Reproductive Health Financing Issues in Romania: An Update

by
Dr. Dan Aurelian Lazarescu

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Contents

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I. Background

This paper provides a background on the financing of health care and identifies and discusses reproductive health (RH) policy issues in the context of the social health insurance system in Romania.

Financing of Health Care in Romania

Health care in Romania is financed through a multilevel system:

1. *Social Insurance.* The National Social Health Insurance (NSHI) is government operated and makes up 65 percent of health expenditures in the country. It is funded through premium contributions from employees and employers who are each contribute the equivalent of 7 percent of the workers' pre-tax salaries. Part-time employees, farmers and self-employed workers are also eligible for insurance coverage and they must contribute with 7 percent of their income to the NSHI. The Health Insurance House (HIH) uses this fund to buy medical services from health care providers. The majority of health care providers have a contract with HIH.

2. *General Taxation Revenue.* State budget funds allocated to the MOH for national-level preventive and sometimes curative health programs (approximately 31). This constitutes 15 percent of health expenditures and covers drugs, health promotion, research and management. It also provides for the salaries of some medical providers.

3. *User Fees/Out-of-Pocket Payments.* Responsible for about 20 percent of health expenditures (World Bank estimates), such payments fall into three categories:

    - *User fees.* Fees that patients pay directly to public providers for health services (e.g., high-tech procedures and/or medical services performed at patient's request, without a clear medical indication), or drugs (30 percent or more of compensated drugs' reference prices, or 100 percent for drugs not in the compensated list and thus not covered by the social insurance fund. This is a legal payment; the patient is issued a receipt for payment received.

        - *Voluntary health care purchases from private providers.* Also considered legal payments, these are made at the discretion of the consumer; the patient is issued a receipt for payment received.

        - *Informal payments.* Private payments/donations to public doctors, nurses, and other health personnel. While these payments compensate for low earnings of health personnel, they are illegal, outside the system's financial control and unreported.

Ownership of Medical Facilities in Romania

Medical facilities in Romania fall into the following categories on the basis of ownership:

1. *State-owned Facilities Having a Global Contract with the HIH.* The Ministry of Health (MOH) owns the majority of these facilities. However, these facilities have a contract with the HIH for services provided by physicians who are paid a fixed monthly salary by the facility. Salaries for doctors, nurses, and other personnel are determined by the government, independent of activities undertaken. This is the case for all hospitals and specialists, others than family doctors or other general practitioners (GPs) (see section entitled "Organization of Health Care in Romania" below), in some secondary-level facilities.

   There is no correlation between the activities reported by doctors (in points) and their fixed salaries. However, points corresponding to the services provided are reported to facility managers who, in turn, report them to the HIH, which pays each facility a stated amount. Facility managers are in charge of paying the fixed salaries to doctors, medical and, nonmedical personnel, as well as covering maintenance/operating expenses, including disposables. Informal payments frequently occur at this level because salaries are very low.

2. *State-owned Facilities with Staff Paid by the MOH.* These facilities are very rare, and the MOH is their designated owner. Using state budget funding, the MOH pays the facilities' doctors and nurses a fixed salary, independent of activities undertaken, as well as maintenance/operating expenses, including disposables. This was the case for family planning (FP) cabinets before 2000.

3. *State-owned but "Rented" Free-of-charge to Physicians.* This type of organization applies to (1) family doctors at the primary care level; and (2) specialists, others than family doctors or other GPs (see section entitled "Organization of Health Care in Romania" below) in some secondary-level facilities. Providers have five-year licenses to operate these MOH-owned facilities (buildings and their medical equipment) on condition that each facility doctor has direct contract with the HIH and that existing personnel (nurses, etc.) are retained for a certain period of time. In this case, payment of both the *cabinet* (clinic) and doctor is activity-dependent. Family doctors are paid under capitation and fee-for-services (FFS) for a few specific types of services, while specialists are paid on an FFS basis. The physician has the obligation to pay the nurse(s) and other medical personnel and to support maintenance/operations of the facilities, including disposables.

4. *Privately Owned Facilities with an HIH Contract.* In this category, which applies only to some specialists, the facility is the property of one or more physicians or a commercial company.[1] It has a contract with the HIH, but prices paid for medical services are below profit, because they do not cover the cost of investment in buildings, medical equipment, and management. HIH' contracts with specialists working in both "rented" free-of-charge and privately owned, HIH-contracted facilities (categories 3 and 4 above) are based on identical prices for specific services. Specialists working in "rented" free-of charge cabinets (category 3), which have existing buildings and some equipment, can operate more readily and immediately with no further major investments. However, specialists working in privately owned, HIH-contracted cabinets (category 4) must build or rent a building and buy medical equipment even before they can initiate any insurance-funded activity. Thus, HIH payments would be reasonable only for free-of-charge cabinets (category 3), yet below the profit level privately owned, HIH-contracted cabinets (category 4). Additional services not covered by the HIH are also performed, whereby patients are charged fees that incorporate overhead and profit.

5. *Privately Owned Facilities with No HIH Contract.* In this category, which applies only to some specialists, the facility may also be the property of one or more physicians, or a commercial company; however, in contrast to the privately owned, HIH-contracted facility (category 4) above, it does not

[1] Some restrictions may apply.

have any contract with the HIH, although its clients may include insured persons. This occurs because many facility doctors consider entering into contracts with HIH to be too tedious, time-consuming, and bureaucratic. They also believe that income earned under health insurance is insufficient to offset informal payments that often must be made to facilitate HIH administrative requirements and processing. Thus, private facility managers prefer to charge user fees for consultations, testing, and other laboratory procedures provided in their facilities.

Clients, on the other hand, choose these facilities because they are well equipped and are perceived as having high medical and professional expertise, or may have standard professional expertise amplified by good advertising and marketing. The fees are high because of a large initial investment. It is estimated that only 10 percent of the population can afford private facilities. An increasingly large number of medium and large private companies located in large cities are asking these private facilities to provide regular medical checkups for employees, for a direct $15–25 monthly fee per employee. This negotiated fee is distinct from contributions employees are already paying to the NSHI every month. There seems to be a preference for such private services despite additional costs because (1) service quality standards are higher, (2) staff are perceived as friendlier, and (3) services are immediately provided compared to longer waiting times in other facilities. Private medical care is also considered an additional "bonus" for employees. However, the absence of an HIH contract means that patients cannot be reimbursed for drugs prescribed at these facilities.

6. *Individual Cabinets within Large Private or State-owned Companies.* Large companies sometimes prefer to have their own medical cabinet, in which GPs, but not family doctors, are paid a fixed salary by the company. GPs attend to minor medical problems and emergencies. The company prevents overuse of medical services by their employees and thus reduces nonworking days for medical reasons. There is no contract with HIH and only the employees have access to the facility. Due to the investment made by the company, these facilities are well equipped and employees' access is free-of-charge. The absence of an HIH contract means that patients cannot be reimbursed for drugs prescribed in these facilities.

   Special Comment on #5 and #6. Although some private large companies make serious financial health care efforts by remitting their monthly contributions to the NSHI (7 percent employers' contributions to match 7 percent from workers' pretaxed salaries) and by either paying a monthly fee to privately owned cabinets with no HIH contract (category 5) or making investments in their own cabinets, their insured employees still encounter problems. Company employees still need to use other facilities to receive drug reimbursements, which can be time consuming. A new legislative provision (Article 40, Health Insurance Methodological Norms, January 2001), granted after lobbying by the College of Physicians (COP), allows these category 5 cabinets to prescribe reimbursed drugs for patients who can prove their insured status. The COP argued that it is the patient's right to have reimbursed drugs and not the facility's privilege to prescribe them. However, strong opposition still persists in the HIH system, as some local HIHs use time-consuming and bureaucratic procedures to discourage this type of contract.

Special Case
MOH-certified GPs Trained and Competent in FP and Not Acting Like Family Doctors

While GPs in FP clinics do not have "specialist" degrees, the HIH recently agreed to attribute points for FP consultation (15 points/10 points—new/old case) and other Ob–Gyn services provided by trained GPs in FP cabinets. FP cabinets, organized and owned by the MOH, are attached to hospitals or are located within hospital grounds. FP cabinets belong to those facilities in which hospitals have contracts with the HIH and physicians (GPs and Ob–Gyns) and nurses, working in the FP cabinets, are paid with a fixed salary. In addition these cabinets receive free contraceptives and other disposables from the MOH through state budget funding for National Health Program No. 12. This special "accommodation" provided to FP cabinets by the HIH is not a common practice under the new health care system; it came about as result of advocacy, intense negotiation, and international technical support. This has resulted in double funding of FP cabinets, in which the MOH provides free contraceptives through National Program No. 12, while the HIH pays for services provided in FP cabinets. This is also illustrative of what could result from cooperation among the HIH, MOH, and COP to fix a health care problem. Such collaboration can serve as a model for addressing other health problems. The challenge is to maintain this cooperation well into the future.

Organization of Health Care in Romania

The health care system in Romania is organized at the primary, secondary (ambulatory), and tertiary (hospitals) levels described below.

Primary level

The primary level consists of family doctors and some GPs providing basic medical services, whom are paid by the NHSI. These doctors are required to enroll approximately 1,500–2,000 people on their list and to provide basic medical services according to the family doctor's training curriculum.[2] Patients who cannot be treated at this level are referred to the secondary-care level or directly to the tertiary level. Payment involves either capitation (CAP), which is age weighted (responsible for 70 percent of the physician's income), and FFS for specific medical services. The latter accounts for 30 percent of the family doctor's income.[3]

The HIH also provides funds for the maintenance of primary-level cabinets and for the salaries of nurses and other nonmedical staff. While linked to services and capitation for enrolled patients and emergency treatments, this specific funding cannot be considered physician revenue. At the end of the year, the cabinet must return any unused funds to the HIH. There is, however, ongoing debate as to whether physicians can tap unused resources for investments in their cabinets, instead of returning unused funds.

[2] These requirements have fostered close linkages between the HIH and the COP.
[3] For remote rural areas additional, financial incentives are available (up to 100 percent).

Secondary level

The secondary, or ambulatory, level consists of specialists, other than GPs and family doctors, who provide advanced medical care (consultation, investigations, laboratory tests) in all medical specialties (cardiology, gastroenterology, etc). Secondary-level facilities include the following:

Facility Type	Source of Funding	Payment to Doctor
State-owned facilities paid by the HIH	NHSI + legal user fees + informal payments	Activity independent fixed salaries
State-owned facilities that are "rented" free-of-charge to specialists	NHSI	Variable, activity dependent
Privately owned facilities with HIH contracts	NHSI + out-of-pocket payments (legal)	Variable, activity dependent
Privately owned facilities without HIH contracts	Out-of-pocket payments (legal)	Variable, activity dependent

Tertiary level

This level includes all public hospitals,[4] which are state-owned facilities with HIH contracts. They receive funding from several sources: the NHSI, legal user fees, informal payments, and, because many national programs are run through hospitals, general tax revenue. Doctors' payments, as well as the payments for nurses and other personnel, is activity independent since they are paid fixed salaries. Moreover, informal payments paid at this level are more common and tend to be higher and most significant in surgery departments.

[4] There are no private hospitals at present.

RH Services Provided at Various Levels

Services provided at primary and secondary levels

Type of Service	Payment Method/ Source of Funding
Primary Level: Family Doctor Networks	
New STD case/contact diagnosed and confirmed by a specialist (20 points)	FFS/HIH
Pregnant surveillance, as follows enrolling/registering (10 points)[5]	FFS/HIH
Surveillance between months 3 and 9 (8 points)	FFS[6]/HIH
Surveillance after delivery and after four weeks (8 points)	FFS[7]/HIH
Basic family planning services - Consultation[8] - Indication of a contraceptive method to risk free patients	CAP/HIH
Screening for cervical and breast cancer, PAP smear, where adequate medical equipment is available according to MOH procedure	CAP/HIH
Minimal laboratory test in World Bank rehabilitated rural dispensaries according to available equipment and family doctor training[9]	CAP/HIH
Counseling for a healthy lifestyle	CAP/HIH
IUD insertion by family doctors where technical equipment or professional expertise, is available[10,11]	CAP/HIH
Secondary-level Services Paid by Health Insurance	
Insertion of an IUD (10 points)	FFS/HIH
Removal of an IUD (8 points)	FFS/HIH
Abortion (25 points)	FFS/HIH
Babes–Papanicolau sampling (8 points)	FFS/HIH
Consultation new case (15 points)	FFS/HIH
Consultation old case (10 points)	FFS/HIH

Note: In addition, the family doctor may refer a patient for cervical cancer or HIV screening to a laboratory; if the lab has a contract with the HIH, then the insurance will cover the cost of these tests.

[5] Detailed consultation, physical examination, Ob–Gyn examination, a set of nine laboratory tests, counseling for the pregnant woman.
[6] For each consultation.
[7] For each consultation.
[8] As a general definition, a medical consultation includes the examination of the patient, the interview, prescribing the drugs, training for using drugs, and devices. Therefore, the counseling, an FP-specific activity, is covered when the term "medical consultation" is used.
[9] It is unclear who will pay for the disposables used with the WB equipment, the HIH doesn't have the right to contract these services with family doctors (only with specialists in Laboratory Medicine), probably is a "user fee" financing type.
[10] FFS services by primary care providers are limited. These include care for newborns and infants less than one year of age.
[11] A lot of debate exists about IUD insertion at primary care level by family doctors. Theoretically, the latest training curricula allows them to insert IUDs, but not all cabinets are well equipped for this procedure. On the other hand, there is powerful opposition from Ob–Gyns, who insist on safety aspects, claiming the low professional expertise of family doctors and lack of emergency equipment especially in rural areas.

Services provided at the tertiary level

Specialists are employed by hospitals (owned by the MOH) full time. Some of these specialists, outside the regular program, offer medical services in secondary-level facilities. Specialist at this level treat abortion complications, attend to normal and pathological deliveries, and diagnose and treat breast and genital cancers as well as STDs—on an inpatient basis. (Although it is probably less expensive to treat STDs at the secondary level, many higher risk patients, such as commercial sex workers (CSWs) whose work is illegal, are generally not registered with a family doctor. In such cases, treatment in hospitals is necessary. Transforming CSWs into legal "independent service providers" will solve at least one medical problem—prevention of STD due to on site examination.)

Services provided through MOH-funded national health programs

The MOH, through state budget funding, undertakes various national programs related to RH care, with the majority of such funding currently directed to hospitals. The hospitals are expected to manage these resources efficiently, although it is generally accepted that these national programs are often underfunded and rarely evaluated to assess cost-effectiveness. Specific RH national programs are

- Surveillance and control of HIV/AIDS
- Surveillance and control of STDs
- FP and healthcare of mother and child
- Surveillance and control of neoplasmic diseases
- Health education

Drug Reimbursement Policy

For hospitalized patients

Patients admitted to hospitals will theoretically receive any medication approved by the National Drug Agency (similar to FDA) to cure their disease free-of-charge. In reality, however, because of limited health resources, hospitals continually experience stockouts for many categories of drugs. Patients, hence, have little choice but to buy these drugs from pharmacies outside the hospital system.

For ambulatory care

In order to receive reimbursement for medication, patients must (1) prove that they are insured; (2) have a prescription (for no more than three drugs and at a cost below $40 for one single monthly prescription), written by an accredited physician in a facility that has a contract with HIH;[12] and (3) purchase such drugs from a pharmacy also having a contract with the HIH.

In actuality, patients would have to find pharmacies willing to sell HIH-reimbursed drugs. Occasional late payments by the HIH to pharmacies have led many to suspend sales of HIH-reimbursable drugs until they receive payment. Thus, having certain drugs on the HIH "positive" list is in itself insufficient to ensure patient access to subsidized drugs.

[12] The National Commission, with representatives from the COP and HIH, is the official body that accredits medical providers working in facilities having a contract with HIH**.** The National Commission sets the standards for local commissions, which actually run the process at the local level.

If the patient cannot prove that they are insured, they will not be reimbursed for drug purchases. After receiving a valid prescription, they have to pay 30 percent of a reference price of the drug (co-payment). If the price is above the reference price, the co-payment becomes greater than 30 percent. For specific diseases, like diabetes, there is zero copayment. Annually, the HIH and MOH negotiate two lists of drugs—the co-payment and the zero co-payment.

II. Issues

Issue #1: Allocation of Points under the New Health Insurance System May Create Incentives that Encourage Abortion Services Relative to FP Services (e.g., IUD insertion)

Discussion

- In 2001, abortion is valued at 25 points. An IUD insertion receives 10 points. At first glance, the relative allocation of points under the health insurance system may be interpreted as providing an incentive for physicians working in public ambulatory facilities to perform abortions rather than provide FP services. However, a closer look shows that 25 points are equivalent to just US$4.99, which is sufficient only to cover the cost of an abortion in public facilities. There is no profit margin at this price. Hence, there is little incentive to perform abortions. There is also no incentive to provide this service in public facilities where doctors' salaries are fixed, independent of services. In public facilities where user fees are charged, an extra US$3 user fee is charged for every procedure. This user fee is deemed too small to serve as an incentive for the facility and serves only to cover related costs for the procedure. Overall, the total of US$7.99 for an abortion does not serve as an incentive for Romanian facilities to encourage this procedure.
- Abortion fees in private facilities are likely to be much higher, but so too are maintenance costs. Hence, currently the system barely provides incentives to encourage abortions. Rather, it may be perceived as providing a disincentive for FP services.
- Reducing abortion points to below 25, or US$4.99, will lead to a situation in which the FFS from insurance will be insufficient to cover the costs of the procedure. Facilities are then likely to solicit a co-payment from clients, thus decreasing access among low-income women and increasing the number of illegal abortions performed outside medical facilities at a tremendous risk to women.

Policy recommendations

- Increase the points for FP procedures. Choice may be better served by increasing the number of points for FP procedures, especially for postpartum/postabortion contraceptive measures, rather than decreasing points for abortion. Currently, through MOH Program Number 12, FP cabinets distribute free contraceptives for targeted populations. This program has potentials if linked closely with postabortion counseling.
- Encourage postpartum/postabortion contraceptive measures. Instead of paying 25 points for an abortion and 15 points for consultation, and so forth, for a total of 40 points, HIH could pay 60 points for this "package" if some measurable action took place.

Issue #2: National HIH List of Reimbursable Drugs Does Not Include Any Contraceptive Products

Discussion

- There are no contraceptive products on the list of reimbursable drugs (the "positive list").
- Out-of-pocket expenditures required to purchase contraceptives at their full price are probably too high for 50 percent of the population who have competing demands (food, housing, heating, children's education) on their incomes.
- Attempting to include contraceptives on the reimbursable drug list would require significant political effort and capital. For one, the effort is likely to meet strong opposition from groups of elders who have, for some time now, been lamenting the absence of certain cardiovascular drugs on these lists.
- Furthermore, the actual benefits of successfully including contraceptives on the "positive" list are debatable. As described in the section, "RH Services Provided at Various Levels," the process of obtaining reimbursable drugs is time consuming and fraught with frustrations. Additionally, poorer populations who are least able to afford to purchase contraceptives are the also the least likely to be represented on a family doctor's patient list, a requirement for reimbursement. They are also most likely to live in remote rural areas with no pharmacies in the vicinity.
- Effectiveness of the reimbursement process can be significantly decreased by the absence of pharmacies in rural areas or by the time-consuming process. Romania, however, does not currently have contraceptives on the positive list; thus, a real comparison cannot be made.

Policy recommendations

- Continue and improve the current policies and practices related to contraceptive distribution. Although contraceptives are not on the reimbursable drug list, at the present time
  - Centrally procured contraceptives (paid for by the MOH) are distributed free-of-charge) in FP cabinets to persons earning below minimum wage, with no income, students, and unemployed persons.[13] Eligible patients do not need to be insured and can obtain contraceptives onsite. There are neither financial barriers nor time-consuming procedures to obtaining these contraceptives. This distribution system should be extended to include family doctor networks, in order to increase access in rural areas. A change in current regulations would allow these physicians to sell/distribute drugs to patients. (At present, they are only permitted to dispense emergency treatment.) However, care must be taken to avoid opposition from the College of Pharmacists, which is likely to fear that, in the future, physicians will be able to sell/distribute any kind of drugs, thus undermining their business. It is not clear at this point whether family doctors want to distribute free contraceptive to their patients, considering that such may be perceived as an extra burden. Pilot efforts in Iasi should be assessed.
  - The MOH provides funds to *judets* to procure contraceptives (in bulk) locally that are then sold at a lower than regular price. Judets are required to use revenue from sales to create a revolving fund for future contraceptive procurement.[14]

[13] Via MOH's Program No. 12.

[14] Some parties question the practice of using scarce MOH funds to buy contraceptives that are then sold at a price, albeit a low one. They argue that those monies are better spent on procuring contraceptives for free distribution. The rationale for this view is that charging a low price for contraceptives will limit access for a significant target population; those who can pay $4 can also pay the regular price of $6; but low-income individuals cannot afford either $6 or $4. Further evidence-based analysis will produce more data in the next months since this system has been working only for four to five months. On the other hand, there is support in the MOH for the two channels because the free-of-charge channel cannot be sustained to cover large population groups in the long term.

- Guidelines and norms should be developed and implemented that (1) effectively target free contraceptives and (2) ensure the proper functioning of the revolving fund.
- Private sector should be involved in meeting the contraceptive needs of better-off clientele.
- The HIH should be encourage to continue and expand coverage of consultations and other services provided in FP cabinets, thus covering the burden of salaries for physicians and nurses, and allowing the MOH to focus its limited financial resources on providing free contraceptives to target groups.

Note: The new government recently declared its intention to increase the "positive" list. If this happens, a new approach can be adopted to reimburse contraceptive methods for target populations (based age, number of children, revenue status). After one year the free/subsidized distribution mechanism and the targeted reimbursement approach can be compared in order to choose the more cost-effective approach in the future.

Issue #3: Health Insurance Coverage for the Uninsured

Discussion

Legislative aspects

- In the basic health insurance law (voted by the Parliament in 1997 (No. 145)), Articles 6 and 9 define insured persons for whom the payment of the insurance contribution is not necessary:
  - Children and persons under 26 years enrolled in a teaching/training process (high school students or those learning specific professions) (Article 6).
  - Spouse, parents, and children (with no income) of an individual paying a single insurance contribution (Article 6).
  - Women during and shortly after pregnancy (Article 9).
  - Persons taking care of sick children under 6 years of age (Article 9).

- Another important legislative document, "General Conditions for Financing the Health Care under the Social Health Insurance System in 2001," requires that medical services providers must[15]
  - Provide assistance in emergency cases (whether or not the person can prove his insurance status). The first presentation of a child or a pregnant woman at a family doctor results in registering these categories of patients on the doctor's list. The newborn will be registered on the same list with his parents, if the parents have no other option.
  - Inform the patients about the medical services that are provided.
  - Respect the confidentiality of the medical act.

- In addition, the document requires that the public HIH must
  - Provide medical information for insured persons (theoretically the majority of the population) and preventive medicine.

Implementation aspects

- The laws favor certain types of clients (e.g., children are automatically considered eligible for public health insurance whether or not the parents are paying a contribution; large families are covered, if

[15] Only attributions relevant for RH issues are presented in this report.

only one member pays the contribution). However, the law can be interpreted (and sometimes is) as meaning that only employed pregnant women should be considered as insured, regardless of premium payment.

- To benefit from the health insurance system, individuals paying contributions or qualifying for exemptions on a temporary or permanent basis must first register to have their names placed on a family doctor list. When registering, they must present documents to prove their contribution payments or one of the exemption criteria.

- Neither the family doctor nor patients know the entire legal framework; often patients who pay no contribution but are eligible (pregnant women having no occupation, for example) are denied registration and thus cannot benefit from the system.

- On university campuses, students clearly eligible for RH services may not be registered immediately because they are young and healthy and do not need medical care. The rationale is that they will see a doctor when they get sick[16] or pregnant.[17]

- Poor or poorly educated people living in the suburbs may encounter difficulties in accessing the system; however, to fully understand the reasons for this (financial, lack of interest or information, impact), a detailed study is necessary.

- Hence, rather than a case of uninsured persons with no access to RH services, Romania experiences a situation in which eligible persons either (1) do not known about the availability of RH services, or (2) are denied access because family doctors and other medical specialists are unaware of legislative changes. This situation is clearly more frequent in rural than urban areas, particularly in areas with low physician coverage.

- However, there are many true uninsured individuals: independent workers, including farmers and those working in the black market, who do not pay contributions[18] to the system and are not exempt.[19] Free access to the health insurance system is denied to such individuals,[20] but is permitted on a user fee basis. Within this group, RH eligible individuals can be found.

- For nonpregnant women, women beyond the need for prenatal care, and persons over 26 years of age that need FP services and STDs treatment, the following options exist:
  - An individual can prove his/her insured status and is registered on a family doctor list (that individual will receive RH services free-of-charge at all three levels).
  - An individual can prove his/her insured status, however is not registered because he/she is not informed about this requirement or there is no family doctor in that area.
  - An individual lives in a rural area and has no regular income. (In this case, local authorities must certify the individual's lack of income and access to the health insurance system by registering on a family doctor list. Detailed regulations concerning this are published by the HIH.)

[16] They can register onsite and receive curative medical care in time.
[17] In this case, the student is too late; the moment for receiving RH preventive care is lost.
[18] They simply do not want to pay or do not have enough financial resources to pay.
[19] On the other hand, any full-time legal employees are considered insured from the day they sign the contract; if their employer does not pay the contribution (e.g., in many state-owned and private companies), employees are still considered insured; the HIH can open a trial and claim the contribution and penalties from the employer; and during this trial, employees never loose their insured status.
[20] Except emergency situations.

- An individual cannot prove his/her insured status because (1) his/her company does not pay the contribution to the HIH; and (2) he/she is working in the informal sector. (In this case, the individual must go to the local HIH, declare at least a minimum income, pay a voluntary contribution, and then register on a family doctor list.)

Policy recommendations

- The HIH and MOH must inform the population, including doctors, about who is eligible for health insurance with and without contributions.
- In the future, any pregnant woman, whether employed or not, should be considered insured.
- The HIH needs to be more active in collecting actual contributions from those who do not want to pay by trying to collect at least a minimum "voluntary" contribution from black-market workers[21] and farmers without income.
- The HIH must encourage people to register on a family doctor list before seeking medical services.
- The HIH, MOH, and COP must cooperate in order to cover all areas with family doctors (it seems that the exclusive financial incentive is not enough to cover these areas).
- Better cooperation between local health insurance and local authorities for better information about people living in all areas. At the present time, family doctors are required to inform patients about insurance policies and change, on behalf of the HIH. However, this does not work well because
  - It is legally required that the HIH inform their customers about the system.
  - Family doctors do not know what exactly to tell patients because they are not supposed to read and teach patients the legislative framework.
  - A better cooperation between the HIH and Ministry of Finance for using the same annual income statements as a basis for collecting the health insurance contribution and general tax revenue. (In my opinion the actual Ministry of Finance has a great experience while working at the World Bank and can understand these aspects.)

Issue #4: Role of the Private Sector in the Health Insurance System

Discussion

What constitutes the private sector in Romania's health system? Although family doctors at the primary care level work in individual cabinets, they do not belong to the true private sector because the MOH owns the cabinets and 90 percent of physicians' income is HIH dependent. At the secondary care level, privately owned facilities, both with and without HIH contract, where specialists (not family doctors) practice, constitute part of the private sector. There are no private hospitals at the tertiary level, and there are no private health insurance companies in Romania.[22]

Private clinics/hospitals with no HIH contract also provide both FP and abortions services.[23] Clients that use these facilities can afford to pay the fees for higher quality services. There is great potential for these private centers to work together with the HIH to provide certain types of RH services that complement those services provided by the public sector (e.g., analysis of PAP smears collected from

[21] This sector represents 40–60 percent of working market (from estimations by the World Bank, IMF, and FBI).
[22] Insurance Law 145 (1997) states that private health insurance companies may exist, but their contribution is optional.
[23] Abortions and other services by private clinics are not reported to the MOH on a regular basis. Health information statistics, therefore, may exclude some data on privately provided abortions

family doctors, provision of FP consultations, and IUD insertions). The HIH and/or MOH could potentially have special contracts limited to these specific preventive activities.

At present, the policy environment in Romania is not conducive for private sector participation as well as collaboration and competition between the public and private sectors in RH service delivery. Some reasons for this follow:

- "All or nothing" contracts that the HIH requires of service providers are not attractive for the private sector, which sometimes opts not to collaborate at all with the HIH.
- Preferring contracts with public facilities, the HIH uses bureaucratic procedures to delay the access of the private sector to public financing.
- As a result, fully private facilities do not have access to health insurance or MOH funds even when they deliver medical services to insured persons. They rely solely on user fees. As a result, the majority of the population who cannot afford to pay user fees do not have access to good medical expertise and sometimes state-of-the-art, high-tech equipment present in private facilities.
- The MOH does not pay private clinics for providing services included in national health programs. Thus, the private sector is not yet a full-fledged partner in furthering national health priorities; more efforts are needed to address this problem.
- Clients in the private sector must pay a lot more for services that require the use of high-tech equipment. In the public sector, clients are expected to pay a small informal payment to the doctor for the use of such equipment purchased using public sector resources. Fees are much higher for private sector clients whose payment covers the cost of purchasing and maintaining the expensive equipment. As a result, private sector facilities are often unable to grow its client base for these types of services.

Policy recommendations

- Create a coherent legislative environment for fair competition between public and private facilities.
- As an alternative to the "all or nothing" contracts, introduce a limited contract to encourage specialized private cabinets to reconsider a relationship with the HIH, thereby introducing a carefully regulated competition between the two sectors. A similar approach can be used for accredited NGOs.
- Provide equal access to public funds through the HIH and MOH for both public and private facilities.
- Institute similar criteria for the evaluation of medical activities performed in both sectors. Often, the MOH uses more permissive standards with public sector facilities.
- Develop clear definitions of the types of services and population segments to be covered by public funds, thus allowing private insurance companies to offer optional but complementary health plans.
- Create a regional/international clearing system with the HIH (private or public) from other countries for medical care delivered to foreign citizens.

Issue #5: Continuing Medical Education/Training for Family Doctors

Discussion

Until three years ago, there was no distinction between GPs and family doctors in Romania. Once health care reform began, the majority of GPs decided to become family doctors. Recently, however, a distinct three-year training was introduced as a qualification for family doctors. The year 2000 was the first year in which family doctors received complete training using this standardized curriculum. In the next 10 to 15 years, it is likely that Romania will have a complete network of family

doctors with initial standardized training and continuing CME training (designed and organized by the MOH and COP).[24]

Policy recommendations

- Provide incentives for family doctors to participate in these training sessions. One such incentive may be to convert the payment mechanism for provision of basic FP services into fee-for-service reimbursement rather than capitation for trained family doctors.[25] In addition, the MOH can help generate more clients for trained family doctors by allowing them to distribute free contraceptives and providing information about the availability of these free contraceptives at family doctor sites.

Issue #6: Expanding the Array of FP Services that Family Doctors at the Primary Care Level Can Provide

Discussion

- Basic FP services: consultation and prescription of a contraceptive method to risk-free patients.
- Free contraceptive distribution for eligible patients to increase accessibility in rural areas, although there is still a need to assess whether family doctors are actually interested in performing this activity.
- The professional department of the COP will need to identify other FP services that can be provided by family doctors.

Policy recommendations

- On a pilot basis, expand the range of FP/RH services that family doctors provide.
- Develop monitoring mechanisms to ensure that family doctors providing expanded RH services have the appropriate training and certification.
- Identify who will be financially responsible for upgrading the family doctor cabinets to be able to actually provide additional services safely and effectively.
- Create a communication channel between family doctors and specialists (especially in rural areas) in order to have a coherent flow of information and referral capability. Mechanisms to transport lab samples, data, and results between family doctors and specialists must also be set in place (e.g., cervical cancer screening).

Issue #7: Bonus System

Discussion

At present, centrally funded contraceptives and MOH funds for other national programs are channeled primarily to judet hospitals. Unfortunately, human resources of the MOH at both central and local levels can accommodate only this easy method and less accountable program financing. At the end of the year, it is usually very difficult to evaluate its impact on the health status and almost impossible to

[24] USAID funded SECS and Project Concern International to conduct FP/RH training programs for family doctors and nurses in selected target judets. The MOH recently organized a training process for trainers. These trainers will provide CME training for family doctors in weekend sessions. This training is supported by UNFPA funds.

[25] Additional bonuses can be linked to the overall improvement of local/regional RH indicators. These bonuses are the responsibility of MOH because the HIH can only purchases medical services for the insured people.

compare various counties.[26] These hospitals are not easily accessible to the rural poor who are most in need of subsidized services. Health personnel most accessible to the rural population are family doctors. To address this issue, the MOH can use the family doctors' network to attain the objectives of the national FP program.

Policy recommendations

- The MOH must take advantage of the family doctor network to reach target populations to ensure implementation of national programs.

- To formalize the MOH/family doctor relationship, produce a contract for MOH "bonuses" to be paid to family doctors on the basis of measurable outcomes (e.g., community-level counseling, follow up of contraceptive users). Also, the MOH could contract with family doctors for performing specific preventive activities outside the time allocated to the HIH (seven hours per working day on average). Clear specifications can link bonus payment to measurable outcomes. In addition, the MOH could provide standard supplies/materials and evaluate outcomes in various regions using the same indicators.

[26] County = judet.