
***FINAL
A.I.D REPORT***

***PRESENTATIONS AT THE SECOND NATIONAL
CONFERENCE FOR PRIVATE MEDICAL CARE
BUCHAREST, ROMANIA***

By

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Mission Dates: May 31 - June 5, 1994

This report was prepared for
Healthcare Enterprise International, Inc.
under contract with
The U.S. Agency for International Development
Contract #: ANE 0351-c-00-1001-00
Private Health Markets Project: 180-0038

Submitted
January 4, 1995

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I. INTRODUCTION

As outlined in the SCOPE OF WORK, PARTICIPATION IN THE SECOND NATIONAL CONFERENCE FOR PRIVATE MEDICAL CARE IN BUCHAREST, ROMANIA, JUNE 2-4, 1994, (Appendix A), this trip was organized at the request of Dr. Vlad Romano and of Dr. Mary Ann Micka, U.S.A.I.D., Bucharest, as a sequel to visits to Bucharest in December 1992 and May 1993. During the December 1992 visit, concepts of managed care in the United States were presented. The May 1993 visit marked the First National Conference for Private Medical Care in Romania, organized by Dr. Romano, who was also one of the founders of a multispecialty group practice in Bucharest. A significant outcome of this first conference was the formation of the Romanian Association for the Development of Private Medical Care (ARDAMP), a non-governmental organization, to "create a national network for private health care, based on medical group practice." Dr. Richmond Prescott's May, 1993, trip report contains the details of these earlier visits to Romania.

In the year since May 1993, progress of the ARDAMP has been slow. The Romanian economy has shared Central Europe's recession. Inflation in 1993 was 300%. Taxes for all social programs, including public medical care, total about 45% of income. Patients cannot pay much for private medical care. Formation of group practices has occurred, but solo practice remains the norm. Almost all physicians continue to work in public employment full time, and to do their private work in the evenings and on weekends. Dr. Romano felt the need for further coaching of physicians in the methods of establishing successful, private, group practices, and for suggestions for the functioning of the ARDAMP, especially lobbying the Parliament.

The United States team named to participate in the Second National Conference for Private Medical Care included Dr. Richmond Prescott, J.D., team leader; Dr. Derick P. Pasternak, M.B.A.; Dr. Mary Ann Micka, Health Projects Manager for U.S.A.I.D., Bucharest; Henry C. Reinhard, Jr., J.D., Senior Health Care Management Advisor to the Health Markets Project of U.S.A.I.D. in Prague, the Czech Republic; and Dr. Robert Budzinski, head of the Lodz-Baluty Z.O.Z. (integrated public health care system) in Lodz, Poland. The team assembled in Bucharest on the evening of June 1, 1994, and, except for Mr. Reinhard who left on June 3rd and Dr. Micka who was elsewhere on June 4th, attended the conference June 2 through 4, 1994.

II. SECOND NATIONAL CONFERENCE FOR PRIVATE MEDICAL CARE

A. Goals. Dr. Vlad Romano provided a specific list of goals for the conference. These included (1) training in the initiation and organization of private group practice; the promotion of the advantages of group practice to physicians; the overcoming of obstacles; financing; and the role the ARDAMP might play in promoting group practice by working for changes in Romanian law; (2) encouraging physicians to continue their medical education after completion of training; and (3) introducing physicians to the evaluation and assurance of quality in medical care.

The title page and the program for the conference, in English, are Appendix B.

B. Themes. The major areas of discussion at the conference were three: (1) How other Central European countries (the Czech Republic, Hungary and Poland) have addressed privatization of medical care in a predominantly public system; (2) Methods of organizing private medical care, particularly private group practice; and (3) Difficulties of financing private medical practices when Romanian banks will not make affordable loans to physicians.

C. Presenters and Seminars. The first of the themes above was of great interest to attendees at this conference because the experience in other countries, especially the Czech Republic and Hungary, offered hope that governments are willing to experiment with new forms of private and public medical care.

o Mr. Henry C. Reinhard, Jr., presented the experience of the Czech Republic. There people can choose where they wish to receive their health care. In 1993 the Czech Republic encouraged primary care physicians to work in private practice. 90% of general practitioners and 70% of pediatricians have done so. They are paid on a point system (so many points for certain kinds of visits and procedures) from a National Health Insurance Fund run by the National Health Agency. This fund's revenues come from a 9% tax on employers and a 4.5% tax on employees. In addition to this fund, there are 19 branch insurance companies, organized by special groups (bankers, the military, other categories of workers), which provide financing for 10% of the population. The unemployed and aged are paid for by the state from general tax revenues. The percentage of Gross Domestic Product which is spent on health care in the Czech Republic has risen from 5.3% in 1991 to 7.1% now. (The comparable figure for Romania is under 4%.)

The problem is that 82% of available funds are spent on hospital care and on pharmaceuticals, and only 18% is left to pay physicians providing ambulatory care. Payments to physicians are low. Physicians find that they must see 60 patients a day to earn the money they need for expenses and

to live. Incomes of some physicians practicing privately are lower than incomes of those who have remained on salaries in the public system. The predominant form of private practice is solo practice, but there is great interest now in group practice and in managing private health care well.

Mr. Reinhard recommended that Romanian physicians (1) form more group practices, (2) understand that managed care with capitation payment to physicians is better than fee-for-service practice, and (3) involve physicians in working with legislators for reform, so that the Ministry of Health will not be the only agency making decisions about this.

o Dr. Derick P. Pasternak had visited Hungary as a health care consultant three times in 1993. He described Hungary's initiatives in health care reform. Hungary during the conservative government (1991-1994) wanted greater privatization of medical care. It is not known how the recent election, in which the conservative government was defeated, will change this.

Hungary has given primary care physicians three options: (1) to remain on salary with the public system; (2) to be paid by capitation (so much per month per patient who gives his or her health insurance card to the doctor); or (3) to become a totally private practitioner whose patients pay all fees, apart from the National Health Insurance Fund.

About 7,500 of Hungary's 35,000 physicians provide primary care; they are beginning to accept options (2) and (3). When a physician agrees to be paid by capitation, the state provides some office furnishings and equipment, including a computer. The physician pays for office personnel and other expenses. Some specialists have been allowed to become private practitioners.

Hungary began National Health Insurance in 1993, a fund from which primary care physicians on capitation are paid and from which some private specialists are also paid.

The Hungarian government wanted hospitals to operate under a non-for-profit, most private system. Two demonstrations of this exist in Budapest, but capital to extend this model is lacking. American investors (of Hungarian origin) are building one entirely private hospital near Budapest.

The government of Hungary has taken steps to extend primary care by starting family practice residencies, and to improve the quality of care by planning to require a national examination and postgraduate training for general practitioners. Experiments in managed health care exist in some isolated industries, but the government has not yet been impressed that managed private care should be encouraged.

o Dr. Robert Budzinski reported on Poland. Poland is lagging behind the Czech Republic and Hungary in its reforms. Privatization, encouraged in other small businesses, has not been well extended to medical care, except that private practice is legal. The state owns all medical centers and finances a public system through taxation, without assuring that an identified portion of the taxes levied must go for health care. There is no national health insurance fund which private physicians and their patients can use. Public salaries for medical workers are very low, lower than the average pay in large industries. Few patients can pay private fees. Political and economic instability prevent an organized, step-by-step approach to privatizing health care or introducing modern methods of management into the public system. Yet physicians are eager for reform and privatization. (Dr. Budzinski is working with U.S.A.I.D. to bring better management to his section of the public sector in Lodz.) The situation in Poland has much in common with Romania. Private practice is growing slowly.

These presentations elicited lively discussion and inquiry into details. Questions and answers covered:

- Emerging requirements for continuing medical education in the Czech Republic.
- The conversion of surplus hospital beds to less expensive skilled nursing beds in the Czech Republic.
- The amount of taxation for social programs in various countries. Romania, the Czech Republic and Hungary all have tax burdens for social programs of about 45%, but in the Czech Republic and in Hungary the National Health Insurance Fund receives the part of the total designated for health care. Poland and Romania do not have such a fund, and the portion of general taxes devoted to health care is politically determined and variable.
- How to obtain space for private practice in various countries.
- The use of copayments in the Czech Republic.
- The widespread problem of "envelope" payments "under the table" by patients to doctors, especially in Poland and Romania, as a disincentive for physicians to enter private practice or to form groups.
- The possibility of not-for-profit organizations for private medical care.

The discussion of the rational role of a private sector for health care in a country where the health care system is

predominantly public followed Dr. Richmond Prescott's seminar outline to be found in Appendix C. Dr. Silviu Radulescu argued that private medical care cannot be considered an example of "free market" economics because this market is not free, but he acknowledged that regulated private practice can enhance a country's total medical care. He suggested the not-for-profit model of private health care organization. He was pessimistic about the growth of private medical practice in Romania until growth of the general economy makes more money available for the public sector. He emphasized the assurance of the quality of private practice and the exploration of group practice.

Appendix C collects the outlines for seminars prepared by Drs. Prescott and Pasternak. These are:

- o THE PLACE OF PRIVATE PRACTICE IN THE FRAMEWORK OF A NATIONAL HEALTH SERVICE
- o ESTABLISHING A PRIVATE GROUP MEDICAL PRACTICE
- o GROUP PRACTICE MANAGEMENT AND PLANNING
- o ENCOURAGING PHYSICIANS TO CONTINUE THEIR PROFESSIONAL AND MANAGERIAL EDUCATIONS
- o EVALUATING AND ASSURING QUALITY AND EFFICIENCY IN GROUP PRACTICE
- o HOW TO ASSURE HIGH QUALITY OF CARE IN A MEDICAL GROUP
- o (Ms. Katie Reikofski's seminar) DEVELOPING A BUSINESS PLAN

Drs. Prescott and Pasternak joined to give the seminars on private-public sector practice and quality assurance. They gave separate seminars on organizing private practice: Dr. Prescott led a group in which participants told each other about their experiences establishing group practices, while Dr. Pasternak concentrated on the business plan essential to starting a medical business. This topic was reemphasized in a separate seminar offered by Ms. Katie Reikofski, a business consultant, who also suggested practical objectives which might be achieved in discussions with members of Parliament, particularly lawful deductions from income for practice expenses - interest on equipment loans and the costs of continuing medical education.

Not on the printed program were a videotape and comments presented by a Romanian ophthalmologist who, with the help of financing from friends in the Netherlands, had established a private ophthalmology center, complete with an operating room. He has one ophthalmology colleague, and they are busy. He has been able to leave his salaried position in the public sector completely, the first physician at this conference to do so. He has found a needed niche in ophthalmological surgery.

The final morning of the conference was devoted to discussion with bankers. A young woman who trains bankers and a young man who is a loan officer of the Romanian Development Bank attended. The woman restated the principle of bank lending - that only persons who appear well able to repay loans will be able to qualify for them. She said that physicians are not being discriminated against when they are denied loans and that they cannot expect special dispensations. The man from the Romanian Development Bank was more hopeful. He said that his bank is hoping to establish a "professional credit" with loans at lower interest rates (perhaps 80% instead of 130%) for professionals whose work brings them a reliable stream of income from which to repay loans. He invited physicians to come to see him personally to discuss their business plans and needs for financing. He will help them to prepare good business plans. He also suggested that of a \$150 million loan to the Romanian Ministry of Health from the World Bank, \$20 million remains unallocated. Perhaps this could be used in part as a revolving loan fund for physicians. (This would be a very unlikely decision by the Ministry of Health.) This banker received generous applause for his sympathy with physicians.

D. Attendees. About 30 persons, other than presenters and staff, attended the conference. All but four of these were physicians; three were in related medical professions and one worked in the Ministry of Health. At the end of the first day, Dr. Vlad Romano asked each attendee to tell something about his or her practice, and the statistics from this recital, collected by Dr. Mary Ann Micka, are in Appendix D. 12 persons reported being in private practice with at least one other professional, while 13 conducted private practice alone. Four had not yet started private work, and one had discontinued it.

The major complaints of attendees about their situation in Romania were excessive taxation, high interest rates for loans and high costs for practice space (12); the expense and difficulty in obtaining office equipment (13); the need for Parliament to provide a legal framework for private practice (8); the perception that the Ministry of Health does not support health care reform (4); and lack of opportunity to continue medical training, obtain up-to-date information and maintain the quality of medical services (8).

In contrast to last year's conference, this one was run on a seminar model, and the attendees quickly became comfortable interrupting presenters to comment and ask questions. This enhanced the discussion and gave presenters information which they lacked.

III. EVALUATION OF THE CONFERENCE

This evaluation is a composite of comments made by the several presenters. Appendix E is a letter from Dr. Prescott to Drs. Romano and Micka, responding to Dr. Romano's urgent request for feedback about the conference so that he himself could make some kind of report. The letter contains a preliminary, summary assessment. Appendix F is the note given by Mr. Henry C. Reinhard, Jr., to Dr. Micka after his one day participation in the conference. Appendix G is a memo from Dr. Pasternak to Dr. Prescott written at the conclusion of the conference.

Evaluation of the conference has two different elements, the organization and conduct of the conference itself, and the successes and failures in covering the important topics.

1. Organization

The conference was organized in haste, largely by one person, Dr. Vlad Romano, who did not have the help of a committee and who therefore could not do all that was required for a better meeting. By United States standards, there might have been:

- Better publicity and larger attendance. This conference should have appealed to physicians and officials in the public sector of health care.
- Better exchange of information about what has happened in Romanian health care during the past year. Presenters had to learn what they could after they arrived.
- Better materials to hand out to attendees, perhaps including seminar notes translated into Romanian.
- Slide materials in Romanian.
- Better attendance by persons whose names were on the program but who did not appear to take part in presentations. Representatives of the government and Parliament were conspicuous by their absence. The three men who did appear - Dr. Toca, a Liberal Party member; Dr. Remus Opris, of the National Peasant Christian Democratic Party; and Dr. Mihai Guran, Vice-president of the Democratic Convention of Physicians - seemed to be part of the government's opposition. They came for a few moments, made political speeches approving private practice but unrelated to the issues of

the conference, and then excused themselves without discussion.

- Separation of advertisers from the business of the conference. The Zepter dinnerware company used one and one half hours of the conference presenting its sales pitch, in addition to having a display in the lobby.
- Better interpretation. The young woman who worked diligently to provide English-Romanian interpretation, Carmencita Marin, was not highly skilled.

2. Success and failure in topic coverage

- The conference satisfied the curiosity of the attendees about other countries' approaches to private medical care and public sector reform. Romanian physicians now know what can be done if the government is willing to attempt change.
- The conference encouraged private practitioners to consider group practice and gave them information about how to proceed in this direction. The sharing of experience among Romanians was valuable. One physician and his friends have organized a 150 member multispecialty group!
- The conference dealt with legislative lobbying, but there is much more to be done here. The non-governmental organization, ARDAMP, which was formed a year ago, has a nominal membership of approximately 100, but it has not found functions and activities with which to represent physicians and have an impact on Parliament and the Ministry of Health.
- The seminar on quality assurance was a moderate failure. There has not been a tradition of this activity in Romania, other than to rely on tough examinations for physician qualification, and the concepts of peer review, chart audits, outcomes measurement, process improvement, and group structure as a key means to maintain quality, did not engender enthusiasm.
- There was evidence throughout the conference of the reluctance, so common in formerly Communist countries, of citizens to try something new in the absence of laws explicitly authorizing the attempt. This attitude is unlike the American "if the law doesn't prohibit it, let's try it" approach. It makes working for legislative change more important than ever.

- The limited borrowing by physicians to equip and furnish private offices may not improve until the entire Romanian economy improves. Inflation is a major problem. Banks have to charge interest rates high enough to cover expected inflation, and physicians can't raise private fees rapidly enough to keep up.
- Dr. Sorin Paveliu, editor of Infomedica, a medical journal for general physicians, asked Dr. Prescott for an interview. He expressed great skepticism about the future of private medical practice in Romania. He does not think patients can pay private fees. He does not see the government allowing physicians to make money privately. He does not think that the ARDAMP will do anything effective. He himself opened a private office and closed it when his earnings did not meet his expectations, compared to salaried public practice supplemented by "envelope" gifts. Dr. Prescott argued for a private-public mix of medical care as being beneficial to both and to patients.
- The issues of reforming the management of the public sector in Romanian health care (issues which U.S.A.I.D./H.E.I. are addressing with Dr. Budzinski in Poland) were not discussed.

IV. NEXT STEPS

The May 1993 trip report for the first National Conference for Private Medical Care contains sixteen next steps which could have been considered during the past year by Romanian physicians and their United States advisors. They include, in summary:

- Study and promotion of the group model of private practice.
- A continuing search for financing and insurance.
- Training managers of private group practice.
- Educating the public about health care and prevention of illness (stop smoking) and injury (use seatbelts).
- Exploration of a "sister organization" concept for a group private practice in Romania and its counterpart in the U.S.
- Development of "one or more medical societies (which may include non-physician health care managers) to give medical workers a more unified voice in dealing with health care reform."

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The last of these offers a good next step this year. Although there will be continuing opportunities for U.S. consultation about group practice management methods, about training of physicians and managers, about preventive practices, and about funding for private medical enterprises, the Romanian non-governmental organization, ARDAMP, needs help now, before its members lose their interest because their organization isn't functioning to serve them.

ARDAMP was barely discussed at the conference this year. Last year, when it was organized, a half day session was devoted to forming it. The conference this year could have been the occasion of its annual meeting, and its functions could have been planned, related to the topics of the conference. Although Mrs. Bucur made remarks on June 4th on the NGO and what it might do, no discussion followed. Mrs. Bucur thinks expansively. She asked the gentleman from the Romanian Development Bank whether a practice group which included a pharmacy and other non-physician services might have a better chance to obtain a bank loan. He said yes.

Recommendations:

1. Find out more detail about the current status of the ARDAMP - who its members are and what it proposes to do.

2. Arrange a consultation (not in the form of a conference) between the leaders responsible for ARDAMP and a United States consultant such as Donald Fisher, Ph.D., Executive Director of the American Group Practice Association; Frederic Wenzel, Executive Director of the Medical Group Management Association; Roger Schenke, Executive Director of the American College of Physician Executives; or Alan Nelson, M.D., Executive Director of the American Society for Internal Medicine.

3. Determine whether ARDAMP can sustain certain functions:

- Legislative lobbying with clear objectives and effective, ethical techniques.
- Consulting with private practitioners interested in forming groups.
- Gathering a library of books and journal on the management of private practice, including group practice.
- Teaching quality assurance.
- Arranging engineering services to maintain medical equipment.
- Running a referral service, to excellent specialists and generalists in private practice.
- Offering a telephone answering service.

- Publishing an association newsletter or magazine.
- Surveying private patients to determine their needs and wants and their level of satisfaction with the public health care sector and with private practice.
- Encouraging the discontinuance of the "envelope" system.

4. Assist ARDAMP with undertaking whichever of these functions seems most important and feasible.

In addition to this work with ADRAMP, more needs to be done among Romanian physicians in both the public and private sectors, including:

5. Developing strategies to heighten physician appreciation of quality assurance, especially in the private sector. Government critics of private practice will try to find fault with its quality. Physicians practicing privately can prevent this by workable quality assurance programs.

6. Finding and using training programs for physician managers of group practice. Dr. Enachescu's World Bank funded Institute has enrolled Dr. Romano and should be available to other candidates.

7. Exploring the interest, if any, among officials, managers and physicians in the Romanian public sector in mounting a demonstration project utilizing modern methods of management to control costs, enhance quality and increase provider and patient satisfaction. (This would be analogous to what U.S.A.I.D./H.E.I. are attempting through Dr. Budzinski in Lodz, Poland. It is equally necessary for Romania.)

Conclusion. Economic growth, the tide which raises all boats, is not guaranteed in Romania's near future. Inflation in 1994 is running at 90%. The remarkable accomplishment of the private health care sector in Romania is that it has come as far as it has despite adverse economic circumstances. The need for high quality care is there, as the ophthalmologist who opened his private surgery clinic has shown. Group practice is becoming understood. To make progress with private care, interested physicians must learn to work closely together, particularly when addressing their government. ARDAMP should be able to lead that cooperation.

Respectfully submitted,

Richmond Prescott

Richmond Prescott, M.D.

June 14, 1994

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V. APPENDICES

- A. Scope of Work
- B. Program for the Conference
- C. Seminar Outlines
- D. Private Practices of Attendees
- E. Letter to Drs. Vlad Romano and Mary Ann Micka
from Dr. Richmond Prescott
- F. Comments of Henry C. Reinhard, Jr., J.D.
- G. Comments of Derick P. Pasternak, M.D., M.B.A.

DRAFT: 5/23/94

SCOPE OF WORK

PARTICIPATION IN THE SECOND NATIONAL CONFERENCE FOR PRIVATE MEDICAL CARE in BUCHAREST, ROMANIA, JUNE 2-4, 1994

BACKGROUND

In December, 1992, HEI consultants William Townsend and Richmond Prescott, M.D., accompanied USAID staff member Ms. Susan Matthies to Bucharest to present a description of the group practice model of managed care to an audience of physicians, professors of medicine, government health officials, and medical administrators. Thereafter, one of the physicians, Dr. Vlad Romano, who had recently founded a small, multispecialty, group practice of physicians working privately after their daily work with the public sector of Romanian health care, organized the First National Conference for Private Medical Care in Bucharest, May 26-29, 1993.

Dr. Prescott attended this conference and presented an overview of how medical practice had developed in the United States in contrast to its development in Europe. He also assisted in seminars discussing private health insurance and private group practice.

During the proceedings, Dr. Romano and associates announced the formation of the Romanian Association for the Development of Private Medical Care (ARDAMP), a non-governmental organization. Its stated goal is "to create a national network for private health care, based on medical group practice." In 1993, however, the small amount of medicine practiced privately was largely the work of solo practitioners seeing private patients after their hours of service with the public system of health care. Romanians lacked funds for private medical care, fees were low, and private health insurance was not available. Nevertheless, physician interest in better serving patients through private practice was strong.

ADRAMP has announced that it will convene the Second National Conference for Private Medical Care from June 2-4, 1994 in Bucharest. With the endorsement of Mary Ann Micka, M.D., a USAID representative in Romania, Dr. Romano has requested presentations by U.S. consultants on medical group practice, including Dr. Prescott. (See Attachment A, Dr. Romano's request, and Attachment B, Dr. Micka's endorsement.)

Dr. Prescott is prepared to attend the conference to deliver requested presentations on the "relational and cooperative" aspects of private group practice; encouraging physicians to

continue professional and managerial education; and the evaluation of quality and efficiency in private practice. HEI is seeking a second presenter, a medical group business manager/administrator, qualified to address other issues of interest to Dr. Romano.

PURPOSE

To participate in the Second National Conference for Private Medical Care in order to assist the ARDAMP in its goals of privatizing medical practice and stimulating the formation of physician groups.

TASKS

The tasks for the HEI presenter(s) are to conduct seminars on the organization and administration of private medical practices, including group practices, and to respond to issues raised by Romanian attendees. Dr. Prescott will also assess the feasibility of USAID/HEI sponsoring follow-up activities to assist ARDAMP and related organizations in furthering private medical practice. These activities could include:

- o Training courses in the development and management of physician groups.
- o Technical assistance to physicians in achieving economies and efficiencies by sharing costs and practicing cooperatively - using methods such as cost accounting, forecasting utilization, collecting data for management, sharing revenues equitably, quality assurance, cost controls, continuing medical education and the introduction of incentives and benefits for physicians.
- o Preparation of written materials - newsletters, manuals - to accompany training and technical assistance.
- o Establishing in Bucharest a reference library of texts on the organization and administration of private medical practice, including multispecialty group practice.

TEAM

Team leader: Richmond Prescott, M.D. (See attached biodata form)

Team member: (An experienced manager/administrator of private medical practice to be identified)

LEVEL OF EFFORT

The presenter(s) will require two to three days of preparation to develop their presentations. Participation in the conference will require two days of travel time and three days in Bucharest. Dr. Prescott will be responsible for preparing a draft trip report and recommendations for follow-up activities. This will require another two working days, for a total of 10 to 20 working days, depending on whether a second presenter accompanies Dr. Prescott.

OUTPUTS

Outputs will include:

- o A trip report which will include copies of presentations.
- o Recommendations to USAID/HEI for possible follow-up activities in support of efforts to stimulate further privatization of medical practice in Romania.

BUDGET

The budget for this activity is estimated at \$6,000 to \$12,000, depending on whether one or two presenters participate in the conference. (See attached budget)

REPORTING REQUIREMENTS

A draft report will be submitted to HEI within 15 days of return. HEI will send the draft to EUR/DR/HS for comments. The final report will be submitted within 15 days after HEI receives comments from EUR/DR/HS.

A 2-a

Conferință Națională

pentru Asistența Medicală Privată

Organizatori: - Asociația Română pentru Dezvoltarea
Asistenței Medicale Private

Sponsori principali: - Agenția Statelor Unite pentru Dezvoltarea
Internațională (U.S.A.I.D.)
- Fundația *Soros* - pentru o Societate Deschisă
- Firma *Zepter International*

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— PROGRAM —

Every morning, between 8¹⁵ - 8³⁰ a bus ROMTUR will wait for the participants, on Ana Ipătescu Blvd., at 50-100 m from Piața Romană. Every day, between 10.⁰⁰ - 10.³⁰, and, on Thursday and Friday between 15.³⁰ - 16.⁰⁰ will be the coffee-breaks and COCA-COLA. Every day, between 13.³⁰ - 14.³⁰, will be the breaks for lunch, enterely supported by ZEPTER INTERNATIONAL.

Thursday, June 2

- 9.⁰⁰ - 9.³⁰ Registration and wellcomes.
- 9.³⁰ Health care reforms and private medical activity in Czech Republic and Poland: lectures
H.C. Reinhard, jr. — AID-Prague, Dr. R. Budzinski — Poland
- 10.³⁰ Workshops
- A - experiences in private health care in Czech Republic — Dr. M. A. Micka - USAID, H.C. Reinhard, jr.
B - experiences in private health care in Poland — ^{RP}~~C. Walker~~ - USAID, Dr. R. Budzinski.
- 14.³⁰ Decisions - and legislative factors: Present opinions regarding the private medical sector in Romania —
M. Guran - presidential counsellor, Dr. F. Bárányi, Dr. I. Crețu, Dr. D. Dobrescu, Dr. R. Opreș -
Romanian Parliament, Ec. E. Erhan, Dr. L. Octavian - Ministry of Health
- colloquy -
- 19.⁰⁰ Cocktail — Casa Universitarilor București

Friday, June 3

- 9.⁰⁰ - 9.³⁰ Summarising the main topics of the first day.
- 9.³⁰ Zepter International: a healthy and modern way for preparation, cook, keeping and servicing the food —
presentation and demonstration
- 10.³⁰ A private network of health care.
- Private medical activity as part of the national health system — Dr. C. Vladu - ARSPMS, Dr. D. Pasternak
- LHS, Dr. R. Prescott - KPMC.
- presentations, discussions -
- 11.³⁰ Round tables: Group practice
- A - initiating and developing a group medical practice — Dr. R. Prescott, C. Walker.
B - group practice management and planning — Dr. M. A. Micka, Dr. D. Pasternak.
- 14.³⁰ Evaluating the efficiency of activity in a private cabinet - lectures and workshops.
- A - business-planning for profit — L. Rașcă, K. Reikofski, D. Reikofski — SBDC
B - quality assurance of health care. The part of continuing professional and managerial educations —
Dr. D. Pasternak, Dr. R. Prescott.

Saturday, June 4

- 9.⁰⁰ - 10.⁰⁰ Summarising the main topics of the second day.
- 10.⁰⁰ Establishing priorities and identifying means for preferential loans.
- colloquy -
- D. Moșoiu, E. Badea — Ministry of Finance, C. Diaconescu, A. Neagoe, R. C. Răduț, — Romanian
Banking Institute, R. Negrea — Romanian Banks Association, L. Mitrache — Banca Română
de Dezvoltare, P. Țirdea — Bankcoop.
- 13.³⁰ End of the Conference

THE PLACE OF PRIVATE PRACTICE IN THE FRAMEWORK OF A NATIONAL HEALTH SERVICE

Seminar: Dr. Prescott, Dr. Pasternak and others

Introduction: Every country addresses this issue differently. Some do not allow private practice; others encourage it. Their reasons are important. Has the Health Commission of the Romanian Parliament established policy for private practice?

Outline:

- I. A partial listing of different countries' policies.
- II. Reasons for discouraging private practice.
- III. Reasons for encouraging private practice.
- IV. The advantages of a balance between private and public medical care.
- V. Remaining problems.
- VI. What is Romania's policy?

I. A partial listing of different countries' policies

1. Definitions of "public" and "private":
 - o Employed by the state = public
 - o Not state-employed but lightly regulated = private
 - o Not state-employed but heavily regulated = ?
2. Entirely public systems:
 - o Canada
 - o Kazakhstan
 - o Remaining Communist countries - China?
3. Entirely private systems:
 - o None! Not even the United States.
4. Predominantly public systems but with private practice permitted:
 - o Great Britain and Germany
 - o France, Spain and Italy
 - o Poland, Hungary and the Czech Republic
 - o Russia
 - o Romania
5. Predominantly private systems but with a growing public sector:
 - o United States. The Clinton proposals for reform.
 - o Hong Kong?

II. Reasons for discouraging private practice

1. Access to private medical care is not equitable.
2. Private medical care increases costs to society.
3. The quality of private medical care can be poor.
4. Private practice takes patients away from the general pool which supports the public system.

III. Reasons for encouraging private practice

1. A different social philosophy: those who earn more should be able to buy more (more food, more housing, more travel, better pensions, more medical care).
2. Private practice provides physicians with incentives to work harder, practice more expertly and innovate.
3. Private practice gives patients greater freedom of choice of physicians and greater personal satisfaction.
4. Market competition in medical care can control costs.

IV. The advantages of a balance between private and public medical care

1. The public sector will cover all who cannot pay.
2. The public sector can be adequate in quality and comprehensiveness of benefits.
3. If all taxpayers are required to support the public sector, those who use the private sector reduce the costs of the public sector without reducing revenues.
4. The private sector can be regulated to assure quality without killing incentives to excel and to innovate.
5. Competition between the public and private sectors can improve both.
6. Private practice supplements low state salaries for physicians.
7. Private practice provides a safety valve when the supply of medical care in the public sector is inadequate.

V. Remaining problems

1. How to improve efficiency and quality in the public sector? Cf. Poland's interest in "managed care."
2. How to increase funding in the public sector?
3. How to decrease gratuities and introduce copayments in the public sector?
4. How to avoid the excessive specialization and the uncontrolled costs of fee-for-service private practice supported by third party indemnity insurance? The experience of the United States is relevant here.
5. How to avoid excessive regulation of the private sector by government?

VI. Romania's evolving policy

1. In the past health care was called an "unproductive sector" and was underfunded.
2. The World Bank, the PHARE program and other initiatives have encouraged investment in improved health care. Has this been effective?
3. Private practice was legalized to boost the supply of medical care quickly. Has this grown?
4. What is the situation of private practice in Romania now, especially in regard to government regulation?
5. What are the needs of private practitioners now? How can ARDAMP and other non-governmental organizations help?

ESTABLISHING A PRIVATE GROUP MEDICAL PRACTICE

Seminar: Dr. Romano, Dr. Prescott, Dr. Pasternak

Introduction: Dr. Romano has had the experience of organizing a private group practice in Bucharest, where conditions are unlike those in the United States. He can keep the seminar related to the realities of Romania's situation at this time.

Outline:

- I. Why would a physician want to work in a group?
- II. How should a group practice be organized?
- III. How can group practice be promoted to physicians and patients?
- IV. What problems arise in group practice?
- V. What sources of help are there to assist in the establishment of group practice?

I. Why would a physician give up independence to work in a group?

1. The complexity of modern medicine requires that physicians collaborate and learn from each other.
2. Group care is often better care for patients.
3. The economics of group care can be better for the physicians, for patients and for society.
(Note: private practice is competitive, and groups are better able to compete.)

II. How should group practices be organized?

This depends in part on Romanian law.
There are four models used in the United States:

1. An informal sharing of space and expenses by physicians who are practicing independently.
2. A scheme where one physician owns the group practice and hires others on salary to work for the group. (Sole proprietorship.)
3. A formal partnership of physicians.
4. A professional corporation formed by physicians.

For all of these models, it is desirable to have legal advice and signed agreements which say how problems will be solved. The main issues to address are:

1. The kind (single specialty or multi-specialty) and size of the group.
2. Location or locations.
3. Capital to be invested by physicians to start the group.
4. How income will be shared.

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5. How expenses will be shared.
6. How new physicians will be selected and added.
7. How physicians will leave the group, and how the group can dissolve if it wants to.
8. How the group will be managed and governed.
9. What productivity will be expected from each physician.
10. How the group's services will be marketed to the public.
11. How a high quality of medical practice will be assured.

III. How can group practice be promoted to physicians and patients?

There are four main advantages of group practice:

1. Group practice generally gives physicians the opportunity to become better doctors and to provide better care to patients.
2. Group practice is generally better able to compete for patients than other kinds of practice.
3. There are financial and non-financial benefits for physicians from working in a group. (higher incomes; scheduled time off call; insurance; sick leave; etc.)
4. The future of medicine worldwide will be the development of more, large, integrated, group practices which will be managed like complex corporations, regulated by government, and expected to provide high quality care at reasonable cost. Now is the time to gain experience with group practice.

IV. What are the problems which arise in group practice?

1. Psychological! Not every physician is suited to work in a group. Those who cannot give up any of their independent autonomy can become unhappy in a group.
2. Start-up funding is needed to support a group until it becomes successful enough to pay its costs from revenues; such funding is limited in Romania.
3. Inexperience with group management may be expensive.
4. Disputes over money and authority occur.

V. Sources of help in establishing group practices.

1. Texts: United States publications on group practice are many, including magazines such as Medical Economics, and Hospitals and Health Care Organizations. A small library could be formed from these.
2. The ARDAMP could play a role in gathering and sharing experience with forming and advising group practices.
3. U.S. organizations which give seminars often on

group practice include the American Group Practice Association, The Group Health Association of America, the American Medical Association, and state medical societies. Their pamphlets and course materials could be obtained.

4. The experience of group practices in the U.S., including the Kaiser Permanente Medical Care Program (Dr. Prescott) and the Lovelace Clinic (Dr. Pasternak) is a source of advice and documents used to maintain and manage these groups.
5. The small business advisory group operating in Bucharest in 1993 may still be available to help with business problems of group practice.
6. Bank loans can be looked into as Romanian banking develops.

Participants in this seminar are encouraged to ask questions and to make comments at any time. The more informal the meeting, the more likely it is to be useful to participants. Differences between the situation in the U.S. and in Romania must be clearly understood. Dr. Romano's group experience is particularly relevant to this seminar.

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GROUP PRACTICE MANAGEMENT AND PLANNING

Derick P. Pasternak MD, MBA

A. Governance and Administration.

1. Governance.
2. Administrative staff.

B. Personnel.

1. Physician personnel issues -- Role of Medical Director.
2. Physician compensation.
3. The personnel function for support staff.

C. Finance and Accounting.

1. The person in charge is responsible for the money. You can delegate authority, but not responsibility.
2. Trustworthy expert needed to keep track of finances.
3. Financial planning (SEE BELOW).
4. Accounting setup (possible purchase of service).
5. Charge structure; Billing issues; Collection.
6. The handling of money.
7. Periodic reports.

D. Purchasing.

E. The Medical Record.

1. A special mode of doctor to doctor communication.
2. No need for records, if doctor has:
 - a. ability to practice 365 days a year, 24 hours a day;
 - b. expectation of very long professional life;
 - c. perfect recall of every illness of every patient;
 - d. ability to treat every illness of every patient.
3. Group must develop consensus on how to keep records.
4. For now, paper record is most feasible; in 15-20 years all records will be computerized in urban practices.

F. Planning.

1. The business plan.
2. Financial planning as part of business plan.
3. Capital planning.
4. Short term financial plan -- the annual budget.

G. An example of a successful group practice in the US.

**ENCOURAGING PHYSICIANS TO CONTINUE THEIR PROFESSIONAL AND
MANAGERIAL EDUCATIONS**

Seminar: Dr. Prescott and others

Introduction: The United States systems for providing continuing education are described. Participants are invited to comment on methods and needs in Romania.

Outline:

- I. Why both kinds of continuing education are essential for physicians, especially in a group practice.
 - II. Continuing medical education.
 - III. Continuing managerial education.
 - IV. Sources of help.
- I. Why both continuing medical and managerial education are needed by physicians.**
1. Medical education.
 - o Medical knowledge changes rapidly.
 - o Physicians leave little time for reading.
 - o Patients suffer when physicians do not keep up.
 2. Managerial education.
 - o Good management is the key to success in group practice, or in any practice.
 - o Physician managers are desirable because physicians will tolerate management by other physicians better than management by non-physicians.
 - o All physicians must take responsibility for both the quality and the cost of medical care.
- II. Continuing medical education.**
1. The United States require a certain number (usually about 30) of hours per year of continuing medical education before a physician can renew his or her license to practice. This is a good idea.

This is in addition to other licensing requirements, to specialty certification and to credentials demanded by hospitals and managed care plans (HMOs) before physicians can practice with them. [Some specialties require recertification (repeat examinations) every few years.]
 2. How do physicians obtain the required hours?
 - a) Courses given by academic institutions

- o Academic medical centers and medical schools
 - o Specialty societies, such as the American College of Cardiology.
 - b) Courses given by physician associations, such as the American Medical Association, or the California Medical Association.
 - c) Lectures at community hospitals, usually at lunch hour, which have been accredited by the state for continuing medical education.
 - d) Teaching medicine in formal lectures.
 - e) Certain correspondence exercises in which a physician completes some reading and mails in responses to a questionnaire.
3. What do physicians do beyond what is required?
- a) Study texts and journals and organize journal clubs
 - b) Listen to audiotapes of medical lectures.
 - c) Use computer software programs, such as those which explore diagnoses in difficult cases.
4. "Mentoring" - having one experienced physician observe the work of a less experienced one and make suggestions. This is possible in a group practice. It is the responsibility of a Chief of Service in a group.

III. Continuing managerial education.

1. On-the-job training in a group practice or managed care plan. First, service on committees; later, the possibility of an administrative position.
2. Courses
 - o At business schools which give the MBA degree.
 - o At associations, such as the American Group Practice Association, the Medical Group Management Association, and the American College of Physician Executives.
3. Reading texts and journals of management.
 - o Groups should develop information systems which produce management reports which can be shared with practicing physicians so that they know how well their group is doing.
4. Is management a career track for physicians?
 - o See I(2) above. Drs. Prescott and Pasternak are examples of physicians turned physician-managers.

IV. Sources of help with continuing education.

1. United States laws, as examples.
2. Continuing education departments of teaching institutions, and their course curricula.
3. An adequate medical library. Sponsored by ARDAMP?

4. Practice guidelines developed by medical societies and by government.
5. Audiotapes and computer software.
6. A management library. Sponsored by ARDAMP?
7. Educational leave with pay as a benefit of group practice?

EVALUATING AND ASSURING QUALITY AND EFFICIENCY IN GROUP PRACTICE

Seminar: Dr. Pasternak and Dr. Prescott

Outline:

- I. Approaches to quality assurance
- II. Approaches to evaluation of efficiency
- III. Will Romanian physicians accept these methods?

I. Approaches to quality assurance

1. Selecting well-credentialled physicians for the group
2. Requiring continuing medical education
3. Four main aspects of quality assurance:

A) Structure of the group

- o The "group goldfish bowl"
- o Responsibilities of Chiefs of Service
- o Incentives which relate income and performance
- o Member satisfaction surveys
- o Patient grievance procedures
- o Fair procedures for dismissing unskilled workers

B) Processes in providing medical care

- o This requires good medical records!
- o Chart reviews, by peers
- o Practice protocols or guidelines
- o Find steps which have been omitted, teach correction, and remeasure compliance
- o Goal is to improve care and systems for treating patients - not to punish individual practitioners

C) Outcomes

- o Mortality, morbidity and subjective quality of life
- o Ask the patients!
- o Adjust statistics for risk in studying outcomes

D) Law and regulatory requirements

II. Approaches to evaluating efficiency

1. Economic measurements, e.g., costs, utilization and productivity
2. Evaluation relates time, cost, productivity, revenues and quality of care
3. For professional services, time is money. How long should a patient visit be?
4. The group must set flexible standards to use in

evaluating efficiency

III. Will Romanian physicians accept these methods?

1. Private practice offers liberation from bureaucratic control
2. Pros and cons of accepting peer governance

HOW TO ASSURE HIGH QUALITY OF CARE IN A MEDICAL GROUP

Derick P. Pasternak MD, MBA

- A. The purpose of Quality Assurance: To be confident that patients are getting the best treatment possible for their ailments. Quality Assurance is the way groups ensure that they place their patients first.
- B. Peer Review.
 - 1. Doctors reviewing doctors' work.
 - 2. "Everyone knows who the good doctors are."
 - 3. Group is jointly responsible for quality of care to all patients.
 - 4. Role of the Medical Record.
- C. Indicators of health care quality.
 - 1. The group has to decide what the indicators will be.
 - 2. Legal and other requirements may exist.
 - 3. Start with simple indicators:
 - a. In clinic.
 - b. In hospital.
 - 4. More extensive and sophisticated review involves entire episode of care.
- D. Who should belong to groups? Who should not?
 - 1. Doctors who are proven to provide bad care.
 - 2. Doctors who cannot tolerate peer review.
 - 3. Doctors who have to make all decisions themselves.
 - 4. Unreliable doctors.
 - 5. Antisocial doctors.
 - 6. Some eccentricities can be tolerated, but within limits.
- E. Impaired (Sick) Physicians.
 - 1. Doctors are a high risk group for social illness.
 - 2. Doctors often deny their illness, even to themselves.
 - 3. The main question: Is the doctor well enough to practice?
 - 4. Secondary question: Can colleagues tolerate illness (call schedule, etc.)
 - 5. Alcoholic doctors.
 - 6. Drug abusers (some high risk specialties).
 - 7. Philosophical question: eliminate the bad apple or treat the sick doctor?
 - 8. Always be aware of and observe laws.
- F. Fairness.

Developing a Business PlanMain messages:

- * Need a business plan before asking investors for money
Mission, Market, Management, and Money
Cine (you, client), Ce, (services) Cum, (how to delivery)
- * Medicine is a business; this is difficult concept for doctors to face in all countries
- * Key words:
Profit (revenues that exceed expenditures)--not just salary; also for payback; expand
Clients- most important; they bring in revenues (need to analyze who you will be serving)
Choices- why clients come to you-
Change- have to change the way you think about profits and clients
- * Every Business has costs:
--how to analyze costs can be difficult, but is necessary. May need to limit costs
(charges, hours work, billable hours, equip.,) compare to revenues-(break-even)
-- Need to define business costs allowed as tax deduction before taxes on income
--pricing is most difficult part--need pricing strategy
- * Good news; bad news:
-- Few banks are lending for medical practice; no history of profitability
--Other investors may be ready (ie. US and W. European doctors)
-- If you have a good business plan (show that you can make a profit) you can probably find an investor. Identify what is in the plan for the investor (profit; interest in services/product)??
in Romania
- * You must be willing to invest or find others (family/friends) that will invest, too.
Banks aren't willing to invest 100%. This shows your commitment; owner contribution.

Questions/comments:

Request for list of investors; Fighting for decent salary; What business expenses can be declared for tax deductions (interest, cont. ed.); Confusion by patients over what will be charged for; need to adapt business plan to local conditions;

Action:

1. Develop priorities for what should be included as part of tax exemptions; need to impact *parliament* legislation that will impact the potential success of your business:
 - a) Interest expense
 - b) Cost of continuing education
 - c) other (bargaining chip)
2. Get assistance from others who have knowledge about developing and implementing a business plan: Small and medium size business development centers (USAID) in several cities. If things are going badly (or well) there may be things to do to make things (even) better.

APPENDIX D - PRIVATE PRACTICES OF ATTENDEES

30 Attendees described their practices

General Practitioners	9	Ophthalmologists	2
Pediatricians	3	Neurologists	2
Related medical workers	3	Surgeon	1
Gynecologists	2	Ministry of Health	1
Dermatologists	2	Unknown	3
Cardiologists	2		

12 were in practice with at least one other physicians or related health care worker.

7 were in multispecialty groups.

4 had not started private practice.

1 had discontinued private practice.

13 were presumed to be in solo private practice.

Problems identified by attendees:

Financial - high taxes, high interest rates, high cost of private practice space	12
Difficulty obtaining office equipment	13
Need for Parliament to provide more legal structure for private practice	8
Ministry of Health does not support reform	4
Difficulty finding opportunities for training, continuing medical education, and maintaining quality in services	8
Does more equipment equal better quality of care?	1
Need for more management assistance	3
Organization of private practice	2

**Richmond Prescott, M.D.
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San Francisco
CA 94123**

June 8, 1994

Vlad Romano, M.D.
Mary Ann Micka, M.D.
"ARDAMP"
Boulevard Alexandru Obroglia, 48
Bl. R10, Ap. 51, Sector 4
Bucharest, Romania

Dear Vlad and Mary Ann,

You have asked me for some preliminary comments on the Second National Conference for Private Medical Care concluded last week. I will, of course, be making a longer trip report to Healthcare Enterprise International, Inc., but I am glad to to send you these perceptions of our work last week.

The material you already have includes the outlines of the seminars which were conducted by myself and Dr. Derick Pasternak. Dr. Pasternak has given me his remarks about the conference, and I will incorporate them into this letter.

The three major areas of discussion in this conference were:

1. How other countries, particularly Poland, the Czech Republic and Hungary, have addressed the problems of reform of their public health care systems and of development of private medical care; and the role of private medical care in countries where the predominant system of care is provided by the government as a public service.

2. The methods of organizing private medical care, especially private group practice; the advantages of group practice; and the need for business plans, trained management and quality assurance.

3. The difficulties of financing private medical care in Romania at the present times, particularly the problems physicians face in qualifying for bank loans.

The first topic appeared to be of great interest to the participants in the conference, because the actions of other countries give examples of what can be done to encourage private practice.

1. Other countries and private-public sectors

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o Poland is lagging behind the Czech Republic and Hungary in its reforms. Privatization, encouraged in other small businesses, has not been well extended to medical care except that private practice is legal. The state owns all medical centers and finances a public system through taxation, without assuring that an identified portion of the taxes levied must go for health care. There is no national health insurance which private physicians and their patients can use. Public salaries for medical workers are very low. Few patients can pay private fees. Political and economic instability prevent an organized, step by step approach to privatizing health care. Yet physicians are eager for reform and privatization. The situation in Poland has much in common with Romania.

o In the Czech Republic people can choose where they wish to receive their health care. In 1993 the Czech Republic encouraged primary care physicians to work in private practice. 90% of general practitioners and 70% of pediatricians have done so. They are paid on a point system (so many points for certain kinds of visits and procedures) from a National Health Insurance Fund run by the National Health Insurance Agency. This fund's revenues come from a 9% tax on employers and a 4.5% tax on employees. In addition to this fund, there are 19 branch insurance companies, organized by special groups (bankers, the military, other categories of workers), which provide financing for 10% of the population. The unemployed and the aged are paid for by the state from general tax revenues. The percentage of Gross Domestic Product which is spent on health care in the Czech Republic has risen from 5.3% in 1991 to 7.1% now.

The problem is that 82% of available funds are spent on hospital care and on pharmaceuticals, and only 18% is left to pay physicians providing ambulatory care. Payments to physicians are low. Physicians find that they must see 60 patients a day to earn the money they need for expenses and to live. Incomes of some physicians practicing privately are lower than incomes of those who have remained on salaries in the public system. The predominant form of private practice is solo practice, but there is great interest now in group practice and in managing private health care well.

Mr. Henry Reinhard recommended that Romanian physicians (1) form more group practices, (2) understand that managed care with capitation payment to physicians is better than fee-for-service practice, and (3) involve physicians in working with legislators for reform, so that the Ministry of Health will not be the only agency making decisions about this.

o Hungary during the conservative government (1991 - 1994) wanted greater privatization of medical care. It is

not known how the recent elections, in which the conservative government was defeated, will change this.

Hungary has given primary care physicians three options: (1) to remain on salary with the public system; (2) to be paid by capitation (so much per month per patient who gives his or her health insurance card to the doctor); or (3) to become a totally private practitioner whose patients pay all fees, apart from the National Health Insurance fund.

About 7500 of Hungary's 35000 physicians have accepted option (2) or (3). When a physician agrees to be paid by capitation, the state provides some office furnishings and equipment, including a computer. The physician pays for office personnel and other expenses. Some specialists have been allowed to become private practitioners.

Hungary began National Health Insurance in 1993, a fund from which primary care physicians on capitation are paid, and some private specialists are also paid.

The Hungarian government wanted hospitals to operate under a not-for-profit, mostly private system. Two demonstrations of this exist in Budapest, but capital to extend this model is lacking. American investors are building one entirely private hospital near Budapest.

The government of Hungary has taken steps to extend primary care by starting family practice residencies, and to improve quality of care by planning to require a national examination and postgraduate training for general practitioners. Experiments in managed health care exist in some isolated industries, but the government has not yet been impressed that managed care should be encouraged.

The discussion of the rational role of a private sector for health care in a country where the health care system is predominantly public followed the outline of the seminar. Dr. Silviu Radulescu argued that private medical care cannot be considered an example of "free market" economics because this market is not free, but he acknowledged that regulated private practice can enhance a country's total medical care. He suggested the not-for-profit model of private health care organization. He was pessimistic about the growth of private medical practice in Romania until more money becomes available for the public sector. He emphasized the assurance of the quality of private practice and the exploration of group practice.

The three members of Parliament who came to address the meeting all spoke in favor of privatization of medical care and of united physician pressure on the Parliament to encourage this, but specific actions were not discussed. These members were apparently opposition members.

The excellent question and answer discussion related to this major topic covered such matters as:

- Emerging requirements for continuing medical education in the Czech Republic.
- The conversion of surplus hospital beds to less expensive skilled nursing beds in the Czech Republic.
- The amount of taxation for social programs in various countries. Romania, the Czech Republic and Hungary all have tax burdens of about 45% for social programs.
- How to obtain space for private practice in various countries.
- The use of copayments in the Czech Republic.
- The widespread problem of "envelope" payments as a disincentive for physicians to enter private practice or to form groups.
- The possibility of not-for-profit organizations for private medical care.

2. Organizing and managing group private practices

The outlines for seminars show what was covered in the discussions. A foundation for this was obtained by asking each of the participants to describe his or her specialty and circumstances of private practice - solo or in a group. Dr. Micka summarized this information very well, and you have her summary.

It was encouraging that some physicians had successfully organized private groups and were rapidly learning about the major challenges of how to divide income and expenses and how to identify leaders who would be responsible for management and decision-making. The seminars were well received, and their content could become the subject matter of further courses, conferences and technical assistance.

The video offered by the ophthalmologist who, with the help of financing from friends in the Netherlands, had succeeded in establishing a private ophthalmology center, complete with an operating room, was inspiring. He was fortunate to get the funding he needed, and his service occupies a particularly needed niche in medical practice, but his initiative and organizational ability were good examples of what can be done, even now.

The seminar on quality assurance was less valuable than it might have been. There is little tradition in Romanian

medicine of quality assurance activities other than qualification by passing examinations, and the participants were unfamiliar with other ways to assure high quality care. Other countries as well have much to learn about quality assurance. It must become an important feature of private practice if private practice is to find support in Parliament.

3. Bank loans for physicians entering private practice

As all persons present expected, this topic was discouraging. Of eight persons on the program, two came. The principle of lending by banks was restated and restated: that banks can only lend to those who appear well able to repay the loans. Most physicians are not in that position. There is no discrimination against physicians, and no special help will be available to them when they request loans. However, the gentleman from the Romanian Development Bank did mention that the bank is hoping to establish this fall a special "professional credit" with loans at lower interest rates (perhaps 80% instead of 130%) for professionals whose work brings them a reliable stream of income from which to repay loans. This man invited physicians to come to see him personally to discuss their business plans and needs for financing. He would help them to prepare a good business plan. He also suggested that of a \$150 million loan to the Ministry of Health by the World Bank, \$20 million remains unallocated. Perhaps this could be used in part as a revolving loan fund for physicians. (This seems a very unlikely decision by the Ministry of Health.) When this banker sat down, he was applauded for his sympathy with the problems of physicians.

Summary:

The three consultants to U.S.A.I.D. would agree on the following assessment of the conference and on recommendations to all participants.

1. It was a good conference which satisfied to some extent the curiosity of the participants about how private practice is being organized, and how health care reform is being proposed, in other countries, including Poland, the Czech Republic, Hungary and the United States.

2. It met its objective of encouraging private practitioners to think about the advantages of forming groups. This conference enabled physicians who have formed groups to share their experiences with each other.

3. It emphasized the importance of physicians uniting to present their arguments for reform to members of Parliament. The NGO which was formed last year has not yet been used as it might be. A further U.S.A.I.D. - sponsored consultation

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with the leaders of the NGO, to explore just which functions the NGO could carry out successfully, seems strongly indicated.

4. Romanian physicians should not be discouraged but should work for what is feasible, such as obtaining tax deductions for private practice expenses for continuing medical education and interest on loans. Investment in expensive equipment should be analyzed carefully for the cost-benefit tradeoff.

5. Opportunities for further teaching of management methods should be explored. This could be a function of the NGO, which could begin a management library. U.S.A.I.D. in Bucharest could help in this exploration.

6. Future conferences need to be organized further in advance, with more extensive efforts made to enlarge attendance. Physicians and managers in the public sector might have been very interested in this conference, and might have shared the management problems they face. The most successful conferences on any complex topic are those in which there is a comprehensive exchange of information in advance between the planners and those who will present material. The consultants from the United States did not learn until the conference itself what has happened in medical care and in the economy in Romania during the past year. For excellent organization, a conference must depend on a committee of interested individuals, not on the efforts of one or two busy persons. Such a committee could logically come from membership in the NGO.

7. The issue of how to assure high quality care while at the same time limiting the costs of medical care needs to be returned to. The basic concepts of adequate medical record keeping, gathering management information, and persuading physicians to submit their practices to peer review, need to be accepted if quality assurance is to be a reality.

I hope this preliminary report is adequate for your purposes. I did not have time to prepare this before leaving Bucharest, but I hope it will arrive in time.

On behalf of the consultants, I want to say how much we enjoyed this conference, and how supportive we are of what you are trying to do. Perhaps much of what you plan will have to await improvement in the Romanian economy, but the steps you can take before that time are many. We wish you good luck and thank you for giving us the privilege of working with you.

Sincerely yours,

Richmond Prescott

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APPENDIX F: COMMENTS OF HENRY C. REINHARD, JR., J.D.

(Letter to Dr. Mary Ann Micka)

2 June 1994

Mary Ann,

Thanks for inviting me to participate in the 2nd National Conference for Private Medical Care. You have asked that I leave behind a brief list of impressions and conclusions from the first day of the conference. They follow hereafter.

1. I'm impressed with the genuine thirst for information about what other Central and Eastern European countries are doing in the area of health care privatization. I have promised to provide various names, addresses, telephone/fax numbers of people in the Czech Republic as well as several publications which various participants have requested.

2. There seems to be a growing awareness of the need to influence the process by which new laws and regulations are developed. Better to help develop a good law than complain because someone else passed a "bad" law.

3. There seems to be a feeling that physicians should be granted preferential tax treatment because of the nature of the services they provide. Since most private practices are organized for the purpose of generating a profit, it is unlikely that such profit-making ventures will be accorded preferential tax treatment. It is reasonable to expect that interest payments, the cost of continuing education, etc., are legitimate business expenses and should be deductible from gross revenues before calculating the amount of profit earned and therefore subject to taxation.

Recommendations for my Romanian Colleagues:

1. Don't get discouraged - continue to look for ways to achieve your objectives.

2. Don't be too quick to buy "needed" equipment. Before initiating an equipment purchase, do a cost/benefit analysis. Know how much revenue the equipment will generate and how long it will take to pay for itself before you make the purchase. With proper planning you will only buy essential equipment and when you share your analysis with the bank, if your projections are accurate and conservative, you may even qualify for a preferential interest rate.

3. Seriously consider group practice as an alternative to solo practice. There is strength in numbers and the efficiencies of shared overhead costs and other benefits

will have a salutary effect on your bottom line as well as your emotional well-being.

4. Be pro-active with the Ministry of Health, the Ministry of Finance and the Parliament on matters of concern to medical practice in Romania.

5. Don't hesitate to contact me if you need information about activities in the Czech Republic.

Henry C. Reinhard, Jr.

APPENDIX G: COMMENTS OF DERICK P. PASTERNAK, M.D., M.B.A.

Memo to Richmond Prescott, M.D.

From: Derick P. Pasternak

Subject: Partidipation in the Second Annual Meeing of the
National Association for Private Medical Care,
Bucharest, 2-4 June 1994

As a result of this conference, I had the following observations:

- (1) The topics chosen were appropriate for the purposes and with one exception (Quality Assurance, see below) well received by the audience.
- (2) The attendees were, few excepted, committed to private practice part time, but not yet ready to go full time, partly because they do not trust the government and so do not wish to leave their salaried positions yet.
- (3) All speakers - including the Romanians who were not invited courtesy of U.S.A.I.D. - suggsted the concept of group practice. Several attendees are also coming to the conclusion that groups are preferred to solo practice and have taken significant steps in that direction.
- (4) Based on the information from attendees at the conference, the Romanian government is not supportive of private practice of medicine, although steps have been taken to legalize the practice and to establish a National Health Insurance. [Not yet in place.]
- (5) Everyone agrees that private group practice success depends on a number of factors, including the current gratuity system in existence. [This is bad.]

The conference was well conceived, but there were several shortcomings in its organizations: Attendance was less than desirable; the translator did her best but had no familiarity with medical terminology; the agenda was repeatedly changed and was completed only because the parliamentary delegation did not show up.

There was no business session in the strict sense of the term, so the leadership is on its own as far as setting priorities is concerned.

Recommendations:

(A) Technical assistance to the National Association for Private Medical Practice in order to teach them how to organize a trade organization and especially to teach

techniques of legislative lobbying. Possible American consultants for this purpose:

Donald Fisher, Ph.D., Executive Director A.G.P.A.
Frederic Wenzel, FACHA, Executive Director, M.G.M.A.
Roger Schenke, Executive Director, A.C.P.E.
Alan Nelson, M.D., Executive Director A.S.I.M.

(B) A legislative agenda established at the earliest possible time with 3-4 priority items, at least one of which should be a "bargaining chip."

(C) Strategies developed to heighten physician appreciation of quality assurance, quality improvement and patient satisfaction. There is little interest in these topics at this time, but they will be important competitive factors.

(D) The current public health / management course supported by the World Bank loan should be explored as a proper vehicle for training physician managers who can become medical directors of group practices.

(E) Hospital physicians should also be exposed to the concepts of group medical practice, methods of management and quality assurance.