Oxford Policy Management

Technical Assistance for Project Management Unit APL 2, within the Ministry of Health of Romania, in order to develop a Strategy for Primary Health Care in Underserved Areas and the Related Action Plan

Contract N40

Final Report

Prepared by

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February 2012

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Acknowledgements

The OPM team would like to record our appreciation to the Ministry of Health (MoH) departments and committees, the WB PMU APL2 Project, and all stakeholders who have contributed to this work.

In particular we are grateful for the contribution of Dr Paul Serban, who guided the entire process involved in the elaboration of all deliverables. His leadership and advice from the very beginning helped the project team to get insights into primary care in Romania, including specificities of remote and underserved areas. Dr Serban provided access to key documents, and kindly introduced us to key PC counterparts. We consider that the success of the project is largely driven with the vital contribution and dedication of Dr Paul Serban.

We would also like to express gratitude to Eng Francisc Czobor, Dr Maria-Cristina Dinescu, and Dr Cosmin Radu, from the WB PMU APL2 project for the time and efforts they gave to the coordination and development of this document. Particular thanks to Dr Maria-Cristina Dinescu for close involvement in discussions and meetings, and for critical and helpful comments, which informed the deliverables.

Special appreciation goes to the representatives of the MoH departments who provided the data and informed the work through multiple meetings. We are especially grateful to Dr Calin Alexandru, Director of the Department of Health Services and Public Policy, who provided specific comments on the draft strategy and implementation support paper; and, most importantly, led meetings bringing together key PC counterparts. This underlined the MoH leadership and ownership over the PC Strategy and Action Plan. Many thanks to Dr Iordan Geanta, Adviser in the Department of Health Services and Public Policy, and Ec Georgiana Bumbac, Director of the Economic Department of the MoH, and to Ec. Adrian Cocos, the Director of Human Resources Department, MoH.

Cordial thanks go to the Societatea Nationala de Medicina Familiei (Romanian Society of Family Medicine /General Practice, SNMF), namely to Dr Rodica Tanasescu, President, to Dr Sandra Alexiu, Secretary of the SNMF, and Dr Raluca Zoitanu. Many thanks also go to Dr Cristina Isar, President of the Centrul National de Studii Pentru Medicina Familiei (CNSMF) for providing understanding on challenges and achievements in Romanian primary care.

We want to express gratitude to Dr Dorin Ionescu, Director General and Dr Marius Octavian Fillip, Chief Physician of the National Health Insurance House (CNAS), for their informative discussions on primary care financing, and substantial contribution to finalization of the Action Plan for 2012-2013.

Our sincere thanks go to the representatives of family medicine, public health and the National Health Insurance House in Alba, Tulcea, Teleorman, Vaslui, and Botoshani for sincere and informative discussions during the field visits, which informed the Needs assessment report and action plan; and their participation in the Primary Care Development Strategy workshop.

Finally, colleagues from the College of Physicians, Order of Nurses, Nursing Association and Academia are kindly thanked for their input in the development of the project deliverables.

I. Project Milestones

On the 4th of October, 2011, the Ministry of Health of Romania (MoH), together with the WB Project Management Unit -APL2, contracted Oxford Policy Management, UK (OPM) to implement the project "Technical Assistance for Project Management Unit APL 2, within the Ministry of Health of Romania, in order to develop a Strategy for Primary Health Care in Underserved Areas and the Related Action Plan". The project duration was defined as 4.5 months, with the deadline of the 14th of February, 2012. On 7th of February the project was extended to the 29th of February to allow final payments to be made within the validity of the contract.

Six milestones were identified for the project:

1. **Inception Report** – **The Primary Care Needs Assessment**;

2. **A National Programme of improving accessibility, efficiency and quality in primary healthcare** (defined as **"Investment Program**" during the contract negotiation; agreement has been reflected in "the Letter of Understanding", attached to the Contract). At the implementation stage, the programme became part of the broader report on **"Supporting the implementation of the Primary Care Development Strategy"**, which included other chapters: one with recommendations on revising the legal framework for the Strategy implementation, and another with recommendations on revising purchasing mechanisms for primary care.

3. **The National Strategy of developing primary healthcare in rural areas** with low access to such type of services. The deliverable was turned into a broader **"Strategy for Primary Care Development in Romania for 2012-2020"**.

4. **The Action Plan** related to the National Strategy of Primary Care Development in areas with low access to such type of services. The deliverable was named as **"The Action Plan for the implementation of the Primary Care Development Strategy in 2012-2013".**

5. **A Monitoring and Evaluation Framework for 2012-2013**;

6. **Final Report**;

2. Phases of project implementation and key areas of work

The project was implemented in **three Phases**, with the respective deliverables, and in indicated deadlines:

Phase I:

- **The Primary Care Needs Assessment** report; Deadline_ November14th, 2011;

Phase II:

- **The Strategy for Primary Care Development in Romania in 2012-2020**; Deadline_ January 3rd, 2012;
- **Supporting document for the implementation of the Primary Care Development Strategy** (containing The Investment programme); Deadline_ January 3rd, 2012;

Phase III:

- **The Action Plan for implementation of the Primary Care Development Strategy in Romania in 2012-2013;** Deadline_ 7th February, 2012;
- **Monitoring and Evaluation Framework for 2012-2013**; Deadline_ 7th February, 2012.
- **Final Report**; Deadline 14th of February;

All deliverables were submitted to the MoH in time. All deliverables were approved by the MoH in the time-frame defined in the Contract.

The following **key work areas** were identified per phase:

Phase I:

- Field assessments in four judets _ Alba, Tulcea, Teleorman and Vaslui
- Analysis on international best practice for rural primary care development
- Analysis of the Public Health School Report of 2008
- Summary of the primary care context in Romania in general
- Summary of challenges and achievements in primary care with the emphasis on rural and remote settings.

Phase II:

- Drafting the Primary Care Development Strategy for 2012-2020;
- Drafting recommendations on amendments in regulations related to PC;
- Drafting recommendations on reviewing regulations related to PC;
- Developing PC Investment Programme;
- Discussing the Draft Strategy and Investment programme with the key stakeholders;
- Conducting the PC Strategy Workshop with the key stakeholders;
- Finalising the PC Strategy and Investment programme;

Phase III:

- Drafting the Action Plan (AP) for 2012-2013;
- Drafting the Monitoring and Evaluation Framework for 2012-2013;
- Discussing the Draft AP and M&E Framework with the key stakeholders;
- Conducting series of meetings with the PC stakeholders on AP and M&EF;
- Finalising Action Plan and M&E Frameworks;

Respective deliverables, which were approved by the MoH after completion of each phase, are presented in annexes 1, 2, 3, 4 and 5.

3. Key counterparts

The process of elaboration of the Strategy, Action Plan and Monitoring and Evaluation Framework was led by the MoH, and involved key Primary Care counterparts listed below:

- Dr Paul Serban, Chairperson of the PHC advisory committee, MoH;
- The representatives of the WB PMU APL2 Project:
  - Eng Francisc Czobor;
  - Dr Maria-Cristina Dinescu;
  - Dr Cosmin Radu;
  - Ec Adrian Niculae;
- The department directors and staff of the MoH:
  - Dr Calin Alexandru, Director of the Department of Health Services and Public Policy;
  - Dr Ec. Adrian Cocos, Director of Human Resource Department,
  - Dr Iordan Geanta, adviser in the Department of Health Services and Public Policy;
  - Ec Georgiana Bumbac, Director of the Economic Department;
- Top management of the National Health Insurance House (CNAS)
  - Dr Dorin Ionescu, Director General of CNAS;
  - Dr Marius Octavian Fillip, the Chief Physician of CNAS;
- Representatives of professional associations:
  - Dr Rodica Tanasescu, the President, the Societatea Nationala de Medicina Familiei (Romanian Society of Family Medicine /General Practice, SNMF);
  - Dr Sandra Alexiu, the Societatea Nationala de Medicina Familiei (Romanian Society of Family Medicine /General Practice, SNMF);
  - Dr Raluca Zoitanu, staff member of the SNMF
  - Dr Cristina Isar, President of the Centrul National de Studii Pentru Medicina Familiei (CNSMF);
  - Representatives of the College of Physicians;
  - Representatives of the Order of Nurses;
  - Representatives of the Nursing Association;
- The representatives of family medicine, public health and CNAS in Alba, Tulcea, Teleorman and Vaslui. The list of the individuals interviewed during the field visits is included into the PC Needs Assessment Report.
- Rural family doctors and head of the Department of Public Health in Botosani judet.

4. Project team

Original composition of the project team was the following:

International team:

Kees Schaapveld	Team Leader, Primary care expert
Tata Chanturidze	Project manager, Health policy consultant
Tamar Gabunia	PC/FM consultant
Wolfgang Tiede	Legal consultant
Robin Thompson	Health financing consultant

Local team:

Att Alexandra Bejan	Legal consultant
Soc Cristina Padeanu	Consultant on qualitative research
Dr Teodora Ciolompea	Field assessment team member, and local project administrator
Mihaela Cimpoeasu	Economist

The team has continuously received excellent support from Oxford based finance and administration team members:

Emma Barker	Project Administrator
Helen Blake	Project financial Manager

In the implementation phase Robin Thompson left the project, due to his resignation from Oxford Policy Management. CVs of two health financing consultants - Michael Thiede and Roland Panea - were presented to the MoH and the WB for consideration. Decision was made to engage both consultants to ensure uninterrupted implementation of the project. Thus, Michael Thiede was engaged in the delivery of Phase II activities, namely in elaborating recommendations for the revision of the primary care purchasing mechanisms. Roland Panea was engaged in implementation of Phase III activities, namely in costing the Action Plan.

All consultants and the support staff are cordially thanked for their dedication to the work and the accomplishments.

5. Process of developing deliverables

The process of elaboration of project deliverables encompassed the following:

- Field work for primary data collection (in phase I);
- Secondary data collection and analyses;
- Meetings, consultations;
- Drafting deliverables, and disseminating them to the counterparts (MoH/WB PMU);

- Feedback from key counterparts;
- Dissemination of updated draft to wide range of stakeholders;
- Workshop with wide range of stakeholders;
- Finalising the deliverables;
- Submitting deliverables to the MoH Committee;
- Feedback from the Committee;
- Producing final versions based on the feedback from the Committee;
- Deliverables approved by the MoH/WB PMU;
- Approved deliverable signed by the Minister

PHASE I

Report on
Rural PHC Needs Assessment in Romania

Prepared by:
Kees Schaapveld
Tata Chanturidze
Tamar Gabunia
Wolfgang Tiede
Cristina Padeanu

October, 2011

Acknowledgements

The OPM team would like to record our appreciation to the Ministry of Health departments and committees, the WB PMU APL2 Project, and all stakeholders who have contributed to this process.

In particular we are grateful for the great contribution of Dr Paul Serban, who guided the entire process involved in the elaboration of this report. We would also like to express particular gratitude to Eng Francisc Czobor, Dr Maria-Cristina Dinescu, Dr Cosmin Radu, and Ec Adrian Niculae from the WB PMU APL2 Project for the time and efforts they gave to the coordination and development of this needs assessment.

Special appreciation goes to the representatives of the MoH departments who provided the data and informed the assessment though multiple meetings. We are especially grateful to Dr Calin Alexandru, Director of the department of Health Services and Public Policy; Dr Iordan Geanta, adviser in the Department of Health Services and Public Policy and Ec Georgiana Bumbac, Director of the Economic department of the MoH.

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Our sincere thanks also go to the representatives of family medicine, public health and CNAs in Alba, Tulcea, Teleorman and Vaslui.

Finally, special thanks to the local team members, Att Alexandra Bejan, Soc Cristina Padeanu and Dr Teodora Ciolompea who contributed to the field assessments and regulation analyses, and who provided valuable inputs to the report.

Abbreviations

BI = Bucharest

C = Central

CNAS = National Health Insurance House (Romanian acronym)

CPD = Continuing Professional Development

EU = European Union

FD = family doctor

FM = family medicine

GP = general practitioner

MOH = Ministry of Health

NE = North East;

NHP = National Health Programmes

RON = Currency of Romania (Romanian Leu)

S = South;

SE = South East

SV = South West

PC = primary care

PHC = Primary Health Care

WHO = World Health Organisation

NW = North West

W = West

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CHAPTER 1: Introduction

This report is the first deliverable by a team of Oxford Policy Management ()PM) consultants that supports the Romanian Ministry of Health in the development of a national strategy and action plan for the improvement of the provision of primary care services in underserved rural and remote areas. Specific objectives of the technical assistance are to:

- Conduct a field assessment of rural primary care needs in four areas, based on the comprehensive needs assessment previously carried out by the National School of Public Health and Health Management in 2008;

- Produce an overview of international experiences in providing primary care in rural and remote areas, with lessons that may be relevant for Romania;

- Drafting the above-mentioned strategy and action plan, plus proposing a monitoring and evaluation plan for the period of implementation.

This present report is concerned with the first two specific objectives and is “work in progress”. It will contribute to the overall objective of our assignment which is the development of the Strategy.

Some remarks must first be made about terminology. Although Primary Health Care (a term coined by the World Health Organisation at the Alma-Ata conference in 1978) is often used as an equivalent of primary care, it is not the same. Primary Health Care is a much more complex and idealistic concept. In this report, we shall use primary care as a more general concept covering primary level health services that can be used by the population without an onward referral. In Romania and European Union primary care and family medicine are often seen as almost equivalent which they are not: Family medicine is the type of services provided by family doctors (FD) and nurses and other types of para-medical staff. Primary care officially also includes pharmacists, dentists and other professions. Our report is mostly about family medicine, but we also use the term of primary care, although in a rather narrow sense.

In Romania, a distinction can be made between family doctors and general practitioners which, according to European regulations, do not exist. In Romania, general practitioners are family doctors who have not yet complete either the 3 years postgraduate residency in family medicine or the upgrading courses needed to become a specialist in family medicine.

As the future strengthening of rural primary care cannot be considered in isolation from the present day state of primary care in Romania, we start in Chapter 2 with a general overview of the current situation in Romanian primary care. It shows what has been achieved by recent reforms, development of human resources, accessibility of services (geographically and otherwise), financing, provision and utilisation of services, the legal framework, and some international comparison. Chapter 2 is based on many sources and reports, including the recently available draft of the World Health Organisation’s report: “Evaluation of structure and provision of primary care in Romania - a survey-based project”.

Chapter 3 presents a summary of the key findings in the report: “Proposal to develop a strategy for a national programme for improvement of access to basic health care services in underserved areas”, by the National School of Public Health and Health Management (2008). This very comprehensive report is in Romanian only.

Chapter 4 summarises the OPM Team's key findings from its own small scale field assessment in four regions selected by the Ministry of Health: Danube Delta (Tulcea judet), Area of Moldova (Vaslui judet), Southern region (Teleorman judet) and Western Carpathian Mountains (Alba judet). This assessment was informed by the report discussed in chapter 3, together with additional questions. This assessment highlighted the specific needs of rural and remote primary care service, including their organization and provision, financing, access, quality of services, availability and state of physical infrastructure, role of nurses, patterns of referrals, organization of emergency care, incentives and motivation for primary care service providers, and patient satisfaction.

Chapter 5 presents a review of how other countries have tackled the challenges of providing primary care services in rural and remote areas based on the published experience in specific countries. It discusses the use of financial and non-financial incentives to attract and retain primary care staff in rural areas. Examples of international best practice are given, together with countries achieving significant improvements in rural primary care services. Challenges to staffing rural health facilities are presented, with the incentives which work best for mobilizing and retaining human resources in remote settings.

Chapter 6 presents a preliminary overview of existing challenges in Romania to rural primary care, as well as to primary care in general and including urban services. Challenges also exist for family medicine as a sub-system of the Romanian health care system as a whole. These are grouped as issues covering policies, financing, human resources, quality, physical infrastructure, organisation and legal issues. This is a preliminary overview since planning discussions with stakeholders will continue and inform the new strategy for the National Strategy for Rural Health Care Development.

Chapter 7 summarises key issues and drivers for change, and defines next steps to be accomplished in a pathway for developing the Rural Strategy and Action Plan. The first draft Strategy should be presented to the Ministry of Health by the end of November 2011. This draft will then be discussed with the other major stakeholders in December 2011. Proposals for the Action Plan and the monitoring & evaluation framework must be presented in January-February 2012.

Chapter 2: Overview of the Present Situation in Romanian Primary Care

2.1. Achievements in primary care in Romania

Primary care has developed considerably in Romania over the past 20 years, despite the changing context with socio-economic transitions, modified demographic and epidemiological trends, and rapidly altered policies for the organisation of health, health financing and services delivery.

Box 1: Key achievements in Romanian primary care

- Creating the profession of family doctor (abolishment of child-adult split)
- Free but compulsory choice of family doctor
- Nearly whole population covered
- Nearly all family doctors contracted by CNAS
- Standard provider payment method
- Standard package of services
- Licensing and relicensing, based on CPD
- Three years residency programme (EU requirement)

Primary care reforms started in Romania in mid-1990s with the introduction of major changes in service provision and financing in eight pilot districts (1994), which were later rolled out nationally in following years. Patients were granted a free but compulsory choice of a provider since nearly the whole population was covered by primary care services (see details later).

The profession of family doctor was established, with clearly defined entitlements for Family Doctors (FD) and General Practitioners (GPs). The split between primary care for children and adults was abolished and FDs/GPs were assigned a gate keeping role.

Further reforms included transformation of FDs/GPs into independent providers, through the Social Health Insurance law (Law 145/1997). Family doctors became directly contracted by the District Health Insurance Houses (DHIH) that were in-charge of delivering services to insured population under the annual national framework contract (The draft WHO/NIVEL/CPSS report, 2011). Later FDs were contracted by the National Health Insurance House (CNAS), with the majority changing to become self-employed and having rights to earn additional income from private practice.

In 2007 the competencies and responsibilities of FDs/GPs were reviewed and enhanced which led to them increasing their output by providing more consultations and home visits, taking on more registered patients and by providing a better coverage of emergency care (the draft WHO/NIVEL/CPSS report).

Later more emphasis was given to patients' needs through the provision of "patient oriented care", as a part of strengthening of primary care as an essential element of health sector reform (2008)[1]. The Presidential Commission for Romanian Public Health Policy Analysis and Development made proposals for a comprehensive and coordinated primary care in the policy document called: "A Health System Focused on Citizen Needs". It emphasised the role of multidisciplinary teams, efficiency and diversification of services, investments in human resources and practice, improvements of health information systems, and introduction of evidence-based medicine.

A three-year postgraduate training programme in family medicine was introduced and standards and requirements for Continuous Professional Development (CPD) were introduced. Today all 11 public medical universities in Romania offer a three-year postgraduate training programme in family medicine, enrolling about a quarter of all medical graduates. One year of this programme is spent in a primary care practice.

CPD regulations obliged all family physicians to meet requirements set by the College of Physicians to keep their license. After a minimum of five years of practice, FDs and nurses can take an examination to obtain a certificate which is a proof of the highest professional qualification in the discipline. Physicians holding a title of "primariat" and nurses - a title of "principal," receive a higher income. Financial motivations drive many professionals towards achieving these high professional standards (The National Society of Family Medicine, 2011).

A complex service purchasing mechanism, comprising an age-adjusted capitation allowance, fees for services and bonuses related to professional rank, were substituted for payment through a system of fixed salaries (The Institute of Public Health, 2009). New payment mechanisms included incentives to increase access in underserved areas.

The latest reforms in 2010-2011 introduced modifications to the purchasing of health services by changing various levels for norms and by the proportion of family doctor's income from capitation and from fees for services, from 70:30 to 50:50 respectively. Other reforms included allowing the coverage of non-insured individuals through services paid for by fee-for-service; and limiting the number of cases to be funded through fee-for-service per day. These initiatives were perceived differently by the primary care providers, some of them favouring positive development, others arguing that these modifications neither established substantial incentives for GPs/FDs, nor increased overall income.

The various reform initiatives described above resulted in improvements of certain aspects of the primary care services organization and delivery. However, the socio-economic context, epidemiological and demographic trends, geographical complexities, and systemic weaknesses in implementation all limited the attainment of desired outcomes. Characteristics of primary care and regional comparisons reveal the shortfall in achievements and the need for further improvements.

2.2. Financing of primary care services

Romania has the lowest share of Total Health Expenditure (THE) out of Gross Domestic Product (GDP) among the EU countries, spending only around 5.5% of GDP on health (2008). This is considerably lower than the Eur-A [selected WHO sub-region] average (9,56% in 2008), as well as in neighbouring countries (Diagram 2.1). The same situation is

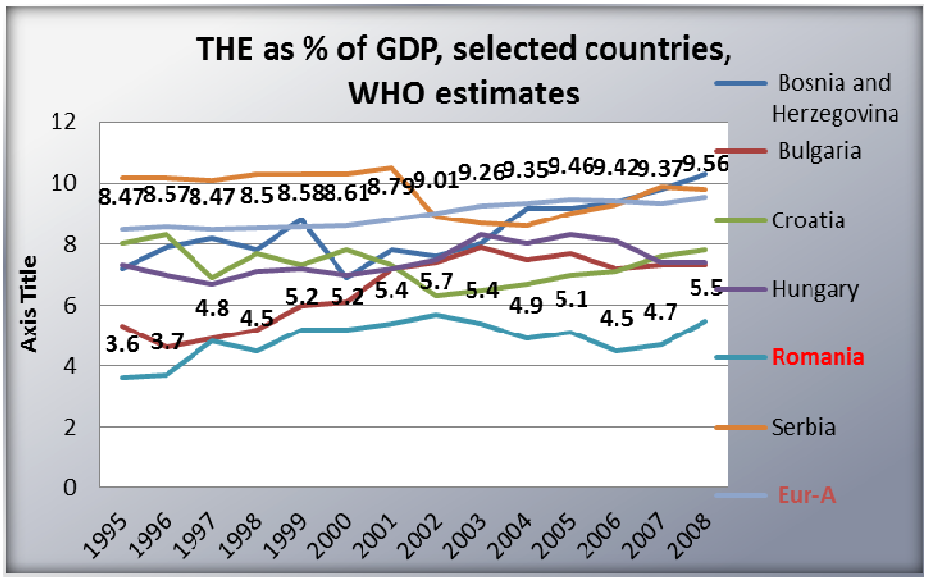
[1] The Presidential Commission for Health; "A Health System Focused on Citizens' needs"; 2008

for Total Health Expenditure, PPP$ per capita, being the lowest in the EUR A region, with a PPP$665 per capita THE (See Figure 2.1 and Table 2.1 below).

Public health expenditure composes 81% of the Total Health Expenditure, leaving 19% for private health expenses. Public health funds are pooled from the compulsory health insurance payments, paid in even shares by the insured and the employer according to the Law of Social Health Insurance, introduced in 1998.

People without an income of their own, like children and young people, handicapped, war veterans and dependants of insured people are given free access to health insurance. For some special groups, like conscripts and prisoners, insurance contributions are paid through the budgets of different ministries.

Figure 2.1: Total Health Expenditure as % of Gross Domestic Product, selected countries



Source: WHO Europe Health for All DB

Table 2.1: Key health care financing indicators, Romania and selected countries, 2008

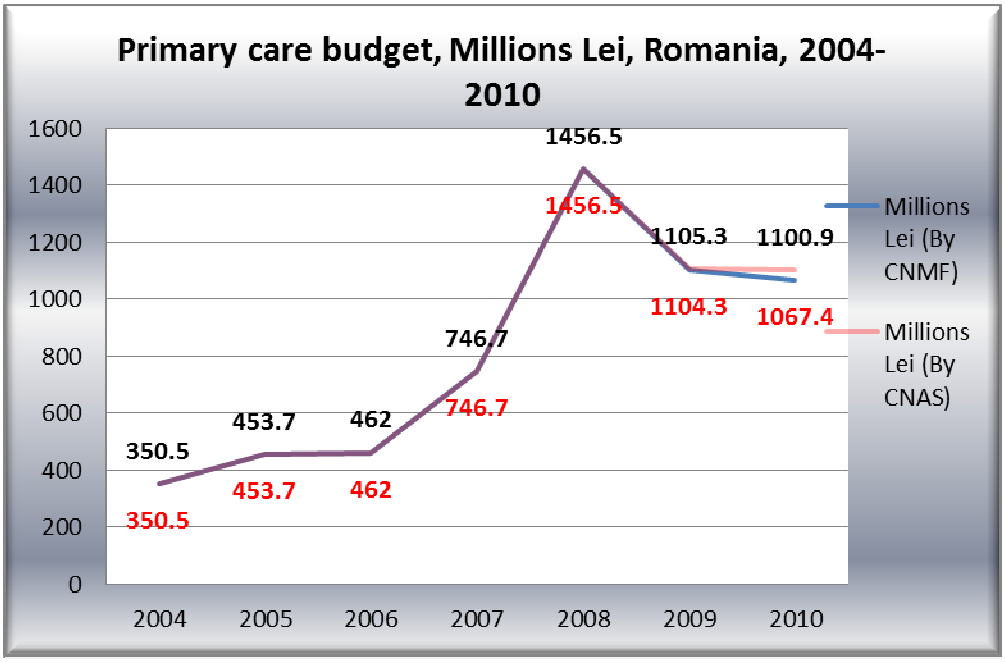
Countries	Total Health Expenditure (THE) as % of GDP, WHO estimates	Public sector health expenditure as % of THE, WHO estimates	Total Health Expenditure, PPP$ per capita, WHO estimates
Bosnia and Herzegovina	10.3	58.2	867
Bulgaria	7.3	57.8	910
Croatia	7.8	84.9	1496
Hungary	7.4	70.3	1419
Romania	5.5	81	665
Serbia	9.8	62.5	838
Eur-A	9.56	77.09	3280.9

Source: WHO European health for all DB

Primary care funding comprised 6.8% of Total Health Insurance Expenditure in 2010, being decreased significantly over the last three years from 8.8% in 2008, to 7.8% in 2009, and to

6.1% in 2010 (CNAS, 2010). This followed a sharp increase during 2004-2008 of 5.1% of the total health insurance expenditure in 2004, up to 8.8% in 2008 (Table 2.2; Diagram 2.2). CNAS and CNFM provide different figures for 2009-2010 spending for primary care.

Figure 2.2: Primary care financing in Romania, 2004–2010



Sources: NHIH activity reports 2004-2010;
SOCIETATEA NAŢIONALĂ DE MEDICINA FAMILIEI / MEDICINĂ GENERALĂ : Financing of the Health Care System *and Family Medicine in Romania 1990-2010*

Table 2.2: Primary care funding in Romania, 2004-2010

	2004	2005	2006	2007	2008	2009	2010
% of PHC funding out of total health insurance expenditure	5.01%	4.95%	4.54%	5.81%	8.80%	7.81%	6.84%

Sources: NHIH activity reports 2004-2010
Note: SOCIETATEA NAŢIONALĂ DE MEDICINA FAMILIEI / MEDICINĂ GENERALĂ: Financing of the Health Care System and Family Medicine in Romania 1990-2010 provides diverse figures for the Primary care funding in 2009-2010, namely, 7.2% in 2009 and 6.1% in 2010;

2.3. Remuneration and Incentives for FDs/GPs

Currently, most of FDs/GPs are self-employed. The remuneration of FDs/GPs consists of a mix of capitation fees and fees for services. Fees relate to the number and age of registered people and can be higher depending on the location (urban or rural). Capitation payment is done for up to 2200 patients per FD/GP. FDs/GPs having more patients in the list receive only fee for service for the remaining patients (SNMF/MG, 2011). Fee for service covers up to 20 consultations a day. There are exemptions for doctors having more than 2200 patients attached and for having more than 24 consultations per day that are paid for through the fee for service. Similarly, doctors having more than 3000 patients are paid for up to 28 consultations per day through the fee for service.

No contractual remuneration is included for practice costs and investments (i.e. renovation and maintenance of premises and equipment). FDs/GPs can generate additional resources by providing privately paid services.

The average monthly gross income for a FM practice is approximately Euros 1650 (The National Society of Family Medicine, 2011). This has to cover the wages for nurses and auxiliary staff, maintenance cost, utilities and other taxes, leaving a family physician with about 450-550 Euros of personal income.

There are some financial incentives for physicians practicing in rural and remote areas (10% -100% extra), and for those with a seniority status gained through specialty examinations (20% bonus and 10% penalty for those not passing the exam).

2.4. Affordability (Financial access) to primary care

Most of the primary care services are available free of charge but there is a list of services provided by FDs/GPs that are to be paid for by patients. According to the Law, FDs/GPs are obliged to put the list of these services in their offices and make patients aware of the costs.

There are co-payments for drugs and injections prescribed by the FD/GP. Regulations define the lists of medicines that are completely or partially subsidized by the government, with the established amount for co-payment for defined pharmaceuticals and medical interventions. More specifically, List A contains medicines with a 10% co-payment; List B presents medicines with 50% co-payment; and Lists C1 and C2 present medicines with 0% co-payment. The latter consist of drugs for cancers, diabetes, certain cardiac and liver diseases, HIV/AIDS, and drugs administered during the organ transplantation. These lists are agreed between the MoH and CNAS.

The majority of drugs are subsidized from the price of a generic drug. If the generic drug is unavailable, subsidized price becomes symbolic. The financial burden from co-payments is particularly severe for rural dwellers, aggravated by the non-availability of pharmacies, and the absence of generic medicines in drug stores.

A study by WHO revealed that most patients who were interviewed referred to difficulties in obtaining drugs due to lack of availability and the costs and co-payments. One fifth of interviewed patients reported paying for a home visit and one fifth for a visit to a medical specialist after referral. Ten per cent of the interviewed patients reported refusing or delaying visits to a FD/GP for financial reasons.

2.5. Human Resources

For the past 20 years Family Medicine has been a recognized medical specialty in Romania, with two national organizations leading on its development. The National Society of Family Medicine (NCFM) has a broad role in setting and implementing professional and clinical care standards. The National Federation of Family Medicine Management Associations (NFFMMA) deals with business and employment aspects for family medicine practitioners. In addition, there is the National Center for Studies in Family Medicine (NCSFM), which contributes towards strengthening the scientific foundations for the discipline and is instrumental in elaborating clinical guidelines for the family medicine practice.

According to the CNAS/MoH data of 30 June 2010, there were 11379 Family Physicians/General Practitioners contracted by the National Health Insurance House, out of which

- **5147 (45,2%) were family doctors, who undertaken additional exams to attain the highest qualification ("medici primari"),**
- **4565 (40,1%) were family doctors with 3 years of residency or equivalent ("medici specialisti"),**
- **1667 (14,6%) were doctors without specialisation/residency in family medicine ("medici").**

However, according to other sources there were about 14, 835 FDs/GPs in the country, comprising 35.5% of total for all physicians, nurses and midwives nationally (HFA DB; 2006). These discrepancies in statistics call for care in interpreting the presented figures within the national context. There appears to be an average of 1,894 inhabitants per physician (See Table 3 below).

Table 2.3: Professionals working in primary care, Romania, selected years

Active Primary care providers	Number	Number of pop. per worker	As a % of all physicians, nurses, midwives*
Total Number of Physicians	41 455 (HFA DB)		
	38, 449 (MoH)		
Total number of active nurses	85 785 (HFA DB)		
Total number of active midwifes	4913 (HFA DB)		
FD/GPs Contracted by Health Insurance (2009)	11 348	1 894	29.5% (MoH)
FD/GPS HFA DB total (2006)	14 835	1 449	35.8% (HFA DB)
PHC Nurses (2006)	10 596	2 029	12.6
PHC Midwives (2006)	378	56 878	7.7
Nurses specialized in paediatrics (2006)	935	22 995	1.1

Sources: Health for All Database; MoH Romania

In 2010, 16% of medical graduates entered the family medicine residency (Table 2.4), which indicates a 50% reduction on 2009. Many FDs/GPs/ indicated that graduates choose family medicine residency as a temporary solution while looking for professional opportunities in other disciplines. This suggests that it may suffer from a low status and may indicate problems in maintaining adequate manpower in future to support high quality primary health care services.

According to the MoH, about 1300 Family Medicine residents will graduate in 2012. The MoH is concerned about finding enough work places for this group and requested that this issue is addressed in the Rural PHC strategy.

Table 2.4: Number of Family Medicine Residents in 2008-2010

Number of Residents	2008	2009	2010
Total number residents in all clinical specialties	2327	2625	2740
Number of Family Medicine Residents	500	858	445

% of family medicine residents	21%	33%	16%

Source: the National School of Public Health, Romania
Note: these numbers refers to enrolees per year

For nurses there was recently an average of 1291 patients registered per nurse[2]. There has been a downward trend in the past decade for the number of nurses nationally, caused by a lack of financial and professional incentives to keep the profession. Nowadays nurses have been limited in their clinical role through medical acts and their work load has increased in management responsibilities. The health system does not reward a good practice in nursing and their incomes depend on subjective decision of their FDs/GPs who reimburse them for their work.

The importance of nurses is fully recognised by professional associations for family medicine, which have supported improvements in Continuous Medical Education for nurses, as well as introduction of contracts for nurses that include objectively defined remuneration.

2.6. Productivity

According to national norms between 1000 and 2200 patients are to be assigned per FD/GP. In exceptional cases in some Judetes this limit is lowered for rural areas so as to allow family medicine practices to be opened in villages with less than 1000 inhabitants. A committee ("Comisia Mixta – Paritara") decides the minimum number of patients in each county. It is composed of 2 county representatives from CNAS, 2 representatives from DSP, 2 from the organizations of family doctors, and 1 representative from the general medical council (CMR).

However, an assessments found that the actual number of patients varies from 1090 to 3310 per family physician (School of Public Health Report, Romania, 2007).

Based on the 11,379 FDs/GPs contracted by the National Health Insurance House, there is an average of 1,955 persons assigned per practitioner in Romania. This is higher than in many Western European countries (See Table 2.5). However, these figures do not show a severe scarcity of family physicians at a national level.

These comparisons and statistics should be treated carefully to avoid making misleading conclusions. For example, in the Netherlands the standard solo practice has 2,300 clients but because there are more and more part-time doctors (for example 1.5 doctors sharing a practice), the national average is 1401 patients per GP.

Table 2.5: Population, GPs and Population attached to GPs, selected countries, 2008

Countries	Population (2008 HFA)	GPs (2008 HFA)	Population per FP
Romania	***21504442***	***11000 (MoH Data)***	***1955***
Sweden	**9219638**	**5734**	**1608**
Bulgaria	**7623395**	**4786**	**1593**
Denmark	**5489022**	**3685**	**1490**
Netherlands	**16445594**	**11741**	**1401**

[2] WHO final draft report; "Evaluation of structure and provision of primary care in Romania"; Primary care in the WHO European Region; WHO Europe; 2011

Spain	**45593384**	**33349**	**1367**
United Kingdom	**61383156**	**46497**	**1320**
Norway	**4768212**	**3901**	**1222**
Estonia	**1340675**	**1147**	**1169**

Sources: WHO HFA database; MoH Romania

The severe shortage of FDs/GPs in some localities leads higher norms being established by the National Health Insurance House. In the WHO assessment of Moldova, Muntenia, Transylvania, about 9 % of respondents reported staff shortages for more than six months, including the shortage of a FD/GP, nurses and support staff.

Most of FDs/GPs report they work for 40 hours a week and on average a FD has 26,3 patient consultations per day, whereas a GP has 24.2 patients per day (Draft WHO/NIVEL/CPSS report, 2011). This is the reverse of what might be expected for rural compared to urban areas. Explanations provided by the MAFM include recent migration of doctors and unreliable and out of date information. The figures may also be driven by the systems for payment and reimbursement that allow for payments for serving 20 or more patients per day.

2.7. Geographical, timely and physical access to primary care

The findings on access in this section are drawn from the quantitative and qualitative studies conducted by the National School of Public Health (2008), WHO (2009-2011) and OPM (2011) in selected regions/Judets of Romania. Though these studies are not nationally representative, they give sufficient understanding of the geographic, timely and physical accessibility to primary care services in rural settings.

According to WHO's assessment in Moldova, Muntenia and Transylvania in 2010-2011, almost 75% of the population had access to primary care services within 20 minutes travel and the majority of patients (90.0%-94.5%) were able to see a physician the same day. Two thirds of physicians reported having an evening clinic at least once per week. Only 10% have one on a monthly basis. According to 95% of physicians an emergency telephone number is provided to patients if their practice is closed. 45% of disabled and wheel chairs users found physical access to premises was inadequate.

According to OPM's team assessment in September-October 2011 in four Judets (Tulcea, Teleorman, Vaslui and Alba), people in mountainous areas and territories surrounded by water still have difficulties in accessing primary care services. In some of the small villages the family physicians and nurses are only available on a day or two during a week. Twenty-four hour services are only provided in areas with "Permanency centers", which are usually hard to be reach for remote village dwellers.

These findings are similar to the comprehensive assessment conducted by the National School of Public Health in 2008, which found that 83.9% of the rural population was registered with family physicians, while 16.1% of population in rural areas had no regular family doctor in 2007. This represents 153,904 inhabitants in 88 settlements were not covered by FD/GP services. The number of uncovered inhabitants varied heavily by regions, being worst in the South-East (49145), South (35156), and West regions (24180).

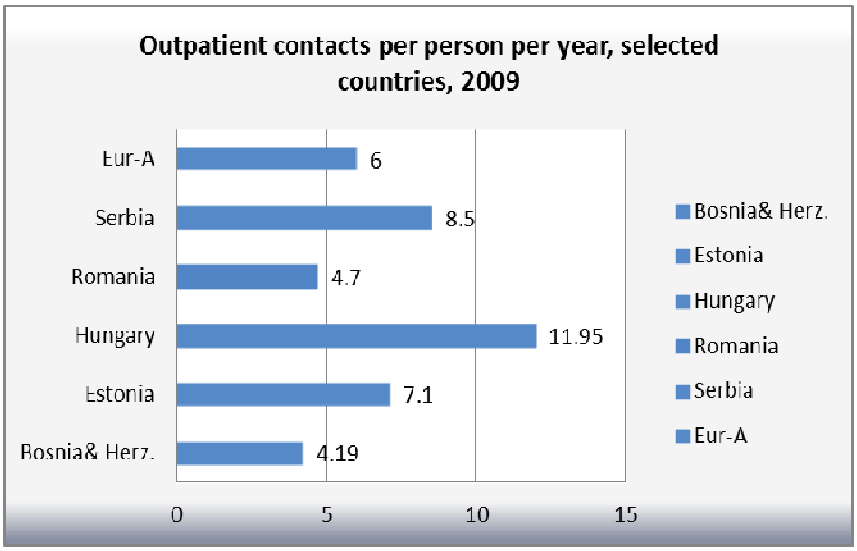
The same study found that about 30% of inhabitants in these regions could reach a practitioner within 5 to 10 KMs. A median value for the distance to the FP/GP was 4 KMs, with the poorest quartile being 7 up to 50 KMs from the delivery point for services.

2.8. Utilization of Primary care services

The number of outpatient contacts per person per year in Romania is falling. In 2006 it was 5.6 outpatient contacts per person, while in 2009 this had decreased to 4.7 (WHO HFA DB). This is lower than the EU average, but is similar to many Eastern European countries, including Hungary, Estonia, and Serbia. These are not primary care contacts per patient per year.

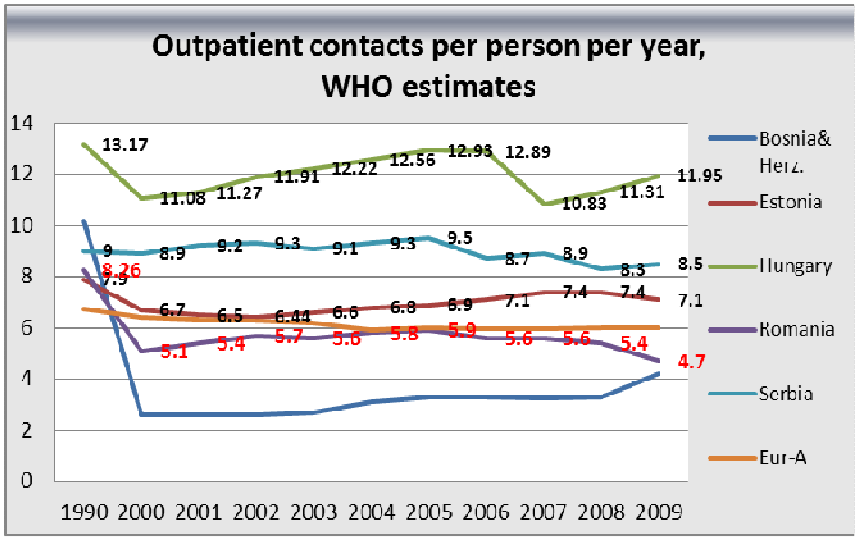
A figure of 4-6 visits per year to a primary care provider could be considered normal from international perspectives. However, in most countries such outpatient visits also includes other primary care providers and specialists (and sometime dentists and pharmacists) at outpatient level. Thus, depending on the provision of services by different primary care providers the Romania figure is hard to interpret.

Diagram 2.3: Outpatient contacts per person per year, selected countries, 2009



Source: WHO European health for all DB

Diagram 2.4: Trends in outpatient contacts per person per year, selected countries,1990-2009



Source: WHO Euro Health for All DB

The Number of visits to PHC service providers by regions was not available for this study at this stage. CNAS will be approached with the further enquiry on these figures.

2.9. Patient satisfaction

Based on the qualitative and quantitative data available from the assessments conducted by WHO and OPM in selected regions, it can be concluded that most patients are satisfied with the work of their FDs/GPs. During field visits the OPM consultants witnessed the respect people expressed towards their practitioners for their dedication, including towards the uninsured. Particular respect was shown to the FDs/GPs who originated from the local area as they were considered "insiders, particularly caring for the local villagers."

In the area of Moldova, Transylvania and Muntenia, from 77% to 82% said that when the practice is open they can visit a FD/GP urgently for a consultation the same day and about the same said that the waiting rooms were convenient and that during opening hours it is easy to get a doctor on the telephone for advice. Almost 80% of respondents said there was always a doctor available, when they visit a practice during the week days. Only 15,9% to 19% said that there was a doctor available during the weekends [source: WHO 2011].

The same study also found that appreciation of FDs/GPs varied between urban and rural areas, with respondents in urban areas being less positive about the availability and quality of care despite the possibility of reaching the practice by public transport.

2.10. Overview of the Legislation Governing Primary Care

The legal framework of the Romanian Primary Care is a mixture of primary and secondary legislation.

Primary Legislation

There are three primary laws in Romania which concern Primary Care: the Health Reform Law No. 95/2006, the Law No. 215/2001 on Local Public Administration and the Law No. 263/2004 on Ensuring Continuity of Primary Care through Permanence Centres.

The Health Reform Law 2006 addresses Primary Care issues in three titles. Title II deals with the National Health Programmes (NHPs). The National Health Programmes include assessment programmes, preventive programmes and curative programmes with regard to health issues. The programmes are funded from the state budget and the National Health Insurance Fund (a state fund). Title III is concerned with the basics of Primary Care. It defines the basic terms of Primary Care, family medicine, family doctor etc. Further, it lays down the conditions of medical assistance provided in family medicine offices and contains provisions concerning duties of the involved parties, the organisation of the family doctor office, the types of medical services provided to patients, and the financing/funding of family medicine. These provisions are detailed in the Government Decision No. 1389/2010. Finally, Title XII deals with the medical profession and the organisation and functioning of the Romanian College of Physicians.

The Law No. 215/2001 on Local Public Administration does not address health care matters as its main subject matter. However, it regulates (among other matters) the powers of the Romanian local authorities to decide on the sale, lease or rental of private assets (e.g. premises) of the respective local area. Theoretically, the local council ensures, within its competence, the conditions for providing local public services on health and decides on the granting of bonuses and other incentives to medical personnel. De facto it only happens on exceptional bases.

The Law No. 263/2004 governs the provision of health care through an additional institution (besides family medicine practices and hospitals), the permanent centres. The law governs the establishment, organisation and operation of these centres.

Secondary Legislation

The secondary legislation on Primary Care in Romania consists of several government decisions and orders.

The Government Decision No. 1389/2010 is a framework contract which mainly provides the foundation for contractual relationships between health care providers (doctors etc.) and the health insurance houses (health insurers). The Order No. 864/538/2011 contains detailed rules for implementing the Government Decision No. 1389/2010. It contains regulations as to the packages of medical services in Primary Care consisting of a minimal, an optional and a basic package of medical services.

Order No. 163/93/2008 deals with the point system that is used to calculate the compensation which medical officials receive for their services. Specifically, the Order stipulates how points should be adjusted to take into account demographics, regional differences and the doctors' respective working conditions.

Order No. 697/112/2011 implements Law No. 263/2004 on the provision of health care through permanence centres. The Order partly re-states the provisions of Law No. 263, but also further details the establishment, organisation and operation of permanent centres.

Government Decision No. 1388/2010 refers to the structure and objectives of the National Health Programmes (NHPs), implementing Title II of the Health Reform Law 2006. There are three main categories of National Health Programmes: Evaluation National Health Programmes, Prevention National Health Programmes and Curative National Health Programmes, which are structured in programmes and sub-programmes (listed, along with their objectives, in Annex 5). Order No. 1591/1110/2010 regulates the general framework for achieving the National Health Programmes, the powers of medical units involved in running the National Health Programmes, the budget, the structure of each program, the activities of

medical units which run the National Health Programmes, the evaluation indicators and other technical details.

Finally, the Government Ordinance No. 124/1998 regulates (among other matters) the forms in which the doctor can exercise his profession (individual medical office, grouped medical office, associated medical office, medical civil society, medical units with legal personality), as well as the medical offices' sources of income.

2.11. Concluding remarks

It is evident that Romania has achieved significant developments in primary care during the transition from the "Semashko" model – based on the former Soviet system - to the modern family medicine. It is also clear, that there are substantial challenges, calling for immediate or gradual improvements.

Current issues and challenges for Romanian primary care will be discussed in Chapter 6. It is essential to note, however, that most of the challenges are very much related to weaknesses in the entire primary care system, rather than being solely due to the problems in rural primary care.
It is proposed, therefore, that the strategic plan also tackles the broad issues for family medicine and general practice in Romania as well as the specifics involved in primary care in rural and remote areas...

Chapter 3: Key Findings from the Report of the National School of Public Health on Rural Primary Care

In order to inform policy makers on gaps and weaknesses in the provision of primary care in rural Romania, the National School of Public Health and Health Management undertook a comprehensive survey of rural primary care facilities in 2008. This survey assessed access to and quality of primary care infrastructure, human resources, and the level of coverage and comprehensiveness of primary care services delivered to the rural population.

The survey examined the linkages between primary care facilities, hospitals and emergency services. The survey team employed qualitative and quantitative tools to identify key factors which hinder effective delivery of family medicine services and may result in unmet health needs of the population. The survey paid particular attention to evaluating access to primary care services for a population in remote and hard to reach areas which were mainly in hills, mountains, or territories surrounded by water where settlements are located at great distances from one another and the nearest town. In addition, access is heavily affected by the weather conditions.

The survey assessed selected characteristics of the existing primary care network, its structure and operations, and characteristics were then translated into the criteria for selecting medically underserved areas, which require support for strengthening primary care infrastructure and improving service delivery (See table 3.1).

Table 3.1: Criteria for selecting medically underserved areas

1. Population characteristics
• High percentage of population with low socio-economic status/villages with more than 40% of population living in poverty • Villages with a high share of elderly population • Poor health indicators as compared to the national average (infant mortality, maternal mortality, high distribution of CVD co-morbidities).
2. Coverage of population with health insurance
• A large share of uninsured (>25% uninsured) • Average number of patients enrolled in the FP list (> 2000 patients)
3. Availability of human resources
• Villages without a family physician • Villages without any medical personnel (family physicians and nurses) • >2500 inhabitants per 1 family physician • >2500 inhabitants per 1 nurse • Shortage of other personnel (number, type and distribution) • Insufficient level of training in some areas of specialty
4. Availability of physical infrastructure
• Villages without family physicians' offices

• Villages without other specialists [= point 3] • Villages without pharmacy/pharmaceutical point • Age of the building for FM office exceeds 45 years • More than 50% of an office building is damaged • Practices without work permits/authorization • Medical practice building under litigation • Medical practice buildings without sewerage system • Medical practice buildings without running water • Lack of adequate space to conduct medical activities • Lack of equipment or outdate equipment • Lack of transportation for home visits
5. Geographic accessibility
• Distance> 4 km between a village and a nearest FM practice • Distance > 14km to the nearest permanent centre • Distance > 22km from a village to the nearest hospital • Distance > 20km from a village to the nearest ambulance station • Distance >8 km from a village to the nearest pharmacy, pharmaceutical point or chemist's shop • Distance to the nearest asphalted road • Lack of communication means (phone, internet connection)
6. Provision of services
• Delivery of comprehensive services according to population's needs (e.g. palliative care, home care, socio-medical centre, community nursing centre) • Limited working hours of family physicians and nurses • Lack of access to 24 hour medical services

These criteria served as a tool for integrated analyses, which allowed for the identification of medically underserved areas and for specific suggestions aimed at improving physical infrastructure, level of equipment, and access to and quality of primary care services. Regional data collected against selected criteria is summarized in annex 3.

In this OPM report the key findings by the National School of Public Health Survey 2008 are presented in relation to the existing primary care network. Although the assessment was conducted in 2007, no major investment projects have been implemented since then. The findings, therefore, remain the best available evidence to inform policy decision making and strategic planning.

3.1. Access

In 2007, primary care infrastructure in rural Romania was represented by 4338 family physician practices (87%), 659 (13%) medical points, and 154 permanent centres providing out-of-hours services in case of emergency. There were also 1073 medical offices staffed by other specialists (e.g. dentist, paediatrician, ENT, OB/GYN). In addition, there were 1770 pharmacies and pharmaceutical points, ensuring access to drugs for the rural communities.

Family medicine practices were not available in every settlement. There were 88 villages with a total of 153904 people without any type of primary care facility.

The population in 34% of villages (out of 780 surveyed) was at a distance of less than 1 km to a family medicine office. The maximum distance to a PHC facility for another 30% was 5-10 km. However, people in approximately 16% of villages were at a distance of 10-50 km. The villages located more than the national average from primary care facilities were in the North West, North East and South West (See table 3.1). Such uneven distribution of primary care facilities was identified as an important problem, which creates barriers in access and may result in undesirable health outcomes.

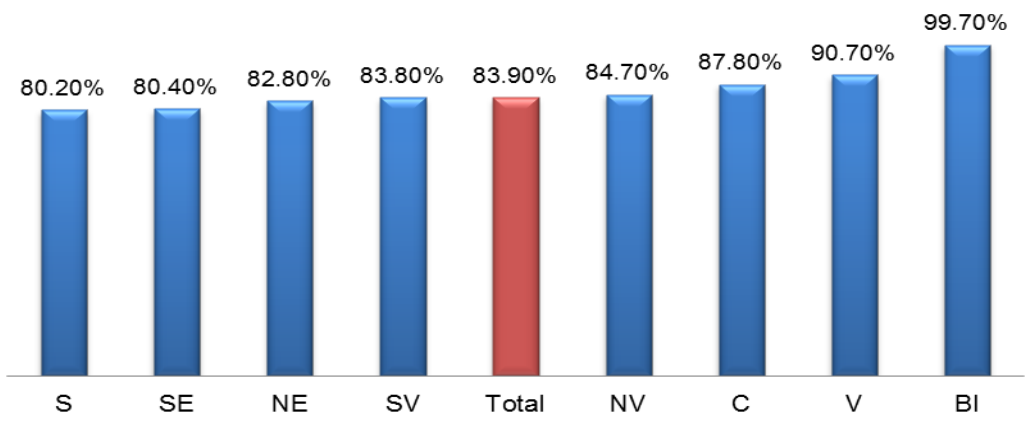
Table 3.1. Number of villages located in a distance of more than the national average from family medicine offices and other types of primary care facilities

Region	Distance to the nearest FM practice >4 Km	Distance to the nearest permanent centre>14 Km	Distance to the nearest hospital > 22 km	Distance to the nearest Ambulance service>20km	Distance to the nearest pharmacy>8km
North West	274	121	208	219	177
North East	217	-	203	236	260
South West	155	112	201	213	199
South	-	125			
Districts with a maximum number of villages					
BH	74	-	54	55	-
VS	-	-	-	47	71
OT	-	46	-	54	55
CJ	-	-	-	-	48

3.2. Coverage

In 2007, 83.9% of the rural population was registered with family physicians, while 16.1% had no regular family doctor. The highest share of a population not registered with family physicians was observed in the Region of South (19.8%), followed by South-East (19.6%) and North-East (17.2%). See figure 3.1. for the proportion of population registered with family physicians.

Figure 3.1: The percentage of population registered with family physicians per regions (2007)



Abbreviations: S-South; SE-South East; NE-North East; SV-South West; NV-North West; C-Central; V-West; BI-Bucharest Ilfov.

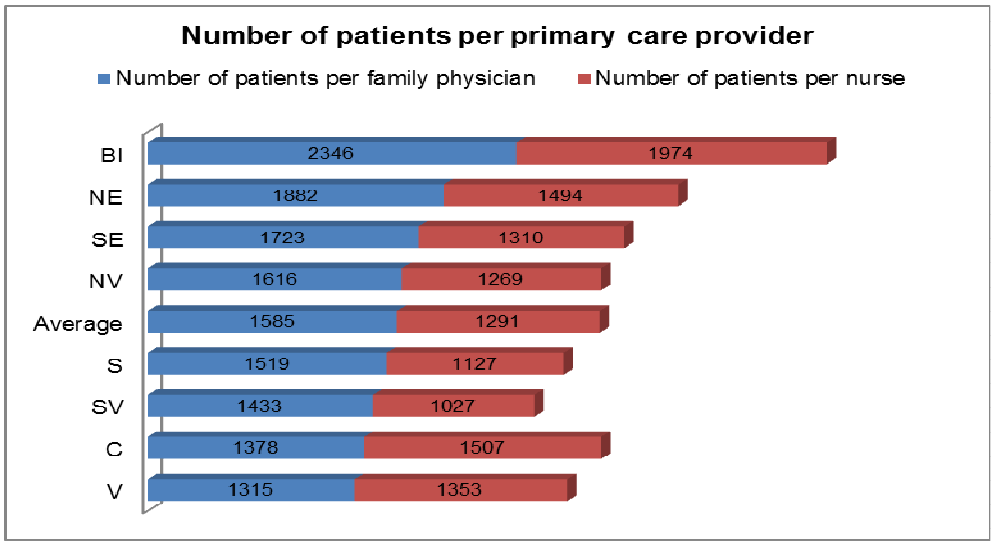
These findings indicate that universal coverage with primary care services for the entire population has yet to be achieved. The factors (e.g. lack of insurance, high mobility/migration, mentality, geographic access barriers etc.) that may prevent rural inhabitants to enrol with a family physician's clinic have to be explored and addressed adequately.

3.3. Human resources

In 2007, there were 4627 family physicians and 5679 nurses practicing in rural areas. Thirty-two percent of physicians and 69% of nurses lived in the same villages where they were offering their services. On average, there were 1585 patients registered per family physician and 1291 per nurse. However, the number of patients per family physician ranged from 1090 to 3310 with more than 2000 patients per family physician in eight villages. Figure 3.2. below shows the regional variation in the patient-to-family physician and the patient-to nurse ratios, with highest figures observed in BI, followed by North-East and South-East.

There were 1451 community nurses[3] with an average of 6026 patients and 285 Roma mediators with an average of 1108 individuals per mediator (ranging widely from 994 to 56475). There were also 1467 specialists (dentist, paediatrician, ENT, OB/GYN) also offering outpatient services to local communities. The nurse to physician ratio was 1.2, with a large regional variation observed, ranging from 0.7 to 1.9.

Figure 3.2. Regional variation in the patient-to-family physician and patient-to-nurse ratios (2007)



[3] *As defined in the report a community nurse should provide homecare, education for young mothers, reproductive health counselling (contraception, pregnancy hygiene, vaccination, prophylaxis of sexually-transmitted diseases), counselling on the effects of alcohol consumption, surveillance of women after delivery and newborn without insurance, provide triage in schools and kindergartens, provide TB surveillance, support mobilization for vaccination campaigns, collaborate with social workers / the police during social investigations.*

The report concludes that although a shortage of family physicians and general practice nurses exists in selected communities, it is not a widespread phenomenon in the rural primary care settings. Nevertheless, the authors expressed fears that the shortage may worsen if uptake of family medicine services by rural population improves, family physicians broaden the scope of their practice to include provision of out of hours emergencies, and the migration of physicians and nurses to EU member states continues. As a potential solution to this problem, the report emphasizes the need to introduce effective strategies for recruitment and retention of rural primary healthcare providers. Without such policies, the rural environment might face more serious problems in the future concerning human resources. Involvement of local authorities may support these policies through attractive offers of accommodation, transportation and other monetary and/or non-monetary incentives.

3.4. Physical infrastructure for primary care facilities

In 2007 the majority (90%) of PHC premises were owned by the local administration and only 5% by family physicians.

The report assessed the physical infrastructure in 2631 practices. The average age was 45 years, with 20% being more than 60 years. The majority of FM cabinets and medical points required some sort of repair (e.g. interior 36%, utilities 22% exterior 16%, a roof 26%, capital repair 7% and building strengthening 6%). Table 3.2.below presents the identified needs of physical infrastructure development in different regions.

Table 3.2. Number of primary care facilities that need different types of repair

Region	Interior repair	Roof repair	Utilities (water, sewerage system, heating, gas)	Exterior repair	Capital repair	Strengthening the building (including a foundation)	Yards (e.g. sidewalk etc.)	Not specified but repair is needed	Other
BI	5	1	3	1	0	2	2	0	2
C	170	85	114	106	8	30	37	8	25
NE	262	163	225	204	11	44	64	11	24
NV	219	140	171	147	22	29	67	12	20
S	338	213	236	176	23	64	46	23	28
SE	217	101	132	143	14	42	28	3	14
SV	193	91	143	129	16	25	25	8	10
V	189	141	149	98	9	26	36	5	25
Total number of health facilities that need repair	**1593**	**935**	**1173**	**1004**	**103**	**262**	**305**	**70**	**148**

This data indicates that physical infrastructure for primary care facilities is obsolete and sometimes dilapidated that may seriously affect the quality of services. The survey report points out that investing in primary care infrastructure usually is not among priorities for the local government. Physicians, although they admit that investment is more than necessary,

are somewhat reluctant to act because of the uncertainty of future returns from the businesses that do not belong to them.

3.5. Equipment

The survey found that family physicians have sufficient equipment to practice effectively. However, additional investment is warranted to upgrade equipment and strengthen diagnostic capacity to avoid secondary level referrals, such as for ECG, ultrasound and simple lab tests.

Basic equipment necessary for family medicine practitioners was available in a majority of FPs' offices and medical points. However, physicians reported the need for new equipment and computers. Table 3.3. below presents the list of equipment identified as needed by family medicine practices. It is worth noting that an ultrasound was included in the list of desirable equipment reflecting an intention of family physicians to expand the scope of their practice and offer additional diagnostics that are not usually part of primary care services but may be highly demanded by patients.

Table 3.3. Number of family medicine practices that require a certain piece of equipment among 4997 FPs offices and medical points surveyed

Equipment	N	%
Computer	1066	21.3%
ECG	947	19%
Medical Instruments	888	17.8%
Sterilization equipment	605	12.1%
Lab Microanalyzor	435	8.7%
Glucometer	408	8.2%
Ultrasound	381	7.6%
Telephone/Fax	249	5%
Gynaecological chair	236	4.7%
First Aid Kit/Minor surgery kit	231	3.7%
Negatoscope	213	3.1%
Otoscope	185	3.7%
Tonometer	130	2.6%
Paediatric scales	105	2.1%
Refrigerator	94	1.9%
Internet connection	75	1.5%
Ophthalmoscope	57	1.1%
ORL scope	36	0.7%
Ambulance	30	0.6%
Other	476	9.5%

3.6. Types and organization of primary care services

Most family physicians work in individual private practice. Some share a premise but run their business independently. Even when working in the same building, physicians do not attempt to make common arrangements in terms of hiring auxiliary and administrative staff or shared purchasing/usage of certain equipment.

The survey identified that perception of the key audiences (health professionals, local government and public) on services to be provided by family medicine practices varied

widely. The services qualified as “needed” included health education for pregnant women, children and general public, establishing health cabinets at schools, providing comprehensive and regular health check-up visits, immunization, homecare for elderly and disabled, early diagnosis of mental disorders, pre- and postnatal and new-born care. Many respondents addressed a lack of dental services locally as an important problem. In addition, difficulties to access specialized services, mainly available in urban areas, were emphasized. The survey found that outpatient specialized services were highly demanded by patients, resulting in unjustified referrals by family physicians for diagnostics and/or consultations.

The survey found that rural dwellers were concerned with the fragmentation and a lack of continuity in service provision. Most family medicine practices were closed in the evening and at night leaving the local communities without an opportunity to seek medical care when necessary. Alternatively, people were used to go to the neighbouring village in which a physician was maintaining regular working hours, try “self-treatment”, or refer to other health professionals available in the surrounding area e.g. community nurses, hospital emergency departments or call an ambulance.

Limited access and poor quality (lack of drugs and emergency kits) of first aid/emergency care provided by permanent centres were reported by respondents in some rural settlements. Moreover, access to pharmaceuticals was not always guaranteed. Despite the existence of pharmacies in some areas, people were not able to obtain reimbursable drugs included in the insurance schemes because these pharmacies were not contracted by the National Health Insurance House.

The qualitative analyses based on the key informant interviews and focus group discussions clearly pointed out that the continuity and comprehensiveness are core characteristics of the primary care service model and every effort should be taken to eliminate fragmentation in the provision of services, establish effective linkages and improve coordination between primary care, hospitals, outpatient specialists and emergency services. The gate-keeping role of family physicians should be strengthened and supported by adequate legislation and administrative mechanisms to ensure continuity of care and efficient use of resources.

3.7. Integrated analyses

Integrated analyses, which combined all selected indicators, were conducted to identify the most deprived regions in which a primary care network and its operations were not sufficient to effectively meet populations’ needs for basic health services. The analyses showed that the regions experience different degrees of difficulties in terms of access to and quality of primary care services. The poorest regions, in which people may have the greatest need and unlimited access to basic health services, were found to be the most disadvantaged. The assessment results showed that many aspects of primary care service delivery were underdeveloped in North East, South and South East as compared to a rural averages. Problems with the provision of primary care services were less prevalent in other regions (See table 3.4).

In summary, the report states that the Rural Primary Care Survey 2008 provides sufficient evidence to prove that primary care services in parts of rural Romania have to be strengthened to meet current and emerging needs of the population. Addressing these problems would require comprehensive strategies and concerted efforts by both national and local authorities, health professionals and local communities.

The challenges of rural primary care provision cannot be viewed and dealt with in isolation from the overall national health and social policies. Investment programs (which are

obviously necessary) aimed at improving health infrastructure locally should be complemented by effective national strategies aimed at improved access, coverage and, most importantly, the performance of primary care providers. On the way to improvement, it is critical to facilitate positive and adaptive relationships between health care providers and those involved in planning and financing of primary care services, including the representatives of the MoH, CNAS and local authorities to ensure effective mobilization of available resources and provide adequate response to specific needs of the rural communities.

Table 3.4. Medically underserved regions as identified by the integrated analyses based on 2008 Survey results

Assessment Criteria	NE	S	SE	W	NW	SW	C	BI	Total/ Average
Number of criteria unmet	8	6	6	5	3	2	2	2	-
% of population in poverty (2005)	35.4	29.9	29.2	18.1	17.7	32.1	20.3	8.1	-
% of uninsured	17.2%	19.8%	19.6%						16.10%
Number of patients per family physician	2273		2141					2354	1545
Number of patients per nurse	1805		1628					1981	1291
The nurse to family physician ratio				1			0.9		1.2
% of health professionals residing in the same community they practice		67.3%				62.8%	61.3%		69%
Number of population in settlements without family physicians	49145	35156		24180					153,904
Number of localities without any type of health facility			16	19		12			88
Number of localities without permanent centres	415	443			152				2330
Number of localities without pharmacy	232	197							1091
Oldest FM premises (age >45 years requiring a significant repair)	Yes			Yes	Yes				-
Lack of sewerage system and running water	26%	17%	15%						-
Equipment needs identified			Yes	Yes	Yes				-

Chapter 4: Key Findings from the OPM Field Visits

The OPM project team, informed by the data and conclusions from the National School of Public Health report, a landmark report, planned and conducted the field visits to regions with an expected high number of medically underserved villages. The team of international and local experts visited settlements in four judets (Tulcea, Teleorman, Vaslui and Alba) and interviewed family physicians, nurses, patients, representatives of the National Health Insurance House, regional Departments of Public Health (DPH) and the local administration (The list of individuals contacted is presented in Annex 2).

The topics explored during the field visits included primary care organization and service delivery, physical infrastructure and equipment, access and quality, role of nurses, attitudes of the people and community leaders towards primary care services, and the challenges and possible solutions. An approach and methodology for this analysis can be found in Annex 1. The observations and key findings of the assessment are summarized below.

4.1. Organization of family medicine services

Family medicine services are organized within the contracting framework established by the National Health Insurance House. All family doctors interviewed are under contract with the CNAS. However, they also offer a set of non-contracted services (e.g. additional home visits, ultrasound) to their patients for a modest fee and in some areas may serve uninsured patients (e.g. tourists, migrant workers etc).

A vast majority of family physicians work in an individual private practice. Only a few of interviewed physicians practiced in the same building with another physician. Nevertheless, they do not share administrative and utility costs.

The number of patients enlisted with family physicians ranges broadly with some family physicians serving 800 patients and others more than 3000. Physician's perception of what is the reasonable size of the catchment population also differs. Some argue that they can only practice effectively with 500 patients, while other colleagues consider that they can serve at least 2000 patients.

The services provided by family physicians included chronic disease management (hypertension, diabetes), acute care, immunization, prenatal care, family planning, well baby health checks, basic lab tests using with dipsticks, ECG and sometimes ultrasound. The latter is highly demanded by patients and many family physicians try to acquire competencies in imaging diagnostics.

Family physicians are expected to play an active role in health promotion activities and health lifestyle counselling. However, some of the family physicians interviewed reported that the consultation time is not enough for giving a life-style advice or that patients are not interested in it.

All family physicians interviewed employ at least one nurse. Nurses assist with administrative tasks, organize calls for chronic disease monitoring and well-baby health checks and may provide first aid if necessary.

Family physicians in some villages are actively involved in providing out of hours services to patients with severe conditions or emergencies. The family physicians in some areas are organized in "centres of permanence" and provide 24 hour services to the local communities.

Family physicians, nurses, community leaders, representatives of the Department of Public Health and patients interviewed all are very positive about the importance of this arrangement and consider it as more than necessary. However, there are concerns about the quality of drugs, equipment and premises that prevent permanent centres to effectively serve the purpose.

The role of local government in supporting primary care in rural/remote areas

Overall, representatives of the local government express interest and good will to strengthen primary care services in their respective communities. However, the extent to which the local governments provide actual support varies greatly. Key issue is that the local governments are owners of premises in which family physicians function. With the international best practice, the ownership would oblige local government to take responsibility on upgrading and maintaining buildings in a good shape to allow provision of descent primary care practice. The reality in Romania is diverse: in some communities it is a periodic refurbishment of a roof or a part of the building. Whilst the local authorities in other communities consider family medicine to be a private business run by a family physician, therefore it is beyond the responsibility of the local authorities to invest in its development.

A close collaboration between the DPH and local governments can effectively facilitate prioritization of primary care development by the local authorities. A good example of this cooperation was seen in Teleorman County where the local authorities, encouraged by the DPH, mobilized a considerable amount of money to invest in establishing a permanent centre and renovating a family physician's office space.

Local authorities in some counties attempt to attract external funds to support infrastructure improvement initiatives that can be beneficial for primary care practices, directly or indirectly. For instance, in Alba local government was interested to develop the running water system, and in Vaslui priority was given to the road infrastructure development.

Thus, the assessment revealed that the involvement of and contribution from the local authorities is a matter of political will of representatives of local authorities. It is politics that can influence their attitudes toward primary care services and drive their decision on investment priorities. These findings call for elaboration of specific advocacy policies and actions to generate motivation among local government in support to primary care. These policies will be described in the Rural Primary care Strategy and an Action Plan.

4.2. Access to services

The recent assessment found that people still have difficulties to access primary care services particularly in mountainous areas and territories surrounded by water. A lack of personal transport and the high travel costs across water complicates provision of services to population residing in those areas (e.g. in the Danube Delta).

Usually a family physician and/or a nurse are available in their practice during all working days. However, there are some small villages in which family physicians and nurses practice only for a day or two. Twenty-four hour services throughout an entire week are provided only in areas with permanent centres.

The means of transportation for the local population can be a private car, a horse, carriage, and a bus, which usually runs once in 2-3 hours. Sometimes people simply walk for 5-9 km to reach a family medicine office or a local pharmacy.

Poor road condition is another area of concern for local health care providers and community members. It is difficult to reach a practice through secondary roads, which are not paved with asphalt and are hardly passable in bad weather.

Transportation costs vary depending on a distance and means. For example, a travel fee for a public bus is in a range of RON 2-10, while a boat ticket to reach the in-land territories in the Danube Delta costs RON 25. In case of medical emergencies, boats are used to transfer patients from the Delta. However, it usually takes 2-3 hours for an emergency boat to reach the destination from Tulcea and boats are not available at night. A helicopter service provided by the Ministry of Interior is another transportation option during emergencies but this service can only be used in extreme cases. These limitations cause delays in obtaining emergency care and may lead to undesirable health outcomes.

Despite the existence of pharmacies, availability of drugs is often limited and a patient may need to travel to the next nearest pharmacy to obtain prescribed drugs. Patients in some villages consider access to pharmacy even more important than access to a physician. This may be a sign of the self-treatment tendency, which can have adverse consequences unless addressed adequately.

4.3. Physical infrastructure

All family medicine practices visited had the basic medical equipment that is necessary to practice e.g. blood pressure measures, stethoscope, otoscope, ophthalmoscope, ECG. Some equipment was out of date and has to be replaced.

Many family physicians report that they wish to have an ultrasound and plan to develop required competencies, if they have not done so already. On the other hand, there are family physicians, which do not share this opinion and can hardly find any justification for having imaging technologies at their clinics.

The condition of the building also varies from those with ancient premises built in the early 20th century and never repaired to the newly built facilities. A vast majority of interviewed physicians think that the building requires some sort of investment (e.g. for utilities, roof, patient reception etc.).

Many family physicians report that they had made their own investment to improve the condition of the building. In some communities the local council also provided support but usually this does not cover all needs.

4.4. Quality of primary care services

Family physicians and nurses are engaged in continuous professional development activities. Thus, they intend to maintain their skills and competencies up to date. Mostly professionals are enthusiastic about on-going educational opportunities and think that the courses are delivered to a high standard.

Some family physicians are well familiar with existing national clinical practice guidelines and protocols and access those regularly on the Ministry of Health website. Others report limited information on availability of the national guidelines and admit that do not use them in their daily practice.

Almost all family physicians, except those in very remote areas, have a good internet connection and could access electronic evidence based resources and even obtain on-line consultation from colleagues if necessary.

Currently family physicians are not required to report against any quality standards. However, the existing information system allows for analysing prescription and referral patterns that often raises concerns about moral hazard being a serious issue for the national insurance scheme.

The representatives of the CNAS report that family physicians give a lot of unnecessary prescriptions and send patients out to lab tests and other investigations repeatedly without proper justification. These statements need to be considered in light of regulatory requirements obliging family doctors to refer patients to specialists for obtaining permission/instruction on prescriptions of defined medicines for certain diseases. It should also be taken into account, that the decisions on referrals or prescriptions are often driven by the fear of family doctors of losing patients if their expectations are not met and requests are not satisfied.

4.5. Job satisfaction and motivation

The degree of job satisfaction among family physicians and nurses varies. Family physicians living in the same community find housing acceptable. However, they report a lack of access to leisure spaces, good schools for their kids and sometimes educational opportunities. The commuters pay less attention to living conditions but complain about not being reimbursed for the cost of fuel they use for business travel.

Family doctors practicing in very remote communities feel that they sacrifice their own interests and social life so that the patients can have the care and treatment they want. The reward for this is never adequate.

Physicians describe different reasons behind their decision to accept rural employment. These include a compulsory assignment before 1989, desire to continue medical practice in the place of origin and difficulties in attracting a minimum number of patients in urban areas required for entering in contract with the CNAS.

Many physicians admit that being a rural family medicine practitioner has some advantages e.g. being with the family, experiencing a high level of professional satisfaction from helping people really in need, and taking advantage of living close to nature. However, they also report disadvantages that impact their everyday and working life. The following are some examples of those: bad roads, dilapidated office and outmoded equipment, lack of property right on FM practice premises, no opportunity to buy/receive some land in the area and build a house, bad housing conditions, lack of appropriate transportation means, high level of stress, and limited support from the local authorities.

Certain factors were identified that may motivate physicians and nurses to continue or initiate their practice in rural areas e.g. ownership of FM practice; tax deductions for the gasoline and for investments in developing medical business; increasing a current level of monetary incentives established by the CNAS; reducing or eliminating compulsory health insurance (5.5% of income); rehabilitation of facilities; availability of a driver paid by the local council and the gasoline covered by the same authority; availability of transportation means (a car for home visits, a boat).

Financial incentives and endowment of the office with equipment / transportation means were mentioned most frequently, while less attention was paid to support in continuous professional development or improvements in pharmaceutical provision.

Respondents underlined several times, that because the investment in renovating space and upgrading the equipment is a substantial investment, physicians expect to take advantage of providing services in the reconditioned space for a long time. Thus, they were linking this issue with the ownership of the premises.

A list of incentives as described by the respondents is presented in box 2.

Box 2. Incentives to practice in rural areas

What would be considered incentives for physicians and nurses them to develop their activity in rural areas
• Be owner of the family medicine practice property • Increase amount of already established financial incentives by CNAS (the extra- income paid for development of the activity in certain conditions) • Tax deduction for the gasoline • Tax deduction from investments in activities aimed at strengthening medical practices • The existence of the practice budget for capital and ongoing costs • Receive a partial tax deduction from CPD course fees • More involvement of the village hall to support the activity of the FP at the office or in the area • Free of charge compulsory health insurance (not paying the compulsory 5.5% out of the income) • Support in refurbishing and equipping the family medicine practices as it happened a few years ago with support of the World bank. Most desirable equipment pieces include ultrasound, ECG, oxygen kit and emergency kit. • Availability of a driver paid by the local council and the gasoline covered by the same authority for small ambulance cars (The Fiat Punto) bought by the MoH for permanent centres. • Availability of a good boat for the territories across the water in the Danube Delta to be owned by the village hall, as well as gasoline covered by the same authority. • Availability of good cars to be exclusively used for providing home visits.

4.6. Financing of PHC services

Although the contract with the National Health Insurance House represents a relative stable source of income for family physicians, they believe that the contract is underfunded and limits their ability to improve and expand their practice.

Moreover, practitioners in rural areas are not satisfied with the level of incentives they are currently entitled to.

4.7. Patient satisfaction

A significant part of the population in visited areas live in poverty experiencing many negative consequences of it e.g. poor housing, a lack of transportation means, need to work hard despite their health status, limited access to drugs and health care services etc. People's perception of a family physician's role and their health needs is diverse. Many aged individuals consider a disease to be a normal part of the aging process and do not seek medical care for chronic conditions unless they experience severe exacerbation and pain. Not everyone has an adequate understanding of health insurance benefits and what does it mean to be insured. It seems that some people do not value health insurance and prefer to pay for medical care when needed or enrol into the insurance scheme after the first episode of hospital care.

Overall, patients seem satisfied with the services provided. The level of their satisfaction is largely influenced by their positive personal attitude toward a family physician and feeling secured when there is a permanent centre operational in the surrounding area. Patients trust and respect their family physicians. A bond of trust is even stronger if a physician belongs to or originates from the same community (observations from Alba).

Patients choose a doctor and prefer to maintain a long-term relationship with him or her. They know well what type of primary care services are provided in close proximity to their residence and when/where they can obtain those. A family physician is the first medical provider whom they would contact when needed for a majority of respondents. However, they may also consider going directly to a hospital because, in their opinion, lab and diagnostic capacity are better there. In general, population from in-land territories can access medical services, regardless of weather conditions. Transportation means include horse and carriage, private car or sometimes public transportation. The latter runs once in every 2-3 hours and is not considered convenient if one wants to see a doctor on time.

Patients seem somewhat reluctant to describe unpleasant experiences in relation to family medicine practice. The main reason for dissatisfaction, as expressed, was absence of a family physician in the office at the time of the visit. However, patients do not hesitate to complain about difficulties in access to pharmacies and cost of drugs. Besides, patients wish to avoid travelling for lab tests and additional investigation in a town. Many pensioners cannot afford transportation costs and their health status also hardly allows them to easily transfer from one place to another.

4.8. Linkages between primary care and public health services

The Directors of Public Health (DPH) are responsible for developing, implementing and evaluating public health programmes. They monitor the health status of the population in relation to the main environmental risk factors. Other responsibilities include controlling and evaluating health care provision and the functioning and organization of health care providers, ensuring food safety, and organizing health promotion and health education activities.

The DPHs collaborate closely with family physicians for immunization, family planning, TB prevention and control, and other publicly financed preventive programs. DPHs are responsible for vaccine and drug (e.g. contraceptive, Vitamin D, Ferum supplements) supplies to each individual family physician. However, services are reimbursed under the contract with the CNAS. From the point of view of the DPH representatives family physicians tend to respect their contractual obligations with the CNAS. But, they do not always complement their services with drugs provided by the DPH. As the representative of one DPH noted “Family physicians are not interested in distributing free medicine supplied by the public health directorate. They prefer to write free of charge prescriptions for small babies instead of distributing pills (e.g. vitamins) provided by the directorate.”

As for the involvement of family physicians in health education activities, the representatives of DPHs report that some family physicians are more active in healthy life-style counselling, while others do not find enough time for this.

The DPHs representatives recognize the need of increased involvement of family physicians in delivering public health services at individual level and have some solutions in mind on how the situation can be improved. The introducing of financial incentives for implementing public health interventions is a possible solution most frequently mentioned.

4.9. Future plans

All interviewed parties including patients, share concerns about the quality of premises and equipment. Refurbishing old buildings and/or creating a patient friendly environment is considered as very necessary for improving FM practice. However, none expresses much enthusiasm about investing in developing FM physical infrastructure.

The fact, that premises do not belong to them, makes family physicians anxious regarding their investment. The current lease contracts with local authorities do not guarantee long-term use of premises by medical practitioners resulting in a fear of being transferred to another building and loss of all investment, if any.

Physicians tend to make investment decisions more easily when it refers to diagnostic equipment e.g. ECG, ultrasound, mini-lab. This can be explained by high demand by the population for those services and the potential to generate additional income. Many of the family physicians interviewed either already have ultrasound training and are eligible to practice or plan to build their competencies in this area. Physicians hope that these services will be covered within the main or additional contract with the National Health Insurance House.

While recognizing the need of effective recruitment and retention strategies for rural practitioners, the representatives of DPHs and CNAS emphasize how important it is that those family physicians own the practice property and/or a house and land in the community where they practice.

Improving continuity and expanding the scope of services with a particular focus on emergencies are identified as priority areas for future actions. All stakeholders agree that the establishment of adequately equipped and staffed permanent centres can be a viable solution to the problem with continuity. None of interviewees mentioned that they would be willing to expand the scope of preventive activities e.g. cervical cancer screening, identification of life style risk factors or cardiovascular disease co-morbidities.

4.9. Conclusions

The findings of a rapid assessment conducted in September-October 2011 mostly agree with the 2008 Survey conducted by the National School of Public Health. Our assessment did not intend to collect any quantitative data. Therefore, the conclusions herein are informed by qualitative information only and reflect the perception of various stakeholders on the severity of problems in organization and delivery of primary care services in rural Romania. Table 4.1 illustrates the extent to which challenges to primary care provision are present in the visited regions in the eyes of the interviewed persons. This may not always reflect real data: for example, the Danube Delta area in Tulcea judet has 8 family doctors for 14,000 inhabitants.

Table 4.1. Key challenges in provision of primary care services in selected regions

Counties (Judet) visited	Geographic Access	Shortage of Family Physicians	Availability of Evidence Based Guidelines	Quality of physical infrastructure	Availability and quality of basic equipment	Motivation and job satisfaction	Patient satisfaction	Level of support from the local
Tulcea	Limited for areas surrounded with water	Yes	Availability of hard copies very limited	Very low to high	Moderate to high	Moderate to high	Moderate to	Low to moderate,

							high	
NOTE	Assessment is based on the observations and interviews with 7 physicians, 4 nurses, 2 representative of local government and 4 patients							
Teleorman	Limited for patients and medical personnel in some villages due to bad roads	Yes	Availability of hard copies very limited	Very low to moderate . ,	Moderate to high,	Low to moderate	Moderate to high	Low to high, resulting from
NOTE	Is based on observations and interviews with 4 family physicians, 1 nurse and 3 representatives of local authorities							
Vaslui	Limited in winter or when weather is bad (strong wind and storm), especially in the valleys	Yes	Availability of hard copies very limited	Very low to moderate	Low to high	Low to high	Moderate to high	Low to moderate.
NOTE	Is based on the observations and self-declarations of the 9 consulted physicians, 3 nurses and 5 local representatives.							
Alba	Limited in mountainous areas	Yes	Availability of hard copies very limited	Very low to moderate	Low to high	Low to very	Moderate	Low to moderate
NOTE	Is based on the observations and self-declarations of the 13 consulted physicians, 6 patients, 2 nurses and 5 local representatives.							

Similar to the 2008 survey by the National School of Public Health, our assessment confirms that many aspects of rural primary care service delivery need improvement. The major challenges to be addressed include the following:

- Factors such as poor road conditions, lack of transportation and communication means, availability of health services providers in the remote areas and costs not covered under the insurance schemes may impede access to primary care services for rural populations.

- To meet the health needs of rural communities more emphasis is needed on comprehensive primary care (which would effectively incorporate health education, preventive and curative services and palliative care for all individuals regardless of age, sex and a clinical condition), improved availability of supportive lab and diagnostic capacity locally and better coordination with hospital and emergency care services

- Sustainability of services is a major concern which is determined by the limited availability of health care workforce in selected rural settlements, inadequate physical infrastructure, and insufficient incentives to motivate effective performance.

- Social factors, access to education, living conditions and economic development all are responsible for difficulties in health services delivery. Therefore, the challenges identified in the provision of rural primary care services can only be tackled through multi-sectoral and integrated approaches supported by relevant national policies.

More in depth analyses of the key rural primary care challenges and the contributing factors is presented in chapters 5 and 6.

Chapter 5: International Experiences in Providing Health Services in Rural and Remote Areas

5.1 Introduction

This chapter describes international experiences that can be used to help formulate proposals to improve the provision of primary care in rural and remote regions of Romania. Such experiences fall into two related and overlapping categories:

- How to design and organise primary care services in rural and remote areas

- The use of incentives to attract and retain health workers in such areas.

Romania is one of many countries that have remote and sparsely populated areas, and indeed other countries face even bigger challenges in this field, for example Australia, Canada, northern Scandinavia, the Russian Federation or Mongolia. Within the European Union, even a country like France finds it difficult to attract family physicians to its rural areas, and the subject has recently been put on the agenda of the French Senate, on the basis of an official report with analysis and proposed solutions (Bruguière 2011, see below).

This short overview is limited to experiences that are relevant for countries with primary care systems such as Romania's, i.e. based on family physicians (general practitioners) and paramedical staff such as practice nurses, community nurses, etc. Fortunately there are a number of recent meta-analyses of different approaches to solve the issue of rural health care provision such as - in chronological order - Lehman et al. (2008), Wilson et al. (2009) and Dolea et al. (2010) (see list of references).

Rural and remote are not synonyms but also not opposites. Rural populations live in larger, more closely settled communities, whereas remote areas are characterised by small populations dispersed over vast areas (Humphreys et al. 2010).

The World Health Report "Health Systems: Improving Performance" (WHO 2000), defines incentives as "all the rewards and punishments that providers face as a consequence of the organisations in which they work, the institutions under which they operate and the specific interventions they provide". This definition suggests that the organisation, the work that is

done and the setting in which work takes place will determine the incentive used and its resulting impact. Buchan et al. (2000) add another dimension by defining an incentive in terms of its objective: “An incentive refers to one particular form of payment that is intended to achieve some specific change in behaviour”. Yet another definition is: “an available means applied with the intention to influence the willingness of physicians and nurses to exert and maintain an effort towards attaining organizational goals” (quoted in Global Health Workforce Alliance, 2008).

Incentives can be used for many purposes, for example to improve the quality of care in a hospital, but in this report we are of course especially interested in incentives for practicing primary care in rural and remote areas. Here again, there are useful review papers that combine experiences in many countries, such as those by Buchan et al. (2000), Maynard (2006), the Global Health Workforce Alliance (2008) and Bärnighausen et al. (2009).

5.2 Attracting and retaining rural health staff

Although the article by Lehman et al. (2008) focuses on middle- and low-income countries, their conclusions appear valid for any situation of underserved rural areas. Their literature review discusses the following broad categories of strategies for attraction and retention of rural primary care staff that have been proposed and implemented, alone or in combination:

* **Recruitment and training** for rural practice;

* Improvement of **working conditions**;

* Improvement of **living conditions**;

* Use of **incentives**;

* **Compulsory service** (this is probably not relevant for Romania).

Recruitment of medical and nursing students from rural areas and rural location of (part of) their training have been successful for their subsequent employment in rural areas in some countries.

In their search, Lehmann et al. found little evidence of successful strategies aimed at improving working conditions and job satisfaction. One exception is the introduction of supportive supervision which has led to improved motivation in a number of countries, thus strengthening the decision to stay in the rural environment.

Improvement of living conditions has been tried in many countries, such as good staff housing including reliable water and electricity supply, telecommunication and good access roads. Although such measures seem logical, evidence of their success was lacking, especially because even after improvement there always remained a gap between urban and rural living conditions.

Many countries have used incentives to attract and retain rural staff. Apart from the well-known increases in salaries or capitation fees, governments have paid for the initial and continuous education of doctors and nurses, for school fees for their children, and have given housing and/or vehicle loans. Incentives are discussed more in detail in section 5.3.

The main conclusions by Lehmann et al. are:

* There is no general answer to the problem of attraction and retention of rural health workers - which is an almost universal challenge - that fits all situations. Every country should design its own strategy based on the results of its own problem analysis, but unfortunately there is insufficient evidence that strategies are indeed based on such results.

* Improvement of attraction and retention or rural health workers depends on multi-sectoral collaboration; this means that ministries of health depend on other ministries, local authorities and other key actors to achieve this goal.

* Because there is little evidence in the literature about what really works, governments should monitor carefully any system they put in place.

Wilson et al. (2009) also did an extensive literature search for papers on recruitment and retention of health workers in rural and remote areas. They classified experiences in this field into the following groups:

* **Selection** of students based on various factors that may increase the likelihood of retaining their services in rural and remote areas once qualified. Selection criteria evaluated include geographic origin, ethnicity, gender, career intent and service orientation.

* **Education**: focus on strategies that optimize medical training programs (pre-vocational and post-vocational) in such a way as to stimulate interest and participation in community-based medicine (including rural practice).

* **Incentives**: focus on the provision of financial incentives or bursary schemes that are linked to rural service agreements.

* **Support**: focus on different ways to support the health professional while practising in rural

locations.

* **Coercion** (again: probably not relevant for Romania).

Wilson et al. found strong evidence that selecting students with rural background was successful in attracting them to rural areas after graduation. This was confirmed in other studies, e.g. for the United States (Rabinowitz et al. 2001) and in Japan. Interestingly, physicians who have a spouse of rural origin were also more likely to practice in a rural setting. Evidence for the benefit of belonging to certain ethnic groups, gender, career intent and service orientation was not strong.

There was some evidence that providing part of the practical training in rural settings increased the likelihood that doctors would chose a career in rural health care. The combination of rural origin of the students and rural field residencies proved to be especially successful in some studies. More in general, less emphasis on hospital medicine and more on primary care during the undergraduate medical curriculum increased the interest in a career in primary care, also leading to more doctors opting for a rural career.

The literature on the results of financial incentives schemes is equivocal. Many service-linked scholarships, loans and loan repayment programmes have been described, but the effect of these on the rural or remote workforce are not clear. The experience with paying direct financial incentives, such as special rural allowances, has been variable. In Canada, the distribution of general practitioners was positively influenced by specifying raised fees in rural and underserved areas, and reduced fees in ‘overserved’ areas.

Rural health professionals often mention the lack of adequate support in various fields. The review by Wilson et al. could not identify optimal strategies to provide such support and little empiric evidence to quantify their impact. Rural doctors complained about academic isolation, lack of consultant support, insufficient locum relief, inadequate accommodation, lack of good schools for children, poor recreational infrastructure, and limited employment opportunities for the spouse. There was a need of an infrastructure of continuous professional development tailored to the requirements and possibilities of rural practitioners.

Wilson et al. agree with Lehmann et al. that evidence for successful strategies to attract and retain rural health workers is limited. Most promising are well-defined selection and education strategies: supporting all students with a stated interest in primary care and rural practice, selecting students of rural origin, and providing undergraduate and postgraduate rural field residencies. Economic incentives alone appear to be insufficient to influence employment. Apart from support with housing and access, support for accessible and appropriate continuous professional development for rural practitioners appears an important factor. As there is no international blueprint, all national strategies must be designed locally and carefully monitored and evaluated.

Dolea et al. (2010) have also analysed papers that describe the impact of interventions to stimulate health workers to practice in rural and remote areas. The emphasis of their article is on the methodology and quality of these evaluation studies; only 27 studies qualified for the review. Their selection consists mostly of studies from developed countries that in 24 out of 27 focussed on physicians.

The final result of having health workers in remote and rural areas depends on two inter-linked aspects: (i) the factors that influence the decision or choice of health workers to relocate to, stay in or leave those areas, and (ii) the extent to which health system policies and interventions respond to these factors. Unfortunately, the link between (i) and (ii) appears to be deficient in most interventions. Just like Lehmann et al., Dolea et al. conclude that rural retention interventions are rarely implemented as a result of an analysis of the preferences or choices of health workers to practise in these areas. A situation analysis should be mandatory as a basis for selecting the most appropriate category of intervention.

These authors group the interventions into four main categories:

* **Education interventions**;

* **Regulatory interventions**, including compulsory service and bonding schemes;

* **Financial interventions**;

* **Personal and professional support**.

Many of the selected evaluation studies were concerned with education interventions. As the other reviews mentioned above, selection of students from a rural background (including scholarships), clinical rotations in a rural setting and adaption of university curricula to include rural health issues were consistently found to increase attraction and retention of rural health professionals. Although policy-makers frequently use financial incentive schemes, there were only four good studies on financial interventions in the review, two of which showed a moderately positive effect (in South Africa and Australia). Personal and professional support interventions were also described in four papers, but results are not elaborated in the review article. Personal and professional support schemes appear to be

not popular with policy-makers and authorities even though such support consistently tops the surveys analysing choices and preferences for work in rural areas.

The article by Dolea et al. (2010) can be seen as a summary or overview of a much more elaborate report by the World Health Organisation of which they were the main authors: “Increasing access to health workers in remote and rural areas through improved retention - Global policy recommendations” (2010). The recommendations made in this WHO document are presented in Annex 4. The document also advises on the principles that should guide the formulation of national rural retention strategies and the selection and evaluation of interventions.

Straume & Shaw described a successful physician retention scheme in one of the most remote corners of the world: Finnmark county in northern Norway. Finnmark is larger than Switzerland but has only 73,000 inhabitants. Northern Norway has long faced a critical shortage of doctors. One of the most successful interventions was to establish a medical school in Tromsø, the capital of northern Norway in neighbouring Nordland county.

Facing a critical shortage of physicians, Finnmark conducted a survey to analyse attraction and retention factors in 1998. Lack of opportunities for professional development were found to be the most common reason for leaving, more common than wage- and workload-related factors. On the other hand, the enjoyable aspects of rural living and working conditions were the most important reasons for staying.

As an answer to the shortage of family doctors, Finnmark actively recruited among Norwegian primary care interns to pass their internship there. The curriculum was modernised, using group tutorials, and adapted to better fit rural requirements. Interns who agreed to take up vacant positions in Finnmark after their internship were guided into groups for post-graduate training in general practice and public health, with all specialist training expenses covered. The county medical association also arranged for courses and professional fellowships twice a year. Hence it is now possible to fully specialize in general practice and public health largely without leaving Finnmark.

The results of the intervention were analysed using a control group in another remote part of Norway. Results for Finnmark were encouraging, halving the number of vacant positions there. The conclusions of the intervention were:

* Postgraduate medical training can be successfully carried out in remote areas in a manner that ensures professional development and counteracts professional isolation, resulting in improved health workforce retention in rural settings. In most countries, postgraduate training is academic and centralised, and physicians are recruited to remote areas as fully trained specialists.

* By allowing for postgraduate medical training in remote areas, the Norwegian model makes it possible for trainees and their families to grow roots in rural communities during training.

* Rural practice satisfies modern principles of adult learning (problem-based training attached to real-life situations) and offers excellent learning conditions for physicians in training.

Australia is probably the country that has best explored the specific requirements of rural and remote primary care. It has even founded an special electronic journal for this subject (www.rrh.org.au). Wakerman et al. complained in 2006 that the health needs of many rural Australian communities are not adequately met despite many initiatives to improve the situation in the previous 15 years, including a Rural Health Strategy adopted in 2004. Therefore they analysed all documents that described past initiatives in Australia to

strengthen rural and remote primary care; 93 documents fitted their requirements. Primary care services were divided into (1) discrete services; (2) integrated services; (3) comprehensive primary health care services ("Alma-Ata model"); (4) outreach services; and (5) virtual outreach services (telemedicine). Most analysed documents proved to be descriptive only and only a few presented a proper evaluation.

In their review, Wakerman et al. concluded that past initiatives have not been tailored to the needs of different communities and have not been evaluated properly. Access to high quality rural primary care was still insufficient, one reason being the lack of staff willing to work in such areas (although this situation had improved somewhat). They recognised that there is a dilemma between providing services in remote areas and operational efficiency. However, they found a number of successful initiatives on which they based their recommendations. Geography and demography cannot be changed in this enormous territory. Successful models are those which aggregate a critical population mass, whether it be a discrete population in a country town or a dispersed population across a region.

Evidence indicates that a minimum population base of about 5000 for rural and 2000 to 3000 people for remote communities are required to support an appropriate, sustainable range of PHC activities. In a small country town, this can take the form of a discrete general practice model and for smaller, more isolated communities a hub-and-spoke model. Combinations of the two are also possible. Wakerman et al. describe the pre-conditions for successful models (an accepted policy and community readiness) and essential requirements in the fields of human resources, funding, management and infrastructure. In 2010, Humphreys & Wakerman repeated the recommendations made in 2006, emphasising that initiatives should be tailored to the various communities and that health promotion activities should be included.

France is quite worried about its sparsely populated and ageing rural territories where services are disappearing such as shops, schools and medical care. The term it uses for the gradual disappearance of primary care from rural areas is "désertification médicale". In France, the state and not local authorities are responsible for health care, but citizens often address their local politicians is case of lack of access to health care. France has one of the highest ratios of physicians to population in the world (290/100,000) but forecasts show a decrease in the years to come, plus an increase in the demand for services. At present, 8% of doctor's work in rural areas, but this percentage is expected to decrease by a quarter in the coming years. Scholarships and financial incentives have been offered in the past but did not have the expected results, therefore the authors of the report to the Senate (Bruguière 2011) also propose different solutions. Their proposals are:

* A part of the clerkships of undergraduate medical students and residents in family medicine should be spent in rural areas, without increasing the total duration of the training. They should be able to spend such clerkships anywhere in France, not only in the region of their university but also elsewhere (if necessary with a scholarship of another region). Local authorities would have an interest to support these students with housing and transport.

* Regional authorities or regional chambers of the Doctors' Association should facilitate the installation of family doctors in rural practices, with advice on the numerous financial, legal and organisational hurdles they are facing.

* Financial support for housing and opening a practice in a rural area, e.g. by interest-free loans from local, regional or national authorities.

* Reducing bureaucracy. A French family doctor spends approximately 20% of his/her time on non-patient-related activities, such as administration and continuous education (many in Romania would be very happy with 20%!).

* Delegation of tasks to paramedical staff, such a nurses and medical assistants, after proper training.

* Development of telemedicine, including development of its legal and financial framework.

5.3 The use of incentives

Some of the interventions described in section 5.2 can be called incentives as defined in section 5.1, for example paying a rural doctor by increased capitation fees or providing him or her with free or subsidised housing. Other interventions should rather be called structural, for example adapting the undergraduate or postgraduate medical curriculum in order to incorporate elements of rural practice. There is a separate body of literature on the nature and use of incentives, not specifically for attracting and retaining rural practitioners, but relevant for that purpose nonetheless.

Buchan's review (2000) examined the application of remuneration and incentive strategies in health care. The major part of the document it a very thorough theoretical analysis that can be recommended for those willing to understand the issues. One chapter is devoted to a review of the literature in this field between 1989 and 2000. After screening, 150 papers were deemed relevant for this review. Nearly all publications (presented in the list of references) were from developed countries (UK 44%, USA 25%) and less than 10% from developing countries. Half of the publications were concerned with interventions for physicians, especially general practitioners. From the quality of the publications, Buchan concluded that little reliable evidence is available on the impact and effect of incentive and reward strategies in health care.

Maynard (2006) distinguishes implicit and explicit incentives. The assumption that health professionals feel the duty to provide the best possible care and the assumption that health care purchasers and patients are convinced that this is indeed the case can be called implicit incentives for an ideal health care system without strife. If trust is lacking, regulation will (have to) be imposed and explicit incentives come into the picture. Each country should assess to what extent trust between doctors, patients and health authorities is missing and why, and how it could be improved.

Explicit incentives are either regulatory controls or financial incentives. An example of regulatory control is systematic and compulsory reaccreditation of physicians by a professional association or by a government agency, based on participation in continuous professional development. The best-known example of financial incentives is the way the payment of doctors is organised. Fee-for-service, capitation and salary produce different and often opposite incentives for overall cost, level of activities, quality of care and intensity of administration. Again, each country should ascertain to what extent the present provider payment system leads to the effects one wants to achieve. In addition to the basic payment system, purchasers can add specific financial incentives, e.g. for better performance or for work in rural areas. Instituting incentives for performance is a worldwide trend that officially should lead to better quality but that also adds to the complexity of the management of the health system.

The report "Guidelines: incentives for health professionals" (2008) by the Global Health Workforce Alliance (GHWA) distinguishes between financial and non-financial incentives, sub-divided as follows:

Financial incentives

* Wages and conditions including insurance, allowances and pension

* Performance-linked payments, including for rural service

* Other financial incentives, such as loans and fellowships

Non-financial incentives

* Career and professional development, including effective professional communication and supervision, support for training, sabbatical and study leave

* Workload management, including after-hours service and availability of locums

* Flexible working arrangements, e.g. flexible working hours and planned career breaks

* Positive working environments including sufficient resources, work autonomy and personal recognition

* Access to benefits and supports including housing, transport, schools for children

The GHWA report presents examples of each of these types of incentives, many but not all from developing countries. It recognises - in agreement with all international experiences - that financial incentives alone are not sufficient to retain and motivate staff and that non-financial incentives are equally important, especially in countries where funding is restrained. As the other authors mentioned in this chapter, the GHWA report regrets the lack of rigorous evaluation of the outcomes of incentives schemes. Nevertheless, it provides a common-sense list of characteristics of an effective incentive scheme. Some of these characteristics are: having clear objectives, reflecting health professionals' needs and preferences, incorporating both financial and non-financial incentives, and ability to being evaluated quantitatively.

Finally, the GHWA report presents practical checklists for the development of incentive schemes tailored to specific target groups.

Bärnighausen et al. (2009) analysed the results of long-running programmes of financial incentives for return-of-service, that means that a student or a fully trained health worker enters into a contract to work in an underserved area for a number of years. Because they applied strict criteria, only 43 studies qualified for inclusion in the review, of which 34 from the USA, 5 from Japan, two from Canada and one each from New Zealand and South Africa. Most studies were concerned with physicians. Incentives were scholarships, loans or direct financial incentives.

The conclusion of the review was that financial-incentive programs for return of service are one of the few health policy interventions to improve the distribution of human resources for health on which substantial evidence exists. The existing studies show that financial-incentive programs placed substantial numbers of health workers in underserved areas and that program

participants were more likely than non-participants to work in underserved areas in the long run. However, the situation in the USA differs considerably from other countries, and none of the studies could fully rule out selection bias between participants and non-participants. Even successful programmes experienced substantial losses to recruitment before the start of the service obligation. Participants more often than non-participants chose to remain in rural areas, but often not in the same place where they were employed first. Financial-

incentive programmes varied substantially in the level of participant satisfaction, and to some extent explanations for these differences could be found. However, for future studies it will be important to pay more attention to this aspect which is crucial for retention of rural health workers.

5.4 Conclusions - Relevance for Romanian rural family medicine

The good news is that international evaluations of rural primary care programmes are quite clear and consistent in their recommendations. One limitation is that all studies point to the specificity of each country or even each region, so that "copy and paste" is not a solution. Another limitation is that the quality of many documents describing interventions of rural attraction and retention is less than perfect, so that one must be careful in drawing conclusions from reviews. Nonetheless, there are conclusions that one can draw from international experiences that could be relevant for Romanian rural family medicine. These are:

1. Rural attraction and retention schemes must be based on carefully collected data on the needs and preferences of the target groups. Such data exist in Romania, especially in the report by the National School of Public Health and Health Management (2008) (summarised in chapter 3 of this report), supplemented by the information in chapter 4 of this report.

2. Because every country and target group is different, new rural attraction and retention schemes must be monitored and evaluated, and adapted or discontinued if necessary.

3. Educational interventions are most promising, but they lead to results only in the medium- to long-term.

4. It is important to analyse the present undergraduate and postgraduate training in family medicine for appropriateness for rural practice, and strengthen the rural practice element if necessary. It is especially important to include undergraduate and postgraduate rural internships in family medicine in selected rural practices.

5. It must be analysed to what extent medical students and nursing students with rural origins can be recruited for medical faculties and nursing colleges, and to what extent this can be stimulated with scholarships.

6. It must be analysed how rural family doctors and nurses can be supported with their continuous professional development, by (free) courses, distance learning and sabbaticals.

7. Financial incentives can help, but should not be the only or even the main approach to rural attraction and retaining. Financial incentives for return-of-service were effective in some countries, but these experiences cannot be copied easily.

8. The need for non-medical support must be explored, such as housing, transport, and schooling of children. This should also interest local authorities in presently underserved areas.

9. Depending on the density and dispersion of the rural population, different models of family medicine provision will probably be needed.

10. It will be helpful to use the WHO recommendations and the GHWA checklist in drawing up an incentive scheme for rural family medicine in Romania.

Chapter 6: Challenges in Rural Primary Care in Romania

Chapter 2 presents an overview of the present situation in Romanian primary care or family medicine. Chapter 3 summarises the needs of rural primary care three years ago, supplemented with recent data from our own field assessment in September-October 2011 in chapter 4. Together with the conclusions of international efforts to attract medical staff to rural areas and to keep them there (chapter 5), we are now in a position to provide a preliminary inventory of challenges to Romanian primary care, and more in particular to primary care in rural and remote areas. This inventory is preliminary, because fact-finding and discussion with stakeholders will continue until a first draft of the National Strategy for Rural Health Care Development can be presented. Therefore one can also consider chapter 6 as an agenda and a check-list for discussions with stakeholders. The first part of the National Strategy will of course be a more definite overview of the challenges that the Strategy will attempt to deal with.

A chapter with “challenges” should not lead to the conclusion that there are only problems in Romanian family medicine. Chapter 2 describes how much has been achieved in a relatively short period. Such accomplishments should be maintained, and the purpose of an analysis of challenges is that it should lead to further improvement, not to a feeling of despondency. It will also not be realistic to propose a solution for everything that does not function well, therefore any strategy must set priorities.

As for chapter 2, the availability of the recent WHO (draft) report on the evaluation of structure and provision of primary care in Romania by NIVEL/CPSS has been very helpful for chapter 6 as well.

6.1 Challenges to Romanian primary care

Challenges to Romanian primary care that are not specific for *rural* services but are valid for the whole sub-system of primary care are described in the following paragraphs.

Policy level

Our present task is to propose a strategy for *rural* primary care only, but this is complicated by the fact that there is no overall long-term strategy for family medicine in general. Although family medicine is firmly established in Romania (see chapter 2), it will be important to have a vision of family medicine within the Romanian health care system in 10-15 years. Key issues are for example the long-term planning of human resources (not only of family doctors), quality assurance in family medicine, the profile (knowledge and skills) of family doctors and family nurses, family medicine as group practice vs. solo practice, interdisciplinary co-operation, and financing of family medicine. As the training of family doctors takes at least 9 years it is obvious that an agreed long-term vision will be helpful.

The Ministry of Health and professional associations should be leading the development of a strategy for family medicine. That requires a strengthening of the primary care section of the Ministry which at the moment consists of one person only, and making more frequent use of the Ministry’s Family Medicine Consultative Committee. It also requires the involvement and professionalization of the Romanian Society of Family Medicine/General Practice and the Romanian Nursing Association, and the involvement of politicians.

Financing issues

There are several financial aspects of primary care that can be questioned. There seems to be some agreement that the percentage of total CNAS funds devoted to primary care should be increased. It is not really possible to copy a percentage from other countries because

“primary care” includes much more than family medicine, for example dentistry and pharmacies, and data are not easily comparable between countries. Increasing one proportion of the CNAS budget leads to a decrease of another proportion (e.g. that for hospitals) unless the total budget is increased, and this is often not feasible politically or technically. Therefore an appropriate budget for family medicine is important but difficult to agree on. A complicating factor is the low total public health expenditure in Romania compared to other EU countries: less than 4% of GDP.

The payment method for Romanian family medicine has shifted in recent years, from mostly by capitation to 50% by fee-for-service. The reasons for this shift are not clear. Professionals in many countries prefer fee-for-service because it allows them to increase their income by working harder although they do not like the increased administration that is its consequence. Fee-for-service is often seen as conducive to quality improvement although evidence is weak. Fee-for-service is an open-ended payment method and if the purchasing agency wants to cap its expenditures, is obliged to put a maximum to the number of services a family practice is allowed to perform, thereby undermining the whole purpose of fee-for-service. At present, this is happening in Romania with the number of consultations per day and the number of home visits per day. In that case it would be better to return to a less cumbersome system largely based on capitation. Present capitation differentials between age groups do not reflect the demand for services by young children, male and female adults, and especially the elderly. There also appear to be discrepancies between the number of insured persons on the lists of doctors and those that are recognised as such by the CNAS due to the complexity of the registry to which various agencies contribute (e.g. for students and pensioners).

One complication of the present insurance system is that apparently it is not possible to achieve a nearly 100% coverage of the population. In theory, family doctors could treat the non-insured as private patients, but in reality this is not so easy, especially among vulnerable groups.

The system of co-payment for drugs prescribed by family doctors appears (too) complicated with complaints by family doctors and patients. No co-payments are required for drugs from lists C1, C2 and C3, but most prescriptions are for drugs from lists A and B. All lists are determined by the Ministry of Health upon advice by a committee of experts. The level of subsidy is based on the cheapest variant from groups of drugs although clinical guidelines or individual doctors sometimes prescribe another variant. Pharmacies may have a financial interest not to sell the cheapest variant leading to higher co-payments by the patients.

Human resources

At present, the number of CNAS-contracted family doctors in Romania (11,379 on 31 December 2010) is sufficient for national coverage of a population of 21 million. The average age of family doctors is 50, which means that many will retire in the coming years. This shows the necessity of forecasting future needs of family doctors (and family nurses) matched by a planning of intake by universities and colleges. Although some family doctors are immigrating (from the Republic of Moldova) others are emigrating to countries of the European Union, therefore migration patterns needs to be taken into account as well.

Most family doctors (85%) have either completed the 3 years residency in family medicine or (for those with experience but who were trained before the residency was introduced) by completing the 6 months upgrading course. Out of these 9,710 family doctors, 5,233 have done additional exams and are called „medici primari”. Then there are 1,669 doctors who are working as family doctors but are not considered as specialists in family medicine. They are presently engaged in a retraining programme, so that in approximately 3 years from now, all family doctors can be considered as specialists in family medicine.

The fact that in urban areas some former paediatricians and some former practitioners for adult persons still have relatively more children or adult persons on their lists than can be expected from the average age distribution in the population is not seen as a problem. Such differences will gradually disappear.

Since a number of years, there is a new profession in the field: community assistants, also known as community nurses. They are employed by local authorities, and this separate management structure could complicate coordination with family medicine practices, although the latter recognise that community assistants could fulfil a useful role. It should be explored how the two professions could avoid overlap and could cooperate better. This requires a good understanding of each other's task descriptions.

Quality of services

The knowledge and skills of family doctors and nurses ("medical assistants") should be further improved by more appropriate residency training and continuous professional development, and by development and use of guidelines, including those for improved prescription, for preventive activities and for taking charge of patients with chronic diseases. Vocational training of family doctors and family nurses still has a strong academic and hospital flavour, and training in rural settings is insufficient. The knowledge and skills of practice nurses need upgrading in order to give them a more responsible role in family medicine. At the moment they are mostly employed in an auxiliary role, especially for bureaucratic procedures. A EU supported project to develop "real" family medicine nursing has just started in Romania.

There are not sufficient clinical guidelines for family doctors and those that exist are often not available in the field or not used. Guidelines for family nurses do not exist at all. The use of guidelines during initial and continuing education and in daily practice is an important tool for quality assurance.

One could discuss an enlargement of the package of services provided by family medicine, coupled to adequate training and remuneration. Family doctors are quite comprehensive in the diagnosis and treatment of diseases, but standard provision of minor surgery, certain preventive services (screening, contraception), chronic disease care, and support for psychosocial problems is not yet standard. The division of responsibilities for diabetes care between family doctors and internists has not yet crystallised.

The CNAS has a wealth of data on provided services, prescription and referral, but they are not used for quality improvement. A feed-back of the performance of a family medicine practice compared to national or regional averages would already be a good incentive for improvement.

Physical infrastructure

Many complaints are made against poor premises for family medicine practices. The main problem is that the family doctors usually do not own the premises and therefore cannot invest in improvement. On the other hand, the owners - usually local authorities - apparently do not see such improvement as a priority. Even if the family doctors would become the owners of the premises, for example by an offer of a symbolic price in return for guaranteed continuation of services, present low incomes would require bank loans that are difficult to obtain.

Basic equipment is usually available in the family medicine practices. Pieces of equipment that are missing more often than not are for example an emergency kit, a vision chart, a speculum, an otoscope and a blood sugar test kit, and even if they are present they are

seldom used (details in the NIVEL/CPSS report). As for the renovation of premises, the purchase of new equipment would often be difficult in view of the limited practice revenues.

Nearly all family doctors use computers for the medical records of their patients and for searching of information. Administrative applications such as booking appointments or financial administration are sparsely used.

Organisation of primary care

Does the gate-keeping and referral system need strengthening? International comparisons of referral rates by general practitioners are difficult to interpret; figures vary between 3% and 10%. The figures for Romania are 9% for rural family doctors and 12% for urban family doctors which is at the high end of the spectrum or - for urban doctors - over it. A high referral rate can have various causes and is a symptom of inefficiency.

There is no doubt that family doctors are burdened with too much bureaucracy and paperwork, especially for CNAS reimbursement. Family doctors feel that some forms of registration are unnecessarily duplicated (electronically and on paper). Regulations and administrative rules change frequently, and doctors feel that this is distracting from their real work. Over-regulation can be a legacy of a previous command and control system and is found in many countries that have switched from a state system to a social health insurance system. As explained in chapter 5, a certain degree of trust between purchasers and providers is needed. Also, analysis of the requirements for data collection may show that many data are neither reliable nor necessary. The establishment of “sentinel stations” could eliminate much routine reporting by family doctors.

Family medicine practices usually do not provide services outside office hours. There are now 172 “permanent centres” where patients can consult family doctors outside office hours. In urban areas such patients more often end up in emergency departments of hospitals even if a family doctor would have been a more appropriate provider. Patients are used to hospital care for complaints outside office hours and hospitals have a financial interest not to refuse them. Therefore, “permanent centres” are seen more as a solution for rural than for urban areas (see below).

6.2 Challenges specifically to rural primary care.

Some challenges to family medicine are specific for or more pronounced in rural and remote areas.

The 2008 report by the National School of Public Health and Health Management concludes that the main need of rural populations in the more remote villages is better access to family medicine and pharmaceuticals. A considerable minority of the rural population is not registered with a family medicine doctor. Primary care staff especially mention inadequate premises and equipment as their main concern. These findings are largely confirmed by the results of our own field assessment that also added suggestions for the expansion of primary care services available to the population both in time and in scope, increased support by local authorities, better use of clinical guidelines, and strengthening of staff motivation.

The main challenge leading to the request for a special strategy for rural family medicine is said to be a lack of human resources in rural and remote areas It is, however, not so easy to find quantitative data about the number of rural Romanians that have insufficient access to family medicine. This depends of course on what is still reasonable and what is insufficient:

distance or travel time from a family medicine practice, daily services or only 1-2 times a week, and how many clients can be handled by a single family doctor.

By the Health Law (95/2006 art. 383 and 788) and the Pharmacy Law (266/2008 art. 2), family doctors are not allowed to provide drugs and in many places there are no rural pharmacies or pharmaceutical points although we have no precise data. Giving a prescription to a rural patient who then has to travel to a town to obtain the drugs is not acceptable. It should not be too difficult to find a solution to this problem that protects against perverse financial incentives, but it will require some legal changes. Presently some ideas about fundholding for primary care drugs are circulation in Romania and these could be linked to the possibility of doctors in remote areas having limited pharmaceutical stocks.

The establishment of “permanent centres” and the problem of underserved rural areas are often mentioned together but they are two different issues: one is not a solution for the other. Permanent *centres* are not possible in remote areas where only a single doctor and/or nurse can ensure emergency services outside office hours. Some doctors have no objection to be on duty permanently, especially if there is a form of compensation. There are methods to protect doctors and nurses against a burn-out from being on duty 7 days a week and 24 hours per day. Permanent or rotating centres in rural areas are only possible when a central location can be found where the distances to outlying villages are not too large. Instead of a “permanent centre” one could also consider a simpler solution namely a duty roster for rural family doctors in a certain region. Presently, doctors are not too interested in participating in permanent centres because conditions are not yet good and remuneration is poor. The whole issue of permanent centres in rural areas needs careful consideration.

There appears to be only limited interest of local authorities in family medicine and limited contacts between family doctors and local authorities. The dilapidated state of rural practices owned by local authorities would certainly point in that direction. However, in our own field assessment local authorities were at least interested in primary care, and the possibility for better cooperation should be explored.

Residency programmes in family medicine do not prepare doctors adequately for rural practice. As described above, they are too hospital-oriented and they lack sufficient training in rural settings which would be useful even for family doctors that will establish themselves in cities. Chapter 5 points to important international recommendations to improve this situation.

Strangely, the average number of clients on the list of a family doctor seems to be smaller in rural areas than in urban areas in the NIVEL/CPSS study. This is contrary to what one would expect in a situation of presumed shortage of doctors in rural areas. It is known that the percentage of uninsured persons is higher in rural areas than in urban areas and that urban family doctors sometimes establish an additional workplace outside the city but this can explain only part of this fact (that could also be an artefact).

Although most rural family doctors can provide some laboratory tests within their own practice they say they have insufficient access to more sophisticated laboratory services (54%) and X-ray services (52%).

Chapter 7: Next Steps

With the results of our analysis - partly described in chapters 2-6 of this report - we now have the building blocks to begin to draft a Strategy for rural primary care development. This strategy will be one for the short and medium term, approximately the period 2012-2020. During the development of this strategy further inputs will be collected from the Ministry of Health and other major stakeholders, leading to a draft that can be submitted to the Ministry of Health, its Project Management Unit and the Primary Care Advisory Committee in early December 2011. After approval by the Ministry as the foundation for developing the final text, the proposed strategy will be discussed during a workshop with stakeholders in mid-December 2011, and the final text submitted at the beginning of January 2012.

The Strategy for (rural) primary care development will be structured as follows:

- an introduction with definitions, the reasons for developing a strategy, an explanation of the structure of the document, and the overall context of primary care policy
- a brief overview of the present state of Romanian family medicine, its achievements and the challenges it faces;
- the overall goals of the strategy and the more specific objectives that it aims at achieving;
- a description of the implementation process, including the assigning of responsibilities to various actors and a time horizon.

In January 2012, we shall develop an Action Plan for implementation of the strategy plus a Monitoring & Evaluation Plan. The Action Plan may cover a period of 2-3 years and describes in details which activities should lead to achieving the desired results in the allocated time and with the allocated resources. The Action Plan will propose amendments to current regulations needed to attain the objectives. The Monitoring & Evaluation Plan will provide the methodology and indicators that are needed to supervise the implementation of the strategy.

The project team will assure that the various actors responsible for implementing the strategy are involved in the development of the Action Plan to guarantee ownership.

8: REFERENCIES

Abăităncei A, Mărginean M, Isar C. Family medicine in Romania - history and perspectives. National Centre for Studies in Family Medicine, no date

Adriana Galan, Institute of Public Health, Bucharest; First Expert Meeting, Geneva, February2009

Bärnighausen T & Bloom DE. Financial incentives for return of service in underserved areas: a systematic Review. BMC Health Services Research 2009, 9:86 (available via www.biomedcentral.com)

Bruguière M-T. Rapport d'information, fait au nom de la délegation aux collectivités territoriales et à la décentralisation, sur les territoires et la santé. French Senate document nr. 600, 14 June 2011

Buchan J, Thomson M & O'May F. Health workforce incentive and remuneration: a research review. Geneva: WHO document nr. WHO/EIP/OSD/00.14 (2000)

Dolea C. et al. Evaluated strategies to increase attraction and retention of health workers in remote and rural areas. Bull World Health Organization 2010;88:379–385

Florescu M. Primary care in Romania. The Permanente Journal 2006;10(3):52-3

Galan A. Health workforce challenges in Romania. PowerPoint presentation, February 2009

Global Health Workforce Alliance. Guidelines: incentives for health professionals. Pre-publication copy. Geneva: WHO/Global Health Workforce Alliance, 2008 [accessible via www.ghwa.org]

Government of Romania. Strategic national report regarding social protection and social inclusion, 2008-2010. Bucharest, September 2008

Haber G. Outcomes of primary care reforms and the new challenges facing Romania. PowerPoint presentation, no date

Humphreys J, Wakerman J. Primary health care in rural and remote Australia: achieving equity of access and outcomes through national reform - a discussion paper (2010), Accessible via www.health.gov.au

International Council of Nurses, et al. Guidelines: incentives for health professionals. Pre-publication copy 2008.

Isar C. et al. "Irrational things" that hamper the good functioning of family medicine in Romania. CNSMF, no date

Lehmann U et al. Staffing remote rural areas in middle- and low-income countries: A literature review of attraction and retention. BMC Health Services Research 2008, 8:19

Luoma M. et al. Review of national and international experiences with human resources incentive packages. Bethesda, MD: Review, analysis and assessment of issues related to health care financing and health economics in Bangladesh, Abt Associates Inc., July 2009

Maynard A. Chapter 8 - Incentives in health care: the shift from the implicit to the explicit. In: Dubois CA, McKee M & Nolte E (eds). Human resources for health in Europe. Copenhagen: WHO/European Observatory of Health Systems and Policies, 2006

National School of Public Health and Health Management. Propunere de elaborare a unei strategii tinta pentru un program de stat focalizat pe imbunatatirea accesului la serviciile de sanatate de baza, in zonele slab deservite - raport final (2 volumes). Bucharest: SNSPMS, July 2008

NIVEL/CPSS. Evaluation of structure and provision of primary care in Romania - a survey-based project. WHO-Europe, validated draft of October 2011 (official publication expected in December 2011)

NHIH activity reports 2004-2010

Rabinowitz HK, Diamond JJ, Markham FW, Paynter MP. Critical factors for designing programs to increase the supply and retention of rural primary care physicians. JAMA 2001;286(9):1041-8

SNMF. Financing of the health care system and family medicine in Romania 1990-2010. Bucharest, no date

SNMF. History of Health Care Law, with regards to family medicine in Romania - 1997-2010. Bucharest, no date

SNMF. Overview of family medicine in Romania - 1990-2011. Bucharest, 20 February 2011

SNMF/FNPMF. Primary health care in Romania - the main problems we are facing. Bucharest, 2 May 2011

Straume K, Shaw Daniel MP. Effective physician retention strategies in Norway's northernmost county. Bulletin of the World Health Organization 2010;88:390-394

Tarantino L, Reynolds M. Financing and training needs of small-scale private health providers and distributors in Romania - market research report. Bethesda (MD), Banking on Health Project, Abt Associates Inc., September 2007

The Presidential Commission for Health; "A Health System Focused on Citizens' needs"; 2008

The National Society of Family Medicine, Financing of the Health Care System and Family Medicine in Romania, Retrieved from www.snfm.ro in September 2011

Vlădescu C, Scîntee G, Olsavszky V, Allin S and Mladovsky P. Romania: Health

system review. Health Systems in Transition, 2008;10(3):1-172

Wakerman J, Humphreys J, Wells R, Kuipers P, Entwistle Ph, Jones J. A systematic review of primary health care delivery models in rural and remote Australia 1993-2006. Australian Primary Health Care Research Institute, September 2006

Wilson NW, Couper ID, De Vries E, Reid S, Fish T, Marais BJ. A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. Rural and Remote Health 9: 1060. (Online), 2009. Available from http://www.rrh.org.au

World Health Organization. World Health Report 2000 - Health Systems: Improving Performance. Geneva: WHO 2000

World Health Organization. Increasing access to health workers in remote and rural areas through improved retention - Global policy recommendations. Geneva, WHO, 2010

websites:

MOH: www.ms.ro

CNAS (health insurance): www.cnas.ro

SNMF (National Family Medicine Society): www.snmf.ro

Rural & Remote Health (journal): www.rrh.org.au

CNSMF (National Centre for the Study of Family Medicine): www.cnsmf.ro

9: ANNEXES

Annex 1: Needs Assessment Methodology

Purpose: To inform development of the rural PHC strategy for Romania.

Background: A comprehensive survey of PHC facilities was conducted in 2008. The report provides the detailed information on number and type of PHC facilities, staffing level, availability of equipment etc. The current exercise intends to verify the validity of problems identified in 2008, explore the new areas which require a particular attention and to probe for views of key stakeholders involved in financing, organizing and delivering family medicine services.

Description of activities: The team of local and international experts will visit selected by MOH geographic locations in Romania, which are considered as remote and may be medically underserved.

1. Tulcea (Dr. Jorj Cristea, Tel: 0788328484)
2. Teleorman (Dr. Mihaela Pop, Tel: 0766746253)
3. Vaslui (Dr. Cornelia Lovin Tel: 0745373991
4. Alba (Dr. George Habâr Tel: 0747085620)

The experts will conduct semi-structured interviews and consultative meetings when appropriate. The main target groups for these interviews will be as follows:

1. Family physicians-Individual or group interviews (4-8 at each area)
2. Nurses-Individual interviews (at least two 2-4 at each area)
3. Patients (including the representatives of the patients organizations)-Individual or group interviews (2-4 at each area)
4. Representative(s) of the judet (county) council -Individual interview
5. Representative(s) of local public health offices- Individual interview
6. Representative(s) of the National Health Insurance House and judet insurance house

Methodology: The data will be collected through semi-structured interviews. The table below identifies the areas to be explored and specific issues to be covered under each. Additional questions can be asked and some may be questions that have not been anticipated in the beginning of the interview. The interview will tape recorded and documented.

Individual interviews will last 90 minutes maximum. The group meetings would require 2 to 2.5 hours, depending on the number of participants.

Questions to physicians and nurses

Areas to be explored	Specific issues
Organization of FM services	• How do you provide services: are you in contract with the NHIH? • How many patients do you have on the list? • Do you practice alone as a solo practitioner or you partner with other family physicians?

Areas to be explored	Specific issues
	• What are responsibilities of family physicians in delivering public health services ? • Are there any limitations in this regard: y/n. If yes, how this can be improved? • What is the role that a local government plays in organizing FM services in the area?
Access to services	How many days per week are physician and/or nurse available in the area? Is there any regular public transportation that can be used by the people if they need to reach a medical practice? What are means of transportation for a family physician during home visits or emergency calls? Is a pharmacy available in the area? If yes, is it open the whole week including weekend? In the area you develop the activity, what are the zones difficult to reach? Why do you call difficult, please give one example. How do you manage with the difficulties?
Physical infrastructure	Availability of basic medical equipment to practice family medicine e.g. blood pressure measures, stethoscope, otoscope, ophthalmoscope, ECG
	Which equipment do you think is necessary but missing?
	How would you describe the status of your building: very good, good, fair, bad, very bad. Explain why you rank it like this? Discussion about the status of the building when started to use it, last time was renovated and who supported this process.
Involvement of nurses	What is the role of nurses in provision of FM services? Are there many primary care clinics staffed by a nurse only that the interviewed physician knows about? (The person should define by itself the area with this type of services, provided by only one person).
Referrals	How referrals are organized: • Hospital referral • Referral to and from specialists
Chronic care	How the care for chronically ill is organized? • Do you have the list of patients with chronic health conditions • Are you able to continuously monitor those with chronic disease e.g. diabetes, hypertension? • Do patients (including those with no health insurance) with e.g. diabetes and hypertension have unlimited access to drugs? • Access to basic lab services and availability of deep sticks for urinalysis, blood sugar monitoring, cholesterol etc.
The organization of emergency care	• Do family physicians provide emergency care during office hours and after office hours? • Do you report back to a regular family doctor if his/her patient

Areas to be explored	Specific issues
	encounters an emergency?
Quality of primary care services: • **Clinical Care Guidelines** • **Continuous professional development** • **Access to online resources** • **Performance management&monitoring**	Are there clinical practice guidelines for family physicians adopted by the MoH or professional bodies? How FPs in rural areas can access guideline documents (are those available online, printed and disseminated etc). Participation in CPD programs • How many hours annually? • Quality of courses (are those accredited by a leading professional body, by MoH or any other authority) Do you have an unlimited access to internet and if so, do you use it to access the internet based EBM resources; obtain online consultation when necessary; Are there any performance management mechanisms in place e.g. performance targets and financial incentives? Any reporting system (clinical audits) in place on quality standards?
Job satisfaction; motivation	• Are family physicians satisfied with their work conditions, income, housing, continuous education etc. • Reasons for developing the activity in the area you are now. • Advantages and disadvantages of providing services in a remote area (Please name two the most important) • What would be considered incentives to develop their activity in the area? • How would you define the situation of medical services provided in the rural area from the judet where the FP develops the activity? "Please, describe it in a few words"
Financing of PHC services	• What are the advantages and disadvantages of a FPs' contract with the National Health Insurance House ? • How the contract with the NHIH should be changed to improve it (perception of FPs, perception of the local authorities, perception of NHIH representatives)?
Future plans	• How family doctors plan to grow and expand their businesses

Questions to patients

Areas to be explored	Specific Issues
• **Patient satisfaction**	• Do you know about the medical services provided in the area? • What are the services provided? • How far are you located? • When you have a medical problem, where you go first/ where do you ask for services? (Provide examples) • Are you insured or not? If not, why?

	• How do you reach the medical services (transportation means/ availability of the doctor in the area a.s.o.) • If doctor is available in the area, how many days a week? • Could you recall one or two unpleasant OR pleasant experience during a last episode of medical care provided by family physician and specify what the reason was?
• **What needs to be changed**	• How can family physicians improve their practice? • What would you wish your physician had done differently?

Questions to the representatives of Public Health departments

Areas to be explore	Specific issues
Role of the PHD in the judet	• What is the role of the PHD in the judet? • What are the main activities developed/ coordinated by the PHD?
Role family physicians play in delivering public health services	• What role do family physicians play in delivering public health services? • How do you collaborate with family physicians in your area on a daily basis? • What administrative mechanisms are in place to support this collaboration? (contracts, accountability etc)
Access to public health services	• Have you ever experienced any difficulties in implementing public health interventions in a particular community because of the absence of a family physician or a nurse? • What is the immunization coverage for the entire judet? What is the reason/ explanation for the rate?
The extent to which public health services are integrated into the family medicine practice	• Are family physicians active in counseling the population on life style risk factors? Do you support them with this e.g. do you provide educational materials for patients, encourage them to place posters and other visuals in their premises? • In your opinion, does the FPs contract with the NHIH encourage family physicians to pay particular attention to preventive services?
What needs to be changed	• What would be two specific actions you could recommend to improve delivery of public health services to the population?

Questions to the representatives of the judet health insurance house

Areas to be explore	Specific issues
Organization and financing	• Could you please describe how does your office operate in relation to family medicine practitioners? • In your opinion, what are the advantages and disadvantages of a

	FPs' contract with the National Health Insurance House ?
Access to PHC services	• How many family physicians are contracted in this area? • To the best of your knowledge are there any physicians practicing which are not contracted by the NHIH? • Do they cover the entire judet or you have locations, which are considered as remote and it is hard to retain a physician there? • In your opinion, what will be the type of incentives a doctor needs for working in such areas?
What needs to be changed	• How the contract with the NHIH should be changed to improve it? • How family doctors can grow and expand their practices?

Questions to the representatives of the judet (county) council

Areas to be explore	Specific issues
The role of the county council in primary care delivery	• Could you please describe the role the county council play in organizing primary care service delivery to the population? • In your opinion, what's the general attitude of a public towards family medicine services? Do local people feel safer when there is a family medicine practice around?
Access to PHC services	• How many family medicine practices are there in the area? • Are there any with privately owned premises? • Do they cover the entire judet or you have locations, which are remote and it is hard to retain a physician there? • Do you know any areas in the region to be considered as remote areas? • In your opinion, what will be the type of incentives a doctor needs for working in the areas
What needs to be changed	• What do you think should be changed to improve delivery of family medicine services to the population? • Do you have any specific plans in this regard? • How family doctors can grow and expand their practices?

The experts will conduct a desk review and consult sources of the national statistics, demographics and other reports to collect the information on the following:

- numbers of the various types of professionals and trends
- geographical distribution of the human resources
- diplomas; level of knowledge and skills

- staff in pipeline (presently being trained)
- legal status of staff
- attached population
- * demographic data: per judet, urban-rural, socioeconomic
- * numbers of CNAS-contracted and non-CNAS-contracted doctors/practices
- Financing of primary care services in Romania
    - Remuneration for primary care providers, monthly revenue and business expenses
    - Payment mechanisms
    - Insurance coverage and the proportion of uninsured (per judet if possible)

Annex 2: Needs assessment locations and interviewed individuals

Location for the Field visits

Location	Interviewers	Dates	Contact person
Tulcea	KS, TG, CP	Sept 25th	Dr. Jorj Cristea
Teleorman	TG, CP	September 29,30	Dr. Mihaela Pop, Tel: 0766746253
Tulcea	CP	October 5,6,7	Dr. Jorj Cristea
Vaslui	CP	October 12,13, 14	Dr. Cornelia Lovin Tel: 0745373991
Alba	TG, CP	October 17,18,19	Dr. George Habâr Tel: 0747085620

KS-Kees Schaapveld
TG-Tamar Gabunia
CP-Cristina Padeanu

The list of individuals interviewed in each target groups (family Physicians, Nurses, Representatives of PHD and regional CNAS, local authorizes)

Name	Position	Workplace
Vaslui	***17-18.10.2011***	
Szekely Csaba **Mihaela Vlada**	prefect (representative of the government at the local level) Director of the PHD	Vaslui Vaslui county
Maria Vlasici	director of the Management and Economic Department	County CNAS
Mihaela Chitariu	director of the "Relation with Providers" Department	County CNAS
Anca Iftode	nurse	Iana
Ecaterina Dulgheru	nurse	Al. Vlahuta
Nicoleta Aliciuc	nurse	Cozmesti
Toader Daniela	community nurse	Iana
Gabita Ciulin	health mediator	Iana
Adriana Lungu	health mediator	Fistici
Petrica Apetrei	family physician	Cozmesti/ Fistici
Participants in the FG	***17.10.2011***	
Luchian Cristina Gabriela	family physician	Costesti
Lovin Cornelia	family physician	Murgeni
Roxana Enache	family physician	Iana
Aureliu Bujor	family physician	Puiesti
Daniel Toma	family physician	Al. Vlahuta
Ala Onia	family physician	Epureni
Adrian Nicolae Grom	family physician	Coroiesti
George Silvestrovici	family physician	Botesti
Nelu Mocanu	mayor	Iana
Georgeta Radacina	secretary of the village hall	Iana

Danut Cojocaru	mayor	Al Vlahuta
Mariana Carausu	accountant at the village hall	Al Vlahuta
Vasile Apreotiei	mayor	Cozmesti
Alba	**21.10.2011**	
Stefan Bardan	prefect (representative of the government at the local level)	Alba
Ion Dumitrel	president of the County Council	Alba
Ana Maria	Counselor - County Insurance House	Alba county
Horea TIMIS	director PHD	Alba county
Gabriela Stan	Economic director PHD	Alba
Corneliu Calatean	family physician	Poiana Vadului
Aurora Cenusa	family physician	Bistra
Eugenia Emilia Floca	family physician	Bistra
Ioana Cristeian	family physician	Intregalde
Pasca Scortaru	family physician	Lupsa
Ileana Sipos	family physician	Ocolis
Enculescu Georgeta	family physician	Horea
Ciubotarescu Cristian	family physician	Garda
Maria Florea	family physician	Vidra
Mariana Popa	family physician	Vadu Morilor
Ionel Cristea	family physician	Albac
George Haber	family physician	Sebes
Candrea Olimpia	former FP/ currently PHD employed	presented the situation in Scarisoara at the FG
Cristian Mindru	family physician	Scarisoara
Bogdan Radu	nurse	Scarisoara
Sonia Nicolae	nurse	Albac
Lazea Nicolae	mayor	Vadu Motilor
Cristian Costea	mayor	Scarisoara
Sofia Tartarian	secretary of the village hall	Scarisoara
Tiberiu Todea	mayor	Albac
Tulcea	**6-7.10.2011**	
Laura Militaru	director PHD	Tulcea
Jorj Cristea	family physician	Murighiol
Roxana Nita	family physician	Sulina/ C.A. Rosetti
Nicolae Jurjea	family physician	Crisan/ Maliuc
Emil Nenciu	family physician	Chilia Veche
Gabriel Arseni	family physician	Nufaru
Angela Badica	family physician	Tulcea/Cetalchioi
Daniela Manescu	family physician	Bestepe
Stefanov Florica	nurse	Murighiol
Ileana Iovi	nurse	Bestepe
Postica Roman	vice-mayor	Bestepe
Florentina Poh	secretary of the village hall	Bestepe
Teleorman	**27-28.09.2011**	
Mioara Comana	director PHD	Alexandria/ Teleorman county
Marius Nica	president and Director of the County CNAS	Alexandria/ Teleorman county

Mihaela Pop **Iulian Rizea**	family physician medical director	Gratia Alexandria/ Teleorman county
Mihai Laban	family physician	Magura
Voicu Gabriel	family physician	Frasinet
Gane Silva Carmen	family physician	Calmatuiu
Liana Anastasescu	nurse	Gratia
Ilie Petris	vice-mayor	Gratia
George Cernea	mayor	Galeteni
Valentin Nitu	vice-mayor	Calmatuiu

Patients Interviewed

Name of the patient	Village
Tulcea	
Maria	Murighiol
Veronica	Murighiol
Daniela	works in Murighiol, from Tulcea city
Cornelia	Bestepe
Teodora	Nufaru
Teleorman	
N/A (3 persons in the waiting room of Dr. Pop)	Gratia
Alba	
Maria	Garda
Calin	Garda
Cristina	Scarisoara
Petre	Albac
Daniela	Vadu Motilor
Vaslui	
Stela	Murgeni (recently a town)
Aristita	Murgeni
Ivan	Bogdanesti
Viorica	Iana
Ion	Iana
Floarea	Cozmesti
Gheorghe	Cozmesti

ANNEX 3: Summary of key findings on access, coverage and human resources for rural primary care services in Romania (Reported in 2007)

Selected Indicators	BI	C	NE	NV	S	SE	SV	V	Total
N of rural population	200,095	895,646	1,812,174	1,180,627	1,745,383	1,229,460	956,385	724,805	**8,744,575**
N of Roma Population	10,579	67,589	27,700	70,669	60,642	27,159	33,412	18,132	**315,882**
Children 0-1	2,029	11,317	244,771	14,577	16,575	12,258	10,763	6,793	**319,083**
Number population registered with family physicians	199,396	786,680	1,499,734	1,000,025	1,400,640	989,032	801,324	657,410	**7,334,241**
N of population not registered with FPs	699	108,966	312,440	180,602	344,743	240,428	155,061	67,395	**1,410,334**
% of population registered with FPs	99.7%	87.8%	82.8%	84.7%	80.2%	80.4%	83.8%	90.7%	**83.9%**
N of FM cabinets and medical points	90	555	782	686	980	615	479	514	**4,701**
N of permanent Centers	1	27	12	44	27	17	14	12	**154**
N of cabinets by other specialists	62	123	188	175	192	132	51	150	**1,073**
N of Pharmacies and pharmaceutical points	47	211	249	344	361	252	164	142	**1,770**
N of health centers	1	2	6	6	9	2	4	-	**30**
N of FPs	85	571	797	619	922	574	559	500	**4,627**
N of PFs living in the area	14	215	242	242	218	148	185	219	**1,483**
N of Nurses	101	522	1,004	788	1,243	755	780	486	**5,679**
N of nurses living in the area	76	362	707	569	837	511	490	355	**3,907**
N of other specialist	69	162	272	180	337	150	128	169	**1,467**
N of community nurses	16	126	394	133	105	247	385	45	**1,451**
N of Roma mediators	12	43	43	52	57	41	24	13	**285**
N of registered population per family physicians	2346	1378	1882	1616	1519	1723	1433	1315	**1585**
Maximum number of patients per FP in the region	2346	2420	2588	1838	2832	2142	3310	1353	**-**
N of registered population per nurse	1974	1507	1494	1269	1127	1310	1027	1353	**1291**
N of inhabitants per FP	2354.1	1568.6	2273.7	1907.3	1893.0	2141.9	1710.9	1449.6	**1889.9**
N of inhabitants per nurse	1981.1	1715.8	1805.0	1498.3	1404.2	1628.4	1226.1	1491.4	**1539.8**
N of population per community nurse	12505.9	7108.3	4599.4	8876.9	16622.7	4977.6	2484.1	16106.8	**6026.6**
N of population per 1 Roma Mediator	882	1572	644	1359	1064	662	1392	1395	**1108**

Selected Indicators	BI	C	NE	NV	S	SE	SV	V	Total
% of nurses living in the area	75%	69%	70%	72%	67%	68%	63%	73%	**69%**
Nurses per FPs ratio	1.2	0.9	1.3	1.3	1.3	1.3	1.4	1.0	**1.2**
N of locations without family physicians	0	10	9	8	14	23	4	20	**88**
N of locations without FPs and nurse	0	3	3	6	1	9	2	16	**40**
N o locations without FPs, and Nurse and medical cabinets	0	1	1	4	0	2	0	4	**12**
N of locations without FM cabinets	0	10	9	11	5	16	12	19	**82**
N of locations without permanent center	31	288	415	313	443	305	277	258	**2330**
N of locations without other specialists	28	117	161	163	178	139	51	110	**947**
N of locations without pharmacies and pharm. points	4	135	232	97	197	123	150	152	**1090**
N of population per pharmacies or pharm. point	4257.34	4244.77	7277.81	3432.06	4834.86	4878.81	5831.62	5104.26	**4940.44**
Number of population in locations without FPs	0	19481	15465	13109	35156	36744	9769	24180	**153,904**

ANNEX 4: W.H.O Recommendations for Rural Retaining

A. EDUCATION RECOMMENDATIONS

1. Use targeted admission policies to enrol students with a rural background in education programmes for various health disciplines, in order to increase the likelihood of graduates choosing to practise in rural areas.

2. Locate health professional schools, campuses and family medicine residency programmes outside of capitals and other major cities as graduates of these schools and programmes are more likely to work in rural areas.

3. Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas.

4. Revise undergraduate and postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention.

5. Design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention.

B. REGULATORY RECOMMENDATIONS

1. Introduce and regulate enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.

2. Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practising in rural and remote areas.

3. Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives so as to increase recruitment and subsequent retention of health professionals in these areas.

4. Provide scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas to increase recruitment of health workers in these areas.

C. FINANCIAL INCENTIVES RECOMMENDATION

1. Use a combination of fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transportation, paid vacations, etc., sufficient enough to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers, to improve rural retention.

D. PERSONAL AND PROFESSIONAL SUPPORT RECOMMENDATIONS

1. Improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools, etc.), as these factors have a significant influence on a health worker's decision to locate to and remain in rural areas.

2. Provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive and thereby increase the recruitment and retention of health workers in remote and rural areas.

3. Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, use tele-health to provide additional support to health workers in remote and rural areas.

4. Develop and support career development programmes and provide senior posts in rural areas so that health workers can move up the career path as a result of experience, education and training, without necessarily leaving rural areas.

5. Support the development of professional networks, rural health professional associations, rural health journals, etc., in order to improve the morale and status of rural providers and reduce feelings of professional isolation.

6. Adopt public recognition measures such as rural health days, awards and titles at local, national and international levels to lift the profile of working in rural areas as these create the conditions to improve intrinsic motivation and thereby contribute to the retention of rural health workers.

ANNEX 5: OVERVIEW AND ANALYSIS OF THE LEGAL FRAMEWORK OF PRIMARY CARE IN ROMANIA

A. Overview of the Legislation on Primary Care

The legal framework of the Romanian Primary Care is a mixture of primary and secondary legislation. For the sake of completeness, the constitutional basis of healthcare in Romania is also outlined below.

I. Constitutional Basis

The constitutional basis for healthcare is laid down in Art. 34 of the Constitution of Romania,[4] which is captioned with "right to protection of health". This right is subdivided into two aspects: the general guarantee of health protection and the positive obligations of the Romanian state with regard to healthcare, in particular the obligation to provide a legal framework of the important health care matters by law (Art. 34(1), (2) and (3) of the Constitution of Romania).

The positive obligations with regard to healthcare entail the duty to ensure public hygiene and health. However, this duty is not specified in the Constitution. It does not contain any determination of concrete aims, means or claims. The legal framework of healthcare referred to in Art. 34(3) of the Constitution of Romania must cover the organisation of the social security system and the medical care institutions, the control over the exercise of medical professions, as well as other healthcare matters.

II. Primary Legislation

There are three primary laws in Romania which concern Primary Care: the Health Reform Law No. 95/2006, the Law No. 215/2001 on Local Public Administration[5] and Law No. 263/2004 on Ensuring Continuity of Primary Care through Permanence Centres.[6]

1. The Health Reform Law 2006

The Health Reform Law addresses Primary Care issues in three titles. Title II deals with the National Health Programme, Title III is concerned with the basics of Primary Care and Title XII details the medical profession.

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[4] The Constitution of Romania from 21 November 1991, last amendment on 31 October 2003, Official Gazette of Romania, Part I, No. 233 of 21 November 1991 (Constituţia României din 21 noiembrie 1991, aşa cum a fost modificată şi completată pe 31 octombrie 2003, publicat in Monitorul Oficial, Partea I, Nr. 233 din 21 nojembrie 1991), English version available at http://www.cdep.ro/pls/dic/site.page?id=371.

[5] Law No. 215 on Local Public Administration from 23 April 2001, republished, last amendment on 22 December 2010, republished in Official Gazette of Romania, Part I, No. 123 of 20 february 2007 (Legea Nr. 215 a administratiei publice locale din 23 aprilie 2001, aşa cum a fost modificată şi completată pana la data de 22 decembrie 2010, republicata in Monitorul Oficial, Partea I, Nr. 123 din 20 februarie 2007).

[6] Law No. 263 on Ensuring Continuity of Primary Care through Permanence Centres from 16 June 2004, last amendment on 31 January 2011, Official Gazette of Romania, Part I, No. 568 of 28 June 2004 (Legea Nr. 263 privind asigurarea continuităţii asistenţei medicale primare prin centrele de permanenţă din 16 iunie 2004, aşa cum a fost modificată şi completată pana la data de 31 ianuarie 2011, publicat in Monitorul Oficial, Partea I, Nr. 568 din 28 iunie 2004).

a) Title II

Title II comprises general provisions regarding National Health Programmes. The law stipulates that National Health Programmes include assessment programmes, preventive programmes and curative programmes. National Health Programmes are developed and implemented separately or jointly by the Ministry of Health and the National Health Insurance House (CNAS) - Romanian state insurance. They are financed either from the state budget or from the National Health Insurance Fund (state fund for the state insurance) and transfers from the state budget and Ministry's of Health own revenue to National Health Insurance Fund.

This title also contains provisions with regard to the reimbursement level of drugs, sanitary materials, medical devices, the specialised units through which the National Health Programmes are carried out and the responsibilities in implementing and running National Health Programmes. The Ministry of Health co-ordinates all National Health Programmes.

b) Title III

Title III of the Health Reform Law defines the basic terms of Primary Care, family medicine, family doctor etc. Further, it lays down the conditions of medical assistance provided in family medicine offices and contains provisions concerning duties of the involved parties, the organisation of the family doctor office, the types of medical services provided to patients, and the financing/funding of family medicine. These provisions are detailed in the Government Decision No. 1389/2010.[7]

c) Title XII

Title XII of the Health Reform Law deals with the medical profession and the organisation and functioning of the Romanian College of Physicians. The law stipulates that the medical profession is exercised by doctors who possess a formal qualification in medicine. The qualification can be a medical degree or a specialist certificate issued by the Ministry of Health (MoH). Also, a medical degree, a diploma, a certificate or other evidence in medicine, issued either by EU/EEA Member States or by a third country which is recognised by an EU/EEA Member State are accepted as qualifications. Monitoring and control of the profession is made by the College of Physicians in Romania and the Ministry of Health (MoH).

The medical profession in Romania is exercised by doctors who have a formal qualification in medicine, who are not in any of the cases of unworthiness or incompatibility and who are fit in terms of practising medical profession and are members of the College of Physicians of Romania.

The doctor may exercise his profession on the basis of relevant professional qualifications as general practitioner (medic de medicina generala) or as specialist doctor; according to Art. 380(1), b) specialist doctor in one of the clinical or laboratory specialties. Family medicine is one of the clinical specialties)

[7] Government Decision No. 1389 from 28 December 2010 (Hotarârea Guvernului Nr. 1389 din 28 decembrie 2010).

medical doctor with expertise in a clinic or laboratory (see the Nomenclature of medical, dental and pharmaceutical specialities).

The law also contains provisions on authorisation of practising the medical profession, on freedom to provide medical services, and on the organisation and functioning of the Romanian College of Physicians.

2. Law No. 215/2001 on Local Public Administration

According to Art. 36 the local council decides on all matters of local interest, except those which are in the competence of other local authorities or the central administration. Thus, every local council exercises the powers on economic and social development of his village, town or municipality. In this respect, the local council approves the strategy on economic and social development, decides on the sale, lease or rental of private assets (e.g. premises) of the village, town or municipality. In exercising its powers, the local council ensures, within its competence, the conditions for providing local public services on health and decides on the granting of bonuses and other incentives to medical personnel.

3. Law No. 263 on Ensuring Continuity of Primary Care through Permanence Centres

Law No. 263 governs the provision of primary health care through permanent centres. It is divided into three chapters: general provisions (1); establishment, organisation and operation of permanent centres (2) and transitional and final provisions (3).

Chapter 1 (Art. 1 to 4) of the Law contains general provisions. Art. 2 includes definition and general rules on permanent centres. It sets out the conditions under which nurses and doctors can be employed, how hourly wages and working schedules are to be determined and where centres can be established. Furthermore, Art. 2 stipulates that associations of physicians have to be made on the basis of an agreement of association according to the law. Art. 3 states that centres shall be established in remote or inaccessible areas or where public health authorities otherwise deem it to be necessary.

Chapter 2 (Art. 5 to 11) contains rules on the establishment, organisation and operation of permanent centres. Thus, Art. 5 regulates the powers of public health department regarding the operation of centres. Art. 6 governs similar powers of local councils. Art. 7 governs the responsibilities of practitioners in the provision of primary care, including ensuring the continuity of care. This includes compliance with several regulations and the duty of care to anyone who needs it, regardless of their insurance status. Moreover, Art. 8 stipulates the minimum staff requirements necessary for setting up a centre (7 doctors + 7 nurses staff in centres). Art. 9 regulates the funding of primary care, which is to be received from the state budget through transfers from MoH`s budget to NHIH. Art. 10 contains further provisions on doctors and emergency care, including rules on equipment. Finally, Art. 11 stipulates the hours of operation of permanent centres.

Chapter 3 (Art. 12 to 16) contains transitional and final provisions. Art. 12 of Chapter 3 stipulates how many hours practitioners are required to provide regarding the operation of the permanent centres. Art. 14 several transitional provisions and also establishes penalties for practitioners who fail to comply with their legal obligations.

III. Secondary Legislation

The secondary legislation on Primary Care in Romania consists of several government decisions and orders.

1. Government Decision No. 1389/2010

The Government Decision No. 1389/2010 is a framework contract which provides the foundation for contractual relationships between health insurance houses and health care providers (hospitals, clinics, medical offices, pharmacies, etc), including general obligations, conditions and model contracts. The Framework Contract consists of 142 articles. Section 6 of Chapter II refers to PC and consists of 20 articles (Art. 23 to 42).

The general provisions refer to the eligibility criteria for health care providers (doctors etc.) and the documents needed for concluding the contract with the health insurance house. They also govern the obligations of health care providers and of the Health Insurance Houses (HIH).

Section 6 regulates the specific eligibility criteria for entering into contract with the health insurance house. It also states the minimum number of persons registered in a family doctor's list and the maximum number of working hours of family medicine offices, the reimbursement of medical services, the penalties for breaching the contract, as well as the suspension and termination of contracts concluded with the health insurance house.

2. Order No. 864/538[8]/2011

The Order No. 864/538 contains detailed rules for implementing the Government Decision No. 1389/2010. This order has three articles and 40 Annexes, which form an integral part of the order (Art. 1). Annex 1 regulates the package of medical services in Primary Care consisting of a minimal, an optional and a basic package of medical services.

The uninsured are entitled to the minimal package. This package includes medical-surgical emergency services, clinical examination and treatment, surveillance and detection of potential endemo-epidemic diseases, consultations to monitor the course of pregnancy and the post-partum phase, immunisation, as well as family planning services.

The optional package for people who apply for a voluntary assurance includes minimal package services, plus curative medical services for acute and sub-acute illnesses, as well as clinical examination, diagnosis and treatment.

The basic package, which benefits the insured, includes medical-surgical emergency services, preventive medical services such as consultations for detecting physical and psychomotor development of children through exams balance and periodic medical

[8] Order of minister of Health and president of National Health Insurance House No. 864/538 from 31 May 2011 (Ordinul ministrului sanatatii si al presedintelui Casei Nationale de Asigurari de Sanatate Nr. 864/538 din 31 mai 2011).

examination of the insured, consultations at home, medical laboratory services and so on.

Annex 2 regulates the payment methods in primary care. The amount of the final payment is composed of the per capita payment and the fee for service payment. These two factors are subject to a differentiated point system. This point system takes into account the following aspects: the patient's age (11.2 points for the 0-3 years and over 60 years old, 7.2 points for the 4-59 years old), the kind of service, as well as the place of the care performance (at the patient's home - 15 points, or in the family medicine office - 5.5 points). One point of the per capita factor is worth 3 RON. One point of the fee for service factor is worth at least 1.8 RON. The number of points per capita can be recalculated on the ground of conditions in which family doctor carries out his activity and of the professional degree.

The law also regulates the optimum (1800) and maximum number (2,200) of insured persons registered on the family doctor's list, the minimum number of people registered (1,000) for which a family doctor may enter into contract with the health insurance house.

The doctor's number of working hours are scheduled as follows: 5h per day in the office (reimbursed per capitation); other two hours per day (reimbursed per fee for service), plus 1h x5 days for home visits. This is combined with the working hours at the permanence centres.

3. Order No. 163/93[9]/2008

The Order No. 163/93 deals with the point system that is used to calculate the compensation which medical officers receive for their services. Specifically, the Order stipulates how points should be adjusted to take into account demographics, regional differences and the doctors' respective working conditions. It contains two articles and one annex, consisting of two further articles.

1. Art. 1 of the Order stipulates " the criteria for classification of primary care medical offices and speciality ambulatories (*speciality medical offices*) depending on the conditions in which the activity is carried out". The Annex of the Order. Art. 1 defines the criteria according to which the points are to be adjusted; more specifically, it brings the "Criteria for classification of medical offices depending on condition in which the activity is carried out". These include, *inter alia*, personal working conditions and infrastructure (Art. 1(1)), population density and size of the area served (Art. 1(2)), distance from existing medical infrastructure (Art. 1(3)) and socio-economic factors (Art. 1(4)).

2. Art. 2 of the Annex defines how the capitation-based points are to be adjusted for primary care service provision. More specifically, it defines percentages of increase of

[9] Order of minister of Health and president of National Health Insurance House No. 163/93 from 18 February 2008, Official Gazette of Romania, Part I, No. 177 of 7 March 2008 (Ordinul ministrului sanatatii si al presedintelui Casei Nationale de Asigurari de Sanatate Nr. 163/93 din 18 februarie 2008, publicat in Monitorul Oficial, Partea I, Nr. 177 din 7 martie 2008).

per capita points for primary medicine, and of actual total points for clinical specialities ambulatories. Increase in Points for primary care providers is calculated on the basis of the criteria defined in Art. 1 of the Annex. The list of providers to which the above mentioned outpatient increases apply. This is reviewed annually by a panel, consisting of **representatives of** health insurance houses, public health authorities and colleges of physicians.

4. Order No. 697/112[10]/2011

2. Order No. 697/112 governs the establishment, oversight and regulation of Permanence centres.

3. Art. 1 of the Order states that primary centres are to be governed by the rules set out in the Annex, which forms the main part of Order No. 697/112. Art. 2 stipulates the public authorities which shall carry out the provisions of the Order. The Annex of Order No. 697/112 consists of ten chapters and further documents, including specific guidelines on primary centres, a convention of association and a model contract for health care providers.

4. Chapter 1 of the Annex contains general provisions on primary health care centres. It stipulates that emergency care is to be provided by these centres (Ch. 1, Art. 3). Chapter 1 further stipulates the rules on doctors on call (Ch. 1, Art. 5) and provides an overview of the services that doctors are required to provide, including treatment, emergency care and referrals (Ch. 1, Art. 7). Medical service is to be provided to all those who request it, regardless of their insurance status (Ch. 1, Art. 8)

5. Chapter 2 of the Annex regulates the establishment of permanent centres. Art. 9 further states the conditions under which such centres may be established. Additional guidelines on the continuity of care are set out in a convention of association (Ch. 1, Art. 10). Areas in which permanent centres are to be established can be proposed by certain public authorities or family physicians (Ch. 1, Art. 12). The Department of Public Health decides whether permanent centres should be established (Ch. 1, Art. 13). Art. 13, 14 specify the formal requirements in establishing such centres.

6. Chapter 3 of the Annex sets out rules on the operation of permanent centres. Notably, they require a permanent staff of 5 to 7 family doctors and 5 to 7 nurses (Ch. 3, Art. 18).

7. Chapter 4 of the Annex deals with funding the permanent centres. Centres are to be financed by the state budget through the transfers from the Ministry of Health to CNAS (Ch. 4, Art. 24). The cost of emergency kits (drugs and sanitary materials) for

[10] Order of minister of Health and minister of Administration and Interior No. 697/112 from 25 May 2011, Official Gazette of Romania, Part I, No. 389 of 2 June 2011 (Ordinul ministrului sanatatii si al ministrului administratiei si internelor Nr. 697/112 din 25 mai 2011, publicat in Monitorul Oficial, Partea I, Nr. 389 din 2 iunie 2011).

permanence centres operating in facilities provided by local councils are to be funded through the state's "Pre-hospital emergency funding programme. MoH supports (Ch. 4, Art. 25).

8. Chapter 5 of the Annex stipulates the necessary documents for the operation of permanent centres. This includes provisions on record keeping. Records must be kept for, *inter alia*, medical consultations, the use of materials and drugs, staff attendance and medical activity carried out (Ch. 5, Art. 27 to 29).

9. Chapter 6 of the Annex, is titled as "Powers on the establishment, organisation and operation of permanent centres." It regulates the duties and responsibilities of public health authorities, health insurance houses, local councils, ambulance services, coordinator of the permanence centre and those of family medicine offices and doctors who ensure the continuity of primary healthcare through permanence centres. These powers include the establishment, organisation and operation of the permanent centres. Art. 30 governs the powers of public health departments. Art. 31 regulates the powers of health insurance houses. Art. 32 deals with the powers of county ambulance services and the ambulance of Bucharest-Ilfov. Art. 33 governs the powers of the local councils regarding the function of the permanence centres. Article 34 regulates the powers of the permanent centre coordinator. Lastly, Chapter 6 also specifies certain organisational obligations for family doctors, including record-keeping (Ch. 6, Art. 35).

10. Chapter 7 of the Annex deals with the contractual relationship between health insurance House and health care providers. In order to operate permanent centres, doctors are required to provide certain documents as well as permits and to sign a contract with the health insurance (Ch. 7, Art. 36). Art. 37 refers to a model contract which is to be used for this purpose and model contract forms part of the Order No. 697/112 as well. Chapter 7 also regulates the pay of family physicians in permanent centres and includes the hourly wages, rules on expenses (Ch. 7, Art. 39) and factors used to adjust pay (Ch. 7, Art. 38).

Chapter 8 stipulates how compliance to the Order is to be monitored (Art. 40). Chapter 9 furthermore defines the role of county public health departments in monitoring and evaluating permanent centres (Art. 41 to 42).

5. Government Decision No. 1388/2010[11]

The Government Decision No. 1388/2010 refers to the structure and objectives of the National Health Programme (NHP). There are three main categories of National Health Programmes: Evaluation National Health Programmes, Prevention National Health Programmes and Curative National Health Programmes, which are structured in programmes and sub-programmes.

[11] Government Decision No. 1388 from 28 December 2010, Official Gazette of Romania, Part I, No. 893 of 31 January 2011 (Hotararea Guvernului Nr. 1388/2010 din 28 decembrie 2010, publicat in Monitorul Oficial, Partea I, Nr. 893 din 31 ianuarie 2011).

National Health Programmes are carried out separately or jointly by the Ministry of Health of Romania and the National Health Insurance House of Romania, as appropriate, and are financed from the state budget from the Ministry of Health revenues, National Health Insurance Fund (NHIF) and budget transfers from the Ministry of Health budget to the National Health Insurance Fund, and other sources, including donations and sponsorships. The Decision regulates the types of units which run the National Health Programmes - public and private health units, public institutions, healthcare providers, medicines and medical devices providers. There are also provisions regarding the access of patients enrolled in National Health Programmes to medical services, medicines, sanitary materials, medical devices, depending on the type of National Health Programmes, and provisions on reimbursement of expenditures.

6. MoH Order No. 1591/1110[12]/2010

The Government Order No. 1591/1110 regulates the general framework for achieving the National Health Programmes, the powers of medical units involved in running the National Health Programmes, the budget, the structure of each programme, the activities of medical units which run the National Health Programmes, the evaluation indicators and other technical details. It also includes the model contracts for providing medical services within National Health Programmes to be concluded between the Health Insurance House/Department of public health authorities and medical providers.

7. Government Ordinance No. 124/1998[13]

The Ordinance No. 124/1998 regulates the forms in which the doctor can exercise his profession (individual medical office, grouped medical office, associated medical office, medical civil society, medical units with legal personality), the medical offices' sources of income and the obligation of registration in the Unique Register of Medical Offices. It also contains transitional provisions regarding the establishment of the medical offices in the former dispensaries and clinics owned by central or local public authorities (private propriety of the state).

It deals with the organisation of medical offices including the establishment, registration, functioning and financing. Chapter I, Art. 1 to 3 is entitled "General Provisions" and provides explanations for some of the most used terms, including "medical office" (Art. 1). Chapter II, Art. 4 and 5, is entitled "Establishment and registration of medical services". Art. 4 provides that the name should reflect the specific services carried out. Art. 5 stipulates who may establish a medical office.

Chapter III, Art. 6 to 12, is entitled "Organisation, functioning and financing of medical service". The activities that medical offices can carry out are stated in Art. 6 and 12. Art. 7 stipulates the minimum requirements for a doctor and Art. 8 deals with the

[12] Order of minister of Health and of president of National Health Insurance House No. 1591/1110 from 30 December 2010, Official Gazette of Romania, Part I, No. 53 of 21 January 2011 (Ordinul ministrului sănătăţii şi al presedintelui Casei Naţionale de Asigurări de Sănătate Nr. 1591/1110 din 30 decembrie 2010, publicat in Monitorul Oficial, Partea I, Nr. 53 din 21 ianuarie 2011).

[13] Government Ordinance No. 124/1998 from 29 August 1998, Official Gazette of Romania, Part I, No. 568 of 1 August 2002 (Ordonanta Guvernului Nr. 124 din 29 august 1998, publicat in Monitorul Oficial, Partea I, Nr. 568 din 1 august 2002).

activities that they can carry out and make an income from, whilst Art. 9 states the states that medical offices` income shall be taxed according to legal provisions on taxation Art. 10 and 11 states that the holder (doctor who owns the practice) or the doctor appointed by associated doctors is the legal representative of the medical office, thus specifying the legal representative (Art. 10) and employees (Art. 11).

Chapter IV, Art. 13, deals with sanctions for non compliance with Art. 5 (Art. 13(1)) and Art. 12 (Art. 13(2)). Chapter V, Art. 14 to 19, is entitled "Transitional and Final Provisions". Art. 14 to 17 are the "transitional provisions" and deal with medical offices set up under previous Romanian law. Art. 18 and 19 are the "final provisions" and stipulate where the ordinance is to be published (Art. 18) and its commencement date (Art. 19).

B. Analysis of the Legislation on Primary Care

Primary Care is mainly regulated by Title III of the Romanian Health Reform Law 2006 (Law No. 95/2006). It is defined as the health sector providing comprehensive health care and being the first contact of any kind of health problems (see Art. 60(a) in connection with Art. 59(2) of the Romanian Health Reform Law 2006) According to Art. 59(1), (3) of the Law No. 95, in Romania Primary Care may be performed only by family medicine staff, who's status is analysed in the following chapter.

I. Legal Status of Family Medicine Staff

As far as the legal status of family medicine staff is concerned, there are some ambiguities as to the profession of the family doctor and his duties and obligations.

1. General Remarks on the Profession of the Family Doctor

The family medicine staff consists of family doctors and other supportive staff such as nurses. A family doctor can be either a family medicine physician,[14] which should be the usual case, or a family medicine physician. A medical doctor is a graduate of medicine prior to 2005, who is allowed to exercise the profession of the family doctor under the conditions prescribed by Law No. 95. This distinction between family medicine physician and medical doctor is the result of reforms in the area of Primary Care by the Law No. 95, which was enacted in 2006. Therefore, the newly introduced profession of family medicine physician ensures that graduates of medicine prior to 2005 are not disfavoured; though the difference in reimbursement of services provided by general practitioners and family doctors who undergone the residency training remains (10%). From 2005, professional competences in family medicine are acquired only on the basis of a residency.

2. Duties and Obligations

The duties and obligations of the family medicine performers are regulated in Title III of Law No. 95 in two different places. First, Art. 63 of Law No. 95 provides for "characteristics" of family medicine, which are (among others) a direct doctor-patient relationship of trust, effectiveness and individuality of health care. The ambiguous

[14] Physician who obtained the speciality of family medicine in accordance with the law, see Art. 60(c) of Law No. 95.

wording (“characteristics”) does not allow a definite answer on the question, whether Art. 63 of Law No. 95 provides for binding duties of family medicine staff including enforceable rights of the patients or whether it merely states some general objectives of family medicine. Further, Art. 83 of Law No. 95 outlines extensive obligations of family medicine performers to different parties (patients, health insurance houses). Art. 83(e) of Law No. 95 refers to patient rights legislation. The relationship to Art. 63 of Law No. 95 is not plain, as the law does not connect them in any way.

Apart from that, Title III of the Law No. 95 should deliver a clear provision on the contracting with the patient taking into account the following: does the Romanian legislator want a doctor’s obligation to contract in the area of Primary Care or should the doctor-patient contract be subject to general principles of private law, in particular the freedom of contract? A moderate solution appears to be the most appropriate: a general freedom of contract on the one hand, but a duty to give objective reasons for denial on the other hand. Exceptions must be certainly provided for emergency situations and alike. Law No. 46/2003 on Patient’s Rights does not provide a clear statement with this regard, either.

3. Licensing and Re-licensing of Family Doctors

Apart from the requirements of being a family medicine physician (or a medical doctor prior to 2005) and of complying with the rules of establishment of a family medicine practice (provided by the Ministry of Health (MoH)), there is no special licensing procedure for family medicine performer in Title III of Law No. 95. Instead, Title XII of Law No. 95 refers to all physicians in general. According to Art. 379(1) of Law No. 95 all physicians must have a medical qualification, be member of the College of Physicians of Romania, have the appropriate skills and comply with the worthiness standards stated in Title XII of Law No. 95. The licensing procedure is tied to the membership of the College of Physicians, since the certificate of membership is issued only after the physicians provide documents proving their qualification, a health certificate, their criminal record and an insurance policy for liabilities caused at work (See Art. 384(3) of Law No. 95).

Further, the physicians are approved annually by the College of Physicians. The procedure is based on mistakes in work recorded by the liability insurance.

II. Legal Status of Family Medicine Practices

Primary Care is provided either in family medicine offices (see Art. 66 of Law No. 95) or in individual or associated practice offices (see Art. 67 of Law No. 95). The organisational forms of FM practices are regulated in G.O. no 124/1998.

1. Establishment and Financing

The establishment of a new family medicine practice is subject to rules approved by the Romanian Ministry of Health (MoH) (see Art. 69(1) of Law No. 95). The same rules also regulate the conditions for the accreditation of medicine outlets within a family medicine practice (see Art. 70(2) of Law No. 95).

a) The Right to Establish a Practice without Family Medicine Specialisation

According to Art. 64(3) of Law No. 95, general practitioners without a family medicine

specialisation who, at the date of Romania's accession to the European Union, provided Primary Care are allowed to carry on their activity under the same conditions. Art. 65 of Law No. 95 governs that such general practitioners will be provided with special training in family medicine. It is unclear, however, whether this will be an obligatory or a voluntary training. The wording seems to indicate an option rather than an obligation. However, presumably it will be in the General Practitioner's interest to complete this training. Otherwise, the law prescribes a charge diminishment of 10% (see Art. 1(2)(d) of Annex 2 of Order No. 864/538). It remains to be seen, whether a 10% increase is a sufficient stimulation in practice. Besides, all graduates of medicine prior to 2005 are allowed to exercise the profession of the family doctor and can therefore establish a new family medicine practice. The Art. 65 of Law No. 95 applies in this situation, related to general practitioners, without specialisation in family medicine.

b) Patient Lists

Art. 23(3), (5), (6) of the Government Decision No. 1389/2010 constitute an obstacle to the establishment of a family medicine practice. In order to contract with a health insurance House~~,~~ the family medicine practice must provide a list with a minimum number of patients. The minimum number of patients for urban areas is 1,000. The minimum numbers in other areas of Romania are determined by a panel (organised at county level) consisting of representatives of HIH, public health departments, colleges of physicians, professional association of FDs , based on criteria approved by Order of minister of Health and of NHIH`s president.- see art. 23 (3) Govt.Dec 1389~~.~~. If existing family medicine practices are not able to meet this requirement for six months in a row, the contract with the health insurance can be terminated.

These provisions are suitable to avoid a strong concentration of medicine practices in one particular area. On the other hand, a balance must be found to ensure appropriate family medicine coverage. In either way, the influence of the National Health Insurance House in this respect is rather problematic. For the purpose of objectivity, such decisions are better met by independent physician associations (in Romania the College of Physicians) in cooperation with the local authorities.

c) Scope of Services

Art. 74 of Law No. 95 guarantees the freedom of profession of the family medicine performer stating that a family medicine practice may provide not only the essential, but also extended and additional medical services on a voluntary basis. This is an important source of income for a family medicine office.

d) Sources of Income

The permitted sources of income of a family medicine practice are stated in Art. 80 of Law No. 95. Rather problematic is the source of donations and sponsorships. The indefinite wording is potentially open for wide interpretation and may also include promotional gifts and offers by the pharmaceutical industry, which may influence the prescription behaviour of family medicine staff. The same source of income is also stated in Art. 7(c) of the Government Ordinance No. 124/1998. To avoid the potential of undesired influence of donors and sponsors, there must be exact legal conditions and limitations of sponsorships of family medicine practices by the pharmaceutical industry. At the same time, such rules should not hinder the industry in supporting family

medicine, especially in rural areas.

2. Ownership of the Practice and the Premises

As far as ownership in the field of family medicine is concerned, two different objects of ownership must be distinguished. First, there is ownership of the family medicine practice. The owner of the practice is the family doctor (see Art. 68 of Law No. 95). The practice may be taken over by another practitioner in accordance with Art. 69(3) of Law No. 95. Secondly, there is ownership of the premises of the family medicine practice. Naturally, the owner of the practice must not be the owner of the premises, the latter can be rented. For this purpose, local authorities may provide facilities in accordance with law (see Art. 69-1 of Law No. 95). In this context, Art. 10 of Law 215 on Local Public Administration empowers the local public authorities to manage and dispose (sell, rent) on the public or private property of communes, towns, cities and counties, in accordance with the local autonomy principle.

This provision certainly raises competition law and public procurement law issues, if there are several potential competitors within a local area. It is assumed that the notation “in accordance with law” refers to all these issues. If this is not the case, an express provision as to the relation with the relevant competition rules and public procurement law should be added. The same applies to Art. 14 of the Government Ordinance No. 124/1998, which allows the local authorities to convey premises for free or on a basis of a rental or sales contract.

III. The 24/7 Duty by Family Doctors

The provision of permanent Primary Care is ensured by Law No. 263 on Ensuring Continuity of Primary Care through Permanence Centres and by Order No. 697/112. The permanence centres are responsible for Primary Care provision on working days between 3 p.m. and 8 p.m. (see Art. 5(2) of Order No. 697/112). On Saturdays, Sundays and public holidays, the permanence centres are providing Primary Care 24 hours per day (see Art. 5(4) of Order No. 697/112).

The composition of permanence centres is governed by Art. 8(1) of Law No. 263 and Art. 18(1) of the Annex of Order No. 697/112. Thereby, the Order deviates from the Law, allowing a minimum of five doctors and nurses, whereas Law No. 263 prescribes a minimum of seven doctors and nurses. Thus, there is an issue of incompatibility of secondary with the primary legislation. Moreover, the doctors working in the permanence centres are the same persons, who run a family medicine practice until 3 p.m.

Accordingly, neither law provides for a 24/7 duty by family medicine practices, which is, in the end, a problematic territorial centralisation of Primary Care In urban areas with a comprehensive structure of family medicine practices, there is no need to take over the Primary Care service as early as 3 p.m., if there are enough family medicine practices to share the 24/7 service. In rural areas, the take-over by permanence centres from 3 p.m. onwards constitutes an inappropriate and unreasonable barrier to Primary Care access for citizens in those rural areas, since a permanence centre requires a minimum of seven doctors. This means that such permanence centres will be usually far away from rural areas. Therefore, the aim of a permanent Primary Care provision in rural

areas is better achieved by establishing a 24/7 duty for local family medicine practices, where possible. The issue of Primary Care provision in rural areas is dealt with in detail in the following chapter.

The permanence centres are funded through transfers from MoH`s budget to NHIF (see of Order No. 697/112).

IV. Legal Framework of Family Medicine in Rural Areas

Art. 81-1 of Law No. 95, Art. 3 of Law No. 263 and Order No. 163/93 contain special regulations in the Romanian health law which are meant to support the provision with Primary Care in rural areas.

1. Support and Incentives

Art. 81[1] of Law No. 95 regulates that infrastructure in rural areas may be financed through the state budget. It can be doubted that this provision guarantees sufficient Primary Care support in the rural areas, as it is of non-obligatory character.

Further, according to Art 69[1] of Law No. 95, local authorities may provide facilities and incentives for the establishment of family medicine practices. However, again this is a non-obligatory provision. In addition, it is questionable whether local authorities are capable of providing potential family doctors with facilities and incentives. As far as premises are concerned, local authorities of rural areas might have appropriate resources. The provision of all other aids beyond that is problematic. The legal issue here is the transfer of the burden of costs for Primary Care to local authorities. This transfer constitutes an impossible task for local authorities of rural areas in particular. The struggle to offer an appropriate Primary Care service in a rural area is directly connected with the lack of finances in this area, which cannot be solved by imposing even more financial burdens on the local authorities. Thus, the incentives for the establishment of new family medicine practices in rural areas must be financed by the state budget. Nevertheless, Art. 81[1] (1), (2) of Law No. 95 allows such a transfer. This constitutes a substantial obstacle for ensuring sufficient Primary Care in rural areas. Although, such shift is not an unusual instrument of the allocation of state competences and duties, the decision to shift should be based on pragmatic considerations taking into account the financial capacities of the local authorities.

2. Permanence Centres in Rural Areas

Art. 3 of Law No. 263 governs that permanence centres must be established in remote or inaccessible locations or in urban or rural areas. However, there is the requirement of at least seven doctors in a permanence centre (see Art. 8(1) of Law No. 263), which will make it rather difficult in practice to ensure permanent Primary Care in rural areas. It is therefore recommended to abolish this requirement at least as far as permanence centres in rural areas are concerned. More generally, it is questionable whether the amount of seven doctors is based on any reasonable considerations.

Further, to get permanent Primary Care for citizens of a rural area means inevitably to break longer distances than in urban areas, partially through inaccessible roads. The provision of permanent Primary Care by permanence centres, and in particular the

concentration of at least seven doctors at one single point, makes the distances even longer. It is therefore suggested to extend the service hours of local family medicine offices in general and for rural family medicine practices in particular. According to Order No. 864/538, family medicine offices serve for 35 hours per week. An extension of up to 48 hours per week would generate over hundred hours of additional Primary Care services per month with the advantage of being on site.

3. Financial Obstacles

There are several financial issues, which a family medicine practice in a rural area may face. First, Law No. 215/2001 on Local Public Administration empowers the local council to decide on the granting of bonuses and other incentives to medical personnel. Again, it must be ensured that this is not simply a transfer of financial burdens to local authorities. Otherwise, the grant of bonuses and incentives for medical personnel in rural areas will be very unlikely to happen.

Secondly, the source of income in a rural medical practice will be usually reduced to payments for basic services, which is the primary need of citizens in rural areas. However, one part of the practice's income is generated through specialised and additional care as well. This loss should be compensated in order to avoid insolvencies of existent and future practices. The legal framework of Romanian health care does not offer a concrete instrument in this respect. The National Health Programme (governed in Title II of Law No. 95) does not provide any concrete instruments fostering rural medicine practices in particular. While urban areas may benefit from a competitive market, the provision of Primary Care in rural areas needs more state support by concrete measures.

Thirdly, Annex of Order No. 163 delivers a point system, which is the basis for billing Primary Care services in remote areas. Generally, it provides for an appropriate system to take into account the disadvantages of working in rural areas. However, the list of practices to which these benefits apply is revised by a panel of representatives of health insurance houses (see Section II.3 of the Annex of Order No. 163/93). Apart from possible conflict of interest issues (should health insurance houses determine, how they are billed?), the revision of beneficiaries and the revaluation of the benefits whenever it appears to be appropriate to the panel, does not offer legal certainty for potential family medicine providers.

Finally, there is the obligatory liability insurance against mistakes at work. If the insurance premium is the same as for practitioners in urban areas, this would constitute a further financial burden, in addition to those stated above, for rural practitioners. A possible incentive for rural practitioners would be the coverage of liability for mistakes at work by a state fund.

4. Legal Obstacles to Drugs Provision in Rural Areas

There are obstacles to drugs provision on rural areas in law applicable to both rural and urban areas, related to restricting family physicians to be involved in provision of medicines to population. Since a rural family medicine office may be the only competent place within an area, it is reasonable to allow them the operation of a medicine outlet. At the same time, such an outlet of medicine is a possible way of compensating the

income losses due to the circumstances stated above.

V. Enforcement of Gatekeeping

The function of family medicine offices as gatekeepers is ensured by Art. 61(1) and Art. 63(a) of Law No. 95. Accordingly, family medicine offices co-ordinate and integrate health care and are the first point of contact for the patients. However, it is more than questionable whether these provisions keep patients from visiting clinics and hospitals directly, as they do not constitute any obligation or duty of the patients.

If, however, the gate keeping by family medicine practices functions in practice, there is potential for increasing this effect by extending the working hours of family medicine offices, as suggested above (see Section B.IV.2 above).

ANNEX 2: The Primary Care Development Strategy in Romania, 2012-2020

PHASE II

The Primary Care Development Strategy in Romania, 2012-2020

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January, 2012

CHAPTER 1. INTRODUCTION

1.1. Aim of the Primary Care Strategy

The Primary Care Development Strategy for Romania, 2012-2020 is a medium term strategic document which defines key principles, goals and objectives of the primary care policy, with emphasis on primary care in rural and remote settings, and is oriented towards the improvement of the health status of the population of Romania.

The primary purpose of this strategy is to improve access to quality primary care services in rural and remote areas of Romania. As many aspects of primary care are common to both rural and urban primary care, and since this strategy has been developed in a context where there is no overall family medicine strategy available, it covers family medicine/primary care issues in general, and does not limit itself to exclusive aspects of rural primary care.

It is envisioned that the strategy will help Romania to create and maintain an enabling environment leading to an improved health status of its citizens, while focusing on the unique strengths and opportunities as well as the specific challenges of primary care service organization and delivery, and exploring possibilities for progress.

The strategy builds on the international best practice of general and rural primary care development as well as on insights of the local context. Within primary care it is focused on family medicine. Thus, the strategy aims to maintain and strengthen the position of family medicine in the Romanian health care system. It aims at improving the effectiveness, efficiency and quality of family medicine in general, and suggests ways for addressing existing challenges nationally and locally, with particular emphasis on rural primary care.

1.2. Time frame

This is a strategy for the next nine years (2012-2020). That will give time to introduce new or improved primary care service organization and delivery patterns, together with incentives for stimulating primary care professionals to work in remote settings. It also enables to establish the monitoring and evaluation system that is necessary to regularly measure improvement from the baseline position of primary care service delivery and utilization.

The strategy suggests to review the strategic priorities at mid-term (i.e. in 2016), to examine the progress made, and to update the strategic priorities/directions in the light of the changed context if necessary.

1.3. Definitions

Primary care is the first level contact with people taking action to improve health in a community. In a system with a gatekeeper, all initial (non-emergency) consultations with doctors, nurses or other health staff are termed primary care as opposed to secondary health care or referral services (World Organisation of Family Doctors cited in the Royal College of General Practitioners roadmap, 2007).

Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most in need, maximises community and individual self-reliance and participation, and involves collaboration with other sectors. It includes the following: health promotion; illness prevention; care of the sick; advocacy; and community

development (Australian Primary Health Care Research Institute, Australian National University, 2010).

Family Medicine is the medical specialty which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioural sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity (American Association of Family Physicians, 2010).

General practice is the central discipline of medicine around which medical and allied health disciplines are arranged to form a cooperative team for the benefit of the individual, the family and the community (The Role of the General Practitioner/Family Physician in Health Care Systems: A Statement from WONCA, 1991).

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease, providing cure, care, or palliation and promoting patient empowerment and self-management (the European Definition of General Practice/Family Medicine, WONCA 2011).

Quality healthcare in family medicine is the achievement of optimal physical and mental health through accessible, safe, cost-effective care that is based on best evidence, responsive to the needs and preferences of patients and populations, and respectful of patients' families, personal values, and beliefs (American Association of Family Physicians, 2011).

Public health is the science and art of preventing diseases, prolonging life and promoting health through organized efforts of society (Acheson, 1988).

Incentives are all the rewards and punishments that providers face as a consequence of the organisations in which they work, the institutions under which they operate and the specific interventions they provide (WHO 2000). Incentives are also defined as an available means applied with the intention to influence the willingness of physicians and nurses to exert and maintain an effort towards attaining organizational goals (quoted in Global Health Workforce Alliance, 2008).

Continuity of care is the ability of relevant services to offer interventions that either are coherent over the short term - both within and among teams (cross-sectional continuity) - or as an uninterrupted series of contacts over the long term (longitudinal continuity) (Health Evidence Network, 2008).

Continuous professional development is a range of learning activities through which health professionals maintain and develop their knowledge and skills throughout their career to ensure that they retain their capacity to practice safely, effectively and legally within their evolving scope of practice (Health Professionals Council, UK, 2011).

Health promotion is the process of enabling people to increase control over, and to improve their health (Ottawa Charter for Health Promotion, WHO, Geneva, 1986).

For the purpose of this Primary Care Development Strategy, family medicine and general practice are considered as synonyms (as they are in EU directives). Family doctors and general practitioners are also considered as synonyms. Primary care also includes other types of health services (for example dentistry) but this strategy focuses on family medicine, with some attention being paid to pharmacies and community nursing. The strategy follows the definition of primary care rather than the more complex definition of primary health care.

1.4. Primary care philosophy and principles

The Primary Care Development Strategy 2012-2020 is based on the following philosophy and key principles:

* Treating health as a fundamental human right and sound social investment.
* Promoting a holistic understanding of health as well-being rather than absence of disease.
* Achieving equity and social justice in health care, and reduction of health inequalities.
* Achieving joint social responsibility of public and private actors in attaining the best health outcomes.
* Promoting person-centred care which focuses on the needs of the individual and works in partnership with individuals and families to support their needs.
* Achieving coordination and comprehensiveness of care; continuous quality improvement; and adoption and implementation of professional and ethical standards.
* Promoting evidence-based primary care policy and decision making.

CHAPTER 2. THE NATIONAL CONTEXT

2.1. Accomplishments of Romanian primary care

Primary care has developed considerably in Romania over the past 20 years, despite the changing context with socio-economic transitions, modified demographic and epidemiological trends, and rapidly altering policies for the organisation of health financing and services delivery.

Patients are granted a free but compulsory choice of a provider. Nearly the whole population is covered by primary care services. Family doctors were assigned a gate keeping role.

The profession of family doctor was established, with clearly defined entitlements for family doctors. The split between primary care for children and adults was abolished. In the transition period, different pathways were available to primary care physicians to become family doctors: additional training courses, examinations and residency programmes. After the transition period, only residency programmes will lead to a licence as family doctor.

Family doctors were transformed into independent providers through the Social Health Insurance Law (Law 145/1997). They became directly contracted by the district (judet) offices of the National Health Insurance House (CNAS). The majority of family doctors became self-employed, having rights to earn additional income from private practice.

A three-year postgraduate training programme in family medicine was introduced. Fifteen months of this programme is spent in a primary care practice. The number of new family medicine residents per year ranges from 500 (2008, 2010) to 858 (2009).

The National Health Insurance House of Romania had contracted 11,379 family doctors by June 30, 2010. Among them 5,147 (45.2%) were family doctors who had undertaken additional exams to attain the highest qualification (“medici primari”); 4,565 (40.1%) were family doctors with 3 years of residency or equivalent (“medici specialisti”), and 1,667 (14.6%) were doctors without specialisation or residency in family medicine (“medici”) (CNAS/MoH, 2010).

In 2007 the competencies and responsibilities of family doctors were reviewed and enhanced which led to increased outputs by providing more consultations and home visits, taking on more registered patients and by providing a better coverage of emergency care (draft WHO/NIVEL/CPSS report, 2011).

Standards and requirements for Continuous Professional Development (CPD) were developed and enforced. CPD regulations oblige family physicians to meet requirements set by the Romanian College of Physicians to keep their license. Nearly all family doctors learned to work with computers for the medical records of their patients and for searching of information.

Financial incentives were linked to the provider competencies, allowing family doctors and nurses to take an exam after five years of practice, to obtain a certificate proving the highest professional qualification in the discipline. Physicians holding a title of “primariat” and nurses with the title of “principal” became entitled to receive a higher income (The National Society of Family Medicine, 2011).

Primary health care funding has increased during 2004-2008 from 5.1% of total health insurance expenditure in 2004 to 8.8% in 2008. However, this was followed by a decrease in primary care spending in 2009 and again in 2010.
A complex service purchasing mechanism, comprising an age-adjusted capitation allowance, fees for services and bonuses related to professional rank, replaced payment through a system of fixed salaries (Order No. 163/93/2008). The new payment mechanisms also include bonuses for rural family physicians as incentives to increase access in underserved areas.

A high level of patient satisfaction has been achieved: the great majority of patients trust and respect their family physicians (OPM, 2011). Family doctors' work is particularly valued in remote settings (WHO 2011; OPM 2011, National School of Public Health 2008).

2.2. Challenges to Romanian primary care

2.2.1. Policy issues

No overall long-term strategy for family medicine exists which would present a long-term planning of human resources, quality assurance measures, the profile (knowledge and skills) of family doctors and family health nurses, service delivery model and practice patterns, interdisciplinary co-operation, and financing and service purchasing aspects.

At present, the capacity of the Ministry of Health for primary care policy development and implementation appears to be insufficient. Without additional support it will be nearly impossible for the Ministry to fulfil its role in the implementation of this Primary Care Development Strategy. The role of professional associations in supporting the Ministry of Health in developing and implementing family medicine policy requires strengthening. In fact, developing and implementing family medicine policy requires the cooperation of all stakeholders: Ministry of Health, professional associations of family doctors and nurses, CNAS, Romanian College of Physicians (CMR), Order of Nurses, Midwives and Medical Assistants in Romania (OAMGMAMR), medical faculties and nursing schools.

2.2.2. Financing issues

Total public health expenditure in Romania is less than 4% of GDP. The percentage of total CNAS funds devoted to primary care (6.8% in 2010) is perceived insufficient, especially in view of the scarcity of total health financing.

The payment method for Romanian family medicine has shifted in recent years, from mostly by capitation to 50% by fee-for-service. At present, the number of consultations and the number of home visits per day are limited (by ceilings). Therefore, current payment methods do not generate extra income for primary care providers, but increase the administrative burden for accountability and reporting.

Present capitation differentials between age groups do not reflect the demand for services by young children, male and female adults, and the elderly.

There are discrepancies between the number of insured persons on the lists of doctors and those that are recognised as such by the CNAS due to the complexity of the registry to which various agencies contribute (e.g. for students and pensioners).

The system of co-payments for drugs prescribed by family doctors is complicated for doctors and patients. No co-payments are required for drugs from lists C1, C2 and C3, but most prescriptions are for drugs from lists A and B. The level of subsidy is based on the cheapest

variant from a group of drugs, although clinical guidelines or individual doctors sometimes prescribe another variant. Pharmacies may have a financial interest not to sell the cheapest variant leading to higher co-payments by the patients. Thus, with an asymmetry of information and absence of choice, the patient suffers.

2.2.3. Service delivery issues

Organisation of primary care

The referral rates are 9% for rural family doctors and 12% for urban family doctors, which is at the high end of the spectrum in international comparison. Many referrals are caused by the regulatory obligations to refer patients to specialists for obtaining permission for prescription of specific drugs.

Family medicine practices usually do not provide services outside office hours. Existing 172 "permanent centres" where patients can consult family doctors outside office hours are not fully utilized in urban areas because of patients' preference to approach hospitals. In rural areas permanent centres cannot always resolve the access/availability issues. Thus, there is room for the expansion of primary care services available to the population both in time and in scope.

Family doctors are burdened with extensive bureaucracy and paperwork, especially for CNAS reimbursement. Some forms of registration are unnecessarily duplicated (electronically and on paper). Regulations and administrative rules change frequently, distracting doctors from their work.

Quality of services

Residency programmes in family medicine and vocational training of family doctors and family health nurses still have a strong academic and hospital flavour, and do not prepare doctors adequately for rural practice.

The knowledge and skills of practice nurses need upgrading in order to give them a more responsible role in family medicine. At the moment they are mostly employed in an auxiliary role, especially for bureaucratic procedures.

There are not sufficient clinical guidelines for family doctors and those that exist are often not used by family doctors. Guidelines for family health nurses do not exist at all. The division of responsibilities for managing certain diseases and conditions (for example, diabetes) between family doctors and internists has not yet crystallised.

The data available in CNAS on provided services, prescriptions and referrals are not used for quality improvement. Feed-back of the performance of a family medicine practice compared to national or regional averages is not functional.

2.2.4. Primary care resource issues

Human resources

At present, the number of CNAS-contracted family doctors in Romania (11,379 on 30 June 2010) is sufficient for the national coverage of a population of 21 million. However, unequal distribution of primary care providers nationally creates shortages in some remote areas.

There are very poor (if at all) staff motivation mechanisms in place.

Many family doctors will retire in the coming years, based on the fact that the average age of family doctors is 50. Some family doctors are emigrating to countries of the European Union.

In urban areas some former paediatricians and practitioners for adult persons still have relatively more children or adult persons on their lists than can be expected from the average age distribution in the population, but this is not seen as a major problem.

There is a new profession in the field: community assistants, also known as community nurses, employed by local authorities. This separate management structure could complicate coordination with family medicine practices. Family doctors consider that community assistants could fulfil a useful role, if appropriately structured in primary care delivery.

Physical infrastructure

The poor condition of many premises for family medicine practices is a main concern of primary care providers. The family doctors usually do not own the premises and therefore cannot invest in improvement. The owners - usually local authorities - apparently do not see such improvement as a priority, and often take a passive role in supporting primary care practice.

Even if the family doctors would become the owners of the premises, for example by an offer of a symbolic price in return for guaranteed continuation of services, present low incomes would require bank loans that are difficult to obtain.

Though the basic equipment is usually available, the purchase of new equipment is often difficult in a view of the limited practice revenues. In addition, family practitioners are missing equipment which is not part of the basic primary care toolkit.

2.2.5. Access/availability issues in remote settings

A considerable minority of the rural population is not registered with a family medicine doctor and with the CNAS. Thus, access of these people to family medicine and pharmaceuticals is an issue.

Access to pharmaceuticals is an issue even for insured patients in remote settings. By the Health Law (95/2006 art. 383 and 788) and the Pharmacy Law (266/2008 art. 2), family doctors are not allowed to provide drugs. In many places there are no rural pharmacies. Giving a prescription to a rural patient who then has to travel to a town to obtain the drugs is not acceptable. Presently some ideas about fundholding for primary care drugs are in circulation. However, a decision on allowing the doctors in remote areas to have limited pharmaceutical stocks is not yet taken.

The permanent centres are considered a solution for increasing the availability of services in underserved rural areas. The issue is that permanent centres in rural areas are only possible when a central location can be found, where the distances to outlying villages are not too long, and where a number of doctors can rotate for duties. This is not always possible in remote settings. In addition, doctors are not always interested in participating in permanent centres because conditions are not yet good and remuneration is poor. Instead of working from a “permanent centre” doctors can also rotate duties working from their own practices.

Although most rural family doctors can provide some laboratory tests within their own practice they say they have insufficient access to more sophisticated laboratory services (54%) and X-ray services (52%).

In summary, there are policy, financing, service organization and delivery, and human and physical resource issues that need to be resolved together with the issues of access and availability of services in remote settings. These issues are drivers for change, forming the priority directions of this Primary Care Development Strategy.

CHAPTER 3 - GOAL AND OBJECTIVES

3.1. Definitions

This strategy for Romanian family medicine presents an overall goal, general objectives and specific objectives.

An overall goal is an expression of what one wants to achieve in a specified period of time (2012-2020) at a high level of abstraction. It does not prescribe objectives and activities, and it is not quantified. It serves as a framework for the formulation of general objectives at an intermediate level of abstraction, and for the development and implementation of specific objectives and very specific and quantified activities.

A general objective is a result that one wants to achieve during the period for which the strategy is valid, without quantification, without specifying activities that should produce those results, without naming organisations that are responsible for producing the results, and without a precise timetable.

The five general objectives of this strategy cover recognisable aspects of family medicine. They are obviously inter-related which means that the division into five general objectives is arbitrary to some extent.

Specific objectives are self-imposed tasks with concrete results that must be achieved by the implementation of precisely described activities by specific actors at precise moments in time. Usually they can be fitted under one of the general objectives but occasionally they belong to two or even more general objectives. For example: the training of family medicine professionals is part of human resource development (general objective 1) but it also belongs to quality improvement (general objective 3). Therefore, some overlap or duplication is unavoidable but this is not problematic. Linkage is indicated in the list of specific objectives below.

The number of specific objectives must be manageable, in other words: the longer the list of specific objectives the fewer chances there are that they will be achieved. A strategy must consist of priorities; not everything that may be desirable should be included. Approximately twenty properly formulated specific objectives should be acceptable for a sub-sector of the Romanian health care system such as family medicine.

Each specific objective consists of a number of activities that can be of a policy-making, legal, technical, organisational, financial or educational nature:

- Policy-making activities (e.g. meetings by the Family Medicine Consultative Committee)
- Legal activities (e.g. change in pharmaceutical law or in ownership of premises)
- Technical activities (e.g. improvement of physical infrastructure)

- Organisational activities (e.g. concerning 7x24 duty or improved gatekeeping)
- Financial activities (e.g. concerning payment method, bureaucracy, incentives)
- Educational activities (concerning undergraduate training, residency, training of nurses, continuous professional development (CPD)).

Activities foreseen for the implementation of this Primary Care Development Strategy are described in the Action Plan. Progress in achieving the specific objectives is measured by a Monitoring & Evaluation Plan that uses a set of indicators, for example: access to 7x24 family medicine services should be available to x% of the Romanian population in the year 2015.

3.2. Overview of objectives

The **overall goal of this strategy** **is to strengthen the position of family medicine in the Romanian health care system, to increase the effectiveness, efficiency and quality of family medicine, and to address the challenges to rural family medicine.**

An overview of the general and specific objectives is presented below.

General objective 1: Ensure proper planning of human resources for family medicine.

1.1. Ensure sufficient inflow of family medicine residents and nursing students so that a proper balance of inflow and outflow of family medicine professionals guarantees adequate staffing by the year 2017 and beyond.
1.2. Enable young doctors to start a family medicine practice.

General objective 2: Ensure a sustainable, efficient and performance-promoting payment method for family medicine practices.

2.1. Optimise the division between capitation and fee-for-service payments.
2.2. Increase the budget for family medicine linked to a reduced referral rate.
2.3. Introduce more appropriate capitation scales.
2.4. Introduce performance criteria into the framework contract.
2.5. Reduce bureaucracy in family medicine through joint effort by CNAS and SNMF.
2.6. Decrease the number of uninsured citizens by a registration drive.

General objective 3: Improve the quality of family medicine services.

3.1. Produce and use clinical guidelines for family medicine.
3.2. Increase family medicine content in undergraduate and residency training (and nursing).
3.3. Improve quality of Continuous Professional Development.
3.4. Ensure regular feedback on performance data to family medicine practices.

General objective 4: Improve the organisational capacity in family medicine

4.1. Strengthen the gate keeping and referral system.
4.2. Increase the role and competencies of the professional associations.
4.3. Gradually organise the availability of family medicine services for urgent cases outside office hours (24 hours per day and 7 days per week) so that such services cover 90% of the Romanian population in 2020.
4.4. Make better use of the Family Medicine Consultative Committee in development, implementation and evaluation of policy.
4.5. Link community nurses to family medicine practices.
4.6. Facilitate transfer of ownership of premises to family doctors.

General objective 5: Improve the accessibility of family medicine in rural and remote areas.

5.1. Stimulate involvement of local authorities in underserved areas.
5.2. Promote family medicine study by rural students (e.g. scholarships).
5.3. Allow pharmaceutical points for family doctors in areas without pharmacy.
5.4. Introduce and monitor financial and non-financial incentives for rural practice.
5.5. Organise rural clerkships for undergraduate and residency students.
5.6. Organise the provision of basic lab tests by family doctors in rural areas.

3.3. Specific objectives of the Primary Care Development Strategy and related activities

General objective 1. Ensure proper planning of human resources for family medicine

Specific objective 1.1

Ensure sufficient inflow of family medicine residents and nursing students so that a proper balance of inflow and outflow of family medicine professionals guarantees adequate staffing by the year 2017 and beyond.

***Activities*:**

- Produce annual statistics of inflow and outflow of family doctors by a) completing the residency, b) being licensed and re-licensed, c) entering and terminating CNAS contracts, d) (pending) retirement, e) immigration, f) emigration, g) other reasons for leaving the profession.

- Organise an annual survey among 5th year medical students to assess their interest in becoming family doctors.

- Produce annual statistics on the numbers of family medicine residents in their 1st, 2nd and 3rd year, including reasons for delay or termination.

- Produce regular trends and forecasts of the availability of family doctors and nurses. If future shortages or surpluses are foreseen, the government, the universities and the nursing schools should propose actions to increase or decrease inflow or outflow.

- Produce a policy document on the education and position of nurses in family medicine practices in 2012, after which family health nurses can be included in the forecasting and planning of human resources.

***Explanation*:**

At the moment there are no overall major shortages or surpluses of family medicine professionals, although there are regional shortages in some remote areas. As it lasts at least 9 years to train a family doctor, systematic long-term forecasting and planning are essential to avoid future shortages but also wasteful surpluses. At present there is too much variation in the annual intake of family medicine residents.
The government, regulatory bodies (CMR and OAMGMAMR), educational institutions and professional associations should cooperate in this planning exercise and agree on targets.

Specific objective 1.2

Enable young doctors to start a family medicine practice.

***Activities*:**

- Explore the feasibility of guaranteeing bank loans by local authorities.
- Explore the feasibility of providing soft loans and/or free premises by local authorities.
- Explore the feasibility of hiring young family doctors as salaried staff in group practices or practices of family doctors who are near retirement.
- Give the opportunity to third-year family medicine residents to provide official family medicine services in permanent centres up to the level of their competencies, under the guidance of the family medicine trainer/supervisor.

***Explanation*:**

The main problem for starting family doctors is to find the funds for setting up a practice: they need premises, equipment and auxiliary staff. Banks are rather unwilling to provide loans, not because they fear that the practice will not be viable but because doctors will have difficulty repaying the loans in the short term due to their low revenues. Attracting young family doctors is especially important in areas where there is a shortage, i.e. in some rural and remote areas. An additional challenge is that there is no overview of practices that will become available in the near future or of areas where there is room for the free establishment of a new practice.

General objective 2. Ensure a sustainable, efficient and performance-promoting payment method for family medicine practices

Specific objective 2.1.

Optimise the division between capitation and fee-for-service payments.

***Activities*:**

- Analyse the rationality of the present fee-for-service payment in the CNAS budget for family medicine.
- Define and calculate in 2012 which services can be considered additional to regular family medicine practice and can be afforded by the CNAS within the remaining fee-for-service payment system. For such services, agreed clinical guidelines should be available. If the guideline is not available is must be made first (see specific objective 3.1). Decide on the type of fee to be paid: for each service or for each case.
- If applicable, introduce a new division between capitation and fee-for-service from 2013.

- Carefully monitor if fee-based payments develop according to projections, with feedback to the family practices and corrections if necessary.

***Explanation*:**

Family medicine is comprehensive and continuous care for a circumscribed population. It is therefore problematic to divide family medicine into "normal" or "standard" family medicine for which the purchaser can pay by the capitation method, and specific services that should be paid separately (with fee-for-service or a case-based system). However, based on an accepted profile of family medicine, one can specify some services that do not belong to family medicine, at least not at this moment in time or in this country. For example, if immunisation is normally provided by public health services, a purchaser can pay a family doctor who immunises the children on his/her list, for efficiency reasons, for better coordination of care by the family doctor, and for the convenience of the children and their parents. This can also be valid for other official prevention programmes. If diabetes care is normally provided by internists, the purchaser can pay the family doctor for (parts of) diabetes care if the family doctor can prove that he or she is able to provide it (for instance by having followed appropriate CPD courses), again for efficiency reasons, for better coordination of care by the family doctor, and for the convenience of the patients. In such cases, the interest of the purchaser is in better coordinated care for the client for a lower price. Therefore the purchaser can pay fees for such additional services. If the purchaser is afraid of the open-ended nature of a fee-for-service system, he can pay a fee per case and period. In the example of diabetes: the purchaser can pay the family doctor a fixed amount for taking care of one patient with diabetes for one year, according to an agreed clinical guideline.

Professionals in many countries prefer fee-for-service because it allows them to increase their income by working harder although they do not like the increased administration that is its consequence. Fee-for-service is often seen as conducive to quality improvement although evidence is weak. Fee-for-service is an open-ended payment method and if the purchasing agency feels obliged to put a maximum to the number of services a family practice is allowed to perform, the whole purpose of fee-for-service is undermined. By reducing the fee-for-service proportion in the overall payment, purchaser's risk is reduced, fees can be better targeted to services that are indeed additional to basic family medicine, and administrative workload for family doctors and purchaser is reduced.

In case of unexpected over-production of services and budget overruns, the volume of services should not be capped, but the fees can be reduced or some services can revert to the capitation part of the payment. Feedback to over-producing family doctors can also be helpful. For some services (such as immunisation or antenatal care) it is not really possible to over-produce if guidelines are followed.

Specific objective 2.2.

Increase the budget for family medicine linked to a reduced referral rate.

***Activities*:**

- In 2012, the CNAS should produce an overview of the referral rates and types of referral from family medicine practices to outpatient and inpatient secondary and tertiary care in 2011, including the presentation of variation between family medicine practices.

- For 2013 and following years, the CNAS and the National Family Medicine Society (SNMF) should agree on a method that reduces unnecessary referrals - especially to inpatient care - and adds the saved funds to the budget for family medicine.

- From the beginning of 2013, all family medicine practices will receive annual overviews of their referrals, with comparison with national and regional averages (see specific objective 3.4).

***Explanation*:**

Referral rates depend on many factors, including the knowledge and skills of the doctor, the age distribution and level of morbidity in the population, cultural habits and geographical location. Bureaucratic rules can also increase referral rates, for example by requiring specialist approval for certain prescriptions. A too high rate exposes patients to useless and wasteful investigations, and a too low rate may reflect over-confidence on the part of the doctor. In Romania, the current referral rate is high in international comparison.
Specific objective 2.2 is linked to specific objective 4.1.

Specific objective 2.3.

Introduce more appropriate capitation scales.

***Activities*:**

- In 2012, the CNAS and the SNMF will agree on a revision of the levels of the capitation fees per age category and sex. The overall amount of capitation payment for an average patients' list can remain the same.

- From 2013, the CNAS will lift the cap on the number of clients for which a rural family doctor in an underserved area will receive capitation payment.

Explanation:

Capitation payment should be based on evidence of the demand for services by each part of the population, i.e. higher rates for young children and especially for elderly patients, and lower rates for adults. Such differentiation can be made on the basis of existing CNAS statistics, with help by the National Study Centre for Family Medicine (CNSMF). Small children and especially elderly persons make much more use of family medicine services than older children and adults. These differences are not sufficiently reflected in the current capitation fees, penalising family medicine practices with more than average small children and elderly on their lists. The purpose of this adaptation is not to channel more funds to family medicine but to spread existing funds more equitably.
In rural areas, it may be more efficient not to limit the number of clients for which a family doctor receives capitation payment from the CNAS (presently 2200).

Specific objective 2.4.

Introduce performance criteria into the framework contract.

***Activities*:**

- In 2012, the SNMF and the CNSMF should analyse the feasibility of introducing performance measurement in family medicine, making use of international experience.

- In 2012-2013, the CNAS and the SNMF should discuss the feasibility of introducing performance-based elements into the payment to family medicine practices, either as part of the fee-for-service payments or additionally.

- Gradual introduction of performance-based payment in 2013-2020 by the CNAS if feasibility has been demonstrated.

***Explanation*:**

The fee-for-service part of the contracts is already a performance element if designed properly. The agreement to more funding for reducing over-referral is another example of performance payment if designed properly. Capitation payment is yet another rough measure of quality because clients will register with a family medicine practice they appreciate. Measuring the quality of individual family medicine practices is notoriously difficult. Quality of care is an elusive concept unless simplified to patient satisfaction or adherence to official clinical guidelines.

Specific objective 2.5.

Reduce bureaucracy in family medicine through joint effort by CNAS and SNMF.

Activities:

- In 2012-2013, CNAS, SNMF, MOH and Ministry of Finance will produce a joint report on the feasibility of reducing bureaucracy in Romanian social health insurance administration.

- In 2012-2013, the Ministry of Health will analyse the requirements for family doctors to collect epidemiological and public health data, and prepare a revision if applicable.

- A system of reduced paper work for family medicine practices can be introduced from 2014. A sentinel network may be part of this system.

***Explanation*:**

Presently, Romanian family medicine practices spend a too large part of their working time on data collection and transmission, mostly in the framework of the CNAS contracts. There appears to be room to streamline this bureaucracy that is detrimental to the quality of the data and to the motivation to work in family medicine. A trial with sentinel stations has been performed in Romania and it should be analysed if a sentinel system can be introduced more widely.

Specific objective 2.6.

Decrease the number of uninsured citizens by a registration drive.

***Activities*:**

- The Government of Romania will intensify its efforts to register all citizens for social health insurance, with a gradual reduction of the number of uninsured between 2012 and 2020.

- The Ministry of Health will issue a guideline for family medicine practices on how to be paid by or for uninsured patients.

***Explanation*:**

The fact that a considerable number of citizens are not participating in the system of compulsory health insurance undermines confidence in the law and social solidarity. It also poses a dilemma for family medicine practices because they do not receive CNAS payment for such patients and they cannot charge them if they cannot afford to pay. The proportion of uninsured citizens appears to be higher in rural areas which add to the challenges doctors face in such areas.

General objective 3. Improve the quality of family medicine services

Specific objective 3.1

Produce and use clinical guidelines for family medicine.

***Activities*:**

- In 2012, the Ministry of Health, the CMR, the CNAS, the SNMF and the CNSMF will agree on which agency or group will be responsible for producing, accrediting, distributing and implementing clinical guidelines for family medicine and how it will be financed.

- The responsible agency will collect and evaluate existing guidelines from Romania and abroad, and decide on a production scheme for the period 2013-2020.

- From 2013, approved guidelines will be introduced into the curricula of all medical faculties in Romania and into accredited CPD courses.

- The Romanian Nursing Association (ANR) and the OAMGMAMR will analyse to what extent guidelines for family health nurses are needed, with help from the SNMF and the CNSMF.

***Explanation*:**

At present, clinical guidelines for family medicine are insufficiently available and used in Romania. Preventive and curative care in family medicine can be described in approximately 100 clinical guidelines. Models for such guidelines are available from many countries with well-organised family medicine. Family medicine guidelines should be made by family doctors, with assistance from clinical specialists if necessary. These guidelines cover family medicine only. Referral criteria must be included in the guidelines, but they should not include treatment at secondary and tertiary level. Producing guidelines is intensive work for which a specific organisation must be responsible and paid, although the workload can be decreased considerably by “borrowing” guidelines from other countries. Government has no role in developing guidelines except for public health activities such as immunisation

programmes. The CNAS can be involved in the production of guidelines but only insofar as cost-effectiveness arguments are needed, for example in the choice of pharmaceutical drugs. The CNAS can insist that family doctors adhere to their own guidelines, but it must be understood that family medicine is less easily codified in strict protocols than hospital medicine. Producing guidelines is one thing, distributing and using them another. Clinical guidelines must be used in the education of doctors and in their daily practice. They need to be updated regularly.

Specific objective 3.2

Increase family medicine content in undergraduate and residency training (and nursing).

Activities:

- In 2012, the joint departments of family medicine in medical faculties will propose to the Ministries of Education and Health a common curriculum for family medicine for undergraduate students, including field work.

- In 2012-2013, the joint departments of family medicine in medical faculties will propose a revision of the family medicine residency curriculum with more emphasis on primary and ambulatory care.

- During 2012-2020, the departments of family medicine will match the number of affiliated training practices for family medicine, including in rural areas, to the training needs of undergraduate students and family medicine residents.

- Before the end of 2013, the ANR will propose to the Ministries of Education and Health and to the Nursing Schools how and to what extent family medicine should be incorporated into the nursing curriculum and/or should be taught as an additional module.

***Explanation*:**

Departments of family medicine in Romanian medical faculties are still relatively weak in comparison with clinical medicine. All medical students should learn sufficiently about family medicine, even the majority who will become hospital specialists. Teachers should preferably be family doctors themselves.

At present, the family medicine residency curriculum is too much hospital-oriented. Most activities should take place in an outpatient, preferably family medicine setting, including a number of rural family medicine practices that are affiliated with a university department of family medicine. Affiliation means an official link, with the doctors trained as trainers (see also specific objective 5.5). In this way, such trainers could earn points for re-licensing.

There is no specific curriculum for nurses working in family medicine practices. In principle, most nursing teachers should be nurses themselves.

The revision of family medicine education for both physicians and nurses will benefit from the assistance by SNMF, CNSMF and ANR, and from international cooperation.

Specific objective 3.3

Improve quality of Continuous Professional Development.

***Activities*:**

- In 2012, the SNMF, the CNSMF and the CMR, in cooperation with the departments of family medicine of the medical faculties, will produce an overview and analysis of the available accredited CPD activities, with recommendations on how to fill gaps in the offer.

- In 2012, the SNMF, the CNSMF and the CMR will provide recommendations for improved accreditation of CPD activities and guidelines for payment for such activities, possibly including external contributions from the Ministry of Health, the CNAS or other agencies.

- A comprehensive programme of CPD for family doctors will gradually be rolled out during 2013-2020, including forms of distance learning.

- In 2012-2013, the ANR, the OAMGMAMR and the SNMF will analyse the needs and demands for CPD by family health nurses, and propose a CPD plan that can be developed in 2014-2015 and rolled out afterwards.

***Explanation*:**

Many possibilities for CPD have been established in Romania. Family doctors can collect points for re-licensing by successful attendance to accredited CPD courses and events. However, there is no comprehensive programme of CPD activities that is geared towards continuing professionalization in family medicine, including training based on approved clinical guidelines. Payment for CPD activities is often difficult for family doctors, possibly leading to too much influence for commercial sponsors of CPD events (pharmaceutical industry). Some CPD activities are available for nurses, but not specifically for nurses working in family medicine practices.

Specific objective 3.4

Ensure regular feedback on performance data to family medicine practices.

***Activities*:**

- In 2012, the CNAS, the SNMF and the CNSMF will agree on which data will be fed back to family doctors with regional or national comparison, and how this shall be done.

- In its annual reports, the CNAS will report on the feedback scheme, providing averages and variation in the activities of family medicine practices.

***Explanation*:**

The CNAS has a wealth of data on activities performed by family doctors, but there is no standard feedback to the doctors. One of the best and cheapest incentives for self-improvement is to compare your performance to the anonymised performance of your regional or national colleagues, with or without comment by the CNAS. Important information to be fed back to the doctors is that on prescription and referral (see specific objective 2.2).

General objective 4. Improve the organisational capacity in family medicine

Specific objective 4.1

Strengthen the gate keeping and referral system.

***Activities*:**

- The SNMF will advise family doctors on how to discuss the (lack of) need for referral with demanding patients.
- The CNAS will not reimburse clinical specialists and hospitals for treatment of patients without a referral letter from their family doctor except in emergencies.
- Self-referred patients will be made to understand that they have to bear all costs of treatment themselves.

***Explanation*:**

There are various methods to reduce or prevent unnecessary referrals, but there will always be some tension if family doctors compete for clients on their lists. Specific objective 2.2 describes a financial incentive for family doctors to reduce high referral rates. A non-financial incentive is the feedback on referrals that the family doctor should receive from the CNAS (specific objective 3.4). An obvious method to strengthen gate keeping is an improvement of the skills and knowledge of family doctors (see specific objectives 3.1 and 3.3). A 24/7 availability of family medicine also reduces unnecessary (self-)referrals (see specific objective 4.3). And then there should be dis-incentives for patients who ask for unnecessary referrals or who refer themselves.

Specific objective 4.2

Increase the role and competencies of the professional associations.

***Activities*:**

- In 2012, the SNMF will develop its own strategy for development, professionalization and funding.
- In 2012, the ANR will develop its own strategy for development, professionalization and funding, at least for family health nurses (presently called medical assistants).

***Explanation*:**

Professional associations are indispensable elements of strong family medicine by independent practices. They defend the interests of their members as a syndicate, but more in general they defend the interests of family medicine and the population it serves. They have an important role in promoting the quality and effectiveness of family medicine. Although largely carried by volunteers, they also need a professional bureau for

administrative and scientific tasks which needs funding. Scientific tasks such as the development of clinical guidelines can be carried out by the associations themselves or delegated to separate agencies such as the CNSMF. The main associations in Romanian family medicine are the SNMF and the ANR. Especially the latter needs extensive professionalization.

Specific objective 4.3

Gradually organise the availability of family medicine services for urgent cases outside office hours (24 hours per day and 7 days per week) so that such services cover 90% of the Romanian population in 2020.

***Activities*:**

- Develop guidelines for family medicine in urgent situations, and training of family doctors.
- Gradually expand the areas where 7x24 Family Medicine is being provided according to the geographical situation, the availability of guidelines and the capacity of the family doctors.
- Decide in which areas duty rosters or permanent centres are more appropriate.
- Improve the remuneration of participating family practices on the basis of services provided and referrals avoided.
- Develop methods to motivate solo practices in remote areas that cannot share in 7x24 duty rosters and to prevent burn-out, such as financial and non-financial incentives and by providing locums for weekend duty and holidays.

***Explanation*:**

Family medicine is comprehensive and continuous care for a circumscribed population. This should include emergency services up to the level of complexity that can be handled by family doctors, as described in guidelines. Patients are protected against unnecessary and expensive specialist diagnostics and treatment. This is not only more convenient for patients but also more efficient for the whole health care system. Most Romanian family doctors work in a solo practice. Because it is difficult to provide 7x24 services by a single family doctor, groups of family doctors should share on-call services after office hours for their joint lists. This can be done from their own practices on a rotation schedule or from newly established “permanent centres”, in both cases serving a circumscribed geographical area. The option of permanent centres is obviously more expensive and it makes family doctors work in unfamiliar surroundings, but it may be useful in certain geographical situations or when regular practice premises are unsatisfactory. The establishment of 7x24 family medicine appears more urgent in rural areas because alternatives (hospital emergency centres and ambulance services) are less easily accessible (see specific objective 4.3), but in principle it is equally valid for urban areas if gatekeeping can be maintained. In really remote areas with small populations, a single family doctor will have to provide 7x24 services, in which case the clients have to be persuaded not to abuse the system and the doctors must be offered regular relief by locums or otherwise.

Specific objective 4.4

Make better use of the Family Medicine Consultative Committee in development, implementation and evaluation of policy.

***Activities*:**

- The Ministry of Health will organise regular meetings of the Family Medicine Consultative Committee.
- The Ministry of Health will appoint additional members to the Committee who represent the family health nurses and the CNSMF.

***Explanation*:**

The Family Medicine Consultative Committee is the official means of communication and discussion between the Ministry of Health and the external stakeholders in family medicine. However, it rarely meets. It is essential for the implementation and evaluation of this strategy for family medicine that the Committee is re-activated. Specific objective 4.4 is situated under general objective 4, but in fact it is relevant for all aspects of family medicine, i.e. for all general objectives. The CNAS could benefit from the deliberations of the Committee by having an observer attending the meetings.

Specific objective 4.5

Link community nurses to family medicine practices.

***Activities*:**

- In 2012, the Ministry of Health will issue additional regulation for community nursing, prescribing official delineation and coordination with family medicine.
- Before the end of 2013, the Ministry of Health, the ANR and the OAMGMAMR will specify educational requirements for community nurses, including CPD requirements.
- Local authorities that employ community nurses will stimulate cooperation and coordination between community nurses and family medicine practices on their territories.

***Explanation*:**

The activities of community nurses are regulated by the Community Emergency Government Ordinance nr.162/2008. At present, community nurses are employed and directed by local authorities without an official relationship with family medicine practices in their work area. Their tasks are in the fields of social care, public health and individual care, and are overlapping with the responsibilities of family medicine practices. Social care is provided for vulnerable groups such as the poor, unemployed and disabled. Public health tasks are for example health education, stimulating compliance with tuberculosis treatment and motivating for immunisation. Examples of individual care are home visits and postnatal care for

uninsured mothers with children.

Specific objective 4.6

Facilitate transfer of ownership of premises to family doctors.

***Activities*:**

- In 2012, the Ministry of Health and the Ministry of Administration and Interior will discuss options to transfer family medicine premises to family doctors for an acceptable price, with safeguards in the interest of family medicine services to the population, such as the continuation of the medical purpose of the buildings, an obligation for proper refurbishment and maintenance, and the avoidance of them becoming objects for speculation.

- From 2013, family medicine premises owned by local authorities will be sold to family doctors who qualify.

- The SNMF will attempt to interest private banks to provide loans to family physicians for renovation of their newly owned premises, with the building as security.

***Explanation*:**

Most premises used by family medicine practices are owned by local authorities. The lack of ownership is seen by family doctors as one of the main bottlenecks in improving family medicine services. They cannot invest in buildings they do not own and local authorities rarely assure renovation and proper maintenance. Family doctors can rarely afford to buy their own premises (see specific objective 1.2). This situation is also not in the interest of local authorities, but they show little inclination to change it. The Ministry of Health is not directly involved but it has an interest to improve the situation.

General objective 5. Improve the accessibility of family medicine in rural and remote areas

Specific objective 5.1

Stimulate involvement of local authorities in underserved areas.

***Activities*:**

- The Ministry of Health and the Ministry of Administration and Interior will try to stimulate local authorities in areas with limited access to family medicine to put such access higher on the local political agenda.

- The Ministry of Health will explain to local authorities the various types of incentives that are available to attract or retain family medicine professionals to rural areas, some of which are non-financial (see specific objective 5.4).

Explanation:
Accessibility to family medicine services is limited or even absent in some remote areas of Romania. In such areas it would seem to be in the political and social interest of local

authorities to try to improve access to family medicine, but there are complaints that in reality they are often not very active in this field. In fact, local authorities have the power but no obligation to provide such access according to the Law on Local Public Administration of 2001. In a system where family doctors cannot be forced to work in remote places, only incentives and political pressure by the local population can increase accessibility. Providing housing and work premises at low cost would be an important incentive (see specific objective 4.6).

Specific objective 5.2

Promote family medicine study by rural students (e.g. scholarships).

Activities:

- Regional health authorities will stimulate local authorities in areas with limited access to family medicine to provide scholarships or other incentives to students with rural background, especially residents in family medicine.

- Regional health authorities will stimulate the nearest medical faculties and nursing schools to reserve a number of places for rural students, with or without scholarships.

Explanation:

Family doctors with a rural background are more likely to practise in such areas. Local authorities in areas with reduced access to family medicine could support local students to study medicine and family medicine, in exchange for a guarantee of return for at least an agreed number of years. Medical faculties and nursing schools could reserve a number of places for students from rural background. However, these are methods that produce results only in the long term.

Specific objective 5.3

Allow pharmaceutical points for family doctors in areas without pharmacy.

***Activities*:**

- In 2012, the Ministry of Health, the CNAS and the SNMF will agree on a model for providing drugs to family medicine patients in areas where there is no pharmacy or pharmaceutical point.

- In 2013, the Ministry of Health will present the legal changes required for the improved provision of drugs in remote areas.

- From 2013, family doctors who themselves provide drugs to their patients in remote areas will be trained in the administrative and pharmaceutical aspects of such provision.

Explanation:

By the Health Law (95/2006 art. 383 and 788) and the Pharmacy Law (266/2008 art. 2), family doctors are not allowed to provide drugs, presumably because of the fear of perverse financial incentives. In many more remote places there are no pharmacies or pharmaceutical points. Giving a prescription to a rural patient who then has to travel to a town to obtain the

drugs is not acceptable, therefore some legal changes are recommended. Presently some ideas about fundholding for primary care drugs are circulation in Romania and these could be linked to the possibility of doctors in remote areas having limited pharmaceutical stocks. Mobile pharmacies could be another solution.

Specific objective 5.4

Introduce and monitor financial and non-financial incentives for rural practice.

***Activities*:**

- In 2012, the Ministry of Health, the CNAS, the SNMF and the ANR will produce an analysis of financial and/or non-financial incentives that probably will promote the attraction of family doctors and family health nurses to rural areas and to retain them there.

- The new incentive system will be introduced from 2013 and carefully monitored.

- A first evaluation of the new incentive system will be produced in 2016, covering the years 2013-2015.

***Explanation*:**

Presently, only some increased capitation rates for rural family medicine practices are being used as incentive to retain family medicine professionals in those areas. The level of increase is sometimes too low, and the effectiveness of this financial incentive is unclear. There is a large body of international evidence about other types of incentives that can be used to attract family doctors and family health nurses to rural areas and retain them there. Some are part of this strategy (see specific objectives 1.2, 2.3, 5.1, 5.2).

Specific objective 5.5

Organise rural clerkships (assignments) for undergraduate medical students and family medicine residents (this is linked to specific objective 3.2).

***Activities*:**

- Universities will select rural family medicine practices that are willing and able to host students and residents, including providing simple accommodation facilities.

- Such rural family doctors should be affiliated with a department of family medicine in the nearest university. The department should ascertain that the practices are sufficiently equipped for educational purposes and that the family doctors have sufficient medical and teaching knowledge and skills to motivate and teach students and residents. If necessary, the departments will organise courses for these doctors that will count towards their re-licencing.

- As the number of affiliated rural practices will only expand gradually, students and residents with an interest in rural practice should have preference in the beginning, but later all students and residents should spend some time in rural practices.

- Affiliated rural practices should receive some remuneration for their teaching activities, to be paid by the universities (this can also be paid in kind by providing courses or providing facilities).

***Explanation*:**

Rural family medicine has some features that are additional to urban family medicine, such as working in greater isolation, more responsibilities in urgent care (also outside office hours), reduced geographical accessibility for patients, and a different form of social life. It has its rewards and its difficulties. In order to create interest in rural practice among medical students and family medicine residents they have to be confronted with it. On the one hand, this may stimulate new family doctors to choose rural practice which is necessary to prevent shortages in the future, and on the other hand it prevents doctors settling in rural areas who are not suitable for such work.

Specific objective 5.6

Organise the provision of basic lab tests by family doctors in rural areas.

Activities:

- Establish the minimum set of simple laboratory tests that must be available to patients in rural areas.
- Ensure that the use of these tests is incorporated in family medicine guidelines.
- Establish a payment method for such testing.

Explanation:

There are no laboratories in rural areas and many rural family practices do not provide lab tests because there is no payment mechanism. Patients have to travel far for simple lab tests that cost only a few lei, and then wait for the results. Examples that can be introduced easily in rural family medicine are dip stick tests (e.g. for albuminuria in pregnancy) and the measurement of haemoglobin. Some biochemical tests needed in family medicine cannot be done by test strips and require a micro-analyser which is more expensive but may still be considered a worthwhile and efficient investment.

ANNEX 3: The support paper for implementation of the Primary Care Development Strategy in Romania

PHASE II

Supporting the implementation of the Primary Care Development Strategy 2012-2020 in Romania

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Abbreviations

ANR = Romanian Nursing Association
AP = Action Plan
BI = Bucharest
C = Central
CNAS = National Health Insurance House
CNSMF = National Study Centre for FM
CPD = Continuing Professional Development
EU = European Union
FD = Family doctor
FM = Family medicine
GDP = Gross Domestic Product
GP = General practitioner
MEF = Monitoring and Evaluation Framework
MOH = Ministry of Health
NIF = National Insurance Fund
NHP = National Health Programmes
NHS = National Health Service
PCDS =Primary Care Development Strategy for 2012-2020
RON = Currency of Romania (Romanian Leu)
PC = Primary care
PCTs = Primary care trusts
PHC = Primary Health Care
PMU = Project Management Unit
OPM = Oxford Policy Management
QOF = Quality and Outcomes Framework
SNMF = National Society of Family Medicine
THE = Total Health Expenditure
WB = World Bank
WHO = World Health Organisation

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CHAPTER 1: Introduction

The Ministry of Health of Romania, together with the WB Project Management Unit -APL2, initiated a process of developing a National Strategy for Rural Primary Care (NSRPC), with the support of Oxford Policy Management, UK (OPM), contracted for the project "Technical Assistance for project Management Unit APL 2, within the Ministry of Health of Romania, in order to develop a Strategy for Primary Health Care in Underserved Areas and the Related Action Plan".

The team prepared a comprehensive background document on Primary Care Needs Assessment in Romania, based on the field visits in four Judets (Tulcea, Teleorman, Vaslui and Alba), the analyses of the secondary data/reports related to national context, and the review of international best practice on rural primary care development. The document has been discussed with the MoH, professional associations, CNAS, and representatives of rural primary care (health service providers and public health specialists). It has been approved by the MoH PHC committee on 2nd December, 2011.

In November- December 2011, the project team under the leadership of the MoH, prepared a draft on the Strategy for Primary Care Development for 2012-2020. This is a medium term strategic document which defines key principles, goals and objectives of the primary care policy, with emphasis on primary care in rural and remote settings, and is oriented towards the improvement of the health status of the population of Romania. The document is developed based on the findings, analyses and conclusions on key challenges, achievements, and drivers of change presented in the PC Needs Assessment paper. It has been enriched and finalised through the intensive consultation process with the primary care stakeholders, including the stakeholder workshop held on 14th December, 2011. The Strategy has been submitted to the MoH PHC committee for approval on 25th December, 2011.

To support the strategy implementation, the project team considered it necessary to elaborate recommendations on modifying the PC purchasing mechanisms, as well as amending regulations related to the primary care. These recommendations are presented in Chapters 2 and 4 respectively.

Following the request of the MoH, the team specified the suggestions for incentives for rural family medicine practice, as well as possible barriers for the strategy implementation. These issues are discussed in Chapters 3 and 5.

Likewise, the project team defined the next steps for the strategy implementation, which includes the suggestions on the process and format for the development of an Action Plan and Monitoring and Evaluation Framework. Chapter 4 presents the consultant's views on these issues.

Finally, as requested by the ToR and specified in the Letter of Understanding attached to the Contract, the project team prepared the Primary Care Investment Programme, to present specifications and cost estimations for primary care premises and a basic list of equipment. The PC Investment programme is presented in Chapter 5.

We believe this report serves as a supporting document for the implementation of the newly developed Primary Care Development Strategy in Romania. The Action Plan and Monitoring and Evaluation Framework will be developed in January- February 2012, as a separate piece of work, and be attached to the PC Strategy after being approved by the MoH.

Chapter 2: Recommendations on reviewing purchasing mechanisms for Primary Care in Romania

2.1. Background

The Primary Care Development Strategy for Romania 2012-2020 emphasises the need to ensure a sustainable, efficient and performance-promoting payment method for family medicine practices (General Objective 2).

The World Health Organization (WHO 2000) identified the key role strategic purchasing has in improving health system performance. Purchasing efficiency is a primary objective with a view to improving access to services as well as financial protection. This is true, both at the systems level as well as at the level of a specific service sector within the broader system. The right design of purchasing arrangements including provider payment supports the improvement of providers' performance by setting financial incentives and increasing provider responsiveness and efficiency (Gottret & Schieber 2006). Purchasing arrangements need to take into account the broader health system context, the specific context of services provision, access to services and service quality as well as a population's needs with respect to the services in question.

In Romania, a single-payer mandatory health insurance fund (CNAS) acts as the sole purchaser of services. In principle, this provides an opportunity for a relatively smooth introduction of purchasing arrangements, targeted strategically to develop a particular sector within the health system. Primary care services, and most prominently - family medicine, have been identified as a priority area. Access to quality family medicine should be further improved, particularly in Romania's rural and remote areas.

Purchasing and provider remuneration arrangements in Romanian primary care are based on a combination of capitation and fee-for-service payments. The relative significance of the two building blocks has been subject to shifts over recent years. In order to achieve the goal of increasing efficiency and equity in primary care, the design of provider remuneration needs to take the following specific objectives into account:

1. Remuneration must be designed, such that the incentives are set for health professionals to engage in primary care in rural and remote areas.

2. Providing high-quality services within a standard primary care benefit package to a group of empanelled patients representative of a rural or remote area must not be economically unattractive to doctors.

3. The reimbursement arrangements must contain components, that incentivise good care and dis-incentivise superficial or low-quality care as well as referrals that are not medically motivated.

2.2. Purpose and objectives

The purpose of this chapter is to outline the current status of purchasing arrangements in Romanian primary care, especially in rural and remote areas, and highlight the potential for improvement with a view to provider reimbursement.

The specific objectives are:

1. To identify arrangements in the current system, that may advance inefficiencies and hamper the improvement of service quality in rural primary care;

2. To suggest modifications of existing arrangements in order to increase efficiency, cultivate equity and promote performance in rural primary care.

2.3. Primary care financing

2.3.1. The CNAS budget

The 2011 overall National Insurance Fund (NIF) budget, which is administered by the National Health Insurance House (Casa Nationala de Asigurari de Sanatate, CNAS), amounts to approximately 16.5 billion RON (approx. 3.8 billion EUR)[15]. After a sound budget increase of 16.0% from 2009 to 2010, this has meant quite a significant decline from the previous year of 6.9% (2010 budget: 17.7 billion RON).

At 1.067 billion RON in 2011, the budget amount spent on primary care services is small (in fact the budget was 1.047 billion RON for PC services, with 20 million out of the 1.067 billion RON having been allocated to permanence centres) This amounts to a mere 6.5% of the total CNAS budget.[16]

International comparisons of the budget share of primary care services are not directly feasible, as definitions of budgets and line items differ dramatically; a common concept of a primary care budget does not exist.

The *share* spent on primary care in Romania is at a reasonable level. However, because of low Total Health Expenditure (THE), the amount of resources spent on family medicine is not sufficient. With current funding, we can assume that PC providers are not able to fulfil their comprehensive role in the Romanian health system, and to sustainably contribute to its development.[17] Romanian total health expenditure as a percentage of GDP takes on a

[15] Reported by CNAS (*Bugetul Fondului National Unic de Asigurari Sociale de Sanatate 2009-2011*).

[16] OPM's Report on Rural PHC Needs Assessment in Romania reports the primary care budget share since 2004: The slight increase since 2004 does not result from a steady trend. The share is rather unstable. Also, the figures reported by different sources deviate.

[17] Primary care is defined as the health sector providing comprehensive health care and as the first point of contact for any kind of health problems (see Art. 60(a) in connection with Art. 59(2) of the Romanian Health Reform Law 2006 – Law No. 95/2006).

bottom position among EU countries. Thus, a particular focus should rest on the share spent on primary care, which must not fall further below in relation to other sectors of the CNAS budget.

2.3.2. MoH contribution to primary care

The Ministry of Health directly supports permanent centres. Centres are financed by the state budget through transfers from the Ministry of Health to CNAS. In 2011 this support amounted to a total of 20 million RON.

2.4. Reimbursement of family doctors in Romania

Payment of family doctors in Romania (currently about 11,400) is made up of two components: capitation and fee-for-service. Whereas capitation used to be the main component, currently the budget for provider payment in primary care is split into 50% capitation and 50% fee-for-service. Hereby, overall reimbursement underlies a “normative” approach of determining the respective sums. Initially, the total amount budgeted for primary care is split in half. Then separate capitation and fee-for-service budgets are divided up following routine approaches of calculating points based on previously determined data on empanelled patients (geographic and age-related head counts).

Currently, points are assigned to empanelled patients according to the following manner: 11.2 points for a patient between 0 and 3 years, 7.2 points between 4 and 59 years (11.2 points for early retirees), 11.2 points for patients of 60 years and above; “institutionalised” patients, e.g. those living in an old-age home, receive an additional 5% of points. Doctors in primary care who are not primary care specialists (currently about 1,660) have to put up with a 10% deduction of the overall sum of points, whereas doctors with another exam on top of their specialist exam, the so-called *primariat*, receive a 20% bonus (currently about 5,150). There is a variable bonus following a percentage scale for rural and remote locations.

The fee-for-service payment, which has been extended in 2010 to include consultations for acute and chronic diseases, is limited to 4 consultations per hour (calculated at a maximum of 5 to 6 hours). A consultation in the doctor’s practice is calculated at 5.5 fee-for-service points, a house visit (1 per day) is worth 15 points.

The CNAS approach to processing the budget leads to differences in quarterly pay-outs and entitlements. Positive accounting balances are distributed according to a non-transparent pattern. There are further reports of frequent incorrect revenue statements received from CNAS.

The calculated average budget per capita and month is about 7,800 RON. Reasonable assumptions regarding the costs of running the practice (including personnel) support an

approximation of a family doctor's average personal monthly income of about 2,500 RON before taxes[18].

2.5. Principles of provider payment

Traditionally, in ambulatory care fee-for-service payments used to dominate social health insurance systems, whereas salaries were the common payment approach in tax-funded systems. Nowadays combination systems predominate. These systems "try to outweigh the positive and negative incentives of each individual payment mechanism to encourage providers to align their behaviour with the purchaser's objectives" (Gottret & Schieber 2006, p. 307). The international landscape of physician payment is still subject to continuous change.

Germany, for example, features a system where regional physician associations receive a 'budget' based on a type of capitation system, which is then allocated on the basis of a floating point-based fee-for-service payment to individual physicians (Blümel & Henschke 2010).

British GPs in the tax-funded National Health Service (NHS), on the other hand, are paid directly by so-called primary care trusts (PCTs) through a combined approach of salary, capitation and fee-for-service. Elements of pay-for-performance have more recently been introduced. Since the introduction of the so-called Quality and Outcomes Framework (QOF; www.ic.nhs.uk/qof) in 2004, GPs have received increases in existing income according to performance with respect to quality indicators covering ten chronic diseases, the organisation of care and patient experience (NHS 2011). Here, fee-for-service payments may come in as supplement payment for otherwise underprovided services, for example, childhood immunizations or cancer screening.

There are many advantages to a capitation system for the reimbursement of primary care services. The argument is well founded in the properties of primary care as comprehensive care and the provider as the first point of contact in the system, endowed with the role of a gatekeeper. Organised as a prospective payment system, the provider bears the risk of overuse and benefits from a light use of services. In principle, the provider should have an interest to operate efficiently and – to prevent illness. Capitation may also increase efficiency as it encourages doctors to compete for patients on the basis of the quality of their care, so that by attracting patients income increases.[19] The costs of administering a capitation system are reasonable. Within the system, single parameters, such as age groups and their respective point values or weights, are easily modifiable. However, a capitation system also bears a certain incentive to under-service as well as cream skimming and cost-shifting, e.g. through patient referrals.[20] Consequently, certain monitoring or peer-review systems need to

[18] OPM; Report on Rural PC Needs Assessment in Romania; 2011

[19] If the number of empanelled patients is capped, this strategy will be of limited effect. Further this may generally not be an option in rural or remote areas.

[20] The systematic review of literature on provider reimbursement mechanisms and their effects by Gosden and colleagues (1999) is very insightful and not outdated.

be in place. Further, patient information and choice need to be strengthened in order to sustain patient autonomy. A dynamic approach to the risk adjustment of payments is key to an efficient capitation system in primary care.

Fee-for-service as a reimbursement principle does not incentivise under-servicing. There is rather a risk of services over-provision and, thus, cost escalation. Further, a true fee-for-service system is associated with high administrative costs. Yet certain fee-for-service arrangements are well justified. This is particularly the case wherever under-provision may be a risk, e.g. in the context of prevention. Also, a fee-for-service approach offers large potential for fine-tuning in the interest of efficiency. For example, a fee-for-service system can be equipped with global caps, together with prices that might be adjusted (ex-post) in adhering to a budget, e.g. in the case of Germany as briefly sketched above.

Capitation and fee-for-service reimbursement can be combined as to increase overall efficiency. Paying general practitioners a flat monthly payment per enrolled patient (adjusted by age and sex) supplemented with fees for specified carved-out services is a rather common model (Robinson 2001).

There are many different ways in which performance criteria can be introduced into a provider payment approach, i.e. into the framework contract. A pay-for-performance component could contribute significantly to efficiency and equity of the reimbursement framework and should be introduced as a complementary payment model, as financial incentives that reward doctors for the achievement of certain objectives. These objectives can be relate to the outcome of the doctor's intervention or treatment, to the process or to the structure of services provided by the doctor.

2.6. A way forward

A way forward for provider reimbursement in Romanian (rural) primary care should be built around the following five principles:

1. To modify the current provider payment approach within the *Primary Care Development Strategy 2012 – 2020*;

2. To bring provider behaviour more in line with the goals of patients and purchasers through incentives and risk sharing;

3. To understand payment in primary care as a form of incentive contract;

4. To keep in mind that financial rewards are only one among a variety of mechanisms for eliciting desired behaviour;

5. To aim at a system that allows optimum transparency of data relevant for operating an efficient approach to provider reimbursement as well as optimum transparency of financial flows.

Overall conclusion is that a hybrid or blended payment approach, which already exists in Romania, is a rational response to the challenges in (rural) primary care. As compared to the current framework there is scope for improvement.

The current differences in point weights according to age groups are not justifiable on the basis of rational (efficiency-oriented) principles. These differences should reflect actual differences in relative service needs (in cost terms) of young children, male and female adults, and the elderly.

Fee-for-service payments for strategically selected services should complement the capitation model. Fee-for-service payments should not extend to the provision of services within the basic family medicine package. These payments should further be "conditioned" by pay-for-performance principles. The provision of services reimbursed via fees should follow a formal ethical code to which doctors should be expected to adhere. This may dilute or remove the incentive for doctors to provide ineffective, dubious or costly treatments merely to increase their income.

Systems for incentivising primary care in areas that appear unattractive to medical professionals need to be fine-tuned. Monetary incentives need to be smart.

The overall provider payment system for primary care services in Romania needs to develop a sophisticated approach to equitable reimbursement of urban and rural providers. The system needs to be sensitive towards the differentials in opportunities of "gaming the system", e.g. by cream skimming or capitalising referral options. Particularly, the capitation component should be designed as sensitive as possible towards regional characteristics and health needs.[21]

A coherent monitoring system based on routine data analysis is crucial for a successful reform of provider payment in primary care. Initially, a particular focus should be placed on consultations and procedures, that lie on the border of primary and specialty care ("candidates for referral").

The Primary Care Development Strategy for Romania 2012-2020 emphasises the relevance of guidelines in improving the quality of family medicine services. Protocols, clinical pathways and other guidelines will also play a key role in the development of an effective system of provider reimbursement in primary care. They are also relevant instruments in ensuring the reimbursement system's efficiency over time.

In summary, the key recommendations from the OPM team were the following:

- **The budget for primary care should significantly increase over time in absolute terms**.

- **A capitation model should form the main pillar of the future primary care reimbursement framework.**

[21] Obviously the design of an efficient reimbursement system in primary care requires thorough data collection and analysis in the planning phase.

The MoH has communicated clearly that “the current proportion of 50:50 for capitation to fee for service payment is part of the Romanian government’s commitment in relation with the international financial organizations”. This ratio has been analysed by the World Bank consultants, and was proposed with the emphasis that it “gives the opportunity to develop more patient and policy sensitive levers for improvement”. The MoH believes, that by increasing the total budget allocated to the primary healthcare, the amount which is paid on capitation base will also increase, to meet expectations of family physicians. If the budget doubles, maintaining the proportion 50:50, the amount paid on capitation bases will equal to the total amount which is paid currently both through capitation and fee-for-service.

The MoH has also argued, that “the increase of the proportion of capitation payment doesn’t offer any incentive for improving the quality of services provided by the Family doctors”. Therefore, intends to introduce the pay for performance elements in the primary care payment.

Aiming to address the MoH concerns, but at the same time trusting in technical soundness of the recommendation provided previously, OPM has modified the formulation of the respective recommendations in a following way:

- Optimise the division between capitation and fee-for-service payments.
    - Analyse the optimal proportions of capitation and fee-for-service payment in the CNAS budget for family medicine.
    - Define and calculate in 2012 which services can be considered additional to regular family medicine practice and can be afforded by the CNAS within the remaining fee-for-service payment system.
    - If applicable, introduce a new division between capitation and fee-for-service, with the emphases on capitation payments. In current context it is unrealistic to expect that this will be achieved in 2012-2013. However, it could be achieved in a lifetime of the new Primary Care Development Strategy for 2012-2020;

- Review the overall provider payment system for primary care services to develop an a sophisticated approach to equitable reimbursement of urban and rural providers;

- Revise the Capitation formula, including the weights for the age/sex groups;

- Fine-tune systems for incentivising primary care in areas that appear unattractive to medical professionals;

Chapter 3: Suggestions on incentives for rural family medicine practice

Specific objective 5.4 of the Primary Care Development Strategy is to "Introduce and monitor financial and non-financial incentives for rural practice". This objective starts with a period of analysis by the Romanian stakeholders in rural family medicine (March-December 2012), for which we are providing some suggestions here. An inventory of actual requests by Romanian rural family doctors and a summary of international experiences in this field have been presented in the Needs Assessment Report.

Financial incentives already exist in the form of an increase of the capitation payment by between 10% and 100%, depending on the type and number of hardship factors. When the capitation share of the payment of family doctors was reduced from 80% to 50%, this automatically entailed a reduction of these financial incentives so that they became less effective in promoting rural practice. As described in the Needs Assessment Report, rural family doctors would like to see an increase of this financial incentive, if possible linked to an increase in the proportion of capitation in total revenues, and otherwise without such linkage.

Other financial incentives that the rural family doctors would like to see are tax and premium deductions or exemptions, and financial support for transportation. In view of the extremely tight budgetary situation for the Ministry of Health, CNAS and local authorities, all requests for additional funds will be difficult to realise in the short term. This is also true for another request, relating to new equipment being paid out of government funds. Therefore it may be more fruitful to first look at incentives that are useful for rural family doctors and nurses but have no major budgetary consequences.

The first and foremost of these incentives comprises the transfer of premises to the family doctors, which is part of the Primary Care Development Strategy as specific objective 4.6. This is also the first request by the rural family doctors interviewed for the Needs Assessment Report.

Other incentives for rural practice can be found in other specific objectives of the Primary Care Development Strategy:

Specific objective 2.2

Increased payment to family medicine practices that reduce their referral rate will benefit especially rural practices because referral rates are usually lower in such areas.

Specific objective 2.3

Lifting the limit on the number of patients that qualify for capitation payment will benefit rural practices.

Specific objective 2.6

A reduction of the number of uninsured citizens will benefit especially rural practice because non-insurance is especially problematic in rural areas.

Specific objective 3.3

Free courses of Continuous Professional Development for rural doctors are not without cost, but such cost is limited and Continuous Professional Development also promotes quality of care.

Specific objective 4.3

Extension of the 7x24 payment to rural solo or duo practices, which do not qualify as permanent centres or other forms of rotation duty but that guarantee 7x24 availability will increase practice revenues. Such practices can also be assisted by regularly providing locums.

Specific objective 5.1

Local authorities can support rural practices by various means (transfer of ownership of premises, financially, transport).

Specific objective 5.3

The ability to provide pharmaceuticals to patients in areas without a pharmacy will enhance both the status and the income of rural family doctors.

Specific objective 5.5

Rural practices that qualify as training practices will improve the quality of their services, their job satisfaction and - to a limited extent - also their revenues by small contributions from the faculties to which they are affiliated or by other institutions.

The most promising incentives for rural family medicine are therefore a) an improved financial bonus, preferably linked to increased capitation payment; b) transfer of ownership of premises to rural family doctors; and c) other incentives mentioned in the Strategy document (especially and with almost immediate effect specific objectives 2.3, 3.3. and 4.3). The year 2012 should be used to discuss and negotiate the incentive system between the Ministry of Health, the CNAS and the professional associations. It will be important to monitor and regularly evaluate all measures that are meant as incentives to promote rural family medicine.

Chapter 4: Recommendations on amendments in the legal framework for Primary Care

Despite the achievements made in Romanian primary care (amongst others by legal reforms), challenges to the legal framework still exist. In order to develop and diversify the range of services in family medicine as well as to establish the appropriate payment for these services, the following proposal of amendments to the legal framework is made. The recommendations are given with regard to the objectives of the present Primary Care Development Strategy, including those related to ensuring proper planning of human resources, improving the quality, organisational capacity and accessibility of family medicine, as well as ensuring sustainable, efficient and performance-promoting payment methods for family medicine practices.

1. Strengthening the gate keeping role of a Family Doctor

According to the law, medical services in secondary care (services reimbursed by CNAS, set in the basic package) have to be provided only on the basis of a referral. In practice, this is not always the case. It is therefore recommended, that the CNAS inspects health care providers and introduces sanctions in case of non-compliance with the rules imposed by law.

At present, the sanction defined in provisions prescribes non-reimbursement of health services provided without referral. This sanction should be enforced. Some other measures can also be considered, as introducing a financial penalty for secondary care providers, delivering services without the referral from a family doctor; or administrative measures, as refusing patients access' to non-emergency health services without referrals from FDs.

2. Decreasing the number of uninsured citizens by a registration drive

Legal measures are needed to enforce the obligation to have social health insurance. An explicit duty to conclude an insurance contract is to be incorporated in the Health Law (95/2006) together with a threat of punishment; e. g. "Failing to conclude a health insurance contract is penalized by the insurer, which is then allowed to claim all unpaid contributions."

3. Increasing the role and competencies of the professional associations

It is evident that the accomplishments of the professional associations in negotiating the contract with CNAS are limited. According to art.217 par. (2) and (5) of Law 95/2006, the framework-contract and its methodological norms are elaborated by CNAS, "based on consultation with the College of Physicians … and representative professional associations." Practical observations however, hint to the fact that, during the negotiation of framework-contracts CNAS, accepts very little from the proposals formulated by the professional associations.

It is suggested that a provision similar to art. 217 (2) could be introduced into Law 95, with regard to determining the budget for each category of health care, based on consultations with professional associations.

The legal position of professional organisations can be strengthened by means of involving the accordant associations (ANR, SNMF etc) into the law making process (e.g. impose the obligation to submit respective drafts).

4. *Streamlining the relations between community nurses and family medicine practice*

In order to strengthen the relationship between community nurses and family medicine practices, it is necessary to amend and supplement art. 7 of Government Decision no.56/2009 - Methodological norms for the application of Government Emergency Ordinance no.162/2008, as follows: "In performing their duties, community nurses collaborate with family doctors and family health nurses in the assigned areas, on the basis of an agreed procedure."

5. *Facilitating transfer of ownership of premises to family doctors and stimulating involvement of local authorities in underserved areas*

The support of primary care in rural areas should be specified by law. It is necessary to formulate the respective provisions as clear duties and obligations, e.g. a clear determination as to the distribution of costs for appropriate incentives between the state budget and the budget of the local authorities is required. It seems plausible to question the shift of the financial burden of supporting local primary care to the local authorities. In any case such a shift needs to be based on pragmatic considerations taking into account the financial capacities of the local authorities.

A concrete legal instrument should be established to compensate the financial losses of the family doctors in rural areas, since the source of income in a rural medical practice is usually reduced to payments for basic services and the income generated through specialised and additional care is thus lacking. This loss should be compensated in order to avoid insolvencies of existent and future medical practices. It is further advisable to establish a legal instrument for the coverage of the liability insurance for rural practitioners by a state fund. These two measures would build a possible incentive for primary care professionals to work in remote settings.

A specific suggestion concerning the support towards facilitating the ownership transfer of premises to FDs could be the establishment of a sale period within which local authorities would be obliged to sell the health premises to family practitioners. This will require the following addition to the respective regulations: "Local authorities shall sell the premises within 3/6 months from the date on which the doctor-buyer expressed his intention to buy."

The goal to stimulate involvement of local authorities in PC in underserved areas, should also be reflected by the legislation. A potential phrasing might involve replacing the term "duties" with the term "obligations" in article 36 of Law no. 215/2001, at least with regard to ensuring access to health services; along with the introduction of sanctions for failure to comply with these obligations (e.g., a fine).

6. *Allowing pharmaceutical points for family doctors in areas without pharmacy*

Legal changes are required in the field of drug provision. It is necessary to modify or partly abolish Art. 383 and 788 Health Law (95/2006), and Art. 2 Pharmacy Law (266/2008), which prohibit family doctors to provide drugs. It is feasible to stipulate the possibility of doctors (especially, but not only) in remote areas to have limited stocks for primary care drugs. A list of such primary care drugs can be determined by means of appropriate secondary legislation. More specifically, we suggest the following steps to be taken:

Step 1: Drafting a new paragraph (as an exception from the general rule stated in art.2(4)) in article 2 of Law 266/2008 (Pharmacy Law), as follows: "By exception from provisions of par.(4), family doctors in remote areas without a pharmacy, are allowed to have limited stocks of primary care drugs."

Articles 383 and 788 of Law 95/2006 shall be amended accordingly, by inserting the phrase "..., unless otherwise provided by law".

Step 2: Establishing an obligation - new articles in Law 95/2006 and in Framework-contract: "Family doctors in remote areas without a pharmacy, are obliged/compelled to have limited stocks of primary care drugs (If we were to use "are allowed to" instead of "are obliged to", the doctors wouldn`t be interested in providing drugs; more paper work, more reporting, increased bureaucracy etc.).

Step 3: List of drugs, management methods and more importantly maximum prices regulated by law to avoid potential abuse by doctors, will be stipulated in specific regulations (new article in Law 95 and Framework-contract). It is also necessary to establish a list of localities, without access to pharmacies and a list of authorized doctors.

Chapter 5: Possible barriers for the PC strategy implementation

Possible barriers for the implementation of the primary care (PC) strategy and Action Plan could be summarised as follows:

1. **Lack of ability and processes for coordination/ joint work**

   There is a lack of culture of cooperation and coordination between the various stakeholders in Romanian primary care. Achievement of several strategic objectives requires the establishment of well-coordinated processes for discussing challenges, considering arguments stated by various actors, proposing mitigation measures that are acceptable for all involved parties, achieving joint inputs (both technical and financial), and producing joint deliverables.

   Examples:
   The implementation of the ***Specific objective 1.1: Design and implementation of a long-term planning mechanism for human resources****, requires well-coordinated processes to produce statistics on family doctorsby bringing together a special group/agency, CMR, CNAS, Medical Faculties.*

   The implementation of the ***Specific objective 3.1: Produce and use clinical guidelines for family medicine*** *requires coordinated inputs from the MOH, CMR, SNMF, CNSMF, CNAS to agree on a process of elaboration of guidelines, as well as on responsible bodies and respective functions. Similarly, joint efforts from ANR, OAMGMAMR, SNMF, and CNSM are required to analyse the need for FM nursing guidelines.*

   The implementation of the ***Specific objective 2.3: Introduce more appropriate capitation scales,*** *requires joint efforts from CNAS, CNSMF, and SNMF to* revise *capitation formula and scales.*

2. **Limited capacity in the MoH, CNAS, SNMF, and other key actors to work on new tasks requiring specific technical competencies and substantial additional time;**

   Examples:
   The implementation of ***Specific objective 1.1: Design and implementation of a long-term planning mechanism for human resources****, requires the MoH to conduct (i) analyses of regular trends and forecasts of PC human resources; as well as to produce (II) a policy document on family nurses. In order to do this, the MoH PC and HRH teams should have the respective capacity and time. However, given that there is only one person in the MoH responsible for all PC issues, this seems unrealistic.*

   The implementation of ***Specific objective 2.1: Limit and better target fee-for-service payments****, requires respective capacity and dedicated time by CNAS and SNMF to define and calculate services to be paid by fees.*

3. **Absence of political will in the government structures/organizations**

Examples:
The implementation of the ***Specific objective 2.6: Decrease the number of uninsured citizens by a registration drive****, requires political will and resources from the Government to introduce special efforts to increase the registration rate for health insurance.*

The implementation of the ***Specific objective 4.6: Facilitate transfer of ownership of premises to family doctors,*** *requires strong political support from the MOH and the Ministry of Administration and Interior, to facilitate discussions with the local government on transferring of FM premises to family doctors. It also requires political will of the local governments to sell FM premises to family doctors at a feasible price.*

The implementation of the ***Specific objective 1.2: Enable young doctors to start a family practice*** *requires political will of the MoH, CNAS, and SNMF for exploring the feasibility of hiring young doctors as well as for providing opportunity to FM residents to practice.*

4. **Lack of additional financial resources**

Implementation of the great majority of strategic objectives requires additional financial resources either for increasing internal capacity of the implementing organizations to undertake new tasks, or to fund new initiatives and improvements.

Examples:
The implementation of the ***Specific objective 5.3: Allow pharmaceutical points for family doctors in areas without pharmacy,*** *will require additional resources at an initial stage in order to train family doctors in pharmaceutical provision. This will result in savings at a later stage, however.*

The implementation of the ***Specific objective 4.3: Gradually organise the availability of family medicine services for urgent cases outside office hours,*** *requires additional resources for* developing guidelines for FM in urgent situations; for gradually expanding 7/24 availability of FM; for improving payment for 7/24 availability; for supporting FM solo practices in 7/24 availability;

5. **Bureaucracy imbedded in current systems**

Example:
The implementation of the ***Specific objective 2.5: Reduce bureaucracy in family medicine through a joint effort by CNAS and SNMF,*** *may be hampered with the general tendency to keep bureaucracy for "better administration". MoH, CNAS and SNMF will need to put additional efforts to demonstrate drawbacks and indicate ways for reduction of bureaucracy, and then introduce a system with reduced paper work*.

6. **Restrictions generated by current regulations/laws and absence of required regulations**

   Examples:
   The implementation of the ***Specific objective 1.2: Enable young doctors to start a family practice,*** *might be restricted by the existing regulations on guaranteeing bank loans or soft loans.*

   The implementation of the ***Specific objective 5.3: Allow pharmaceutical points for family doctors in areas without pharmacy,*** *will require revision of current regulations/laws on pharmaceutical provision in underserved areas.*

   The implementation of the ***Specific objective 2.4: Introduce performance criteria into the framework contract,*** *requires development and enforcement of respective regulations for pay for performance, including modification of provider payment methods, and introduction of corresponding changes in the PC contract.*

7. **Inefficient information systems and monitoring capacity**

   Example:
   The implementation of the ***Specific objective 2.4: Introduce performance criteria into the framework contract,*** *also requires a strong information system to collect and analyse the data needed for introducing and sustaining an objective pay for performance system. It also requires strong monitoring capacity in the organization, which will be assigned to oversee pay-for-performance implementation.*

Chapter 6: Next steps for Strategy Implementation

After the Primary Care Development Strategy is approved by the MoH, it is necessary to develop the Action Plan and Monitoring and Evaluation Framework for its implementation.

Process wise, the involvement of all key primary care actors in drafting the Action Planning is necessary, as organisations and institutions will need to cooperate to achieve the desired results during the implementation process. Respectively, the responsibilities must be clearly allocated to these actors, and consensus should be built around the fact that the implementation of most activities from the Action Plan will require intensive consultations and joint efforts from various stakeholders.

The Action Plan (AP) will be elaborated for the first two years of the strategy implementation to cover 2012-2013. The AP will list specific activities corresponding to specific objectives of the Strategy, to be implemented by specific actors in specific periods of time with specific resources. The suggested format for the Action Plan is presented in Annex 1.

To a large extent, the Action Plan will take the form of a table describing for each specific objective the required activities in a number of rows, with the following captions of the columns:

* description of the activity

* desired output or outcome

* time frame

* organisations and institutions responsible for executing the activity

* resources required for the execution of the activity.

As stated in the Strategy, the activities can be of a policy-making, legal, technical, organisational, financial or educational nature.

The Action Plan will not describe the total range of activities to be undertaken in the field of family medicine, but leave a possibility for additional activities to be developed in parallel, in accordance with priorities and the availability of resources.

The implementation of the Primary Care Development Strategy 2012-2020 must be monitored and evaluated in order to ensure that the implementation is on track and to provide the opportunity to adapt if necessary. For this purpose, **a Monitoring & Evaluation Framework (MEF)** will be developed that presents the same activities with the same numbers as in the Action Plan, but this time with the following captions of the columns:

* name of the activity

* indicators that will be used to measure the activities (process indicators) and especially the outputs and outcomes (outcome indicators)

* time schedule for collecting data for the indicators

* sources of information for the quantification of the indicators.

The suggested format for the MEF is presented in Annex 2.

While the MEF developed in January will cover a two year implementation period, the exercise of the Action Plan and MEF development should be repeated in 2013 to prepare the AP and MEF for 2014-2015. The rational is that the evaluation of the strategy shall have a systematic character being carried out during the whole period of implementation and shall include the development of annual progress reports, an evaluation report at mid-term, and the final evaluation report. It is desired, that the strengthened PC capacity of the MoH and professional associations will create sufficient local capabilities to carry out these exercise without external technical assistance from 2013.

Chapter 7: Investment Programme for strengthening primary care Physical Infrastructure in Romania

7.1. Background

The Government of Romania intends to strengthen primary care services and support the formation of a rural family medicine model to improve physical and financial access to quality services. The Primary Care Development Strategy for Romania 2012-2020 articulates specific objectives aimed at increasing the effectiveness, efficiency and quality of family medicine services, decreasing the disadvantages and problems of rural family medicine as compared with urban family medicine.

Improving the quality of family medicine services is among the priority objectives of the Primary Care Development Strategy for Romania. Needless to say, that the quality of physical infrastructure and level of professional competence of medical personell are among the key determinants of service quality and may significantly influence health care access and clinical outcomes. The rural primary care situation analysis conducted in 2008 found many premises used by family physicians in a state of dispair. The same analysis hinted at the need for modernizing or upgrading existing medical equipment to better serve diagnostic needs of patients and avoid unnecessary referrals for basic lab tests and imaging. Improving physical infrastructure is a key building block of primary care reforms in many countries and holds good promise in terms of creating good working conditions for primary care teams and encouraging better performance. Investing in physical infrastructure seems to be a well-justified step toward improving the quality of primary care services in Romania.

This ‘investment plan’ aims to inform the Government on basic structural elements for the primary care system in Romania, which form building blocks for a well functioning health care model. The plan identifies investment needs for constructing and equipping typical family medicine offices in Romania, which are mainly presented as solo and in a few occasions as small (2-3 physicians) group practices. Furthermore, the plan envisages supporting establishment of out-of-hours services by family physicians. It depicts premises and equipment needed for permanent centres and provides an illustrative budget necessary for their launch.

7.2. Purpose and objectives

This chapter aims to support primary care providers to expand their capacity to provide high quality primary care services to population in rural Romania. The following objectives are to be met:

3. To describe physical infrastructure (equipment & premises) needs of family medicine.
4. To estimate the investment costs, related to single family medicine practices and permanent centres.

7.3. Family medicine service models

1. 7.3.1. Organization of services as solo and group practices

Different opinions exist about the most appropriate way to structure the delivery of PHC services. Among European countries, there are arrangements based on solo general practice, on group practice and on multidisciplinary health centres. Solo practice is the most common organizational model for family medicine services in Romania. The same trend is observed in countries where GPs are self-employed (e.g. Austria, Denmark, France, urban Greece, Germany, Italy and the Netherlands). However, FPs increasingly share their premises or work as employees of health centres owned by health insurance funds, the government or other owners.

Working in teams provides good opportunity for sharing experience, skills and expertise. This enables patients to call on a wider range of skills than those possessed by a physician working in a solo practice. Evidence suggests, that shared decision making and management can lead to better clinical outcomes.[1] Close collaboration of family physicians and nurses bears the potential to improve service quality.

It is obligatory for family physicians in Romania to be assisted by a nurse (*assistant medical*). However, nurses do not yet assume a significant role in patient management and are mainly busy with administrative tasks. The Strategy suggests, that this practice should be changed in a way that would encourage a greater involvement of nurses and expanding their functions. In many countries and many setting, nurses are the first and most consistent point of contact that patients have with the health care system. The contributions of this professional group have been increasingly recognized worldwide, and there is a widespread agreement about the need to strengthen and develop its functions. Nursing is seen as a cost effective resource for delivering health care services, particularly in the fields of public health and family medicine. Thus, nursing development can be viewed as a part of the more general trend to increase the cost–effectiveness of health care delivery. In parallel, with expanding primary care services it may be necessary to revise the established ratio of 1 family physician per 1 nurse and employ more nurses to work in collaboration with family physicians. The Strategy also intends to link community nurses to family medicine practices.

Premises and equipment needs described in this plan intend to accommodate a team composed of 1 family physician and 1 nurse. Additional infrastructure in terms of an extra office space and equipment pieces would be required for the expanded teams if established in coming years.

2. 7.3.2. Organization of emergency services by family physicians

The Primary Care Development Strategy for 2012-2020 envisages to gradually improve the availability of family medicine services for urgent cases outside office hours (24 hours per day and 7 days per week) so that such services cover 90% of the Romanian population by 2020.

Family physicians in Romania are adequately trained to handle many common medical emergencies and thus to avoid unnecessary use of hospital emergency facilities. The

establishment of 24/7 services by a group of family physicians would make a FP available for the population at any time they may experience exacerbations or any other type of emergency. It is recommended that family physicians group and jointly set up the out-of-hours service.

24/7 services can be arranged from the practitioners' own practices on a rotation schedule or from newly established "permanent centres", in both cases serving a circumscribed geographical area. This does not seem a viable option in very remote areas in which a single family doctor will have to provide out-of-hours services. But even in areas where only between two and four family doctors may be available to share duties, effective arrangements are possible.

The provision of 24/7 services from already functional FM practices will not incur significant costs for developing physical infrastructure, unless the premises are seriously damaged and dysfunctional.

In larger geographical areas, the organisation of transport for home visits may play an important role in the planning process.

7.4. Physical infrastructure

3. 7.4.1. Premises for family medicine services

Considerable investment need exists with respect to the improvement of the current physical condition of buildings used for the provision of family medicine services. Apart from necessary repairs on building structures, in many places water installations, sewerage and heating systems are in poor condition.

The National School of Public Health report based on the findings of a facility assessment conducted in 2007 stipulates that there is a need of interior, exterior and roof repair in 36%, 20% and 26% of FM premises respectively. Capital repair is warranted in 7% of facilities. 22% of facilities experience problems with utilities (lack of water, sewerage and heating systems). Conditions have not improved significantly since the assessment took place. During the 2007/8 assessment no monetary value was assigned to the investment needs described. There is an investment backlog in Romanian primary care practices, particularly in rural areas, that requires attention in the short term. The overall investment costs can hardly be determined as for single facilities they range between a couple of thousands RON in the case of minor damages and close to a hundred thousand RON for a full renovation.

In addition to the need to improve the country-wide coverage with primary care services by closing gaps and building new premises, it appears only rational to substitute those existing practices that are far below standard in terms of standards and space requirements with newly built facilities.

The Ministry of Health of Romania defines functional standard and space requirements for medical and dental offices (Ministerial Order No 1338/2007 "Rules on the Functional Structure of Medical and Dental Offices"). A medical office could be used as a family

medicine practice if it is composed of at least a waiting area, bathroom, treatment and consultation rooms and storage space. Space requirements have been officially defined at 1.0 to 1.5 square metres per adult patient and 1.5 to 2.0 square metres per child in the waiting room. The consultation room should have a minimum area of 9.0 square metres and access to a sink connected to hot and cold running water. In medical offices with three or more physicians which offer preventive care it is recommended to have a separate vaccination room. The administrative rooms should be separated from those in which medical activities are carried out. Based on existing physical infrastructure norms Table 1 describes space requirements for family physicians' offices.

Table 1: Minimal space requirements for FM practices depending on staffing

Premises	Space in m^2 1 FD, 1 FHN*	Space in m^2 2FD, 2 FHN	Space in m^2 3FD, 3 FHN	Space in m^2 4 FD, 4 FHN	Space in m^2 5 FD, 5 FHN	Space in m^2 6 FD, 6 FHN	Minimum required
Waiting area	10	14	18	22	26	30	1.5 – 2.0 m^2 per patient
Family physician consultation room (s)	12	24	36	48	60	72	9.0 m^2, access to sink
Nurse room	12	16	18	28	38	48	
Treatment room	20	20	24	24	24	24	9.0 m^2, access to sink
Sterilization	10	10	10	10	10	10	
Sanitary room	8	8	8	8	8	8	
Storage	12	16	20	24	28	32	
Sub total	84	108	134	164	194	224	

Other additional space**	20	20	30	30	40	40	
Reception	0	0	0	10	16	24	
Space for administrative staff	0	0	0	16	16	16	
TOTAL for FM practice	**104**	**128**	**164**	**220**	**266**	**304**	
Additional space requirement for "permanent centre"							
Patient observation room with 2 beds	**-**	**-**	40	40	40	40	
TOTAL for permanent centre	**-**	**-**	**204**	**260**	**306**	**344**	

* FD: family doctor(s); FHN: family health nurse(s)

** e.g. space to ensure easy movement within the building, toilets, generator room, room for heating system and etc. (approximately 20% of functional area).

An analysis of diverse materials and government documents, including cost standards (e.g. Order no. 2748 of 29/11/2010) show that a realistic cost estimate for building a primary care practice would amount to approximate costs for constructions and installations (C+I) of between 580.00 and 630.00 EUR (between 2,436 and 2,646 RON; 1 EUR = 4.20 RON) per square metre. C+I costs for a new small family medicine practice would therefore amount to between 60,000 and 65,000 EUR (between 252,000 and 273,000 RON). Building a large permanent centre (with six family doctors supported by six nurses, and a patient observation room) would cost a minimum of 200,000 EUR (840,000 RON).

The development and building process of new premises will be guided by the relevant legal documents. The main steps to be taken for construction of medical premises are summarized in table 2.

	Table 2. Steps to be taken for construction of medical premises
1.	Identify desired location and initiate the process for purchasing the land (see steps 2, 3, 4). A land area under consideration should be within territorial/administrative boundaries of the town (i.e. *intravilan)*
2.	Obtain the Detailed Urban Plan (DUP) from the city/local council. DUP specifies the parameters, the rules applicable to a building: height, percentage of land occupied by construction, the coefficient of land occupation, the destination of the building (housing, offices, health facilities, commerce etc.).
3.	Obtain a geological survey report of the land from the local council. Sometimes, to minimize the risk, a new survey can be commissioned to be conducted by a private company.
4.	Consult local suppliers on location of utility (water, electricity, gas, sewerage) systems in relation to the land chosen. There should be no pipelines, equipments, power lines etc. placed underground.
5.	Purchase the land
6.	Contract an authorized architect/architectural company to design the building (infrastructure & architectural & installations plans). Space requirements are regulated by Ministerial Order no.1338/2007, as amended.
7.	Obtain a “Town-Planning” Certificate (in RO,*Certificat de Urbanism*), from local council, based on architectural project.
8.	Obtain a Construction Permit, from the city/local council, based on a town-planning certificate and an architectural project.
9.	Obtain permits from local suppliers on the usage for utility systems (water, gas, electricity supply, sewerage). The connection is required if the utility system exists in that area. Legal requirements on connection to utilities are stipulated in order no. 1338/2007, article 10.

10	Contract a building company to perform construction works. The building company should be identified through tender if the beneficiary is a public institution.
11	Recruit an authorized chief engineer (site supervisor) who will supervise the execution of construction works and will elaborate the Building`s Book. The chief engineer represents and acts on behalf of the building owner.
12	Execution of construction works and connection to utilities.
13	Registration of property - land & building- to the Land Registry Office. Registration is based on construction permit and building's book.
14	Equipping the building with specific equipment & furniture, according to Order of Minister of Health no.153/2003, Annex 2.
15	Obtain the sanitary authorization, according to Order no.1030/2009. A sanitary authorization is issued by the local public health authority, on the basis of self-declaration (statement on own responsibility of the medical office holder/legal representative). Other forms of authorization to be obtained include environmental and fire safety.

In case of rehabilitation works, the steps to follow are: point 6 -8, 10, 11,12, 14 and 15, if necessary. However, it depends on the complexity of the works. For example, if consolidation works are necessary, the geological survey will be needed. If some structural changes are required to ensure the best possible functional adaptation of health premises, an infrastructure development plan can be consulted with local public health authorities. Public health authorities provide advice with regard to construction, rehabilitation, functioning of a health unit on request of a facility owner (Order No 1030/2009).

4. 7.4.2. Ownership issues

According to the National College of Public Health 2008 Report, approximately 90% of primary care practices are owned by the local public administration. Doctors own only 5% of primary care facilities. In the short term there is no economically viable approach to upgrade the standard of primary care facilities. The problem of ownership needs to be addressed before a long-term comprehensive investment strategy can be developed. Government Emergency Ordinance No 68 as of 28.05.2008 acknowledges the need to incentivise private ownership after evaluation of the condition of premises. However, any strategy to improve the physical state of primary care facilities requires ownership structures that incentivise and facilitate investment.

The success of an immediate push for more private ownership would be limited in its effect because primary care doctors are lacking the financial means. Even though a few banks have a particular department for the financial affairs of family doctors, the general willingness to provide loans to family doctors is limited as a consequence of the relatively low income level. There is a case for introducing a system of loans custom tailored to family doctors. Stakeholders should work towards a solution with respect to securing loans for family doctors' investments in practice space.

The drive towards more private ownership of family medicine practices should also lead to clarity on the issue of how young doctors can enter family medicine practice and the related issue of practice succession in the case of retirement of an older family doctor. Here, complex legal and economic issues need to be tackled. Different country examples may serve as models. In Germany, for example, the transfer of a practice from a retiree to a younger doctor involves the transfer of property and equipment as well as the list of patients and the accreditation to the statutory health insurance scheme.

5. 7.4.3. Structural Funds

Before solving the more complex issues sketched in Section 4.2, an opportunity for financing the premises for family medicine practices could lie in the EU's Structural Funds. The strategic objective of the Structural Funds consists in supporting the economic, social, territorially balanced and sustainable development of Romania. In 2007-2013 the European Union provides reimbursable financial assistance to Romania through the following three structural instruments: the European Social Fund (ESF); the European Regional Development Fund (ERDF) and the Cohesion Fund (CF).

At present the guidelines for the 2014-2020 period are being discussed. The Ministry of Health and the professional associations of family doctors and nurses should be involved in demanding, that the need to finance family medicine premises in the rural area be taken into consideration. A special measure could be introduced, either within the Regional Operational Programme, Priority Axis 3 – improvement of social infrastructure, measure 3.1 Rehabilitation / modernization / endowment of the health services infrastructure, or within the Rural Development National Programme, Axis 3 Quality of life in the rural areas and diversification of the rural economy.

Thus, the local authorities and/or the family doctors could apply for grants under such a scheme, while providing a certain percentage of co-financing. Under such schemes, banks are usually more willing to provide credits for covering the co-financing. Certain rules can be imposed on the eligible beneficiaries and eligible costs, as well as on maintaining the investment for a number of years.

6. 7.4.4. Minimal diagnostic and laboratory equipment items suitable for FM practice

According to the assessment conducted by the School of Public Health in 2008, almost half (45%) of Romanian family physicians have limited access to laboratory and X-ray diagnostic capacities. Laboratory facilities are available inside or outside the practice, and a level of access to those varies from place to place with 40% of family physicians reporting none or insufficient access to lab and X-ray. Whereas X-ray equipment does not constitute a part of the equipment of a family medicine practice, X-ray services should be available through diagnostic referral. Yet certain basic diagnostics must be provided by the family physician. Additional investment is warranted to improve the current situation to ensure adequate access to basic diagnostic services for the population.

Normally, clinical decision in family medicine is not based on high technology investigations. The specific probability based decision making process is mainly informed by knowledge of

patients and the community. However the family physician ought to make a decision on the need of such investigation and ensure timely referral. While planning for a diagnostic capacity at primary care level, it should be considered that a family physician usually sees the patient at an early stage of disease when the predictive value of clinical examination and tests are low or less certain. Laboratory tests and investigations at a very early stage of disease, even if those are available at FM level, may still not have much diagnostic value as long as the issue of referral for urgent, severe cases is a concern. Even so, the availability of some basic tests and investigations in FM service units is very important. Family physicians should offer investigations, which are used in evidence based, effective screening programmes or those recommended for monitoring chronic conditions e.g. blood pressure measurement, ophthalmoscope to screen for hypertensive/diabetic retinopathy, sugar in blood or urine, blood cholesterol, protein in urine, serum creatinine etc. Some tests may be helpful in decision making on referrals to secondary care for non -urgent cases e.g. sputum microscopy, ECG, X –ray and ultrasound (US). Many family physicians in Romania think that ultrasound, if it is easily available at FM facilities, will significantly improve the clinical practice and attract more patients. It is worth to note that ultrasound has increasingly been used in many countries at primary care level to diagnose or monitor patients for certain conditions including screening for aortic aneurysms, gallstones, musculoskeletal injuries, breast lumps, testicular or thyroid swellings, and some antenatal scans. The results of some recent observational studies indicate that ultrasound offered by primary care physicians substantially reduces the number of intended referrals to a medical specialist, and makes it easier to reassure patients. Evidence on diagnostic accuracy of ultrasound scanning provided by family physicians and its cost-effectiveness is still limited. Taking into consideration the potential clinical benefits of ultrasound scanning at primary care level and a positive attitude of Romanian family physicians towards this practice, this plan recommends ultrasound as an optional piece of equipment to be installed at family medicine practices and provides cost estimates for US modalities, which are most frequently used by primary care providers in different countries

The list of equipment recommended for family medicine practice is presented in Table 3. The list is largely based on Ministerial orders[22] defining minimum equipment for family medicine office and permanent centres. Besides, it offers some optional equipment which can improve a diagnostic and treatment capacity of FM practices. The list contains minimum equipment items required for family medicine offices and permanent centres.

The prices are given for the equipment of a family medicine team, i.e. a family doctor and a family health nurse.

[22]Order of the Minister of Health # 153/2003 on minimum equipment for family medicine offices and Order #697/112 of June 2011on standards for permanent centres

Table 3: Medical equipment recommended for family medicine teams

	Item	Quantity	Ave. price (in RON)
1.	Ear syringing equipment „propulse“	1 per practice	880
2.	Weighing scales-Adult	1 per practice	200
3.	Sphygmomanometer	At least 1 per team	200
4.	Manometer (with three size cuff)	One each: doctor and nurse	600
5.	Pelvimeter	1 per practice	230
6.	Tape measure	1 per practice	30
7.	Vaginal speculae	5 per team	425
8.	Reflex hammer	1 per each physician	32
9.	Negatoscope for X Ray	1 per practice	500
10.	Minor surgery sets	1 per practice	240
11.	Thermometer	10 per practice	280
12.	Heightmeter	2 per practice	300
13.	Gynaecological chair	per each physician room and one extra forthe treatment room	2100
14.	Refrigerator	1 per practice	860
15.	One channel ECG	1 per practice	5000
16.	Adjustable couch	1 per family physician	1800
17.	Weighing scales-Baby	1 per practice	200
18.	Ophthalmoscope	at least one per team	550
19.	Otoscope	1 per family physician	450
20.	Nebuliser	1 per practice	250
21.	Adult and paediatric nebuliser sets	1 per practice	250
22.	Peak flow meters	at least 2 per team	160
23.	Examination lights	1 per practice	500
24.	Height Measure	1 per practice	345
25.	Paediatric examination table	1 per practice	1400
26.	Trolleys	1 per practice	1000
27.	Dressing chair	1 per practice	400
28.	Stethoscope	One per each physicians and nurse	280
29.	Vision Chart	1 per practice	100
30.	Colour vision chart	1 per practice	150
31.	First aid kit	1 per team	500
32.	Autoclave	1 per practice	10000
33.	Dry sterilisation	1 per practice	4000
34.	Drug cabinet	1 per small practice (1-3 teams)	2000
Optional			
35.	Fetal Doppler	1 per practice	5000

36.	Ultrasound	1 per practice	33000
37.	Generator	1 per practice	1000
Compulsory in case of out of hours service provision			
38.	Emergency kit with a portable defibrillator	1 per practice	8000
Laboratory equipment			
39.	Glucometer	at least 1 per practice	40
40.	Microanalysor	1 per practice	4000

Price sources: Price lists of international and national providers of medical products (e.g. Medisal Romania).

The prices for basic equipment (items 1 to 34) amount to a sum of 36,212 RON (approximately 8,600 EUR). The full equipment list excluding Fetal Doppler (35) and ultrasound (36) amount to approximately 50,000 RON (12,000 EUR).

A family medicine practice also requires basic IT equipment, at least laptop and printer. The range of market prices is generally known. In 2007, every doctor within the national evaluation programme received a laptop and a printer. Table 4 lists the minimum office furnishing of a primary care practice.

Table 4: Office furnishing of a primary care practice

	Office furnishing	Quantity
1.	Table for office	2 per practice of 1 FP and 1 Nurse
2.	Chair	10 per practice
3.	Office armchairs	2 per practice of 1 FP and 1 Nurse
4.	Bookcase	2 per practice
5.	Small table for patient education materials	1 per practice
6.	Tables for kitchen	1 per practice
7.	Coat hook	2 per practice
8.	Book shelves for medical records	10 per practice

A rather basic set of new furniture would reasonably require an investment of between 1,500 and 2,000 EUR (between 6,300 and 8,400 RON).

The costs of a range of disposables also need to be taken into account in the context of a practice's basic equipment. However, these do not count as investment costs and do not significantly change the overall range of costs.

Disposables include medical products, such as surgical gloves, tongue depressors or (rectal) tubes, but also disposable supplies for quick laboratory tests, e.g. occult blood tests, pregnancy tests, urine analysis strips or strips to use with the glucometer.

Permanent centres should be well equipped to accommodate needs of patients during medical emergencies. Standard emergency medical kits with a portable defibrillator have to be available as minimum requirement at permanent centres and family medicine practices offering 24/7 services. Depending on the size of the permanent centre, additional furniture

and medical equipment will be required. Prices in Table 2 provide an overview of equipment prices, that indicate the relative dimensions of costs faced in setting-up a practice or permanent centre.

6: References

American Association of Family Physicians (AAFP) _
http://www.aafp.org/online/en/home/policy/policies/f/fammeddef.html

Blümel M, Henschke C (2010), Reform of provider payment in ambulatory care. *Health Policy Monitor*, October 2010. Available at http://www.hpm.org/survey/de/a16/3 (accessed 18/12/11).

Gosden T, Pedersen L, Torgerson D (1999), How should we pay doctors? A systematic review of salary payments and their effect on doctor behaviour. *QJM* 92:47-55.

Gottret P, Schieber G (2006), *Health Financing Revisited: A Practitioner's Guide*. Washington DC: World Bank.

Health Professionals Council, UK, 2011 http://www.hpc-uk.org/registrants/cpd/

Health Promotion Glossary, WHO/HPR/HEP/98.1

http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf

Health Evidence Network. What are the arguments for community-based mental health care? Annex 2. Key principles for balanced community-based mental health services [web site]. Copenhagen, WHO Regional Office for Europe, 2004
http://www.euro.who.int/HEN/Syntheses/mentalhealth/20030903_1

Juan Gervas (2004) Primary Care: Western Europe best practice of institutional involvement and responsibilities in Human Resource policy.

Miranda Pallan, John Linnane and Sam Ramaiah, Evaluation of an independent, radiographer-led community diagnostic ultrasound service provided to general practitioners, Journal of Public Health, Vol. 27, No. 2, pp. 176–181

National Health Service (NHS)(2011), Quality and Outcomes Framework Achievement Data 2010/2011. NHS/Information Centre for Health and Social Care (26 October 2011).

Primary Health Care – 2010; The Australian Medical Association (AMA)
http://ama.com.au/node/5992

Speets AM, Hoes AW, van der Graaf Y, Kalmijn S, de Wit NJ, Montauban van Swijndregt AD, Gratama JWC, Rutten MJCM and Mali WPThM. Upper abdominal ultrasound in general practice: indications, diagnostic yield, and consequences for patient management. Family Practice 2006; 23: 507–511.

The Role of the General Practitioner/Family Physician in Health Care Systems: A Statement from WONCA, 1991

The Royal Australian College of General Practitioners, Submission to the Department of Health and Ageing: Detailed Review of Funding For Diagnostic Imaging Services 30 April 2010

Robinson J (2001), Theory and practice in the design of physician payment incentives. Milbank Quarterly 79(2): 149-177.

The world health report 2000 - Health systems: improving performance; WHO, 2000; http://www.who.int/whr/2000/en/

UK Royal College of General Practitioners 2007a http://www.rcgp.org.uk/

World Health Organization (2000), *The World Health Report 2000. Health Systems: Improving Performance*. Geneva: WHO.

World Health Organization; final draft report; "Evaluation of structure and provision of primary care in Romania"; Primary care in the WHO European Region; WHO Europe; 2011

Websites:

MOH: www.ms.ro

CNAS (health insurance): www.cnas.ro

SNMF (National Family Medicine Society): www.snmf.ro

Rural & Remote Health (journal): www.rrh.org.au

CNSMF (National Centre for the Study of Family Medicine): www.cnsmf.ro

9: ANNEXES

ANNEX 1: Template Action Plan

Outcomes	Activities	Timing	Responsible bodies	Resources required
Strategic objective 1:				
Strategic objective 2:				
Strategic objective 3:				
Strategic objective 4:				

Annex 2: Template Monitoring and Evaluation Framework

Activities	Verifiable indicators for Outputs	Timing	Sources of information
Strategic objective 1:			
Strategic objective 2:			
Strategic objective 3:			
Strategic objective 4:			

ANNEX 4: The Action Plan for the implementation of the Primary Care Development Strategy in Romania in 2012-2013

PHASE III

ACTION PLAN 2012-2014
FOR THE IMPLEMENTATION OF THE ROMANIAN PRIMARY CARE DEVELOPMENT STRATEGY 2012-2020

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ACTION PLAN 2012-2014 FOR THE IMPLEMENTATION OF THE ROMANIAN PRIMARY CARE DEVELOPMENT STRATEGY 2012-2020

The specific objectives presented in the Primary Care Development Strategy must be achieved by specific activities implemented by specific actors in specific periods of time with specific resources. Such details are provided in this Action Plan. As stated in the Strategy, the activities can be of a policy-making, legal, technical, organisational, financial or educational nature. The Action Plan is elaborated for the first two years of the implementation of the strategy (2012-2013) although some activities are shown to be continuing after 2013. For many activities in the Action Plan, organisations and institutions must cooperate to achieve the desired results, and responsibilities are clearly allocated.

The Action Plan does not describe the total range of activities to be undertaken in the field of family medicine, but leaves a possibility for additional activities to be developed in parallel, in accordance with priorities and the availability of resources.

An explanation of the resources required to implement the Primary Care Development Strategy is presented at the end of this document.

Abbreviations used in the Action Plan:

ANR	= Romanian Nursing Association
CMR	= Romanian College of Physicians
CNAS	= National Health Insurance House
CNSMF	= National Study Centre for Family Medicine
CPD	= continuous professional development
DPH	= (Judet) Department of Public Health
FM	= family medicine
FTE	= full-time equivalent
IT	= information technology
MOH	= Ministry of Health
NIPH	= National Institute of Public Health
OAMGMAMR	= Order of Nurses, Midwives and Medical Assistants in Romania
SNMF	= National Family Medicine Society

GENERAL OBJECTIVE 1: ENSURE PROPER PLANNING OF HUMAN RESOURCES FOR FAMILY MEDICINE

Specific objective 1.1. Ensure sufficient inflow of family medicine residents and nursing students so that a proper balance of inflow and outflow of family medicine professionals guarantees adequate staffing by the year 2017 and beyond.				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. produce statistics on family doctors	Annual statistical overview	Design: before July 2013 Overviews: annually	Special group/agency with contributions from CMR, MOH, CNAS, Medical Faculties, NIPH	1 permanent FTE for data processing per year, 10 weeks combined FTEs of regular staff per year, administrative expenses;
b. annual survey of 5th year medical students	Annual survey data	Annually	Medical Faculties, MOH and Ministry of Education	6 weeks combined FTEs of regular staff for set up; then 3 weeks FTEs per year, administrative expenses;
c. annual survey of residents in family medicine	Annual survey data	Annually	Medical Faculties, DPHs, MOH	2 weeks FTEs for each DPH; 5 weeks FTEs in MOH; administrative expenses;
d. regular trends and forecasts	Regular trends and forecast reports, with recommendations	Every two years (beginning of 2013, 2015, 2017, 2019)	MOH, assisted by the special group/agency with contributions from CMR, CNAS and Medical Faculties	10 weeks combined FTEs of regular staff; administrative expenses;
e. produce policy document on family health nurses	Policy document	March-December 2012	MOH, ANR, OAMGMAMR, Ministry of Education	10 weeks combined FTEs of regular staff; workshops;

Specific objective 1.2. Enable young doctors to start a family practice				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. explore the feasibility of guaranteeing bank loans	Analytical paper	March 2012 until December 2013	Local authorities, SNMF	8 weeks combined FTEs of regular staff;
b. explore the feasibility of providing soft loans or free premises	Analytical paper	March 2012 until December 2013	Local authorities, SNMF	8 weeks combined FTEs of regular staff;
c. explore the	Analytical paper	March 2012	CNAS, SNMF	8 weeks combined

feasibility of hiring young doctors		until December 2012		FTEs of regular staff;
d. provide opportunity to practice to 3rd-year FM residents in permanent centres	Decree	March 2012 until December 2012	MOH, SNMF, Medical Faculties	12 weeks combined FTEs of regular staff; workshops; administrative expenses;

GENERAL OBJECTIVE 2: ENSURE A SUSTAINABLE, EFFICIENT AND PERFORMANCE-PROMOTING PAYMENT METHOD FOR FAMILY MEDICINE PRACTICES

Specific objective 2.1. Optimise the division between capitation and fee-for-service payments.				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. analyse the rationality of the present fee-for-service payment	review of the list of paid services for consequences for cost and quality	March-December 2012	CNAS, SNMF	6 weeks combined FTEs of regular staff; meetings;
b. establish the proportion of capitation payment	revised division between capitation and fee-for-service payment	March-December 2012	CNAS, SNMF	12 weeks combined FTEs of regular staff; meetings;
c. introduce new fee-for-service system	new fee-for-service system	From January 2013	CNAS	12 weeks FTEs of regular staff; administrative expenses; conference;
d. monitor fee-based payments	monitoring system	From January 2013	CNAS	6 weeks FTEs of regular staff per year; (potentially) update/standardization of IT system;

Specific objective 2.2. Increase the budget for family medicine linked to a reduced referral rate				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. produce overview of referral practices	overview of referral data	March-December 2012	CNAS, SNMF	6 weeks FTEs of regular staff depending on data quality; meetings;
b. agree on reduction of	agreement for reducing	September-December	CNAS, SNMF	Workshops; negligible staff

unnecessary referrals especially to inpatient care	referrals + financial consequences	2012		time, subject to outcome of 2.2.a
c. distribute referral data to all FM practices	annual overviews of referral data	Early 2013, and from then annually	CNAS	4 weeks FTEs of regular staff; administrative expenses; printing and distribution cost;

Specific objective 2.3. Introduce more appropriate capitation scales				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. revision of capitation scales	revised capitation scales	March-December 2012	CNAS, CNSMF, SNMF	9 weeks combined FTEs of regular staff; workshop;
b. lifting of cap on capitation payment in underserved rural areas	decision to lift cap on capitation payment in underserved rural areas	From January 2013	CNAS, MOH	negligible once data availability is ensured

Specific objective 2.4. Introduce performance criteria into the framework contract				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. analyse options for performance payment	analytical report	March-December 2012	CNSMF, SNMF	8 weeks combined FTEs of regular staff; meetings;
b. discuss feasibility of introducing performance payment	feasibility report	January-December 2013	CNAS, SNMF, MOH	8 weeks combined FTEs of regular staff; meetings;
c. gradual introduction of performance payment	functioning performance payment system	From January 2014	CNAS	12 weeks FTEs of regular staff for pilot introduction; conferences (given feasibility); 12 weeks FTEs of regular staff for roll-out per year;

Specific objective 2.5. Reduce bureaucracy in family medicine through joint effort by CNAS and SNMF				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. produce report on reduction of bureaucracy	report on the possible reduction of bureaucracy	2012-2013	CNAS, SNMF, MOH, Ministry of Finance	9 weeks combined FTEs of regular staff; workshops;
b. analyse requirements for	MOH decree	2012-2013	MOH advised by NIPH and	8 weeks regular FTEs given availability of

public health data			SNMF	reasonable current data base; workshops;
c. introduction of system with reduced paper work	new reporting system	From January 2014*	MOH and CNAS	10 weeks combined FTEs of regular staff; 8 weeks FTEs for IT expertise; updated/upgraded IT infrastructure depending on current system; meetings;

*though implementation time frame goes beyond the strategy, the activity requires preparation in 2013, therefore is included in the AP;

Specific objective 2.6. Decrease the number of uninsured citizens by a registration drive				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. special efforts to increase registration rate for health insurance	decrease in number of uninsured citizens	2012-2020	Government of Romania, local authorities	12 weeks combined FTEs per year; information campaign (media, radio, TV); printing and dissemination costs;
b. issue guideline for payment for uninsured patients	MOH guideline	March-December 2012	MOH, CNSMF, CNAS	Meetings; administrative expenses; potentially negligible staff time if consensus established;

GENERAL OBJECTIVE 3: IMPROVE THE QUALITY OF FAMILY MEDICINE SERVICES

Specific objective 3.1. Produce and use clinical guidelines for family medicine				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. agree on structure of FM guidelines agency	agreement on guidelines agency	March-June 2012	MOH, CMR, SNMF, CNSMF, CNAS	8 weeks combined FTEs; meetings and workshops; administrative expenses;
b. collect and evaluate national and international guidelines	overview of existing guidelines	July-December 2012	guidelines agency	26 weeks FTEs per year for web administration/secretarial work; 10 weeks FTEs per guideline; (alternative: 52 weeks FTEs per year e.g. split into 2 half-time positions); translation costs; administrative expenses;
c. introduce guidelines in	guidelines incorporated in	From January	Medical Faculties,	for set up: workshops, administrative & travel

curricula	undergraduate, residency and CPD curricula	2013	providers of CPD courses	expenses; then average 8 weeks FTEs per year for medical faculties; FTEs for CPD providers subject to number of courses; printing and dissemination costs;
d. analyse need for FM nursing guidelines	report with results of analysis	March-December 2012	ANR, OAMGMAMR, SNMF, CNSMF	12 weeks combined FTEs of regular staff; workshops; administrative and travel expenses;

Specific objective 3.2. Increase family medicine content in undergraduate and residency training (and nursing)				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. proposal for common undergraduate FM curriculum	proposal to MOH and Ministry of Education, via the Medical Faculties	March-December 2012	Departments of FM in the Medical Faculties, CMR, SNMF, CNSMF, Ministry of Education	12 weeks combined FTEs; meetings; workshops; administrative expenses; Potentially, international travel costs, translation costs;
b. agree on revised FM residency curriculum	proposal to the Medical Faculties	before December 2013	Departments of FM in the Medical Faculties, CMR, SNMF, CNSMF, MOH	9 weeks combined FTEs; meetings; workshops; administrative expenses; travel costs; translation costs;
c. match number of affiliated FM practices to need	appropriate number of affiliated FM practices	Estimate in September 2012; implementation from September 2012	Departments of FM in the Medical Faculties	8 weeks combined FTEs; Meetings; workshops; Potentially travel costs;
d. propose FM content in nursing curricula	proposal to MOH, Ministry of Education and Nursing Schools	2012-2013	ANR, OAMGMAMR, MOH, Ministry of Education	12 weeks combined FTEs; administrative expenses; travel costs; translation costs;

Specific objective 3.3. Improve quality of Continuous Professional Development				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. evaluate existing CPD activities and propose	overview of CPD activities and proposal for improvement	March-December 2012	SNMF, CNSMF, CMR, departments of FM in Medical	negligible for overview given the current data availability at CMR;

improvements			Faculties	6 weeks combined FTEs for proposal for improvement; meetings;
b. improve accreditation of CPD activities and their payment	proposal for improved accreditation and payment	March-December 2012	SNMF, CNSMF, CMR	4 weeks combined FTEs of regular staff; workshops; given already established standardization level;
c. roll out comprehensive CPD programme	expansion of agreed CPD programme	2013-2020	all institutions offering accredited CPD courses	8 weeks FTEs for administration of expanded programmes; implementation of CPD courses potentially financed by sponsorships;
d. analyse and propose CPD programme for FM nurses	analysis + proposal	2012-2013; development of CPD programme: 2014-2015	ANR, OAMGMAMR, SNMF, CMR	12 weeks combined FTEs of regular staff; workshops; administrative expenses; travel costs;

Specific objective 3.4. Ensure regular feedback on performance data to family medicine practices				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. agree on feedback of performance data	agreement on feedback mechanism	March-December 2012	CNAS, SNMF, CNSMF	6 weeks combined FTEs of regular staff; meetings; workshops;
b. produce annual reports on performance	performance data in annual reports	first time in 2012 annual report	CNAS	6 weeks FTEs of regular staff per year; administrative expenses; printing and dissemination costs

GENERAL OBJECTIVE 4: IMPROVE THE ORGANISATIONAL CAPACITY IN FAMILY MEDICINE

Specific objective 4.1. Strengthen the gate keeping and referral system				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. advise family doctors on referral discussions	advisory note	March-December 2012	CNAS, SNMF	4 weeks combined FTEs of regular staff; meetings;
b. do not reimburse secondary/tertiary	decision	March-December	CNAS	Minimal staff time; administrative

care for self-referred patients		2012		expenses;
c. explain out-of-pocket payment for self-referred patients	explanatory note	March-December 2012	CNAS, MOH, SNMF	6 weeks combined FTEs of regular staff; administrative expenses; printing and distribution costs for leaflets;

Specific objective 4.2. Increase the role and competencies of the professional associations				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. develop SNMF strategy	SNMF strategy paper	March-December 2012	SNMF	6 weeks FTEs of regular staff
b. develop ANR strategy	ANR strategy paper	March-December 2012	ANR, OAMGMAMR	8 weeks combined FTEs of regular staff time; meetings; potentially travel costs

Specific objective 4.3. Gradually organise the availability of family medicine services for urgent cases outside office hours				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. develop guidelines for FM in urgent situations	set of guidelines for urgent situations	2012-2014	guidelines agency	10 weeks FTE of regular staff (per guideline, if based on existing one); potentially translation costs;
b. gradually expand 7/24 availability of FM	increasing proportion of the population covered by 7x24 FM	2012-2020	FM practices, CNAS, MOH	8 weeks combined FTEs of regular staff for set-up; meetings; additional resources for increased working hours of FM
c. analyse appropriateness of permanent centres and duty rosters	analytical report	March-December 2012	MOH, SNMF, local authorities	9 weeks combined FTEs of regular staff; meetings and workshops; travel costs;

d. improve payment for 7/24 availability	improved payment system for 7x24 availability	Methodology_ 2012-2013; implementation_ 2014-2020	MOH, CNAS, SNMF	8 weeks combined FTEs of regular staff; meetings and workshops;
e. support FM solo practices in 7/24 availability	proposal for support to rural solo practices without group duty rosters	2012-2013	CNAS, SNMF, MOH, local authorities, Medical Faculties	10 weeks combined FTEs of regular staff; Meetings; workshops; travel costs;

Specific objective 4.4. Make better use of the Family Medicine Consultative Committee in development, implementation and evaluation of policy				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. organise regular meetings of the FM Consultative Committee	regular meetings	From March 2012 onwards	MOH	3 weeks FTEs of regular staff per year; administrative expenses; potentially travel costs;
b. appoint additional members to the Committee	appointments	March 2012	MOH	negligible staff time; administrative expenses;

Specific objective 4.5. Link community nurses to family medicine practices				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. issue additional regulation for community nursing	MOH decree	March-December 2012	MOH, local authorities, SNMF	6 weeks combined FTEs of regular staff; meetings and workshops; potentially travel costs;
b. specify educational requirements for community nurses	MOH decree	2012-2013	MOH, ANR, OAMGMAMR	9 weeks combined FTEs of regular staff; meetings; workshops; travel costs; administrative expenses;
c. stimulate cooperation between community nurses and FM practices	cooperation mechanism	2012-2013 and further continued till 2020	local authorities, FM practices	6 weeks combined FTEs of regular staff for set-up; then 3 weeks FTEs per year; meetings;

Specific objective 4.6. Facilitate transfer of ownership of premises to family doctors				
Activities	*Desired*	*Time frame*	*Responsible*	*Required resources*

	output/outcome		*actors*	
a. discuss option for transfer of FM premises to family doctors	joint statement by MOH + Ministry of Administration and Interior	March-December 2012	MOH, Ministry of Administration and Interior, SNMF	6 weeks combined FTEs of regular staff;
b. sell FM premises to family doctors	increased number of premises sold	2013, and further continued including 2015	local authorities, FM practices, MOH, Ministry of Administration and Interior	16 weeks combined FTEs of regular staff; meetings; administrative expenses;
c. examine possibilities for private banks to provide loans to family doctors	analysis by SNMF	March-December 2012	SNMF	3 weeks FTEs of regular staff time;

GENERAL OBJECTIVE 5: IMPROVE THE ACCESSIBILITY OF FAMILY MEDICINE IN RURAL AND REMOTE AREAS

Specific objective 5.1. Stimulate involvement of local authorities in underserved areas				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. stimulate involvement of local authorities	joint statement by MOH + Ministry of Administration and Interior	March-December 2012	MOH, Ministry of Administration and Interior	minimum staff time; meetings and workshops;
b. explain possible incentives to local authorities	MOH paper	March-December 2012	MOH advised by SNMF and CNSMF	8 weeks combined FTEs of regular staff; administrative expenses; printing and distribution costs;

Specific objective 5.2. Promote family medicine study by rural students (e.g. scholarships)				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. stimulate local authorities to provide scholarships	increasing number of scholarships provided	2012-2013 and further continued till 2020	Judet Health Authorities, local authorities	5 weeks combined FTEs of regular staff per year; scholarship costs (mostly living expenses)
b. stimulate medical faculties and nursing schools to reserve places for rural students	increasing number of places reserved for rural students	2012-2013 and further continued till 20202020	Judet Health Authorities, Medical Faculties, Nursing Schools	8 weeks combined FTEs of regular staff; meetings; workshops; then 5 weeks FTEs of regular staff per year;

Specific objective 5.3. Allow pharmaceutical points for family doctors in areas without pharmacy				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. agree on a model of pharmaceutical provision in underserved areas	agreement on a model of pharmaceutical provision in underserves areas	March-December 2012	MOH, CNAS, SNMF, College of Pharmacists	8 weeks combined FTEs of regular staff; meetings; administrative expenses; travel costs;
b. present legal changes for pharmaceutical provision in underserved areas	proposal for legal amendments	January-June 2013	MOH	3 weeks FTEs of regular staff;
c. train family doctors in the management of pharmaceutical provision	increasing number of family doctors trained	2013-2015	Medical Faculties, other institutions providing CPD courses, CNAS, CMR	6 weeks combined FTEs of regular staff for administration; potentially lecturer fees; potentially rent; administrative expenses; travel costs; printing costs

Specific objective 5.4. Introduce and monitor financial and non-financial incentives for rural practice				
Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. analyse incentives for rural FM practice	analysis of promising incentives for rural FM practice	March-December 2012	MOH, CNAS, SNMF, ANR	12 weeks combined FTEs of regular staff; meetings; workshops; administrative expenses; travel costs;
b. introduce and monitor new incentives system	new incentives system introduced and monitored	2013-2020	MOH, CNAS, local authorities	9 weeks combined FTEs for introduction; 6 weeks FTEs for monitoring per year; workshops, meetings, administrative expenses;
c. evaluate new incentives system	evaluation report	2016	research institution	10 weeks FTEs for research institution;

Specific objective 5.5. Organise rural clerkships (assignments) for undergraduate medical students and family medicine residents

Activities	*Desired output/outcome*	*Time frame*	*Responsible actors*	*Required resources*
a. select rural FM practices for training purposes	evaluation report on the availability of rural FM training practices	March-December 2012	FM Departments of Medical Faculties, SNMF, CMR, CNSMF	9 weeks combined FTEs of regular staff; meetings; administrative expenses;
b. affiliate and improve rural FM practices for training purposes	increasing number of rural FM training practices affiliated and improved	2013-2020	FM Departments of Medical Faculties, SNMF, CMR, CNSMF	9 weeks combined FTEs of regular staff per year; Meetings; administrative expenses; travel costs
c. gradually increase the period of training in rural FM practices	increasing number of students and residents trained in rural FM practices	2013-2020	FM Departments of Medical Faculties	8 weeks FTEs of regular staff for set-up; then 4 weeks FTEs of regular staff per year; meetings; administrative expenses;
d. design remuneration method for rural FM training practices	remuneration method approved	March-December 2012	Medical Faculties, CMR	8 weeks FTEs of regular staff; (potentially) piloting expenses;

Specific objective 5.6. Organise the provision of basic lab tests by family doctors in rural areas.				
Activities	***Desired output/outcome***	***Time frame***	***Responsible actors***	***Required resources***
a. agree on minimum set of lab tests in rural areas	agreed minimum set of lab tests	March-December 2012	CNSMF, SNMF, CNAS	6 weeks combined FTEs of regular staff; meetings; administrative expenses;
b. incorporate these tests into FM guidelines	tests incorporated in FM guidelines	2013-2015	guidelines agency	6 weeks combined FTEs of regular staff per year; Meetings; administrative expenses;
c. establish payment system for rural lab tests	agreed payment system for lab tests	March-December 2012	CNAS, SNMF	8 weeks combined FTEs of regular staff per year; meetings, administrative expenses;

Explanatory note on the required resources for the implementation of the Primary Care Development Strategy

The required resources for the implementation of the Primary Care Development Strategy have been determined together with national stakeholders, taking due account of the specific context and current status quo.

In order to allow for practical application and planning of the resources a monetary estimate has been omitted. Instead, staff time has been identified as the main element for the required resource planning, expressed in full-time equivalents (FTEs). Additionally, organisational (meetings, conferences etc.), administrative and transport costs have been stated, where applicable. This approach has been chosen to reflect the general notion, that the majority of the specific training activities may be implemented with modest additional resources. The notion is believed to hold particularly true in terms of required FTEs, since with a few notable exceptions (see below), the great majority of activities may be implemented with the staff currently available in the stakeholder institutions. There are, however, institutions where the number of currently available staff is very limited. Example could be the MoH PHC staffing capacity, which definitely needs extension.

Following an analysis of the current policy processes, it is believed that a strong cooperation among stakeholders is a key resource investment to assure the successful implementation of the Primary Care Development Strategy. This should be done in informal ways (phone, e-mail exchanges) as well are through more formalized arrangements, e.g. regular meetings, conferences and workshops, bearing in mind that these would require additional resources.

It is noteworthy to mention, that certain activities benefit from economies of scale if conducted in conjunction or with little time difference in between, such as activities 1.2a and 1.2b. Other activities, can be classified as consequences from former steps and thus require negligible staff time or pure administrative inputs, given that the data in question is already existent, such as activity 4.4b

In the case of several activities, the initially required resources may be offset by significantly larger savings made in later periods, once the implementation has been done. This is particularly evident in the case of the activities summarized under specific objectives 2.5., 2.6 as well as following the anticipated reduction in financial and technical resources stemming from a streamlined administration and a universal health coverage targeted as outcome under these points. In a similar manner, once the specific objectives 4.1 and 4.3 are achieved savings may be expected from reduced referral time and increased efficiency of care during after-hours. Specific objective 4.6 also yields a potential for savings, given that once premises are sold to family physicians, government authorities are exempted of the obligations associated with maintenance and further investments, while freeing up administrative resources. In a subsequent instance, these savings, e.g. in staff time maybe fed back into other activities.

A more comprehensive resource investment is required for achieving the specific objectives 1.1, 3.1, and 4.3, a fact which is also reflective for the overall importance of these objectives in the sustainable implementation of the Primary Care Development Strategy. With respect to the specific objective 1.1 it is estimated that, a sizeable amount of information is needed, for which no platform or collection routine has been established. Subsequently, the largest share of the envisaged resource need is required for setting up a data collection and processing system as well as establishing a survey and dissemination routine.
With the aim to establish a new technical agency, specific objective 3.1 calls for the largest investment in resources. On the one hand, the stated considerations foresee a set-up, where an already existing organisation, acts as the host or secretariat of the new agency, tapping

its existing infrastructure. On the other hand, due consideration should be paid for ensuring enough human and technical resources are available to facilitate guideline review, screening, evaluation, approval and dissemination. These elements most likely demand additional staff to be employed, given that current structures, which might act as hosts for such an agency such as the CNSMF and the SNMF, have highly limited free capacities.

The importance of coordination and exchange mechanisms is to be particularly highlighted in the activities leading to the establishment of a guidelines agency. From a comparative perspective, it is believed that, while the resources involved in implementing the activities under 3.1. are considerable, this scenario of using existing organisations still poses a larger potential for cost-effectiveness than other options, which might involve setting up a completely new infrastructure, staff base and financial budget. Additionally to specific objective 3.1, achieving specific objectives 4.1 yields significant savings for future time periods, given that medical over-consumption, unnecessary referrals and mismanagement may be reduced once adherence to the guidelines is assured.

Finally, ensuring the availability of family medicine services for urgent cases outside office hours, as stated under 4.3, marks the third objective with initially sizeable resource requirements, given the need for creating new and improved systems like duty rosters as well as particularly adapting the payment systems to account for physicians working during afterhours. As stated above these initial resources are expected to be more than offset during subsequent time periods.

In conclusion, the implementation of the Primary Care Development Strategy will require modest additional resources during the first two years (2012-2013). Thereafter, besides the improved quality of care, budget neutrality or even cost savings for the overall health care sector during the subsequent period may be expected.

PHASE III

The Monitoring and Evaluation Framework, 2012-2013

Prepared by:

Kees Schaapveld

January, 2012

MONITORING AND EVALUATION FRAMEWORK FOR 2012-2013

The implementation of the Primary Care Development Strategy 2012-2020 must be monitored and evaluated in order to ensure that the implementation is on track and to provide the opportunity to adapt the Strategy if necessary. Key instrument applied for this purpose is a monitoring and evaluation framework, which is developed in accordance with specific Action Plans for Strategy implementation. By itself, the Action Plans are to be elaborated throughout the Strategy life time on by-annual bases.

The evaluation of the strategy should have a systematic character being carried out during the whole period of implementation, and shall include the development of annual progress reports, an evaluation report at mid-term, and the final evaluation report.

The aim of the **Monitoring and Evaluation Plan** presented in this document is to provide instrument for monitoring of an Action Plan for implementation of the Primary Care strategy in 2012-2013. For this purpose, this Monitoring & Evaluation Plan presents the same objectives and activities with the same numbers as in the Action Plan, but this time with indicators that will be used to measure the activities (process indicators) and especially - if possible - the outputs and outcomes (outcome indicators), the timing of their measurement, and sources of information for the quantification of the indicators. In some cases the time period for measurement exceeds the life-time of the Action Plan, considering that indicated activities and respective measurements will be continued in next phases of implementation of the Primary Care Strategy.

Abbreviations used in the column of “responsible actors”:

ANR	= Romanian Nursing Association
CMR	= Romanian College of Physicians
CNAS	= National Health Insurance House
CNSMF	= National Study Centre for Family Medicine
CPD	= continuous professional development
FM	= family medicine
MOAI	= Ministry of Administration and Interior
MOE	= Ministry of Education
MOH	= Ministry of Health
NIPH	= National Institute of Public Health
OAMGMAMR	= Order of Nurses, Midwives and Medical Assistants in Romania
SNMF	= National Family Medicine Society

GENERAL OBJECTIVE 1: ENSURE PROPER PLANNING OF HUMAN RESOURCES FOR FAMILY MEDICINE

Specific objective 1.1. Ensure sufficient inflow of family medicine residents and nursing students so that a proper balance of inflow and outflow of family medicine professionals guarantees adequate staffing by the year 2017 and beyond.			
Activ.	*Indicator*	*Timing*	*Sources of information*
1.1.a	publication of statistical overview on family doctors	annually	databases of CNAS, CMR, universities
1.1.b	publication of survey results on 5th year medical students	annually	databases of universities
1.1.c	publication of survey results on FM residents	annually	databases of universities
1.1.d	publication of trend and forecast reports	every two years	reports of 1.1.a, 1.1.b and 1.1.c
1.1.e	publication of policy report on family health nurses on websites of MOH and MOE	before 31 December 2012	information from MOH, ANR, OAMGMAMR

Specific objective 1.2. Enable young doctors to start a family practice			
Activ.	*Indicator*	*Timing*	*Sources of information*
1.2.a	publication of analytical paper	before 31 December 2013	local authorities, banking sector
1.2.b	publication of analytical paper	before 31 December 2013	local authorities, banking sector
1.2.c	publication of analytical paper	before 31 December 2012	CNAS, SNMF
1.2.d	publication of decree by MOH	before 31 December 2012	SNMF, Medical Faculties

GENERAL OBJECTIVE 2: ENSURE A SUSTAINABLE, EFFICIENT AND PERFORMANCE-PROMOTING PAYMENT METHOD FOR FAMILY MEDICINE PRACTICES

Specific objective 2.1. Optimise the division between capitation and fee-for-service payments.			
Activ.	*Indicator*	*Timing*	*Sources of information*
2.1.a	publication of list of paid services with consequences for cost and quality	before 31 December 2012	CNAS communication
2.1.b	published agreement on division between capitation and fee-for-service payment	before 31 December 2012	CNAS communication
2.1.c	actual introduction of revised fee-for service payment	1 January 2013	CNAS communication
2.1.d	overview of results of revised fee-for-service payment	annually from January 2013	CNAS annual reports

Specific objective 2.2. Increase the budget for family medicine linked to a reduced

referral rate			
Activ.	*Indicator*	*Timing*	*Sources of information*
2.2.a	publication of overview of referral data	early 2013	CNAS database
2.2.b	publication of agreement on reduction of referrals	before 31 December 2012	joint CNAS-SNMF communication
2.2.c	mailing of referral data to all FM practices	early 2013 and then annually	CNAS database

Specific objective 2.3. Introduce more appropriate capitation scales			
Activ.	*Indicator*	*Timing*	*Sources of information*
2.3.a	publication of revised capitation scales	before 31 December 2012	joint CNAS-SNMF communication
2.3.b	publication of decision to lift cap on capitation payment in underserved rural areas	before 31 December 2012	CNAS communication

Specific objective 2.4. Introduce performance criteria into the framework contract			
Activ.	*Indicator*	*Timing*	*Sources of information*
2.4.a	publication of analytical report on CNAS and SNMF websites	before 31 December 2012	international literature, joint CNAS-SNMF communication
2.4.b	publication of report on the feasibility of performance payment on CNAS and SNMF websites	before 31 December 2013	joint MOH-CNAS-SNMF communication
2.4.c	results of implementation of performance payment	annually from 2014	CNAS annual reports

Specific objective 2.5. Reduce bureaucracy in family medicine through joint effort by CNAS and SNMF			
Activ.	*Indicator*	*Timing*	*Sources of information*
2.5.a	publication of report on the reduction of bureaucracy	before 31 December 2013	joint CNAS-SNMF-MOH communication
2.5.b	publication of MOH decree	before 31 December 2013	international and national requirements and obligations
2.5.c	implementation of new reporting scheme	from 1 January 2014; results annually	MOH and CNAS annual reports

Specific objective 2.6. Decrease the number of uninsured citizens by a registration drive			
Activ.	*Indicator*	*Timing*	*Sources of information*
2.6.a	number of uninsured citizens at various administrative levels	annually	national statistics
2.6.b	publication of MOH guideline on MOH website	before 31 December 2012	MOH communication

GENERAL OBJECTIVE 3: IMPROVE THE QUALITY OF FAMILY MEDICINE SERVICES

Specific objective 3.1. Produce and use clinical guidelines for family medicine			
Activ.	*Indicator*	*Timing*	*Sources of information*
3.1.a	signed agreement	before 30 June 2012	joint communication
3.1.b	overview of national and international guidelines	before 31 December 2012	publication
3.1.c	increasing number of curricula using guidelines	2013-2020	reports by educational institutions
3.1.d	report with need of nursing guidelines	before 31 December 2012	communication

Specific objective 3.2. Increase family medicine content in undergraduate and residency training (and nursing)			
Activ.	*Indicator*	*Timing*	*Sources of information*
3.2.a	joint proposal available on MOH and MOE websites	before 31 December 2012	joint publication
3.2.b	agreement on FM residency curriculum published on MOH and MOE websites	before 31 December 2013	joint publication
3.2.c	estimate of need of affiliated training practices + implementation of affiliation	September 2012 followed by implementation	joint publication + reports by medical faculties
3.2.d	proposal on need of FM training in nursing curricula available on MOH and MOE websites	2012-2013	published proposal

Specific objective 3.3. Improve quality of Continuous Professional Development			
Activ.	*Indicator*	*Timing*	*Sources of information*
3.3.a	overview of CPD activities and proposal for improvement available on relevant websites	before 31 December 2012	published report
3.3.b	proposal for improved accreditation available	before 31 December 2012	published proposal
3.3.c	number and type of CPD courses available on SNMF website	2013-2020	reports by educational institutes
3.3.d	analysis and proposal available	before 31 December 2013; development of the CPD programme: 2014-2020	published report; published programme

Specific objective 3.4. Ensure regular feedback on performance data to family medicine practices			
Activ.	*Indicator*	*Timing*	*Sources of information*
3.4.a	joint agreement available	before 31 December	communication of joint

		2012	agreement
3.4.b	performance data published	annually after 2012	CNAS reports

GENERAL OBJECTIVE 4: IMPROVE THE ORGANISATIONAL CAPACITY IN FAMILY MEDICINE

Specific objective 4.1. Strengthen the gate keeping and referral system			
Activ.	*Indicator*	*Timing*	*Sources of information*
4.1.a	publication of advisory note	before 31 December 2012	joint SNMF-CNAS communication
4.1.b	decision on strict rule on non-payment for self-referral	before 31 December 2012	CNAS communication
4.1.c	information leaflet for patients on self-payment for self-referral	before 31 December 2012	joint SNMF-CNAS publication

Specific objective 4.2. Increase the role and competencies of the professional associations			
Activ.	*Indicator*	*Timing*	*Sources of information*
4.2.a	publication of medium-term SNMF strategy document on SNMF website	before 31 December 2012	SNMF publication
4.2.b	publication of medium-term ANR strategy document on ANR website or otherwise	before 31 December 2012	ANR publication

Specific objective 4.3. Gradually organise the availability of family medicine services for urgent cases outside office hours			
Activ.	*Indicator*	*Timing*	*Sources of information*
4.3.a	guidelines for urgent situations available on SNMF website	2012-2014	guidelines agency
4.3.b	proportion of population covered by 7x24 FM care	2012-2020	MOH and CNAS data
4.3.c	availability of analytical report on permanent centres vs. duty rosters	before 31 December 2012	MOH information via judet Departments of Public Health
4.3.d	proposal for improved payment available; followed by results of implementation	proposal before 31 December 2013; results of implementation annually after 2013	joint MOH-CNAS-SNMF proposal; results in CNAS annual reports
4.3.e	proposal for support to rural solo practices available	before 31 December 2013	joint MOH-CNAS-SNMF proposal

Specific objective 4.4. Make better use of the Family Medicine Consultative Committee in development, implementation and evaluation of policy			
Activ.	*Indicator*	*Timing*	*Sources of information*
4.4.a	minutes of regular Committee meetings available	regularly during 2012-2020	Committee minutes

4.4.b	new Committee members appointed	March 2012	MOH communication

Specific objective 4.5. Link community nurses to family medicine practices			
Activ.	*Indicator*	*Timing*	*Sources of information*
4.5.a	MOH decree on community nursing functions published	before 31 December 2012	MOH website
4.5.b	MOH decree on community nursing training published	before 31 December 2013	MOH website
4.5.c	evidence of improved cooperation between community nurses and FM practices	2012-2020	MOH information via judet Departments of Public Health

Specific objective 4.6. Facilitate transfer of ownership of premises to family doctors			
Activ.	*Indicator*	*Timing*	*Sources of information*
4.6.a	joint statement by MOH and MOAI available	before 31 December 2012	MOH and MOAI communication
4.6.b	number of FM premises sold to family doctors	2013-2015	MOH information via judet Departments of Public Health
4.6.c	SNMF analysis on bank loans done	before 31 December 2012	SNMF communication

GENERAL OBJECTIVE 5: IMPROVE THE ACCESSIBILITY OF FAMILY MEDICINE IN RURAL AND REMOTE AREAS

Specific objective 5.1. Stimulate involvement of local authorities in underserved areas			
Activ.	*Indicator*	*Timing*	*Sources of information*
5.1.a	joint statement by MOH and MOAI available	before 31 December 2012	MOH and MOAI communication
5.1.b	MOH letter to local authorities distributed	before 31 December 2012	MOH communication

Specific objective 5.2. Promote family medicine study by rural students (e.g. scholarships)			
Activ.	*Indicator*	*Timing*	*Sources of information*
5.2.a	number of scholarships provided by local authorities	2012-2020	MOH information via judet Departments of Public Health
5.2.b	number of places reserved for rural students	2012-2020	MOH information via judet Departments of Public Health

Specific objective 5.3. Allow pharmaceutical points for family doctors in areas without pharmacy			
Activ.	*Indicator*	*Timing*	*Sources of information*
5.3.a	agreement reached on pharmaceutical provision in	before 31 December 2012	MOH communication

	underserved areas		
5.3.b	legal amendments proposed by MOH	before 30 June 2013	MOH website
5.3.c	number of rural doctors trained in pharmaceutical management	2013-2015	CPD statistics

Specific objective 5.4. Introduce and monitor financial and non-financial incentives for rural practice			
Activ.	*Indicator*	*Timing*	*Sources of information*
5.4.a	joint analysis on promising incentives available	before 31 December 2012	joint communication by MOH, CNAS, SNMF, ANR
5.4.b	monitoring results of new incentive mechanisms	2013-2020	CNAS annual reports
5.4.c	results of new incentive mechanisms evaluated	2016	joint MOH-CNAS-SNMF report, potentially based on report by a research institute

Specific objective 5.5. Organise rural clerkships (assignments) for undergraduate medical students and family medicine residents			
Activ.	*Indicator*	*Timing*	*Sources of information*
5.5.a	report on availability of rural FM training practices available	before 31 December 2012	data from FM Departments of Medical Faculties, SNMF, CMR, CNSMF
5.5.b	number of rural FM training practices affiliated	2013-2020	data from FM Departments of Medical Faculties
5.5.c	number of medical students and FM residents trained in rural FM practices	2013-2020	data from FM Departments of Medical Faculties
5.5.d	remuneration method for rural FM trainers approved	before 31 December 2012	communication from Medical Faculties and CMR

Specific objective 5.6. Organise the provision of basic lab tests by family doctors in rural areas.			
Activ.	*Indicator*	*Timing*	*Sources of information*
5.6.a	agreed set of lab tests in rural FM available	before 31 December 2012	joint communication by CNSMF, SNMF and CNAS
5.6.b	agreed lab tests incorporated into FM guidelines	2013-2015	publications by the guidelines agency
5.6.c	agreed payment method for lab tests in rural FM practices available	before 31 December 2012	joint communication by CNAS and SNMF

Annex 6: Recommendations on amendments in the legal framework for supporting implementation of the Primary Care Action Plan 2012-2013

PHASE III

Recommendations on amendments in the legal framework for supporting implementation of the Primary Care Action Plan 2012-2013

Prepared by:

Alexandra Bejan

February, 2012

Implementation of the new Primary Care Development Strategy for 2012-2020 and the respective Action Plan for 2012-2013 requires addressing the existing challenges related to the legal framework, as well as introduction of new regulations.

The following proposal on amendments to the legal framework is made to allow diversification of the range of services in family medicine, to establish the appropriate payment for these services, and to encourage local government to enhance the support provided to the primary care personnel. The recommendations are given with regard to the objectives of the Primary Care Action Plan, including those related to ensuring competencies to work in rural settings for family doctors and nurses, improving accessibility of family medicine and pharmaceuticals, as well as ensuring sustainable, efficient and performance-promoting payment methods for family medicine practices.

Recommendations on altering the legal framework to allow the family physicians to manage pharmaceutical units in isolated rural areas

In order to increase the access to pharmaceuticals in remote settings, legal changes are required in the field of drug provision. It is necessary to modify or partly abolish art. 383 and 788 in the Health Law (no. 95 /2006), and art. 2 in the Pharmacy Law, no. 266/2008, which prohibit family doctors to provide drugs. It is feasible to stipulate the possibility for doctors, especially in remote areas to have limited stocks of primary care drugs. A list of such primary care drugs can be determined by means of appropriate secondary legislation. More specifically, we suggest the following steps to be taken:

- Drafting a new paragraph within article 2 of Pharmacy Law no. 266/2008, as an exception from the general rule stated in art. 2 par.(4), as follows: "By exception from provisions of par.(4), family doctors in remote areas without a pharmacy, are allowed to have limited stocks of primary care drugs."

- Articles 383 and 788 of Law 95/2006 shall be amended accordingly, by inserting the phrase "..., unless otherwise provided by law".

- Introduce new articles in Law 95/2006 and in Framework-contract: "Family doctors in remote areas without a pharmacy are obliged (or eligible) to have limited stocks of primary care drugs, being authorized in this regard."

- Introduce new provisions in Law 95/2006 and Pharmacy Law, given that it would be feasible to establish a fundholding system enabling family doctors to receive (from judet health insurance funds) a fixed budget from which to pay for primary care drugs, as follows: "The budget for purchasing the required primary care drugs, managed by family doctors in remote areas without pharmacy, will be determined by Ministry of Health and CNAS."; and "In order to obtain the authorization, family doctors who are to be allowed to provide drugs will be attending a special training program on administrative, technical, pharmaceutical and management aspects of drugs provision."

- Introducing a new article in Law no. 95/2006, respectively in the Framework-contract: "The List of primary care drugs, the minimum drug quantities, the management methods and more importantly maximum prices regulated by law to avoid potential abuse by doctors, will be developed by the Ministry of Health and the CNAS, on the basis of consultations with the College of Physicians, College of Pharmacists and representative professional associations of family doctors."

It is also necessary to establish a list of localities, without access to pharmacies and a list of authorized doctors who are allowed to provide PC drugs, by means of secondary legislation.

Recommendations on altering the legal framework to facilitate increased involvement of local authorities in providing funds for primary care

The support of primary care in rural areas should be specified by law. It is necessary to formulate the respective provisions as clear duties and obligations of a local government, e.g. a clear determination as to the distribution of costs for appropriate incentives between the state budget and the budget of the local authorities.

The transfer of ownership of medical premises is perceived as the most important issue among family doctors. Although the Government Emergency Ordinance no. 86/2008 regarding the sale of medical premises owned by state or administrative-territorial units entered into force in 2008, up to the present, very few medical facilities have been sold to family doctors, due to (in part, at least) local authorities` unwillingness to sell. The first step should be supporting enforcement of existing regulation. A specific suggestion concerning the support towards facilitating the transfer of ownership of premises to family doctors could be the establishment of a sale period within which local authorities would be obliged to sell the health premises to family practitioners. This will require the following addition to the Government Emergency Ordinance no. 86/2008: "Local authorities shall sell the premises within 3/6 months from the date on which the doctor-buyer expressed his official intention to buy."

The modifications in regulations to stimulate involvement of local authorities in PC especially in underserved areas, could include replacing the term "duties" with the term "obligations" within article 36 of Law no. 215/2001 on local public administration. This should relate, at least to ensuring access to health services; along with the introduction of sanctions for failure to comply with these obligations (e.g., a fine).

As indicated in the Action Plan for 2012-2013, in order to attract and retain family doctors in remote areas, local Government could grant free concession of premises (or the concession at a symbolic price) in the form of commodatum for a certain timeframe. This might be achieved by a separate government decision which in essence should reflect the following: „In case there are no applications submitted for purchasing the medical premises within a [x] period of time, the local authorities will provide free usage of those medical facilities to family doctors,or lease at a symbolic price, for a period of at least 5 years."; or by local authorities issuing specific decisions in this regard, in the latter case, the local council`s decision will be founded on the provisions of art. 36 par.(2) let.c) and par.(6) let.a), pct.3 of Law no. 215/2001 .

Recommendations on altering the regulatory framework to modify the calculation method for service charges and the range of reimbursed services

The Action Plan for 2012-2013 defines an objective to include specific services into fee-for-service payment system. Currently this is regulated by the Order no. 1723/950/27 of December 2011, in Chapter III let.B pt. 2 let.c., and let.D., Annex 1 of Methodological Norms of the Framework Contract, as part of the capitation payment system. Respectively, implementation of this objective will require amending the art. 1 par. (2) let.e) and art. 1 par.

(3) let.c) , Annex 2 of Order. no 1723/950/2011. However, this could only be done when the technical work on defining the list of services to be paid through fee-for-service is completed.

Similarly, when the technical work on modifying the Capitation Payment Methodology and the Capitation Formula is completed, respective changes should be made in Order no. 1723/950/2011.

One of the objectives of the Action Plan 2012-2013 refers to reduction or prevention of unnecessary referrals. It is necessary to insert the following new provision within art. 34 of the Framework Contract and within art. 7 of the Contract for providing PHC services: “Health insurance fund will transmit monthly/quarterly feedback reports on referrals (in anonymised individual, regional and national comparison) to family doctors.”

Similarly, in order to introduce changes related to improving the PC monitoring system, it is advisable to put a new provision in art. 270 par.(1)of Law no. 95/2006 (with regard to CNAS` duties), as follows;
”CNAS will prepare and submit to the Ministry of Health quarterly progress reports based on information on fee-for service and capitation received from local health insurance funds (judet). ”

Action Plan 2012-2013 states that the gate keeping function of family doctors should be strengthened. According to the law, medical services in secondary care (services reimbursed by CNAS, set in the basic package) have to be provided only on the basis of a referral. In practice, this is not always the case. It is therefore recommended, that the CNAS inspects health care providers and introduces sanctions in case of non-compliance with the rules imposed by law. At present, the sanction defined in provisions prescribes non-reimbursement of health services provided without referral. This sanction should be enforced. Some other measures can also be considered, as introducing a financial penalty for secondary care providers, delivering services without the referral from a family doctor; or administrative measures, as refusing patients access to non-emergency health services without referrals from family doctors.

Action Plan 2012-2013 calls for decreasing the number of uninsured citizens. New legal measures are needed to enforce the obligation to have social health insurance to achieve this objective. An explicit duty to conclude an insurance contract is to be incorporated in the Health Law (95/2006) together with a threat of punishment; e. g. “Failing to conclude a health insurance contract is penalized by the insurer, which is then allowed to claim all unpaid contributions.”

There is an urgent need of enforcing the obligation of health insurance funds to inform the population (*ex officio*) on their rights and obligations. This could be achieved through:

- Inserting a new paragraph in art. 271 “the attributions of health insurance funds”, Law no. 95/2006
- Imposing sanctions for failure to comply with this obligation. Explaining the benefits and risks of being uninsured, in a clear and simple language will result in a decreasing number of the uninsured persons particularly in rural areas.

Currently, the information of citizens is made through CNAS/CAS` websites, which is not a practical solution for the population in rural/remote areas, and by leaflets posted on FM office walls and written in formal legal language.

Recommendations on altering the regulatory framework regarding the motivations given for working and settling down in rural or isolated communities

The Action Plan 2012-2013 calls for putting in place incentives for Primary Care providers. The proposed amendments in existing regulations are related to issuing local authorities` decisions regarding heating, electricity, sewage, waste disposals expenses, transportation reimbursement, and granting free housing, and inlcude the following:

- Amending the *Order no. 163/93 of 2008 on the approval of criteria for classification of medical offices depending on the conditions in which the medical activity is carried out*, by increasing the percentage of increase of per capita points stipulated in pt. II.1 of the Annex. This is intended to attract and retain family doctors especially in remote rural areas with poor living conditions.

- „Under the art. 36 par. 6) let.a) pct.3 of Law 215/2001, local council will bear the cost of heating, electricity, sewage, waste disposals etc of family medicine practices in remote areas.", and „Local council will reimburse transportation expenses for FDs`consultations at the patient home in remote areas, within a determined budget, approved by the local council."

A similar provision might be subject to the local council`s decision with regard to providing free housing (for a certain period) for family doctors and their families who want to set up a family medicine practice in remote rural areas, based on the same provision of Law 215 stated above.

As it is observed, most of the measures for stimulating health professionals working in remote areas are to be applied by way of local regulations issued by local authorities within the limits of Law 215/2001. We consider it less feasible to amend Law 215, as this law regulates the general framework of public authorities` involvement in supporting health care in a determined territory. Instead, we propose developing additional local regulations.

Stimulating rural family doctors could also be achieved by introducing new provisions in *CMR`s Decision no. 67/2005 on establishing the CPD credit system based on which doctors` training is assessed, the criteria and standards for accreditation of CPD programs and CPD providers*, according to which CPD providers should reserve a certain number of places without payment of training-fee, dedicated to rural family doctors working in remote areas. If necessary, it might be done through a separate CMR`s decision.

Another practical incentive method is introducing an exemption from residency tax for residents who apply for family rural practices located in remote and underserved rural areas and for residents who intend to set up a family medicine practice in such areas. – Government Ordinance no. 18/2009 on organisation and financing of residency.

Recommendations on altering the regulatory framework to modify the family medicine residency curriculum for providing appropriate training for practicing in rural environment

The Action Plan 2012-2013 states that the family medicine curriculum should be revised so that the family medicine modules (theoretical and practice training) are strengthened and, as a consequence, the family medicine residents develop the required competencies for practicing family medicine in a rural environment.

This measure will require amending the curriculum for training in the specialty of family medicine, which is currently approved by joint Order of the Minister of Health and the Minister of Education, no. 1.141/1386 of 2007, on methods of performing residency training programmes in medical specialties.

In this respect, we suggest, as a first step, including accredited rural family medicine practices or groups of practices (and, possibly, the fixed permanent centres) into Annex 3, pt. 2 which contains the list of university medical centres and medical units accredited to run FM residency programs. Currently, the list includes only hospitals.

The structure of the training stage, as stated in pt.1.4, Annex 4 of the above mentioned Order, consists of 15 months dedicated to family medicine stages (6 months for pt.1.4.1 stage and 9 months for pt.1.4.14 stage) and 21 months dedicated to other medical specialties. Idealy is two thirds for family medicine and one third for other medical specialties. Therefore, the amendments in the current curricula should aim to enhance the content of rural FM stages in terms of training hours.

Regarding the duration of residency training, under the current curriculum, the 6-month-FM stage is carried out exclusively in university clinics, while the 9-month-FM stage is carried out in university clinics for 6 months and for 3 months in „other health care facilities", namely other hospitals. We suggest introducing a new paragraph, within Annex 4, as follows:

„The training activities of the first FM stage will be carried out in university clinics and/or hospitals for a period of 2 months and in family medicine practices/groups of practices/permanent centres for a period of 4 months out of which at least 2 months are to be spent in **rural** FM practices/groups of practices/permanent centres.The training activities of the second FM stage will be carried out in university clinics and/or hospitals for a period of 3 months and in family medicine practices/ groups of practices/permanent centres for a period of 6 months out of which at least 3 months are to be spent in **rural** FM practices/groups of practices/permanent centres. " The table containing the duration of residency training will be amended accordingly.

Similarly, the Action Plan 2012-2013 calls for increasing the family medicine content in the training curriculum of nurses. The curriculum is approved by Order of the Minister of Education no. 2713/2007, based on a thorough analysis conducted by OAMGMAMR and ANR, assisted by SNMF. Thus the modifications in the Order have to be made.