ANALYSIS OF CHARACTERISTICS OF PALLIATIVE CARE SERVICES IN ROMANIA VERSUS CARE NEED BASED ON THE ANALYSIS OF HOSPITAL ADMISSIONS TO PALLIATIVE CARE WARDS DURING 2014-2016

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INTRODUCTION

Palliative care must be considered as an integral part of modern medicine to supplement curative medicine when the patient’s condition is serious, invalidating and the means of curative therapy have been exhausted.

In the lives of patients facing this stage of life and treatment, a very important role is played by physician and multidisciplinary care team, since at this stage they go through very complex processes, being in great need for care from both a medical perspective – such as controlling pain and other symptoms – and a psychological, social and spiritual one.

Although until relatively recently palliative care has been regarded as a limited medical care activity for patients in terminal stages of chronic diseases, the modern medicine concept it is aimed at ensuring a quality of life as good as possible for patients and their families. Not only could the adults benefit of palliative care but also children suffering from conditions such as congenital malformations, cystic fibrosis, AIDS and spina bifida. In their cases both the evolution of disease and the means of treatment and communication are different.

The World Health Organization (WHO) has elaborated the following basic principles according to which palliative care [1]:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- treats the physical, emotional and social needs of patients according to their own and family preferences and limitations as well as to medical, social and cultural issues;
- affirms life and regards dying as a normal process;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;

The modern concept of palliative care sets a broader scope for it, starting before the terminal stages of a disease, much earlier in the evolution of the disease, accompanying specialized care for serious incurable diseases. In Romania, palliative care is provided mostly in bed-equipped wards as inpatient care, while very little funding is allocated from the health insurance budget for home palliative care.

The modern approach of this medical specialty places the start of palliative care as early as the diagnosis of the incurable disease as this is the way the restrictive concept of terminal care wards during 2014-2016 shows a steady increase of the need, while there is a wide range of conditions calling for medical assistance of this type, as well as the necessity of an adequate provision of medical care after patient’s discharge from hospital. All these call for a reshaping of the strategy for health services in this field.

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Coverage of population with palliative care services varies intensely in territory, several counties lacking suppliers of such services to have concluded agreements with the respective health insurance fund. The analysis of using palliative care wards during 2014-2016 shows a steady increase of the need, while there is a wide range of conditions calling for medical assistance of this type, as well as the necessity of an adequate provision of medical care after patient’s discharge from hospital. All these call for a reshaping of the strategy for health services in this field.

Keywords: palliative care, hospitals, patient coverage.

- it is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

The modern approach of this medical specialty places the start of palliative care as early as the diagnosis of the incurable disease as this is the way the restrictive concept of terminal care services (the last 12 months of life) is converted to palliation (extended).

Some countries, like Republic of Moldova, have set clear criteria for inclusion of patients in palliative care: patients with a life expectancy lower than 12 months, suffering from uncontrolled clinical symptoms or having psycho-emotional and spiritual needs. Such an approach defines palliative care rather as terminal care, yet it enables a clear selection of patients [2].

In Romania the standard number 02.08 for hospital accreditation states that „palliative care is aimed at patients suffering from progressive chronic diseases and their families and is meant to improve the quality of their life by reducing suffering”, „is provided within an appropriate environment, as close as possible to the family”. Admission of eligible patients is based on the decision of a multidisciplinary committee, while the terminal condition signs and symptoms are rated based on specific scales and are documented.

The patient’s management is performed based on the protocols established by the multidisciplinary committee.
The minimal structure of such multidisciplinary committee includes a physician, a clinical pharmacist, nurses, nurse aids, a social worker, a psychologist and a spiritual counselor. As the case might be, the extended team may comprise a Kinetotherapist, an occupational or game therapist, a dietician, volunteers etc. The continuity of care upon discharge „is carried out by taking into account the patient’s options” [3].

As post-hospitalization care or in the absence of hospitalization, in order to be eligible for home palliative care, patients need to meet a series of predefined criteria – to suffer from oncological conditions or HIV/AIDS, to have a limited life expectancy and an ECOG status 3 or 4 (are confined to a chair or bed 50% of the time and need support for basic care or are completely confined to bed being eligible for receiving a recommendation for home palliative care from a physician in hospital, ambulatory care unit or from a family physician).

Home palliative care suppliers must hire a full-time physician and a nurse certified in palliative care and may also have Kinetotherapist, psychologists or logopedists [9].

In comparison with the member states of EU, Canada and USA, palliative care in Romania is still in the beginning era. Mostly, the palliative care is provided in bed-equipped medical units, palliative care wards (code 1061_PAL according to the current classification of wards) [4]. They started to operate in a stand-alone manner approximately in 2010 as wards with a chronic profile and are paid with an average rate of hospitalization day upon completion of such duration.

However, the national legislation allows provision of home palliative care to patients based on the recommendation of a specialized physician, by suppliers having medical staff specialized in palliative care. There is the possibility of assisting patients in continuous care only if the provision of home palliative care is not possible.

Given the increasing prevalence of chronic, serious and invalidating diseases and the phenomenon of population ageing, the over-utilization of palliative care wards and the waiting lists for this type of care have become notorious – as a proof, an increasing number of privately-held suppliers have entered the Romanian medical service market.

**OBJECTIVES**

Considering the actual state of art in this field in Romania, which has been described in the introductory part of this work, it is necessary to be carried out an analysis of the current state of services supplied, the patients’ profile and geographical distribution, the hospitalization mode and related costs.

This may contribute to the assessment of the real need for services and financing and may serve as a base for the updating of the legislation regulating this field, as well as for measures contributing to increase the efficiency of such services and to the increase in their quality.

This work is aimed at elaborating an extended descriptive analysis with regard to the current situation in Romania, the need for palliative care services from a territorial perspective, the financing of this field from the health insurance fund, the supply of palliative care services, the use of services, as well as to an example for calculating home palliative care to help setting the minimal necessary requirements so that patients suffering from incurable diseases can benefit in an equitable way from services in compliance with the WHO’s principles.

**METHODOLOGY**

Authors proceeded to evaluate the legislative provisions concerning the authorization of home palliative care suppliers, those regarding contracting and reimbursing palliative services in hospital and at home from the Framework Contract and its application Norms, to analyze the National Health Insurance Fund (CNAS) activity reports, as well as the public information available on the National Palliative Care Association’s (ANIP) website.

The descriptive analysis performed on hospitalization services in palliative care wards, as well as on the patients’ profile and territorial distribution has been carried out, by taking into account the data reported by all hospitals, having contracts with The Health Insurance House, between 2014-2016, to the National DRG data base administered by the National School of Public Health, Management and Training in the Health field in Bucharest (SNSPMPDSB)-all validated cases. The analyze excluded the patients who have benefited from home palliative care since such cases are not reported to the institution in charge of data validation.

The processing of data has been performed by using Microsoft Excel and statistics have been calculated according to the number of patients or according to the number of cases (namely, the number of hospitalization episodes, as a certain patient may have one or more hospitalization episodes during a calendar year). Hospitalization duration for each case has been calculated as the difference between the discharge and admission date.

To evaluate the provision of Romanian specialty services by comparison with countries recognize as model of healthcare in Europe, the information available on HOSPIZ ÖSTER-REICH’s website concerning palliative care services from Austria have been used.

A cost structure for home palliative care have been modeled on the basis of a case study data provided by a supplier of home palliative care from Cluj county.

**RESULTS**

**Overall description of use and dynamics of continuous hospitalization services in palliative care wards during the studied period**

The number of patients discharged from palliative care wards constantly increased over these 3 years, reaching 14559 patients in 2016, higher by 77% than in 2014.
The number of hospitalization episodes also went higher by 74%, yet the death rate increased by almost 86%.

Table 1 - Indicators 2014-2016

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients hospitalized in</td>
<td>8,217</td>
<td>12,171</td>
<td>14,559</td>
</tr>
<tr>
<td>Number of deaths</td>
<td>3,331</td>
<td>5,200</td>
<td>6,192</td>
</tr>
<tr>
<td>Number of episodes of hospitalization</td>
<td>13,449</td>
<td>19,062</td>
<td>23,371</td>
</tr>
<tr>
<td>Number of hospitals</td>
<td>52</td>
<td>29</td>
<td>33</td>
</tr>
<tr>
<td>Of which private hospitals</td>
<td>20</td>
<td>28</td>
<td>32</td>
</tr>
<tr>
<td>Average rate of rehospitalization</td>
<td>1.7</td>
<td>1.6</td>
<td>1.6</td>
</tr>
</tbody>
</table>

(Source: DRG National database)

The evolution of the number of palliative care suppliers (bed-equipped wards) shows an increase by 62%, with the privately-held ones accounting for roughly 40% of them throughout this period.

Graph no. 1 – Evolution of the sanitary units with beds who reported discharges from palliative care wards between 2014-2016

Based on this graph we can group counties according to the number of hospitalized patients, within the palliative care wards from the respective counties, as follows:

- **Group A** no. of patients – Bucharest and Iasi, with a number of patients ranging between 1,000 and 2,200
- **Group B** no. of patients – Bacau, Cluj and Timis, with a number of patients ranging between 500 and 1,000
- **Group C** no. of patients – the rest of the counties, with a number of patients lower than 500

The percentage of hospitalization episodes after the county of the hospital where the patient was treated, in comparison with the national level, is outlined in the graph below. According to the percentage of county cases out of total national cases, counties may be grouped as follows:

- **Group A**: between 15% and 30% - Bucharest
- **Group B**: between 5% and 15% - Iasi
- **Group C**: between 3% and 5% - Arad, Bacau, Bihor, Brasov, Cluj, Mures and Timis
- **Group D**: between 0.1% and 3% - Alba, Arges, Bistrita-Nasaud, Braila, Buzau, Constanta, Dambovita, Dolj, Galati, Giurgiu, Hunedoara, Ilfov, Maramures, Neamt, Prahova, Salaj, Satu Mare, Sibiu and Suceava
- **Group E**: 0% - Caras Severin, Gorj, Mehedinți, Olt, Vâlcea, Teleorman, Calarasi, Ialomita, Tulcea, Vrancea, Covasna, Harghita, Vaslui, Botosani

Based on this graph (Graph no. 3), it can be noticed that in Romania palliative care services are not distributed homogeneously within the territory, a high number of patient suffering from incurable diseases or no longer responding to treatments do not actually have equitable access to adequate services, in compliance with the WHO’s principles.

For having a transparent situation regarding the palliative care in Romania, it is crucial to learn how palliative care is distributed on national level from a territorial perspective on one hand, while on the other one it is crucial to analyze the situation of hospital deaths in such wards.

The graph below outlines the territorial distribution of patients and deaths in palliative care wards during 2014 – 2016.

Graph no. 2 – Territorial distribution of patients and deaths in palliative care wards between 2014 and 2016

(Source: DRG National database)
Graph no. 3 – Percentage of cases in palliative care wards in Romania after the hospital county, out of total number of cases at national level

![Graph showing percentage of cases in palliative care wards](image)

(Source: DRG National database)

**Figure 1 – Geographic coverage hospital palliative care services, reported to the county population, according to demographic statistics 2012 (Number of patients per 10,000)**

**Estimates concerning the need for palliative care from a territorial perspective**

The analysis of hospitalization episodes according to the county of the hospital, shows that there are counties with no sanitary units with beds having hospitalized patients in palliative care wards.

The need for care on a national level can be estimated on the basis of the analysis of patients hospitalized in palliative care wards, after the county in which the patient resides (patient county), this offering the picture of the coverage of the patients living in counties having no sanitary units with palliative care wards.

In order to describe the landscape of provision of palliative care at national level, Graph no. 1 outlines the level of coverage with this type of services, reporting the number of patients from the respective county who were hospitalized in palliative care wards to the population living in the respective county (to 10,000 residents).

According to statistics in 2012 Romania’s population was approximately 19,292,000 residents, out of whom 4,347,743 residents living in counties that do not provide hospital palliative care services, which accounts for roughly 22.5% of Romania’s population.

On the other hand, the counties – Bucharest and Iasi - which account for the highest number of cases, differentiate between themselves when reporting the patients to their population. Having a large population, Bucharest has a ratio of patients hospitalized in palliative care wards with the domicile in Bucharest of only 7.95 to 10,000 residents, while Iasi keeps a high ratio of 22.57/10,000.

Since these patients need palliative care as a result of serious and usually chronic conditions it is interesting to analyze the patient’s pathway through other specialty wards, before being admitted to palliative care wards.

The results of the analysis of the cases admitted to palliative care wards one day after the discharge from another specialty ward, show that approximately a quarter of those cases were previously discharged from medical oncology wards, roughly 15% from neurology wards and 10% from internal medicine wards, followed in order by general surgery, pneumology and other wards.

**Distribution of cases according to the palliative care unit’s ownership type.**

Distribution of cases according to the hospital’s ownership type shows that 59% of cases were allocated to state-owned units and 41% to privately held ones.
health insurance funds, could be estimated based on framework agreement provisions (annex 23C) which set the maximum cost per hospitalization day [maximum cost/hospitalization day] of 235.62 RON.

The number of hospitalization days [no. of hospitalization days] during 2014-2016 was as follows:

In state-owned units – 673,666 hospitalization days
In privately held units – 480,815 hospitalization days

The formula to calculate the total amount estimated to be reimbursed:

Total amount = No. of hospitalization days x maximum cost/hospitalization day

Total amount in state-owned units = 673,666 x 235.62 = 158,729,182.92 RON
Total amount in privately held units = 480,815 x 235.62 = 113,289,630.30 RON

The above calculations are based on the data presented in Table 2.

The conditions for contracting home care palliative services are regulated separately within the Framework Contract and its application Norms. According to them (annex no. 30), a patient who needs home palliative care could benefit of maximum 90 days of a once-in-lifetime, upon referral from a specialized physician. The duration of a care episode is 15 days, according to the recommendation letter.

The maximum tariff per day of home palliative care is 70 RON for patients having an ECOG 4 performance status, while the maximum tariff per day of care provided to the insured patients having an ECOG 3 performance status is 65 RON.

Based on a real case study we will exemplify within the following section the situation of actually

Therefore, according to graph no. 5, between 2014 – 2016 the number of episodes of palliative care in state-owned units was 39,261 at national level, whereas in privately held ones was 16,960.

Aspects related to financing palliative care and budgetary impact

The budgetary impact of these validated cases, if it would have been be completely reimbursed by the local
incurred costs related to providing a patient with home palliative care.

**Necessary time for providing a patient with palliative care** at home:
- The duration of a perfusion ranges between 1.30 – 2 hours depending on the patient’s condition;
- The transportation time is approximately 30 minutes (one way), yet depending on traffic it may take even longer;
- The time necessary for the carrying out of a medical procedure according to the service package is approximately 30 minutes.

The total time for the carrying provide the package of services according to medical recommendation is between 3.00 – 3.50 hours.

**Costs**
- The patient lives 17 km away from the medical service supplier’s address;
- The distance covered in one day is 34 km;
- The duration of a care cycle is 15 days;
- The total number of kilometers covered during a care cycle is 510 km;
- The average fuel consumption is 7 liters per 100 km;
- The total cost is: 35.7 l x 4.34 RON / l = 154.93 RON
- The cost for each kilometer covered is approximately 1 - 2 RON / km (510 km x 2 RON / km = 1,020 RON)
- The total cost of necessary materials is 213.14 RON
- The (minimally proposed) salary for a full-time physician is *3,457 RON (assuming that the care service supplier had only one patient requiring home palliative care in a month)
- The (minimally proposed) salary for a full-time nurse is *1,900 RON (the same as above)
- The (minimally proposed) salary for a full-time Kinetotherapist is *1,400 RON (the same as above)

* The salaries taken into account are lower than the maximum grading level according to the wage grid.

The amount according to the Framework Contract = 70 RON / day x 15 days = 1,050 RON

Total actual costs = Fuel + Health-related materials + cost per one kilometer covered + Physician’s salary + Nurse’s salary + Kinetotherapist salary = 154.93 +1,020.00 + 213.14 + 3,457.00 + 1,900.00 + 1,400.00 = 8,145.07 RON

**Results of the analysis of budgetary impact**
The total number of hospitalization days for the patients admitted to palliative care wards during 2014-2016 accounted for approximately 5% of the total hospitalization days accounted by all wards with a chronic profile together, in all Romanian hospitals having contract with the Health Insurance Funds (roughly 7,700,000 annual hospitalization days on all wards with a chronic profile)
The death rate on palliative care wards during the 3 years studied was on average 42.5%, which means that approximately 57.5% of the hospitalized patients could have been provided with palliative care in a different environment (at home) upon their discharge. Out of the total of 34,747 patients hospitalized in palliative care wards between 2014-2016, approximately 57.5%, namely 19,980, may have needed out-of-the-hospital palliative care (out of whom 8,370 in 2016 alone). Assuming that not all of them had asked for home palliative care, even half of them would have meant roughly 4000 patients who could have been eligible for such care.

However, according to a report posted on the National Health Insurance Fund’s website on 31.12.2016, only one contract had been signed with a supplier of home palliative care and 8 contracts with suppliers of general medical home care and home palliative care. 93 decisions of home palliative care were reimbursed (93 patients) corresponding to 3588 reimbursed days of home palliative (comparing to 7072 days that would have been necessary, according to medical recommendation), accounting to 224,340 RON [6]. The tariff reimbursed for home palliative care is not even close to actual cost.
The costs incurred by a supplier of home medical care services could be covered only if such a supplier would assist at least 8 patients every month. In this case the reimbursement would cover the costs.

If the same tariff per day valid for palliative care wards in hospital setting would be applied also for home palliative care, this would mean that for a 15-day palliative care cycle the reimbursement would be 3,534,30 RON, which would mean that a home palliative care supplier would need only 3 patients/month to cover the actual costs. ANIP recommended in 2014, projecting the accreditation of the suppliers of home palliative care services, that such suppliers need to have a multidisciplinary team, composed of a full-time specialized physician certified in palliative care, nurse, kinetotherapist, psychologist, social worker and a part-time priest [7]. Such a complex team would involve additional costs per a patient assisted at home, higher than those calculated herein.

**The analysis of pathologies for which patients were hospitalized in palliative care wards**
According to the DRG (Diagnosis Related Groups) classification, the top 10 most frequent diseases account for 51.58% of the cases discharged from palliative care wards. As shown in graph no. 6, the most frequent is dementia and other brain function disorders, followed by respiratory neoplasms without CCs and digestive malignancy without catastrophic or severe CCs.

Other diseases account for 48.42%, each DRG group of this category contributing individually with fewer than 2.89% of cases. As shown in the graph, the group OTHERS includes 277 groups according to DRG codes, which confirms the wide range of diseases treated on palliative care wards. Graph no. 7 shows the impact of the first 10 diseases, accounting for 55.31% of the hospitalization days, for cases discharged from palliative care wards in 2016.
The highest share in the hospitalization days corresponding to the 10 most frequent diseases corresponds to dementia disorders and other chronic brain function disorders. One may also notice that for other conditions, the shares of hospitalization days for a certain condition are lower than those of the cases having this condition, except for cardiac failure and neurodegenerative disorders where the situation reverses.

This means that the patients who suffered/suffer from dementia and other chronic brain function disorders, cardiac failure and neurodegenerative disorders consumed more hospitalization days. Except for the top 10 diseases, the other conditions gathered fewer hospitalization days. 48.42% cases thus accounted for 44.69% of hospitalization days on palliative care wards in 2016.

Analysis of utilization indicators for palliative care wards during the period studied

The average duration of hospitalization in 2016 was 22.67 days, with a median of 13 days, yet with the amplitude of 977 days. The huge difference between the average and median level, as well as the amplitude of hospitalization duration may be a proof of the heterogeneity of the care provided – potentially caused by both the local care protocols and the various pathologies admitted to various palliative care wards in various types of hospitals and geographical regions.

The patients’ average age was 68.8, with a median of 70 and an amplitude of 101 years.

The average readmission rate per patient was approximately 1.60 admission episodes per patient, yet there are also cases with 12, 16, 18 and up to 33 readmissions during a calendar year.

Comparing the situation concerning the types of palliative care service suppliers in Romania and Austria

In order to have an overall picture regarding the situation of palliative care in Romania could be useful to draw a parallel between situation in Romanian and Austria in 2015. Austria has been chosen as a model for the reconfiguration of health services in many European countries. According to 2014 data from the Catalogue of Palliative Care Services in Romania and 2014 HOSPIZ ÖSTERREICH data in Austria [8], the situation stands as in table 3.
The range of conditions for which patients may benefit from home palliative care is very limited and, judging after the eligibility criteria and after the services reimbursed by the National Health Insurance Fund, home palliative care in Romania this is actually end-of-life care [10]. Unfortunately, data provided by ANIP in the Catalogue of palliative care suppliers and data published on the local health insurance funds’ websites indicate that the number of home palliative care suppliers is very small — there are many counties which actually do not have such services — and the allocated funds are extremely low. The estimated reimbursed amounts incurred by palliative care wards are much higher than ones reimbursed for home care, yet in the lack of an analysis of the cost data in such wards it cannot be said whether the tariff per a hospitalization day allocated through the Framework Contract is adequate or not, or whether the funds were used effectively or efficiently, for the very patients needing palliative care.

The analyze of the correspondence between the patient’s county of residence and the county of the hospital to which such a patient was admitted for palliative care, one may notice that there are counties in Romania where patients needing palliative care do not benefit from it or have a limited access. This is because in their counties there are no hospitals to offer specialized care and they need to go somewhere else, only if they have the necessary money and they are able to find a free place in a hospital.

Those who are not able to do this will most likely not benefit from specialized care and their quality of life will permanently and quickly deteriorate leading to their death. This refers to the patients from counties classified above in group E: Gorj, Valcea, Dolj, Olt, Mehedinti, Teleorman, Giurgiu, Dambovita, Ialomita, Tulcea, Vrancea, Covasna, and Harghita. Currently, the patients from the Southern part of our country seem to be concentrated in Bucharest, yet only a few patients living in such counties have actually access to hospitalization in a palliative care ward, since it is only approximately 1 patient to 10,000 residents that was hospitalized in such a ward in 2016. Unfortunately, in counties where there are fewer beds for palliative care, the situation is not balanced by contracting more suppliers of home palliative care.

At the opposite spectrum lie Bucharest and Iasi where the rate of admission to palliative care wards was 8.59/10,000 inhabitants, respectivele 22.57/10,000 inhabitants, which at first sight may lead to the conclusion that the population of these counties is more affected by terminal diseases that the rest of the country, or that here there are much more beds in palliative care wards than in the rest of the country. Statistics concerning the number of beds by specialties are not publicly available, it can only be noticed that in above mentioned counties there are more sanitary units with beds providing such services than in the rest of the country.

As a conclusion, there is a deficit of coverage both with specialty hospital services in the South-West and South of Romania and in the South-East of Romania.

### Table 3 – Situation of Palliative Care in Romania, compared to Austria

<table>
<thead>
<tr>
<th>Indicators</th>
<th>PC 2014 Romania</th>
<th>Population RO (hundred of thousands)</th>
<th>PC + Hospice 2014 Austria</th>
<th>Population AUT (hundred of thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice teams</td>
<td>0</td>
<td></td>
<td>155</td>
<td></td>
</tr>
<tr>
<td>Centers of palliative care</td>
<td>0</td>
<td></td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Home palliative care - Romania</td>
<td>20</td>
<td></td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Units with beds - palliative care</td>
<td>47</td>
<td></td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Units with beds - Hospice</td>
<td>0</td>
<td></td>
<td>9</td>
<td></td>
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<tr>
<td>Day care centers</td>
<td>5</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Ambulatory palliative care</td>
<td>3</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Mobile hospital teams for palliative care</td>
<td>4</td>
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<td>0</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>79</td>
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<td>152</td>
<td></td>
</tr>
<tr>
<td>Patients (thousands)</td>
<td>14</td>
<td></td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Population (thousands)</td>
<td>19,292</td>
<td></td>
<td>8,505</td>
<td></td>
</tr>
</tbody>
</table>

### Graph 8 – Situation of providers of palliative care, reported to 100 thousand inhabitants in Romania and Austria in 2014
Transilvania and of home palliative care in most of the regions, judging by the minimal funds allocated in this regard by the National Health Insurance House (NHH). As shown above, the annual need for home palliative care could be of roughly 4000 patients, despite the fact that NHH is currently reimbursing approximately 90 patients. If this current trend maintains its evolution and the need increases by 30% per year, the lack of quick measures in this regard may become a major issue for these patients. The constant and major increase in the number of hospitals with specialized wards is accompanied by the increase in both the admission and death rate. These arguments confirm the idea that a further development of palliative care services both within and outside hospitals is necessary, since many patients would thus probably have a more peaceful death and a better quality of life during their last moments if tended to within their family environment. Although among the 10 top reasons for admission to palliative care wards are frequently included chronic cerebrovascular conditions, serious cardiovascular and respiratory conditions, according to the current legal regulations, these patients cannot receive home palliative care since it is only meant for patients suffering from oncological conditions and HIV/AIDS. It would be necessary to extend the range of conditions for which home care can be provided, in order to reduce the pressure placed on hospitals and to ensure an adequate quality of life for patients who could benefit from palliative care within their family environment. Also, it would be necessary that physicians of other specialties (cardiology, neurology, internal medicine, pneumology or with competences in palliative care) who have treated such patients in the hospital or ambulatory care units be able to issue a recommendation of home palliative care. The number of physicians with a training in palliation is still limited so the legal provisions, requiring a multidisciplinary team with a full-time staff, although aimed to ensure an adequate quality of care, they actually limit the access on the market of health care services for the small-sized home care suppliers which, in spite of their reduced staff, might actually represent a very good solution particularly for the rural patients. A temporary measure could be to allow specialized staff to work part time, according to the number of patients actually assisted, until the demand and offer will be balanced. There are data and arguments, some even provided by this work, supporting the articulation of a coherent strategy in the field of palliative care to take into account both the assessment of the actual needs, definition and differentiation of palliative care from end of life care, training of necessary professionals, the adequate service reimbursement and structuring of specialized assistance. These should be based on joint action of different pillars of assistance: hospice – mobile teams and sanitary units with beds, palliative counselling centers, ambulatory care units, day care centers, mobile palliative care teams, sanitary units with beds and home palliative care. Although the first steps have been taken and numerous NGOs and ANIP have got involved, it is necessary that society and health care system become aware of the importance of this specialty and start a health policy process to ensure a fair access of the patients to this type of care.

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3. Autoritatea Națională de Management a Calității în Spital, Standarde de acreditare și liste de verificare ediția a doua, Capitolul II Managementul Clinic, disponibil la http://amncs.gov.ro/web/standarde-de-acreditare-si-liste-de-verificare-editia-ii/ accesat in 08.06.2017
4. Ordinului ministrului sănătății și familiei nr. 457/2001 privind reglementarea vedenimii și codificării structurilor organiza-torice (secții, compartimente, laboratoare, cabine) ale unităților sanitare din România, cu completările ulterioare
9. Ordin 1728/DG266/2017 al Ministrului Sănătății și presedintelui Casei Naționale de Asigurări de Sănătate privind a-probarea Normelor Metodologice de aplicare în anul 2017 a Hotărârii Guvernului nr 161/2016 pentru aprobarea pachetelor de servicii și a Contractului Cadru care reglementează condițiile acordării asistenței medicale, a medicamentelor și a dispozitivelor medicale, în cadrul sistemului de asigurări sociale de sănătate pentru anii 2016-2017
10. MINISTERUL SĂNĂTĂŢII ŞI FAMILIEI, ORDIN nr. 318 din 7 aprilie 2003 pentru aprobarea Normelor privind orga-nizarea și funcționarea îngrijirilor la domiciliu, precum și autorizarea persoanelor juridice și fizice care acordă aceste servicii, MONI-TORUL OFICIAL nr. 255 din 12 aprilie 2003