PERSPECTIVE OF ROMANIAN HEALTH CARE CONSUMERS ON PATIENT CO-PAYMENTS (II)

Silvia FLORESCU1, MD, PhD, Researcher, Constanța Mihăescu PIN/TA1, Ec. PhD, Mihaela GALAN1, MD, MPH Vasilea CONSTANTINESCU1, MD

1 National School of Public Health, Management and Professional Development, Bucharest, Romania

Limitation of patient payments

In many countries patient payments are limited in order to protect those needing frequently health care services. Two types of limitations might be adopted: 1) maximum limit of the total amount directly paid per patient per month/year, or 2) maximum limit of the volume, as number of services directly paid per patient per month/year (e.g. the first three visits to GP per year, the first ten inpatient days per year).

During the sessions of focus groups, the limits of patient payments perceived as being most appropriate for Romania, to be applied to all patients, irrespective of their socio-economic status and health conditions, were discussed.

The pensioners living in a city consider that none of the thresholds is acceptable, claiming that all health services should be paid for as a tax/contribution on pension, function of the pension level. The persons with pension under certain amount (up to 1500 lei = approx. 350 Euro) should not pay anything (either tax or co-payment); while those with pensions exceeding 1500 lei (350 Euro) could pay contribution and co-payment also. They insisted that as contribution for all/all health services, only the amount of pension exceeding 1500 lei, to be taxed. As regards the copayment for the health services for those having their pensions over 1500 lei (over 350 Euro), the pensioners specified that the needs for co paid services still should be certified by GP recommendation. They would not like an imposed limit per number of health services because many services have no real healthcare content. “Just think of that: I am retired, dependent on the treatment, my blood pressure is high, and I go every 3 months to my family doctor to get my medical prescription.. The family doctor does not provide me with any medical service, even the prescription is written by his nurse. So, you go to the family doctor for nothing”. Generally, the pensioners are against co-payments, considering that it would be a devastating measure against them. “I am sure that these co-payments will not be adopted. I can assure you that it will not! All the pensioners across the country will demonstrate against it. In our situation, it would be a pure genocide”. Some want a limitation of the total amount to be co paid and not of the number of services; They think that it would be better to set a limit on amount as thus it would not be necessary to get many certificates (regarding the services used by the patient).

Regarding the willingness to pay a copayment, there is a limited willingness to pay because of: low level of incomes, extended poverty, low quality, already low access and addressability to health services. This opposing attitude towards co-payments varied from one group of health care consumers to another, the opposition being more intense in the groups of pensioners, mothers and disabled persons. Some of them agree that, for providing adequate healthcare, some additional funding would be necessary, because if relied only on the contributions to the social health insurance, it cannot be completely covered. The patients consider that any co-payment could be abusive without a basic package clearly defined. Most of focus group participants agree that co-payments should be applied for the abusing and excess users of health services, or requesting a medical referral without recommendation from a MD. Exemptions should include the following: children up to a certain age, partially for the pregnant women, severely disabled persons, very poor, pensioners according to their income threshold. Respondents doubt that the money collected through co-payments will be used for the health system and for the patients.

They doubt about the fact that money will be really used for the improvement of health services delivery. They have basic doubts regarding the fairness of money use, not believing that the public institution and state objectives favour them. Some of them want these payments to be used for rewarding the doctors hoping in diminishing of unofficial payments.

Keywords: patient payment, co-payment, informal patient, health care consumers, opinion.
area (salaries) than to answer the patient medical needs (equipement, investments). In their opinion, the co-payment should be provided only for the additional services to the basic package which, unfortunately, is not defined yet. “That is what I say: let’s see this basic package”. Some people see the co-payment as an official raise of the contribution already paid to the social health insurance fund, thinking that this co-payment would be perceived either as an increase of the health insurance contribution, or as a “formalisation” of the informal payment. They think that rising the health contribution would not be either well received or accepted because of it would involve a higher level of taxation of both individual and employer, potentially causing a deviation towards the “black market”. Few of them accept that the copayment is needed, but by their opinion at this (low) level, it would not be very useful or effective. “If we do not apply co-payment, we do nothing, then the situation in hospitals will be the same (bad). At the same time, you cannot say that having a 10 lei (2.3 Euro) co-payment is likely to cover good quality services. In a society with such a (poor) health system, I really do not know what we can cover with these co-payments! I do not think that they will solve the situation”. A person proposed private insurance, while the direct payments to be applied just for those services with costs exceeding a certain threshold, up to which a contract between the Social Health Insurance Fund and the private fund, would be operational. Some persons from the group were skeptical about co-payment, saying they do not trust the future computation of the actual health care costs. “Can I be sure that 5 pairs of gloves and not just 3 were used for surgery? Or those 3 were mentioned... while only one was actually used?” By them, the services quality is very disappointing and regardless the copayments, health facilities would be able to offer only their poor quality services as available. Others recognised that health care involves high cost. “But nothing is for free, we have to understand that health does cost”. Some expressed the ideas of equity as regards the access to the health services: “Making differences between the rich and the poor, does not seem fair to me: in fact, we should think to everybody and, if someone can afford to pay, to pay a quote, but the state should also pay for everybody.”. Some patients reported that sometimes, they have paid directly big amounts of money for surgical procedures, without knowing how much was officially needed for some medical devices and how much for „under the table” payments (as they neither did ask nor receive any receipt). Some of them got informal payment even when they used private services (“just because I wanted to pay something in addition”).

From the group of students living in a city, some agreed that the limitation should be on the volume of services, according to the service type, having not only a maximum limit but an inferior limit as well. “When I need a service at first, I pay an amount, the more often I need services, so as much to be reduced the amount paid, but never up to zero”. When suffering from a chronic condition, they would like to co-pay for that condition alone, with a descendent gradient of contribution but not for any other condition that should be exempted from any co-payment; many participants adhered to this idea.

Chronic and disabled persons living in a city would like to have a limitation on the paid amount. The reason of this option is to stop those consuming services in excess. “If they pay, maybe they would not come to the hospital all the time anymore”. They were also concerned by the equity aspects, about the persons resourceless. “Social problems in Romania must be solved. It does not mean to push aside those persons in need who are not able to pay. If someone got sick and had no money to pay for it, what to do, to shoot him?” Some persons from the group of chronic and disabled persons would prefer the limitation on number of services and each employee to have “a health card” (as a travel one) for recording all the services used. Surprisingly, the persons from this group (with important and quite severe morbidity) judged the issue of limitation of co-payment assuming that their use of health services will be extremely low. “Co-payment for the first three services used......I need less or not at all; in my situation, it is better this way”. This approach draw the attention about the mentality that bad things regarding the health can occur only to others.

The participants from the group of families with children living in city would prefer a limitation of co-payments based on volume of services per family, not per individual. “Because at family level, only one or two out of four or five family members, could be more affected (by disease) and then the money would be spent more wisely in the family”. “Per family, because not all family members are equally affected nor go frequently to the doctor”.

They found the limitation on the amount “quite dangerous” as “usually the state sets (as for any tax) a threshold pretty high and you most likely do not even use it at all. For instance, if the threshold is 1000 lei (around 230 Euro), I would not agree with because it is very high for me. Well, during a full year, I could struggle to accumulate it but maybe I would need to go to doctor only twice that year.” Again, can be noticed that people either healthy or with health problems use to think about the future and possible health or services needs in a very optimistic way.

People from rural areas would like a limitation of co-payment on number of services. They think that patients getting healed, recovering after the first 3 co-paid visits to doctor are disadvantaged within the co-payment system as compared to those benefitting further from the services (and not co-paying anymore). The fact that in their view, those recovering within the visits where the co-payment is applied are in an inferior position compared to those continuing to be sick and benefitting from free of charge visits, after crossing the threshold, prove that people are more feared by paying than suffering from a disease, which could mean that poverty, lack of money is the prevailing concern, overcoming the health concern.

Co-payment exemption

Participants had different opinions regarding the population groups that should be fully or partially exempted from patient payments in Romania.
According to pensioners living in a city, fully exempted should be the following: children ("If you have seven children, what do you do with them?"); pensioners having under 1500 lei = 350 Euro ("the co-payment exemption to be applied starting from the same level from which the state exempts them on taxation"), chronic patients ("in any case, they should not pay"), pregnant women ("if the state struggles to increase the birth rate, how do they actually support the new families?"); disabled persons ("yes, all such patients to be fully exempted"), those having incomes below a certain level, irrespective to what population group they belong.

Some of the employees living in a city told that the following groups should not be exempted from co-payment: "children from Bucharest and those of rich parents" (as compared to "those from rural areas who pay even for the vaccination"), pensioners having incomes over a certain threshold, disabled persons if they are not in severe condition. Others were against partial exemption, claiming for a full one for children and pensioners, thinking that "they - pensioners or parents - already contributed quite a lot, especially those with high incomes", and recognizing that "even rich people could have very high medical needs (with unbearable costs)". Some of them recognized that making a classification of people rights and deciding who should and who should not be exempted from copayments, it is really very difficult task.

Some of the students living in a city estimated that all of the mentioned categories should be exempted from copayment, while others thought that each category could be split in many strata by income and severity of disease and consequently family members could be differently entitled to exemption. By them, "the rich parents" should contribute to very expensive interventions of their children, as the medical sector cannot afford it.

The chronic and disabled patients living in a city believed that the following groups should be exempted from copayment: the children ("under certain age"), the retired and poor people ("up to a certain level, over which they could pay"), the chronic patients ("needing many services"), the disabled persons ("most severe disabilities"), part of the pregnant women, the homeless people, the street children. Others were against the exemption applied to children, pregnant women, the last receiving consistent support from society ("they receive paid prenatal and postnatal leave, while other patients receive no support, so they should co-pay"), pensioners ("there are big differences among them, only those of low income should be exempted"). Many agreed that social cases should receive support for drugs, while chronic patients should not co-pay.

Members of families with children living in a city proposed full exemption for children, regardless the socio-economic status of their family (as "they have no incomes or autonomy, being under their parents care"). According to some of them, The retired persons receiving low pensions should be partially exempted. A certain tension arose when the case of pensioners was discussed, these being perceived as intensive consumers of (more or less) needed health services, with minor health contributions in comparison with the employees who are high contributors but low consumers. "We are active, we pay, we do not go to the doctor or we have no time to go because we are busy with our work, while retired people having pensions of 10.000 lei (2500 Euro) should not pay? They go to the doctor every day". The exemption for pregnant women was also an issue of dispute. Most of them told that pregnant women should be partially exempted according to their incomes, those "from high society" should fully pay; others underlined that pregnancy it is not a luxury but "an obligation" of women, so the society should give them support. As regards chronic patients, most of the members of families with children proposed fully exemption from copayment, but some of them - a partial one. In the opinion of mothers, the disabled persons should be fully exempted because "they are already misfortunate, so why to increase their burden by co-payment?". Most of them proposed that people earning under a certain level of income to be fully exempted, while few of them were in favor of partial exemption.

Rural participants think that all the categories mentioned should be exempted, except for those earning over 30.000 lei (around 6900 Euro) per month (AN: very few). In their opinion, pensioners earning over 30-80.000 lei (6900-18600 Euro) per month should co-pay but the pregnant should not, as "their mission" is to give birth.

Co-payment policy objectives

Participants have been explained that in different countries, patient payments were introduced with different objectives as to discourage the unnecessary use of health care services, to generate additional resources for the healthcare system, to allow hospitals/clinics to generate additional resources, to increase the income of individual health care providers or to control the overall health care expenditures. Then they were asked to specify what objectives should primarily have the patient payment policy in Romania.

The pensioners living in a city think that one of the objectives for patient payment policy should be the improvement of medical services (objective not found on the displayed list). In their opinion, although co-payment is to be applied, "under the table" payments would still exist. They all agree that the informal payment is not effective to improve the health system, being beneficial exclusively at individual level. From pensioners’ perspective, the main objectives for patient payment policy in Romania would be to generate additional resources for the health care system and to allow hospitals/clinics to generate additional resources.

The employees from urban areas commented that perhaps all the objectives are important to be targeted. At first, generating additional resources for the hospital it is very important; then, to increase the individual revenues of healthcare providers; bringing additional resources for the health system and finally "this matter"... to discourage the abusing persons (, because there is this kind of persons going to their GP all the time without a serious reason, overloading the
defended the idea that labeling people who request services as "patients by charging them co-payment" so, the health facility should discourage those abusing that with the physician incomes”. Some employees defended the idea that labeling people who request services as “abusive patients” would not be acceptable. They mentioned that for every service beyond the basic package covered by the Health Insurance Fund, the patient is already asked to contribute to the lab tests, so the copayment is applied and those being high consumers contributed already. One participant sustained the same, narrating: “When my mother was admitted in a neurology ward for a stroke, the doctor asked from the beginning <go to buy these drugs if you want to start immediately all the lab tests>”.

The students living in a city rank on the first place the objective of enabling hospitals and clinics to generate resources, then that of increasing the doctors’ salaries, and discouraging the unnecessary use of services. Some of them think that the increase of the doctors’ salaries should come on the first place.

Disabled persons and chronic patients living in a city considered important all the objectives except for the last one - to control the overall healthcare costs. They do not trust that the state works for the citizen and the term control is perceived as of a negative connotation. “When the state knows where to take money from in order to be in control, it is not good”.

Members of urban families with children don’t think that the objective of discouraging the unnecessary use/misuse of health services would ever work here „because alcoholics never think three times before going to the doctor”. As soon as in comparison with those “becoming sick by misfortune”, these persons “have fun... with drugs and buzz” ignoring the efforts and rules of everybody else, many of the members of families with children, agreed that a punishment should be considered in such cases „a big tax for hospital admission and for all required services should be applied to these individuals, and the society should not pay for them”. Next they agreed that increasing the income of individual healthcare providers would be an important objective, given that they really deserve it as “they stay on duty working for so many hours, 12-24, after they learned so much”; and mostly, “our health depends on these doctors”. Another objective to be targeted by copayment policy would be to let hospitals / clinics to generate additional resources. Most of them agreed with this objective and expressed their reasons. At first, there was the opinion that keeping money near where were generated is better as “when money walks, it never reaches its destination”. Second, there was a general mistrust in the way the state responds to their needs. “I never agreed with the priorities established by state for the allocation of funds to certain sectors; by me, the utmost importance should be given to the healthcare and education”, and all joined this opinion. Reaching this objective to allow clinics and hospitals to generate additional resources, would bring another important positive effect: the competition between health care facilities. This would appear when “they (staff of other hospitals) would hear that a health unit is accessed by patients, it is better positioned in terms of co-payment”, then “the others will struggle to improve their services in order to attract customers as well”.

People from rural areas think that a priority objective would be to discourage the unnecessary use/misuse of health services. “Elderly living in Bucharest have money, they receive pensions, so what to do at home? They take care of their health, so these people should co-pay”. They mentioned all the three objectives related to financial improvement: to increase the individual incomes of healthcare providers, to generate additional resources for the health system, to allow hospitals/clinics to generate additional resources. “From my point of view, lets have all the objectives, as they are all necessary because if doctors have no salaries, they leave and then nobody takes care of patients; and hospitals should have money, medicines”.

Criteria for assessing the adequacy of co-payment policies

When the patient payment policies are analyzed, one of the main concerns is to assess to which extent they were appropriate for a particular country. There is a broad range of assessment criteria that could be considered: economic, social, institutional, historical, geographical, ethical, cultural, demographic, health sector specific criteria. Regarding the assessment of adequacy of patient payment policies, the participants have been asked about what assessment criteria they would take into account.

From the group of pensioners living in a city, some participants chose the economic and social criteria on the first place, others told that “all criteria from the list are interrelated to each other, so they should be applied all together.” Health sector specific criteria were also specified: conditions at the level of facilities providing healthcare, quality of health services. Pensioners would agree to give co-payment only when a high level of quality of services would be reached, similar with that found abroad.

The employees living in a city chose the social, economic and health sector specific criteria. The transparency regarding the destination of money gathered and the visibility of investments in medical equipment are perceived as good criteria for assessing the adequacy of co-payment policies. “You should ask yourself where the money goes; I would like to check next year at the hospital where I used (and copaid) services if they have a new equipment; yes, copayments should be visible in endowments.” By them, the right to choose your favourite doctor would also be a valuable assessment criterion from the patient perspective.

The students living in a city gathered the most eclectic opinions and the three nominated criteria (social, economic and specific), covered the most ranks: 1st to 2nd place for the social criterion, the 4th, 3rd, 1st ranks for the health sector specific criterion, and from 1st to 4th for the economic one. The institutional criterion was mentioned on 2nd place while the demographic one, on 5th.
Disabled persons and chronic patients living in a city selected homogeneously within the group the social criterion on 1st place, the economic one (referring to the payment capacity) on the 2nd place, and the criteria specific to the health sector (the use of services) on 3rd place.

Members of city families with children selected economic and institutional on the 1st place, the social and ethic criteria on 2nd place and demographic plus specific to health sector criteria, on the 3rd place. When speaking about the criteria specific to health sector, they use to think about the severity of diseases, frequency of services utilization. Regarding the validity of the social criterion for the assessment of co-payments policies, one mother emphasised that sometimes there is a discontinuity in the allocation of such benefits due to some restrictive rules. “Social allowance for child: some of them benefit of it, others do not; I did not receive it because my girl was given to fostering and then I got pregnant with the second child and I did not work anymore; I did not benefit anymore, you cannot receive that allowance until working at least one year; actually there was no continuity in receiving the benefit”.

Some parents think that the requested severity level for disease in order to receive social support is set too high. “For example, they give you nothing for hipoacusia; they do not diagnose over 70 decibels, except for bilateral hipoacusia; this child has no others rights; yes, I would like these criteria to be diagnosed over 70 decibels, except for bilateral hipoacusia; this child has no others rights; yes, I would like these criteria to be taken into account”.

Rural participants ranked the economic criterion (including the financial level of household) on the 1st place and the social one, on the 2nd place.

Measurability of the assessment criteria for co-payment policies

Respondents were asked if the criteria listed seem measurable to them and if not, to propose another alternative measurable criterion.

In the opinion of some pensioners, the economic criterion is “confusing, it cannot be measured”, no matter if it is about the economic level of patients, the cost of services, or the effect of co-payments in the health system. The price could also be difficult to assess. For most of them the economic and social criteria can be measured, but not the others, according to the participants’ opinion. Some pensioners think that the social criteria are “dubitable”. “There are persons coming to the City Hall to cash their unemployment benefit, by driving a Mercedes”. Goods acquired during their active professional life are taken into account when the assessment is done, creating an artificial “inflation” of the received score and excluding them from the eligible list, despite their real need. (now) “I am a widow, retired person, (but) I have a house inherited from my family, with furniture, TV set etc. Well, I did not get all these staff at this age! In case that the social expertise comes to evaluate me, as I need aid for a (hearing) prosthesis, I would not be found eligible. They come into your house to see if you have all you need, and then you find out that you are not entitled to benefit of compensations.” When it comes to how they perceive the society understand their needs, pensioners think that are in a disadvantaged position in society (as opposed to the children or institutionalized elderly). “Organizations for child protection look after children, monitor and assist them, but the things are so different for the social cases”. “In the elderly hospices like “Saint Nectarie”, everyone has to pay 1000 lei (230 Euro) per month so they could take care of you”.

The employees living in a city recommend to those willing to assess how measurable is each criterion “to look on Insomar studies saying that 60% of the Romanian population can barely survive from their salaries”. Some of them think that socio-economic status at individual level can be measured but others do not trust the measuring capacity of this criterion. “There are unemployed persons, so no income, but they actually have earnings bigger than all of us here”. Therefore employment status is not a criterion good enough to measure the socio-economic status. As regards the use of services at individual level, some of them think that the recording system is obsolete, inappropriate and should be replaced by an informatics system (MIS). “Supposing you go to your GP every week and you have a medical file there. If you go to another doctor who asks you: what conditions did you suffer of?, you take your medical file (if you have it by chance) and start looking for the investigations and history of disease. Instead of this, it would be much easier to have an informatics system available”. In the absence of this one, patient needs to ask for a lot of “papers” and to do a lot of rides: “If I want to go to specialist, I have to take a referral from the GP, then to go to the specialist and to come back to my GP in order to inform him what happened”. Some of them are convinced that the use of services can be measured because the personal patient file is recorded in computer, certified by the doctor ID and seal. The city students said that they would base the selection of the most measurable criteria on a multistage research (firstly on hospitalized patients, then on population). “I would initiate studies on patients in the hospitals to find out what their problems are, and then I would also enlarge the surveys on a very wide range of subjects in order to see their problems and to what extent they would be willing to pay: based on these studies, I could measure these things; a health survey at national level, related to the measurement of specific criteria, pathology; I would make an electronic database (based on findings from studies and surveys) with all the patients in the country, available at any time to be accessed and allowing a hierarchy of people by diseases.” Others are preoccupied to raise the health literacy level of the population “by seminars and to improve the health infrastructure, as now they do not have either pharmacy or hospital”. Consequently to their appropriate information and acquired health literacy and culture, “people would go for medical checkups at every 6 months, so diseases would be early diagnosed”, while those from rural areas at least would go to be registered on a medical file to the GP. “If people would have some health culture, they would go at least to be registered to a family doctor”. Most of the students think that socio-economic criteria are measurable. Chronic and disabled participants cannot appreciate how measurable are these criteria, while persons from
rural areas think the opposite, that they can be measured. But the participants coming from rural areas are skeptical about the final results of co-payment policies: “those who are rich, they are well known and do not pay, poor people would rather pay”.

Most of the urban family members believe that the socioeconomic, specific (related to the health status and to the use of the services) and institutional criteria could be measured. One respondent doubts about realistic information on socioeconomic status could be obtained, given that she saw contradictory situations - either when a person retired for medical reasons but having no disease, or when her daughter suffering from severe diseases (deafness and severe nephritic syndrome) and herself as caregiver companion, were not entitled to anything and moreover, she had even to pay for many services. So she thinks that there is a huge, not understandable gap between the real situation and its certifying documents.

Opinions about informal payments
Participants were asked about what they think of informal patient payments in the health sector.

Pensioners living in a city cannot access the health services and have to give an additional payment all the time, according to the level of under the table payment practiced, although they face (financial) restrictions. “The main truth about the informal payments is that they are part of our everyday life.” “Absolutely. I think everybody agrees on that. Absolutely. We cannot say that we got used to it, we feel it like a burden”. Pensioners think that in our country the official patient payments/co-payments will never replace the informal payments. The main reasons for the persistence of this behavior are that “the doctors got accustomed with this behavior, while it is also in the patient mentality”. There are situations “when the doctor tells you that he will not provide the intervention until you give the money”. Some pensioners underline the fact that the doctors receive cash informally and pay no tax at all on it. A few pensioners wanted to emphasize that there are also exceptions and “we should not generalize a bad behavior”. They told the story of a reputable Romanian professor who used to say every time when facing with the intention of a payment abruptly requested by medical personnel and the stallment payment is allowed: “Put it in the box from the donation box for the hospital”. But nowadays is there such a doctor anymore?”. Some of them told that bribe is a matter of reality. Others mentioned that “there are circumstances when you do not need to give it”.

The urban students find this habit of informal payment is “however, something humiliating” that „should not exist”. Students noticed that „unfortunately, bribe exists and if you do not pay it, then it becomes obvious in the way you are treated. Or sometimes it is directly asked from you”. One participant tells her story: “I had another experience, I refused to give bribe in a public hospital so I left the hospital riddled by 50 vein catheters, full of bruises, with my arm veins broken”. One student believed that Romanian mentality matters very much for the persistence of bribe (“not only in the health field”), so that it will be very difficult to change something about it. Somebody else reported a different story: “It seems I am lucky, my family doctor and my specialist are happy cases, I had no problems, never experienced something like this”. One student brought into discussion another “annoying habit”: the fact that some patients use their own relationship network. “When you wait in line for something, one comes accompanied by I do not know what doctor and really the services delivered were included in the two payments). Another respondent also wanted to share his experience. “It happened to go to a doctor, and being in the medical profession (non-clinic nurse), I thought that the doctor would feel offended if I go directly and tell from beginning what I want, giving also the money; but he felt offended that I did not pay him money and refused to provide me the additional lab procedure that I wanted. My intention was to give the payment at the very end, just before leaving the health facility”. Some of them told that bribe is a matter of mentality. Others mentioned that “there are circumstances when you do not need to give it”.

Management in health XVI/3/2012; pp. 22-29
system level. A major role in the bribe occurrence is played by the patient. “Yes, but… we taught them - the doctors - with these bribes. There are people saying that they cannot go to the doctor without giving anything, because they feel embarrassed. (The habit) exists, it is a generalized phenomenon but it is not compulsory”.

Solutions against informal payments

Respondents were asked what solutions they would foresee to solve the problem of “under the table” payment custom. The answers of pensioners living in a city covered alternatives either ironic, such as (“it is the first thing in order to access the doctor’s office before those who paid nothing”), or suggesting institutional control (“as in other companies or institutions where you must declare your belongings when you get in or leave the work place”), or legal control (“This problem can be fixed in the same way I was treated in 1986: I had to declare how much I spent, how much I earned, my total income and what I did with my money”). Some of respondents think that a solution would be that “everybody involved to officially declare the under the table payment: patient, nurse, doctor, state”. (AN: but they did not discuss if it should be taxed).

Most of the urban employees think that patient formal payment will not replace the informal one. One of them believes that “it will be perpetuated even more”. Some others appreciate that informal payments could decrease firstly “if the patient revenue diminishes and crisis becomes deeper”. One participant expressed the opinion that consequently to the co payment “maybe the physician will change his attitude”, but this sentence raised astonishment of the others. “How could the physician change towards you? But if he knows that the money come to him, it is definitely something else”. Some of them insisted that the copayment money given to the institution should be invested in medical equipment. One participant underlined: “if I know that the state develop the policy and arranges appropriately all these aspects, then I give some money”.

Urban students think that informal payment “is a mentality and this cannot be changed”. Moreover, the bribe became organized and known within the health services market: “there are prices already set for the surgical procedures, for the main surgeon, his assistant, anesthesiologist, nurse etc.”. All of them shared the opinion that formal payment will not replace the bribe in Romania.

Chronic patients and disabled persons think that it will “never” disappear. From their point of view, this is a habit strongly nourished by the both sides. “Romanian has a bad habit: to give bribe. If the doctor is willing to receive it, bribe does not disappear”. A solution is ironically proposed: “The doctor should wear an outfit without pockets”.

Members of urban families with children living in a city also believed that the co-payment never replaces the bribe. The strength of this behavior comes from the determination of those offering it. “I want what is best for my health and that’s why I give it”. One participant underlined that he prefers co-payments to go to the health institutions, but not to the doctor. “It is possible that I need a doctor today, but tomorrow I need another doctor from that institution, so I am interested in that institution to benefit from this co-payment”.

People from rural areas declare they do not to know if the bribe is replaced by co-payments.

C onclusions

Relied on the focus group discussions, it was concluded that some payments are already requested; people were asked to contribute to price of the lab procedures or to completely cover the cost of services. The willingness to pay co payment is limited due to: the low income, the extensive poverty, the low quality, access and addressability already noticed for health services. This attitude of opposition towards the copayment was variable from one group to another of health care consumers, the opposition being more intense in the groups of pensioners, mothers and disabled. Some agree that in order to be delivered proper medical care, additional funding would be necessary because only relied on the social health insurance contributions, it cannot be completely assured.

The patients consider that without a clearly defined basic package, any copayment may be abusive. Some suggest that healthy people could pay for investigations, check ups, better or luxury accommodation conditions or when an investigation or a visit is not recommended by a doctor, but it is the patient's desire. They would agree to contribute 5-50% of what Health Insurance refunds, provided that will not give any informal payment. Some suggest that the co-payments limitation should be established in terms of total amount of money, others - in terms of number of services. Exemption from co-payments should cover: children up to a certain age, partly the pregnant women, people with very severe disabilities, very poor people and the retired related to income threshold. The sick should be exempted and only the “hypochondriacs” and the excessive users of health services should pay. Very few have accepted the idea that chronic patients could pay in order to support the underfinanced health system. In case of accidents, true emergencies it is unlikely, difficult as a victim to have available even then the needed cash. The benefits of the co-payments would be that people could get used with the idea that health services have a price, that individuals have responsibilities regarding their health, not only the governmental structures.

Almost everyone thinks that money from co-payments will not be used in order to make the health system better, but will be used by the Ministry of Finance to cover deficits in other sectors or areas of society. The criteria to be considered when evaluating the payment policies should be primarily social and economic. The economic criterion for assessing the co-payments policies is seen on first place by pensioners, city families with children, rural people, few students on second place by employees, chronic patients. The social criterion is ranked on first place by the employees and chronic patients, by few of students and on second place by pensioners, urban families and rural people and the majority of the students. The specific conditions to health sectors are seen on first place by half of the students. The institutional criterion is seen on first place by city families and on second place by students. The ethical criterion is ranked on second place by the families with children from the cities.
The informal payments are a national habit behaviors fueled by both - medical staff and patients. Some want that some of these payments to be used to reward doctors, hoping to reduce the informal payments. The population experiences frustrations because, although they pay their contributions as individuals and through their employers, they have to pay again when they need health services, even for basic services. Patients have no reliable information or control on the money flow or its use. Most of focus group participants agree that co-payments should be applied for the abusing and excess users of health services, or requesting a medical referral without recommendation from a MD. They do not trust that money will be really used for the improvement of health services delivery; they have basic doubts regarding the fairness of money use, not believing that the public institution and state objectives would favor them. Healthcare consumers consider that co-payments would not solve any of the problems they are supposed to solve, disclosing a total distrust regarding the effectiveness and efficiency of such policies. The amount of money available for motivating health service providers, medical equipment, building rehabilitation or quality improvement, would not be substantially increased. The two sides of the unofficial payment as behavioral custom, would not be cancelled (patient would continue to offer, while physicians would still accept it). The consumers consider that copayments would bring many other problems: tensions among different categories of patients, between patients and health care providers; the addressability of the sick persons would diminish; it would be a very heavy, unbearable burden for some poor people; perverse reactions would appear from both providers and consumers.

The co-payment could change the behavior of some payers who would increase their demands in order to recuperate their loss by using excessive or non necessary medical services. Money collected from co-payments should be allocated at local level; otherwise no effect would be noticed. Respondents do not trust that the money collected through co-payments will be used for the health system and for the patients but for other fields of society. Other strategies such as creating appropriate structures for solving social cases would help more the healthcare system.

The co-payment is not seen as a solution for financial problems of the health system, as the amount of money gathered this way would be insignificant, the use of money would not be transparent and accountable.

The discussion about co-payments revealed many others problems of the healthcare system, such as: low quality of health services, low access and addressability, perceived inequity, poor definition of the basic package of services; lack of awareness among population about the level of health expenditures, tensions between policy makers, providers and users, mutual distrust, lack of knowledge of the population about the principles, rules, norms of the health system and their own health rights. The relationship between health system institutions and health consumers is dominated by distrust as the health system failed to gain consumer confidence regarding the right, fair and appropriate use of money collected and equitable use of services. Obviously more transparency of the money flow and financial problems arising within the health system is needed; the institutions should transparently and accountable report the public money spending. Providers and consumers should also be involved in health decision making process. Decision makers should adapt and adjust their reasoning to the patient needs and expectations in order to get their support and to build an effective consensus. Balance between the conceptual and operational levels of the co-payment policies is difficult to be achieved as long as people and structures involved did not become true partners in the relationship established for social aspects and the relationships for contracting, providing, delivering, using and supporting the health services.

Some key messages for decision makers would be the following: it is necessary that public debates to be opened in order to disseminate the patient payment policies, to inform the people about the philosophy, pragmatic aspects and consequences of these policies; social contracts at community level, between decision makers, providers and consumers should be achieved, so that becoming clear for both sides what could be offered and which are the actual demands, needs and expectations. Public health and health economics experts should be involved to a larger extent in working on simulating the effects of different resources (financial and not only) entered into the health system on the quality, effectiveness, efficiency (in a scientific, technical approach).

References
3. FLORESCU, S., MIHĂESCU-PÎNŢĂ, C.-Preliminary findings from focus group discussions and in-depth interviews on patient payments in Romania, policy brief no.PPB/2003 elaborat în cadrul Proiectului FP7-SSH ASSPRO CEE 217431 „Assessment of patient payment policies and projection of their efficiency, equity and quality effects: The case of Central and Eastern Europe” (2009, http://www.assprocee2007.com/ASSPRO%20CEE%202007%20PB%202009.pdf)

Acknowledgement
Our special thanks to the following physicians for their valuable support for focus groups during the qualitative phase of the FP7 ASSPRO CEE project: Iulia Constantinescu, specialist PHBM, health services management advisor; University Emergency Hospital Bucharest Emilia Cioșogeu, PhD, senior neurologist, Children and Youth Ambulatory-Cotroceni Cristina Icar, senior specialist Family Medicine, National Centre for Studies in Family Medicine Despina Gheaman, Professor at the University of Medicine and Pharmacy Bucharest, Dept. of Medical Expertise for Work Capacity Michaela Nanu, PhD, senior endocrinologist, researcher, Institute of Mother and Child “Alfred Rusescu” Ion Dina, PhD, senior gastroenterologist at Emergency Clinic Hospital “Sfântul Ioan”, Associate Professor at Internal Medicine Chair of the University of Medicine and Pharmacy Bucharest