ROMANIA: general context

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Overview, 2007

Indicator	Romania	EU-27
Population density / sq km	90.5	116
GDP/capita, $PPP	11755	32700
Population below poverty line	24%	17%
HDI	0.837	0,937
Life expectancy (years)	73.5	79.3
Health expenditures as % of GDP	4.7 %	8.1%
Public health expenditures as % of GDP	3.7%	5.9%
Total health expenditure per capita, $PPP	592	1911
Physicians / 100,000	224	321.6
Hospital beds / 100,000	654.3	564.8
Inpatient care admissions / 100	24.2	17.6

Sources: Eurostat, WHO, IMF, UNDP

Health issues

- Highest TB incidence in Europe
- Mother and child health
- Vulnerable groups
- Mental health
- Ageing
- Smoking, alcohol consumption & other behavior related health problems

Romanian healthcare system

- Former Semasko
- Largely public - ownership, financing, while delivery of care is mixed
- Based on social health insurance without competition between funds, no private insurance plans
- Hospital-oriented, poor GP gate-keeping system
- Ascending private sector - direct payments
- Decreasing role of DHAs
- Transferring hospitals to local councils

Methods of payment

- GPs: capitation + fee for service
- specialty ambulatory care: fee for service
- Hospitals: case-based (DRG) for acute care (280), per diem for chronic & rehabilitation, per service for day hospitalization, national programs

Health system (cont.)

- Overall performance of health system: rank 99 (1st: France)
- Life expectancy: rank 90
- HDI: rank 63 (1st: Norway)
- Euro health consumer index: rank 32 of 33 states (1st: Netherlands)

sources: WHO 2000, WHO, EHCI 2009

Main issues

- Under-financing
- Poor access especially for rural population
- Infrastructure not adapted to health needs
- Still centralized, authoritarian, bureaucratic
- Paying with public money not necessary services
- Over utilization of hospital services, underuse of ambulatory care
- Lack of clinical guidelines, protocols & standards
- medical personnel: low salaries, migration
- Poor management capacity
- Changing legislation

- Basic package not clearly defined
- Some direct payments exist in public system for several services
- Persist communist mentality of “free healthcare” and lack of individual responsibility for health
- Spread informal payments largely accepted, especially in hospitals
- Former and current minister released idea of introducing official payments in 2010
- Population is not well informed about
- Low willingness to pay besides their contributions, especially in rural and poor urban areas

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Romanian consumers and providers perspective on co-payments

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Findings from focus groups discussions

- Focus group discussions on patient payments in Romania
- Data collected in June-July 2009
- Transcripts and translation
- Intermediary analysis

Research objectives

- Attitudes, their reasons
- Acceptability from social, cultural point of view
- Views about the implementation of the co payments in Romania from the perspective of the providers and consumers

Research approach and methodology (1)

- The interpretative paradigm (many truths, need to look to the each one reality, from the point of view of those concerned, involved by that reality)

- Accordingly with this paradigm the answers were considered firstly in a qualitative manner, and less in a quantitative one

- Some quantitative data collected through a semi structured questionnaire - to validate the answers obtained in qualitative phase rather than represent findings per se

Research approach and methodology (2)

For opinions, attitudes, social acceptability will be analysed:

- The direction of the opinions,
- The direction of social acceptance (positive, negative)
- The intensity of social acceptance or rejection
- The contrast between consumers and providers respondents categories
- The potential conflicts could arise consequently
- The possible tensions among the actors.

The opinion of health care consumers (1)

- The consumers are generally reluctant to co payments (INTERVENTION REJECTION ATTITUDE – ESTIMATED RESISTANCE-ADAPTATION MECHANISMS-PERVERSE EFFECTS)
- They agree the co-payments to be applied for those abusing and using excessively or searching for not recommended/without referral, luxury services (CONDITIONAL ACCEPTANCE RELATED TO THE "OTHER" PATIENT BEHAVIOURS)

The opinion of health care consumers (2)

- They experience frustrations about the fact that even they are paying their contributions as individuals and their employers too, when they need services again they have to pay for basic things (FRUSTRATIONS RELATED TO THE ITERATIVE PAYMENTS EXPERIENCE).
- They doubt that the money will be really used for the improvement of health services delivery (BASIC DOUBTS REGARDING THE FAIRNESS OF THE MONEY USE-MISTRUST IN STATE/PUBLIC INSTITUTIONS GOALS)
- The patients have not any trustful information or control about the money flow or use (MARGINALISATION/EXCLUSION FEELINGS RELATED TO THEIR DISADVANTAGEOUS STATUS/POSITION COMPARED TO PUBLIC INSTITUTIONS)

The opinion of health care consumers (2a)

Reluctance to co payments

Frustrations iterative payments

Doubts the money use

Lack of information or control the money flow

The opinion of health care consumers (3)

The consumers consider

- The co payment will not solve any of the problems thought to be solved by co-payments (GLOBAL MISTRUST REGARDING THE EFFICACY, THE EFFECTIVENESS)
- Will not improve the amount of money available for
  - providers motivation
  - equipment
  - building rehabilitation
  - quality improvement

  (SPECIFIC MISTRUST REGARDING THE REAL EFFECTS ON THE HEALTH SYSTEM - STRATEGY CONCERNS)
- Will not cancel both sides habit of under table payment behaviour (the patient will still offer, the physicians will still accept) (MISTRUST ABOUT BEHAVIOUR CHANGE POTENTIAL)

The opinion of health care consumers (4)

The consumers consider

Will bring many other problems: (DOUBTS REGARDING THE REAL EFFECTS)

- tensions among patients, among patients and providers (POTENTIAL CONFLICT CONCERNS)
- will diminish the addressability of the real sick persons (ADDRESSABILITY, ACCESSABILITY CONCERNS)
- will be a very heavy, unbearable burden for some poor people (ECONOMIC BURDEN CONCERNS)
- will develop perverse reactions on behalf of both providers and consumers ()

The opinion of health care consumers (5)

- No co payment should be asked before to clarify the content of basic package (ACCEPTANCE CONDITIONED BY THE CLARIFICATION OF THE EXCHANGE BETWEEN HEALTH STRUCTURES-PATIENTS – CONTRACTUAL FAIRNESS DOUBTS)
- Emergencies, services for children and for severe handicaps, for poor people should be definitively excluded from co-payment (ACCEPTANCE CONDITIONED BY EXEMPTION CRITERIA – ACCESS, EQUITY CONCERNS)
- The money gathered from co-payments should be allocated at local level, otherwise no effect will be noticed (ACCEPTANCE CONDITIONED BY THE FINAL MONEY ALLOCATION)

The opinion of health care providers (1)

The health care providers think that the co-payment:

- is partially effective (DOUBTS ABOUT THE EFFECTIVENESS)
- cannot rehabilitate or repair the gaps in financing (DOUBTS ABOUT REACHING THE PURPOSE-GOALS – THE STRATEGY UNDER QUESTION)
- cannot be a real support in acquiring a new equipment (DOUBTS ABOUT THE EFFECTIVE CHANGE POTENTIAL)

The opinion of health care providers (2)

- The population would become more responsible about the own health (using rather the preventive services, following the diet recommendations, complying with the treatment etc.) (PATIENT MENTALITY EMANCIPATION – HOPES-EXPECTATIONS)
- It would be tempered the excessive use/over utilization of health services (PATIENT BEHAVIOUR EVOLVING – HOPES/EXPECTATIONS)
- Also they see as an important advantage that everybody would understand that the health has a price (SOCIETY PERSPECTIVE BECOMING MORE REALISTIC, MORE RESPONSIBLE – HOPES/EXPECTATIONS)

The opinion of health care providers (3)

- Generally they would exclude from the co-payment: the children, the poor people, those with severe health condition (EXEMPTION RULES NEEDED – MORAL/ETHICAL INQUIERIES)
- Related to the income, they would ask it to all other categories (A LARGE, SOCIALLY TAILORED INCLUSION – INFERENCE EXPECTATIONS)
- They consider that only if the money collected would remain to local level, it could be possible to see any positive consequences regarding the health services delivery, quality (ACCEPTANCE CONDITIONED BY THE FINAL MONEY ALLOCATION)

The opinion of health care providers (4)

- As the consumers, the providers too do not believe that the co-payment will reduce the under table payments BASIC DOUBTS ABOUT UTILITY
- Additionally, they do not want to be involved in the pragmatic, operational aspects of communicating to the patients the criteria for co-payments/exemption, or providing the bill, or cashing considering that is not their job, task and that would bring enormous tensions among those directly involved DECLINING THE ADDITIONAL IMPLEMENTING EFFECTS, EFFORTS
- Rather they prefer that the patients would pay firstly everything and afterwards will be reimbursed by National Health Insurance House ACCEPTANCE CONDITIONED IF THEIR PROFESSIONAL TASKS WILL NOT BE CHARGED

The opinion of health care providers (5)

- What will be gained by the co-payments could be wasted by the operational needs brought by this new mechanism: the staff involved (training, supervision) the formal documents to be filled in (a bureaucracy increase) RESOURCES WASTING IN IMPLEMENTATION AND RUNNING PHASES
- They see very necessary the protocols, guides STANDARDIZATION of THE MEDICAL PRACTICE

Overall policy recommendations (1)

It appears that accurate, valid and reliable simulations should be done in order to see:

- The co-payment EFFECTS on efficacy, equity and quality of services in order to measure:
  - the real BENEFITS,
  - the real IMPACT on micro and macro level of the health system.
- A better COMMUNICATION among patients, providers and decision makers’ categories is highly needed

Overall policy recommendations (2)

- Some aspects of health services delivery contracts should be:
  - completed and
  - clarified

  - a more clear definition of basic health services package
  - more transparency in money use
  - a deeper involvement of patients and providers in decision making process

FORMAL/LEGAL/ASSUMED PARTNERSHIP

Key messages for policy-makers and society (1)

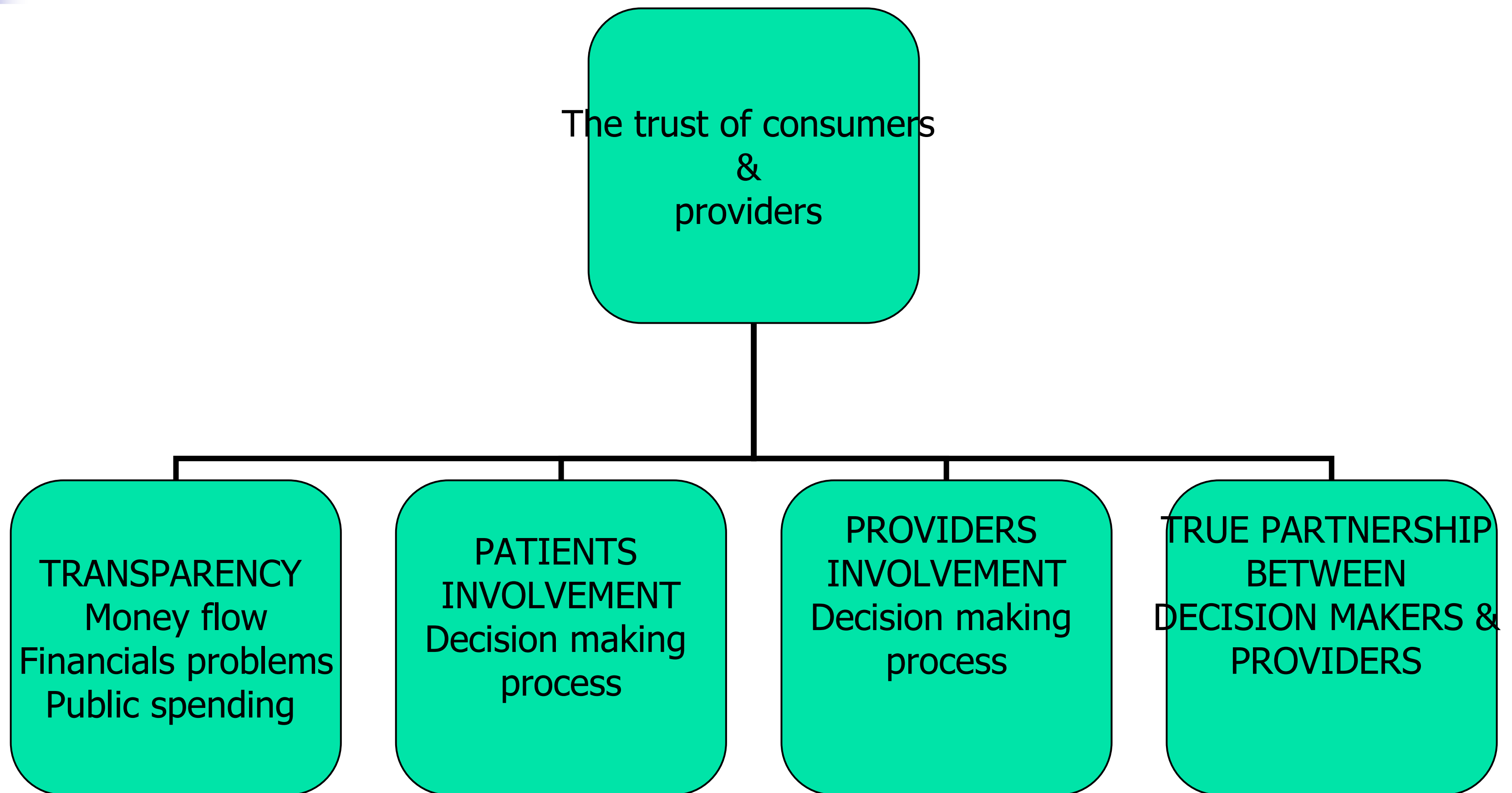
- Findings: Reliability/Credibility
- The health system failed in gaining the confidence of the consumers & providers regarding:
  - the right, adequate use of money collected and
  - the equitable use of services

The relationship is dominated by mistrust

Key messages:

- More transparency about the money flow, the financial problems met
- Displaying, proofing more the public spending
- To involve the providers and consumers in decision making process
- The decision makers should adapt and adjust the reasoning to the patient/providers expectations, in order to have their support and to build an effective consensus

Building trust in system-beneficiary relationship (1a)



Key messages for policy-makers and society (2)

- Findings: The co payment is not seen as a solution for financial problems of the health system:
  - the amount of money would be insignificant
  - the money use would not be transparent, responsible
- Key message: To be involved more health economics, public health experts in simulating the effects of different input into the system on quality, efficacy, efficiency (scientific, technical approach)
- To disseminate, open public debates about this, in order to inform the people about
  - The philosophy
  - The pragmatic aspects and
  - The consequences

The negative perception about co-payment (2a)

Co-payment is not a solution for financial problems

- SCIENTIFIC/TECHNICAL APPROACH

  Rather than experimental
- DISSEMINATION
- PUBLIC DEBATE

Key messages for policy-makers and society (3)

- Findings: The balance between the concept and operational level of the co-payment is difficult to be achieved as many of people, structures involved did not become real partners in the social relationship/contract of providing/delivering, using/supporting the health services.
- Key message for decision makers: To be realised social contracts at community, individual level between decision makers, providers and consumers, to make clear what can be offered and what is the real demand.

Key messages for policy-makers and society (4)

- Findings: The discussion about the co-payment revealed many others problems of health system as would be:
- Low quality of health services
- Low access
- Low addressability
- Inequity
- Poor definition of basic services package
- Lack of awareness of population about the level of expenditures
- Tensions among policy makers, providers and users
- Mistrusting each other

ASSPRO: In-depth interviews findings – Romania, 2009

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Maastricht, March 2010

11 interviews

- **MoH**: 2 representatives
- **district PHA**: 2 representatives
- **NHIF**: 2 representatives
- **district HIF**: 4 representatives
- **College of Physicians**: 1 representative

- 10 MDs, 1 economist
- Management positions, mixed professional background

- Period: June-August 2009

General considerations

- Official patient payments are necessary in Romania, like other reforms
- Purpose: for filtering access to medical services, less for increasing funds
- Main concern for consumer reaction after 50 years of “free healthcare” communist mentality

HIF representatives

- Clear & realistic basic package need to be established before introducing PP
- PP should cover a % of health service cost
- But socio/economic status of different groups needs to be considered
- PP could decrease unnecessary / overuse of some medical services & make patients become aware of
- Health expenditures cannot be controlled through PP
- Economic categories & health system criteria are to be considered for PP
- Population should be informed about PP

HIF representatives (cont.)

Informal payments:

- largely tolerated and excused, except for preconditioning
- are expected to be decreased but not replaced by PP
- should be studied as realistic estimation for patient willingness to pay officially

MoH & DHA representatives

- PP - useful to limit utilization of medical care paid from public funds (aimed for absolutely necessary care)
- Co-payments or co-insurance as additional contributions to health services aside from what social insurance & national programs cover
- PP will discourage overuse of medical care and generate additional resources but not necessarily for providers
- Consider economic, medical & social criteria while cultural, historical or ethical would induce discrimination

MoH & DHA (cont.)

Informal payments:

- complex, Balkanic, very extended phenomenon, difficult to approach
- custom, sign of gratitude from patients after receiving the service, not to be blamed
- could be decreased by PP in ambulatory, but impossible to extinct from hospitals

Preliminary conclusions

- PP are useful but not as a financial solution for Romanian underfinanced health system
- PP at realistic levels will filter the use of medical services
- economic context and individual perceptions must be considered for implementing PP system
- using co-payments is difficult because of financial issues, mentalities, inequity & poor communication

Preliminary conclusions (cont.)

- aspects of basic package & health care delivery should be clarified
- IEC campaign about PP is recommended before applying PP system
- transparency in the use of resources (including PP) needs to be assured
- informal payments are very extended and tolerated in health sector, while PP would diminish them only if providers could use the resources generated