physicians instead of their local health care provider.

In 2007, a health reform was planned and initialized in Hungary forced by the coalition of parties who were in power at that time. This reform was poorly communicated to the society and health professionals as well, and was attacked also by the parties, who were in opposition. From February 2007 patients had to pay a symbolic co-payment, as visit-fee (300 HUF, -cca.1 EUR), directly to the health care providers, for each consultations or days stayed in hospital. After a long political campaign where the parliamentary opposition was supported by civil movements, co-



payment was abolished in April 2008 after a nation-wide referendum. Previously planned private health insurance funds were not established.

Since January 2012, according to new laws and regulations, the government took over all hospitals from local and county municipalities. The declared goals of these reforms were:

- to rationalize the financing of the health care system;
- to decrease governmental expenses;
- to decrease existing overlaps between hospitals and specialities in the big cities;
- to establish a better centralized managing system, as it was practically impossible to coordinate the different interests of municipalities.

The restructuring process should cope with the shortage of doctors and experienced nurses. Beside the enormous increase of administrative tasks, almost nothing happened in the primary care during the last years. A small increase of salary was promised for doctors, especially for young residents. Many of them declared to leave the country when the salary of starting doctors remains unchanged (net 300-400 EUR, monthly).

2.2. Pediatric Education

2.2.1. Pediatrics at university, MD degree

Medical studies in Hungary withstand the European standards and are of highest quality. The relatively comfortable admission requirements and the reasonable tuition fees attract many students from abroad.

Hungary welcomes international students with four universities that offer English medical, pharmacology & dentistry programs: Semmelweis University, Debrecen University, Szeged University & Pécs University. A medical degree from a Hungarian university is recognized by the European Union and the United States, which brings many international students to study medicine in Hungary.

The number of students admitted to the Faculty of Medicine is determined on a yearly basis by the Ministry of Human Resources. Since the number of applicants is two to four times higher than the number of places available, the selection procedure is based on the student's previous academic record.

The 12-semester training period covers at least 6,000 hours of teaching, which is divided into two parts. The first part consists of a two-year preclinical study period in the basic sciences; the second part is focused on clinical studies, and lasts for four years. The internship period takes place during the 11th and 12th semesters, and is generally spent at university clinics or hospitals.

Upon completion of the six-year programme, students must submit and defend their written thesis and take a final written test and oral exam before an examination board. Having successfully passed all examinations, the student is granted the diploma and title M.D. (Medical Doctor). [4]



2.2.2. Continuing medical education

Participation in the CME is a mandatory requirement for medical doctors in Hungary, who are obliged to take part in a Continuing Medical Education (CME) programme every five years in order to have their qualifications renewed in the medical practice registry of the Hungarian Medical Chamber.

The faculties contribute to the continuing education of medical doctors practicing in Hungary by organising courses and programmes, which consist of theoretical and practical activities. Altogether, 250 credit points must be collected over the five-year training period.

2.3. Paediatric Services

2.3.1. Public paediatric services

In Hungary, paediatric practice is public and free for everybody. Every child has free access to paediatric care by law. Nevertheless, private practices exist and are available for anyone who is willing to pay for them. If there is a possibility to choose the paediatrician as a primary care doctor for children, the paediatrician must be chosen.

If a child is eligible for the Hungarian state insurance, normally the district paediatrician will provide paediatric care for them free of charge. Each district has several paediatric offices, often in the same building with the health care associate (educated nurse) offices. (In Hungary, educated nurse is a combination social worker and a nurse whose primary role is to provide information to patients and to do the administrative work of tracking children's general health). Children are assigned a paediatrician based on their registered addresses, but unlike the educated nurse whom the families cannot choose, parents can always select a different paediatrician. The advantage to using the district paediatricians is that they are nearby, have regular office hours, and will make house calls free of charge. [5]

There are five university paediatric clinics and all the county hospitals have paediatric departments. In addition, Hungary has two independent hospitals for children in Budapest and a paediatric centre in Miskolc (second biggest town in the country). There are paediatric departments in some special institutions as well. Outpatient service for children regarding various subspecialties is mainly organised according to the in-hospital distribution of services.

2.3.2. Private paediatric services

There are several private clinics around Budapest that cater to expats or foreigners. All of them provide paediatric care. Private outpatient clinics take private insurance, some of them will even arrange direct billing with the insurance company.

Private paediatric outpatient clinics offer a wide range of medical services to be able to handle more complex problems. In some clinics, the paediatrician is available 24 hours a day (even for house calls) and it is common to have a hotline that accepts calls day and night on weekends and holidays as well. Private outpatient clinics provide medical treatment, screenings and vaccination for children from new-born to 18-year-old age.



III. PEDIATRIC HEALTH SYSTEM IN ITALY

3.1. The National Health System

The Servizio Sanitario Nazionale (SSN) was instituted by the Parliament law no 833 in December 1978 [1]. SSN includes all the functions, structures, services and activities which are guaranteed by the Italian State to all the Italian citizens. Its goals are the maintenance and care of the physical and psychical health and the promotion of health systems, according to the article 32 of the Italian Constitution. The Ministero della Salute is the main functional organ of the Italian SSN: its mission is to care for the public health.

The Italian National Health System (NHS) follows a model similar to the Beveridge model developed by the British NHS (Beveridge 1942; Musgrove 2000). Like the British NHS, healthcare coverage for the Italian population is provided and financed by the government through taxes. Universal coverage provides uniform healthcare access to citizens and is the characteristic usually considered the added value of a welfare system financed by tax revenues. Nonetheless, in Italy the strong policy of decentralization, which has been taking place since the early 1990s, has gradually shifted powers from the state to the 21 Italian regions. Consequently, the state now retains limited supervisory control and continues to have overall responsibility for the NHS in order to ensure uniform and essential levels of health services across the country. In this context, it has become essential, both for the ministry and for regions, to adopt a common performance evaluation system (PES).

The **Piano sanitario nazionale** is drawn by the Ministero and approved by the Parliament. It states the general objectives for the public health, the budget and the distribution of the resources to the Regions, which are responsible for the regional health activity. The main local health structure is the ASL (Azienda Sanitaria Locale). They coordinate and organize the work of all the prevention, admission, care and rehabilitation posts, offices and local services (ASL).

The Ministero della Salute states general rules for the administration of these services, the guidelines for formation and updating of the health personnel and the systems of control and verification of the results.

3.2. Pediatric Education

During the University students have to follow and pass the exam of a main course of Paediatrics, plus some others such as Paediatric surgery, Puericulture, Applied Genetics, which are optional for the most, often mandatory or warmly suggested for the future Paediatricians. For many of them, practical work in children wards is mandatory.

After the degree, to be allowed to work as a Paediatrician one must attend five years of the School of specialization in Pediatrics, with five years of work in children Hospitals or Universities, regularly paid by a proper salary. At the end of this school you can work as a paediatrician. All over the nation masters and long courses in different subspecialties (neonatology, adolescentology, rheumatology and so on) allow to improve the specialty according to the field you work in or you simply want to improve.

After the specialization course, three pathways are possible:

1. private activities,
2. hospital activities,



3. consultant for public health authority with ASL as paediatric.

ECM is the way for the health professional to keep himself updated to respond to patients' needs, the needs of the health care and service to his own professional development.

The continuing medical education concerns the reception of new knowledge, skills and attitudes useful for a competent and expert practice. It is an obligation of ethics for the health professionals to practice new knowledge and competence to offer a qualitatively useful assistance, basically, to take care of their patient with update skills, without moral conflicts, in order to be good health professionals.

The start of the national program of ECM in 2002, based on DLgs 502/1992 integred by the DLgs 229/1999 which had established a requirement of permanent formation for the health professionals, was a strong message to the health world.

The new ECM's phase contains many news and it will be an instrument to build a modern approach to the development and the monitoring of individual skills. The continuing medical education is closely linked to research in the clinical setting.

3.3. Pediatric Services

Paediatric Public Services are included in the concept of Paediatric area, which means a special approach to spaces, services and care of patients, with dedicated structures and procedures. This concept includes structures such as children's hospitals and children's wards in general hospitals, where only paediatricians and specialized nurses are accepted. There is a children side in the family offices called consultori, scattered in the territory of most ASL, a paediatrician who works in many public kindergartens, school doctors, and there are new emerging figures, called "Community Paediatricians". All these people have to stay in contact with the main figure to care for all children, the Peditra di Famiglia (Family Paediatrician).

This figure in conceived as the paediatrician who monitors all the aspects of the physical and psychical growth from birth to adolescence, He should know the whole history of the patient and his family, care for the needs of his patients in terms of regular organized visits and checks with the possibility of ordering visits and exams if needed, phone consultations, vaccinations. He is also in charge of certificates. He is supposed to be the union between the family and the second level structures.

The paediatrician's patient list is combined, depending on availability in terms of free places and choices of the citizen.

Pediatricians can be involved in projects of group or network medicine. The ICT tools for pediatrics are compulsory caused by new procedures, in order to write a prescription of drugs and/or examinations.

They work together with the Director of Districts of Local Healthcare Public Authority. Pediatricians follow the children using the health balance until the age of 6 years and the last will be planned before the transition to general practitioner. [1] Legge 23 dicembre 1978, n. 833 "Istituzione del servizio sanitario nazionale", GU n. 360 del 28-12-1978 - Suppl. Ordinario

The activities of child Neuropsychiatrist are aimed at children and teenagers aged between 0 and 18 years. The service makes use of child psychiatrists, doctors operating within the territorial structures and / or hospital in collaboration with other institutions of the area (Social Services, School).



The Child Neurology deals with the prevention, diagnosis, treatment and rehabilitation of disorders of child and adolescent development: neuromotor damage, congenital and acquired neurological diseases, epilepsy, psychiatric and behavioral problems, communication disorders and language disorders' learning. It also deals with finding and certification (operating descriptive profile - PDF second model ICF) of disabled pupils according to national law for the special education teacher in schools and activation of the procedures for the recognition of civil disability and disability of minors.

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IV. PEDIATRIC HEALTH SYSTEM IN SPAIN

4.1. The National Health System

The Health Care System in Spain is a public body encompassing health services, founded in 1908 as *Instituto Nacional de Previsión*, step by step extending its coverage to all the population. This universalization process has been driven by the application of a Bismarckian model implemented with a national law enacted in 1942, the *Ley de Seguro Obligatorio*, imposing health insurances for the private companies and offering health care to alternatives beneficiaries of insurance. In 1963, due to reasons of the economic growth, private insurances became domain of public management and this process was completed in 1986 through the *Ley 14/1986 General de Sanidad* (General Health Law). This law accomplishes the mandate of the Spanish Constitution to protect citizens' health and recognizes the right to have health services for all citizens and for foreigners who are residents in Spain.

The sanitary management responsibility has been transferred to the local authorities since the 90s' following the mandate of Title VIII of the Constitution conferring to the autonomous communities the territorial control of public services in order to take care for the needs of specific areas, and health care system is included in all the competences delegated to the local governments. Currently health care services are on charge to the *Comunidades Autonomas*, regional institutions with a territorial responsibility in matter of public services.

The Health care system provides services in several areas: preventive, diagnostic, therapeutic, rehabilitative and promotion and implementation of population health. Health care is one of the main instruments of redistributive income policies among Spaniards: each person contributes taxes according to their economic capacity and receives health services according to their health need. Health care for common illness or non-work accident in Spain is a benefit independent from fiscal contributions and is financed by regional administrations.

In 2003 the General Health Law has been complemented by the *Ley 16/2003 de Cohesion y Calidad del Sistema Nacional de Salud* (Law of Cohesion and Quality) to face the cultural, technological and socioeconomic changes affecting contemporary Spanish society, and its patterns of disease. This Law establishes a set of functions common to all autonomous communities in matter of health care services, such as benefits provided, pharmacy, health professionals, research, health information systems, and the overall quality of the health system. Several national institutions have been developed in order to promote the quality of services at national level, and assess regional health care services.

In 2012 with *Real Decreto 16/2012* (Royal Decree Law) consistent modifications have been introduced to the national public health policies in relation to the economic sustainability of the public health services. This Law introduced a significant modification to the universal character traditionally assigned to the Spanish public health system: healthcare services are not free for all citizens but they could be on charge to the families' in reason to their incomes, and unregistered foreigners have not access to the public health, however, not all autonomous communities applied the this Law nowadays.

The Ministry of Health and Social Policy establishes the national policies in matter of health in order to respect the constitutional right of citizens to health care



services and regulates the functioning of *Sistema Nacional de Salud* - SNS (National Health System). As a consequence of the decentralization process promoted by the Constitution and enacted by General Health Law each autonomous community created a proper Health Care Service, with an independent administrative structure. The Law of Cohesion from 2003 establishes the institution of the *Consejo Interterritorial del Servicio Nacional de Salud* – CISNS (Council of the Spanish national Health Service) as the organ of general coordination in matter of health between the Central State and the autonomous communities and the institution giving the guarantee for the coordination of the SNS.

Autonomous communities manage local health care services through the *Consejería de Sanidad* (Health Council) who has the task to coordinate and execute the autonomous Government health policies in matter of social security and coverage of health needs of population, health care system management, mental health, pharmaceutical services, health care professional training, research and development, public health, food security and addiction disorders.

The autonomous health care system is divided in *Áreas de Salud* (Health Areas), administrative districts with the functions to organize primary care. *Atención primaria* (primary care) assures a comprehensive and continuous level of care throughout the patient's life, and from this perspective each patient can count on a personalized coordination and regulation of care plan through the role of a *medico de familia* (general practitioner).

The general practitioner plays a coordination role in order to assure health education, prevention, care maintenance, physical rehabilitation and social health care. Primary care covers home services, emergency services, and scheduled or on demand services. *Atención especializada* (specialized care) offers medical specialists services provided at the request of the primary care general practitioner. This service is commonly situated in the hospital, where it covers inpatient and outpatient care, or in specialist centres and day hospitals.

Specialized care is integrated to primary care and covers patients' needs that are not affordable from primary care. Specialized care is commonly provided through outpatient consultation and day hospital, when patient's clinical circumstances are favourable for this kind of care. *Atención socio-sanitaria* (social health care) offer a service for chronic patients who require at the same time, health care services and social services to manage the limitation of chronic illnesses and promote social integration.

4.2. Pediatric Education

Medical education in Spain is regulated by the Directive 2021/12/2004 enacted by European Parliament in 2004. Medical Schools according to the Bologna Agreement adopted the European Credit Transfer System to accomplish the harmonizing strategy of education within the EU. Undergraduate medical students in Spain are introduced to paediatrics subject at the 5th year of the medicine, even if the number of credits (ECTS) could vary with the University from 12 to 14 of the total of 360 ECTS for the entire degree. In a public University where paediatrics courses correspond to 12 ECTS students follow 75 hours of theoretical study program and 84 of practical training, divided into 36 hours of guided activity and 48 hours of non-guided activity, integrated with 137 hours of individual study. Practical training generally corresponds to 1 month in a paediatrics hospital Unit, with a rotation system where medical students stay 1



week in neonatology, 1 week in clinical consultation, 1 week in paediatric emergency, and 1 week in a paediatric unit.

In Spain, postgraduate medical students after a previous national exam can start their specialization training. According to their results, they accede to a selected speciality and start a 4 years postgraduate program becoming *Medico Interno Residente* (MIR). Residency has a duration of 5 years, but in the case of paediatrics it is 4 years, and the debate about this issue is common in Spanish paediatrics literature.

MIRs are doctors with an agreement based on the national regulation, this activity being paid and physicians contribute to the taxation system as other professionals. Residency in paediatrics includes three kinds of training: primary care, outpatients clinical consultation, that can be performed in the hospital or in the primary care centres. During the residency paediatricians accede to the sub-specialities of paediatrics through a cycle of rotations in neonatology, paediatric emergency, paediatric orthopaedic, paediatric surgery, paediatric intensive care. The hospital teaching board establishes a core of training courses common to all specialities that are mandatory for all the residents.

During the 1st year of residency paediatric residents must follow a mandatory training program related to the following specialities: introduction to paediatrics, paediatric radiology, paediatric cardiology (focused on electrocardiogram reading), workshop on communication skills and clinical interview, paediatric emergency.

In the 2nd year residency training program includes: cardio-pulmonary resuscitation, bioethics and lactation as mandatory program, and optional programs related to the research skills, such as biostatistics, bibliographic research and other specific scientific workshop. Training programs can be different according to autonomous regulation, organization of area services or hospitals according to the demand of health care services, even if there is a common core of competences required to conclude residency. Rotations up to two or three months are mandatory for all the residents in all the paediatric specialities and subspecialities, during the first 3 years of residency, in the last year residents can follow for 6 month a specific area according to their preferences. A tutor and the Head of the Unit supervise the rotation cycle of each resident. All residents doing rotation on emergency services, perinatal area, paediatric intensive care and neonatology intensive care, paediatric oncology and haematology, primary attention. Among the subspecialities available for rotation are: cardiology, endocrinology, nephrology, neurology, pneumology, digestive and allergy. According to the directive of the Ministry of Health residents can rotate in emergency 4 - 6 time per month according to the needed services.

Soft skills in the Spanish medical education are developed in the subject *habilidades de comunicación* (communication skills) and *humanidades médicas* (medical humanities). The educational model applied in the Spanish Medical Schools is structured in the outcome-based curriculum. Medical students outcomes suggested by the *Agencia Nacional de Evaluación de la Calidad y Acreditación* (ANECA) are classified in two groups: general outcomes allowed through transversal competencies and specific outcomes, among them there are included soft skills.

Specific competences of medical students are: 1) clinical skills, 2) scientific foundations of medicine, 3) population health 4), Professional values, attitudes, 5) Communication skills, 6) Population and health systems, 7) Management information. This subject can be taught by a psychologist, as a part of medical psychology course, or by an ethicist, as a part of medical humanities course, or both. In the first case soft skills are focused on the way of communication, it means how physicians can



communicate with the patient, in the second case about what to communicate, it refers to the physician's attitudes in the doctor-patient relationship.

Differences between the first and second aspect are essential, a psychologist can recommend a specific physical posture during the communication process, a group of preformed question to establish empathy. In the second case ethicists work on professional attitude, being proactive during the information process in order to involve the patient in decision-making processes. Both are essential aspects to improve soft skills, for that reason an integration in the same course of psychological and ethical approaches is essential.

In some Spanish private universities, softs skills are part of a course called *Humanidades Médicas y Habilidades de Comunicación*, taught in the first year of medical school. In this course soft skills are part of 1 module including 5 lectures each one of 2 hours per week: 1) introduction, 2) communication process, 3) active listening 4) assertiveness, 5) breaking bad news. Each lecture has a corresponding practice during 1 hour and an objective structured clinical examination (OCSE) in the simulation hospital. This format in Spain can show some variation but is adopted in all the universities, and represents a structured approach to the soft skills for undergraduate medical students.

Continuing medical education in Spain is regulated by the *Ley 44/2003 de Ordenación de las Profesiones Sanitarias* (Law regulating health care professions), a comprehensive law integrating all previous legislation about the subject. Continuing medical education is defined as a training process focused on the active and continuing learning of graduate health care professionals, in order to improve knowledge, skills and attitudes to face the challenges of technological progress in medicine and respond to the citizens' health care needs. Continuing medical education has been regulated through a specific certification system by the Ministry of Health and is a requirement for each health care professional.

Continuing medical education in the Spanish hospitals is supervised by the *Unidad de calidad* (Quality Unit) of each hospital. Professionals' associations have in charge the organization of external or online activities for their health care professionals. Frequently, professional associations are jointly coordinated with the quality units in order to organize training programs. Continuing medical education in the hospitals includes constant teaching activities such as clinical sessions, training courses, oral presentations at national and international congresses, research activities and paper publication. In order to have an official credit assignment, training programs receive a previous assessment by the *Comisión de formación continuada de las profesiones sanitarias* (Continuing education board for health care professionals), on behalf of public administration in matter of certification for health care professionals.

The *Asociación Española de Pediatría - AEP* (Spanish Paediatric Association) has an important role in continuing medical education program for paediatricians. Debate about the implementation of professional training to develop soft skills in paediatrics in Spain is focused generally on two subjects: paediatrician-patient-family relationship and bioethics. Literature about the subject has been frequent in the last decades especially in relation to the paediatrician competences. The need to improve the training of paediatric residents in matter of communication skills, abilities to recognize and manage cultural differences, identify and promote values centered on involving families and promoting shared decision-making, are common in the Spanish literature.

A common belief among the paediatricians involved in the public debate about this issue in the specialized reviews such as *Educación Médica*, or *Anales de Pediatría*,



shows that current training programs available for residents are not adequate to respond to the needs of the health care scenario and to the requirements of the outcome-based curriculum applied in medical education. An interesting initiative promoted through the AEP in Spain is the project *Continuum*, an online platform to improve continuing medical education in pediatrics. This project started in 2003 and is based on the Global Curriculum for Pediatric Education, a version for paediatrics of the outcome-based educational model proposed by the Institute for International Medical Education and recommended in Spain by the ANECA. *Continuum* promotes a competency-based training for undergraduate, graduate and practicing physicians and offer training courses and learning activities.

4.3. Pediatric Services

Paediatric care in Spain is organized in 5 kinds of services: hospital, emergency, day hospital, home care and external consultation, performed in the *Centro de Salud* (Health Care Centre) or in the hospital, for those hospitals where the service is provided. Services are assigned according to the patients' health care needs and age. This model reflects the more general organization of the health care system, divided in primary care, and specialized care and social health care. In this way paediatric patients receive an integrated care focused on physical, psychological and social patient's needs.

Paediatric Units, Paediatric Surgery and Neonatology are commonly coordinated and cover all the pathologies of paediatric patients for all the different ages. A model of excellence in paediatrics in Spain can include the following services:

- 1) perinatology unit, includes perinatal care in collaboration with obstetrician department;
- 2) neonatology unit, with a specific area for intensive care (*Unidad de cuidados intensivos neonatológicos*);
- 3) lactation unit;
- 4) paediatric intensive care unit (*Unidad de cuidados intensivos pediátricos*);
- 5) oncology and haematology unit;
- 6) paediatric unit, for the patients not included in the previous units with an age between 2 and 17 years;
- 7) paediatric surgery;
- 8) paediatric home care;
- 9) paediatric emergency;
- 10) day hospital;
- 11) external consultation in the health care centres.

All other pathologies not included in these services are withing adult units, but include health care professionals with specific competences for paediatric patients: i.e. ophthalmology, orthopaedic, psychiatry, otorhinolaryngology.

The current model of health care system in Spain coming from the *Ley General de Sanidad* de 1986, a national health system offering a universal care on the basis of citizens' health right guaranteed by the Spanish Constitution. This model offered a prevalent public provision of health care in Spain, even if since the 90s a slow process of modification opened to a mixed health care system started in some autonomous communities and becoming progressively a national standard.

In line with this local modification of the health care system, a first national intervention has been proposed through the *Informe Abril* (April Report) in 1991, where all the measures later adopted have been proposed, such as co-payment, private



criteria to manage health care services, implementation of the private market for the health care services, support for the role of insurance and private provision of health services, change of the agreement conditions of health care professionals. All these measures provoked a social refuse among health professionals, patients, policy makers, as a consequence most of them have been provisionally suspended.

Since 1992 several public hospital have been created with the management criteria of a private company, under a different legal status, i.e. foundation using the new criteria applied for the *Ley de Fundaciones* on 1994, and constituted by autonomous communities legislation under the control of regional parliament. In 1994 started a new approach assigning competences to the private company to create a private hospital and provide health services to public demand of a specific area, where management and provision of services are totally private, but the private company receives public funds. In 1999 with a specific legislation the Government offered to the autonomous communities the possibility to switch from the traditional model of public hospital to the Public Foundations Model. This new legal framework provoked a great debate by the stakeholders and currently it is not completely applied in all the regions, even if the legal option is available at national level.

The option to fund health services only with private funds and offer an exclusively private service started in Spain in 2007 in Madrid and is progressively extended to other autonomous communities. With the financial crisis a new Law, the *Real Decreto Ley 16/2012* introduces emergency measures in matter of sustainability of public health system. Among the interventions, new criteria for the private funding and the promotion of private insurances are introduced in the majority of autonomous communities with the aim to introduce a private health care system in the future.

One of the most important aspect of this Law is the discussion for the first time of the principle of universality of health care, only foreign residents have accesses to public health, for other foreigners public services are private and require an insurance to be provided.

To conclude, in the private system paediatrics follows the same criteria and structure as in the public system, and the same legislation is applied in all the circumstances.

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V. PEDIATRIC HEALTH SYSTEM IN GERMANY

5.1. The German Healthcare System

The most important aspect of the German Health Care System is the mandatory statutory health insurance for employees, called the Bismarck Model.

The origins of the health care system can be found in the craftsmen guilds in the Middle Ages with their early form of health insurance based on solidarity principle. Members of the guilds paid into a fund to support other members in case of medical issues. In the year 1883 Bismarck implemented a social security system that required certain employers and employees to make payments to existing voluntary sickness funds, which would pay for the covered employees' medical care. The modern Statutory Health Insurance (SHI) system that grew out of that early beginning has remained basically the same over the years and insures approximately 90% of German citizens with mandatory sickness funds. SHI covers essentially the cost of all medical care. Coverage is universal for all legal residents. The health care system in Germany is based on four basic principles:

1. Compulsory insurance
2. Funding from premiums
3. Principle of solidarity
4. Principle of self-governance

Table 1. Selected Health Care System Indicators for the German Health Care System

Population		Year
Total population (millions)	80.646	2013
Percentage of population over age 65	21.1%	2013
Percentage of population aged 0 - 14	13%	
Spending		
Percentage of GDP spent on health care	11.3%	2015
Health care spending per capita	\$4920	2013
Average annual growth rate of real health care spending per capita, 2009–13	1.95%	2013
Out-of-pocket health care spending per capita	\$649	2013
Hospital spending per capita	\$1,423	2013
Total spending of hospital care (in billions)	84,2	2015
Spending on pharmaceuticals per capita	\$678	2013
Physicians		
Number of practicing physicians per 1,000 population	411	2014
Average annual number of physician visits per capita	9.9	2013
Hospital spending, utilization, and capacity		
Total number of hospitals	1956	2015
Number of acute care hospital beds per 1,000 population	5.34	2013
Hospital spending per discharged	\$5,641	2015
Hospital discharges per 1,000 population	252	2013



Hospital beds per 100 000	823	2014
Average length of stay for curative care (days)	7.7	2013
Health		
Estimated life expectancy	81 years	2015
Estimated infant mortality per 1000 live births	3	2015
Infant deaths per 1000 live births	3%	2014

The German health care system can be divided into the three sections of players, payers and providers.

5.2. Players

The German health care system is based on a decentralized and self-governing system run by a number of different players. Decision-making powers are traditionally shared between national (federal) and state (*Länder*) levels, with much power delegated to self-governing bodies.

The Federal Assembly, the Federal Council, and the Federal Ministry of Health are the key actors on national level. The Federal Ministry of Health (*Bundesministerium für Gesundheit - BMG*) is responsible for policy-making at the federal level. The state is responsible for setting the legal framework, embodied in the Social Code Book V (*Sozialgesetzbuch*), by which the health insurances funds and service providers must abide. The Ministry of Health directs a number of institutions and agencies responsible for dealing with higher-level issues of public health, including the Federal Institute for Drugs and Medical Devices (*Bundesinstitut für Arzneimittel und Medizinprodukte - BfArM*) and the Paul Ehrlich Institute (*PEI*). The Federal Institute for Drugs and Medical Devices makes decisions involving the approval of pharmaceuticals. The Paul Ehrlich Institute is responsible for approving vaccines.

The most important body within the self-governing health system is the Federal Joint Committee (GBA), the highest decision-making body at federal level. It brings together the federal associations of sickness funds and the federal associations of provider groups (physicians, dentists and hospitals). It is responsible for defining the public financed package of services and setting quality standards for ambulatory, inpatient and intersectoral health care. (Nolte et al. 2008). The National Association of Statutory Health Insurance Funds (*GKV-Spitzenverband*) is the federal-level association of all statutory insurers. Its activities are governed by law. The private insurers are represented by the Association of Private Insurers (*PKV-Verband*).

Public health is mainly competence of the 16 Federal States. The Federal States are also responsible for planning inpatient capacities and financing investments in hospitals.

The federal government governs all five social insurances through the body of federal legislation known as the Social Code Book. The five pillars of the Germany's Social Welfare are unemployment Insurance, Pension Insurance, Health Insurance, Accident Insurance and Long-term Care Insurance.

5.3. Payers

It is a decentralized system in which government at the *Länder* level and the non-profit sickness funds have maintained autonomy. The sickness funds are closely regulated, non-profit, competing, not-for-profit, and nongovernmental institutions (113 in



2017) (GKV-Spitzenverband 2017). The funds are required to cover a broad range of benefits, including hospitals and physician services, prescription drugs, and dental, preventive, and maternity care. Under the statutory SHI system, services are provided free at the point of access.

The level of statutory SHI contributions is dependent on income, rather than individual risk, and is calculated as a proportion of income from gainful employment (or pensions) and benefits cover non-earning dependants without any surcharge. Everybody in the same sickness fund at the same salary level paid the same amount.

In the German health care system, statutory health insurance members mutually carry the individual risks of loss of earnings and the costs of medical care in the event of illness. Everyone covered by statutory insurance has an equal right to receive care. Premiums are based solely on income. This means that the rich can help the poor, and the healthy can help the ill. However, these premiums are only based on a percentage scale up to a certain income level (*Beitragsbemessungsgrenze*). Anyone earning more than this amount pays the same maximum premium.

The contribution rate is 14,60% of gross income (BMG). The funds are not allowed to exclude people because of illness, or to raise contribution rates according to age or medical condition. SHIs are obliged to contract with any eligible applicant. Every citizen has free choice among sickness funds. Contributions are shared between SHI-insured employees and their employers (~ 53% and 47%). 90% belong to the mandatory sickness fund system, 8% of the population opt for private insurance,, 2% receive medical service as members of the armed forces or police, and less than 0,2 % have no coverage.

5.3.1. Private insurance

Workers who earn more than 48.000 Euro per year may enroll in a sickness fund or opt out and purchase private insurance. They are not required to pay into Statutory Health Insurance system and may choose from among a variety of plans offered by many private insurance agencies. The patients pay the treatment costs up front and will be reimbursed later. The level of reimbursement will depend on the individual policy of the insurance company.

5.3.2. Healthcare Expenditures

The amount of the health care expenditures is € 2,911 per capita and 10,7 % of GDP which is the highest share of EU. 57% of total health expenditures were paid by statutory health insurance. 14% were paid by private households including direct payments and co-payments, 9% were paid by the private insurance sector, 5.7% were financed by governmental sources, and 7.5% were paid by long-term care insurance. The private households contribute around 14% of the total expenditure on health (including direct payments and co-payments). Patients have to pay 10 € per inpatient day (max. 28 days) (Parsi & Fischer 2009).

5.4. Providers

German medicine separates strictly ambulatory care physicians and hospital-based physicians. Most ambulatory care physicians are prohibited from treating patients in hospitals, and most hospital-based do not have private offices for treating outpatients. 2,8 million people working in a medical profession (Destatis).



The concerted Action sets guidelines for physicians' fees, hospitals rates, and the prices of pharmaceuticals twice a year. Based on these guidelines, negotiations are conducted at state, regional, and local levels between the sickness funds in a region, the regional physicians' association, and the hospitals to set physicians fees and hospital rates.

Inpatient care

Acute inpatient care is delivered by a mix of public, public/private non-profit and private for-profit providers (34%, 38%, 28%) in 1956 Hospitals existent in Germany. Hospitals are principally staffed by salaried doctors. Inpatient care is reimbursed through a system of global budgets with DRG allocated per admission. The reimbursement of inpatient services is carried out directly by health insurance funds.

5.4.1. Outpatient care

Ambulatory care is mainly delivered by private for-profit providers working in single practices. Patients have free choice of physicians. SHI-Insured have free access to 96% of all ambulatory physicians (4% are not SHI affiliated and treat only patients who are privately insured or pay out of pocket). Ambulatory care is organized at the level of the federal states (*Länder*), through 17 regional physicians' associations. Those are responsible for licensing SHI physicians and arranging reimbursement of services provided in the ambulatory sector. Ambulatory care physicians are required to join their regional physicians' association. Sickness funds pay a global sum each year to the physicians' association in their region, which in turn pays physicians on the basis of a detailed fee schedule.

5.5. Pediatric Education

Pediatrics is part of the medical education in Germany but the structure of the academic program differs from university to university.

As an example, we describe in the following the program of pediatric education at the Ludwig-Maximilians-University in Munich:

In total, medical education is divided in 6 modules, pediatrics is part of module 5. The pediatric module comprises lectures, seminars, online-seminars, tutorials, practice training. Besides these mandatory courses, there are voluntary online seminars and practice training courses to deepen knowledge. At the end of the pediatric program the students have to pass 2 exams.

Lectures

- Giving important basics
- 28 lectures à 45 min
- Topics: pulmonology, neonatology, endocrinology, metabolic diseases, infectiology, oncology, hematology, gastroenterology, cardiology, pediatric neurology, hemostaseology, nephrology, nutrition

Seminars

- 6 seminars
- Topics: developmental neurology, emergencies in children, gastroenterology, vaccinations, breaking bad news, course in examination of newborns and babies



Online-Seminars

- Case-based learning

Tutorials

- Group size: 8-10
- 4 cases are discussed in 8 tutorials à 90 min

Practice training

- Group size 3
- Students “work” 4 days on the ward
- Topics: bedside teaching, taking a history, clinical examination, writing a medical report

Voluntary practice training

- Training courses in: neurological examination, pediatric surgery, improving conversational skills, initial care of newborns

After 6 years at university and passing the final exams, students can start working as MD, Medical Doctors. To become a pediatrician, they have to work at least five years at a children`s hospital or – in part – at a specialized outpatient care as residents. During this time, they are trained in general pediatrics, neonatology, intensive care medicine and ultrasound. After the five years they have to pass a final exam and are then specialized in pediatrics.

As pediatrics is a specialty with lots of sub-specialties, pediatricians can specialize in a 3 year term further in

- Neonatology
- Pulmonology
- Pediatric Neurology
- Cardiology
- Hemato-oncology
- Endocrinology- and diabetology

There are some further sub-specialties one can be trained in a shorter period like rheumatology, hemostaseology, gastroenterology, palliative care,...

5.6. Pediatric Services

In Germany, the medical care of children and adolescents takes place in

- Pediatric practices
- University children`s hospitals and non-university children`s hospitals, pediatric wards in general hospital (n=364 in 2013)
- “Social pediatric centers” (SPZ)* (n=153 in 2017)
- rehabilitation clinics

* Social pediatric centers

During the last three decades, social pediatrics (German Society for Social Pediatrics and Child Medicine Center – DGSPJ) has established its social-pediatric centers in the German healthcare system as an excellent platform that does justice to the developmental anomalies and the specific needs of children and adolescents



affected or predisposed to become affected by disablement. Importantly, services provided by these centers are clearly anchored in the German Social Security Code (Sozialgesetzbuch, § 119).

The teams available for treating the children and adolescents in the social-pediatric centers generally provide multi-professional and transdisciplinary health care throughout the entire developmental process. This applies to ongoing needs for care as well as to preventative measures.

Consequently, the DGSPJ announced in 2017 the extension of these systems to include chronic disorders – in Children with Medical Complexity – Center for Children with Medical Complexity (CCMC). At 31.12.2016, there are 14.466 (8.412 female) medical doctors in Germany working as specialized pediatricians, thereof 5984 pediatricians in a children`s hospital or a pediatric ward in a general hospital.

This report is a summary of information and data based on the sources listed at the end of this document.

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CHAPTER 2

RESEARCH ON SOFTSKILLS NEEDS IN PAEDIATRICS

IN: ROMANIA, HUNGARY, ITALY, SPAIN, GERMANY

ABSTRACT

The current chapter presents the empirical results of softskills needs for the field of paediatrics in the five countries who are members of the project no. 2016-1-RO01-KA203-024630 Softskills for Children's Health conducted within the framework of Erasmus+ Strategic Partnerships in: Romania, Hungary, Italy, Spain, and Germany, for four categories of populations: i.e. paediatric patients, patients' parents, paediatricians and health care staff, in terms of: communication, transparency, hospital environment, intercultural issues, and time management.

1. MATERIAL AND METHOD

This empirical research is part of the Softisped project, which aims to improve paediatric students' soft skills in order to increase the performance and adaptability of paediatric services according to the needs and expectations of children and families, as well as the trainers' ability to build these skills through innovative methods and strategies.

The medical curriculum does not focus on the soft skills. According to the literature, medical educators lack experience in developing soft skills in pre-service and resident studies in paediatrics. As such, "soft skills may be the biggest challenge for the medical education" (Dwyer, Canadian Journal of Surgery, 2014).

The aim of the current project is to identify the most important soft skills for paediatricians, match them with the best teaching methods and strategies, and elaborate guidelines and materials for training the trainers to use these methods and develop future paediatricians' soft skills. As such, the current study will accomplish the first part of the project aims, i.e. to identify the soft skill needs in the project countries.

The survey findings will eventually conduct to improvements of paediatric education and services by improving communication with children patients and their families, implementing ludic activities, interaction with children through games, storytelling designed to distract, soothe, and help kids surmount fear of the doctor and deal with pain, stress and anxiety associated with hospital stays.

In the long run the results on softskills will impact the adequate formation of paediatric specialists by improving medical education in terms of cognitive skills and practical soft skills abilities (Soft Skills May Be the Biggest Challenge in Medical Education, Dwyer, Canadian Journal of Surgery, 2014).



1.1. Background of researchers

The researcher group involved a paediatrician, communication/ethics specialist/lecturer, and resident in the field of paediatrics. They had appropriate experience and expertise as well as communication skills to adapt to the very sensitive field of paediatric patients and their parents in obtaining their answers in the most adequate, carefree and atraumatic but also relevant manner.

The following researchers have agreed to lead the researchers' team in each country and be in charge of national data collection. The supervisor in each country was responsible for selecting participants: paediatricians, parents/tutors/relatives, children and healthcare staff involved with children, to include in the survey:

- Prof. Oana Marginean, PhD, Paediatrics Clinic 2, University Emergency Hospital of Tirgu Mures, University of Medicine and Pharmacy of Tirgu Mures, **Romania**
- Prof. Martin Fischer, PhD, Ludwig-Maximillan Universitat, Munchen, **Germany**
- Sabrina Grigolo, Health coordinator with a degree in Pedagogy and clinical tutor for the Nursing Training Programme, Azienda Sanitaria Locale, TO3, Torino, **Italy**
- Benjamín Herreros Ruiz Valdepeñas, principal investigator and Emanuele Valenti, project manager, deputy director of the Instituto de Ética Clínica Francisco Vallés, Hospital Universitario Fundacion Alcorcon, **Spain**
- Dr. Andras Gabor, Filab, Associate Professor of Information Systems, Corvinus University of Budapest, **Hungary**

We performed a prospective study in order to analyze the expectations of the main actors of the paediatric health services: doctors, paediatric patients and their parents and health care staff by filling in ad hoc questionnaires, and following interview guidelines. A number of 25 questionnaires were filled in and each subsequent area was analyzed.

All the data and parameters presented below were obtained through the questionnaires applied to paediatricians, child patients, parents/relatives and health care staff.

1.2. Method

The study used **questionnaires** to find out the attitudes and expectations as well as the main challenges and problems that may be encountered by the following target groups: paediatricians, parents (relatives), health care staff, and paediatric patients in different European countries (Romania, Hungary, Italy, Germany, Spain) in terms of:

1. Communication, interaction and empathy, ability to explain the child's illness, treatment, building mutual trust and respect
2. Transparency in communicating information about disease and therapy
3. Organization of the hospital environment (dimension of rooms, privacy, television, toys, pictures), services during hospitalization
4. Time management
5. Intercultural issues (language barriers, dealing with different beliefs and values)

Questionnaires were translated and administered in the national languages.

1.3. Participants

In each country the questionnaires were administered to:

- 25 paediatricians,



- 25 parents/tutors/relatives,
- 25 health care staff (nurses),
- 25 patients.

Each group filled a questionnaire aimed to measure 5 areas: communication, transparency, hospital environment, intercultural issues and time management.

Inclusion criteria:

- Paediatricians: paediatricians in a hospital setting or specialists working with children (i.e. intensive care, psychiatry, neurology, pedodontics),
- Parents/tutors/relatives of the surveyed patients,
- Health care staff: working in paediatric units,
- Paediatric patients: with ages of 5-14 years of age and acute or chronic conditions.

Procedure. Participants in the study were selected according to the sampling criteria and approached by the researchers who obtained written informed consent to participate. The questionnaires were submitted to relevant ethics committees in each country and followed all rules of research governance as appropriate and required.

All the data were collected and interpreted, maintaining strict anonymity of the participants in the survey. For transparency and feedback to the participants, as well as improvement of the softskills education and practice which is the ultimate goal of the project, survey results will be published in e-book format in all the project languages (Spanish, Italian, German, Romanian, Hungarian).

Children who were offered the opportunity to participate in our clinical research were asked their opinion and gave their permission to proceed.

1.4. Variables

The research variables were:

- For healthcare staff: gender, age, place of birth, city of residence, years of experience and role in the hospital;
- For paediatricians: gender, age, place of birth, city of residence, years of experience, training courses attended in 2016. Paediatricians were also asked if they had always worked in hospitals located in the same context.
- For patients and parents: gender, age, place of birth, city of residence, duration in years of the illness.

In Romania the surveyed **child patients** were predominantly boys (57%) versus only 43% girls, whereas the distribution on the three age ranges was: 12-14 years (47%), 5-7 years (33%) and 8-11 years (20%).

Duration of the disease of the surveyed children ranged between one to three months in 47% of the cases and between 4 to 8 months in 33% of the cases, with only 7% of the patients having a longer hospitalization period.

All **paediatricians** who responded to the questionnaires were females with ages over 45 years (63%), with 37% of them with ages between 36-45 years, and a work experience of over 15 years in 63% of the cases, whereas 37% had a work experience between 5 and 10 years, all paediatricians working in the same context and participating to training courses in the previous years.

Health care staff who participated in the study were mostly over 45 years (67%) and a work experience of over 15 years in 67% of the cases.



Parents and relatives who participated in the study were mostly women (81%), most of them with ages between 36-45 years (53%). Duration of the disease of the patient whose relatives filled in the questionnaires was of 1-3 months in 47% of the cases and in 33% of the cases with a period of 4-8 months of hospitalization.

In Hungary, the two surveyed groups consisted of 25 educated nurses and 23 paediatricians from the district XIII Budapest. All the nurses who filled the questionnaire were female. 56% of the surveyed health care staff were older than 45 years; 32% belonged to the age group 36-45 years and only 12% were between 26 and 35. Regarding their working experience, the majority, 72% spent more than 15 years working as a nurse. 24% of the surveyed health care staff had a working experience between 10 and 15 years while the remaining 4% had been working as a nurse for 5-10 years.

The sample number of the paediatricians' group was 23, 58% of them were females while males are 42% of the surveyed group. The PCPs questioned were all above the age of 36, 39% of them belonging to the age group 35-45, and 61% were older than 45 years. 61% of the surveyed paediatricians spent more than 15 years working as a doctor, 17% had a working experience between 10 and 15 years while the remaining 22% had been working as a physician for 5-10 years.

The 13th district is the fourth most populated district of the capital with 110 000 inhabitants and this number is constantly growing. In the district, there are 5 paediatrician offices and each one is responsible for the treatment of about 600-1500 children.

All the physicians who undertook the survey were primary care paediatricians (not secondary care or emergency physicians). Primary care doctors are the first stop for medical care for children and can treat conditions in their own offices. Patients should see the primary care paediatrician for a routine check-up and for non-emergency medical care. These can also refer the parent and the child to a trusted specialist if needed. In case of sudden or severe cases parents should visit an emergency department. One of the primary care paediatrician's most important job is to help keep kids from getting sick in the first place. This is called preventive care. Primary care paediatricians, unlike secondary care doctors, are continuously responsible for the general health of a child. Therefore, primary care physicians treat the person, while emergency doctors tend to focus more on a specific case and a specific illness. Generally, patients have a greater autonomy in the primary care offices than in emergency care.

In Italy, the surveyed **healthcarers** were 100% females. 41 healthcarers were involved in the survey by healthcare coordinators of Rivoli and Pinerolo Hospitals. They were:

- nurses
- paediatrics nurses
- social and healthcare workers
- midwives.

41 were health carers who work in Rivoli and Pinerolo Hospitals. Most health carers were over 45 (86%). 95% of them had been employed in the hospital for more than 15 years.

30 **paediatricians and experts of paediatric care profiles** were involved by Director of Maternal and Childhood Department of ASLTo3. They were predominantly females (63%) versus 37% males. 64% were over 45 in terms of age and only 7%



being 26-35 years. 62% were employed in the hospital for more than 15 years and 21% for 10-15 years. 57% of paediatricians and experts work in **hospitals** (and not in the schools) of ASLTO3. 48% of paediatrician experts attended at least 1 training course during the previous year while 52% did not attend any training courses.

The medical doctors involved in this survey were:

- paediatricians
- specialists in child neuropsychiatry
- neonatologists
- experts in emergency care.

27 **patients** were involved in our survey by the Paediatric and Neuropsychiatric Services of ASLTO3. 58% of the patients were female versus 42% males. The most frequent category in terms of age were “12-14 years” (58%). Regarding the “duration of illness”, the most frequent category was “1-3 years”. We attributed to this topic the following meaning: the duration of illness from T0 (confirmed diagnosis) to T1 (filling the questionnaire). This time is different from the “duration of take in charge or treatment” by Paediatrics and Neuropsychiatric Services.

27 **relatives** have been involved by Paediatric and Neuropsychiatric Services. 48% were males while the most frequent category in terms of age was < 35.

In Spain, 50 health care professionals were involved in three different hospitals, 25 Physicians working in paediatrics and 25 health care staff: 20 questionnaires at Hospital Universitario Fundación Alcorcón (HUFA), 10 at the Hospital Infantil Universitario Niño Jesus (HINJ), and 20 at the Hospital Universitario XII de Octubre (HUXII), all located in Madrid. 25 patients and 25 relatives have been surveyed at the Unit of Paediatric of HUFA. The research team in each hospital has administered the questionnaires through a one-to-one interview.

Healthcare staff profile: 100% of health carers were females. The health carers who have been involved in this survey are: paediatric nurses, midwives, healthcare workers of which 10 work at HUFA, 10 at HUXII and 5 at HINJ. The majority of health carers were over 45 (66%), 24% between 36 and 45, and a 10% between 26 and 35 years. The work experience was between 0 and 5 years for the 5% of the health carers, between 5 and 10 years for 7%, between 10 and 15 for 11%, and over 15 years for 77% of the sample

Paediatricians: 75% of the paediatricians and physicians working in paediatrics surveyed were female and 25% were male. The age range corresponds to 4% for physicians between 26 and 35, 37% between 36 and 45, 59% over 45%. The working experience corresponds to the following rates: 1% between 0 and 5 years, 26% between 5 and 10 years, 15% between 10 and 15 years and 58% over 15 years. The 63% of surveyed physicians had been working on the same clinical areas, whereas 37% worked in several clinical fields. From the physicians interviewed, 89% received a training course in the last years and 11% did not.

Patients: 52% of the interviewed patients were male and the 48% were female. The age range was between 5 and 7 for 44%, between 8 and 11 for 25%, and between 12 and 14 for 31% of the patients. The duration of illness for whom they were in the pediatric unit was ≤ 1 year for 67%, and between 1 and 3 years for 33% of them.

Relatives: 43% of the relatives involved in the study were male and 57% female. The range age was ≤ 35 years old for 9% , 77% were between 36 and 45, and 14% were over 45.



In Germany, the surveyed **healthcarers** were 100% females. 12 paediatric nurses were involved in the survey working on the ward of the Children's University Hospital of the Ludwig-Maximilians-University Munich and/or in the integrated social paediatric centre. Age of the health carers was 26-35 years (50%) and over 45 years (50%) 50% of them had been employed in the hospital for more than 15 years.

28 **paediatricians** of the Children's University Children's University Hospital of the Ludwig-Maximilians-University Munich and its integrated social paediatric centre were involved in the survey. They were females (48%) and males (52%) in almost equal parts. 32% were over 45 in terms of age, 29% being 26-35 years and 39% being 36-45 years. 41% were working as paediatricians for more than 15 years, 22%% for 0-5 years, 18% 5-10 years and 19% 10-15 years. 57% of paediatrician experts attended at least 1 training course during the previous year while 43% did not attend any training courses.

26 **patients** of the Children's University Children's University Hospital of the Ludwig-Maximilians-University Munich and its integrated social paediatric centre were involved in the survey. 58% of the patients were female versus 42% males. The most frequent category in terms of age were "12-14 years" (54%). Regarding the "duration of illness", the most frequent category was > 8 years (40%) , followed by 4-8 years (36%), 1-3 years (16%) and < 1 year (8%)

27 **relatives** have been involved, 62% were females while the most frequent category in terms of age was 36-45 years (54%)



RESULTS AND DISCUSSIONS

2.1. COMMUNICATION (c)

The center of paediatric unit's activity is the sick child and communication between different actors in the paediatric health care unit (paediatrician, health care staff on the one hand, and paediatric patient and his/her parents on the other, is crucial for his welfare and successful outcome of any medical intervention.

However, different studies support the assumption that the child's role in medical communication has been insufficiently explored and studied. Even when the patient is a child, the focus of research is usually doctor-parent, rather than doctor and child, the child being given little attention¹ Even if the triadic nature of paediatric patient interactions would require more time, the child's preferences and values should be considered and accepted, in addition to those of the parents.

The next section is a survey of the communication among paediatricians, health care staff, patients and patients' parents in Romania, Hungary, Italy, Spain and Germany, in terms of support to the patient, respect in hospital, support offered by the medical team, quality of patient's life, doctor's availability, making appointments for checkups, and follow-up information.

2.1.1. Doctor's support for the patient

In Romania, the support offered by the doctors to paediatric patients was evaluated with 4.9 by the patients themselves, with a similar perception by the patients' parents/relatives (i.e. also 4.9). Doctors' perception of this communication was rated with a maximum of 5.0, which represents the strongest point in the communication section, but only with 4.8 by the health care staff, which is a more reserved perspective regarding the doctors' support to the patient.

health carers' rating: 4.8
patients' rating: 4.9

paediatricians' rating: 5
parents/relatives' rating: 4.9

In Hungary, both educated nurses and doctors think that doctors mostly or completely offer the kind of support the patients need. The major obstacle in providing the best possible support is that paediatricians do not have enough time for patients (the obligatory consultancy hours for a paediatrician are 3 hours during which they treat an average of 15-25 patients/usual day). Patient care suffers when doctors are overloaded with work and administrative tasks. As a result, the average medical consultation lasts 5-6 minutes. Generally, patients receive information related to the disease and treatment from the doctor, while the nurses provide mostly hygiene information.

¹ Doctor-parent-child communication. *Social Science & Medicine* 52(6):839-51 · April 2001 A (re)view of the literature (PDF ...https://www.researchgate.net/.../12096746_Aug_11_2016



health carers' rating: 4.2
patients' rating: 4.7

paediatricians' rating: 4.4
parents/relatives' rating: 4.2

In Italy, the average results of healthcare is 3.7 while the paediatricians' result is 4.1 rated out of a maximum of 5.0, which represents the value of the communication section by the health care staff and doctors. Both think that doctors mostly offer the kind of support the patients need, even if they are often overloaded with work for many patients but also for administrative tasks. The perception of patients and relatives is different from healthcare staff and medical doctors. They confirm that the main problem is related to the amount of time. The reason is the low number of medical doctor versus the number of performances.

health carers' rating: 3.7
patients' rating: 3.3

paediatricians' rating: 4.1
parents/relatives' rating: 3.2

In Spain, the health carer's perception of doctor's support to the patients is slightly inferior to the paediatricians' perception. Physicians have a better perception about their work than other health care staff. Among users, patients differ a little from the relatives; both perceive the support as inferior to the health carer professionals' perception.

health carers' rating: 4.0
patients' rating: 3.8

paediatricians' rating: 4.4
parents/relatives' rating: 3.9

In Germany, patients and parents rate the doctor's support to the patients better (4.3. and 4.4) than paediatricians and health carers do. This result underlines the critical view of the paediatricians and healthcare staff in regard to their work.

health carers' rating: 3.7
patients' rating: 4.3

paediatricians' rating: 4.0
parents/relatives' rating: 4.4

2.1.2. Respect in the hospital

Being in the hospital may be a humbling experience, therefore respect is the key to maintaining dignity for both the patient and the parents who are suffering and deprived of the normal life conditions on the one hand, and for the doctors and health care staff who work on the pressure of time and a busy schedule to save lives and provide proper support, on the other.

In Romania, respect for the patient was rated as being extremely good, all patients offering the maximum score (5) at this item. Respect offered by the patients to the doctors was evaluated with 4.2 by the doctors, lower than the respect offered by the doctors to the patients. Respect offered by the patients to the health care staff was 4.6 as perceived by the health care staff and 5 by the relatives.

health carers' rating: 4.6
patients' rating: 5.0

paediatricians' rating: 4.2
parents/relatives' rating: 5.0



In Hungary, Interestingly, nurses think that doctors get only moderately the kind of respect they need, while doctors themselves think they get it most of the times. Different evaluation can be attributed to the different kind of feedback they receive. Most of the times nurses meet patients in their homes and not in the paediatrician's office, which facilitates personal, open communication and makes nurses more susceptible to adopt the parents' point of view. Unlike in presence of the doctors, patients communicate in a direct way with the nurses. They may complain more about their experiences with physicians, as well. Another factor which may contribute to the difference in the results is the subjective evaluation of respectful behaviour. Patients' behaviour might be evaluated more critically by an all-female group (health care staff).

health carers' rating: 3.2
patients' rating: 4.5

paediatricians' rating: 4.4
parents/relatives' rating: 4.3

In Italy, the average results of healthcarers is 3.4/5.0 while the paediatricians' result is 4.0. Different evaluation can be attributed to the different kind of feedback they receive. The type of relationship between patient and healthcare/doctors is different. Healthcarers feel to be less respected by patients than doctors. Patients and relatives confirm that "respect in the hospital" is a good practice in ASLTO3.

health carers' rating: 3.4
patients' rating: 3.9

paediatricians' rating: 4.0
parents/relatives' rating: 3.5

In Spain, the average results of health carers' staff is 3.7/5.0 and that of paediatricians is 4.0/5.0. The difference between health care staff and physician is consistent, and could be attributed to the different relationship, in the case of doctor-patient relationship: the role of confidence is crucial as it can improve the sense of respect towards the doctor. Interesting correspondence is showed between physicians, patients and relatives' results, a data supporting the link between this item and the quality of clinical relationship.

health carers' rating: 3.7
patients' rating: 4.2

paediatricians' rating: 4.2
parents/relatives' rating: 4.2

In Germany, both patients and parents are very satisfied by the respect they get in the hospital by doctors and health care staff. On the other side, the respect offered by the patients/parents to doctors and healthcare staff was evaluated as insufficient.

health carers: 3.7
patients' rating: 4.9

paediatricians' rating: 3.9
parents/relatives' rating: 4.8

2.1.3. Support offered by the medical team

Support can be quantified in different ways. It can imply a friendly welcome and help with orientation in the clinic, a warm guidance throughout the course of care, thus reducing patient and parent stress.



In Romania, patients perceive the support offered by the medical team as very good – 5.0, which is similar to the respect offered to patients. Doctors, however, estimated that the support offered to patients by the medical team is hardly ideal, which is reflected in their score of 4.4. Health care staff and relatives offered a similar score, i.e 4.9.

health carers' rating: 4.9
patients' rating: 5.0

paediatricians' rating: 4.4
parents/relatives' rating: 4.9

Hungary. Although the difference is a bit less sharp, doctors also feel more supported by the medical staff than nurses think doctors are. Doctors marked “mostly” on the questionnaire, while nurses feel doctors are supported “moderately”. In Hungary, there are no group-practices in primary care. Actual financial regulations do not allow it. Vertical cooperation of PCPs like locum construction exists but only between practices within the same office or area. PCPs are working in single handed practices but parallel with each other, supported by physician’s assistants in the office and nurses responsible for patients of their working area. (generally, doctors have direct contact with nurses of those areas from which they have “guest patients” as well). According to the law there should be a leading paediatrician in every primary care paediatric office but this rule is rarely implemented in practice.

Most of the times there is a strong horizontal cooperation between primary care paediatricians and secondary care specialists. Some type of secondary care specialists could be reached directly by patients, others only by referral (neurology, rheumatology, radiology, laboratory and admission to hospital), except emergency cases. Specialists within secondary care are mostly civil servants, with fixed salary, employed by the health services of local municipalities or hospitals, which are financed by the NHIF, based on fee for service. The same employment system exists in the hospitals as well.

health carers' rating: 3.4
patients' rating: 4.4

paediatricians' rating: 4.2
parents/relatives' rating: 4.1

Italy. The average results of health carers is 3.7/5.0 while the paediatricians’ result is 4.0. Doctors feel more supported by the medical staff than health carers feel. Health carers feel a major load of work to carry on. Patients and relatives confirm that the support offered by medical team is positive and this represents a good practice.

health carers' rating: 3.7
patients' rating: 3.7

paediatricians' rating: 4.0
parents/relatives' rating: 3.6

In Spain, the average results of health care staff is 4.0/5.0 and that of paediatricians is 5.0/5.0. The difference between the sample groups is well marked, physicians perceive themselves as more supported than the health care staff. Perception of patients and relative are consistently different from that of health care professional, and they correspond as rate with a small difference of 0.1.

health carers' rating: 4.0
patients' rating: 3.8

paediatricians' rating: 5.0
parents/relatives' rating: 3.9



In Germany, paediatricians rate the support from medical staff worse than health carers. In Germany, doctors are responsible for a lot of organisation work which is in large parts not the genuine responsibility of a doctor; this fact may contribute to this low ranking. On the contrary, patients (4.6) and parents (4.3) feel well supported by the medical team.

health carers: 4.0
patients' rating: 4.6

paediatricians' rating: 3.7
parents/relatives' rating: 4.3

2.1.4. Quality of the patient's life

Hospitals are far more than places where diseases are diagnosed and treated. At the core of every process is the care of patients who are physically and often psychologically vulnerable (first because they are children and second because they are sick), and separated from the comfort of their families and daily lives. Therefore, the quality of their life is crucial for a swift recovery.

In Romania, patients rated the quality of their lives in hospital as 4.4, similar to their parents'/relatives' rating and almost similar with the doctor's availability. Whereas the doctors rated the patients' quality of lives with 4.6, the health care staff gave a 4.8 score to this variable.

health carers' rating: 4.8
patients' rating: 4.4

paediatricians' rating: 4.6
parents/relatives' rating: 4.4

In Hungary, patients and parents offered a very similar rating regarding the children's quality of life. Paediatricians' rating was a little bit lower while the health care staff gave the lowest score (3.2) to this variable.

health carers' rating: 3.2
patients' rating: 4.4

paediatricians' rating: 4.0
parents/relatives' rating: 4.3

Italy. The average results of health care staff is 4.4/5.0 while the paediatricians' result is 3.7. Health carers evaluated their patients' quality of life better than doctors did. Doctors admit that hospital conditions are far from the necessities of patients, especially of children. The perception of relatives and patients is different from health carers and doctors, their results being low versus the perception of the other two categories. The reason is related to the quality of patients' and relatives' lives who live the illness and disease of their children.

health carers' rating: 4.4
patients' rating: 3.3

paediatricians' rating: 3.7
parents/relatives' rating: 3.3

Spain. The average results of health care staff is 4.1/5.0 and that of paediatricians is 4.6/5.0. Doctor considers the patient's quality of life to be better compared to the health care staff's rating; perhaps the different aims of their role make them aware about the efficacy of the treatment offered to the patients. Health care staff are closer to the daily life of the patients and they can perceive the lack of attention, respect, and the quality of life in their stay at the hospital - independently of the



therapeutic results. Patients and relatives have the same perception 4.0, slightly different from the health care professionals’.

health carers’ rating: 4.1
patients’ rating: 4.0

paediatricians’ rating: 4.6
parents/relatives’ rating: 4.0

In Germany, the average result of health care staff is 3.2/5.0. and from paediatricians 3.6/5.0. The asked medical team is working in a large university hospital with a lot of patients suffering from severe, rare and chronic diseases. So compared to healthy children, the quality of life in these patients seems low. Fortunately, the patients` and parents` rating is a little bit better, which may be explained by the care and support of these children in every bio-psycho-social aspects of their life.

health carers: 3.2
patients’ rating: 4.0

paediatricians’ rating: 3.6
parents/relatives’ rating: 4.3

2.1.5. Doctor’s availability

Access to care and wait for an appointment or lack of the doctor’s availability can be a patient and parent’s main frustration.

In Romania, for the item Doctor’s availability child patients scored only 4.5, which is higher than the previous item making appointment for check-ups, but lower than the score for support and respect granted to patients. Doctors evaluated their availability by only 3.9, since they are aware that their time is hardly sufficient. Doctor’s availability was given a 4.4 score by both the health care staff and the children’s parents or relatives.

health carers’ rating: 4.4
patients’ rating: 4.5

paediatricians’ rating: 3.9
parents/relatives’ rating: 4.4

Hungary. While doctors feel that it is mostly easy for patients to speak with the doctors during the office hours, nurses find this more difficult, rating availability “sometimes not easy” in the questionnaire. Ease of availability in the office varies from time to time and season to season. Summer vacation period is characterized by a lighter workload. Most of the physicians are easy to speak to in these months while the rest of the year paediatricians are generally busy treating ill children and signing sick notes for schools. During the 3-4 consulting hours, there’s no maximum limit of patients accepted by a paediatrician. Patient number in an average workday is 15-25 while it can reach 60-80 children in epidemic periods.

health carers’ rating: 3.0
patients’ rating: 4.1

paediatricians’ rating: 4.2
parents/relatives’ rating: 3.9

Italy. The average results of healthcarers is 3.6/5.0 while the paediatricians’ result is 4.0. Doctors feel that it is mostly easy for patients to speak with them during the office hours, while health carers find this more difficult.

The difference of results among these 4 categories is related to the number of medical doctors in relation to the number of performances. In ASLTo3 the number of



medical doctors is low and the perception of patients and relatives is of little time for managing the care.

health carers' rating: 3.6
patients' rating: 3.2

paediatricians' rating: 4.0
parents/relatives' rating: 3.0

In Spain, the average results of health care staff is 3.8/5.0 and that of paediatricians is 3.9/5.0. The difference between the groups is not significant, both agreeing about the need of increased availability of clinicians in the unit. Patients and relatives have a different perception from that of the healthcare professionals. It is interesting to highlight that all ratings are under 4.0.

health carers' rating: 3.8
patients' rating: 3.2

paediatricians' rating: 3.9
parents/relatives' rating: 3.4

In Germany, both health care staff and paediatricians evaluate the doctor's availability worse than patients and parents. Compared to adult medicine, every paediatrician tries to be available in the best possible way and appointments can be rescheduled very quickly if the child suffers an acute illness or deterioration. Patients and parents seem to appreciate that, whereas members of the medical team think it could be much better.

health carers: 3.5
patients' rating: 4.5

paediatricians' rating: 3.4
parents/relatives' rating: 4.0

2.1.6. Making appointments for checkups

In Romania, availability for making appointments for checkups was evaluated with 4.2 by paediatric patients, the lowest, weakest point in the communication with children. This result may be due to the doctor's overload and job involvement as well as the bureaucratic system in Romania, resulting in insufficient time for the doctor. This is compensated by residents and health care staff who take over the responsibility from the doctor. An electronic system for computerized appointments and checkups would be extremely useful and would save precious time for the doctors. This aspect was evaluated by the health care staff by 4.2, similar to the paediatric patients and by the relatives with 4.4.

health carers's rating: 4.2
patients' rating: 4.2

paediatricians' rating: 3.7
parents/relatives' rating: 4.4

In Hungary, both doctors and nurses rated doctors' availability for making an appointment for check-ups (physical exams, well visits, routine follow-up appointments) between "sometimes available" and "mostly available". In consulting hours the paediatrician's calls are answered by the physician's assistant. In the remaining working hours the primary care paediatrician is available for calls while he is visiting patients who are not able to visit his office due to sickness. It's a common practice of doctors to exchange phone numbers and e-mail addresses with parents. Mostly younger doctors keep contact with patients this way.



health carers' rating: 3.5
patients' rating: 3.9

paediatricians' rating: 3.4
parents/relatives' rating: 3.7

Italy. The average results of healthcarers is 3.9/5.0 while the paediatricians' result is 3,7. Doctors' and healthcarers's availability results "mostly available" were due to the time of waiting for an appointment and the sometimes difficult access to care.

The perception of patients is good, at the same level with the healthcarers and paediatricians. The perception of relatives is low compared to that of other categories, caused by a difficulty of balancing the different times of check-ups with the daily activities.

health carers' rating: 3.9
patients' rating: 3.9

paediatricians' rating: 3.7
parents/relatives' rating: 3.4

In Spain, the average result of health care staff is 3.9/5.0 and that of paediatricians is 3.7/5.0. Again, in in order to evaluate the efficacy of perceptions of health care services, the doctors' is slightly different from the doctors', both consider waiting lists and overload of patients as an obstacle to assure the best quality of the services in matter of response time. Patients and relatives consider this aspect with a different perception and results are all under the 4.0/5.0.

health carers: 3.9
patients' rating: 3.5

paediatricians' rating: 3.7
parents/relatives' rating: 3.6

In Germany, making appointments for check-ups are rated a little bit better by the medical team (3.8/5.0; 3.7/5.0) than the estimated doctor`s availability. Patients and parents see potential for improvement but are satisfied in large parts.

health carers: 3.8
patients' rating: 4.1

paediatricians' rating: 3.7
parents/relatives' rating: 4.2

2.1.7. Follow-up information

Romania. The follow-up information was seen as critical by the doctors, i.e. 3.8, followed by the patients with 4.3, health care staff – 4.4 and relatives – 4.5, which offers a lot of opportunities for improvement, especially in the pediatricians' point of view.

health carers' rating: 4.4
patients' rating: 4.3

paediatricians' rating: 3.8
parents/relatives' rating: 4.5

Hungary. Both groups agree that it is "sometimes easy" for patients to obtain follow up information (test results, medicines, care instructions) and care. To obtain follow up information parents can communicate with the doctor 1) seeing the paediatrician in his office 2) via phone calls 3) via e-mail. There has been a recent push for electronic communication to be used more frequently to improve quality of care. Examples include emailing test results to patients or managing conditions without



requiring time-consuming and costly office visits. Despite the push, few physicians use electronic communication because two main reasons. On one hand, computer illiteracy is still a common problem among elderly physicians. On the other hand, despite its advantages, electronic communication also increased the volume of physician work and makes some feel that their day is never ending.

health carers' rating: 3.4
patients' rating: 4.2

paediatricians' rating: 3.4
parents/relatives' rating: 3.7

Italy. The average results of healthcare is 4,1/5.0 while the paediatricians' result is 3,7. Healthcare workers show they consider it easier to obtain follow up information than doctors do. The quality of follow up information is high, except for relatives. Perhaps the reason is related to the kind of information: the relatives need useful information in order to manage the daily activities and treatment.

health carers' rating: 4.1
patients' rating: 3.8

paediatricians' rating: 3.7
parents/relatives' rating: 3.3

In Spain, The average result of health care staff is 4.0/5.0 and that of paediatricians is 3.8/5.0. The difference between the sample groups is not significant; they have a common perception about the information level patients should receive after hospitalization. Patients and relatives are slightly under paediatricians.

health carers' rating: 4.0
patients' rating: 3.5

paediatricians' rating: 3.8
parents/relatives' rating: 3.6

In Germany, patients and parents think that follow-up information and care is quite good. They are provided with test-results, prescriptions, on a regular basis (medical report) and most of the patients and parents could email the doctors to get further information or updates. The average result of health care staff and paediatricians is a little bit lower, but not bad.

health carers: 4.1
patients' rating: 4.8

paediatricians' rating: 4.1
parents/relatives' rating: 4.6

2.1.8. Communication - Conclusions

Communication learning needs in Romania

For **Romania**, the lowest general average score for communication was given by the doctors: 3.8, lower than the average communication score offered by the child patients. This result is due to the difficult chronic conditions, consecutive psychologic problems, doctors not having enough time to deal with all these problems, besides their other commitments (students, courses, many patients, administrative bureaucracy).

The health care staff general average for communication was 4.6, similar with the relatives and the patients' average. For the patients, the average score of 4.6 is acceptable, given their chronic conditions, long hospitalizations and invalidating



diseases (malignancies, chronic inflammatory conditions, malabsorption syndromes, chronic renal pathologies, rheumatic diseases).

Communication	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	4.6	4.6	4.2	4.6
Support to patients	4.8	4.9	5.0	4.9
Respect form patients	4.6	5.0	4.2	5.0
Support from medical team	4.9	5.0	4.4	4.9
Appointment for checkups	4.2	4.2	3.7	4.4
Availability during office hours	4.4	4.5	3.9	4.4
Quality of patient life	4.8	4.4	4.6	4.4
Follow up information	4.4	4.3	3.8	4.5

Table 1. Communication results for Romania

The lowest among communication results is held by the variable *appointment for checkups* for all the surveyed groups and the highest for all the surveyed groups is *support offered to patients*. Paediatricians feel they need to improve their appointment for checkups, availability during office hours and offering follow-up information and they also feel entitled to receive more respect from the patients.

Paediatric patients expect a better scheduling of appointments for checkups and clearer, **adapted** follow-up information. This is an aspect that could be improved through adapting the style of communication to the children's capacity of understanding and involvement of different strategies of communication. Children would also appreciate a better availability of doctor's support during office hours and a better quality of their hospital life.

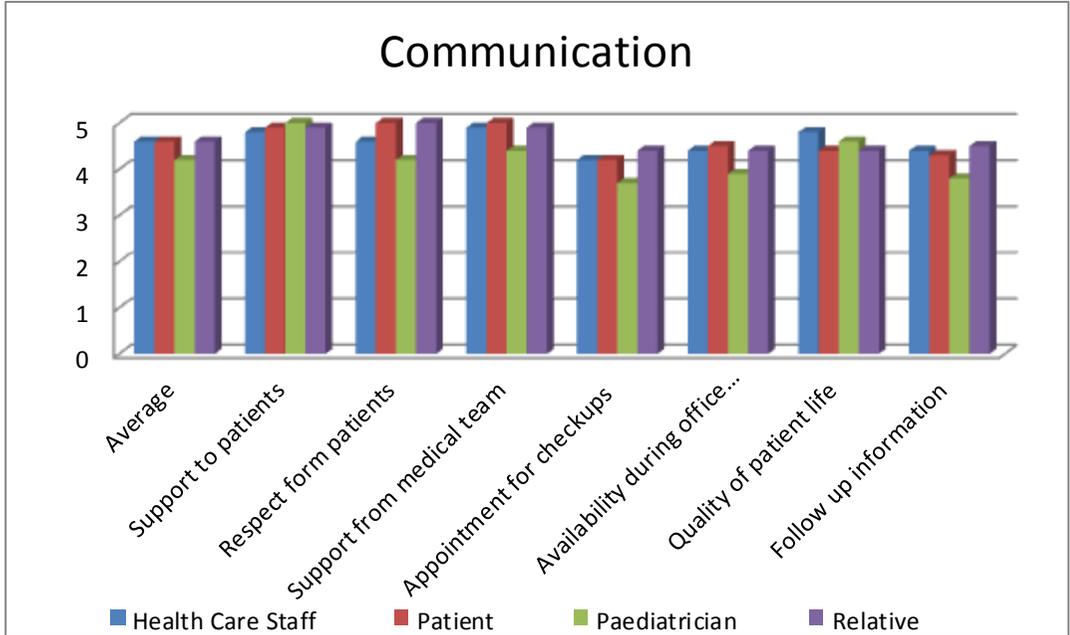


Fig.1 Communication results for Romania

Communication learning needs in Hungary

Communication	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3,4	4,3	4,0	4,0
Support to patients	4,2	4,7	4,4	4,2
Respect form patients	3,2	4,5	4,4	4,3
Support from medical team	3,4	4,4	4,3	4,1
Appointment for checkups	3,5	3,9	3,4	3,7
Availability during office hours	3,0	4,1	4,2	3,9
Quality of patient life	3,2	4,4	4,0	4,3
Follow up information	3,4	4,2	3,4	3,7

Table 2. Communication results for Hungary



For **Hungary**, the lowest general average score for communication was given by the health care staff (3.4). Relatives' and paediatricians' general average for communication was 4.0 close to the patients' average (4.3) which means these three groups are mostly satisfied with communication.

Similar to the Romanian results, the highest among communication results is held by the variable *support offered to patients* for all the surveyed groups while the lowest were *appointment for check-ups* and *follow up information*. Paediatricians feel they need to improve their appointment for check-ups and offering more follow-up information. Paediatric patients expect a better scheduling of appointments for check-ups while parents expressed their need for a clearer, age-adapted follow-up information, as well. The surveyed health care staff complained about the increasing number of administrative tasks which reduces considerably doctor's availability during office hours.

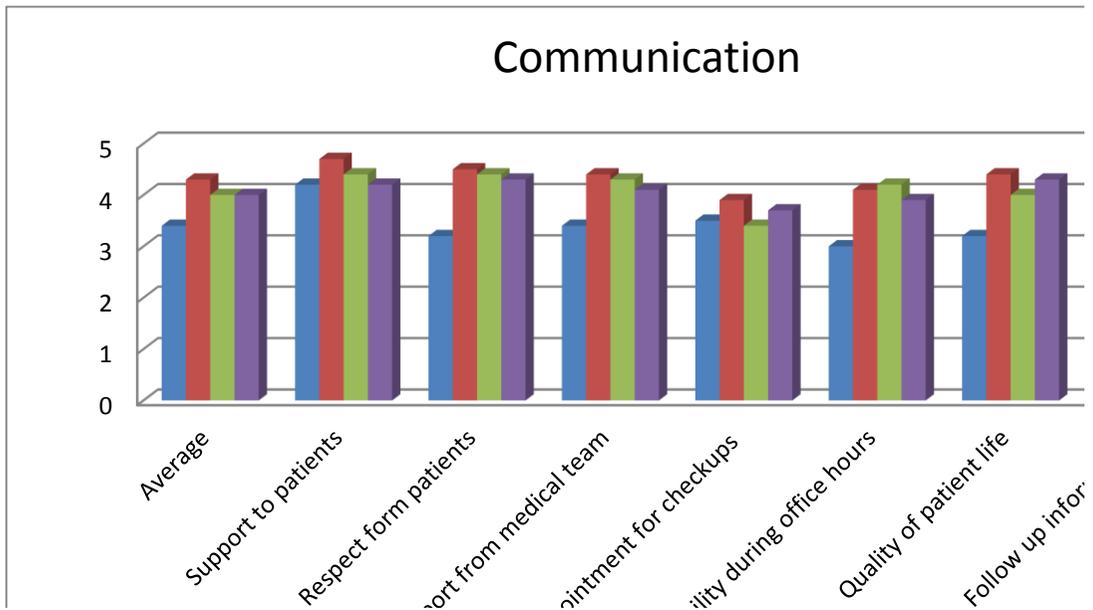


Fig.2 Communication results for Hungary

Communication learning needs in Italy

For **Italy**, the lowest general average score for communication was given by the relatives. The difference of results among relatives and paediatricians is due to the number of medical doctors versus the number of services they have to perform. Patients' and relatives' perception is of reduced time for managing the care because in ASLTo3 the number of medical doctors is low.

The health care staff general average for communication was 3,8, similar to the paediatricians' average. For the patients, the average score of 3.6 is related to low



scores in *availability during office hours* and *quality of patient life*: these results lead to a low respect to the perception of doctors and healthcare workers, related to the patients' and relatives' quality of life, who live the illness and disease of the children. Healthcare workers evaluated their patients' quality of life better than doctors did: doctors seemed to admit that the hospital conditions are far from the patients', especially the children's needs.

Communication	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3,8	3,6	3,9	3,3
Support to patients	3,7	3,8	4,1	3,3
Respect form patients	3,4	3,9	4	3,5
Support from medical team	3,7	3,7	4	3,6
Appointment for checkups	3,9	3,9	3,7	3,4
Availability during office hours	3,6	3,2	4	3
Quality of patient life	4,4	3,3	3,7	3,3
Follow up information	4,1	3,3	3,7	3,2

Table 3. Communication results for Italy

Relatives think paediatricians need to improve their *availability during office hours*, *follow-up information*, *quality of patient life* and *support to patient*. These expectations are the same as of the paediatric patients'. Support and information are aspects that could be improved through adapting the style of communication to the children's and relatives' capacity of understanding and involving different strategies of communication.

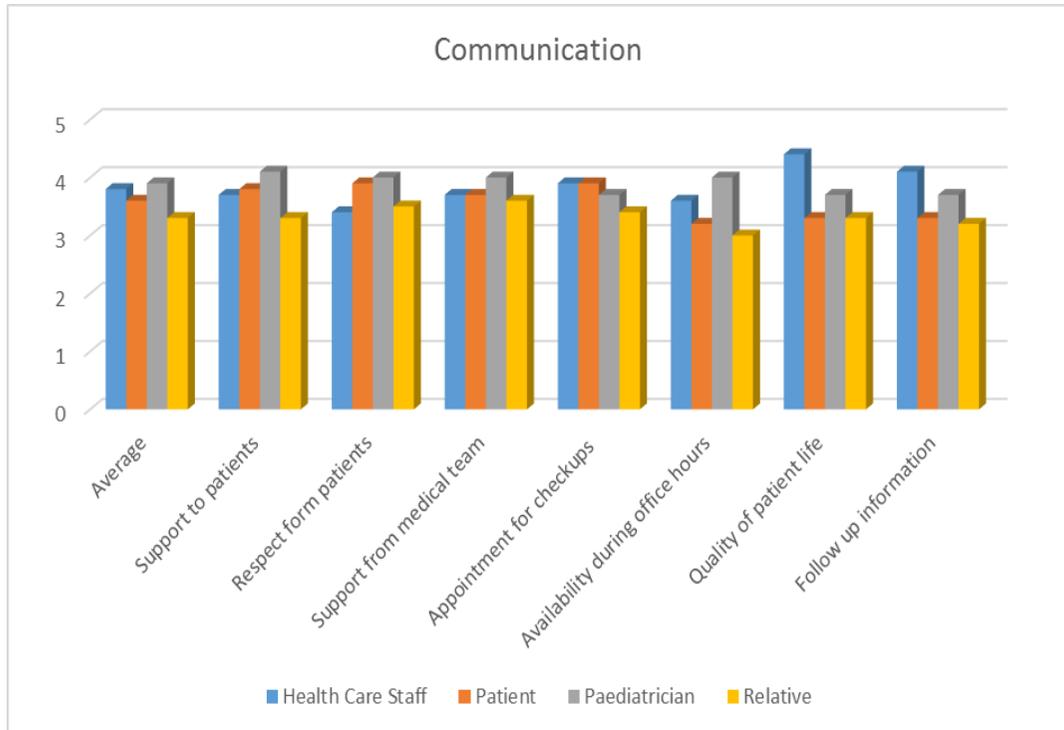


Fig.3 Communication results for Italy

Communication learning needs in Spain

For Spain, the average related to communication is globally good, the physicians' perceptions being relatively better than those of the other sample groups. We consider this aspect dependant on the national legislation available in Spain regulating patient's information process and the training of clinicians in matter of communication, comparatively better than that of the health care staff. This aspect is supported by the perception of all the aspects explored in the questionnaire. All items related to the communication process and attitudes in clinical relationship are perceived by clinicians with a higher rate than other participants. Just in case of the *follow up information* clinicians show a worse perception, and the difference from health care staff rate is significant. On the one hand, the health care staff is directly involved in the follow-up process and they perceive their role as a supportive aspect in this process, and on the other, clinicians, patients and relatives are aware about the real patients' needs.



Communication	Health Care Staff Questionnaire	Patient Questionnaire	Pediatricians Questionnaire	Relative Questionnaire
Average	3,9	3,8	4,2	3,8
Support to patients	4,1	4,1	5,0	4,1
Respect from patients	3,7	4,2	4,2	4,2
Support from medical team	4,0	3,8	4,4	3,9
Appointment for checkups	3,9	3,5	3,7	3,6
Availability during office hours	3,8	3,2	3,9	3,4
Quality of patient life	4,1	4,0	4,6	4,0
Follow up information	4,0	3,5	3,8	3,6

Table 4. Communication results for Spain

Respect from patients perception of health care staff is lower than in other sample groups, perhaps because they are exposed to all kinds of dysfunctions perceived by patients and family during the stay in the unit. The health care staff assumes the role of mediator between patients, family and health care services, and this supposes they face all the conflictive situations happening in the ward. All items related to the quality of health care services in terms of organization of human resources and services are under 4.0, and this circumstance is shared by all the sample groups. These data are not in line with the subjective perception of the sample group related to the quality of life in the ward, other item where there is a positive consensus and the average is over 4.0 for all groups.

In conclusion the need to improve communication in Spain is specifically focused on the communication among health care staff, especially doctors and other health care professionals. The role of health care staff is essential to improve users' satisfaction of health care services in paediatrics. Clinicians need to involve nurses and other health care staff in clinical relationship and think about the doctor-patient relationship in paediatrics in terms of a team. This aspect is, for example developed in other medical specialties where patients are particularly vulnerable, such as palliative care. **Team building** is an extremely important soft skill in paediatrics and is the consequence of the improvement of communication among health care professionals. Team care in paediatrics must include relatives, and the health care staff plays a key role in this respect.



Communication

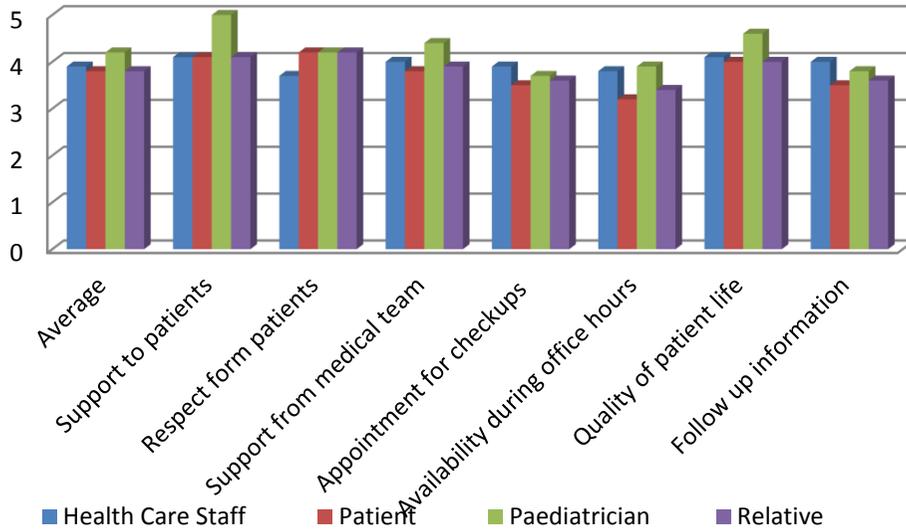


Fig.4 Communication results in Spain

Communication learning needs in Germany

In **Germany**, the lowest general average score for communication was given by the health care staff (3.7) followed by paediatricians (3.8). In contrast, patients and relatives seem to be mostly satisfied with the communication (4.5. and 4.4).

Paediatricians rate their *support to patients* and providing *follow up information* with the highest results in their group (4.0 and 4.1) and health care staff also think that *follow up information* is sufficient (4.1.). In general the increasing number of administrative tasks reduce the time doctors can talk to patients and relatives.



Patients and relatives appreciate all the communication aspects, parents think that the *availability during office hours* could be improved (4.0).

Communication	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3,7	4,5	3,8	4,4
Support to patients	3,7	4,3	4,0	4,4
Respect from patients	3,7	4,9	3,9	4,8
Support from medical team	4,0	4,6	3,7	4,3
Appointment for check-ups	3,8	4,1	3,7	4,2
Availability during office hours	3,5	4,5	3,4	4,0
Quality of patient life	3,2	4,0	3,6	4,3
Follow up information	4,1	4,8	4,1	4,6

Table 5. Communication results in Germany

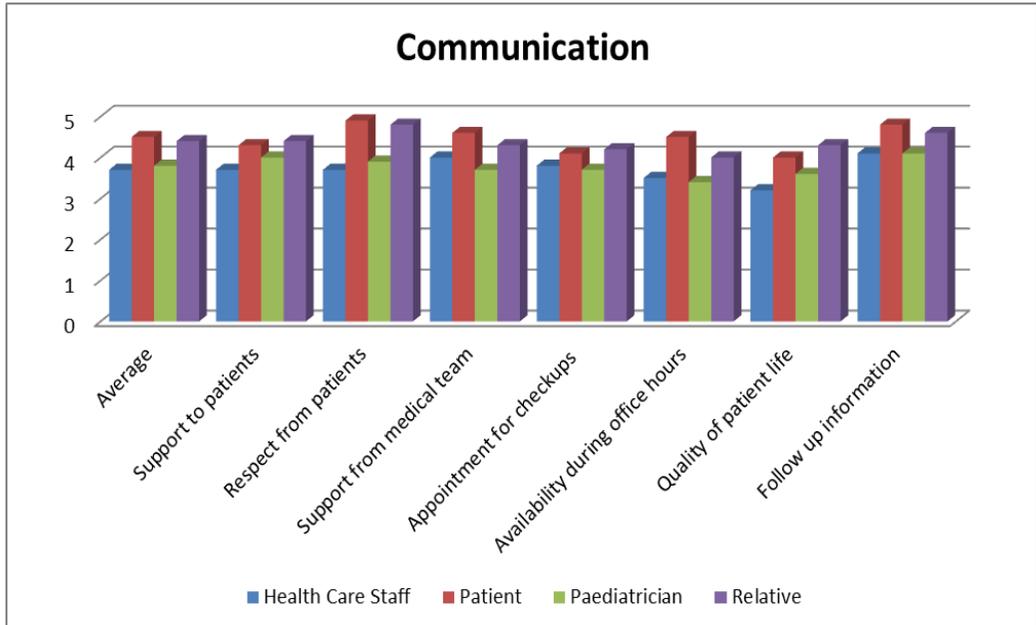


Fig. 5. Communication results in Germany



2.2. TRANSPARENCY (T)

Transparency generally refers to making better information to patients about costs and quality of care. In this study, transparency is evaluated in terms of other doctor's involvement, efficiency and rapidity in solving patients' complaints, delivery of important information to patient (oral/written) and information about care, treating the patient with courtesy and respect, privacy issues and offering written information. Optimized transparency is likely to bring forth changes that are essential in the case of paediatric health services.

2.2.1. Other doctor's involvement

Romania – The other doctors' involvement was evaluated with 4.3 by paediatric patients and their parents/relatives. However, the health care staff considered that other doctors' involvement was lower, which resulted in a 3.3 score, and lowest by pediatricians: 3.1 – **the lowest aspect for Transparency.**

health carers' rating: 3.3
patients' rating: 4.3

paediatricians' rating: 3.1
parents/relatives' rating: 4.3

Hungary - A paediatrician's office financing is largely dependent on the number of referrals to secondary care. If the doctor sends fewer patients to next level examinations his official rating as a physician changes. This will result in a different amount of money given to his practice. First contact visit usually does not need further medical examinations: in 80% of the cases patients do not need secondary or emergency care. According to the survey answers nurses, patients and parents think that doctors involve other health care staff and caregivers in the patient's care most of the times while doctors see that they only do it when needed.

health carers' rating: 3.7
patients' rating: 4.2

paediatricians' rating: 2.9
parents/relatives' rating: 3.8

Italy – The average results of healthcarers is 3.9 while the paediatricians' result is 3,7. Doctors feel they are involved less than the healthcarer staff, even if often the first contact visit needs further medical examinations.

Patients and relative perceive the low respect to the healthcare and paediatricians to be caused by an organisational problem: speech therapist, psychologist, paediatricians of territory services, they do not belong to the Neuropsychiatric Services and Paediatric Units. The impact is related to the responsibility of the health care project as a team.

health carers' rating: 3.9
patients' rating: 3.1

paediatricians' rating: 3.7
parents/relatives' rating: 3.3

Spain – The average results of health care staff is 3.7/5.0 and that of paediatricians is 3.1/5.0. The difference between staff and doctors is clear, perhaps doctors' perceptions are influenced by their role in the decision making processes. Patient's responsibility, confidence, trust are all aspects that in some way personalize



the clinical relationship, more than the health care staff, were rotations are frequent. Patients and relatives show some uniformity in assessing this aspect of the information process, their rating being slightly different from that of the physicians.

health carers' rating: 3.7
patients' rating: 3.5

paediatricians' rating: 3.1
parents/relatives' rating: 3.6

Germany – The average result of health care staff is 3.7 – the lowest result. Paediatricians, patients and parents rate other doctor's involvement higher (4.2-4.4)

health carers: 3.7
patients' rating: 4.4

paediatricians' rating: 4.2
parents/relatives' rating: 4.2

2.2.2. Patients' complaints

Romania - Patients may complain for different reasons: something that went wrong, a painful experience, lack of information, dissatisfaction with care². Their complaints may represent a stressful experience for the doctors and the staff. However, it has been estimated that 23% of complaints can be solved by a sincere apology, and 34% by an explanation of the circumstances surrounding the event in question³. Handling complaints and grievances is an important aspect of patient-centred care and it offers opportunities for quality improvement.

Response to patients' complaints was estimated as fair and good by the patients and staff (4.8) and a little better by doctors and parents (4.9). If staff is trained to *listen effectively, employ a pro-active approach*, and manage children's and family expectations, small problems can be solved before they escalate.

health carers' rating: 4.8
patients' rating: 4.8

paediatricians' rating: 4.9
parents/relatives' rating: 4.9

Hungary - Generally, there are no blood sample results or other medical findings available in the first visit. At this point, doctors' only source of information is what the parent or the child is telling him about the symptoms. All surveyed groups feel that doctors listen carefully to patients' complaints most of the times.

health carers' ratings: 4.4
patients' rating: 4.0

paediatricians' rating: 4.4
parents/relatives' rating: 4.0

Italy – The average results of healthcare is 3.9/5.0 while the paediatricians' result is 4.0. Healthcarers and doctors feel that doctors listen carefully to patients' complaints most of the times. The perception of patients and relatives is lower than

² <http://www.avant.org.au/uploadedFiles/Content/resources/member/risk-200912-dealing-with-patient-complaints.pdf>

³ Victorian Office of the Health Services Commissioner. Annual Report 2008: 18-9: www.health.vic.gov.au/hsc/downloads/annrep08.pdf.



those of the healthcarers and paediatricians because the answers are different from what information the relatives and patients want.

health carers' rating: 3.9
patients' rating: 3.1

paediatricians' rating: 4,0
parents/relatives' rating: 3.2

Spain – The average results of health care staff is 4.3/5.0 and that of paediatricians is 4.9/5.0. The difference between the groups is not consistent, health care staff seems to give less attention to the patients' claims, perhaps due to the typology of claims a patient can show to a doctor, generally considered responsible of the patient's condition in the unit. Patients and relatives do not consider the complaints aspects of the communication to be shared by the health care professionals.

health carers' ratings: 4.3
patients' rating: 4.0

paediatricians' rating: 4.9
parents/relatives' rating: 4.0

Germany - Patients think that the medical team listens carefully to their complaints, they seem to appreciate this a lot (4.7). Paediatricians and parents show similar high results (4.4). In contrast, health care staff is not that satisfied with handling complaints (3.6).

health carers: 3.6
patients' rating: 4.7

paediatricians' rating: 4.4
parents/relatives' rating: 4.4

2.2.3. Information to patients (available and easy to understand)

Romania - The amount of quality of information offered to patients was rated with a score of 4.8 by patients, health care staff and parents, whereas doctors considered that this could be improved and their score was a little lower: 4.5.

Doctors may have considered besides the information provided about the patient and course of treatment to other type of information that should be available to patients when they are admitted to hospital: patients' rights and responsibilities while in hospital, information about what to bring to hospital, for a certain test or as an outpatient, visiting hours, access to health records – all these in an easy to remember way such as through leaflets and videos rather than notices on the hospital walls.

health carers' rating: 4.8
patients' rating: 4.8

paediatricians' rating: 4.5
parents/relatives' rating: 4.8

Hungary - Doctors self-reported that most of the times they can explain information to the patients in a way that is easy to understand. Nurses, relatives and patients seem to confirm this opinion although patients' rating falls behind the other groups' rating.

health carers' rating: 3.9
patients' rating: 3.8

paediatricians' rating: 4.2
parents/relatives' rating: 4.0



Italy – The average results of healthcarers is 4,1/5.0 while the paediatricians result is 4.2. From the organisational point of view, information sharing with the parents, relatives and children is an important process of care. The average is high both for healthcarers and paediatricians regarding the project of care and the taking charge of cases. This is a specific point of internal mission. The perception of relatives and patients is lower than that of other two categories, which is caused by the kind of information viewed by them: they want useful and effective information for managing the daily activities and lifestyle.

health carers' rating: 4.1
patients' rating: 3.5

paediatricians' rating: 4.2
parents/relatives' rating: 3.3

Spain – The average results of health care staff is 4.2/5.0 and those of paediatricians is 4.5/5.0. The information process presents some uniformity for both sample groups, even if in the case of patients and relatives it is a little inferior.

health carers' rating: 4.2
patients' rating: 4.0

paediatricians' rating: 4.5
parents/relatives' rating: 4.2

Germany – For best compliance and medical outcome it is important that patients and parents understand the medical information from doctors. In paediatrics, it is essential that parents and relatives understand the main aspects of the child's disease, diagnostic steps and treatment options. In Germany, parents think that this information is provided in an excellent way by paediatricians (4.9). It cannot be explained properly why health carers are so unsatisfied with the provided information (3.3).

health carers: 3.3
patients' rating: 4.5

paediatricians' rating: 4.4
parents/relatives' rating: 4.9

2.2.4. Courtesy and respect

Romania – Investigators have found that doctors-in-training are unlikely to introduce themselves fully to hospitalized patients or sit down to talk to them eye-to-eye, despite research suggesting that courteous bedside manners improve medical recovery along with patient satisfaction. A report on the research, published in the *Journal of Hospital Medicine*⁴, considers that some simple adjustments to intern communications would make the whole experience of a hospital stay, better.

The **courtesy and respect** score ranged between 4.8 in the case of doctors and health care staff, 4.9 by paediatric patients and a maximum by the parents and family (5.0).

health carers' rating: 4.8
patients' rating: 4.9

paediatricians' rating: 4.8
parents/relatives' rating: 5.0

⁴ Common courtesy lacking among doctors in training
http://www.hopkinsmedicine.org/news/media/releases/common_courtesy_lacking_among_doctors_in_training



Hungary - Both doctors and nurses feel that doctors almost always treat their patients with a great amount of respect. Patients seem to perceive similarly the level of respect they are treated with, while parents are slightly less satisfied with the courtesy towards their children. Rankings for this question are especially high, which demonstrates that respect is a core value for the healthcare personnel of the sample.

health carers' rating: 4.5
patients' rating: 4.7

paediatricians' rating: 4.6
parents/relatives' rating: 4.3

Italy – The paediatricians' result is 4.5. During the taking charge of a case it is important to guarantee courtesy and respect for relatives and children as well as colleagues (healthcarers and medical doctors). Courtesy and respects are two key elements of organisational behaviour for both paediatricians and health carers.

The perception of the patients and relatives is lower than other two categories caused by the duration of medical examination: few minutes are not enough to answer the questions of parents and patients.

health carers' rating: n/a
patients' rating: 3,5

paediatricians' rating: 4.5
parents/relatives' rating: 3.4

Spain – The average results of health care staff is 4.3/5.0 and that of paediatricians is 4.8/5.0. The health care staff perceive this aspect slightly different than physicians, even if the difference is not consistent, patients and relatives confirming the good environment of health care services.

health carers' rating: 4.3
patients' rating: 4.5

paediatricians' rating: 4.8
parents/relatives' rating: 4.5

Germany - Patients and parents feel treated with a great amount of respect (4.9 and 4.6) and the self-estimation of paediatricians is the same (4.7). The health care staff is less satisfied (3.9)

health carers: 3.9
patients' rating: 4.9

paediatricians' rating: 4.7
parents/relatives' rating: 4.6

2.2.5. Information about care

Romania – Children as well as their parents rated information about care with 4.7, whereas the staff considered this to be better (4.9) and the doctors to be maximum (5.0), which implies that the provided information is complete and appropriate and it corresponds with the degree of patients' understanding and the type of their disease.

health carers' rating: 4.9
patients' rating: 4.7

paediatricians' rating: 5.0
parents/relatives' rating: 4.7

Hungary - Nurses think that providers keep patients informed about care most of the times while doctors think they almost always keep patients informed. Patients'



opinion falls closer to doctors' rating while parents tend to agree more with the nurses' perspective.

health carers' rating: 3.7
patients' rating: 4.2

paediatricians' rating: 4.5
parents/relatives' rating: 4.0

Italy – The average results of healthcarers is 4,5/5.0 while the paediatricians' result is 4.3. From organisational point of view the information sharing process with the parents, relatives and children is an important process of care. The average is high both healthcarers and paediatricians regarding the project of care and the taking charge of cases. This is a specific point of internal mission. The perception of the patients and relatives is lower than of the other two categories and is caused by the duration of medical examinations and the kind of information: a few minutes are not enough to answer the questions of parents and patients.

health carers' rating: 4.5
patients' rating: 3.5

paediatricians' rating: 4.3
parents/relatives' rating: 3.2

Spain – The average results of health care staff is 4.4/5.0 and that of paediatricians is 5.0/5.0. The Staff perceive that the information processes is not full, whereas paediatricians are totally aware about the maximum effort done to inform patients and families. The latter expect more information about care.

health carers' rating: 4.4
patients' rating: 4.3

paediatricians' rating: 5.0
parents/relatives' rating: 4.1

Germany – Parents and patients are totally happy with the provided information about care (4.5 and 4.8) whereas health care staff see room for improvement (3.9)

health carers: 3.9
patients' rating: 4.5

paediatricians' rating: 4.4
parents/relatives' rating: 4.8

2.2.6. Information about test results

Romania – The highest score in the case of pediatricians at this point means that they consider they have given an adequate amount of information, followed by health carers and parents whereas patients consider that this aspect could be improved.

health carers' rating: 4.8
patients' rating: 4.7

paediatricians' rating: 5.0
parents/relatives' rating: 4.8

Hungary - Primary care paediatricians can send blood test results, laboratory and clinical evidences to patients via e-mail explaining those values which are over or under the healthy range, enabling patients to play a more active role in medical care.



health carers' rating: n/a
patients' rating: 4.0

paediatricians' rating: 4.3
parents/relatives' rating: 4.0

Italy - From organisational point of view the information sharing process with the parents, relatives and children is an important process of care. The average is high for both healthcare workers and paediatricians regarding. The problem is related to the expectations of the patients and relatives in order to better understand the test results: in a critical situation of time management and low number of professionals, how long is a typical consultation for sharing the information about the test results? For HC and paediatrics, a few minutes while the parents and relatives at least 20-30 minutes.

health carers' rating: 4.4
patients' rating: 3.1

paediatricians' rating: 4.3
parents/relatives' rating: 3.1

Spain – The information process related to the clinical evidence is considered with a full score for clinicians. Their perspective depends on the effective evaluation of the information required by the patient to make decisions. Clinicians are in condition to select the information in order to have positive effects on the patient's autonomy. This perspective is completely different in the case of patients and relatives, where information selection can be considered a limit to their involvement in the decision-making process. The same view is shared by the health care professionals, where the rate is higher than the patients' and inferior to the clinicians', reflecting the level of information managed by each sample group.

health carers' rating: 4.5
patients' rating: 4.2

paediatricians' rating: 5.0
parents/relatives' rating: 4.1

Germany – Information about test results is rated quite similarly to information about care. Health carers are not so satisfied (3.5), whereas paediatricians, patients and parents are (4.2-4.5).

health carers: 3.5
patients' rating: 4.6

paediatricians' rating: 4.2
parents/relatives' rating: 4.5

2.2.7. Privacy

Romania – Privacy goes hand in hand with dignity and respect and it may refer to silence, possibility to carry out hygiene (the bed pan, the toilet), lack of odors. Conditions of privacy where parents can play with their children whereas families can spend some quiet moments with each other, are essential.

Privacy was perceived differently by the four categories of surveyed populations, which means that different people may have different privacy habits. Privacy scores ranged between 4.5 for the doctors through 4.6 as evaluated by patients and health care staff and 4.7 in the parents' opinion.

health carers' rating: 4.6
patients' rating: 4.6

paediatricians' rating: 4.5
parents/relatives' rating: 4.7



Hungary - All surveyed groups agree that patients almost always have privacy when discussing health related issues. In primary care there's only one patient in the office during consultation. Emergency care is characterized by a lower level of privacy. In the sample population, there were no doctors or nurses working in emergency care.

health carers' rating: 4.5
patients' rating: 4.6

paediatricians' rating: 4.6
parents/relatives' rating: 4.3

Italy – The average results of healthcare is 3.8/5.0 while the paediatricians' result is 4,1. The reason of the difference between healthcarers and paediatricians is related to the logistic structure of wards and services: we do not have a specific room aimed for privacy management. The perception of patients and relatives is different from healthcarers and the physician due to the logistical aspects of hospital environment. The privacy is strictly related to the kind of room and places in which the medical doctors talk about the care and treatment: the hospitals and territorial services of ASLTO3 have a good level of appearance but the building is very old and needs to be updated.

health carers' rating: 3.8
patients' rating: 3.6

paediatricians' rating: 4.1
parents/relatives' rating: 3.2

Spain – The average results of health care staff is 4.1/5.0 and that of paediatricians is 4.5/5.0. About this aspects health care staff perceive a lack of privacy in the unit, a difference that could be related to the role of professionals in patients' daily life. The health care staff is more in contact with all the patients and for a longer period of time, perhaps this factor is a reason for perceiving more situations where privacy is not respected. Patients and family have the same perception about privacy, and they show a similar assessment of the item confirming a uniform tendency.

health carers' rating: 4.1
patients' rating: 4.3

paediatricians' rating: 4.5
parents/relatives' rating: 4.3

Germany – Patients and parents think that they have almost always privacy when discussing health related issues (4.7 and 4.5). Questionnaires were not distributed in patients waiting in the emergency room where it is more difficult to have enough privacy. Health care staff and paediatricians also know sometimes the lack of privacy in emergency situations and therefore the rates may be lower (3.5 and 4.0)

health carers: 3.4
patients' rating: 4.7

paediatricians' rating: 4
parents/relatives' rating: 4.5

2.2.8. Written communication

Romania – The item **written communication** acquired only 4.4 scores from the patients versus the 4.5 score from the doctors, which is critical; a 4.8 score was obtained from the health care staff and from parents/relatives: 4.5. The quality of written



communication therefore ranges from 4.4 scores - patients < doctors and parents/relatives 4.5 < to 4.8 - health care staff.

health carers' rating: 4.8
patients' rating: 4.4

paediatricians' rating: 4.5
parents/relatives' rating: 4.5

Hungary - According to the current legal rules in primary care level it is not obligatory to provide written information about symptoms or problems to take care about, after the patient leaves the paediatrician's office. The paediatrician communicates the necessary information verbally. Written information is given to the patient after he/she leaves the hospital.

health carers' rating: 4.5
patients' rating: 4.2

paediatricians' rating: n/a
parents/relatives' rating: 4.2

Italy – The average results of healthcare is 3.8/5.0 while the paediatricians' result is 3.9. The reasons are related to the internal procedures of patients discharge according to the care continuity process. The problem is how to guarantee the continuity of information in the healthcare system among relatives and children, territorial paediatricians and other institutions as schools, community services, etc. The perceptions of patients and relatives confirm the need of managing the care continuity.

health carers' rating: 3.8
patients' rating: 3.0

paediatricians' rating: 3.9
parents/relatives' rating: 3.2

Spain – The results average of health care staff is 4.2/5.0 and that of paediatricians is 4.5/5.0. Paediatricians consider written information somewhat better than the healthcare staff even though the difference is not significant. The relatives' perception about this item is under 4.0/5.0 and very close to the health care staff's.

health carers' rating: 4.2
patients' rating: 4.1

paediatricians' rating: 4.5
parents/relatives' rating: 3.9

Germany – Parents do not expect more written information whereas all other groups would consider it helpful to provide and get more written information.

health carers: 3.6
patients' rating: 3.9

paediatricians' rating: 3.8
parents/relatives' rating: 4.7



2.2.9. Conclusion – Transparency needs for the surveyed countries

Transparency learning needs in Romania

Transparency	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	4.6	4.5	4.6	4.7
Other doctors' involvement	3.3	3.1	4.3	4.3
Patients' complains	4.8	4.9	4.8	4.9
Information to patients	4.8	4.5	4.8	4.8
Courtesy and respect	4.8	4.8	4.9	5.0
Information about care	4.9	5.0	4.7	4.7
Information about test results	4.8	5.0	4.7	4.8
Privacy	4.6	4.5	4.6	4.7
Written communication	4.8	4.5	4.4	4.5

Table 6. Transparency results for Romania

Transparency

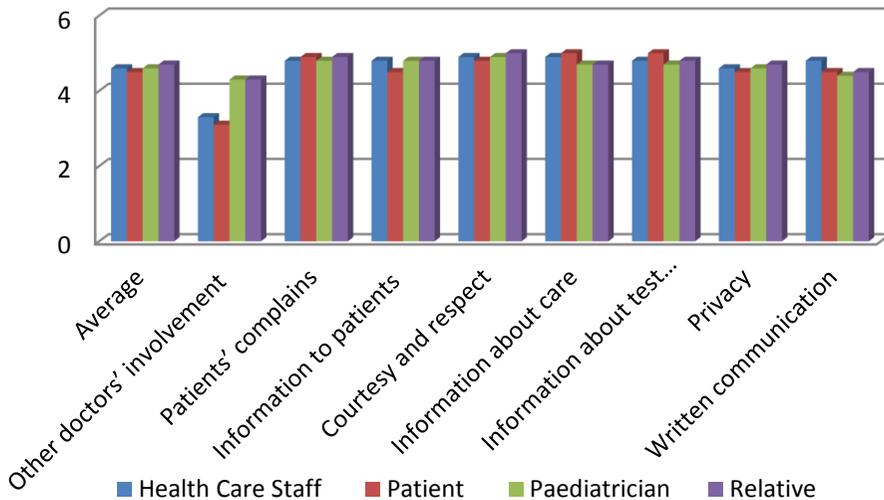


Fig.6 Transparency results for Romania



In order to optimize transparency, both health care staff and patients consider that other doctors should be involved, this aspect having the lowest score, although the paediatricians may have a little better perspective. The best scores for transparency were obtained in responding to patients' complaints as seen by all the surveyed groups, as well as courtesy and respect, information about test results and about care.

Since complaints may represent a stressful experience that is superimposed on the already deteriorated health status of hospitalized children, dealing with complaints remains in focus as a stringent necessity to be solved. Solving complaints is important for quality improvement and, sometimes it may simply require an explanation of a misunderstanding or a sincere apology.

Paediatric patients would also like to find more age-adapted information about tests, hospital rules, in an easy to remember way that may include less conventional ways such as child-customized leaflets and animations.

Courtesy and respect obtained high scores, which means that new doctors-in-training are also expected to introduce themselves fully to hospitalized patients or sit down to talk to them eye-to-eye, and **adapt their bedside manner** to the paediatric patients, as senior paediatricians do.

Privacy goes hand in hand with dignity and respect and it may refer to silence, possibility to carry out hygiene (the toilet), lack of odors. Conditions of privacy where parents can play with their children whereas families can spend some quiet moments with each other, are essential and can be further improved.

Transparency learning needs in Hungary

Transparency	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	4,2	4,2	4,2	4,1
Other doctors' involvement	3,7	4,2	2,9	3,8
Patients' complains	4,4	4,0	4,4	4,0
Information to patients	3,9	3,8	4,2	4,0
Courtesy and respect	4,5	4,7	4,6	4,3
Information about care	3,7	4,2	4,5	4,0
Information about test results	n/a	4,0	4,3	4,0
Privacy	4,5	4,6	4,6	4,3
Written communication	4,5	4,2	n/a	4,2

Table 7. Transparency results for Hungary



In **Hungary**, health care staff, paediatricians, relatives and patients gave a very similar average rating for transparency. The surveyed groups expressed the highest level of general satisfaction in this category.

The highest general average scores for transparency were obtained in *courtesy and respect* and *privacy*. Health care staff, relatives and paediatricians agree that involving other doctors would improve the quality of healthcare. From the results, it becomes evident that children would appreciate more age-adapted explanations about their conditions, cause of their illness and possible treatment methods. Providing children with easily understandable information fosters cooperation and makes younger patients more trusting in doctors and healthcare staff, as well.

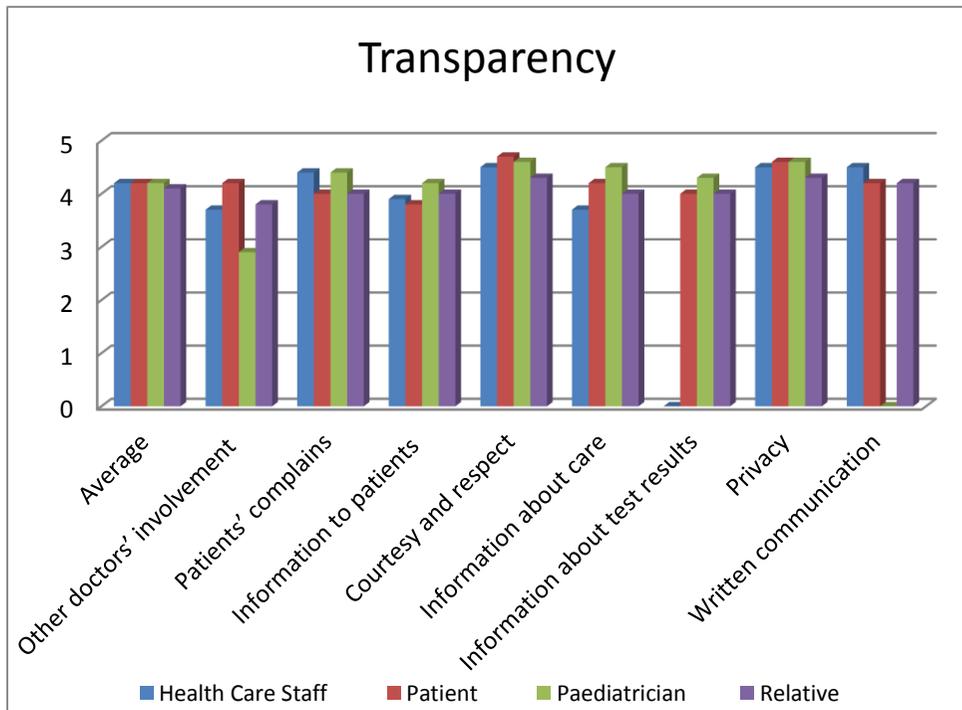


Fig.7 Transparency results for Hungary

Transparency learning needs in Italy

Transparency results in **Italy** show that patients' and relatives' perception is lower than healthcare workers' and paediatricians' perception. This is related to the responsibility of the health care project as a health team, which cannot always be guaranteed due to an organisational problem: speech therapist, psychologist, paediatricians working for territory services they do not belong to Neuropsychiatric Service and Paediatric Units. The lowest score for transparency is 3, in *written communication*: this perception confirms the care continuity management problem. Continuity of information must be



guaranteed among healthcare system parts, relatives and children, territorial paediatricians and other institutions as schools, community services, etc.

Information to patients and *information about care* both got high scores in the healthcarers and paediatrician questionnaire. From organisational point of view, sharing information with parents, relatives and children is an important process of care. The project of care and the taking charge of case are specific points of internal mission of ASL TO3. The perception of relatives and patients is lower than that of the other two categories caused by the kind of information viewed by them: they want a useful and effective information for managing the daily activities and lifestyle, and doctors must be aware of this expectation.

Transparency	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	4,1	3,3	4,1	3,3
Other doctors' involvement	3,9	3,1	3,7	3,3
Patients' complains	3,9	3,1	4	3,2
Information to patients	4,1	3,5	4,2	3,3
Courtesy and respect	4,5	3,5	4,5	3,4
Information about care	4,5	3,5	4,3	3,2
Information about test results	3,4	3,1	4,3	3,1
Privacy	3,8	3,6	4,1	3,2
Written communication	3,8	3	3,9	3,2

Table 8. Transparency results in Italy

The perception of patients and relatives about listening to *patient's complaints* is lower than the healthcarers' and paediatricians', probably because their answers are different from the information that relatives and patients expect.

While being in charge of a case, it is important to guarantee courtesy and respect for relatives and children as well as colleagues (healthcarers and medical doctors). The duration of medical examination determines the patients' perception of *courtesy and respect*. This aspect needs to be studied in order to find a way of improving doctors' and healthcarers' skills that could help them answer the questions appropriately in a short time.

Also the logistical aspects of hospital environment are important in transparency: *privacy* is strictly related to the kind of room and places in which the medical doctors



talk about care and treatment, buildings of ASL TO3 being very old and relatives seem to have noticed that, so they need to be updated.

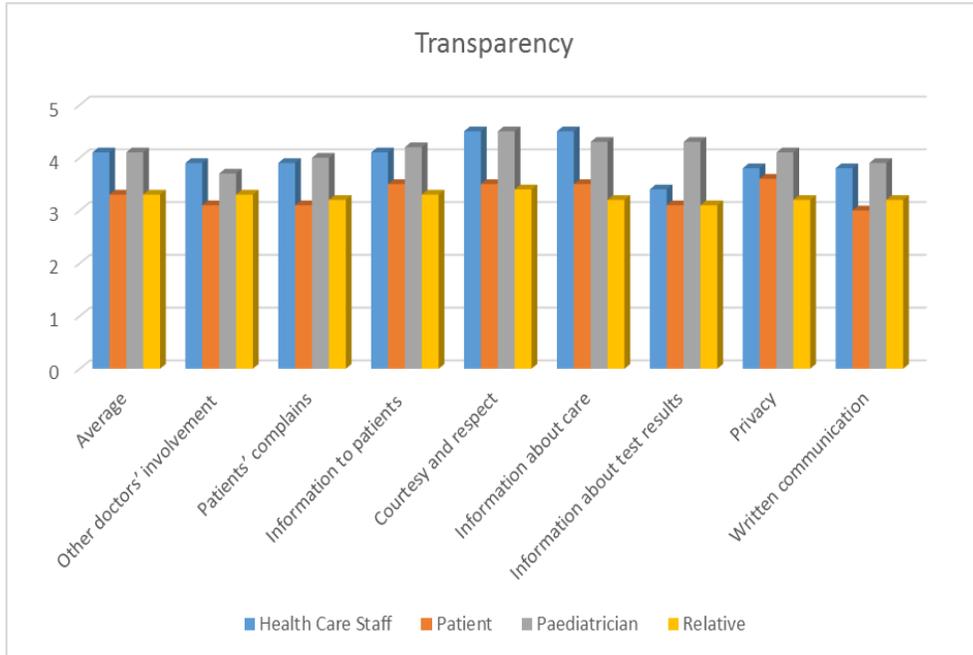


Fig.8 Transparency results for Italy

Transparency learning needs in Spain

In Spain, the global assessment of the information process is positive and always over the 4.0. These good results are corresponding with the legal, ethical and deontological values of the informed consent which exists in Spanish health care services since the early 90s. Clinicians' perception related to this item are always slightly better than for other sample groups.

The only aspect surprising is the sharing of information among clinicians of different specialties. Communication between professionals is an aspect requiring improvement, the soft skills of clinicians must be oriented to improve the communication inside the health care team.

Transparency	Health Care Staff Questionnaire	Patient Questionnaire	Pediatricians Questionnaire	Relative Questionnaire
Average	4,2	4,1	4,5	4,1
Other doctors' involvement	3,7	3,5	3,1	3,6
Patients'	4,3	4,0	4,9	4,0



complaints				
Information to patients	4,2	4,0	4,5	4,2
Courtesy and respect	4,6	4,5	4,8	4,5
Information about care	4,4	4,3	5,0	4,1
Information about test results	4,5	4,2	5,0	4,1
Privacy	4,1	4,3	4,5	4,3
Written communication	4,2	4,1	4,5	3,9

Table 9. Transparency results for Spain

All the other aspects related to the information processes show a high degree of satisfaction in all the sample groups, an inferior result being in the parents' perceptions regarding written communication. In this sense the need for a more person-centered informed consent is expressed by these data, the improvement of the informed consent contents and the increment of written information being considered by relatives a source of satisfaction.

In conclusion this dimension is repeating the first result allowed for communication, even though perceptions related to transparency are very positive, there is a difference between the evaluation of clinicians and other actors involved in the paediatric scenario. The need to re-think the care team in paediatrics comes through the involvement of other clinical areas and specialists involved in the care team and is extended to all health care staff and users.

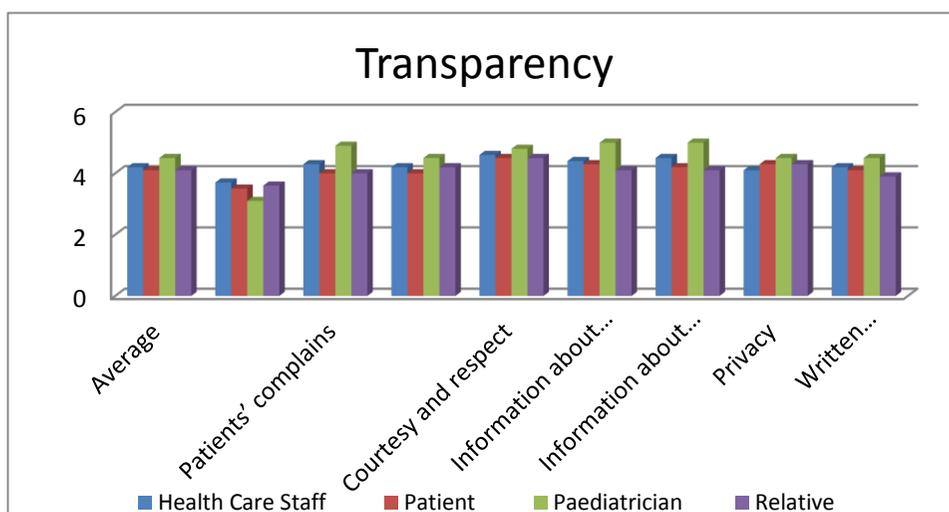


Fig.9 Transparency results for Spain



Transparency learning needs in Germany

In Germany, patients, parents and paediatricians gave a very similar and very good average rating for transparency (4.2-4.6). It is surprising, that the rating of health carers is much worse (3.6) and differs in almost all aspects. One explanation could be that most nurses participating on the survey are working on the ward whereas patients were mostly asked in a kind of outpatient setting where the medical team has more time for providing information for patients and parents, interdisciplinary case conferences. There may also be a lack of privacy on the ward for patients sharing the room with other patients.

Transparency	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3,6	4,5	4,2	4,6
Other doctors' involvement	3,7	4,4	4,2	4,2
Patients' complains	3,6	4,7	4,4	4,4
Information to patients	3,3	4,5	4,4	4,9
Courtesy and respect	3,9	4,9	4,7	4,6
Information about care	3,9	4,5	4,4	4,8
Information about test results	3,5	4,6	4,2	4,5
Privacy	3,4	4,7	4,0	4,5
Written communication	3,6	3,9	3,8	4,7

Table 10. Transparency results for Germany

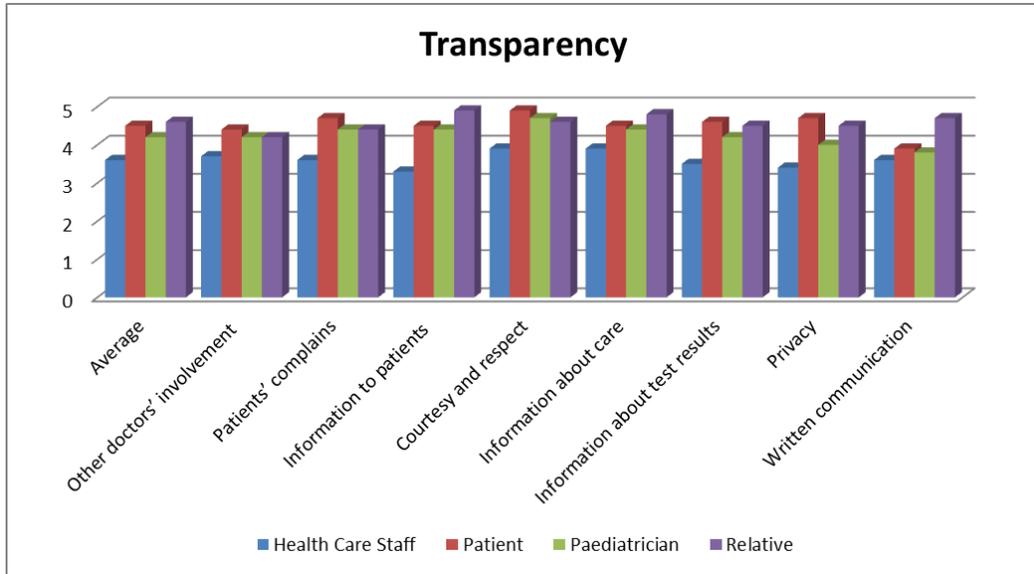


Fig. 10. Transparency results for Germany



HOSPITAL ENVIRONMENT (HE)

The hospital environment and conveniences should help children have a positive hospital experience - an extension of their home, by reducing their fears and increase the feelings of safety and well-being.

Inadequate hospital environment can cause a low quality of medical service in paediatric units, this aspect being crucial for the welfare of the children and their families in hospital.

British studies⁵⁶ explored the patients' perspective on hospital environment using qualitative and quantitative methodologies, finding some personal needs of patients: personal space, homely welcoming atmosphere, supportive environment, good physical design, access to external areas and provision of facilities for recreation and leisure. Responses suggest that patient attitudes and perceptions for the environment of hospital facilities relates to whether the hospital provides a welcoming homely space for themselves and their visitors that promotes health and wellbeing. Patients perceived sustainable health-care environments to be supportive of their health and recovery. Improving hospital appearance and convenience will certainly increase the perception of medical services' quality.

The next section shows the results of a survey of the hospital environment among paediatricians, health care staff, patients and patients' parents in Romania, Hungary, Italy, Spain and Germany, in terms of hospital appearance and convenience.

2.3.1 Hospital appearance

Romania – Hospital appearance shows certain problems linked with aspect and facilities that are offered, considering the fact that this is a public hospital. Patients assessed hospital appearance by 3.9, health care staff 3.7, parents/relatives 3.6 and doctors offered the lowest score: 3.3, their expectations being the highest as far as the hospital appearance is concerned.

The health care staff average for Hospital environment was identical with the children's evaluation: i.e. 3.7, whereas parents/relatives' score was somewhere in between: 3.6, higher than the doctors' but lower than their children's.

health carers' rating: 3.7
patients' rating: 3.9

paediatricians' rating: 3.3
parents/relatives' rating: 3.6

Hungary – The average rating for hospital appearance for nurses is "very satisfied", while parents, patients and doctors are "satisfied" with the hospital's appearance. Although there are no surgical instruments needed in the primary care office, doctors can be dissatisfied with poor lighting, slow internet connection and outworn furniture. Primary care practices are financed by local governments. In most of the cases, the money available for the practice is not enough to carry out necessary renovations.

⁵ Douglas CH, Douglas MR. Health Expect. *Patient-centred improvements in health-care built environments: perspectives and design indicators*, 2005 Sep; 8(3):264-76.

⁶ Douglas CH, Douglas MR. Health Expect., *Patient-friendly hospital environments: exploring the patients' perspective*, 2004 Mar; 7(1):61-73



health carers' evaluation: 3.9
patients' rating: 3.0

paediatricians' rating: 3.2
parents/relatives' rating: 3.3

Italy – The results average of healthcarers' is 2.4 while the paediatricians' result is 2.7, both being lower than the patients' and parents' scores. These results show that health care and medical staff need hospital appearance improvement, probably because they feel responsible for the children's stay. The hospitals of Rivoli and Pinerolo are old as a previous model of healthcare organisation. As territorial public organisation, the paediatric services are located throughout the local area. The main problem is related to the impact of territory, which is very widespread and information exchange procedures are difficult.

As a public institution, in ASL TO3 fundings are often allocated towards the quality of medical services rather than the facilities; however, health care and medical staff know that facilities are fundamental to increase the quality of medical services.

health carers' rating: 2.4
patients' rating: 3.6

paediatricians' rating: 2.7
parents/relatives' rating: 3.6

Spain – The results average of health care staff is 3.3/5.0 and that of paediatricians' is 3.3/5.0. Perception of both groups is the same and rate average is extremely poor compared to other items explored by the survey. Perceptions of patients and relatives are much better than health care professionals'.

health carers' rating: 3.3
patients' rating: 3.7

paediatricians' rating: 3.3
parents/relatives' rating: 3.6

Germany – Compared to other items explored by the survey, the rating for *hospital appearance* is low and there is room for improvement. The university children's hospital in Munich is located in the city centre of Munich with an excellent transport connection but parts of the building require renovation.

health carers: 3.1
patients' rating: 3.8

paediatricians' rating: 3.5
parents/relatives' rating: 3.9

2.3.2 Hospital convenience

Romania - Hospital conveniences may include a wide range of facilities that are offered, such as free wi-fi, laundry, traveling-on-wheels store, games: Medbuddies (= a program that pairs a volunteer medical or nursing student with an inpatient⁷), activity centers (= procedure-free zones, where celebrations, arts, crafts, music, games that are matched to the child's developmental needs), bedside music⁸, etc.

It is significant that patients evaluated hospital convenience by 3.6, higher than the doctor's, the latter's score being the lowest, i.e. 3.2, which underlines the paediatricians' dissatisfaction with the hospital conveniences and their desire for improvement. Health care staff and parents/relatives offered a similar score, i.e. 3.6.

⁷ <http://www.mottchildren.org/mott-patient-visitor-guide/amenities>

⁸ <http://www.mottchildren.org/mott-patient-visitor-guide/art-cart>



The children's general average for hospital environment was 3.8, the lowest of all the items under survey, which is explained through the type of hospital, a public institution which is subfinanced, where the quality of medical services is stressed rather than the facilities, the latter needing further future optimization.

The doctor's general average score for the item Hospital environment was even lower, i.e. 3.3, paediatricians being dissatisfied with the children's hospital conditions that have to be optimized as it is them who feel responsible for the children's stay, an aspect which they think that needs to be somehow compensated through attitude, approach, personal skills.

health carers' rating: 3.6
patients' rating: 3.6

paediatricians' rating: 3.2
parents/relatives' rating: 3.6

Hungary - Nurses and patients rated the hospital's convenience (location, parking, hours, office layout) above average, stating they are "very satisfied". Doctors and patients are "satisfied" but still the rating falls below average. The low rating may be attributed to the lack of private parking spots of PCP offices. It's especially difficult to find a parking location in the 13th district where the interviewed healthcare professionals work.

health carers: 3.6
patients' rating: 3.8

paediatricians' rating: 2.9
parents/relatives' rating: 3.4

Italy – The results average of healthcarers is 3.1 while the paediatricians' result is 2.9. Their results are lower than patients' and parents' scores, just like in the *Hospital appearance* item. In particular, paediatricians' average score is the lowest. The perception of patients and relatives is different from the other two categories because, maybe, they do not know which are exactly the standards of environment quality in hospital and territorial services.

health carers: 3.1
patients' rating: 3.4

paediatricians' rating: 2.9
parents/relatives' rating: 3.6

Spain – The results average of health care staff is 3.1/5.0 and that of paediatricians is 3.2/5.0. The difference between the groups is not significant and the rate average is low compared to other items. Patients and relative show a little increase of the rate, even though it is not significant compared to the general perception.

health carers' rating: 3.1
patients' rating: 3.4

paediatricians' rating: 3.2
parents/relatives' rating: 3.4

Germany – As mentioned above, the university hospital is an old building, and especially rooms for patients require renovation. Therefore, it is not surprising that the overall ranking for hospital convenience is low.

health carers: 2.7
patients' rating: 2.5

paediatricians' rating: 2.6
parents/relatives' rating: 3.1



2.3.3 Conclusion – Hospital Environment needs for each country

Hospital Environment learning needs in Romania

Hospital Environment	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3.7	3.8	3.3	3.6
Hospital's appearance	3.7	3.9	3.3	3.6
Hospital's convenience	3.6	3.6	3.2	3.6

Table 11. Hospital environment results for Romania

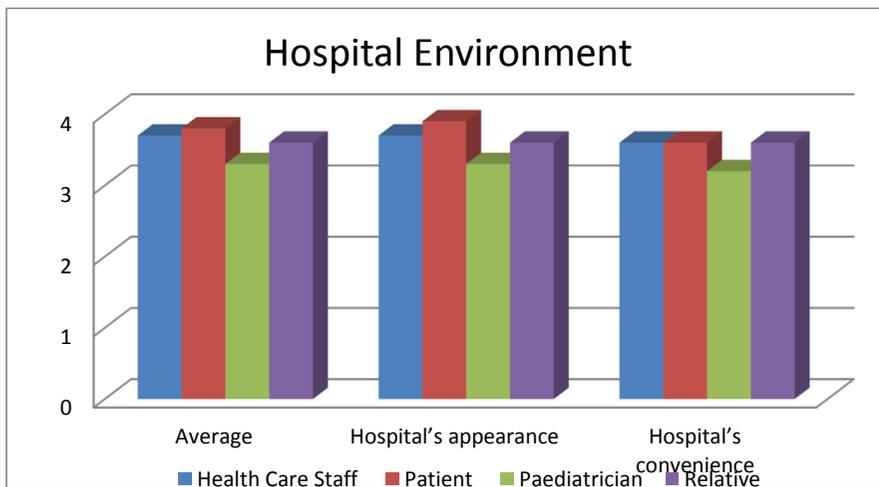


Fig.11. Hospital environment results for Romania

In **Romania**, paediatricians have the highest expectations with reference to the hospital appearance and conveniences they offer to patients and consider that these should be improved. Hospital conveniences in the literature includes among others free laundry, games, volunteering services, free wi-fi, play-zones (music, painting, crafts for the children), etc. If certain aspects cannot be changed easily in a public hospital



conveniences, attitude, skills and involvement can compensate for the lack of certain modern facilities.

Hospital Environment learning needs in Hungary

Hospital Environment	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3.8	3.4	3.0	3.4
Hospital's appearance	3.9	3.0	3.2	3.3
Hospital's convenience	3.6	3.8	2.9	3.4

Table 12. Hospital environment results for Hungary

In **Hungary**, the lowest rated category was hospital environment. In total, paediatricians were the less satisfied group with hospital appearance and conveniences. Many patients expressed their disappointment towards the hospital appearance while paediatricians had the highest expectations regarding the hospital conveniences.

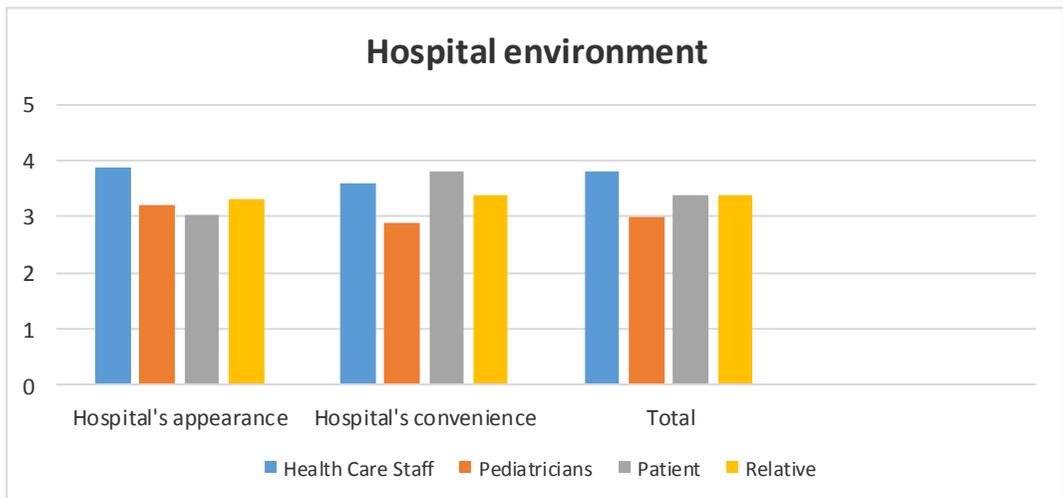


Fig. 12 Hospital environment results for Hungary

Hospital environment is an area where there are considerable unmet needs in every Hungarian region. Doctors are the most dissatisfied with the convenience of the hospital or in our case, the paediatrician's office. One of the main problems in the 13th district is parking. Parking at many medical office buildings and hospitals is genuinely an obstacle to obtaining care here. These issues are among the most common consumer concerns about hospitals in other countries as well.



Hospital Environment learning needs in Italy

Italian needs about Hospital environment are related to the large extension of territory and the difficulty to guarantee adequate information about exchange procedures. Both healthcarers and patients wish the *hospital's appearance* to be optimized.

The lowest average score is for healthcarers', who would like a better hospital environment so that they can work in a suitable way.

Hospital Environment	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	2,6	3	3.3	3.6
Hospital's appearance	2,7	2,9	3.3	3.6
Hospital's convenience	2,4	3,1	3.2	3.6

Table 13. Hospital environment for Italy

The perception of healthcarers and paediatricians about *hospital convenience* is different because, as medical professionals, they do know which are exactly the environment quality standards in hospital and territorial services.

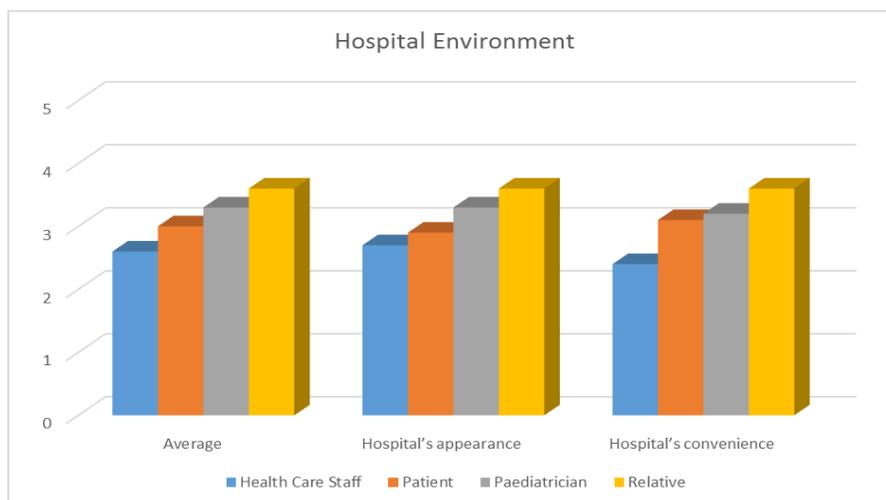


Fig.13 Hospital environment results for Italy

Hospital Environment learning needs in Spain

Health care facilities are not the best aspect of our survey. Criticism related to the infrastructure and organization of health care system in paediatrics is shared by all the



sample groups and is one of the worst evaluation of the entire survey. A special approach for paediatrics is required by all the actors involved in the health care scenario.

Hospital Environment	Health Care Staff Questionnaire	Patients Questionnaire	Pediatricians Questionnaire	Relatives Questionnaire
Average	3,2	3,6	3,3	3,5
Hospital's appearance	3,3	3,7	3,3	3,6
Hospital's convenience	3,1	3,4	3,2	3,4

Table 14. Hospital environment results for Spain

Users show more satisfaction for the *hospital appearance* than providers. This data shows that some efforts have been done in Spain to improve patients' environment, even if more must be done, especially from the perspective of health care professionals. Perception related to the convenience of the services are slightly worse than those related to the appearance of services.

In conclusion, the organization of space can be another aspect to improve, by creating appropriate areas responding to the patients and relatives' need, therapeutic results are also likely to improve. Mapping patients' needs and personalizing responses in terms of space and time is another skill required by the health care staff working in paediatrics.

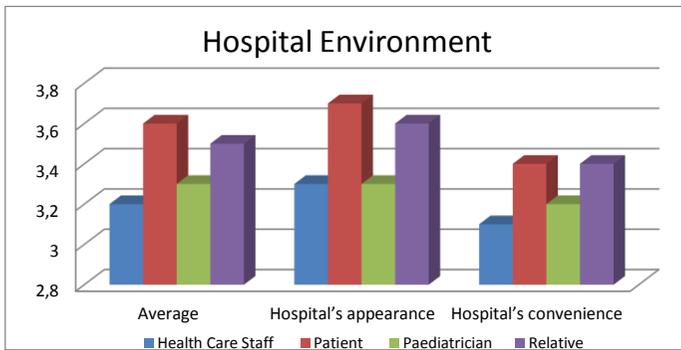


Fig.14 Hospital environment results in Spain



Hospital Environment learning needs in Germany

The hospital appearance and convenience could be optimized. This result does not surprise – the hospital was founded by 1846 and some parts of the first building are still in use. Especially patients' rooms need renovation and are not in compliance with parents' and patients' expectations.

Hospital Environment	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	2,9	3,2	3,1	3,5
Hospital's appearance	3,1	3,8	3,5	3,9
Hospital's convenience	2,7	2,5	2,6	3,1

Table 15 Hospital environment results in Germany

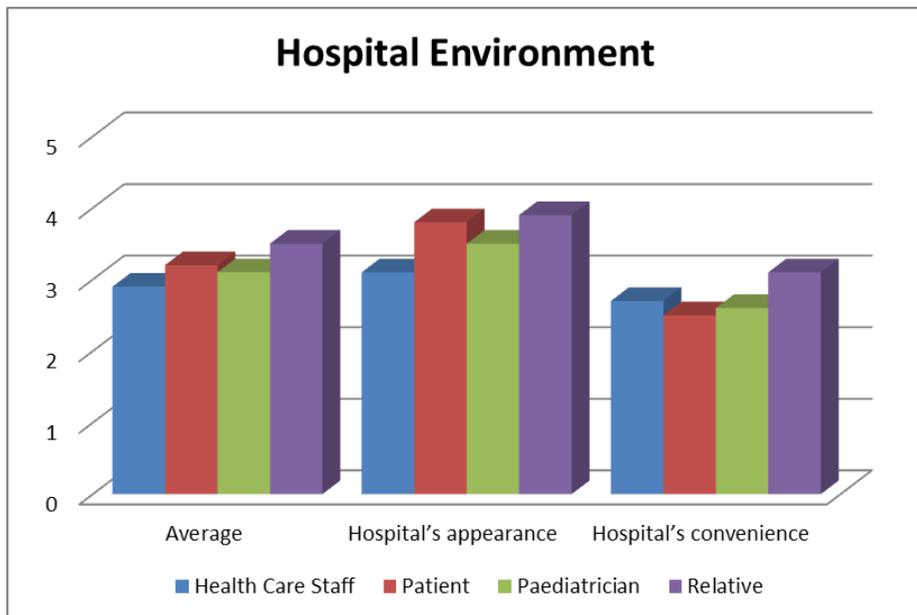


Fig. 15. Hospital environment results in Germany



2.4 INTERCULTURAL ISSUES (II)

Pediatric units, like other institutions, are places where patients from diverse cultural backgrounds interact with one another. Awareness of cultural differences, sensitiveness to intercultural communication and the need to surpass intercultural communication barriers, are essential in pediatric health care. Decision-making processes in paediatrics are complex and should consider several aspects of care not strictly linked with clinical facts.

Taking into account clinical evidences and patient's circumstances is a fundamental aspect of care, but at the same time, assigning to the cultural background and related value system a precise role, is extremely important in order to avoid conflict between patients and providers. Religion, culture, socio-economic circumstances, can represent an obstacle to understand and share the therapeutic strategy and make significant decisions.

Detecting cultural values and managing conflict consequent to the cultural diversity is one of the most significant aspects of the communication in paediatrics, especially for the vulnerability of patients and relatives facing illness circumstances. One of the risks of Western health care system is the application of a unique standard in matter of legal, ethical and deontological aspects characterizing the normative framework regulating doctor-patient relationship. Democratic and plural societies are constituted by pluralities of values systems, in which differences have a big impact in health care. For that reason, to develop soft skills adequate to the challenges of modern, multi-ethnic societies, is a very important concern.

2.4.1 Behaviour towards patients (treatment)

Romania – Romanian average about cultural issues is extremely positive, all groups sharing a positive perception about this item, and an interesting aspect is the lack of differences between providers and users, all the score are very close to the maximum rate.

health carers' rating: 4.9
patients' rating: 4.9

paediatricians' rating: 5.0
parents/relatives' rating: 4.9

Hungary – The Hungarian average related to this item identifies a consistent difference between users and providers, especially among physicians. This aspect points out a clear discomfort among pediatricians in order to assume responsibility about the treatment without a satisfactory communication with the patient due to the cross cultural differences. Users show a higher satisfaction in relation to this aspect, even if their perception is not completely satisfactory.

health carers' rating: 3.6
patients' rating: 4.2

paediatricians' rating: 2.7
parents/relatives' rating: 4.2

Italy – The results average of healthcare is 2,7/5.0 while the paediatricians result is 1,9'. The service mission is to care for the children and their parents and relatives and to manage and safeguard the children's health. The healthcarers as well as the paediatricians are involved in the care process but they would like to "do all things". The number of healthcarers and paediatricians is very low as a consequence of the impact



of the economic crisis in Italy: no new workers have been hired by the management of ASLT03 because of “Piano di Rientro” of the Health Ministry.

health carers’ rating: 2.7
patients’ rating: 3.9

paediatricians’ rating: 1.9
parents/relatives’ rating: 3.4

Spain – The results average of health care staff is 3.5/5.0 and that of paediatricians is 5.0/5.0. The difference between the groups is consistent; physicians have a better perception about their behavior toward patients, showing a completely good attitude. The health care staff do not agree with this perception. With reference to the treatment, the perceptions of patients and relatives are different than those of the health care professionals but this difference is not significant; it is interesting to observe the frequent accord between health care staff and relatives.

health carers’ rating: 3.5
patients’ rating: 4.0

paediatricians’ rating: 5.0
parents/relatives’ rating: 3.9

Germany – In Germany all groups share a positive perception about this item. Paediatricians think that they act in a perfectly professional manner towards their patients (5.0).

health carers: 4.5
patients’ rating: 4.9

paediatricians’ rating: 4.6
parents/relatives’ rating: 4.8

2.4.2 Behaviour towards patients (action)

Romania – About this item we have a confirmation of the previous result, a common perception about the role of cultural issues, a very high score, slightly different than previous, related to the treatment. This difference is not significant compared to the global assessment of Romanian data.

health carers’ rating: 4.8
patients’ rating: 4.9

paediatricians’ rating: 4.8
parents/relatives’ rating: 4.8

Hungary – The general evaluation about strategies focused to manage intercultural issues are positive: the decision-making related to the therapeutic approach highlights a better involvement of health care professionals to consider cultural background and patients’ wishes as relevant. Among doctors, patients and relatives data are homogeneous, a significant difference characterizes the perception of health care staff, with almost a point of difference.

health carers’ rating: 3.8
patients’ rating: 4.5

paediatricians’ rating: 4.6
parents/relatives’ rating: 4.4

Italy – The results average of health carer is 3.7/5.0 while the paediatricians’ result is 3.6. The perception of the patients and relatives is lower than of the other two categories, a fact caused by the duration of medical examination and kind of information: few minutes are not enough to answer the questions of parents and patients.



health carers' rating: 3.7
patients' rating: 3.1

paediatricians' rating: 3.6
parents/relatives' rating: 2.9

Spain – The results average of health care staff is 4.1/5.0 and that of paediatricians is 4.8/5.0. The perception of both groups is similar and very positive, paediatricians having a stronger awareness about their good relationship with patients. Patients' and relatives' perception is consistently different between users and providers, perhaps health care professionals are not aware about the role of culture and traditions in communication. This aspect is really important in order to elaborate new tools to detect the lack of satisfaction related to the cultural issues.

health carers' rating: 4.1
patients' rating: 1.8

paediatricians' rating: 4.8
parents/relatives' rating: 1.9

Germany – The results average of health carer is 4.3 while the paediatricians' is 4.9. The perception of patients and parents is similar.

health carers: 4.3
patients' rating: 4.8

paediatricians' rating: 4.9
parents/relatives' rating: 4.7

2.4.3 Conclusion – I₁ needs for the surveyed countries

Intercultural issues learning needs in Romania

Intercultural Issues	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	4.9	4.9	4.9	4.8
Behavior towards patients (action)	4.9	4.9	5.0	4.7
Behavior towards patients (treatment)	4.8	4.9	4.8	4.9

Table 15. Intercultural issues - results for Romania

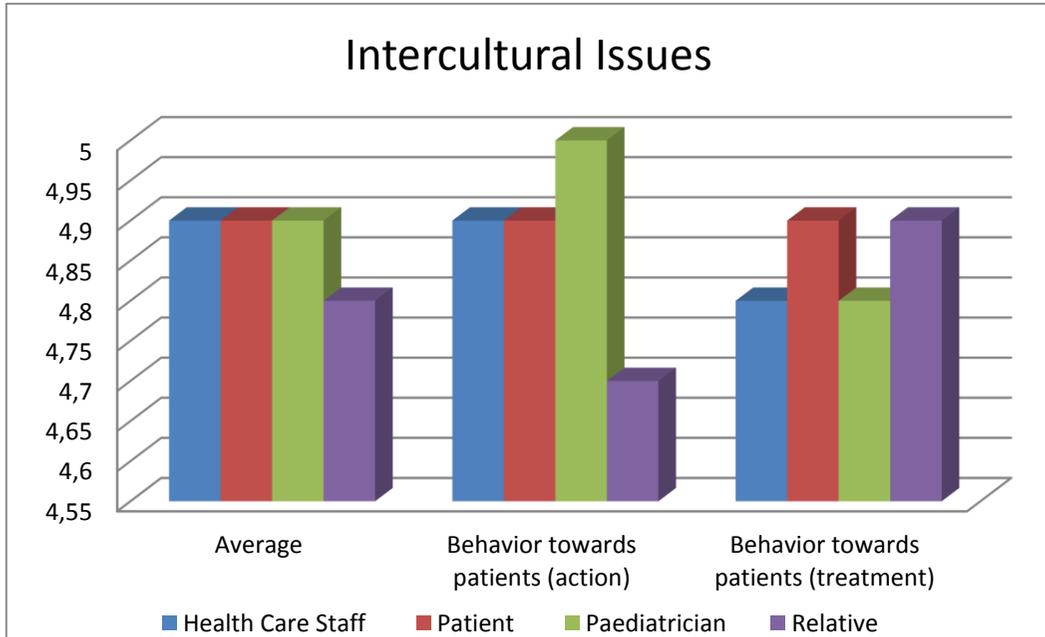


Fig. 16 Intercultural issues - results for Romania

In **Romania**, the surveyed populations, i.e. doctors and health care staff need to meet basically the health needs of Romanian patients, which requires them to understand patients from these backgrounds: their communication styles, health practices, their expectations from the health system, family involvement in treatment, attitudes towards pain and the opposite gender.

Intercultural issues do not seem to represent a problem in Romania, reasons for this results can be linked to the good training of health care professionals, or to the low rate of patients with different cultural backgrounds in the Romanian health care services. The uniformity of the cultural background is a facilitator for the good communication and the harmonized decision making processes.

However, with reference to behavior towards patient (action) parents do perceive a certain barrier that can be improved through intercultural communication strategies. Similarly, in terms of treatment, the pediatricians and health care staff consider this aspect could be improved whether this may mean understanding/acceptance of “different” behavior and beliefs, language (complexity, jargon) which are likely to be misunderstood.

For this, an awareness raising course in intercultural communication could be designed, including different communication styles, health practices, and culture-determined expectations from the health system, family involvement in treatment, attitudes towards pain and the opposite gender.



Intercultural issues learning needs in Hungary

Intercultural Issues	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3,1	4,4	4,0	4,3
Behavior towards patients (action)	2,4	4,5	3,3	4,4
Behavior towards patients (treatment)	3,8	4,2	4,6	4,2

Table 17. Intercultural issues – needs for Hungary

Hungarian physicians and health care staff maintain equally good communication with both Hungarian and Roma patients. Similar to Romania, due to the longstanding experience in dealing with patients of other cultures, major misunderstandings and conflictive situations are rare.

The lowest average rating in intercultural communication was given by the health care staff while patients and relatives seem to be the most satisfied with this aspect. Paediatricians and health care staff rated their behaviour (action) significantly lower than patients and relatives. One possible reason why doctors and health care could feel acting more impersonal and business-like towards patients is that they might want to clarify the roles in the patient-healthcare professional communication in order to maintain a better medication and lifestyle adherence. Suboptimal adherence to medication and lifestyle modification can contribute to development of long-term complications. If patient adherence to diet, physical activity, self-monitoring and especially to drug purchasing and drug taking do not reach the expected levels, doctors hoping for better compliance might feel more in control when acting business-like but friendly towards patients and their relatives.

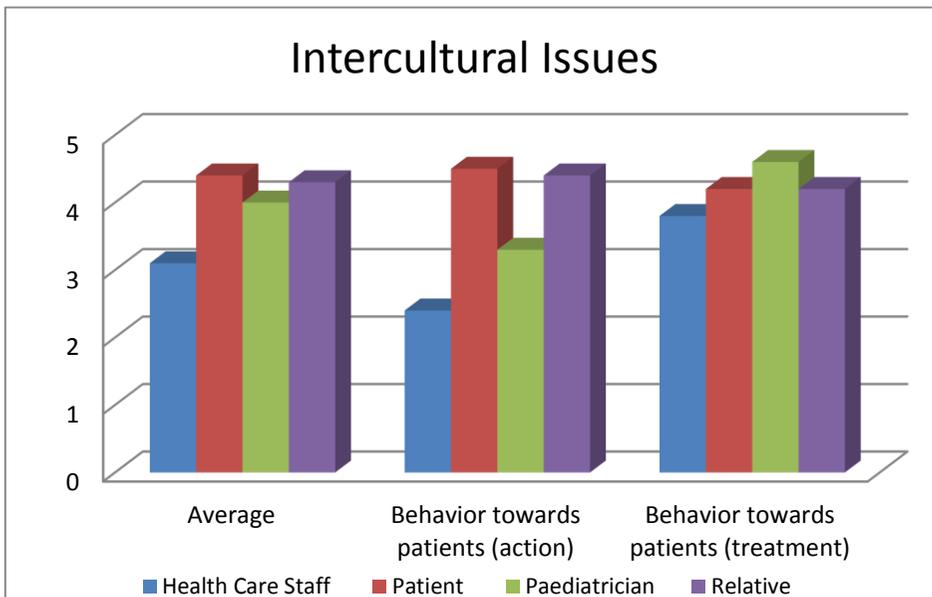


Fig. 17 Intercultural issues - results for Hungary

Intercultural issues learning needs in Italy

In **Italy**, highest average score on Intercultural issues was given by paediatricians (4,9). The lowest score was given by patients on *behaviour towards patient (action)*. The duration of medical examination and the kind of information given are aspects that influence patient's and relative's perception on intercultural issues: for instance, a few minutes are not enough to answer many questions of parents and patients.

Intercultural Issues	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3,2	2,8	4.9	3,2
Behavior towards patients (action)	2,7	1,9	5.0	2,9
Behavior towards patients (treatment)	3,7	3,6	4.8	3,4

Table 18. Intercultural issues – results for Italy



The number of healthcare workers and paediatricians is getting lower and lower and this is affecting the patients', relatives' and healthcare workers' perception on *behaviour towards patient (action)* too. Paediatricians' perception on *behaviour towards patient* is definitely higher: this means that professional skills actively contribute to good practice and intercultural issues.

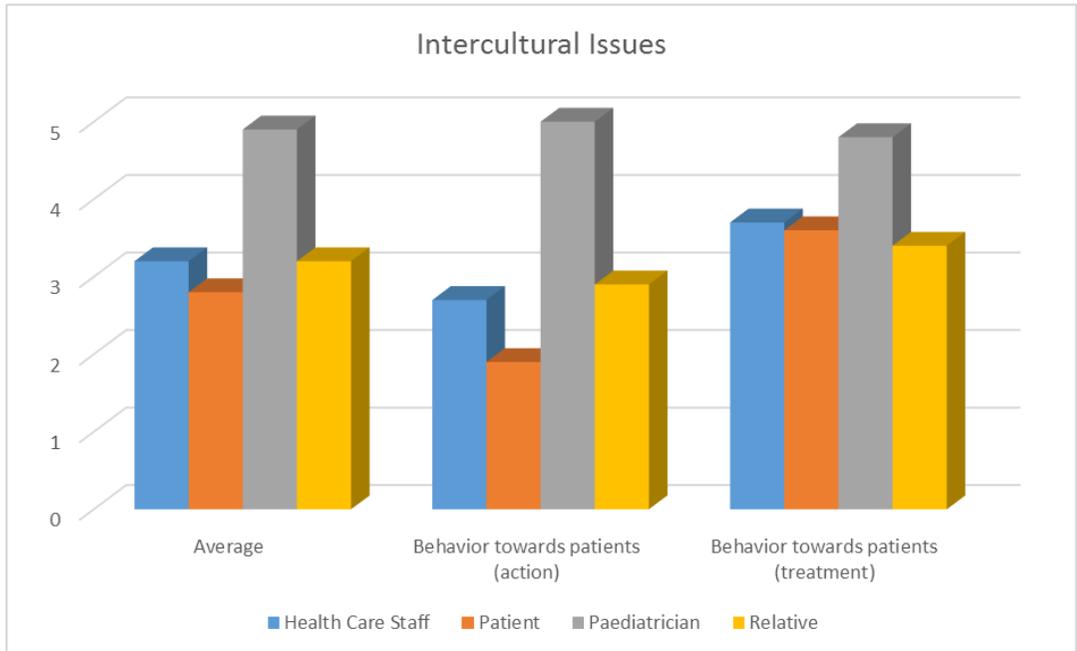


Fig. 18 Intercultural issues - results for Italy

Intercultural issues learning needs in Spain

Cultural background differences are frequently responsible of communication issues and ethical issues between users and providers. Differences of values are essential in order to understand the score obtained by these dimensions of the survey. Behavioural strategies linked to the patient treatments are considered very positively, in fact these data are confirmed by the positive results showed on transparency and information processes, quality of life and other aspects connected with the quality of the doctor-patient relationship.

A great difference is underpinned by data related to the actions, and the way to communicate with the patient with a difference of culture and values. The lack of satisfaction among users is heavily showed by the rate of this item, one of the worst of the survey, 1.8 for patients and 1.9 for parents. Among providers, perceptions are different, even if not so diversified, health care professionals seem to be aware about the deficit of this aspect and the need to improve professional skills and attitude to



manage intercultural issues and integrate different value systems in the decision making processes.

Intercultural Issues	Health Care Staff Questionnaire	Patient Questionnaire	Pediatricians Questionnaire	Relative Questionnaire
Average	3,8	2,9	4,9	2,9
Behavior towards patients (action)	3,5	1,8	5,0	1,9
Behavior towards patients (treatment)	4,1	4,0	4,8	3,9

Table 19. Intercultural issues – results for Spain

In conclusion, intercultural issues are an urgent need for pediatric health care services in Spain, the users' perception being radically different from that of clinicians. This asymmetry can be solved integrating the role of nurses in the communication with patients and relatives. Soft skills focused on the team building and sharing of knowledge are required to approach intercultural issues in paediatrics. Sharing of information between health care professionals, relatives and patients is a need for developing the right attitude to approach intercultural issues.

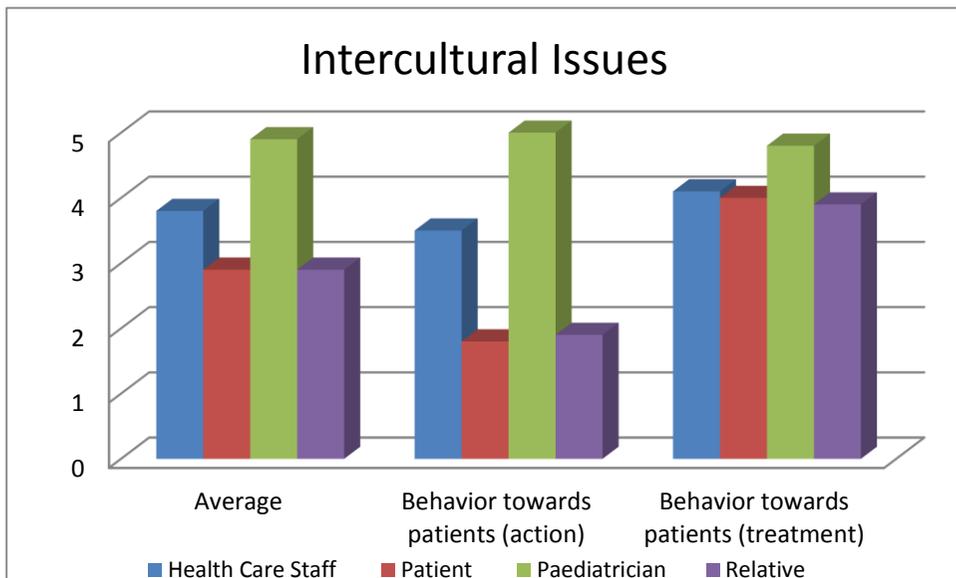


Fig. 19 Intercultural issues - results for Spain



Intercultural issues learning needs in Germany

In **Germany**, the results of all groups participating to the survey show are homogenously good. This reflects a friendly and respectful environment in all parts of the hospital.

Intercultural Issues	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	4,4	4,8	4,8	4,8
Behaviour towards patients (action)	4,3	4,8	4,5	4,7
Behaviour towards patients (treatment)	4,5	4,9	4,6	4,8

Table 20: Intercultural issues – results in Germany

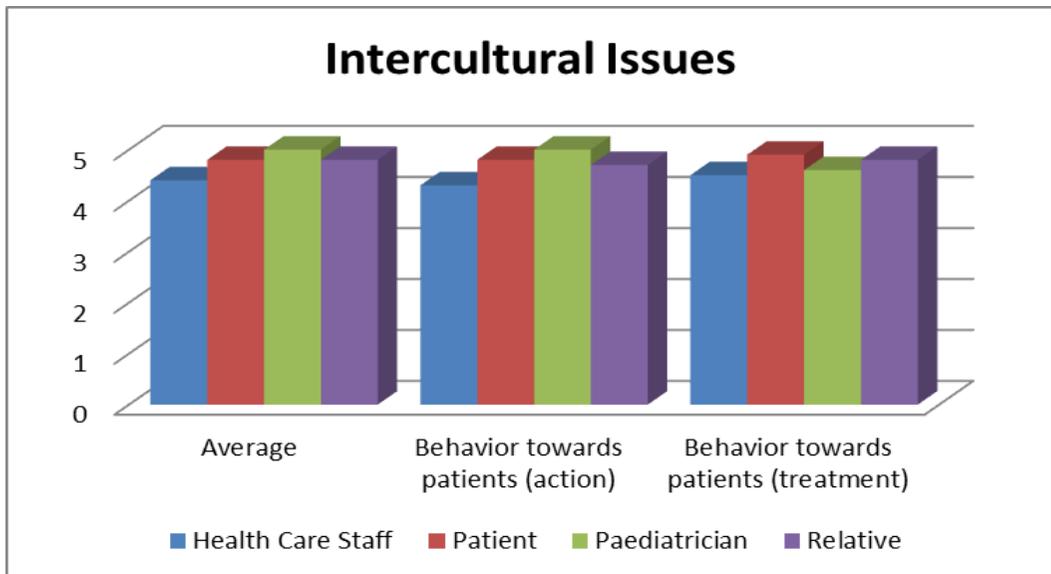


Fig. 20 Intercultural issues – results in Germany

2.4.4. Intercultural issues – General Conclusions

Data show an accord between the perceptions of South Europe and Eastern Europe in order to approach cultural issues in paediatrics. These differences can be



explained from several perspectives: the organization of health care services, the diversity of cultural background of the patients' population, the training programs available for health care professionals and the legislation regulating information processes in health care services.

In all the circumstances, data show a great demand of new skills to improve communication with patients with different cultural background, especially with those countries where the multi-ethnic society is a reality structured by political and legal framework such as EU countries, where health care professionals have specific responsibilities toward patients and relatives. Strategies to improve the management of intercultural issues can vary according to the countries or health care system diversity, but in all surveyed countries there is a common tendency in relation to the communication between health care staff and physicians.

Soft skills for pediatricians must improve the team work and communication between clinicians and non-clinical professionals, and from this perspective there is a clear interest for the health care staff to be involved in the doctor-patient relationship, not with respect to responsibilities, but to the sharing of knowledge to improve the answers to the patients' needs. This communication process among health care professionals should take into account relatives, an allied for health care professionals.

Data show that in terms of action and treatment, the management of cultural issues passes through the family assessment plan of care. This aspect is not just related to the health care professionals' training, because culture requires legal tools, ethical values and new professional attitudes, but professional education is of course the point of start to sensitize professional organizations and share a culture of respect for the cultural diversity and the plurality of ethical codes.



2.5 TIME MANAGEMENT (TM)

Time management is one of the most, if not the most important problem in primary care offices and paediatric units. The most common reasons why appointments run late in paediatric practices are unexpectedly long patient visits (when patients come in with a list of complaints), scheduling problems (not enough time allocated to patient visits, overbooking, etc....), difficulties in using new technologies, EHR and emergencies. These factors can all contribute to the loss of control over time in paediatric offices.

Lately, paediatricians are pressured to follow guidelines, deliver an increasing number of preventive services and patient-centered care, while the number of practising paediatricians continues to decrease in many countries. As a result, many doctors and patients express dissatisfaction with consultation length.

Improving time management skills and developing optimal time management strategies contribute to better healthcare provisions. A systematic review⁹ found no direct association between average appointment length and doctors' stress level, but did find longer physician visits associated with more attention to psychosocial problems, lower prescribing rates, better quality prescribing, lower referral rates, lower return consultation rates and better patient satisfaction indicators.

The next section presents the results of a survey measuring time management among paediatricians, health care staff, patients and patients' parents in Romania, Hungary, Italy, Spain and Germany, in terms of time spent with the patient, ease in contacting the doctor when his office is closed, waiting lists, response time to urgent problems and waiting time in the paediatrician's office.

2.5.1 Time with the patient

In **Romania**, the amount of time spent with the patient was evaluated by a score of 4.4 by paediatric patients whereas the health care staff, doctors and parents/relatives considered this to be higher, still not ideal.

health carers' rating: 4.5
patients' rating: 4.4

paediatricians' rating: 4.6
parents/relatives' rating: 4.6

In **Hungary**, a paediatrician is required to spend at least 15 hours per week in the paediatrician's office. This means 3 hours per day from which 1 hour is spent with healthcare counselling and vaccination. In the remaining time the paediatrician must be available for patients.

Children and health care staff think doctors spend enough time with patients most of the times while doctors and parents think that sometimes the time spent with patients is not enough. Paediatricians have to diagnose the patients' illnesses from the symptoms which can be a very time-consuming task. Evidently, nurses are also conscious of the time pressure on primary care paediatricians, although doctors feel the

⁹ Wilson A., Childs S. (2002) The relationship between consultation length, process and outcomes in general practice: a systematic review. *Brit J Gen Pract.* 2002;52:1012–1020. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1314474/pdf/12528590.pdf>



problem more directly. For example, in a flu epidemic period there can be 60-80 patients in the paediatrician's office, waiting to receive medical care.

health carers' rating: 3.7
patients' rating: 3.9

paediatricians' rating: 3.3
parents/relatives' rating: 3.3

Italy – The results average of healthcare is 3.3/5.0 while the paediatricians' result is 3.7. The time with patient is low for healthcare workers and doctors in order to answer the question of relatives, parents and children, when compared to the quality of care standards.

The perception of the patients and relatives is lower than that of the other two categories, and this is due to the duration of medical examination: a few minutes are not enough to answer the questions of parents and patients.

health carers' rating: 3.3
patients' rating: 3.1

paediatricians' rating: 3.7
parents/relatives' rating: 3.0

Spain – The results average of health care staff is 2.0/5.0 and that of paediatricians' is 4.6/5.0. In this aspect differences are relevant, the perceptions of health care staff are consistently different and totally opposite to the paediatricians'. Perceptions of patients and relatives are better than those of the health care staff and below those of the paediatricians.

health carers' rating: 2.0
patients' rating: 3.8

paediatricians' rating: 4.6
parents/relatives' rating: 3.7

Germany – Health carers and paediatricians know that it would be better to spend more time with the patient. Sometimes, the number of administrative tasks is overwhelming and there seems to be less and less time for physical examination and talking to patients and parents. The perception of patients and parents is higher; this result could be influenced by the experiences from adult medicine where even less time is available to answer the patients' questions.

health carers: 3.0
patients' rating: 4.6

paediatricians' rating: 3.7
parents/relatives' rating: 4.5

2.5.2 Doctor's availability

In **Romania**, doctor's availability was rated by children by 4.1, the doctor's office being closed during the weekend. Doctors also considered that their availability to patients, parents/relatives is hardly sufficient, i.e. 4.3 scores, whereas health care staff rated it with 4.0, lower than that of the children's (4.1) and the parents/relatives, i.e. 4.2

health carers' rating: 4.0
patients' rating: 4.1

paediatricians' rating: 4.3
parents/relatives' rating: 4.2

In **Hungary**, doctors think that it is easy to contact them when their office is closed (nights and weekends) while nurses think they are very easy to contact during those times. Parents can contact doctors via phone and e-mail during this period.



Children and their parents found contacting the paediatrician significantly more difficult, rating this question with 2.7 and 2.3 respectively.

health carers' rating: 3.9
patients' rating: 2,7

paediatricians' rating: 3.0
parents/relatives' rating: 2.3

Italy – The results average of healthcarers and paediatricians is 3.0. Because of a low number of workers and a kind of activities that should be managed all day long, healthcarers and paediatricians perceive as not very good the level of easiness to contact them. The main contact point is the emergency room for all needs

health carers' rating: 3.0
patients' rating: 2.8

paediatricians' rating: 3.0
parents/relatives' rating: 3.2

Spain – The results average of health care staff is 3.0/5.0 and that of paediatricians is 4.3/5.0. In this aspects perceptions are consistent between the groups. The needs of patients and relatives are different from the perceptions of health care professionals, this items shows a real deep distance between users' need and awareness of the health care service provider.

health carers' rating: 3.0
patients' rating: 2.3

paediatricians' rating: 4.3
parents/relatives' rating: 2.3

Germany – The availability from doctors and health carers is low when the office is closed – this is true. But the interpretation of the question maybe misleading as our hospital has an 24/7 emergency service and paediatricians and even further specialized paediatricians (f.e. oncologists) are present by phone and in person during nights and weekends.

health carers: 3.2
patients' rating: 2.9

paediatricians' rating: 2.7
parents/relatives' rating: 3.0

2.5.3 Doctor's waiting list

In **Romania**, patients are frustrated to wait on a list or in the waiting room. The doctor's waiting list obtained the following scores in ascending order: doctor's 3.4 – they perceived the waiting lists to be too long, parents/relatives 3.7, patients 3.9 and health care staff 4.1.

health carers' rating: 4.1
patients' rating: 3.9

paediatricians' rating: 3.4
parents/relatives' rating: 3.7

In **Hungary**, doctors rated the waiting lists as “usually short”. In the country, there are no waiting lists in primary care medical services but patients do have to wait to get an appointment for secondary care. This may take some time as hospitals can treat only a limited number of patients per day due to financial reasons. Patients and relatives found the waiting lists mostly short, perceiving the waiting time acceptable but indicating that there is still a room for improvement in this area.



health carers' rating: 3.4
patients' rating: 3.2

paediatricians' rating: 3.8
parents/relatives' rating: 3.0

Italy – The results average of healthcare is 3.2/5.0 while the paediatricians' result is 3.6. The waiting list of doctors is monitored in two different ways:

1. Director of Department – Healthcare level
2. Financial Manager – Management level

The monitoring processes includes the analysis of procedures and operative mechanism in order to guarantee high level of performances.

The perception of relatives and patients is different for the following reasons:

- paying patients: the admission procedure has been applied and the patients follow the normal pathways.
- non-paying patients: in ASLTO3 a waiting list exists in order to access to care. The time of waiting for first visit is around to 5-6 months.

health carers' rating: 3.2
patients' rating: 3.4

paediatricians' rating: 3.6
parents/relatives' rating: 3.1

Spain – The results average of health care staff is 3.0/5.0 and that of paediatricians is 3.4/5.0. Perceptions are similar even if the health care staff has a more marked opinion. The difference between users and providers is not consistent, even if patients and relatives show less satisfaction.

health carers' rating: 3.0
patients' rating: 3.1

paediatricians' rating: 4.3
parents/relatives' rating: 3.2

Germany – All groups agree: the waiting lists are too long. But this fact is not changeable at the moment due to staff cuts.

health carers: 2.5
patients' rating: 3.1

paediatricians' rating: 2.6
parents/relatives' rating: 2.7

2.5.4 Reaction to urgent calls

In **Romania**, in terms of reactions to urgent calls the scores offered by the four categories of surveyed populations were: parents/relatives 4.1 < patients 4.2, followed by doctors 4.3 and health care staff 4.6.

health carers' rating: 4.6
patients' rating: 4.2

paediatricians' rating: 4.3
parents/relatives' rating: 4.1

In **Hungary**, nurses perceive the reaction time to urgent calls as usually short while doctors think the waiting time is always short. Primary care healthcare professionals are putting strong emphasis on training parents when they have to call the paediatrician's office and when it is better to contact the emergency services. In some special cases, like asthmatic and croup attacks, allergic reactions, parents are encouraged to see the primary care physician.

health carers' rating: 4.5
patients' rating: 4.5

paediatricians' rating: 4.6
parents/relatives' rating: 4.0



Italy – The results average of healthcare is 3.8/5.0 while the paediatricians result is 4.0. The perception of patients and relatives is lower than of the other two categories. The reasons are related to:

1. Clinical condition: In ASLTO3 there are two emergency services based in Pinerolo and in Rivoli. As standard of procedures, the reaction of healthcare team must be “very fast” with the collaboration and the cooperation of 112 Services.
2. Kind of performances of paediatricians and neuropsychiatric services: they are not able to manage the urgent clinical calls. The timetable of medical doctors of NPI and paediatrics is from 8.00 am to 8 pm, from Monday to Friday.

health carers’ rating: 3.8
patients’ rating: 3.5

paediatricians’ rating: 4.0
parents/relatives’ rating: 3.2

Spain – The results average of health care staff is 3.0/5.0 and that of paediatricians is 4.3/5.0. Differences are clear in this respect and paediatricians are convinced to support patients in the best way. Relatives and health care staff have very close perceptions regarding this item.

health carers’ rating: 3.0
patients’ rating: 3.1

paediatricians’ rating: 4.3
parents/relatives’ rating: 3.2

Germany – In Germany, in terms of reactions to urgent calls the scores offered by the four categories of surveyed populations were highest in paediatricians and patients (3.9) and lowest in health carer (2.9) All groups see need for improvement.

health carers’ rating: 2.9
patients’ rating: 3.9

paediatricians’ rating: 3.9
parents/relatives’ rating: 3.7

2.5.5 Waiting time in paediatrician’s office

In **Romania**, the waiting time in the paediatrician’s office was rated lowest by the patients: 3.8. Doctors, health carers and parents had a higher rating for this question, qualifying the waiting time as mostly short.

health carers’ rating: 4.2
patients’ rating: 3.8

paediatricians’ rating: 4.0
parents/relatives’ rating: 4.2

In **Hungary**, health carers and doctors agree that the waiting time in the paediatrician’s office is mostly short. In Hungarian medical offices patients cannot book an appointment. Treating sick children generally happens on a “first come first served” basis. In an average day 15-25 patients visit the paediatrician’s office. Waiting time can be longer when there is a vaccination period or doctors are busy with administration tasks or registering a new patient’s medical history.

health carers’ rating: 3.6
patients’ rating: 2.9

paediatricians’ rating: 3.3
parents/relatives’ rating: 3.1



Italy – The results average of healthcarers is 3.0/5.0 while the paediatricians' result is 3.3. The time with the patient is low for healthcarers and doctors in order to answer the question of relatives, parents and children comparing to the quality of care standards. There is a Waiting list for each doctor and the perception healthcare and paediatricians' perception about it is low compared to the time of reservation of medical examinations.

health carers' rating: 3.0
patients' rating: 3,2

paediatricians' rating: 3,3
parents/relatives' rating: 3,2

Spain – The results average of paediatricians is 4.0/5.0. Waiting list is not a big problem even than paediatricians recognize the need to improve the service and reduce waiting time. Perceptions between physicians and patients are different, even than not consistently.

health carers' rating: 2.8
patients' rating: 2.7

paediatricians' rating: 4.0
parents/relatives' rating: 2.7

Germany – Waiting time in paediatrician's office is rated as moderate by health carers and paediatricians. Patients and parents are more satisfied and think that waiting time is acceptable.

health carers: 3.1
patients' rating: 3.6

paediatricians' rating: 3.3
parents/relatives' rating: 3.8

2.5.6 Conclusion – TM needs for each country

Time Management learning needs in Romania

Paediatricians face intense pressures to provide health care for increasing numbers of children and their families, including many with complex medical problems. In today's health care environment, time management skills are essential tools for providing effective health supervision.



Time Management	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	4.3	4.1	4.1	4.2
Time with patient	4.5	4.4	4.6	4.6
Doctors' availability	4.0	4.1	4.3	4.2
Doctors' waiting list	4.1	3.9	3.4	3.7
Reaction to urgent calls	4.6	4.2	4.3	4.1
Waiting time in paediatrician office	4.2	3.8	4.0	4.2

Table 21 Time management results for Romania

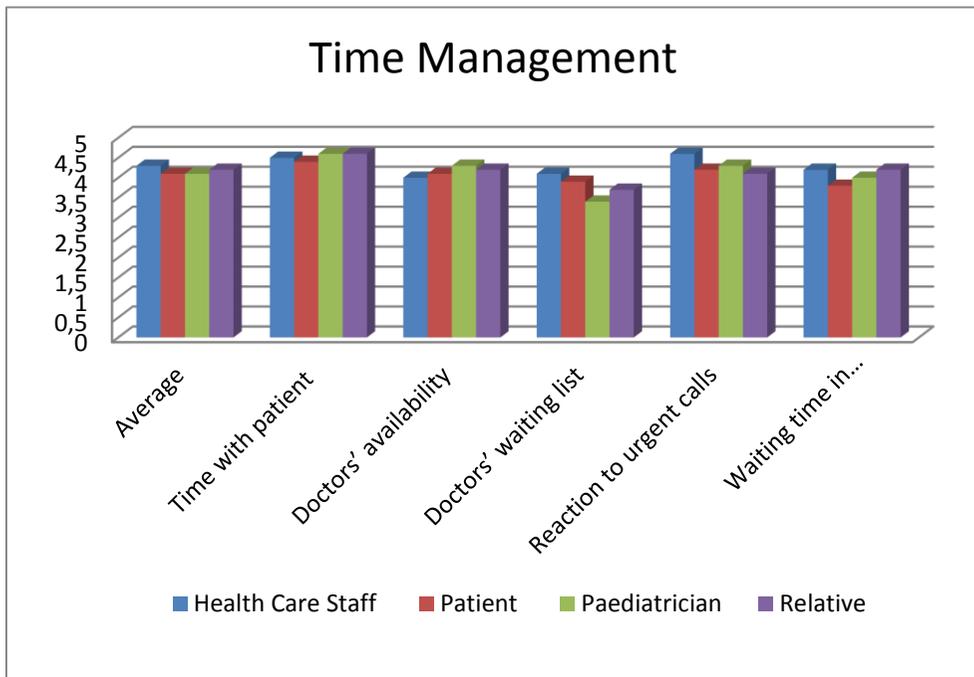


Fig.21 Time management results for Romania



Doctors are mostly dissatisfied by the doctor's waiting list and also the waiting time in the paediatrician's office. Also the health care staff and patients consider that the doctor's availability could be improved among others, by saving time from other activities: prioritizing goals, using certain time-saving strategies such as active listening, family-centered skills, eliciting patients' and parents' concerns, offering individual counselling, better planning.

Time Management learning needs in Hungary

Time Management	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3,8	3,4	3,6	3,2
Time with patient	3,3	3,9	3,6	3,3
Doctors' availability	4,5	2,7	4,6	2,3
Doctors' waiting list	3,4	3,2	3,8	3,0
Reaction to urgent calls	3,9	4,5	3,0	4,0
Waiting time in paediatrician office	3,7	2,9	3,3	3,1

Table 22. Time management results for Hungary

For **Hungary**, the lowest average score for time management was given by the relatives and patients, 3.2 and 3.4 respectively. Although ratings given by the paediatricians and healthcare staff are a little bit higher all surveyed groups expressed a general dissatisfaction regarding this aspect.

The highest among time management results is held by the variable *reaction for urgent calls* for all the surveyed groups while the lowest were *waiting time in the paediatrician's office*. Parents and patients would like to improve doctor's availability when their office is closed and they also expressed their need to reduce the waiting time in the office. Paediatricians and health care staff think they need more time to spend with the patient.

In Hungary, a cloud-based Electronic Healthcare Service Platform will be launched operatively by the end of this year. The pilot phase has already started and the physicians are required to upload patient data and family history. This is an extra burden for the healthcare professionals in the next few years, however, the same community will enjoy the benefits later.



Fig.22 Time management results for Hungary

Time Management learning needs in Italy

Regarding time management, in **Italy** the lowest score was given by patients on *doctors' availability*. Neither healthcare workers nor paediatricians perceive easiness to contact doctors as good.

Time with patient is also low rated by all the survey participants, compared to the quality of care standards.

Time Management	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	3,2	3,2	3,5	3,2
Time with patient	3	3,1	3,3	3
Doctors' availability	3	2,8	3	3,2
Doctors' waiting list	3,2	3,4	3,6	3,1
Reaction to urgent calls	3,8	3,5	4	3,2
Waiting time in paediatrician office	3,3	3,2	3,7	3,2

Table 23. Time management results for Italy



The patient's clinical condition and the kind of performances of paediatricians and neuropsychiatric services influence the *reaction to urgent calls*, which is considered almost adequate by paediatricians.

Time management is a central aspect in paediatric care, whether the patient's needs are urgent or not. Managing time must be taught as a transversal skill of paediatric professionals.

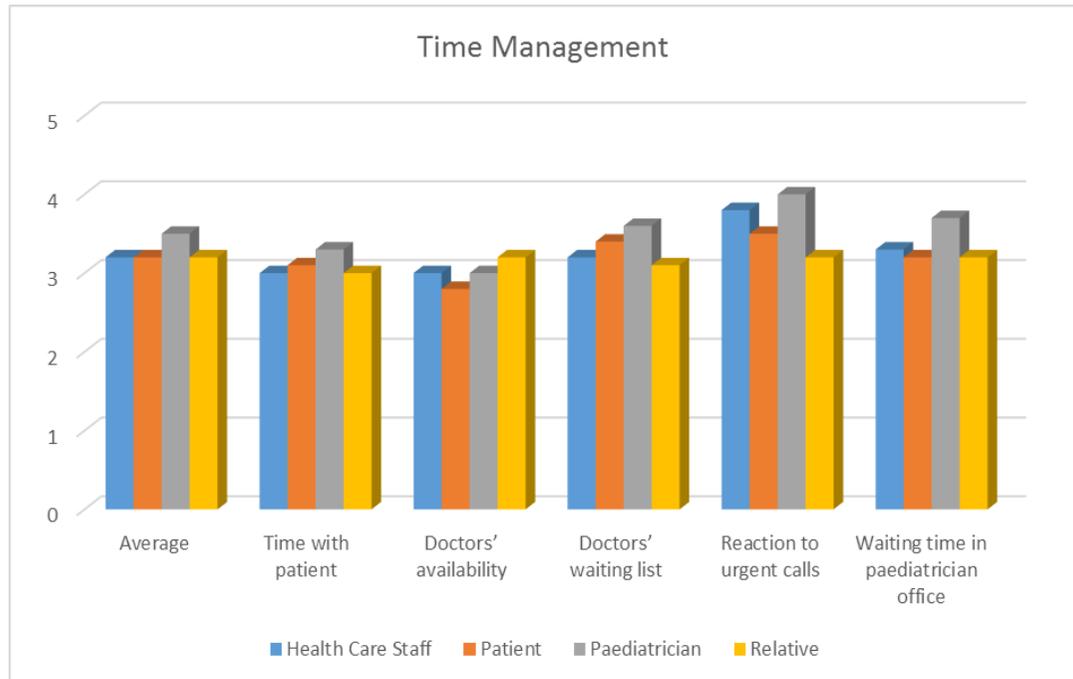


Fig.23 Time management results for Italy

Time Management learning needs in Spain

The global result related to this dimension of the survey is negative, all scores are around 3.0, as usually the clinicians' perceptions are better than those of the other sample groups, the perceptions about time management are always above 4.0, the only aspect criticized by this group is *Doctors' waiting list*, an aspect not entirely dependent on the health care professionals' performances, but on the organization of the health care services. The worst scores are given by the users, always under the 3.0, frequently around 2.0. This aspect together with the cross cultural issues is one of the most surprising results of the survey.



Time Management	Health Care Staff Questionnaire	Patient Questionnaire	Pediatricians Questionnaire	Relative Questionnaire
Average	2,8	2,9	3,2	3,0
Time with patient	3,7	3,8	4,6	3,7
Doctors' availability	3,5	2,3	4,3	2,3
Doctors' waiting list	3,5	2,7	3,4	2,9
Reaction to urgent calls	4,1	3,1	4,3	3,2
Waiting time in pediatrician office	3,6	2,7	4,0	2,7

Table 24 Time management results for Spain

In order to consider the results associated to this dimension of the questionnaire, it is important to underline the big difference between users and providers, especially between clinicians and users. This difference is a clear indicator of the need to improve communication between pediatricians, patients, relatives and health care staff, because even if differences with this group are not equal with those of the users, communication between clinicians and non-clinical health care professionals in relation of the use and the organization of time is quite different, and can be organized in a better way, if a common strategy is defined by the health care team.

In conclusion, if the improvement of space organization and appearance are one of the results of our survey, skills to learn how to improve the use of available time are also required by the health care professionals. A better time management can be the object of a future paediatric team. Sharing of information related to the timing can help to map patients' needs and organize the patient-centered services.

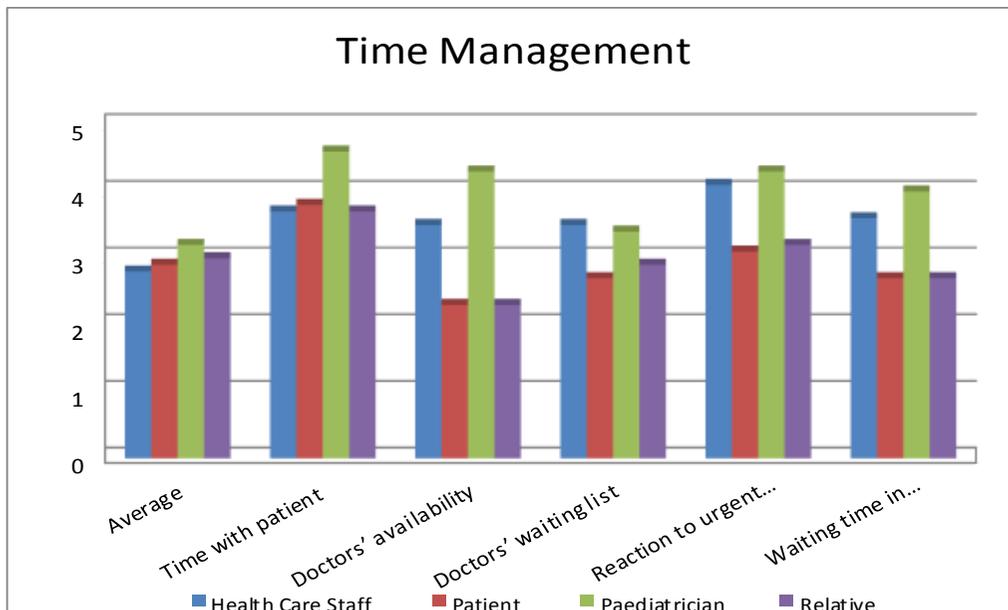


Fig.24 Time management results for Spain

Time Management learning needs in Germany

Time management seems to be a problem in the German healthcare and the medical team as well as patients/parents are aware of it. Time for the patient is reduced in the same way as the number of administrative tasks increases. Spending more time with a patient in an outpatient care often means less money for the providers – a great risk to decrease quality. But in the survey, the patients and relatives are more satisfied with the time management than paediatricians and health care staff.

Time Management	Health Care Staff Questionnaire	Patient Questionnaire	Paediatrician Questionnaire	Relative Questionnaire
Average	2,9	3,6	3,2	3,5
Time with patient	3,0	4,6	3,7	4,5
Doctors' availability	3,2	2,9	2,7	3,0
Doctors' waiting list	2,5	3,1	2,6	2,7
Reaction to urgent calls	2,9	3,9	3,9	3,7
Waiting time in paediatrician office	3,1	3,6	3,3	3,8

Table 25 Time management results for Germany

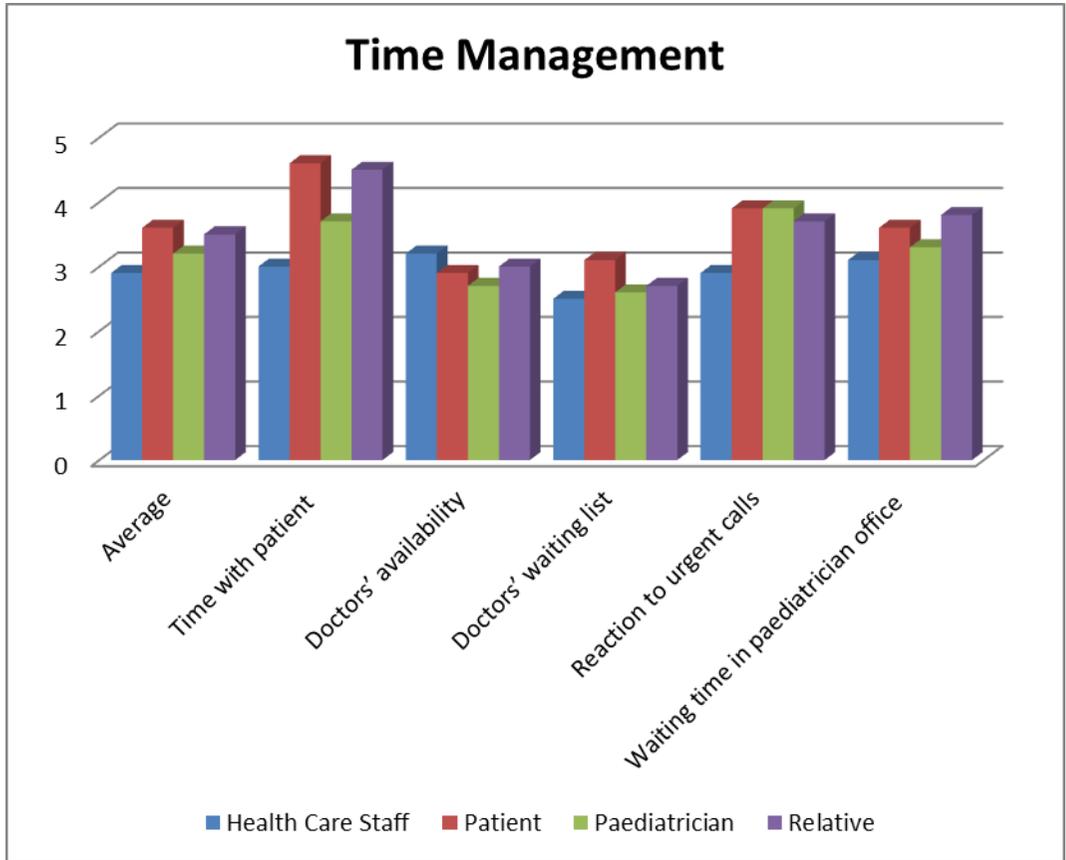


Fig. 25 Time management results for Germany



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CHAPTER 3

CONCLUSIONS

3.1. ROMANIA

The most critical aspects that need to be improved as viewed by all four groups of participants in the survey are:

hospital environment < time management < communication < transparency < intercultural issues

Paediatricians consider that communication is in need of improvement followed by transparency, whereas patients do not make any distinction between the importance of the two items.

If generally parents/relatives have rather similar opinions with their children for the five items, parents seem to need more transparency than their children and they seem a little less sensitive than their children to the hospital environment.

From the point of view of the health care providers, the health care staff consider that communication, hospital environment and time management should be improved to a larger extent than doctors.

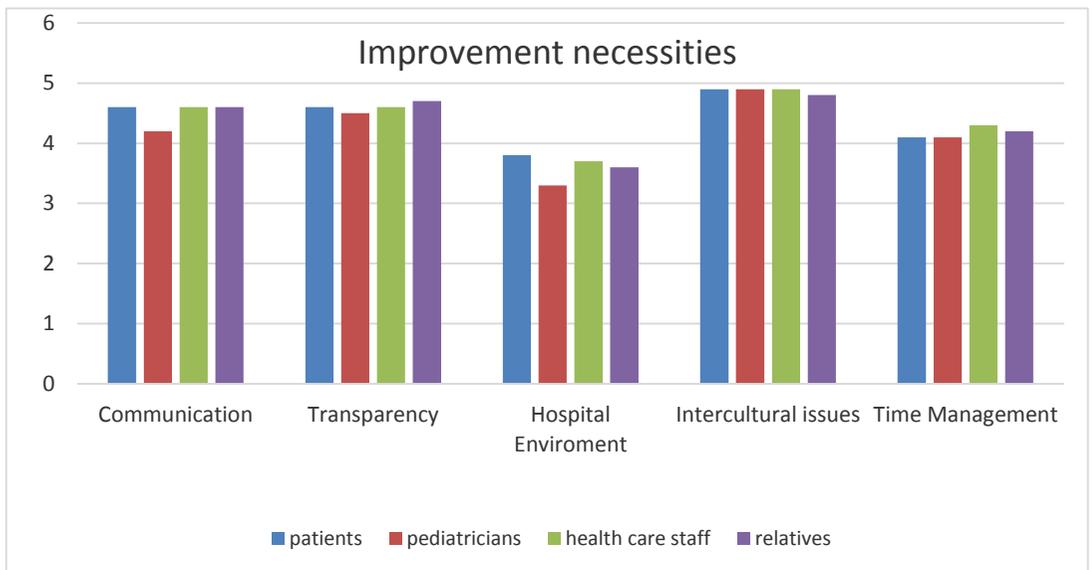


Fig. 26 Improvement necessities for Romania



The **general average for communication** was rated by the doctors with 3.8 and by the children, health care staff and parents/relatives with 4.6. We consider that there is space for improvement of the doctor/patient communication is optimizable and it can be performed through further training and hands-on practical communication courses specific for the paediatric field.

The general average for **Transparency** ranged between 4.5 and 4.7 considering that we had patients with chronic conditions and long hospitalization periods and the doctor who is extremely busy and involved in the patients' therapy needs to manage time efficiently. Psychologic support and adequate counselling should be offered to paediatric patients.

The general average for the item **Hospital environment** was the lowest ranging from 3.3 to 3.8, which calls forth an adequate financing and modernization of Romanian hospital premises, which can only be compensated by a deeper involvement of the doctors and health care staff, at the detriment of the time amount they have to offer to their patients.

The general average for **intercultural issues** was almost maximum (4.9) and did not fluctuate among the four groups of participants in the survey, which demonstrates that the medical process (communication, diagnosis, and treatment) is not influenced by intercultural issues. Still attention needs to be paid to intercultural issues due to the fluctuation of populations across Europe and the latest influx of migrants from outside the European Union.

In terms of **time management**, the general average ranges between 4.1 – 4.3, which demonstrates that this is optimizable as far as time spent by patients while on the waiting lists and hence a latency in their diagnosis. It is obvious that a better time management seen as easy access to the doctor and shorter-term waiting lists for access to hospital services, are necessary.

3.2. HUNGARY

The most critical aspects that need to be improved as viewed by all four groups of participants:

hospital environment < time management < communication < intercultural issues < transparency
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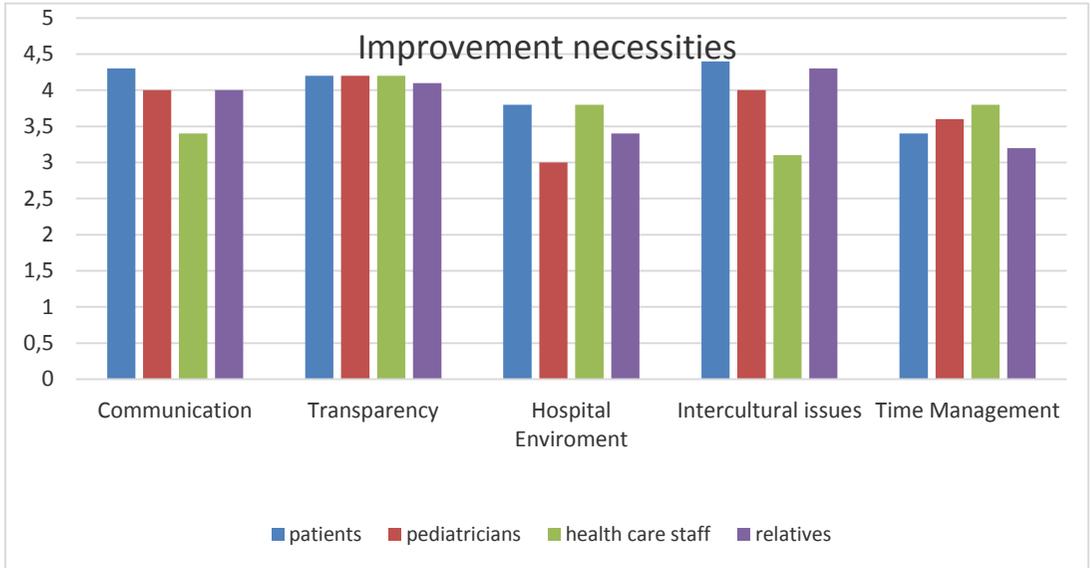


Fig. 27 Improvement necessities for Hungary

Average ratings for **Communication** vary from 3.4 (health care staff) to 4.3 (patients). Although most Hungarian medical universities now include some form of training in communications skills, this is fairly a recent phenomenon. Most of the practicing physicians have not participated on communication courses. Consequently, further communication training is needed focusing on history-taking skills, issues related to communicating across cultures, communicating with “problematic” parents, interviewing techniques adapted to younger patients and empathetic responses.

The general average for **Transparency** ranged between 4.1 and 4.2. More effective information flow should be ensured towards patients and relatives. It’s also important to involve in this process the pharmacy staff members, as often they are the last information source for patients regarding the condition and medication. To optimize transparency it is necessary to give more written material to the pediatric patient.

Average ratings for **Hospital environment** varied from 3.0 to 3.8. Hungarian hospitals’ conditions are heavily affected by the lack of financial resources which were withdrawn from healthcare. Even though Hungarian paediatricians are working as entrepreneurs, paediatricians’ offices are still maintained by the local governments. Financing problems should be solved in order to improve hospital appearance and convenience.

In terms of **Intercultural issues** the general average ranges between 3.1 and 4.4, which means the greatest fluctuation among the four groups of participants in the survey. Intercultural communication skills should be included in the communication training with a patient-centred approach.

The general average for **time management** varies from 3.2 to 3.8, which indicates that there is still much to do in this area. The waiting time may seem a less significant factor but it can have a powerful effect on the overall patient satisfaction. To



reduce waiting time, patient information should be gathered before the visit and more documentation should be delegated to the staff. A survey designed to identify bottlenecks in the office, using secure messaging through the Electronic Healthcare Service Platform, telehealth and mobile queueing solutions (where patients can join a virtual waiting line) can also contribute to developing better time management habits and practices.

3.3. ITALY

In recent years, the concern for the sustainability of health systems in Europe has grown. New models of care have been recommended by scientific and management committees. In this survey, a lot of comments from healthcare workers were collected in order to identify the causes of professional distresses:

- organisation
- knowledge management
- perspectives.

The most critical aspects that need to be improved as viewed by all four groups of participants were:

hospital environment < time management < intercultural issues < communication < transparency
--

Paediatricians consider that hospital environment needs to be improved, followed by time management. Patients and healthcare workers make the same distinction between the importance of the two items. Relatives' answers underline improvement necessities in intercultural issues as well as time management.

If generally parents/relatives have rather similar opinions with their children for the five items, parents seem to need better communication and they seem a little less sensitive than their children to the hospital environment.

The health care staff underlines the greatest improvement necessity to be that of the hospital environment, followed by time management and intercultural issues, while paediatricians appreciated the level of these issues.

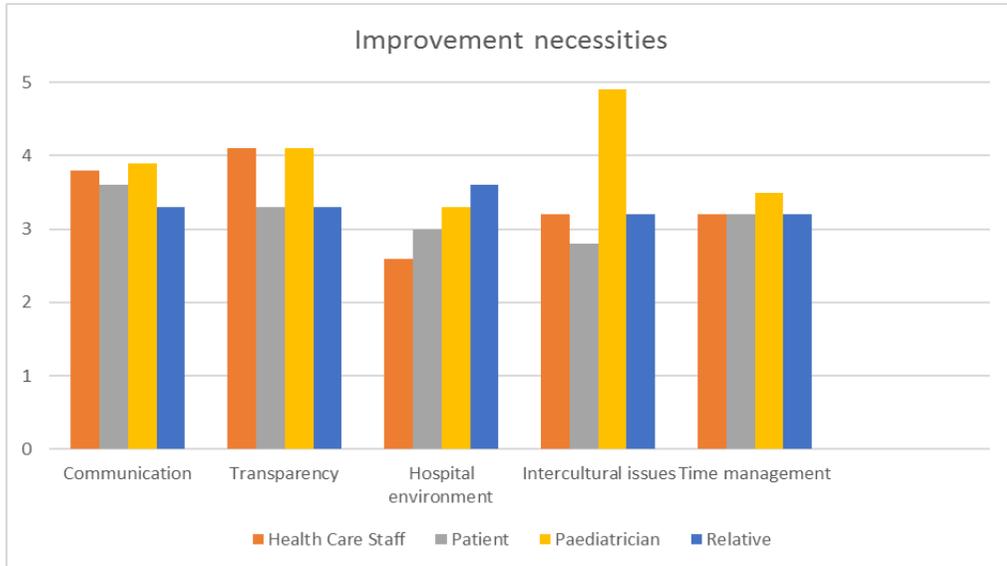


Fig. 28 Improvement necessities for Italy

The general average for **Communication** was rated only 3.3 by relatives. Communication needs to be improved in the relatives' opinion: these results underline the necessity of improving the relation skills in order to improve the level of efficacy of communication.

The general average for **Transparency** is the same for healthcare workers and doctors (4.1) and lower for the patients and their families (3.3). The most important result is related to the need of healthcare workers and paediatricians to be monitored and supported by a specific counselor in order to guarantee the high level of care quality and relation with the patients and relatives. The supervision would be a strategy for improving the coping and efficacy communication.

The results on **Hospital environment** underline two needs, those are the items below the average score of 3 points: the hospital appearance (Healthcare workers' 2.4 and Paediatricians 2.7) and convenience (Healthcare workers 3.1 and Paediatricians 2.9). As territorial public organisation, the paediatric services are located throughout the local area. The main problem is related to the impact of territory which is very widespread and therefore on the difficulty of information exchange procedures.

The general average for **Intercultural issues** was very different between paediatricians (4.9) and all the other surveyed participants (patients 2.8). Attention must be paid to intercultural issues: academic institutions that educate healthcare professionals should interact differently with the many stakeholders to create effective, efficient and culturally appropriate healthcare systems.

In terms of **Time management**, the general average is similar between different participants' scores. It will be important to develop staff strategies of proactive behavior and to apply creative thinking in work procedures in order to cope with time management necessities.

"Practising nursing professionals assume responsibility for the planning and management of patient care, including the supervision of other healthcare workers,



working autonomously or in teams with medical doctors and others in the application of preventive and curative care. Although nurses have traditionally provided care to patients under the guidance of a physician, they are increasingly permitted in many EU Member States to practise independently as professionals. This, however, depends to some degree on their qualifications and level of training, with an increasing proportion of nurses following university courses to degree level. The number of nurses may vary according to differences in healthcare systems. Equally, the number of nurses compared with other personnel (such as physicians) also varies between different providers of healthcare, for example between hospitals and long-term nursing care facilities". (Eurostat, *Healthcare personnel statistics – nursing and caring professionals*, 18.01.2017)

In Italy 374100 people work in public and/or private health system with a ratio of 615 per 100.000 inhabitants (Eurostat, *Healthcare personnel statistics – nursing and caring professionals*, 18.01.2017).

In our organisation, the average age of healthcare professionals is 49 for women and 51 for men. The Italian Public Administration doesn't provide an adequate turnover of workforce.

Healthcare is becoming increasingly complex across the globe; technology, delivery models, economic requirements, demographics and the epidemiology of disease are changing at a rapid pace. Despite the multiple efforts in defining common competencies and standards that all healthcare professionals should meet, it has become clear that educational and training programs have to adjust to the needs of societies they serve, and that the institutions that design and deliver those programs need to be accountable to society for the products they produce. Academic institutions that educate healthcare professionals should interact differently with the many stakeholders needed to create effective, efficient and culturally appropriate healthcare systems.

Medical education has its roots in the European university which traditionally valued academic freedom, autonomy and independent research over serving society and the job market; future efforts will require a fundamental shift in the outlook and measures of success for academic institutions. The recent outcomes and competency movement is a first step in that direction but more will need to be done. Rather than being one participant, possibly a reluctant one, academia should become the catalyst for change, the hub for stakeholder interactions, and the breeding ground for the new healthcare workforce (H. Thomas Aretz, *Some thoughts about creating healthcare professionals that match what societies need*, Journal Medical Teacher, Volume 33, 2011 - Issue 8).

Emerging changes in health-care delivery are having a significant impact on the structure of health-care professionals' education. Today it is recognized that medical knowledge doubles every 6–8 years, with new medical procedures emerging every day. While the half-life of medical information is so short, the average physician practices 30 years and the average nurse 40 years. Continuing education thus represents an important challenge to face (Mantovani, Castelnovo, Gaggioli, and Riva, *Virtual Reality Training for Health-Care Professionals*, CyberPsychology & Behavior. August 2003, Vol. 6, No. 4: 389-395). The Service of Workforce Development of ASLTO3 had promoted a survey in 2016 regarding the "Professional 2.0" as a new profile of healthcare professional worker. The results underline the importance of devices in workplace in order to update the knowledge, to create the professional network, to know the last information on care (Presutti M., *Professionista 2.0*, ASLTO3: 2016).



A new organisation of work has been applied in ASLTO3: a lot of services have been unified by management in a different setting of care. One of most important goal of ASLTO3 is to guarantee the care continuity from hospital to territory services focusing the efforts on integration of workers and interoperability of ICT system.

After the “Piano di rientro” of Health Minister, Piedmont Region should hire new medical doctors in the Services of NPI and Paediatrics.

3.4. SPAIN

The core result of Spanish data is the need of a new model of the care team in paediatrics. All the dimensions explored by the survey highlight the need to share information, mapping the patient's need and share therapeutic strategies to improve the results. To allow this result, the role of relative/parent in the care team is essential. The involvement of carers in therapeutic strategy is a new tendency of research in health care, other specializations of medicine, such as psychiatry or palliative care, shown their interest for carers' involvement in care plan and decision making processes. The building of a pediatric care team locates the family on the hearth of doctor-patient relationship. Other important aspect highlighted by our investigation is the role of nurses, and other health care staff in the care plan, especially for the function developed in mapping the patients' needs. Communication improvement passes through the transparence and the information process. The care team should involve other specialists and relatives/parents in the decision-making processes. In order to improve the health environment, a mapping strategy is required by the care team to understand how to improve the use of spaces available in the services and respond with a common strategy promoted by the health care team. Sharing of information about religion, values, cultural background, is a way to involve the family in the care plan and avoid ethical and legal issues with patients. Time management is a requirement for patients and relatives, even though it is not easy to solve the structural problem related to human resources; improvement of best practices in the time management can help to improve patient satisfaction and therapeutic results.

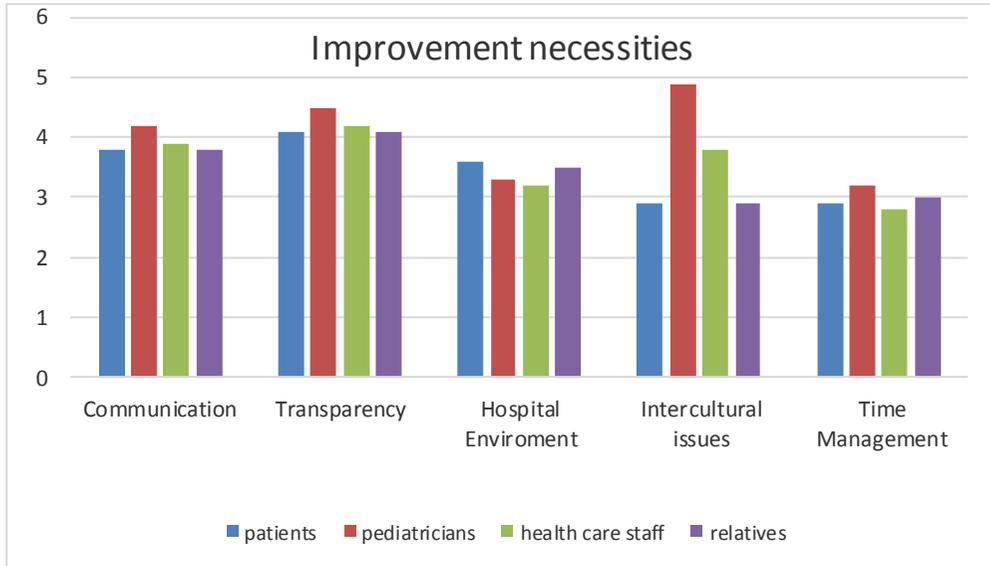


Fig. 29 Improvement necessities for Spain

3.5. GERMANY

The most critical aspects that need to be improved as viewed by all four groups of participants in the survey are:

hospital environment < time management < communication < transparency < intercultural issues

The **general average for communication** was rated by the paediatricians with 3.8, by the health care staff with 3.7, by patients with 4.5. and by parents with 4.4. As the medical team see room for improvement, they would appreciate the development and offering of training modules to improve their communication skills.

The general average for **Transparency** ranged between 3.6 (health care staff) and 4.6 (patients). The low rating by the health care staff may be due to the fact, that the participating nurses are working on the ward and are not that much aware of interdisciplinary conferences with other caregivers, phone calls to paediatricians working in ambulances and contact to family doctors.

The general average for the item **Hospital environment** was the lowest, ranging from 2.9-3.5, which calls forth an adequate modernization of the old buildings of the university hospital. In Munich, there are concrete plans to build a large modern university children's hospital.



The general average for **intercultural issues** was almost maximum (4.8) in all groups except for the group of health care staff (4.4). This homogenous high rating demonstrates that diagnosis and treatment as well as communication is not influenced by intercultural issues. Still attention needs to be paid to intercultural issues due to the increasing number of migrants from outside the European Union.

In terms of **time management**, the general average ranges between 2.9 and 3.6. Especially the medical staff recognizes that time for physical examination of the child as well as for providing oral and written information is much too short compared to the time the medical team has to spend with administrative tasks. Furthermore, hospitals and time management suffer from staff cuts as part of cost-cutting measures.

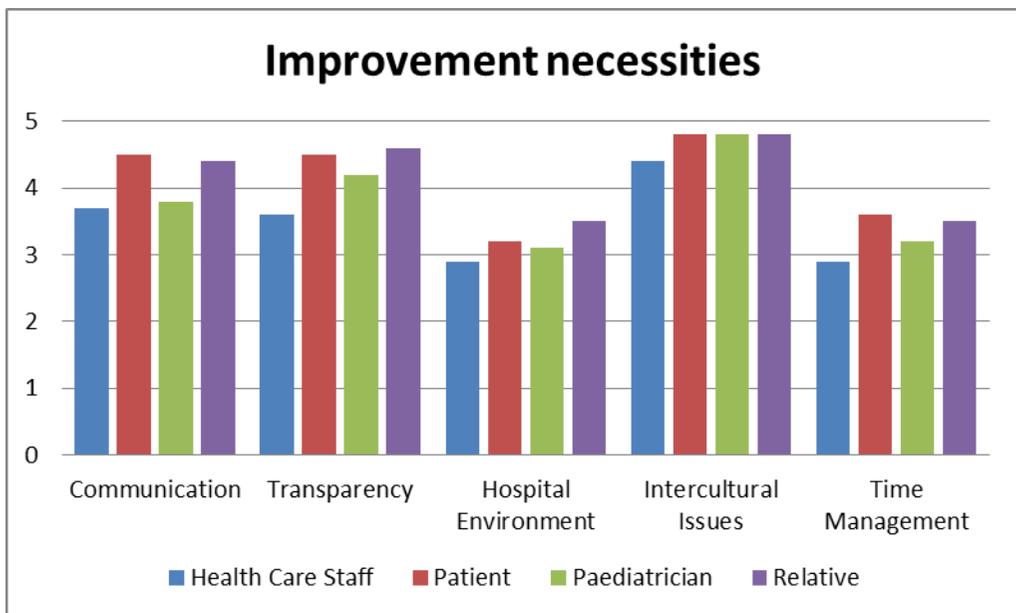


Fig. 30. Improvement necessities for Germany