The article relies on focus group discussions on patient payments in Romania. Data were collected in June-July 2009, within the European collaborative research Project ASSPRO CEE no.217431, “Assessment of patient payment policies and projection of their efficiency, equity and quality effects: The case of Central and Eastern Europe”, 2008-2013, coordinated by dr. Milena Pavlova, Department of Health Organization, Policy and Economics (BEOZ), Faculty of Health, Medicine and Life Sciences (HMLS), Maastricht University HMLS-Maastricht University, within a Consortium of 7 members including SNSPMPDS-Romania. For details, see http://assprocee2007.com/.

Research objectives are meant to identify: the acceptability from social, cultural point of view; the views, the opinions and the motivations about the implementation of the copayments in Romania from the perspective of the consumers.

Research methodology

A number of 6 focus groups sessions have been applied on different health care consumers (pensioners, working individuals, master students, chronic and disabled, adult members of families with children living in a city, individuals living in a rural area) [3,6].

All participants of every session were explained about the European project achieving this qualitative research phase and confidentiality assurance has been given.

It was explained that for the ASSPRO research project, patient payments have been defined as direct charges paid offically not “under the table” by the patient when using health services provided within the public system.

These payments might be of several types: co-payments, co-insurance, deductibles, user fees, user charges, etc. but not compulsory contributions to social health insurance, not payments for drugs and neither tariffs charged by the private healthcare providers not in contract with insurance funds.

In order to adapt the patient payments policies to the specific national context, it is important to be known: the social and cultural acceptability; the views, opinions and motivations regarding the implementation of co-payments in Romania, from consumers’ perspective.

This article contains the main results of focus group discussions, applied in June-July 2009, within the qualitative phase of the European Project ASSPRO CEE entitled “Assessment of patient payment policies and projection of their efficiency, equity and quality effects: The case of Central and Eastern Europe”.

Were held six focus group sessions with the following categories of consumers of health services: pensioners, employees, students, chronically ill and disabled, adult members of families with children living in urban areas, people living in rural areas.

In Part I of this issue will be presented: health care consumer opinion on the opportunity of co-payment in Romania, types of services that should be applied the co-payment, level of co-payments accepted by the consumers of health services.

In the second part, to be published in the next issue will be presented: population groups that should be exempted from Co-payment, co-payment policy objectives, criteria for adequacy assessment of co-payment policies, view on informal payments, informal payment solutions from the consumer perspective services.

Keywords: patient payment, co-payment, informal patient, health care consumers. Opinion.

The interpretive paradigm and focus group technique was applied. When society is facing a new event and there are many views about, it is important to understand the reality from the point of view of those concerned, directly involved in that reality.

Qualitative research can offer many things to research inquiry in general but probably the best features of its contribution lies in its living stories and richness of meanings revealed by participant words [7].

Qualitative research assists people to tell their stories about how it is like to be a certain person, living in a particular time, place and set of circumstances [7].

This means that even the most ordinary people can be part of it because, if they can tell stories and speak about subjects they know the best, such as their own life experiences, then they can be part of the qualitative research. The researcher invites them to share an opinion or a story and from those, he can get rich, useful data full of significance [7].

Kaplan and Ade-Ridder (1991) argue that qualitative models confer us greater possibilities for capturing and generating understandings on phenomena or researched, allowing us to effectively address policy makers and those involved in the provision of health services. [4]

The interpretive stance involves the listening to people or watching what they do and using human imagination and understanding of participants in order to capture and interpret their meanings [1].
Main results and discussion

Focus group administration took place in June, 2009 soon after the ministry of health at that time has launched the proposal of introducing a co-payment system.

Group dynamics was good, with few circumstances when respondents have not expressed each a view to a particular topic.

For opinions, attitudes, social acceptability, the following aspects were analyzed: direction of opinions; direction of social acceptance (positive / negative), intensity of social acceptance or rejection; contrast among consumers’ categories; potential conflicts arising consequently.

Opinion of health services consumers about the opportunity of co-payment in Romania

The participants were asked to tell if by them, the patients’ payment should exist in Romania and to motivate their opinion.

Health care consumers are generally reluctant to copayments.

_Pensioners living in a city_ considered that the main reason for what the patient payments should not exist in Romania – at least not applying to them- is that “People pensions are very low, they cannot afford these payments, and they cannot cope with them.’’

They are against copayments because they already had limited access to some paid services (as dental care), lower compared to pensioners from developed countries.

Pensioners believe that they are overtaxed: they pay health insurance contributions from each category of their revenue (rented lands, houses etc.) besides their pension, even that they contributed “all their life” to healthcare and the properties were given back to them after Revolution (as a compensation for abuses done against their families by confiscation).

As “every pensioner earning a pension over 1,000 lei has to pay a health insurance contribution”, by this aspect they feel discriminated compared to those without instruction working in low paid jobs but having access to healthcare free of charge.

They feel in a disadvantageous position compared to employees (who can get an extra job) as the age, tiredness brought by 30-40 years of work, chronic diseases and recent law restrictions do not allow them to have a paid job in the public system (to increase their earnings) while getting their pension.

Pensioners claim that there are no hospitals available “for poor” anymore (where the poor could receive both social and health care).

Some of them realized that “By the contributions to the Health Insurance Fund alone, it is not possible to ensure/guarantee the appropriate medical assistance”. 

Co-payment is seen as a possibility, opportunity to bring additional revenue into the health system.

They expressed their availability, agreement for co-payments “Only if the medical services could be improved”, so the availability would be conditioned by improvement of healthcare quality.

The reason why the employees living in a city would not like to pay also directly for healthcare is related to the service quality: “As long as the quality is not so good”, they are not willing to pay additionally.

Some of the participants of working group think that instead of co-paying, they would rather have the opportunity to be cared on private health facilities.

After they contributed constantly and consistently from their earnings to social health insurance, sometimes without even using any medical services, they perceive as unfair the fact that they need to wait or to pay for; in order to have access to better quality healthcare they prefer to use private services.

Being “forced” to this option is perceived as an unfair arrangement between the state and individuals as long as they and their employers already paid the contributions to health insurance.

“But to avoid waiting, as the quality of services is different (better), and they are treated there as human beings”, they would prefer to pay <out of pocket> in a private hospital instead of going to a public one.

Instead of paying medical insurance in the public system, some of them would agree to pay that monthly contribution to a private hospital, not as additionally to the health insurance but as a contribution exclusively to the private system.

Some employees, users of private services, complained to have negative experiences when using public hospitals: “The truth is that when I went to public hospital, I paid (additionally as <under the table>) or I offered a gift to the physician, but finally I asked myself: was is too much, too few, enough, was is good or bad? So (going in private), I do not have to think about it, I do not have this problem anymore”.

Few working people would agree to pay but officially (not informally) and for quality according to the standards.

Even the poor consider that there are are certain situations, as hospitalization for surgery when, instead of paying informally, they would prefer to pay an official charge, if possible.

Other working people cannot afford (to go in a private hospital) because they do not earn enough money.

The informal payment is perceived as essential for getting the adequate and timely health assistance. “If you do not have money, it happens what we all can see – hospital corridors are so crowded”.

Given their contribution to the health system, working people perceived that they were unfairly treated when asked the services they presume to be entitled to receive while facing a health problem.

By them, their constant and continuous contribution should be taken into account when a service is delivered – to have the record history of their health contribution and “The medical staff not to say bothered (probably wrong): <This one comes ten times every month to our unit>”.

Some of the working people underlined that, as very sick patients would need many services, then paying additionally would become a financial burden.
They consider that people should receive the needed health-care, regardless their income level.

*Students living in a city* are aware that currently the government cannot afford to cover all the health care expenditures, especially for “the expensive” investigations, from the available health budget.

As a solution, they can see a double contribution system (to the mandatory insurance and to a private one) and a direct payment with threshold.

They expect taxes to be used in order to improve the health care system (especially the medical equipment).

They would want a bilateral contract between health system and patient. “I offer my contribution and I expect something of quality in return, but to be a trade as fair as possible: when I become a health service consumer, facing a health problem, I prefer to pay (a considerable or less considerable amount according to your individual earnings) but to get back something of quality”.

Some of the students told they would agree to co-pay but would expect that co-payment to be invested in additional services, equipment, facilities, while a part to be used for motivating the doctors according with “their professional degrees and competencies”, as “The patients feel more comfortable when they know for sure that the doctors are well paid, motivated to perform a special activity”.

Other students think that doctor-patient relationship depends rather on doctor psychology and philosophy rather than the payment received.

Most of them agreed that “Part of co-payments should be used for training the doctors and providing them with up to date information, so that they would be able to handle the new cases”.

Most of chronic and disabled patients living in a city are against co-payments as “A lot of people are poor and payments represent big amounts of money compared to their salaries and pensions”, but would agree that relatively healthy people to pay when asking for medical check-ups.

Some would agree to pay as “The amount from the public budget will never be sufficient for all the health services” needed. Few proposed that this health contribution to be a bank card of savings to store “white money for dark days”. In their opinion, this alternative would make people aware that currently the government is not able to cover all the health care expenditures, even for “the expensive” investigations.

Representatives of family with children living in a city do not agree to pay co-payments, given the fact that they already pay contributions to the Health Insurance Fund.

Somehow they agree that “something” should be paid but their low incomes prevent them of doing so.

They are totally against direct payments, being more in favour of the increasing monthly contribution up to a certain amount. Regarding this increase, they underlined that “A distinction should be made between the unemployed, un-insured, employees earning low wages, people without income sources but looking after their children or other dependents and those of great financial possibilities”.

Respondents are concerned by paying out of pocket cash payments in certain circumstances.

They would like these co-payments postponed until the standard of life could be substantially improved, a balance between market prices and wages would appear; only then the co-payment could be bearable.

But given the current low earnings, high level of expenditures per household “Perhaps many people will not be able to pay co-payments if introduced and will give up visiting a doctor”.

This perspective - of giving up to address health care, the number of patients accessing health facilities would decrease, clinics would be closed, doctors would have less patients, mortality would increase, birth rate would decrease and patients would follow the neighbour medical advices - was shared by the majority of participants.

They know that many people – mostly from rural areas – already “left the health system”, being no patients anymore while they see in the future a deterioration of the health status and of the health system due to financial reasons.

Members of urban families think that disabled or severe chronic ill patients face a particular situation.

“A disabled child or adult needs frequent consultations, medications, hospitalizations” and the request for them to cover a part of their healthcare costs will get the things worse for these people. Some members, knowing that they should offer “an attention” at every visit to the doctor costing more than 10 lei (around 2,24 Euro), agree to co-pay, but presuming that doctors would not be pleased with this situation, concluded that it would be better not to pay any copayment as would be just an additional financial burden when patient go to a doctor.

Mothers of disabled children confessed that “There are just a few doctors whereat you would not feel pushed, obliged to give them <something>”.

Generally they look for those doctors who pay use to attention to their children and whereas “They would have the pleasure to offer <a flower>”.

The habit of offering “an attention” in-kind is so strong that “You simply cannot go to the doctor with empty hands”.

They see “under table” payment as a custom so stable so that they would not be willing to co-pay knowing for sure that co-payments will not diminish at all doctor expectations to receive unofficial payments and patient commitment to give them.

If co-payment would diminish “the under the table” payment, they would agree to pay it but as long as this will never happen, they prefer to refuse the co-payment.

People from rural areas did not agree to pay co-payments because they have no resources.
Services for which the co-payment should be applied

When pensioners living in a city were asked if patient payments should be applied for the primary care (provided by GP), ambulatory units/policlinics, hospital services, emergency room, dental care, they would agree to pay additionally for services only if treated in a private clinic and received everything “from A to Z” (in terms of services); otherwise they already paid health contributions during “their entire life”.

They do not agree to pay for outpatient services as they have already to pay for some investigations and treatments, while for hospital services they consider that only those having “high pensions” should pay, but not those with “low pensions”.

Some accept the idea of co-paying only if the number of visits exceeds a certain threshold.

Few respondents claimed that they were already asked to pay for the second visit during the same month or for referral to a specialist.

Cancer patients or having other severe diseases should not pay directly as in order to cover the expenditures related to their care “already consume the earning of the whole family not only their own revenue”.

The pensioners consider themselves over charged with different payments.

They would like to have defined the basic package, “to be clearly displayed on the physician door”.

They do not consider that unofficial payments would be eliminated by introducing the co-payments, as patients have the behavior pattern of “offering something” to the physician.

Some consider this additional payment helped them to maintain or improve their health status, so “the under the table” payment is perceived as a manner of accessing better/optimal services and care.

From the pensioners’ point of view, people accessing the emergency room services should definitively not be charged.

By them, a person facing some disease symptoms or signs cannot assess, is not able to diagnose if there is a medical or surgical emergency and if they need or not to go to the hospital in order to get appropriate diagnostic and treatment.

Only the alcohol abusers or aggressors needing care after their fights could be “charged”, but again it is difficult to establish if there was a behavior pattern or first time involved.

Pensioners think that the needs for medical services and voluntary involvement in acts determining a need for health services should be objectively assessed.

In case of alcohol overusing, “They should pay not only the co-payment but a penalty as well.”

Regarding dental medical care, pensioners consider that they already have a limited access to it due to the prices so they do not want to pay any more money.

Some cannot afford these services anymore after retirement. “Here in Romania, there are people who have no longer teeth to eat with; they simply cannot afford to go to the dentist!”

In regard of the access to hospital services, pensioners recognise that some patients “Get stuck in front of the (physician) door and ask more and more services”. From their point of view, in such cases the hospital staff should send them to the family doctor to take referral and “not to allow them to reach the hospital as easily as the tavern door”.

Regarding the emergency room, they consider that sometimes doctors refer patients from one hospital to another, thus being “irresponsible” and sometimes the access of pregnant women is denied because they have no ID card or health insurance.

By them, in such cases, the local authority should pay for them.

In their opinion, patients should co-pay only when attending “better hospitals”, not when going to the hospitals “for poor”. As “municipal hospitals for poor” are worldwide spread, they should also exist in Romania (“hospitals of 1 or 2 hotel stars, for the poor”). They claim that hospital for elderly should exist (regretting that they were closed). “The acute care hospitals are overloaded by social cases coming because they have no heating at home (minimum living standard)”.

Some pensioners think that only those with low pensions are “overcharged”, while those with higher pensions never pay, using a system of family or social relationships giving them access to excellent, free of charge care. For instance when doctors become patients, they have direct access to specialists avoiding the access through family doctor as everybody else would otherwise do.

It was given the example of one of the former health ministers who, When asked by journalists <Who is your family doctor?>, he started groping after an answer saying <I have my colleagues as family doctors>”

Such a situation is interpreted like: “Those who saw that, what they could understand? Only that even the health minister does not comply with the health insurance law!”

In order to have a better access and to wait a shorter time, they have to go with “the tote bag” (of informal payment).

Pensioners think that co-payment should be applied beyond a certain level of the pension, or it should vary according to the pension / income level as “People with different earnings simply cannot give the same co-payment”.

They claim that the visit to doctor is lapidary and superficial: “The doctor writes the prescription, maybe measures your blood pressure and then <goodbye>”, without appropriate triage by your health status, “They neither ask if you feel well, nor even if you can stand up in the waiting room”.

They doubt that after the co-payment is given “the doctor will not expect anything else anymore”.

They consider that the physician errors cause to a larger extent the health system expenditures, doubling the reimbursements made by the Health Insurance Fund.

Those working in a city had the following opinion: if the doctors would feel an improvement of their earnings, in case of appropriate remuneration, “They would not wait anymore to receive a contribution from their patients.”
They agreed with the idea that the physicians should receive a part from the co-payments “as otherwise the patients would prefer to give them directly the payment” and some disputed if better equipment or the doctor remuneration should be the first destinations of the money gathered by co-payments.

Working people had at least a reason/scenario for being against the co-payment for primary care services, ambulatory, hospital, emergency or dental care.

Looking to the perspective of becoming older and getting half of the present earnings (pension instead of salaries), they concluded that “The patients would delay going to the doctor, their health status would aggravate and would reach the health facility in the last disease phase”.

If - for instance - the emergency is a car accident, people may not have the needed cash.

If a relative is in need for hospitalization, they would do anything to ensure the payment for it, even by borrowing the money, but many people are completely alone and could not get their family support.

“The quality of services it is not so good” so after “so many years” of contribution to health insurance they are not willing to additionally pay.

They stated again the principle that people regardless their earnings, should access, and benefit from the same services. The students living in a city do not agree to pay co-payment for family doctor, ambulatory or hospital services.

As regards the family doctor services, they would like that the access to be covered by the health insurance contribution; for ambulatory services would agree to be paid “some”, but not in the case of children/students, only those “very expensive” and accordingly with the earnings of the patients.

For hospital services, most students consider that patients are already charged, asked to pay some surgery materials or if they want better conditions (separate room) so again, the health insurance contribution should cover all of these; few agree that the hospital services could be co-paid.

In case of emergencies, most do not agree to co-pay as their life could be at risk and cash may not be available then. Some would agree copayments to be applied in certain circumstances, for instance for drunkenness, traumas resulted from fights or robbery, but not for coma after substance use.

If some ascertained that certain diagnostics should be either free or other complex operations, then some additional criteria must certainly be, but particularly, the financial aspects and family situation of the persons concerned should be taken into account”.

They noticed that for dental care neither the first consultation to establish the oral health status of children, nor a tooth ache in emergency are not free of charge.

About the likelihood of co-payment – regardless the level of services – they consider that following aspects should be taken into account: “Primarily the incomes, family status, type of illness, how frequent the patient should visit some specialists, probability of being admitted in the hospital, if this admission is for something very severe and patient is able to bear the costs; in case of transplants, heart surgery or other complex operations, then some additional criteria must certainly be, but particularly, the financial aspects and family situation of the persons concerned should be taken into account”.

Some parents do not trust any criteria set.

“Do not be so optimistic! Children with disabilities are entitled by law to free social security, free medicines, free medical devices but (actually) I put a lot of money in many services, so they (law stipulations) are not taken into account; the law is always formulated in a way that when put in place, various interpretations to be possible”.

“Romanian legislation is undertaken from the European Union and applied word by word”, very little effort is spent to adapt the methodological norms for its application into the particular country context, to the living standard of the country and to people needs. “There are inappropriate laws”.

Parents would like to be built a criterion/ set of criteria as a basis to establish the categories of patients that should co-pay and the services under co-payment. They are confident that by involving competent people who would take into account the level of income, health conditions, doctor and patient preferences, so a frame/ a set of operational criteria could be defined.

Thus, those with “low income” would not be ignored and those with “high income” could choose “the most expensive options”.

Parents think that co-payments should not be applied for emergency services. The type of specialists who should see further the patients, patient management and referrals should be decided by the doctor and not by the patient.

So they would like “an intermediary office” within the hospital ward where the doctor would have among his responsibilities the task of deciding if the patient could
or could not be qualified as emergency and if not, to write their referral and drug prescription.

*People from rural areas* do not agree to co-pay for any of the enumerated services “as they have no money and until now they were not asked to pay”.

Those having money could co-pay but not the dental, hospital and emergency room services.

**Copayments’ level accepted by the health care consumers**

Then was discussed the accepted level of co-payments.

From *the pensioners living in a city* perspective, for saving health system resources, “Doctors should rather do their job better, to be updated at the latest scientific findings”, so that people would not have to co-pay for so called “system rescuing”.

“If they would fulfil their job better, taking more care of their patient, there would not appear so many <holes>/wastes in the system (to be covered), and the patients would be more satisfied”.

Pensioners recognize that the health system is underfinanced but they consider that the government, advocating/displaying certain methods (for so-called problem fixing) is actually doing only an image maneuver. “Actually the contributors never know where the money goes and how is it spent”.

Pensioners would like to know the actual cost of services so that the process of reimbursement to be transparent.

By the pensioners’ opinion, the government institutions spend irrationally the resources for glamour and the patients became sceptical about the use of public money.

Without knowing the money flow, they fall under the doubts, rumours about National Health Insurance Fund money goes to the Ministry of Finance to be managed or even spent by them.

Funds flow is entirely non-transparent, “so we cannot see where the money goes”.

“There are ministries that waste their money; if you watch TV, you can see opulence everywhere and might get confused: is there any crisis at all? – and becomes sceptical regarding the way money is spent.There are ministries complaining (about the lack of money), like Ministry of Health, - this is our problem - while other ministries waste, spent a lot of money”.

“On TV, they said that the minister X spent a large amount for useless things. Meanwhile the Health Ministry, facing so many social cases, cannot meet the needs of people who have worked/ (and contributed) their entire life”.

Pensioners understand that many people are unemployed, money collection fails, consequently the systems are under-financed and the ministries receive little money.

“So you can see very clearly that there is a huge, stringent need for money”.

“From one side you hear that hospitals do not have money for drugs, materials while from other side you hear that generally hospitals have a good situation”.

By them, whole government should spend the resources more rationally, more wisely and accept that if society as a whole makes sacrifices (they should also do that) “in crisis times, everybody should make sacrifices, not just some of us”.

Respondents think that actually it looks inappropriate to them to discuss about co-payment when the system is in such a bad situation.

“No (other) co-payment should be applied, as long as we (already) pay the investigations and even the lab procedures done in hospitals”.

They recognize that the family doctor “is suffocated by some patients” who abuse creating long waiting time or inability to schedule those who come rarely. “To the family doctor – there are people coming 5-6 times and we who need only once a consultation cannot be scheduled because of them”.

Pensioners think that for the annual check up, there should not be the same standard set of tests, but different sets (according to diseases of each one).

Working people living in a city want to know specifically: how much would be the total amount requested as copayment, by whom this money would be used, where the money would go, what would actually mean for the government, whether it would not be a wasted resource for sure: “Yes, how they (the government) would use it... not going to a <black hole>”.

Instead of co-paying they would prefer the contribution to the health insurance to be increased.

Any of these services could become more important for the patient in time (more being needed).

*Students living in a city* said that no co-payments at all should be requested for GP services and emergency, while for outpatient specialized care, hospital and dental care, they would relate the copayment value to actual costs of care, as a percentage.

Copayment could be 0-25% of actual cost for ambulatory and policlinic services, 5-50% or even more for hospital care depending on what is needed (on how complex are the investigations and treatment received) and on individual income, 50% for dental care.

They underlined that they would agree to cover the co-payment “if only all co-payments would become visible in further investments”.

Some told that it is difficult to decide the level of co-payment before knowing clearly how much is the actual cost of a certain procedure, to what extent is this reimbursed by the Health Insurance Fund and how much of that amount is already covered by the patient compulsory contribution to health insurance; proposed contribution of 10 lei could be “nothing” compared to the actual cost of service (even less than 1%).

Few were against the idea of assuming that only the dentists use expensive equipment and proposed their services to be equally considered with all the other outpatient specialties.

*Disabled and chronic patients living in a city* expressed their doubts regarding the further use of
money gathered from co-payments: “Who could guarantee to me that, if I give 1000 lei, at least a quarter of this amount arrive where the need is? When I was treated in emergency room, I had to buy vessel catheters.”

Someone proposed co-payment level to be 50% of costs reimbursed by the Health Insurance Fund, the costs to be 50%-50% shared by the patient and the Health Insurance Fund “...but without any other <under the table> payment!”

This proposal generated opposition of others: “But you agree that you have money, while I do not have, so I do not agree; anyway the bribe never disappears.”

Two struggling camps for each issue were noticed within the group of chronic and disabled: the ones having money versus the poor. All together were against those not present there judged as “hypochondriacs”.

They accepted that 5 lei for a visit to family doctor and 10 lei for a visit to the specialist “is only about half or a full cigarette pack”.

They think that “all hypochondriacs” are admitted in the hospital and stay for long time, e.g. “Yes, they stay three weeks for high cholesterol values”.

So they would think that emergencies and chronic patients should not pay any co-payment, social cases should not be admitted in acute hospitals but referred to social care facilities.

They believe that social care facilities should exist “everywhere but mostly in Bucharest”, where the hospitals are complex and admitting such social cases in acute facilities is extremely expensive.

Rehabilitation services, when appearing as a consequence of an emergency, should not be charged with co-payment.

For dental care, excepting the emergencies that should not be paid, a co-payment of 50% of National Health Insurance Fund reimbursement per service, could be applied.

In the group of families with children living in a city some told that a co-payment of 5 lei for family doctor visit and 10 lei for specialist visit is an “acceptable fee”, but 100 lei for hospital admission is too much and they cannot afford.

Participants argued on this fee, advocating on one side that the fee “is not so much for a hospital admission” while the other side asserted the need for long hospital lengths of stay but having neither the money nor from where to borrow.

Those admitting their intense demand for services and low economic level proposed “health insurance contribution to be a little bit higher”, or accepting a smaller amount for co-payment for those paying a health insurance.

Some recognize that by going weekly to their family doctor, 5 lei per visit seem not appropriate to them (being too expensive by cumulating).

Finally they agreed that a universal co-payment would be better if not too large because some people need their family doctor for occasional acute diseases (“colds”) but others need intensively specialty services.

Besides mothers of 2-3 children suffering from severe conditions, those mothers of single healthy child, suggested as well that the level of co-payments should be low.

A mother with 3 children suffering from complex pathology commented that one of them was consulted by a lot of specialists until got a diagnostic; the treatment involves not only many medical specialties but also a lot of other specialists (kinetic therapy, rehabilitation, psychologists). Therefore for her family the co-payments could become a severe financial burden.

The participants felt the selfless enthusiastic need to think about rural population who would be forced to sell their agricultural products got through such a hard work, in order to raise money for going to the doctor; sick persons would not be able to work so their access to family doctor would be limited and no access to the specialists.

Some of the participants from rural areas found reasonable a higher co-payment for hospital to be paid: “In hospitals they take care of you, so <it is natural> to pay”, but some others asked: “A person who has no money, so how could she pay?”

To be continued nex issue

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