FINANCING AND TRAINING NEEDS OF SMALL SCALE HEALTH CARE PROVIDERS AND DISTRIBUTORS IN ROMANIA

MEETING PROCEEDS
BUCHAREST, 15 FEBRUARY 2007

July 10, 2007

This publication was produced for review by the United States Agency for International Development. Lisa Tarantino wrote this report for the Banking on Health Project.

THE BANKING ON HEALTH PROJECT

The Banking on Health Project (BoH) is a USAID funded global project which seeks to improve the ability of private health sector businesses to access finance, thereby improving their capacity to deliver high-quality reproductive health and family planning services and products.

In Romania, in addition to furthering the core goals of the Banking on Health Project, BoH seeks to support USAID/Romania's Strategic Objective 3: "Increased Effectiveness of Selected Social and Primary Health Care Services for Targeted Vulnerable Population."

In Romania, the Banking on Health Project (BoH) seeks to increase access to financing among private sector providers and distributors in order to increase reproductive health (RH) and family planning (family planning) outcomes in the private sector. To this end the project has undertaken a series of activities including: development of a course on financial management and accessing finance for family doctors, market research on financing needs of private providers and distributors, technical assistance to financial institutions to encourage lending to the sector, and technical support for a policy round-table.

Banking on Health coordinates its Romania activities with the Romanian Family Health Initiative (RFHI), a USAID project managed by JSI. The RFHI project has been working closely with the Government of Romania since 2001 to improve the health of women and children through primary health care and reproductive health and family planning policy reform, training, provision of supplies, and public education.

Banking on Health Project activities in Romania began in January 2006 and will continue through the end of 2007.

For more information on the Banking on Health project see www.bankingonhealth.com.

Banking on Health is led by Abt Associates Inc. in collaboration with:
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ACKNOWLEDGEMENTS

The Banking on Health Project is a USAID funded global project GPO-I-00-04-00007-00, Task Order Two under the PSP IQC. The project is led by Abt Associates Inc. in collaboration with Banyan Global, ACDI/VOCA, Bitran y Asociados, and IntraHealth International, and is managed by USAID's Global Health Bureau.

The Romanian Family Health Initiative project is a USAID funded project based in Romania, led by JSI R&T. The Romanian Family Health Initiative organized and sponsored this roundtable meeting, and funded the implementation of Banking on Health's "Enhancing the Financial Health of the Medical Practice" training for family doctors, conducted by the Society for Education in Contraception and Sexuality (SECS).

The Romtens Foundation conducted the research on family doctors and other health sector providers and distributors discussed within this report under contract with the Banking on Health Project.

The Banking on Health Project work in Romania is made possible by the support of the USAID Bucharest mission, particularly the Democracy and Social Sector Reform Office.

The Banking on Health Project thanks the participants of the meeting for their inputs and insight into these important issues for the health of Romanian women and families today. The project would like to thank Dr. Narcisa Murgea, Dr. Mihaela Haratua, and Dr. Dan Sava for their comments on this report. Any oversights or errors present herein are the sole responsibility of the author.

LIST OF ACRONYMS

BoH	Banking on Health Project
CME	Continuous Medical Education
DHIH	District Health Insurance House
LMIS	Logistics Management Information System
MFI	Microfinance Institution
MoPH	Ministry of Public Health
NGO	Non-Governmental Organization
NHIH	National Health Insurance House
OB/GYN	Obstetrician/Gynecologist
OMRO	Opportunity Microcredit Romania
RFHI	Romanian Family Health Initiative
SECS	Society for Education on Contraception and Sexuality
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

On February 15, 2007, the meeting "Financing and Training Needs of Small Scale Health Care Providers and Distributors in Romania" was held in Bucharest, Romania with 24 participants from government, the private sector, multilateral organizations and non-governmental organizations (NGOs.)[1] The purpose of the meeting was to discuss the Banking on Health (BoH) Project research findings on family doctors and other private health care providers and distributors. The event was organized by the USAID funded Romanian Family Health Initiative Project, managed by JSI R&T.

The global, USAID-funded Banking on Health Project (BoH) seeks to increase access to finance in order to increase reproductive health and family planning outcomes in the private sector. In the past, a major constraint to private health sector development has been limited access to finance. Finance is an essential input that assists the private sector in expanding the range and types of services, entering underserved areas, and making quality improvements. The Banking on Health Project currently works in eight countries, taking a two-pronged approach to increasing access to finance by:

- working with local financial institutions to promote health sector lending; and
- improving credit-readiness among private health care businesses.

In Romania, the BoH Project identified family doctors, now firmly private sector actors contracted by the government to provide primary care, and other small-scale providers and distributors as important outlets for family planning and reproductive health. These family doctors, rural pharmacies, medical clinics, and private obstetric and gynecological practices are particularly vital for those in underserved areas. Many of these family doctors have been recently trained as family planning counselors and distributors and are serving the rural poor. Yet they face obstacles to accessing finance that inhibit their prospects for sustainability, growth and improvement of their businesses. As USAID prepares to leave Romania and withdraws support to the Ministry of Public Health (MoPH) for family planning, the fate of the family doctors struggling under the capitated system is a concern.

To assist these providers and distributors in Romania, the BoH project undertook a series of activities. These activities included: development of a course on financial management and accessing finance for family doctors, market research on financing needs of private providers and distributors, technical assistance to financial institutions to encourage lending to the sector, and technical support for the policy roundtable which is described herein.

The breadth and depth of the research on family doctors is unique and particularly timely for Romania. The national research includes findings on: characteristics of family doctors and their practices, the impact of the National Health Insurance House (NHIH) contract, the financial standing of private practices, reinvestment in the practices, plans for business growth, impediments to improving practices, training needs, and the outlook on accessing financing. The reality, problems, and hope reflected in the findings can serve to inform the reform process related to ensuring quality primary health care, particularly concerning the framework contract between doctors and the National Health Insurance House. The research also informs the outlook on the future of family planning distribution in Romania after USAID support ends and the Ministry of Public Health takes on full responsibility for budgeting and distribution. The research presented at the meeting was conducted in September – December 2006.

It was clear at this meeting that there were many points of convergence among the interests of

[1] See Appendices 1 and 2 for a complete list of participants and agenda of this meeting.

the stakeholders. Participants included representatives from:

- family doctors' associations;
- the National Health Insurance House;
- the Ministry of Public Health;
- NGOs active in training and supporting family doctors;
- institutes of health research;
- multi-lateral organizations;
- donors;
- banks; and
- microfinance institutions (MFIs).

The expertise, good will, and hard work of the organizations represented by the parties at the table comprise almost all the pieces of a puzzle. This puzzle, once put together, would look like a national network of healthy family doctors' practices–sustainable, well-functioning providers of quality primary care including family planning and reproductive health services. However, the research highlights that some pieces of this puzzle are clearly missing.

Research findings indicate that family doctors are running financially healthy medical practices. They are earning enough to live, but are not reinvesting in their practices. As a result, their facilities are declining and they often need some of the most basic tools, such as scales and computers, to run their practices. The vast majority would like to grow or improve their practices and a large number would like external financing to do so, particularly for equipment and the purchase of facilities. In addition to clinical training, many family doctors would like business management training, with nearly 30% stating that it is the single most important training they need for their practice. Doctors feel that if their NHIH contracts allowed for higher payments per capita or per service, and/or an expanded range of services, they would be able to better improve and grow their practices.

Independent pharmacists appear to be in a more difficult situation than the family doctors, with cash flow and profit impediments resulting from the payment terms of suppliers and the government. Pharmaceutical distributors of family planning products have varied needs and outlets depending on whether they are multinational or local distributors. Private medical clinics and obstetric/gynecological practices are faring well as businesses, and are generally optimistic about their prospects with the market for these services growing, and standards rising with increased competition and government regulation.

Recommendations outlined in this report distill analysis of research findings as well as a number of viewpoints expressed at the meeting and in subsequent conversations with stakeholders. Some key recommendations include the following:

I. POLICY CHANGES TO IMPROVE THE BUSINESS ENVIRONMENT FOR FAMILY DOCTORS:

A. Increasing payment levels to family doctors under the contract, either per capita, per acta or both

B. Expanding the range of services that family doctors can provide under the contract. Examples of services that could be considered include:

- Ultrasound services
- Low risk prenatal care
- Prescriptions for a wider range of drugs
- Electrocardiograms

C. Continue MoPH supply of family planning products for underserved groups

D. Clarify and enforce family doctors' ability to purchase facilities

E. Longer contract terms

F. Streamline procedures

II. INCREASE SUPPORT FOR FAMILY DOCTORS' BUSINESS DEVELOPMENT SUCH AS:

G. Expand and enhance continuous medical education in the following way:

- More training in family planning, including for those in urban areas
- Standardize continuing medical education training courses with high standards and required approval by provider associations
- Business Management and Financial Management Training

H. Strengthen other business support

- Health foundations, institutes, and NGOs can to continue to be vital resources to the sector and serve the various institutions represented at the meeting.
- Professional associations should continue to strengthen their advocacy role on behalf of provider groups.

III. INCREASE ACCESS TO FINANCE

Many of the above policy recommendations will have the effect of increasing access to finance for family doctors. In addition:

I. Banks can educate and market in a more targeted manner to family doctors, rural pharmacies, and other small-scale health care providers.

J. Banks should also lend to the doctors' practices, not only to them as individuals.

K. Lenders to market more to doctors in rural areas

L. Enact policy changes involving independent pharmacies, listed below, most of which will have the effect of increasing their ability to access finance.

IV. ENACT CHANGES IN LAWS AND REGULATIONS INVOLVING PHARMACIES INCLUDING:

M. Clarify and streamline the administration of limits on the amount of reimbursable medications under the contract

N. Rationalize payment terms from the government to pharmaceutical suppliers and pharmacies

O. Remove or increase upper limits on the number of pharmacies in urban areas

P. Remove or increase upper limits on margins charged by pharmacies

The institutions represented at the meeting have the capacity to solve all of the problems discussed. Continued communication can lead to finding areas of mutual benefit. One positive outcome of this meeting is the establishment of direct communication between family doctors groups and lenders. This relationship can eventually lead to tangible benefits to both groups and ultimately for primary health care patients in Romania. Other recommendations proposed herein could serve to promote greater transparency in the sector. As the sector develops, doctors will soon see the benefits of more extensively declaring all payments for products and services, such as the ability to invest these funds and declare them as income in support of credit applications. Small steps and investments can lead to big returns for public health, particularly for women and children in rural Romania.

BACKGROUND

ROMANIAN PRIMARY HEALTH SECTOR, REPRODUCTIVE HEALTH, AND USAID SUPPORT

In the early 1990s, WHO ranked women's health in Romania as the poorest in the region. Since then, the reproductive health and family planning programming of the Ministry of Public Health, supported by USAID and UNFPA has contributed to tremendous gains in women's health. The total abortion rate has dropped from 4.1 in 1993 to an estimated 0.84 in 2004. Total use of contraception has increased from 41 percent in 1993 to 58 percent in 2004. The successes in Romania can be contributed to a confluence of strategies and factors. These are summarized as: government commitment and support; provider training campaigns; policy changes which broke barriers to accessing family planning and reproductive health services and products; public awareness campaigns; initiatives to promote supply in the public and private sectors; economic growth which has increased women's ability to pay for family planning products; and cultural factors–Romanians do not have significant cultural pressures to have large families.

In spite of the successes achieved in Romania a number of challenges remain for women's health. As USAID prepares to depart the country, these challenges lie within the sustainability and quality of family planning counseling and services for the rural and urban poor, primarily at the level of the family doctor, as well as in the quality of services available to all women in the public and private sectors.

The government of Romania and other stakeholders have an opportunity to help ensure the sustainability of the gains that have been made in women's health over the past 5 years, particularly the striking gains in reproductive health. In spite of the Ministry of Public Health's pledges to continue some of the activities and initiatives begun in these areas, the continuation of reform and supply to underprivileged markets will be difficult. By supporting the private sector, in particular the outlets where the poor are most likely to go for family planning and reproductive health products and services, the MoPH supports:

- The viability of family doctors in rural areas who are the backbone of primary health care of the country and often the most accessible point of contact for family planning counseling and products for the poor
- The expansion of availability of lower cost products
- Greater choice in health care for women throughout the country

Family doctors, rural pharmacies, and other private health actors are in pivotal stages of evolution within the health system. In the past five years, family doctors have become an important source of family planning counseling and products for the rural poor. These doctors face significant barriers to operating sustainable, quality practices including barriers to accessing financing for working capital and investment purposes. Family doctors are struggling without guidance on financial management under a capitated system, yet they have tremendous opportunity, as they now own their practices and should soon be able to purchase their facilities. Rural pharmacies, which also face barriers to accessing finance, are often the only source of medical supplies, drugs, and commercially marketed family planning products for doctors and poor women in rural Romania. Banks are keen to lend to new markets, such as family doctors, and to expand lending activities in markets already served, such as distributors and pharmacies, and yet have been inhibited by a few factors. These factors included the nature of the businesses, which have low levels of fixed assets to offer as collateral and lack of reliable market information for loan product development.

BANKING ON HEALTH IN ROMANIA

In Romania, the Banking on Health Project (BoH) seeks to increase reproductive health and family planning outcomes in the private sector by increasing access to

financing among private sector providers and distributors. Worldwide, it has been found that a major constraint to private health sector development has been limited access to financing. Financing, particularly in the form of credit, is an essential input that assists the private sector in expanding the range and types of services, entering underserved areas, and making quality improvements. In Romania the project works to assist providers and distributors to access finance and thus improve and expand their provision of quality services and products by working to:

- Increase the credit-readiness of family doctors and other small scale providers and distributors of family planning and reproductive health services and products; and
- Increase the capacity of banks, leasing companies, and microfinance institutions to provide financing to these providers and distributors.

I. Banking on Health coordinates its Romania activities with the Romanian Family Health Initiative (RFHI), a USAID project managed by JSI R&T.

In early 2006, BoH assessed finance needs among private health care providers and distributors of reproductive health and family planning products and services in Romania. Family doctors and other providers of reproductive health and family planning in rural and underserved areas were identified as most in need of support in the areas of access to finance and financial management skills in order to sustain and improve their delivery of quality services. In 2006 through early 2007, Banking on Health conducted a series of activities to support the growth of the private sector:

Banking on Health Project conducted a national survey of financing and training needs related to business management and finance for family doctors.

Research on family doctors, OB/GYN practices, rural pharmacies, distributors, and medical clinics was commissioned and conducted on a national basis with qualitative and quantitative components. The study included a national survey of family doctors, focus groups with other market segments, as well as desktop research and interviews with key informants. This survey provides important information and analysis for the following purposes:

- to provide market data for financial product development and marketing initiatives for interested banks and microfinance institutions, thereby facilitating practice improvements, sustainability and growth;
- to provide fortifying information into the course developed for family doctors on financial management and access to finance to grow or improve their practices; and
- to inform stakeholders on contracting and health promotion at the family doctor level.

The national survey covered topics such as family doctors' income, expenses, services provided within and outside the NHIH contract, plans for practice improvement, impediments to improving the practice, and interest in accessing finance to grow their practices. These topics were also covered in focus groups with OB/GYNs, medical clinic managers, pharmaceutical distributors, and owners of rural pharmacies.

II. BoH developed a course in financial management, including accessing finance, in consultation with the National Institute for Health Research and Development (NIHRD) and SECS.

This course "Enhancing the Financial Health of the Medical Practice" serves to increase family doctors' ability to manage their practices for the ultimate good of the local population they work in. This three-day course has been successfully piloted in each of the eight Romanian developmental regions with 140 family doctor participants. See Appendix 4 for a course agenda.

III. BoH conducted a series of individual workshops with three banks and two microfinance institutions on marketing and product development for the small-scale health care sector.

In early 2006, BoH reviewed potential financing sources for health care providers including banks, leasing companies, and microfinance institutions. The project produced a short-list of bank and microfinance institution partners to work with: Banca

Transilvania, Libra Bank, Raiffeissen Bank, CHF/Express Finance and Opportunity Microfcredit Romania (OMRO). These institutions were interested in deepening their work with the sector, and yet expressed a need for market information on family doctors and other small-scale providers and distributors in order to move forward with initiatives to reach the sector. BoH designed marketing and product development training for these institutions that included a presentation of the results of BoH's in-depth market research on family doctors, rural pharmacies, OB/GYN practices, medical clinics providing family planning and distributors of family planning products.

As a result of these workshops and market information, each institution is taking further steps such as product roll-outs and marketing campaigns to meet the needs of the market, particularly family doctors and rural pharmacists who are key providers of reproductive health and family planning to underserved areas.

IV. BoH facilitated a closed meeting hosted by the FHI Project to present the results of the Financing and Training Needs of Small Scale Private Health Service Providers and Distributors in Romania study.

The purpose of this half-day meeting was to bring together stakeholders including professional representatives, Ministry of Public Health and National Health Insurance House representatives, and financial institutions for a presentation and discussion of findings of the research. This report outlines the topics discussed and ideas generated in that roundtable meeting. (See Appendices 1 and 2 for a list of participants and meeting agenda.)

"In 1989, we were let go, dropped, by the Ministry of Health into the water. And we didn't know how to swim. Now, after 17 years, you are teaching us how to swim."

- *Family Doctor from Calarasi Participant in BoH course (Oct 2006)*

RESEARCH METHODS

Banking on Health commissioned research to be undertaken by Romtens Foundation, a Romanian research organization with a specialization in the health sector. The study is comprised of a desktop review of private providers and distributors of reproductive health and family planning products and services, interviews with key informants, focus groups, and a large-scale national survey of family doctors.

The quantitative component of the research consists of a national survey of family doctors under contract with the NHIH. In all 1,215 valid surveys were collected, representing more than 10% of the total population of family doctors under contract. Qualitative research was also conducted as part of the study in the form of focus groups and interviews with other types of private health sector businesses, such as obstetricians/gynecologists, medical clinics that offer family planning, distributors of family planning and reproductive health products, and private rural pharmacies.

SURVEY OF FAMILY DOCTORS – SAMPLING PLAN

TARGET GROUP POPULATION:

This is a group composed of all the family doctors practicing in Romania, regardless of their business registration, whether individual practice, partnership, group practice, associated medical practice, medical civil society, or limited liability company. The only criteria was that they have their businesses registered at the Medical Offices Registry, and they provide their services based on a contract with their DHIH.

SAMPLING POPULATION AND FRAME:

This was defined as the family doctors in contract with their District Health Insurance House, based on the electronic datasheet supplied by the Centre for Sanitary Statistics and Medical Documentation of the Ministry of Public Health. The sampling frame is comprised of all the family doctors that fulfill the criteria defined in the target group population. This number was estimated to be approximately 10,485.

SAMPLING PROCEDURE:

The goal of the sampling process was to get a distribution of family doctors within the produced sample based on two criteria that would be identical with the distribution of the units in the sampling frame. Random extraction of sample units from the frame allowed for representation. The sampling was 1) randomized, 2) stratified, and 3) proportional to the size of each layer.

The first stratification of survey units was by county, with each of the 42 counties in Romania represented. The second stratification was based on the location of the family doctor's office as "city," "town," or "rural."[2]

SAMPLING SIZE:

The selected sample was 1,232 family doctors. This number was approximated to represent more than 10% of the entire target group population. In total 1,215 valid surveys were collected.

SURVEY OF FAMILY DOCTORS – SURVEY METHOD

The survey questionnaire was developed by Romtens Foundation with input from Banking on Health project managers. The questionnaire is comprised of 63 primarily multiple-choice questions. Sixteen survey operators were trained to administer the questionnaire to respondents verbally and individually at their place of work. The operators input answers into a hand-held electronic device that was used to send data back to a centralized source for compilation and analysis. Monitoring was conducted on a regular schedule to ensure data integrity. In the end 1,215 valid

[2] See the "Summary Report of Financing and Training Needs of Small Scale Health Service Providers and Distributors in Romania" Banking on Health Project, September 2007, for further details.

surveys were collected, which is more than 10% of the total population of family doctors under contract with the NHIH.[3]

FOCUS GROUPS WITH OTHER PROVIDERS AND DISTRIBUTORS

Focus groups were held with OB/GYNs in private practice, rural pharmacy owners, medical clinic owners, and distributors of family planning products. For each business type, at least two focus groups of 5 to 8 participants were held in two different locations of the country. The only exception to this format is the distributors. As there are so few distributors only one focus group was held.

INTERVIEWS AND LITERATURE REVIEW

A literature review was conducted to gather statistical information on the market size as well as information on developments that impact the sector, such as government initiatives, policies, and internationally sponsored projects. Sources for this review included government statistics offices as well as relevant published articles and papers.

Interviews were held with key informants including representatives of financial institutions, government, NGOs, and professional associations.[4]

[3] See the "Summary Report of Financing and Training Needs of Small Scale Health Service Providers and Distributors in Romania" Banking on Health Project, June 2007, for further details.

[4] Ibid.

HIGHLIGHTS OF RESEARCH PRESENTED

CHARACTERISTICS OF FAMILY DOCTORS

More than 75% of the family doctors are female, and more than three-quarters are married. Family doctors are typically in their late 40s to early 60s, with approximately 20 years of professional experience.

Table 1. Family Doctors' Gender

Gender	Number	Percentage
Male	259	21.3%
Female	956	78.7%
Total	1215	100.0%

FAMILY DOCTORS' PRACTICES

Almost all (92.7%) of the family doctors work as individuals in their private practice; very few are part of a partnership or medical society. Family doctors employ an average of 3.2 other people in their practice (full-time, part-time, or volunteers). Almost all employ nurses.

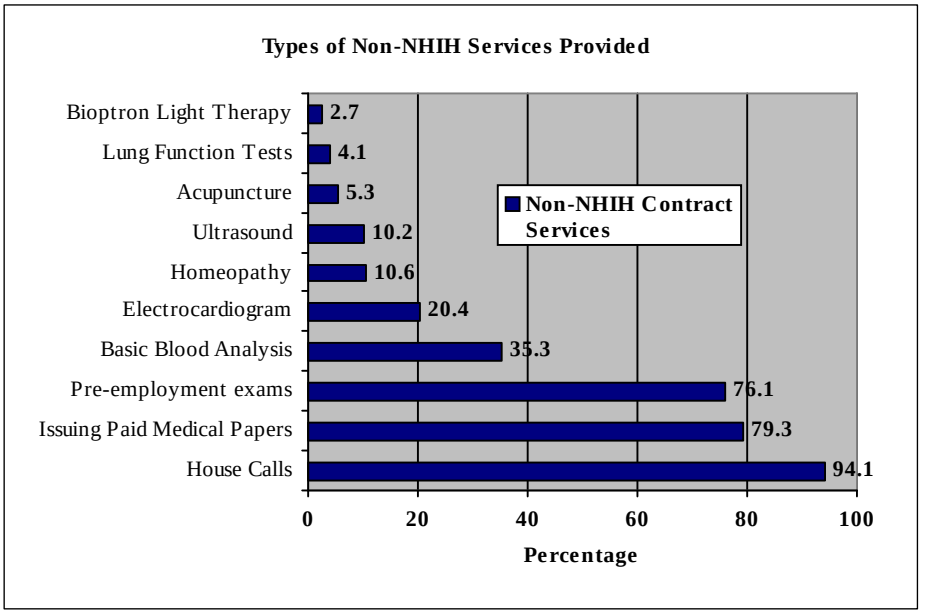
Business registration	Number	Percentage
Individual private practice	1126	92.7%
Partnership private practice	31	2.6%
Commercial company (LLC, corporation)	28	2.3%
A group of individual private practices	26	2.1%
Medical civic society	4	0.3%
Total	1215	100.0%

The average number of patients on the list of each family doctor is 1,854.

The practice of each doctor averages 581 consultations per month.

PROVISION OF FAMILY PLANNING & REPRODUCTIVE HEALTH SERVICES & PRODUCTS

Fifty-two percent of family doctors provide family planning counseling, averaging 22 visits per month for those who do offer this service. In addition to family planning counseling, family doctors provide condoms (45%), pills (43%), injectables (31%), and counseling specifically on IUDs (27%), tubal ligation (6%), and vasectomy (1%).



More than two times the amount of family planning visits are provided by family doctors in rural areas as opposed to those in urban areas or towns. In focus groups and interviews doctors indicated concern that the supply of MOH-provided family planning products may end in the future, which would adversely affect their under-served patients and their practice.

NON-NHIH CONTRACT SERVICES

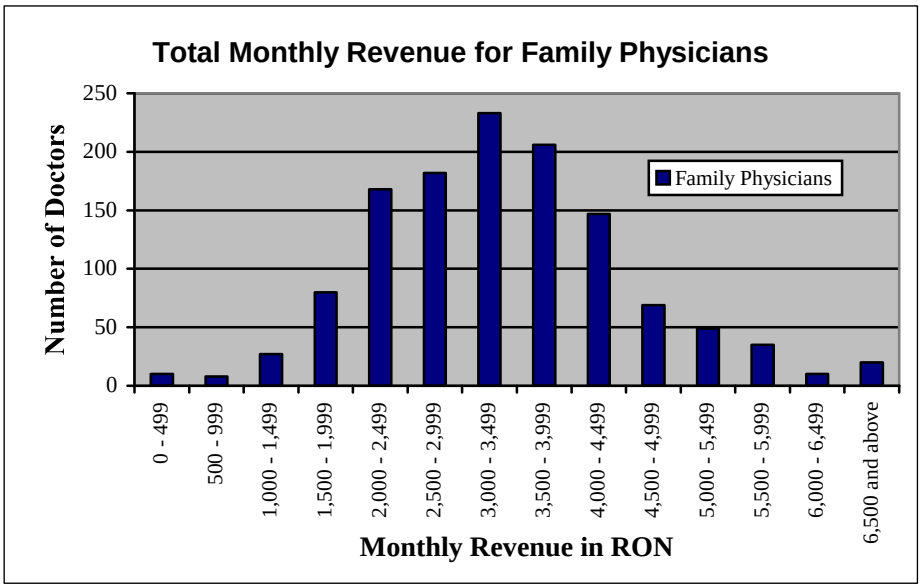
The majority, about two-thirds, of family doctors provide services outside of the NHIH contract for which they charge fees to the patient. The most common non-contract services are house calls (94%), issuing medical papers (79%) and pre-employment exams (76%).

PRACTICE REVENUES, EXPENSES & REINVESTMENT

NHIH-contract revenue is the largest source of income for the family doctors, providing 95% of the monthly revenue of their practices. Non-contract services are approximately 5% of their revenue.

The average total monthly revenue of the family doctors from their practice is 3,387 RON. Most had income in the range of 2,000 RON and 5,000 RON, including all sources of income from the practice. Business expenses average 2,080 RON. This leaves an average monthly net profit of RON 1,307.

The average that doctors claimed to reinvest into their practice was RON 2,428 per annum. However, over 30% of the doctors do not reinvest any profit in their practice at all.



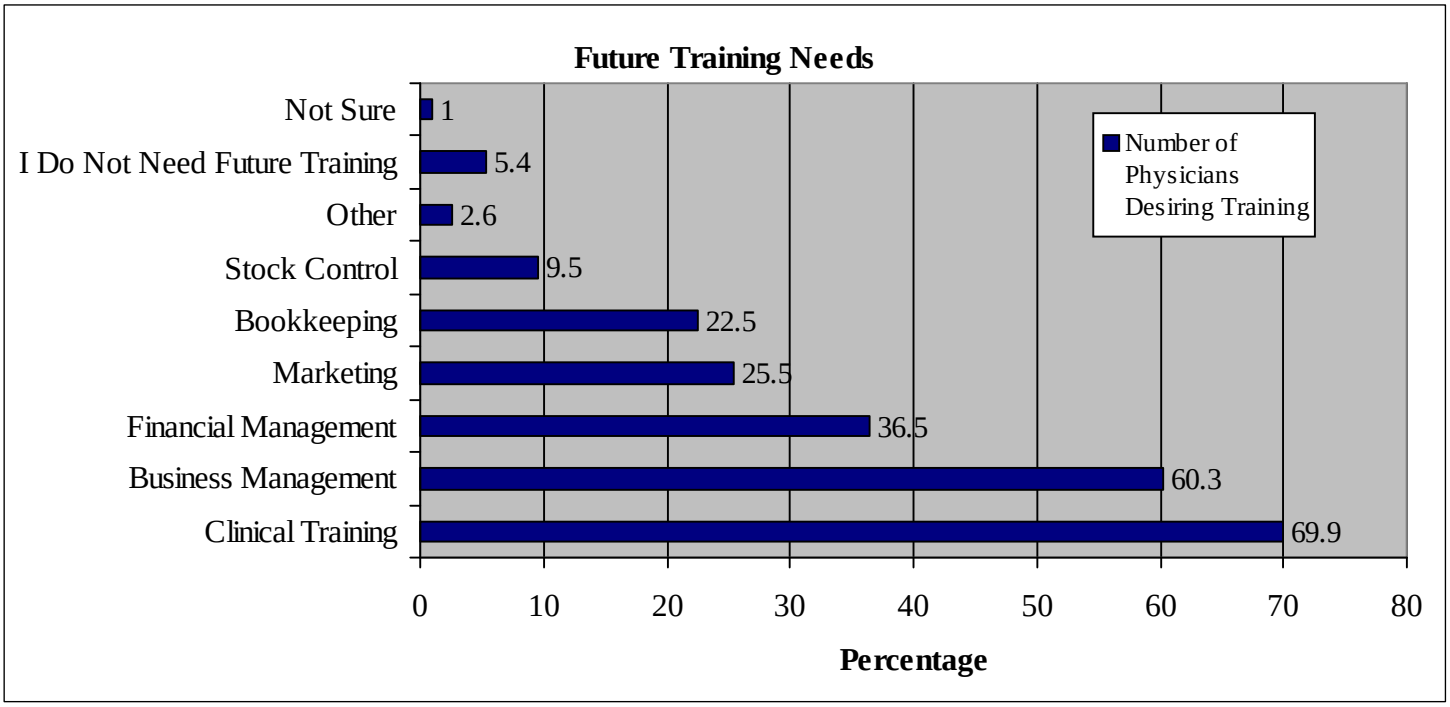
HOUSEHOLD INCOME & EXPENSES

Total household income from all sources within the family for family doctors ranges from RON 1,500 to RON 2,499. Total household expenses range from RON 1,400 to RON 1,999.

Family doctors say that their medical practice is their households' main source of income, and the income of a spouse is also significant for 72% of the doctors.

PREVIOUS TRAINING & FUTURE TRAINING NEEDS

In the last 5 years, over half of the family doctors had attended continuing medical education training, and 50% attended family planning training. Training in financial management was attended by only 4% of the doctors. Yet, about one-fifth of the doctors



prepare their own financial statements.

The vast majority, or 94%, of the doctors want more training in the future for their business development needs. The highest demand is for clinical training (70%), followed closely by business management (60%), financial management (37%), marketing (26%), bookkeeping (23%), and stock control (10%). The questionnaire did not ask about types of clinical training desired.

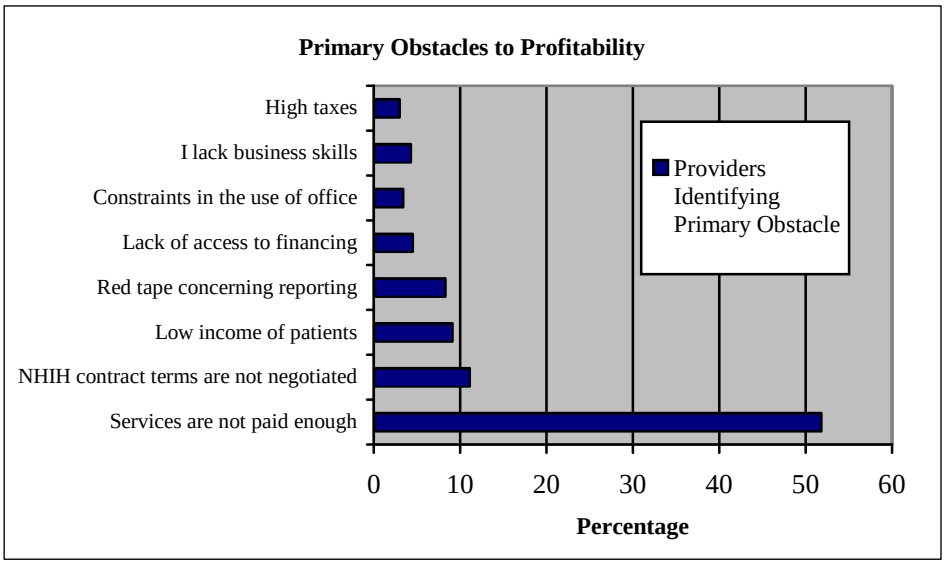
IMPACT OF THE NHIH CONTRACT ON FAMILY DOCTORS

The largest percentage of respondents (47%) believe the NHIH contract has had a positive impact on their business, citing stability of revenue, amount of revenue, and number of patients as prime reasons.

A negative impact is perceived by 17% of the doctors, who felt at a disadvantage under the contract when it came to access to finance, access to facilities, and their ability to grow their practices.

The rest (36%) see no positive or negative impact from the NHIH-contract or were unsure.

Family doctors would like to see increased payments for both their per acta (92%) services, and per capita (86%) services. Fifty-eight percent of the doctors would like the contract period to extend beyond one year. A quarter of the family doctors feel that valuation under the contract should be monetary and not calculated in points.

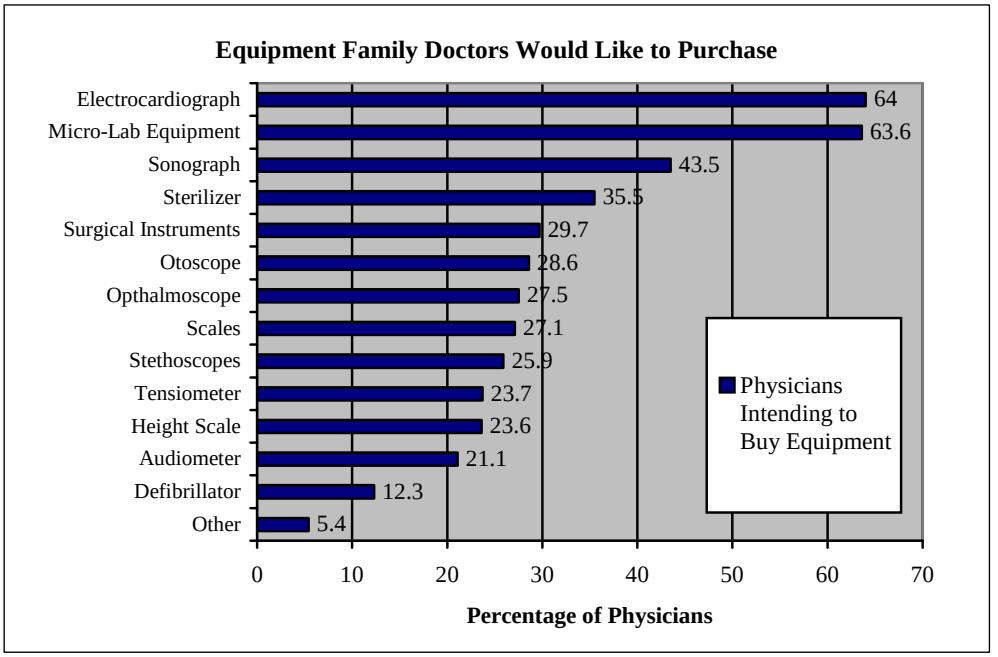


IMPEDIMENTS TO PROFITABILITY

The primary obstacle to profitability cited by doctors is under compensation for existing services (52%), followed by less-reported reasons such as inability to negotiate their contracts (11%), the low incomes of patients (9%), excessive reporting requirements under the contract (8%), and lack of access to financing (5%).

DESIRE TO IMPROVE THEIR PRACTICES

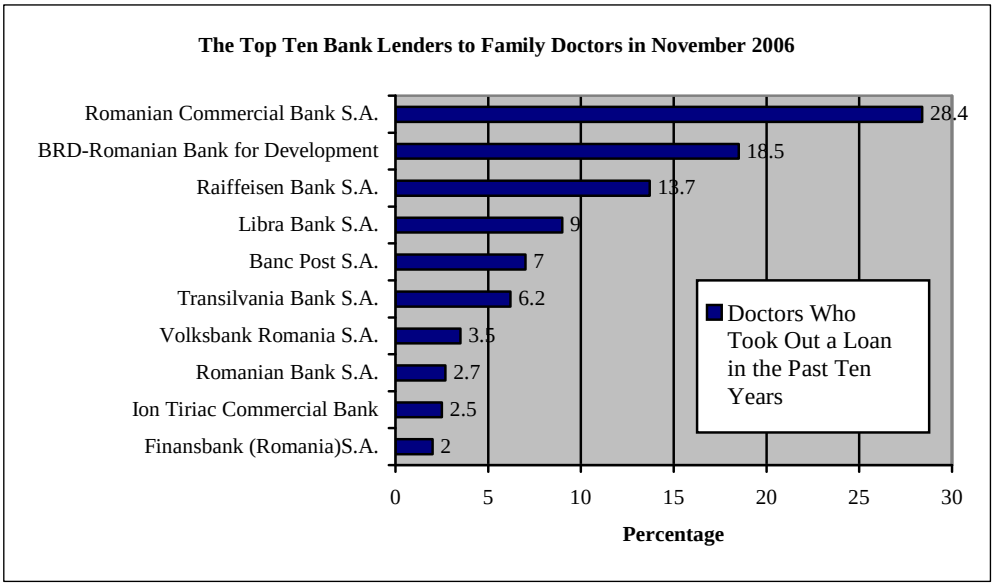
The vast majority (95%) of the family doctors plan to grow their businesses. The most frequently cited means of growth was to buy medical equipment (78%.) Concerning the type of equipment the doctors would like to purchase, 64% would buy an electrocardiograph. Another 64% would buy micro-lab equipment, 44% would purchase a sonograph,



and 36% would buy a sterilizer. A smaller percentage would like to purchase some basic equipment such as scales (27%), stethoscope (26%), and height scale (24%).

Sixty-seven percent would like to buy their facilities. Others are interested in expanding or refurbishing their facility (54%).

About half the doctors (51%) would like to provide new services. Smaller percentages would like to buy a new computer (38%) or hire staff (23%).



BORROWING EXPERIENCE

Over 50% of family doctors have had a loan in the last 10 years, with the highest percentage of them borrowing from banks. The main use for the loan was to buy a car (44%), followed by investments in their practice (30%). Most of those with borrowing experience had an outstanding loan at the time of the interviews. Forty percent of total respondents had an average of EUR 6,649 outstanding at the time of the survey.

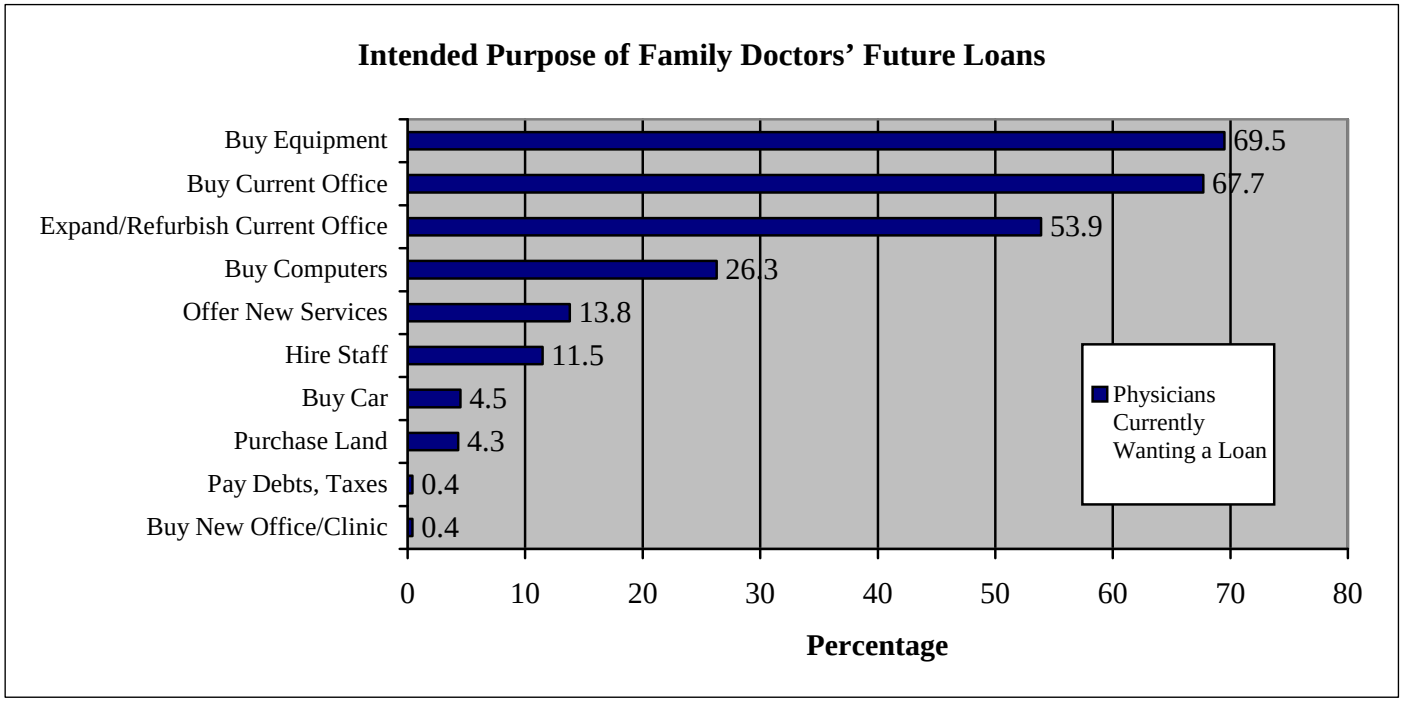
Of those who had never borrowed in the past, most had never tried– only 16% had tried to borrow.

INTEREST IN LOANS FOR EQUIPMENT AND PURCHASING FACILITIES

A large percentage (42%) of family doctors is interested in taking out a loan now. The average amount they'd like to borrow is EUR 3,300, with monthly payments around EUR 165. Of those who want to borrow, 73.5% are willing to offer collateral.

Most (70%) would use the loan to purchase medical equipment and 68% said they would like to buy their current medical facility.

Of the 58% who did not indicate that they want to borrow now, 48% do not want to take a loan and 10% are not sure. When asked



why they did not want a loan, only 9% of that group of 58% indicated that they did not need a loan. The most common answer that most (58%) gave is that they felt that they could not afford it financially. Smaller percentages said that they do not like the idea of borrowing (21%), and other very small percentages said that they did not want to offer collateral, know of a bad borrowing experience, or can use their own funds.

RURAL V. URBAN

Surprisingly there was no substantial difference in revenue or expenses between urban and rural family doctors. There was also no difference in their desire for future loans. City doctors were slightly more likely to have credit experience than their counterparts in rural areas.

DISTRICTS

Among the districts and regions, revenue levels were fairly consistent, ranging from a low of 3,036 RON (West) to a high of 3,540 (Northeast). The same was true for expenses, with a low of 1,835 (Central) to a high of 2,326 (Northwest).

PRACTICE TYPES

Those registered as individual professionals had slightly lower average incomes than those registered in a partnership, commercial company or society, although those in a group practice earned about the same as those individual professionals. Individual professionals were somewhat more interested in borrowing than others.

GENDER

There was no substantial difference in business income or expenses between men and women. Women were slightly more interested in future loans, although they wanted a slightly lower amount.

OB/GYNS PRACTICES

The focus groups conducted with ob/gyns, medical clinics, pharmacies, and distributors showed the wide range of business types within the private health sector. Ob/gyns are running profitable businesses, which they intend to grow and expand. They have optimistic outlooks on their business prospects and have hopes to purchase or refurbish their facilities with loans of over EUR 15,000.

MEDICAL CLINICS

Commercial medical clinics are expanding in an increasingly competitive market. They have needs of higher loan amounts for facilities and equipment with loans of over EUR 15,000.

PHARMACIES

Rural pharmacies are suffering from low profit margins and a challenging reimbursement/supply situation, depending on expensive supplier credit to bring their cash flow needs while awaiting reimbursement for NHIH covered medication.

DISTRIBUTORS

Private distributors differ greatly in needs and profitability, as many are international and a smaller set is local. Distributors also claim to face difficulties with government payment schedules. They must offer payment terms to their clients that can hinder cash flow.

INTERPRETATION OF FINDINGS

READING THE TEA LEAVES OF DATA

The research findings are primarily quantitative in nature, and thus the data is open to interpretation to explain the reasons behind the findings. There was a good deal of debate and discussion at the meeting regarding the data. Participants expressed opinions and suggested explanations for the findings, which are represented below.

I. THE BUSINESS ENVIRONMENT FOR FAMILY DOCTORS

Working under contract

The doctors' schedules are full and their time valuable. Each doctor averages 581 consultations per month, including house calls. It is vital for them to keep the time they spend on administration such as record-keeping, reporting, training, and other non-medical service providing activities (such as long loan application processes) to a bare minimum.

In order for doctors working under contract to have adequate incentive to enter and remain in their position and to reinvest and improve their practice for the ultimate benefit of patients, they must have prospects for profitability.

The primary obstacle to profitability cited by doctors is that services are not paid enough (52%). As can be seen on Table 3, page 28 family doctors manage their expenses to a reasonable level and take home a net income which is relatively average for this business type in terms of percentage of gross revenue. However in real terms, the amount of income is fairly low for a medical professional. Thus income can only be affected by increasing the top line – the revenues, and with more than 95% of income coming from the NHIH contract, the doctors are looking to the government for opportunity to earn more.

There was debate regarding the compensation package for family doctors under the Health Insurance House contract. Doctors' representatives expressed their members' feeling that they are put in a position under the contract with limited resources and yet great responsibilities for delivering primary care, particularly in rural areas.

Doctors feel underpaid and that the range of services covered is too narrow. They would like the number of services to be expanded to include all that family doctors are qualified to provide as well as those which they may provide with a limited amount of further training. The argument was not for an expansion of total services provided under national health insurance, rather for an expansion of which providers may be contracted to provide those services. The idea is that if a family doctor is qualified to offer the same service as a specialist, then they should be allowed to offer this service under contract. Fair competition in offering these services could lead in the end to better service for patients and lower costs for the government.

For example, EKG exams are currently provided by hospitals but family doctors can get training to use this equipment and offer this exam as part of annual health exams for their patients. An argument against allowing this is that by opening these services to family doctors, the added income may serve as incentive, which pulls them away from their primary health duties. These primary health care duties are more basic yet vital in nature, such as well-baby care, vaccinations, house-calls, and care for those with chronic conditions.

There was heated debate about the NHIH contract, with one professional association representative stating, *"The government wants to keep us low and guilty."*

According to research findings and participant discussion, the lack of stability and ongoing changes in the NHIH regulations do not allow the family doctors to develop sound business plans. One of the reasons the family doctors have been reluctant to contract loans in the past has been the instability related to the contract, which changes annually and allows for the points to be revalued even more frequently than that.

Doctors are constrained in their practices by the limited amount of services covered by the contract and the limited range of medications that doctors can prescribe. In order to feel confident to reinvest or access external financing for new services, these services must either be covered by the contract or the family doctors must be fairly certain that their patients can pay out of pocket for the new services. The contract mechanism is preferable to the doctors, as it takes away the burden of understanding the willingness to pay and demand of their patients. For those interested in offering services outside the contract, most could use guidance on making financial investment decisions, in addition to the financing itself.

The doctors are struggling under a holdover of the former drug budgeting mechanism of the government, wherein family doctors were the gatekeepers of the amounts of compensated medicines distributed. Now, the pharmacies are burdened with limits of the amounts of free drugs they can distribute, yet family doctors still must be responsible for writing the instructions to pharmacists for drugs they are not even authorized to prescribe. This situation, wherein a patient must go to a specialist for the prescription, then go to the family doctor for the prescription formula, before going to the pharmacy, is an inefficiency that burdens the family doctors and patients unnecessarily. The solution would be to either allow the family doctors to prescribe more drugs, or to allow the specialists to write prescriptions for compensated medications that can be taken directly to the pharmacist.

Lastly, doctors feel burdened with excessive record keeping and reporting requirements from the Ministry of Health and also from the NHIH as part of their contract obligations.

A future without donations?

Fifty-two percent of family doctors provide family planning counseling. This correlates with the percentage trained in family planning by the RFHI project. Significantly, more than two times the amount of family planning visits are provided by family doctors in rural areas as opposed to those in urban areas or towns. This is due in part to the fact that RFHI focused most family planning trainings in rural areas. Since all family doctors, whether located in urban or rural areas, who provide family planning counseling or services, have about the same number of visits for such services on a monthly basis, it is likely that in fact urban doctors are not overly affected by competition with ob/gyn specialists for these services.

The cessation of the supply of these family planning products could thus harm the doctors' practice as well as have a detrimental health impact on those who currently benefit from their provision.

In interviews and focus groups conducted under a previous BoH study, doctors expressed concern that the Ministry of Health donations of family planning products would end in the near future. Without these products, some women of childbearing age in underserved areas and ethnic groups may come to the family doctor less frequently. Less frequent interaction weakens the family doctor relationship with these patients that goes beyond care of the mother to care of the children, often infants, who benefit from a close relationship with the family doctor. The cessation of the supply of these products could thus harm the doctors' practice as well as have detrimental health impact on those who currently benefit from their provision.

II. BUSINESS DEVELOPMENT AND SUPPORT

Accidental Entrepreneurs

Family doctors generally entered into practice at a time when their profession dictated that they be employees of the government. Since that time they have become "accidental entrepreneurs" as a result of health system reforms. They are now running medical practices under contract with full responsibility for managing staff and expenses and ensuring quality of service to achieve a measure of competitiveness particularly in urban areas. These are activities for which their medical training did not prepare them.

For every family doctor in practice, at least three other individuals are employed, thus there are more than 30,000 people, in addition to the doctors themselves, who rely on their practices for employment, and who contribute to the public health of the nation through these primary health practices.

The doctors themselves are experienced, and have been in their practices for more than 15 years on average. This can have a number of potential implications:

- The population of family doctors in primary health care is aging, which raises the questions of what will happen over the next 15 – 20 years and how to ensure that there be a new cadre coming in to take their place as they retire? What to do if the younger of these choose to pursue opportunities outside of Romania in other countries of the European Union?
- It is possible that the family doctor practice is a comfortable, sought-after position, thus those that are in these practices do not want to leave for another job as they are in a good place or are committed to their professional calling or both.
- The family doctors may have little other professional opportunities open to them, thus the lack of mobility.

Services Offered

It is clear, from the doctors' ideas for future business growth and use of possible loan proceeds, they would like to add services currently not covered by the contract. The equipment that they are seeking would allow them to perform non-NHIH contracted services. One reason for this is likely to be that in rural areas some of these services are demanded and not easily accessible, such as EKG exams, even though they may be covered by national health insurance through the hospitals or specialist practices. Another reason the doctors are seeking to increase quality services offered outside the contract is that they see their income limited by the terms and negotiation methods of the contract, which provides little incentive for investing in increased quality of care within the contract.

Revenues, Expenses & Reinvestment

As a service business, looking at the level in percentages of expenses, and the net profit of the business, the doctors have relatively profitable practices. Yet, their incomes are low because total revenue is low. Expenses are managed, and family doctors do not have much room for cost cutting.

Table 3 depicts total practice revenues. Note that while informal income was not discussed at the meeting, the research team addressed this issue carefully in the questionnaire design and survey implementation. The survey asked about income from the following sources: revenue from services provided under the contract, revenue from non-contracted services, and revenue from other sources such as donations and other sources. At another point, there is a question asking about total household revenue that could also capture any other informal income.

Table 3. What Family Doctors Do with Their Income	Amount	Percent of Total Revenue
Average Total Practice Revenue	**3,387 RON**	**100%**
Business expenses	2,080 RON	61%
Net profit (approximately)	1,307 RON	39%
Monthly reinvestment	202 RON	6%
Net profit after reinvestment	1,105 RON	33%

The level of reinvestment is relatively low. This could be due to a number of factors that were discussed at the meeting:

1. Uncertainty of future income due to annual renegotiation/revaluing of the NHIH contract

Each year the value of the points and the number of points assigned for per capita and per acta services changes as a result of a budgetary and negotiation process. Family doctors believe that they have very little influence or control over both of these processes. This factor, combined with the recent history of radical sector reform impacting family doctors, has made them cautious about the future, and thus they have not invested their profits significantly in the past in their practices.

2. Low levels of funds available for reinvestment

After paying the necessary expenses for salaries, rent, utilities and suppliers, there is little remaining free cash for reinvestment.

3. Low initial investment needs

When the family doctors first became "accidental entrepreneurs" some years ago they inherited facilities that were already equipped with the basic tools needed to run a family practice. It is only now that they are beginning to need to replace or upgrade these tools and equipment.

4. Inability to purchase facilities

A large percentage of doctors would like to purchase their facilities. Of those who want to borrow now, nearly 68% would like to use those funds to purchase facilities. Yet there is a perception that the laws and regulations that allow this to happen are not being enforced or enacted. There was great debate as to the status of this regulation. This debate was not resolved satisfactorily at the meeting.

Desire to Improve their Practices

In spite of complaints of being under-compensated and over burdened by administrative requirements, the vast majority (95%) of the family doctors want to grow or improve their practices.

The most frequently cited means of growth was to buy medical equipment (78%), followed by buying their office (67%), and expanding/refurbishing their office (54%). About half the doctors (51%) would like to provide new services.

Concerning the type of equipment the doctors would like to purchase, 64% would buy an electrocardiograph. Another 64% would buy micro-lab equipment, and 44% would purchase a sonogram machine. Thus, they are seeking to expand their services beyond the basic contract with the NHIH. Most likely the doctors are seeking to meet unmet demand (perhaps particularly in rural areas where hospitals and specialists are not closely available) and to correspondingly increase their income gained outside of the NHIH contract.

The vast majority (95%) of the family doctors want to grow or improve their practices.

Interestingly, 36% would like to buy a sterilizer, and a smaller percentage would like to purchase some basic equipment, such as scales (27%), stethoscope (26%),

and height scale (24%). These are all required equipment under the contract, which are relatively inexpensive. Yet, these very basic items, as well as a computer that is vital for electronic reporting to the NHIH, are needed and wanted by at least a quarter of all family doctors currently contracted.

Training and Business Support Needs

Doctors have both financial and non-financial needs related to growing and improving their practices. They need to be secure in the future of their practice, so that they feel with confidence that reinvestment is a wise decision or that they will be able to pay back a loan with a term longer than their 1-year government contract. They need a relationship with a lender who takes the time to understand their business, treats them with understanding and respect, and explains the terms, risks, and opportunities associated with borrowing.

The family doctors also need and want training in business and financial management to increase their confidence as practice managers. While only 2.5% and 4% respectively have had business and financial management training in the past 5 years, these physicians clearly recognize a need for it. They are effectively managing their own practices/businesses without training or guidance on how to run this practice in a financially sustainable manner, or how to make sound reinvestment decisions. Most doctors believe that clinical training is the most needed training. After that, they are interested in business management (60%), financial management (37%), and marketing (26%).

III. ACCESS TO FINANCE

Family Doctors as Good Borrowers

The fact that the majority of family doctors are women, committed to their profession, married, and in the same practice for at least 10 years, makes them attractive borrowers to banks in terms of their character. They are stable, respected members of their communities. Also, the income of a spouse is significant for 72% of the doctors, which provides the banks with a possible secondary source of income for added security for lending.

An interesting aspect of the findings is that income of family doctors in rural areas is the same or higher on average than those in urban areas. Even when looking at districts and economic regions, some of the findings seemed counter-intuitive with income and expenses not directly correlating with the economic development level of the regions. Thus doctors in rural areas, potentially with larger patient lists and less competition from other family doctors or specialists, can be considered more attractive borrowers than would be assumed by the demographics of their districts. Another factor that may influence profitability aside from the size of the patient lists in various districts are the terms of the family doctor's arrangement with the District Health Authority or municipality for the use of the facilities. In some cases, family doctors may have access to free facilities or pay a very small rent that may contribute to relatively higher profit levels.

The research presentation pointed out that one way for bankers to assess a healthy family doctor practice is by the number of patients, with the national average number of patients on the list of each family doctor being 1,854. Number of patients is directly tied to income under the contract with the NHIH. Family doctor representatives asserted that these practices should also be considered in terms of the quality of services, as it is true that quantity and quality may not correlate, particularly in areas where there is little choice for patients geographically to choose their family doctor.

One weakness in the doctors' business from a lender's perspective is that most do not own their facilities, which would normally be a good source of collateral.

The lenders at the meeting expressed general interest in creating more opportunities to educate the doctors on the financial services that are available to them.

Borrowing is a relatively new phenomenon among the family doctors. They are generally first time borrowers. There was some discussion of the finding that most who had borrowed in the past had

done so for the purpose of financing a car. While some saw this as a sign of a lack of professional seriousness on behalf of the doctors – that doctors were buying cars presumably for personal use as opposed to medical equipment – others pointed out that family doctors are required to make house calls and that after hours, these house calls are the major source of non-NHIH contract income. Thus a reliable car could indeed be a valuable asset for a practice of this type.

Currently, in most cases, banks lend to doctors as individual persons, as opposed to the doctors' practice. This is not in the doctors' interest for two reasons:

- As an individual person, doctors must generally lend against collateral that is personally owned, such as their house or personal property.
- The doctors cannot consider the interest payments or amortization as tax-deductible business expenses, even though in most cases the asset purchased with the loan (such as a car or equipment) is used by the practice.

A possible reason for this lending preference on behalf of banks is related to the size of the loans, being smaller than most banks typically lend through their business lending departments. Another reason may be the fact that most lending institutions are not familiar enough with the business model and nature of business collateral to lend to the practice itself. The exception to that rule as of February 2007 would be Libra Bank, which is actively lending to family doctors' practices.

It is a common perception on behalf of health sector policy makers and often bankers, that doctors are not interested in credit. However, the BoH research shows in Romania (as in many other countries) doctors want to improve their practices and increase their income and they want financing to do this. A large percentage (42%) would like to borrow now.

Of those that either did not want to borrow now or were not sure, only 9% stated that the reason that they did not want to borrow was because they did not need a loan. Most thought they could not afford to borrow. Thus, there could be unmet demand among those interested in borrowing now as well as among those who are fearful that they cannot afford to pay a loan.

Going beyond their willingness to obtain external financing, the doctors are indeed credit worthy. As stated above, they have proven, excellent characters and in that respect are the ideal clients of a bank. They have sufficient cash flow to support the amount of loans they are interested in taking, and they are willing and able to offer collateral to secure those loans.

IV. INDEPENDENT PHARMACIES

In rural areas, most pharmacies are independently owned. These small businesses are essential outlets for the people living in these areas where there is only one pharmacy per village. The pharmacists in the focus groups professed to be under extreme stress, barely making ends meet. They have lower profit margins than would be common in other countries. Most do not consider their businesses profitable, and seem to continue with their work out of a sense of civic duty and in the hopes that the conditions under which they work will improve with changes in government policy or contracting terms. Their difficulties stem from the following:

- Recent changes in accounting regulations on the values of stocks wiped out their profits in 2006
- The system of allocating amounts of covered drugs on a per pharmacist basis, as opposed to a per capita in catchment area basis, puts small pharmacies in rural areas in a difficult position. Many report running out of drugs in their communities in the first week of the month, leaving people in their communities underserved or under pressure to travel to bigger towns for the medications they need.
- Conditions of payment from the Health Insurance House, which can take more than 60 days to remit payments for

drugs provided under national insurance

- Amount of payments for these covered drugs – independent pharmacies have little if any negotiating power vis-à-vis the health insurance house which puts them at a disadvantage
- The terms of credit payments offered from suppliers. The pharmacists must take supplier credit in order to purchase the goods that they sell or provide. This credit comes with a price, which eats away at their profit margins.

One possible impediment for pharmacy businesses that was not mentioned in the focus groups or in the meeting are limits on the numbers of pharmacies allowed to operate in urban areas.[5] This may have the effect of limiting those interested in expanding in urban areas and certainly would have the effect of limiting competition, which generally does not benefit consumers nor does it promote reduced prices and better service within the industry.

[5] See Ministry of Health Order #1199 / 2004. "…setting up pharmacies in urban areas will not exceed / comply with following ratios: 1 pharmacy / 3000 people in Bucharest, 1 pharmacy / 3500 people in county seats, 1 pharmacy / 4000 people in any other city."

RECOMMENDATIONS

Finding the missing pieces to the puzzle

In the course of the roundtable discussions it was clear that among the disparate actors, there were many points of convergence, where the interests of the stakeholders led to solutions which could be widely supported. The expertise, good will, and hard work of the organizations represented by the parties at the table comprise almost all the pieces of the puzzle. This puzzle, once put together, would look like a national network of healthy family doctors' practices – sustainable, well-functioning providers of quality primary care including family planning and reproductive health services.

As a result of analysis of the research findings and discussion at the meeting of stakeholders, Banking on Health recommends the following:

This puzzle, once put together, would look like a national network of healthy family doctors' practices - sustainable, well-functioning providers of quality primary care including family planning and reproductive health services.

I. POLICY CHANGES TO IMPROVE THE BUSINESS ENVIRONMENT FOR FAMILY DOCTORS

The Ministry of Public Health and the National Health Insurance House are clearly key to the development and sustainability of the health of the family doctors' practices. They are the primary caretakers of the health of the nation and must bear in mind health outcomes while balancing issues of finance, capacity, equity, and accessibility. The family doctors are the face of primary health care for the nation, also providing valuable family planning and reproductive health services in the rural areas.

Romania has a relatively well-functioning primary care system. As the Ministry of Health approaches reform in the contracting system of family doctors and pharmacies, it has tremendous opportunity to continue an economic and social transition that could yield tremendous dividends to the general public.

A. INCREASE PAYMENT LEVELS TO FAMILY DOCTORS UNDER THE CONTRACT, EITHER PER CAPITA, PER ACTA OR BOTH.

A cost-benefit analysis of increasing payments to family doctor practices under the HIH contract should be done to weigh the potential impact on the health system. Increasing payments would address what doctors claim to be their primary business impediment, and allow them to access greater amounts of external financing to grow and improve their practices.

Another way to increase family doctor's ability to improve their practices would be to introduce co-payments in conjunction with appropriate regulation and social protection measures.

More financially healthy practices would create public health and reproductive health and family planning benefits. An additional long-term effect could be the gradual reduction of informal payments by patients to doctors. By capturing payments under contract and/or co-pays, the revenues are in the system, and can then be reinvested, taxed, and counted as official revenue by banks when calculating debt capacity. In addition, official payments increase doctors' accountability to patients and to the NHIH.

B. EXPAND THE RANGE OF SERVICES THAT FAMILY DOCTORS CAN PROVIDE UNDER THE CONTRACT.

By increasing the range of services covered by the contract, the government would increase patients' access to care, and potentially create lower cost distribution points for some services. There is concern over the provision of primary health care, and the possibility of diluting family doctors' commitment to primary health with the

introduction of some specialized services. Yet the doctors see the situation differently; they see that their underserved patients need these services to be closer to them, and more readily available.

There is also a budgetary concern – can the government afford to compensate doctors for this service? The puzzle piece will remain missing until economic analysis is done, weighing the costs and benefits to *the entire health system* of compensating doctors for these services. By leveraging external financing sources for the purchase of the assets, in the form of banks, MFIs, and medical equipment leasing suppliers, and with the doctors financing their own training in using the equipment, this indeed could be a low cost way for the MoH to save higher costs incurred in cases where the services are offered at more expensive outlets such as hospitals. In some cases it is possible that the services are not in reality readily accessible at the specialist level particularly for rural patients.

Some examples of services family doctors could offer under a framework contract worth considering include:

- Ultrasound services
- Doctors themselves want financing for equipment such as sonogram machines. This service would allow doctors to provide more complete prenatal care to pregnant women, as well as other services that are vital in rural areas that are far from hospitals. It would also bring in extra income to the doctors. Banks are willing to finance the machines. Yet, sonogram services are not covered under the contract between the doctors and the NHIH. Here is a missing puzzle piece.
- Low risk prenatal care
- Prescriptions for a wider range of drugs, thus eliminating the need for patients to see some specialists
- Electrocardiograms

C. CONTINUE MOPH SUPPLY OF FAMILY PLANNING PRODUCTS FOR UNDERSERVED GROUPS

It is important that subsidized or free contraceptives continue to be made available at the family doctor level in rural areas and for the rural poor. The Government of Romania has committed to continue this after the departure of USAID in 2008. This is a valuable service offered by family doctors, and has important health care implications beyond the distribution of contraceptives themselves, by deepening the level of interaction with women of childbearing age, many of whom are mothers of infants.

D. CLARIFY AND ENFORCE FAMILY DOCTORS' ABILITY TO PURCHASE FACILITIES

Guvernul României ar face un mare The Government of Romania would do the family doctors and by extension primary health care in general, a great service by clarifying and enforcing laws and regulations related to the ability of family doctors to purchase their facilities in a transparent manner.

According to government sources, family doctors can become the owners of the facilities in which they practice. This is per Law 236/2006, regarding the sale of the spaces with medical consulting room designation, as well as the spaces in which adjacent activities to the medical act are conducted, which entered into effect in July 2006. Officially, the right to purchase the facilities is given to the family doctors, dentist, biologists, bio-chemists, physicists, dental technicians, and other persons with free practice rights, that are developing adjacent activities to the medical act and that legally possess that respective facility, which, have as sole purpose of activity the provision of medical services.[6]

Some doctors have been given the opportunity to purchase their facilities at below-market rates, but in practice this is very difficult if not impossible in some areas. This uncertain situation inhibits investment in the facility both on behalf of the family doctors, who are not owners, and on behalf of the owners of the facilities.

E. LONGER CONTRACT TERMS

A low-cost way that the government could increase the quality of services at the family doctor level would be to provide a

[6] See the website of the District of Arad Council: http://www.cjarad.ro/judetul-rad/modules.php?module=epress&id=283&lg=ro

more stable business environment, in which doctors will feel more confident investing and borrowing to improve their practices. If the framework contract were revised not annually, but every two years, with point revaluation allowed only at the time of the contract revision, which would allow for some sense of stability.

F. STREAMLINE PROCEDURES

1. Prescriptions

Rationalizing the prescription methods, reducing the back and forth that patients must do to get compensated methods would make the system more efficient and free family doctors' time to do what they do best – be health care providers to their communities.

2. Raporting

Excessive reporting requirements and inefficient methods of reporting overburden family doctors' time.

II. FAMILY DOCTORS REQUIRE INCREASED SUPPORT FOR BUSINESS DEVELOPMENT

A. EXPAND AND ENHANCE CONTINUOUS MEDICAL EDUCATION IN THE FOLLOWING WAYS:

1. Offer more family doctors training in family planning, including those in urban areas

Those that have training in family planning do find that they have demand for counseling and services. It would be best for patients and doctors to continue to have access to this training, particularly for new family doctors and for all those not yet trained.

2. Standardize continuing medical education training courses with high standards and required approval by provider associations

Nearly 70% of family doctors surveyed want more clinical training. In interviews they expressed a desire for high quality continuous medical education training that would serve to uplift the status of their profession.

3. Business Management and Financial Management Training

Another missing piece to the puzzle is doctors' access to business and financial management training. Thirty-percent of family doctors say business management training is the single most important training they need for their practice. Clearly the family doctors want to be better versed in these areas. Continuing medical education is only clinical in nature, and medical school in Romania, as elsewhere all over the world, offers little guidance on how to run a medical practice as a business.

"Enhancing the Financial Health of the Medical Practice" course developed by BoH and offered by the NGO SECS has been proven to be a valuable resource for family doctors. This three-day course was positively received by 140 family doctors participants from each of the eight development regions of the country in late 2006. SECS has a relationship with family doctors born out of years of training and technical assistance provided in the field of family planning and reproductive health. The SECS network of trainers has the capacity to continue to offer this course with a combination of (yet to be secured) external funding and participant fees. *(See Appendix 4 for a course description.)*

B. STRENGTHEN OTHER BUSINESS SUPPORT

1. Health foundations, institutes, and NGOs can to continue to be vital resources to the sector and serve the various institutions represented at the meeting.

Their value is their continued impartiality and display of the highest professional standards of research and analysis.

2. Professional Associations to continue to strengthen their advocacy role on behalf of provider groups.

Professional Associations continue to perform a vital service to their members as advocates of their interests. By strongly voicing opinions on the interest of the doctors and pharmacists in light of the impact on primary and reproductive health, these associations play a part in building a stronger, transparent, health system. When the doctors feel secure in the representative function of their associations and gain access to vital resources such as training, information, and financing, they will also feel more secure in the long term prospects for their practices and more likely to invest in the future of them. Through better organization and coordination of activities, these professional associations could play

an important role in lobbying the National Health Insurance House to achieve greater financial benefits for family doctors.

The family doctors are interested in being evaluated and recognized for the quality of service they provide, not just the quantity. This kind of qualitative assessment can be facilitated by the MoPH, with the active involvement of doctors' association for the betterment of primary health care. Family doctors practices have a strong social component and the family doctors themselves are committed to high professional standards. A quality incentive could even be non-financial in nature, potentially using a peer network to evaluate awards for high standards in maternal and child health care or family planning and reproductive health, for instance. This would benefit patients, the family doctors themselves, and others such as lenders interested in understanding better the quality and earning potential of the practice during the credit application process.

Lastly, the associations took an important step in opening dialogue with banks and other financial institutions at the February 2007 meeting. This communication is important, as providing information to the doctors and pharmacists on financing options can be a valuable service to this group that is currently underserved by banks.

Banks seek to serve doctors' needs

Libra Bank, the bank that is furthest advanced in developing products for doctors, is now developing a credit card that doctors may use to purchase supplies and for other short term working capital needs. Libra Bank continues to develop "non-financial" product features that doctors' value. For example, business planning advice is accessible at the branch level and through the Libra Bank website, which is the most visited by private doctors in Romania.

III. INCREASE ACCESS TO FINANCE

Much of the policy recommendations above will serve to increase family doctors' ability to access finance and thus improve and grow their medical practices.

With only 9% of the doctors stating that they do not want a loan because they do not need one, evidently there is a need for financing and a need for banks, MFIs and leasing companies to reach out, actively market, and communicate to these doctors regarding the benefits and the terms of financing. Communication between the bankers and doctors can be beneficial to both, as they increase their understanding of each other's needs.

The Banking on Health Project has conducted a number of workshops and management meetings with banks and MFIs in Romania on the topic of "Marketing and Product Development for the Small Scale Health Sector," using the same research findings presented at this roundtable meeting. The workshops were successful in that each manager in charge indicated concrete next steps that would be taken to continue the process of reaching out to the market.

A. BANKS CAN EDUCATE AND MARKET IN A MORE TARGETED MANNER TO FAMILY DOCTORS, RURAL PHARMACIES, AND OTHER SMALL-SCALE HEALTH CARE PROVIDERS.

Banks and MFIs are keen to gain closer business relations with doctors in private practice, to better understand and meet their financial needs. The doctors want loans for investing in their practices, yet they are a generally under-banked market segment. At the meeting, dialogue began between professional associations and bankers on how the banks may participate in association events and publications, and what information and guidance the banks could offer to the members. Clearly, this communication could ultimately benefit the doctors themselves with greater access to information and finance that they need and want.

A few banks and MFIs have expressed interest in participating and/or sponsoring future "Enhancing the Financial Health of the Medical Practice" courses developed by BoH and offered by SECS, which would be a positive development for both the banks and doctors. B. Banks to lend to the doctors' practices, not to them

as individuals.

It would be beneficial for banks to lend to the doctors' practices (as opposed to as individuals), which is preferable to the doctors.

C. LENDERS TO MARKET TO DOCTORS IN RURAL AREAS

Another way that banks and MFIs can reach out to family doctors is to market to those in rural areas, whose incomes are similar to those in urban areas, but who may not have as many financing options available.

D. ENACT POLICY CHANGES INVOLVING INDEPENDENT PHARMACIES

Enacting the policy changes listed below will have the effect of increasing private pharmacies' ability to access finance.

IV. ENACT CHANGES IN LAWS AND REGULATIONS INVOLVING PHARMACIES INCLUDING:

- Clarify and streamline the administration of limits on the amount of reimbursable medications under the contract.
- Rationalize payment terms from the government to pharmaceuitical suppliers and pharmacies.
- Remove or increase upper limits on the number of pharmacies in urban areas.
- Remove or increase upper limits on margins charged by pharmacies.

SMALL INVESTMENTS IN HEALTH YIELD BIG RETURNS

The focus of this meeting was on the financing and training needs of family doctors and other private providers and distributors of reproductive health and family planning in Romania. While these needs may seem removed from the actual care of the population, in fact they are directly linked to the ability to provide sustainable, high quality care under a capitated health care system.

Investing in a population's health is critical for improving livelihoods and creating sustainable, long-term economic transition. Recent reports by the World Health Organization have established that investment and improvement in essential health services contribute to both poverty alleviation and overall economic growth. This is an exciting and opportune moment for Romania in many ways; energy, hope, as well as technical and financial investments can have a catalytic effect that will be felt for many years to come. The stakeholders represented at the February 2007 meeting can all play important roles in this process. The end results will be long-term economic and social dividends that enhance the quality of life for the people of Romania and contribute to widespread positive change in the country.

ANNEX I

LIST OF MEETING PARTICIPANTS

ORGANIZATION	NAME	TITLE
Association of Family Doctors	Dr. Rodica Tanasescu	President
Banking on Health Project	Lisa Tarantino Makaria Reynolds	Banking and Business Manager Project Manager
Center for Health Policies and Services (CPSS)	Dr. Andreea Lavrov	Program Coordinator
JSI / Romanian Family Health Initiative	Dr. Merce Gasco Dr. Narcisa Murgia	Chief of Party Program Manager
Libra Bank	Emil Bituleanu Andreea Poida	Acting President & Vice President Head of Marketing & Communications
Ministry of Public Health (MoPH)	Virginia Ciocoiu Dr. Cosmin Radu Prof. Dr. Afilon Jompan Dr. Daniel Verman	Head of Project Management Unit (PMU),World Bank, MoPH Project Management Unit (PMU), World Bank, MoPH President, Commission on Family Doctors Counselor
National Health Insurance House (NHIH)	Dr. Carmen Murarescu Dr. Florin Lazaroiu	Counselor Counselor
National Institute for Health Research and Development (NIHRD)[7]	Dr. Cipriana Mihaescu Pintia	Head of Development and Programs Department
Opportunity Microcredit Romania (OMRO)	Janos Bereczki Raluca Racz	Director of Credit Marketing Assistant
Romtens Foundation	Dr. Theodor Haratau Dr. Mihaela Haratau Dr. Silvia Florescu	Managing Director Program Manager Head Researcher (Head of Research at INCDS)
Society for Education in Contraception and Sexuality (SECS)	Dr. Borbala Koo Ana Vasilache	Director Program Coordinator
UNFPA	Dr. Mihai Horga	Assistant Representative
USAID Romania	Daniela Farcas	Democracy and Social Sector Reform Office
World Bank	Dr. Dan Sava	Health Specialist

[7] NIHRD is known as INCDS or SNSPMS in Romanian.

ANNEX 2

MEETING AGENDA

PRESENTATION OF THE STUDY: "ASSESSING THE FINANCIAL AND TRAINING NEEDS OF HEALTH SERVICE PROVIDERS AND PRODUCT DISTRIBUTORS IN ROMANIA"

Date:	Thursday, February 15, 2007
Time:	9.30 – 12.30
Location:	Novotel Hotel, Bucharest

9.30 – 11.00: Session 1

Welcome Remarks & Introductions of Participants
Dr. Merce Gasco, Chief of Party, JSI R&T

Overview of Banking on Health Project in Romania
Ms. Lisa Tarantino, Banking and Business Manager, Banking on Health, Banyan Global

- Previous activities in Romania
- Why focus on family doctors

Background on Research and Methodology
Ms. Makaria Reynolds, Project Manager, Banking on Health, Abt Associates, Inc.

Survey Findings
Ms. Makaria Reynolds, Project Manager, Banking on Health, Abt Associates, Inc.
Ms. Lisa Tarantino, Banking and Business Manager, Banking on Health, Banyan Global

- Types of private providers
- Characteristics of family doctors, services provided
- Income and expenses
- Family doctor plans to grow & improve practices
- Business obstacles

11.00 – 11.30: Coffee Break

11.30 – 12.30: Session 2

Survey Findings Continued

- NHIH contract impact
- Financing experiences & needs
- Training needs
- Correlations from research

Facilitated Discussion
Ms. Lisa Tarantino, Banking and Business Manager, Banking on Health, Banyan Global

Closing Remarks
Dr. Merce Gasco, Chief of Party, JSI R&T

ANNEX 3

"ENHANCING THE FINANCIAL HEALTH OF A MEDICAL PRACTICE: THE KEY TO SUSTAINING REPRODUCTIVE HEALTH AND OTHER SERVICES"

COURSE AGENDA

DAY 1

Introduction to Enhancing the Financial Health of a Medical Practice

Measuring the Financial Health of a Medical Practice: Financial Reporting

The Importance of Financial Information

The Balance Sheet

The Income Statement

The Cash Flow Projection

DAY 2

Diagnosing the Financial Health of a Medical Practice: Analyzing Financial Statements

Introduction to Financial Analysis & Overview of Financial Ratios

Analyzing the Balance Sheet

Analyzing the Income Statement

Analyzing the Cash Flow Statement

Access to Finance

Financing Options

DAY 3

A Detailed Look at Loans and Leasing

Guest Speakers: Access to Finance

Planning for Financial Health: Preventative Care for the Medical Practice

Planning; Understanding Yourself, Your Medical Practice, And The Environment

Reviewing Goals: Where You Want to Go

Quantifying Business Goals

Action Plan