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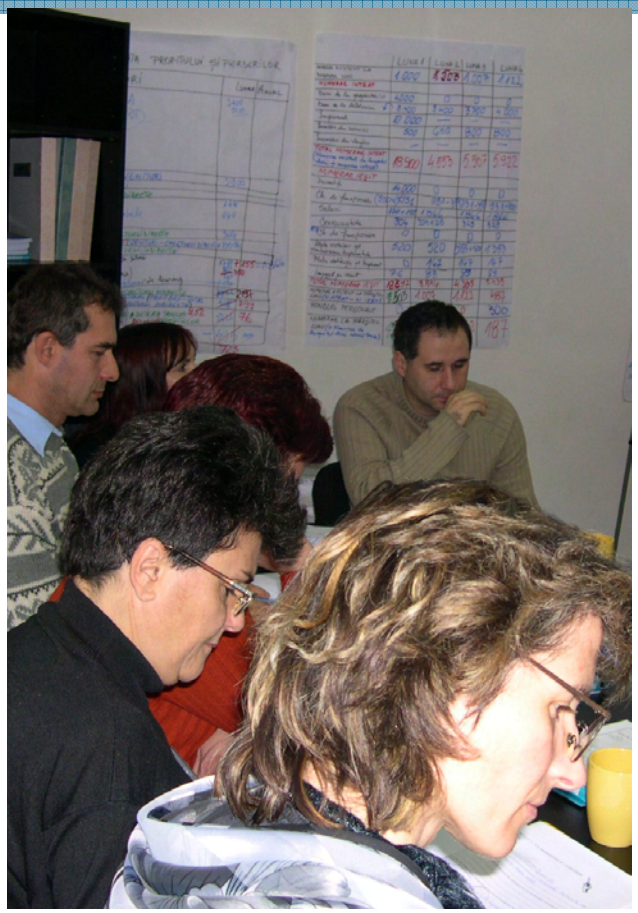
FINANCING AND TRAINING NEEDS OF SMALL-SCALE PRIVATE HEALTH CARE PROVIDERS AND DISTRIBUTORS IN ROMANIA

MARKET RESEARCH REPORT



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Banking on Health

Market Research Series Report # 1

Market Research Series: The *Banking on Health* Project has developed a series of country-specific market research reports on the private health sector. This market research examines private health care providers' financing and business development needs. It also explores service provision, focusing on reproductive health and family planning services. The market research provides information to financial institutions that are interested in lending to this sector. This information can be used for loan product development and designing marketing strategies.

The *Banking on Health* Project uses the market research to design business development services for the private health sector. The market research also is shared with policy-makers who are interested in engaging the private health sector.

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DISCLAIMER
The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

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ABBREVIATIONS

BI	Bucharest-Ilfov
C	Central
CAPA	Creditar, Asisenta, si Pregatire pentru Afaceri Foundation
CDE	Economic Development Center
CHF	Cooperative Housing Foundation
DHIH	District Health Insurance Houses
IUD	Intrauterine device
IT	Information technology
MFI	Microfinance institution
MoPH	Ministry of Public Health
MSME	Micro, small, and medium sized enterprises
NE	Northeast
NGO	Nongovernmental organization
NHIH	National Health Insurance House
NW	Northwest
OB/GYN	Obstetrician/gynecologist
OMRO	Opportunity Microcredit Romania
RFHI	Romanian Family Health Initiative
RON	Romanian lei
S	South
SE	Southeast
SECS	Society for Education in Contraception and Sexuality
SW	Southwest
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
W	West

ABSTRACT

OBJECTIVE

This report assesses the business development needs, particularly financial and training, of private health care providers and distributors of reproductive health and family planning products and services in Romania. That information will be used to develop a program to expand access to financing for the private health sector. Specifically, assessment findings will

- provide market data to assist interested banks and microfinance institutions to develop loan products and marketing strategies for the sector
- provide a needs assessment and background for a training course developed for family doctors on financial management
- inform government policies on contracting and health promotion with the private sector

METHODS

This assessment consisted of a quantitative and qualitative study composed of a desktop literature review, survey, focus group meetings, and interviews with stakeholders. Using different data-collection methods, the study examined family doctors under contract with the National Health Insurance House (NHIH), obstetrician/gynecologists (OB/GYNs) in private practice, other private medical clinics, rural pharmacies, and product distributors.

A statistically significant survey of family doctors was conducted in each of the 42 districts in Romania, segmented according to population at the district level and urban versus rural locations. A questionnaire with 63 questions was pretested with a sub-sample of interviewees. Then surveyors at the doctors' places of business implemented it verbally and individually. Valid surveys were collected from 1,215 family doctors, more than 10% of the entire target-group population of family doctors under contract with the NHIH. Monitoring was conducted on a regular schedule to ensure the data's integrity.

Furthermore, two focus groups each were held with OB/GYNs in private practice, rural pharmacy owners, and medical clinic owners, with five to eight participants each in two different locations of the country. One focus group was held with product distributors. A literature review was conducted that examined government statistics and published articles and papers. Interviews were held with informants, including representatives of financial institutions, government, nongovernmental organizations (NGOs), and professional associations.

FINDINGS

More than 50% of family doctors offer reproductive health and family planning products and services; most of them do so in underserved rural areas. Almost all (95%) of the family doctors plan to improve or grow their practices. The most frequently cited means to do so was to buy medical equipment (78%). A large number, 42%, would like financing immediately to improve their practices. Most of them believe that better contract terms with the NHIH and clinical and business training would help their practices. Differences in the opinions of family doctors based on district, gender, and location are negligible. In addition the study found that independent

pharmacies are under pressure because of the terms of payment under the NHIH contract. Private medical clinics and OB/GYN practices are faring well in the improving economy with little reliance on the public health system. Findings on distributors vary and are thus less conclusive.

CONCLUSIONS

Family doctors struggle under the NHIH capitated health system to reinvest and improve their practices. They are surviving financially, but need additional inputs to improve their practices by purchasing equipment, renovating facilities, and adding services. Family doctors cited access to finance, better contract terms, ownership of facilities, and training as factors that can improve their practices. Independent pharmacies and family doctors would benefit from minor policy changes that would enable their businesses to function and improve using external finance.

1. INTRODUCTION

Private health care providers worldwide cite the inability to access finance as one of their key impediments to business growth and improvement. For these businesses, as with all businesses, credit is an engine for expansion.

For many health care providers interested in accessing finance to increase their outreach or improve their services, banks in many countries are not interested in lending to the sector. Financial institutions often view health as a public good, not a business opportunity, and they may not take the time to understand the business models in the sector, preferring instead to lend to more familiar businesses, such as those in the trade and manufacturing sectors. Banks that require security may not be interested in the type of collateral that health care providers offer. The businesses themselves, often run by clinicians with little business management experience, may not produce the type of bankable business plans that are necessary to obtain financing. These constraints to financing and the resulting impediments to improving and expanding private practice are particularly true in economies in transition, where the commercial banking sector is maturing and the health sector is evolving from a state-dominated system to include private activity.

The more financial institutions that reach out to the health care market, the more likely it is that doctors, pharmacists, and other providers and distributors of reproductive health and family planning products and services will be offered favorable terms that meet their financing needs. To assess the market's potential, and possibly view providing financing for the sector more favorably, these institutions require market information and, in some cases, training in marketing and lending to the sector.

The United States Agency for International Development (USAID)-funded Banking on Health Project was designed to expand access to financing for private health providers in developing and transitional economies. Banking on Health works with financial institutions to promote health-sector lending and with private health providers to improve their businesses and ability to access financing. Banking on Health began working in Romania in January 2006 by conducting a preliminary assessment of the financial and private health sectors. This assessment revealed that access to financing was a constraint in Romania and information about the sector was lacking.

Banking on Health designed this study to develop a program to expand access to financing for the private health sector. The results of this survey and research are designed to inform the financial institutions in Romania about how to best target the private health sector and provide the products and services these businesses need to expand and improve their practices. The research also was intended to provide Banking on Health with information about family doctors' business practices for use in developing a business-training curriculum to improve the viability of practices and prepare family doctors to access financing. The research is intended to inform the health sector reform process. Family doctors are the backbone of primary health care in Romania and are key distributors of family planning and reproductive health care in underserved areas. Family doctors obtain most of their income under contract with the National Health Insurance House (NHIH), which administers the Romanian health insurance system. Rural pharmacies and other businesses rely in part on government contracts and are also important links in the family planning supply chain for poor and rural Romanians.

The main objectives of this research are to

- provide market data to assist interested banks and microfinance institutions (MFIs) to develop loan products and marketing strategies for the sector
- provide a needs assessment and background for a training course developed for family doctors on financial management and access to finance to grow or improve their practices
- inform government policies on contracting and health promotion with the private sector

2. BACKGROUND

2.1 THE ROMANIAN HEALTH CARE SYSTEM

The Romanian health care system provides universal coverage of a basic package of services and medicines, plus emergent and some specialized and tertiary care. The system has undergone a series of reforms since the country began moving away from a socialist system in 1989. In recent years the annual budget allocation for health care has increased, but the system is still stressed by the low funding of the national health system. In 2004 the total expenditure on health as a percentage of gross domestic product in Romania was 5.1%.[1]

Health sector reform resulted in new roles for many actors in the Romanian health care system. The Ministry of Health and Family is now responsible for health policy making, setting standards, and developing public health programs. As part of the reform process, Romania separated financing from service provision. The NHIH was established to be the purchasing agency responsible for buying health services from providers. The NHIH is funded primarily through employer and employee contributions and contributions paid by the state for unemployed, retired, and underserved groups.

Health care delivery also changed during this reform period. Secondary and tertiary care in Romania is provided largely by state-owned facilities. In contrast, family doctors, the backbone of the primary health care system, were formerly state employees but now operate as private practitioners and work under contract with their District Health Insurance House. The District Health Office assigns each person in Romania a family doctor according to his or her location, but people may switch to another one in that area. The features of the contract are determined at the national level, by the NHIH, to pay the family doctor for providing a basic package of services to the population on his or her patient list. The payments are based on a combination of per-capita (85% of the payments) and fee-for-service basis. The family doctor is responsible for paying the practice's expenses (such as rent, nurses' salaries, and supplies) from the contract's payments. Patients who need specialized services must be referred by their family doctor for the national health insurance system to cover their care. National health insurance covers most hospital and emergent care.

In addition to the basic package of services, there is a list of basic medicines that the national health insurance covers. The medicines must be prescribed by the family doctor or physician and then obtained at a local pharmacy. Pharmacies then invoice the government for the medicines that are provided.

2.2 PRIVATE HEALTH SECTOR

The market for private medical services in Romania is growing. Over the past five years, as the middle class has grown, there has been a trend towards the increased utilization of private medical services. The private health sector is composed of a number of actors involved in service provision and product and equipment supply. Private service providers include family doctors, private hospitals, general and specialized medical clinics, obstetrician/gynecologists (OB/GYNs), and dentists. As service providers, family doctors in Romania represent a unique public-private partnership. While family doctors provide

[1] World Health Organization. 2007. *World Health Statistics 2007,* Geneva, Switzerland.

publicly available services, they are under contract and thus manage themselves as private businesses. There are more than 10,000 family doctors under contract with the NHIH in Romania.[2]

There are also many service providers in the private sector that are not contracted through the NHIH. In January 2007, there were six private hospitals registered with the Ministry of Public Health (MoPH). There were 281 private medical clinics, also known as medical centers, in 2005, and that number has risen since then, although official figures were not available as of 2007.[3] While private health insurance does not exist, there are a growing number of subscription schemes whereby employers can purchase memberships for their employees to access the services of private medical clinics. These clinics provide primary and some specialized health care. Dental care is available primarily in the private sector. Most OB/GYN specialists have private practices, with some of them practicing in both the public and private sectors. There are 1,107 OB/GYNs in the country.

In addition to service providers, other segments of the health sector are in the private sector, including pharmacies, pharmaceutical distributors, and medical equipment suppliers. Despite the health reform, a system of informal payments in the public sector continues to be prevalent, and it erodes patients' rights and transparency within the public health care system. Increasingly, the private sector offers increased choice and transparency.

2.3 REPRODUCTIVE HEALTH

2.3.1 HISTORICAL CONTEXT

In the early 1990s, the World Health Organization ranked women's health in Romania as the poorest in Europe.[4] Before 1989 the Romanian government had pronatalist policies that outlawed contraception and abortion. After 1989 abortion was legalized and limited family planning services were introduced. But due to service delivery constraints and misinformation, abortion became a major method of fertility control. In 1993 Romania had one of the lowest rates of modern contraceptive prevalence in the region at 10% among married women aged 15 to 44 and one of the highest total abortion rates in the world at 4.1 abortions per woman.[5,6] This behavior not only represented a significant public health problem, but it also was seen as an impediment to the country's accession to the European Union. Embarking on an ambitious program to expand family planning coverage, the Romanian government was faced with an important problem—while there was a large unmet demand for contraceptives, public resources were not sufficient to fund the needs for the whole country.

2.3.2 REFORM

Since this time the MoPH has collaborated with donors, including USAID, the United Nations Population Fund (UNFPA), and the World Bank, to address this problem. This collaboration has contributed to tremendous gains in women's health. Free contraceptives were made available to those most in need: rural populations and the urban poor. And for those who could afford to pay, contraceptives were made more available in the private sector. The total abortion rate

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[2] Romania's District Health Directorates. 2006. Databases of family doctors under contract with the NHIH. Bucharest: Information gathered by Romtens Foundation during survey implementation. Bucharest.

[3] Romanian National Institute of Statistics. 2005. *Statistical Yearbook 2005*. Bucharest.

[4] European Observatory on Health Care Systems. 2000. *Health Care Systems in Transition: Romania*. Copenhagen.

5 The total abortion rate is the number of abortions a woman would have in the course of her lifetime if the age-specific rates were to remain the same.

[6] Serbanescu, F. and P. Stupp, et al. 1995. *Romania Reproductive Health Survey 1993*. Bucharest: Centers for Disease Control and Prevention and Instituti de Ocrotire a Mamei si Copilului.

has dropped to an estimated 0.84 in 2004. The modern contraceptive prevalence rate among married women aged 15 to 44 is now 38%, with the increase concentrated in the use of oral contraceptives and condoms. Total use of contraception has increased from 41% in 1993 to 58% in 2004[7] While still high relative to Eastern and Western European nations, maternal mortality has declined. Family planning products are now available in urban and most rural areas.

The successes in Romania can be attributed to a confluence of strategies and factors.

- **Education**—With the commitment of the MoPH to increase access to reproductive health and family planning products and services for women via primary health care outlets, USAID and other donors built the capacity of local nongovernmental organizations (NGOs) through a number of projects to provide training to doctors and to conduct educational campaigns among users. This work had a great impact on the availability and acceptance of modern contraceptive methods. Training of doctors in 18 districts, totalling more than 50% of those under contract with the NHIH, enabled them to provide free contraceptives to qualified women.
- **Policy work**—Initiatives aimed at decentralizing and rationalizing the health system have been pursued. The nearly 11,000 family doctors located throughout the country, who are often the first point of contact for the rural poor and others, now are legally able to provide family planning counselling, prescriptions, and products once they receive on-going professional training. Previously, only OB/GYN specialists, primarily located in larger towns and district centers, could offer those services. This restriction hindered increasing the access to reproductive health and family planning services for women.
- **Public awareness**—The public-awareness campaigns USAID sponsored informed the public and clarified damaging misconceptions.
- **Supply**—USAID and other donors, primarily UNFPA, assisted with purchasing and procurement systems for the MoPH. With insufficient funding to meet country-wide contraceptive needs, Romania used market-segmentation analysis to plan the expansion of public family planning services, primarily by providing free supplies —via the newly trained family planning doctors—to the rural poor. Qualified groups to receive free contraceptives included all women living in rural areas and the urban poor (those with no income). In addition, early USAID projects introduced products into the private sector that contributed to growth in the market.
- **Economic growth**—As per-capita income in Romania has grown over the past 15 years, so has women's ability to pay for family planning products. As of the end of 2004, 78% of women who purchased oral contraceptives obtained them in the private sector.[8] In addition, the economic situation in the country has encouraged more suppliers with better and lower-cost products to help meet demand. There are a number of private suppliers on the market now. Many private providers also have emerged, usually with subscription-based service packages that offer quality primary health services, including family planning counselling and products, to middle- and upper-income clients. These providers are mainly in urban areas, but they do alleviate some of the burden from the public system.
- **Cultural factors**—Romanians are well educated and do not face cultural pressures to have large families.

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[7] Romanian Ministry of Health, World Bank, the United Nations Population Fund, the United States Agency for International Development, and the United Nations Children's Fund. 2005. *Reproductive Health Survey: Romania, 2004*. Summary Report.

[8] Romanian Family Health Initiative (RFHI) project data, JSI R& T, USAID, 2006

2.3.3 PROVIDERS OF REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES AND PRODUCTS

As a result of the reforms, a wider range of providers (including family doctors, specialists in obstetrics and gynecology, and general physicians in private medical clinics) offer family planning services in Romania. The public sector continues to be an important provider through family planning offices. In addition pharmacies and distributors have an important role on the supply side.

FAMILY DOCTORS

Since 1989 when the reform of the Romanian health care system began, family doctors have been exposed to many experiments and attempts at reform. Under the old system, family doctors were state employees. Overnight, however, they were transformed into entrepreneurs without guidance in business management or how to operate a private practice. Many family doctors continue to struggle and are frustrated by their role in a primary health care system.

Family planning is part of the minimum package of services the national health insurance system offers, but not all family doctors are trained to provide them. Family doctors who graduated from a family planning course with a minimum of 40 hours have the right to distribute contraceptives at their practices. Public health authorities organize these courses in collaboration with the Society for Education in Contraception and Sexuality (SECS), a not-for-profit organization. To date 5,484 family doctors (approximately half of all those in contract with the NHIH) and 3,620 nurses have graduated from this course, the majority hail from rural areas.[9]

FAMILY PLANNING OFFICES

There are 180 public family planning offices in urban areas, mainly big cities, with funding coming from the national insurance fund via the hospital budgets.[10] The number of clients visiting these offices varies according to their location and the availability of free contraceptives and medical personnel.

OBSTETRICIANS AND GYNECOLOGISTS

There are 1,107 obstetric and gynecological practices in the country, with more than 85% of them operating privately, without a contract with the NHIH.[11] In a country of 22 million people, only 155 OB/GYN practices in the country operate under contract with the government to provide care under the national health insurance system.[12]

PHARMACIES AND DISTRIBUTORS

In 2004, 4,772 pharmacies and 617 pharmaceutical outlets were registered at the national level. Of these entities 529 pharmacies and outlets were public and 4,860 were private.[13] Private rural pharmacies are often the only source of medical supplies, drugs, and commercially marketed family planning products for doctors and poor women in rural Romania.

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[9] Society for Education in Contraception and Sexuality, and RFHI project data, 2006.

[10] The Romanian National Centre for Organizing and Providing Data and Information within the Health System, 2006

[11] Ibid.

[12] Romanian National Institute of Statistics. 2005. Statistical Yearbook 2005.

[13] Ibid.

2.4 FINANCING OPTIONS FOR THE PRIVATE HEALTH SECTOR

The Romanian financial system is benefiting from a growing economy and the privatization of the banking system as part of the European Union accession process. The increase in capital and banking sophistication resulting from increased foreign ownership in the banking sector has led to major branch expansion programs for many of the larger banks to target retail customers in the heretofore under-served areas.

Given the growth strategy of the larger banks, the private sector's access to credit is increasing rapidly, particularly in the consumer sector. The smaller banks, which remain locally owned with under-developed franchises, may be compelled by their decreasing market share in the traditional sectors to pursue growth opportunities in other segments, such as micro, small, and medium enterprises (MSMEs) and the health sector. Larger banks have been keen to lend to new markets, such as family doctors, and to expand lending activities in markets already served, such as distributors and pharmacies. Yet a few factors have inhibited them, including the nature of the businesses, which have low levels of fixed assets to offer as collateral, and the lack of reliable market information for loan product development.

Developments in inflation and interest rates reinforce the push for new lending sectors. Following years of hyperinflation, the authorities are finally succeeding in subduing inflationary pressures. With narrowing interest margins between loans and deposits, banks are seeking new sectors for lending where interest margins may be more rewarding.

In Romania MSME loans are accessed mainly from commercial banks and donor-funded MFIs. The Romanian banking system is highly concentrated, with the five largest banks controlling 60% of the market. Interest rates continue to be high for MSMEs, and collateral generally is required for loans longer than six months and greater than $7,000.

There are 14 MFIs in Romania. Many of them are clustered in the Transylvania region and Bucharest-Ilfov. Their types and sizes vary, with the five largest ones having a combined market share of less than 25% of the aggregate MFI loan portfolio.[14] Although some MFIs have collateral requirements, most are open to cash-flow-based lending for short-term loans. The largest MFIs in Romania include the Center for Economic Development; Cooperative Housing Foundation (CHF)-Express Finance; Creditar, Asisenta, si Pregatire pentru Afaceri Foundation (CAPA)/World Vision; and Opportunity Microcredit Romania (OMRO).

The leasing market in Romania is in a rapid stage of development, primarily for large industrial equipment and cars. Some medical equipment-leasing firms exist, and some medical equipment suppliers will sell on credit. Pharmaceutical distributors also offer credit to their customers.

2.5 CHALLENGES REMAIN

Despite the successes achieved in Romania over the past 10 years, challenges remain for women's health. These obstacles pertain to the sustainability and quality of family planning counselling and services for the rural and urban poor, primarily at the level of the family doctor, as well as in the quality of services available to all women in the public and private sectors.

Family doctors, rural pharmacies, and other private health actors are in pivotal stages of evolution within the health system. In the past five years, family doctors have become an important source of family

[14] Perrett, Graham. 2003. *Report on the Current State of Microfinance in Romania.* Micro, Small and Medium Sized Enterprises Program (MSME); Shorebank Advisory Services.

planning counselling and products for the rural poor. With 74% of the poor and near poor in Romania living in rural areas and nearly one-third of the population living below the national poverty line, these doctors are a valuable resource to this vulnerable group.[15] Family doctors, who distribute MoPH oral contraceptives to 22% of the women who use them and provide advice and prescriptions to a large percentage of primarily lower-income women, are struggling under the current capitated payment system.[16] Many of these doctors are entrepreneurs by accident and do not have the financial and business-management skills that are necessary to grow and expand their businesses. These doctors face barriers to operating sustainable, quality practices, including hurdles to accessing financing for working capital and investment purposes. Family doctors are struggling without guidance on financial management under a capitated system. Yet they have tremendous opportunities, as they now own their practices and soon should be able to purchase their facilities.

Rural pharmacies, which also face barriers to accessing finance, are often the only source of medical supplies, drugs, and commercially marketed family planning products for doctors and poor women in rural Romania.

2.6 BANKING ON HEALTH ROMANIA

In Romania the Banking on Health Project designed a program to address these constraints to improve access to financing to support the sustainable delivery of reproductive health and family planning services in the private sector. This USAID-funded global project seeks to increase reproductive health and family planning outcomes in the private sector by increasing access to financing among private sector providers and distributors. Banking on Health works to

- increase the credit-readiness of family doctors and other small-scale providers and distributors of family planning and reproductive health services and products
- increase the capacity of banks, leasing companies, and MFIs to provide financing to these providers and distributors

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

1. The project conducted a national survey of financing and training needs related to business management and finance for providers and distributors.
2. Banking on Health developed a course in financial management, including accessing finance, for family doctors in consultation with the National Institute for Health Research and Development and SECS. Enhancing the Financial Health of the Medical Practice, improves family doctors' ability to manage their practices for the good of the local population.
3. The project conducted a series of individual workshops with three banks and two MFIs on marketing and product development for the small-scale health care sector, incorporating the research findings contained in this report.

[15] Romanian National Institute of Statistics. 2005. *Statistical Yearbook 2005.*
[16] Romanian Family Health Initiative project data, JSI R& T, USAID, 2006.

4. Banking on Health facilitated a closed meeting hosted by the USAID-funded Romanian Family Health Initiative (RFHI) project to present the results of research contained in this report. This meeting assembled stakeholders (including representatives of professional associations, the MoPH, the NHIH, and financial institutions) for a presentation and discussion of the research's findings.

3. RESEARCH METHODS

3.1 OVERVIEW

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

The quantitative component of the research consisted of a national survey of family doctors under contract with the NHIH. In all, 1,215 valid surveys were collected, representing more than 10% of the total population of family doctors under contract.[17] Qualitative research also was conducted as part of the study through focus groups and interviews with other types of private health sector businesses, such as OB/GYNs, medical clinics that offer family planning, distributors of family planning and reproductive health products, and private rural pharmacies.

3.2 SURVEY SAMPLING PLAN

3.2.1 TARGET-GROUP POPULATION

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

3.2.2 SAMPLING POPULATION AND FRAME

The population was defined as the family doctors in contract with their District Health Insurance House, based on the electronic datasheet the MoPH's Centre for Sanitary Statistics and Medical Documentation supplied. All the family doctors that meet the criteria defined in the target-group population comprise the sampling frame. This number was estimated to be 10,485.

3.2.3 SAMPLING PROCEDURE

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

The first stratification of survey units was by district, with each of the 42 districts in Romania represented. The second stratification was based on the location of the family doctor's office as city, town, or rural. The second step was done by organizing a randomized proportional sampling by

[17] Romania's District Health Directorates. 2006. Databases of family doctors under contract with the NHIH. Bucharest: Information gathered by Romtens Foundation during survey implementation. Bucharest.

extracting doctors from within each layer, according to the probability of being selected (which was calculated for each type of survey unit individually).

3.2.4 SAMPLING SIZE

The selected sample was 1,232 family doctors. This number was approximated to represent more than 10% of the entire target- group population.

3.3 SURVEY METHODOLOGY

The Romtens Foundation, with input from Banking on Health project managers, developed the survey questionnaire. It consists of 63 primarily multiple-choice questions. Topics included demographic, business, and financial information, as well as opinions about obstacles, opportunities, and plans for the future.

The research team addressed the issue of informal revenue carefully in the questionnaire's design and survey implementation. The survey asked about revenue from services provided under the contract, non-contracted services, and other sources (such as donations). At another point, there is a question asking about total household revenue that also could capture informal income.

Sixteen survey operators were trained to administer the questionnaire to respondents verbally and individually at their places of work. The operators input answers into a handheld electronic device that sent the data to a centralized source for compilation and analysis. Monitoring was conducted on a regular schedule to ensure the data's integrity.

In sum, 1,215 valid surveys were collected, which is more than 10% of the total population of family doctors under contract with the NHIH. The non-response rate (17 family doctors out of 1,232, 1.4%) was lower than the one used in the computation of the sample volume (10%), thus the precision of the sample was not distorted.

In all cases when the family doctor was unavailable or the private practice did not exist, a similar family doctor was substituted from the list of reserve ones within the same level. There was no need for a weighted mean.

3.4 DATA ANALYSIS

Data analysis was performed using the Statistical Package for the Social Sciences and based on an analysis plan reflecting the goals of the survey. The analysis included statistical procedures used to analyze single variables describing the group—a representative sample— involving measures of central tendency and measures of variation. Frequency distributions also were determined, and the relationships among variables were analyzed. Correlations were used to see the positive or negative associations between variables in the study.

3.5 FOCUS GROUPS WITH OTHER TYPES OF PROVIDERS AND DISTRIBUTORS

Focus groups were held with OB/GYNs in private practice, rural pharmacy owners, medical clinic owners, and distributors of family planning products. For each business type, at least two focus groups of five to eight participants were held in two different locations. The only exception to this format is the distributors: as there are so few of them only one focus group was convened. The focus group discussions covered more generally the topics assessed in the survey of family doctors: current business

operations, including products and services offered; financial status; financing needs; perceived business obstacles and opportunities; and future plans.

3.6 INTERVIEWS AND LITERATURE REVIEW

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

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

4. GENERAL RESULTS OF THE SURVEY OF FAMILY DOCTORS

The research findings are presented here in three sections: general results of the survey of family doctors; cross-tabulations and correlated results of the survey of family doctors; and results of the research conducted on OB/GYN practices, independent pharmacies, distributors, and medical clinics.

4.1 CHARACTERISTICS OF FAMILY DOCTORS

4.1.1 GENDER AND MARITAL STATUS

More than three-quarters of family doctors are female (78.7%), and more than three-quarters of family doctors are married (76.7%.)

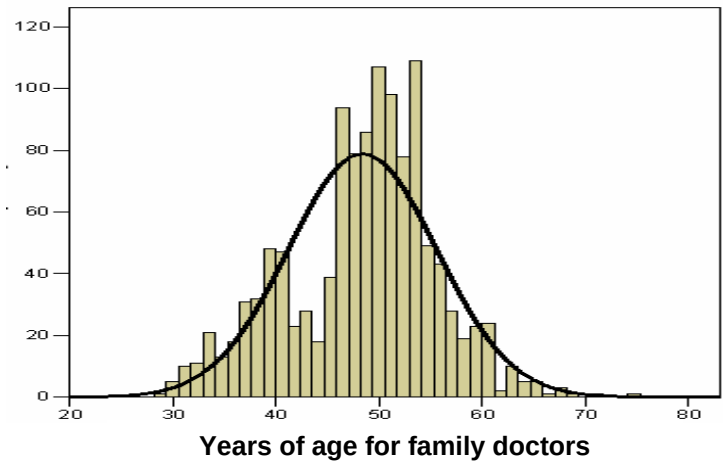
TABLE 1. GENDER OF THE FAMILY DOCTORS

Gender	Number of family doctors	Percentage
Male	259	21.3
Female	956	78.7

4.1.2 AGE

Family doctors are typically in their late 40s to 60s, with approximately 20 years of professional experience. In the survey sample, the average age is 48 years (50% of the sample is between 44 and 53 years old).

FIGURE 1. AGE OF FAMILY DOCTORS

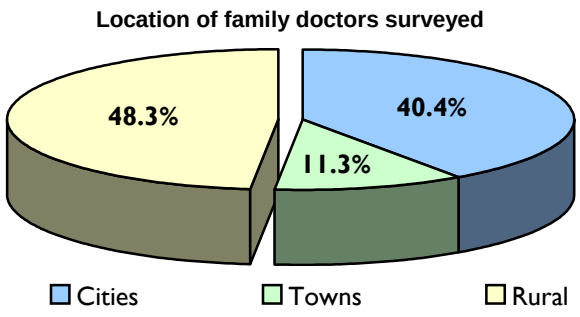


4.2 LOCATION

4.2.1 URBAN VERSUS RURAL

Of the interviewed family doctors, 51.7% are urban residents and 48.3% are rural residents. The urban family doctors practice mainly in cities (40.7%) compared to towns (11.3%). In the cross-tabulation section, results for cities and towns have been grouped together as urban for easier analysis.

FIGURE 2. URBAN-RURAL DISTRIBUTION OF FAMILY DOCTORS



4.2.2 REGIONAL DISTRIBUTION

Family doctors were surveyed according to their regional presence under the NHIH contract, as shown in Figure 3.

FIGURE 3. THE DEVELOPMENT REGIONS OF ROMANIA

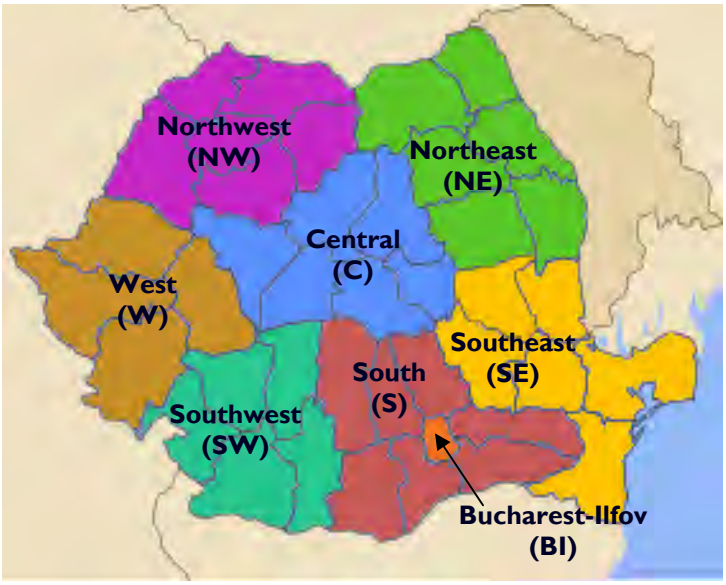


TABLE 2. REGIONAL DISTRIBUTION OF FAMILY DOCTORS

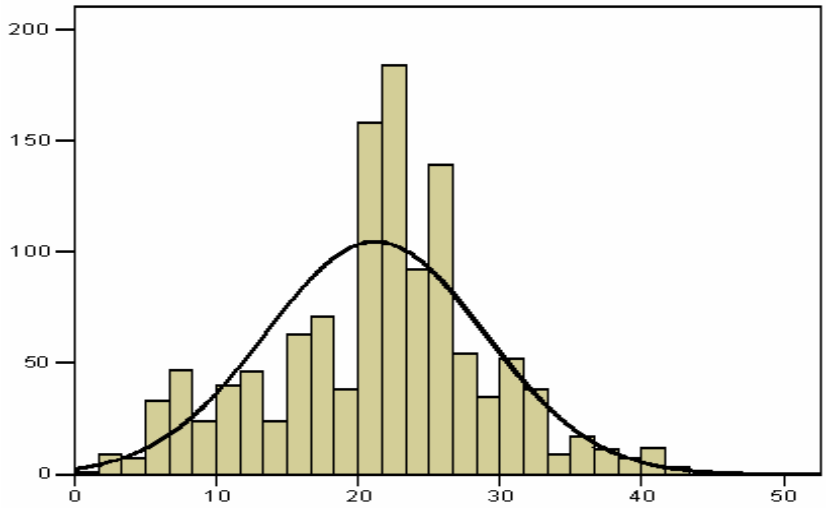
Region	Percentage of family doctors
Northeast	17
South	15
Central	15
Southwest	13
Southeast	12
Northwest	10
Bucharest-Ilfov	9
West	9
Total	**100**

4.3 CHARACTERISTICS OF PRIVATE PRACTICE

4.3.1 PROFESSIONAL EXPERIENCE

The family doctors surveyed are experienced in their field. The average experience in the medical field as a general practitioner or family doctor is 22 years.

FIGURE 4. YEARS OF EXPERIENCE AS A FAMILY DOCTOR



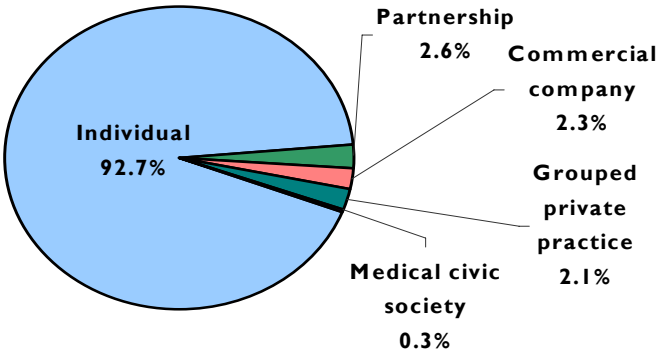
Fifty percent of family doctors have worked at their current clinic or office for 7 to19 years.

Another 25% of them have worked at their clinic for 19 to 39 years.

4.3.2 TYPE OF PRIVATE PRACTICE

Most family doctors in the sample (92.7%) work in an individual private practice. Approximately 2% work in each of the following categories: partnership private practices, commercial companies, and groups of individual private practices. Only 0.3% function as part of a medical civic society.

FIGURE 5. PRACTICE TYPES OF FAMILY DOCTORS



Of all the family doctors that have business partners, almost two-thirds (63.5%) have only one of them. Over one-third (36.4%) have between two and seven partners.

4.3.3 EMPLOYEES

The 1,215 family doctors employ 3,924 other individuals (regardless of their employment category or full- or part-time status). Family doctors employ an average of 3.2 other people in their practice (full-time, part-time, or volunteers). Almost all family doctors (98.5%) employ nurses. Over two-thirds of the doctors (68.6%) have one nurse and more than a quarter (26%) have two nurses. Most nurses (89%) are full-time employees. The second most common type of employee is accountant/economist. More than three-quarters (76.8%) of family doctors employ an accountant/economist, although only one-tenth of these people work full-time. A similar number also employ administrative staff, but again these are mainly part-time employees.

TABLE 3. THE AVERAGE NUMBER OF EMPLOYEES PER FAMILY DOCTOR, BY CATEGORY

Employee category	Number of employees	Average (employees per family doctor)
Nurse	1,627	1.3
Accountant/economist	981	0.8
Administrative staff (cleaning, statistician, electrician, etc.)	940	0.8
Resident physician	109	0.09
Medical facilitator	76	0.1
Social assistant	121	0.06
Other: Physician, psychologist, biologist	31	0.026
Other: Information technology (IT) technician, computer/IT operator	35	0.029
Other: Lawyer	4	0.003
Total	**3,924**	**3.2**

4.4 SERVICE PROVISION

4.4.1 PATIENT LISTS

The average number of patients on a family doctor's list is 1,854. Fifty percent of family doctors have between 1,450 and 2,200 patients.

TABLE 4. THE DISTRIBUTION OF FAMILY DOCTORS BY NUMBER OF ENROLLED PATIENTS

Number of enrolled patients	Number of family doctors	Percentage
345–500	1	0.1
501–1,000	63	5.2
1,001–1,500	314	25.8
1,501–2,000	406	33.4
2,001–2,500	300	24.7
2,501–3,000	92	7.6
3,001+	39	3.2
Total	**1,215**	**100**

4.4.2 CLIENT VISITS PER MONTH

The average number of client visits in the last month per family doctor is 581, including house calls. More than four-fifths (82.6%) had between 300 and 900 visits in the month preceding the survey. Less than a tenth had fewer than 300 client visits that month.

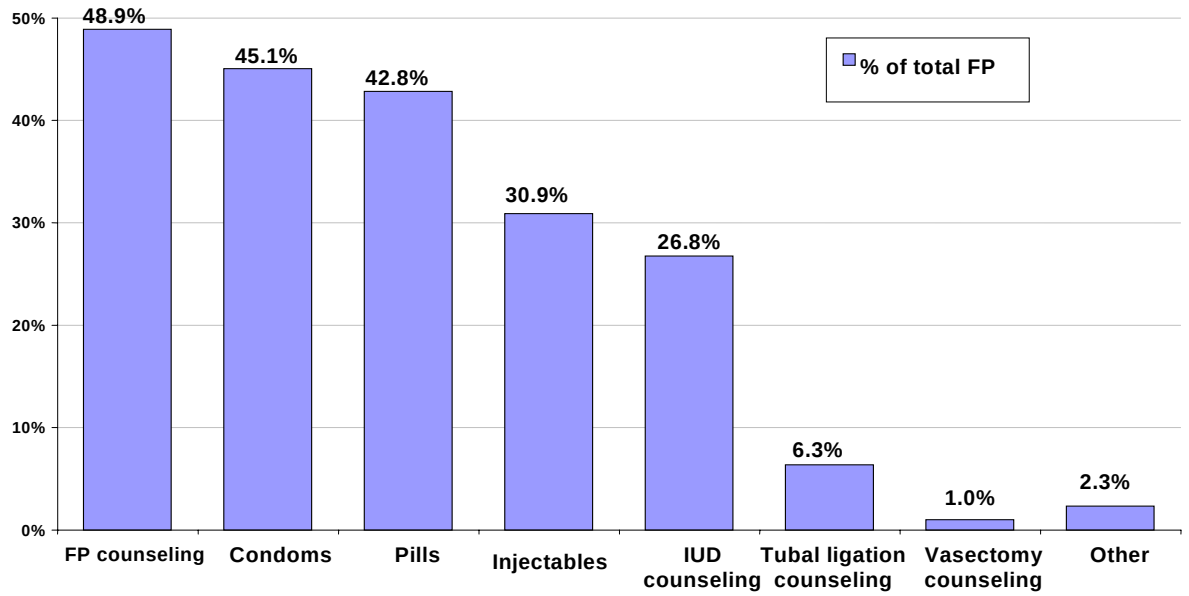
4.4.3 FAMILY PLANNING CONSULTATIONS AND SERVICES OFFERED

Just over half (52%) of the family doctors that were interviewed claim to offer some form of family planning counselling and/or services. Those doctors that do, average 22 family planning visits per month.

TABLE 5. AMONG DOCTORS PROVIDING THESE SERVICES, THE RANGE OF FAMILY PLANNING CONSULTATIONS OFFERED PER MONTH

Number of family planning consultations last month	Number of family doctors	Percentage
1–10	271	42.9
11–20	164	25.9
21–30	106	16.8
31–40	29	4.6
41–50	28	4.4
51–60	9	1.4
61–70	5	0.8
70+	20	3.2
Total	**632**	**100**

FIGURE 6. FAMILY PLANNING AND REPRODUCTIVE HEALTH SERVICES AND PRODUCTS FAMILY DOCTORS OFFER*



** The question allowed multiple answers.*

Only 28 family doctors (2.3% of the survey) offer reproductive health and family planning products or services besides those listed in Figure 6. Of those 28 doctors, nearly 40% recommend traditional or natural methods of family planning.

Doctors expressed concern that the Ministry of Health's donations of family planning products would end soon. Without these items some women of childbearing age in underserved areas and ethnic groups may visit their family doctor less often. This less frequent interaction weakens the doctor's relationship with his or her patients, which go beyond care of the mother to include care of the children, often infants, who benefit from a close relationship with the family doctor. Thus the Ministry of Health ceasing to supply these products could harm the doctors' practice and have a detrimental health impact on those who benefit from their provision.

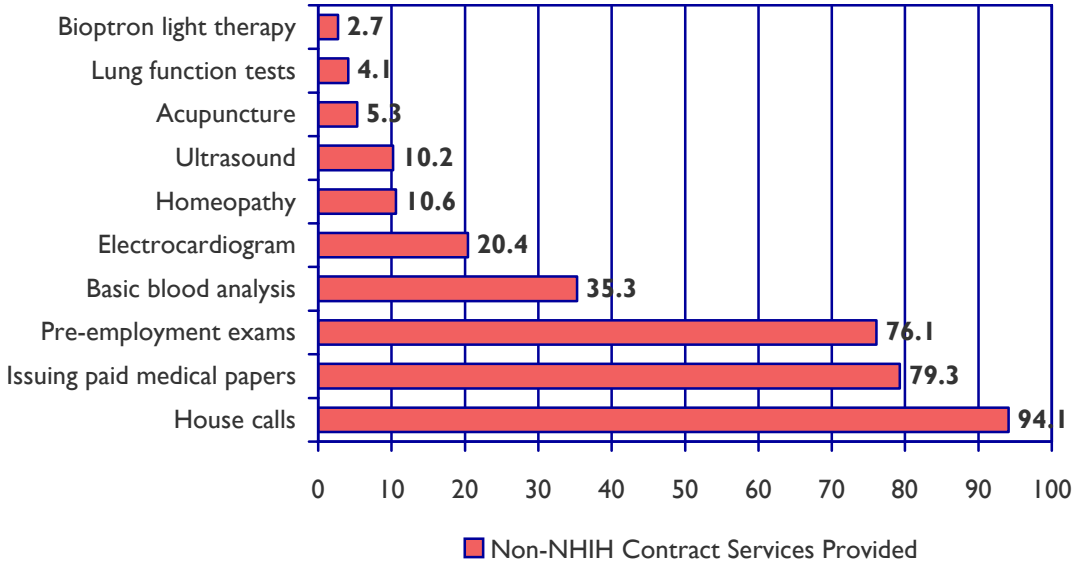
4.4.4 SERVICES OFFERED OUTSIDE OF THE NHIH CONTRACT

Although all of the doctors interviewed provide services in contract with the NHIH, the vast majority also offer non-contracted services for their patients, receiving fees from the patient for these services. Fewer than 3% of family doctors provide no services outside of those the NHIH contracts.

Of the non-contracted services they frequently provide, 94.1% of family doctors offer house calls for a fee (outside of the required NHIH house calls). The second most frequently reported service for fee was issuing medical papers, which 79.3% of the doctors interviewed provide. Seventy-six percent also offer pre-employment medical exams for a fee.

A smaller number of family doctors provide highly specialized services requiring expensive equipment, such as electrocardiograms (20.4%), ultrasounds (10.2%), and light therapy (2.7%). Only a few family doctors offer services such as health promotion (0.7%), psychological counseling (0.3%), and palliative care (0.2%).

FIGURE 7. SERVICES FAMILY DOCTORS PROVIDE OUTSIDE OF THE NHIH CONTRACT



** The question allowed multiple answers.*

4.5 REVENUE, EXPENSES, AND REINVESTMENT

4.5.1 MONTHLY REVENUE FROM THE NHIH CONTRACT

Approximately 50% of family doctors earn between 2,499 and 3,999 Romanian lei (RON) ($1,033 and $1,652.70) from the NHIH contract.[18] Just over a quarter of the family doctors (27%) receive gross monthly revenues of less than 2,499 RON, and a fifth (21.1%) collect over 3,999 RON. The highest revenue category (5,000 RON or more, $2,066.39) has 5.5% of the family doctors in it.

TABLE 6. THE DISTRIBUTION OF FAMILY DOCTORS BY MONTHLY REVENUE (RON) FROM THE NHIH CONTRACT

Monthly revenue from NHIH contract	Number of family doctors	Percentage
0–499	8	0.7
500–999	3	0.2
1,000–1,499	33	2.7
1,500–1,999	101	8.3
2,000–2,499	186	15.3
2,500–2,999	203	16.7
3,000–3,499	251	20.7
3,500–3,999	174	14.3
4,000–4,499	141	11.6
4,500–4,999	48	4.0
5,000+	67	5.5
Total	**1,215**	**100**

[18] This report uses an exchange rate of 2.42 RON = 1 USD which was the approximate rate at the time the survey was implemented.

The NHIH contract provides an average of 3,164 RON ($1,297) in monthly income for the family doctors.

4.5.2 MONTHLY REVENUE FROM FEES FOR SERVICES NOT COVERED BY THE NHIH CONTRACT

While many family doctors offer services outside of the NHIH contract, for most of them this source of revenue is insignificant. Approximately 78% of family doctors earn nothing for services provided outside of the NHIH contract (31.6%) or earn between 1 and 99 RON ($0.41 and $41) a month (46.8%). It is likely that many providers offer additional services, such as house calls, for free. Only 14.2% of the family doctors make between 100 and 499 RON ($41 and $205). And just 1% make more than 2,000 RON ($820) per month. On average, family doctors earn 180 RON ($74) per month for services outside of the NHIH contract.

TABLE 7. THE DISTRIBUTION OF FAMILY DOCTORS BY MONTHLY REVENUE (RON) FROM FEES FOR SERVICES NOT COVERED BY THE NHIH CONTRACT

Monthly revenue from non-NHIH contract services	Number of family doctors	Percentage
0	384	31.6
1–99	569	46.8
100–499	172	14.2
500–999	39	3.2
1,000–1,499	19	1.6
1,500–1,999	17	1.4
2,000–2,499	2	0.2
2,500–2,999	3	0.2
3,000–3,499	1	0.1
3,500–3,999	3	0.2
4,000–4,499	3	0.2
4,500–4,999	0	–
5,000+	3	0.2
Total	**1,215**	**100**

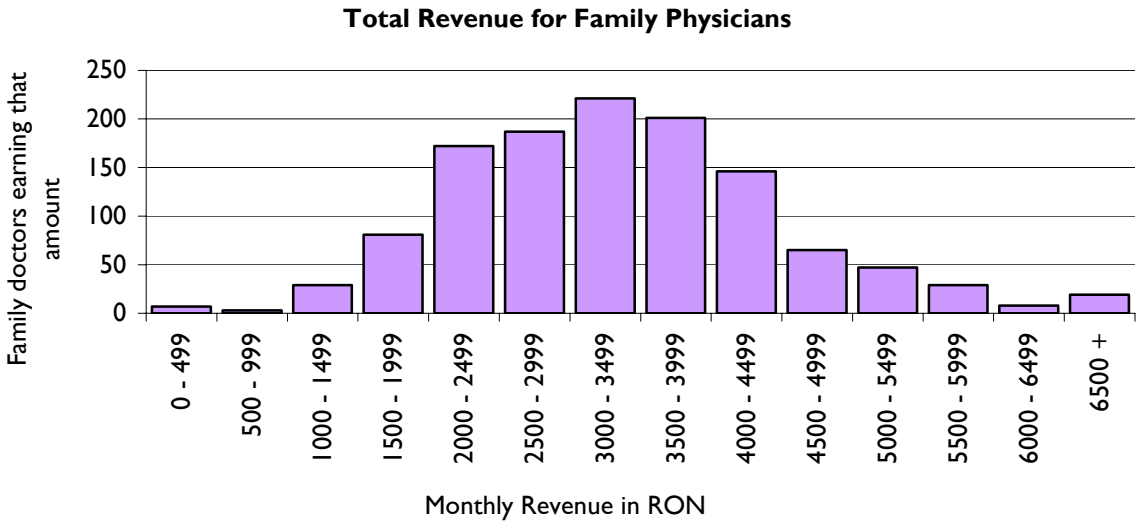
4.5.3 MONTHLY REVENUE FROM SPONSORSHIP

Only 4.9% of family doctors obtain revenue from sources other than the NHIH contract or private fee-based services. Typically this income comes from sponsorships or donations. These additional earnings, however, are negligible as the average monthly amount was only 43 RON ($18).

4.5.4 TOTAL MONTHLY REVENUE OF THE FAMILY DOCTORS

To ensure an accurate response to questions regarding income, the researchers asked the family doctors to indicate the level of their income by source, providing ranges for each income source. To analyze these responses, the research team used these ranges to compute means using the midpoint of each answer bracket as the assigned value for all responses falling within that range. This approach allowed the research team to add all of the income sources to approximate the total revenue for each family doctor. These amounts, however, were not collected directly, but rather they were extrapolated based on the ranges the doctors indicated. The average monthly revenue from all sources combined was 3,387 RON ($1,388).

FIGURE 8. DISTRIBUTION OF TOTAL MONTHLY REVENUE (RON) FOR FAMILY DOCTORS



4.5.5 BUSINESS EXPENSES

For analyzing the total monthly expenses of the private practice, the average monthly business expenses over the last three months was requested, including all types of expenses, such as wages, overhead charges, interest on loans, lease expenses, and supplies.

TABLE 8. MONTHLY EXPENSES (RON) OF FAMILY DOCTORS' PRIVATE PRACTICES

Monthly business expenses	RON
Mean value (calculated from ranges)	2,080
Modal value	1,500–1,999
Minimum value	0
Maximum value	5,000+
First quartile (25%)	1,000–1,499
Second median quartile (50%)	1,500–1,999
Third quartile (75%)	2,500–2,999

The average monthly business costs for family doctors is 2,080 RON ($852). A quarter of the family doctors (25.6%) spend between 1,500 and 1,999 RON ($616 and $819) monthly in their private practice. Approximately 20% have monthly expenses between 1,000 and 1,499 RON ($410 and $615) and another 20% have expenses between or 2,000 and 2,499 RON ($820 and $1,024). About three-quarters (73.4%) have expenses less than 2,499 RON ($1,024).

4.5.6 INVESTMENT IN BUSINESS

Of the family doctors that responded to this question, those that reinvested their profits in the last 12 months on average spent 8,290 RON ($3,398). The minimum reinvested figure is 101 RON ($41) and the maximum one is 1,008,571 RON ($413,349). Close to a third of the respondents (30.3%) did not

reinvest any of their profits. More than 40 of those surveyed, however, did not respond to this question.[19]

TABLE 9. AMOUNT OF FAMILY DOCTORS' INVESTMENTS (RON) IN THEIR BUSINESSES IN THE PAST 12 MONTHS

	RON	USD
Mean value	8,290	3,398
Minimum value	101	41
Maximum value	1,008,571	413,349
First quartile (25%)	1,009	414
Second median quartile (50%)	2,521	1,033
Third quartile (75%)	5,043	2,068

As a service business, looking at the level in percentages of expenses and the net profit, the doctors' practices are profitable. Yet, their incomes are low. Expenses are managed, and they do not have much room for cost cutting. The following table depicts their total practice revenues. The level of reinvestment is low. This finding could be due to a number of factors:

- *Uncertainty of future income because of the annual renegotiation and revaluing of the NHIH contract*—Each year the value of the points and the number of points assigned for per-capita and per-acta services changes as a result of a budgetary and negotiation process. Family doctors believe that they have little influence or control over these processes. This factor, combined with the recent history of radical sector reform impacting family doctors, may have made them cautious about the future. Thus they have not reinvested their profits in the past.
- *Low levels of funds available for reinvestment*—After paying their expenses for salaries, rent, utilities, and supplies, little money remains for reinvestment.
- *Low initial investment needs*—When family doctors became accidental entrepreneurs some years ago, they inherited facilities that were equipped with the tools needed to run a practice. It is only now that they are beginning to need to replace or upgrade these tools and equipment.
- *Inability to purchase facilities*—As shown in the following table, family doctors manage their expenses and take home a net income that is average for this business type in terms of percentage of gross revenue. In real terms, however, the income is low for a medical professional. Thus income only can be affected by increasing the top line—the revenues. And with more than 95% of their income coming from the NHIH contract, doctors are looking to the government for opportunities to earn more.

TABLE 10. WHAT FAMILY DOCTORS DO WITH THEIR INCOME

	Amount (RON)	Percent of total revenue
Average total practice revenue	3,387	100
Business expenses	2,080	61
Net profit (approximate)	1,307	39
Monthly reinvestment	202	6
Net profit after reinvestment	1,105	33

[19] Responses were given in euros as that currency is the one family doctors considered when thinking of business investments. The exchange rate at that time was approximately 3.53 RON to EUR 1.

4.5.7 HOUSEHOLD INCOME

In a question allowing for multiple answers, most family doctors (96.9%) cited their private practice as a main source of revenue in their household. Three-quarters (72.3%) stated that the wages of their spouse is an important source of revenue. Between 2 and 6% of family doctors mentioned other sources, such as another private practice (5.7%); support from children, parents, and other relatives (4.6%); revenue from a non-medical business (3.2%); and wages from a state job (2%).

Approximately 50% of the household revenues are between 1,000 and 3,499 RON ($410 and $1,434). Nearly a third (31.7%) have household revenues between 1,500 and 2,499 RON ($616 and $1,024). Fifty-eight percent of the family doctors have monthly household revenues of less than 2,499 RON ($1,024).

TABLE 11. THE DISTRIBUTION OF FAMILY DOCTORS BY MONTHLY HOUSEHOLD REVENUE (RON)

Total monthly household revenue	Number of family doctors	Percentage
0	17	1.4
1–99	1	0.1
100–499	30	2.5
500–999	107	8.8
1,000–1,499	164	13.5
1,500–1,999	193	15.9
2,000–2,499	192	15.8
2,500–2,999	140	11.5
3,000–3,499	101	8.3
3,500–3,999	78	6.4
4,000–4,499	48	4.0
4,500–4,999	41	3.4
5,000+	101	8.3
Total	**1,213**	**99.8**

4.5.8 HOUSEHOLD EXPENSES

Each month a fifth of the family doctors' households spend between 1,500 and 1,999 RON ($616 and $819); more than half of the family doctors' households (54.6%) spend under 1,999 RON ($819). Over a quarter of them (28.6%) spend more than 2,500 RON ($1,025).

4.5.9 CORRELATION BETWEEN DIFFERENT SOURCES OF REVENUE AND PATIENT LISTS

There is a powerful, direct, statistically significant correlation between the number of enlisted patients and the revenues of family doctors.[20] There is no correlation between the fee-for-service revenues outside the NHIH contract and the number of enlisted patients.

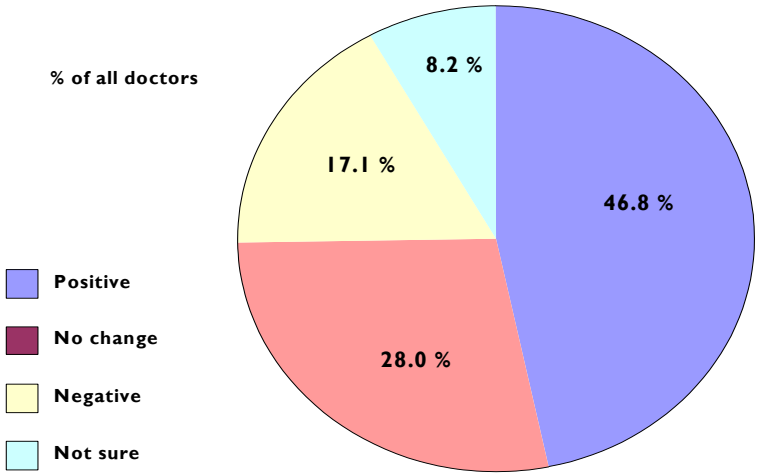
[20] The correlation has a 0.738 Spearman coefficient.

4.6 FAMILY DOCTORS ATTITUDES TOWARD THE NHIH CONTRACT

4.6.1 IMPACT OF THE NHIH CONTRACT

Despite their financial dependency on it, less than half of the family doctors (46.8%) believe that the NHIH contract has had a positive impact on their medical practices. Over a quarter of them (28%) stated that there has been no change and 17.1% declared that it had a negative impact. About 8.2% were undecided.

FIGURE 9. FAMILY DOCTORS' PERCEPTION OF THE NHIH CONTRACT'S IMPACT ON THEIR PRACTICES



When asked for further details about their views on the contract, the majority of the family doctors stated that the NHIH contract allows for stability of monthly revenue (51.1%), and nearly half believe it has a positive impact on total monthly revenues (47.9%). Over a third (35.8%) mentioned that it has a positive influence on the number of enlisted patients, and 29.7% noticed an improvement in their access to medical training. Almost a quarter (22.6%) believes that the contract allows them to grow their business. The improvement of access to facilities and financing was respectively noted by 16.4% and 14.9% of the family doctors.

TABLE 12. FAMILY DOCTORS' PERCEPTIONS OF HOW THE NHIH CONTRACT IMPACTS THEM POSITIVELY

Positive impact	Number of family doctors	Percentage
Consistent monthly revenue	621	51.1
Total monthly revenue	582	47.9
Number of patients	435	35.8
Access to training	361	29.7
Expanding the private practice	274	22.6
Access to facilities	199	16.4
Access to financing	181	14.9

** The question allowed multiple answers.*

Over half of the family doctors stated that the NHIH contract had a negative impact on their ability to access financing (57%) and their access to facilities (55.6%.). Nearly 50% see the contract with the NHIH as an impediment to expanding their private practice (49.4%).

Over 42% consider that the NHIH contract to have had a negative impact on their medical training, and over a third believe that the number of patients has been influenced negatively. A quarter (24%) consider their total monthly revenue to be impacted negatively, and a fifth (20.8%) state that their monthly revenue stability was hurt.

TABLE 13. FAMILY DOCTORS' PERCEPTIONS OF HOW THE NHIH CONTRACT IMPACTS THEM NEGATIVELY

Negative impact	Number of family doctors	Percentage
Access to financing	693	57.0
Access to facilities	675	55.6
Expanding the private practice	600	49.4
Access to training	513	42.2
Number of patients	439	36.1
Total monthly revenue	292	24.0
Constant monthly revenue	253	20.8

** The question allowed multiple answers.*

4.6.2 CHANGES DESIRED IN THE NHIH CONTRACT

When asked how the NHIH contract could be changed to impact their practices positively, overwhelmingly family doctors cited increasing the payments they receive for service provision—91.8% believe that increasing the amount they receive for the fee-for-service portion of the contract will impact their practices positively. And 86% believes that increasing the capitated rate will help them. In addition to increasing payments, more than half (57.8%) think that extending the term of the contract beyond a year would be useful. A longer contract term could provide more stability and enable longer-term planning. A number of providers also mentioned changing the ratio within the contract of revenue from fee-for-service and revenue from capitated services, although they had differing views on the impact. Approximately 40% believe that their practices would be impacted positively if the ratio was changed in favor of fee-for-service, while about 30% believe that their practices would benefit from a change in favor of capitation.

A large number of respondents also suggest other changes. Many recommend expanding the contract to cover other services, such as client visits, house calls, emergency duty, sonography, acupuncture, preventive services, and care for chronic diseases. A significant percentage of family doctors suggest that they should be allowed to offer the services they provide under contract on a freelance basis outside of their practice. Others believe that the contract should structured so that there are line items for wages, expenses, and investments, thus providing them with more guidance in financial management. Family doctors also believe that their evaluation to be contracted under the NHIH and their payment rates should consider special factors, such as competencies; practices located in an isolated, rural, or underprivileged areas; difficult conditions; and occupational risks. Some doctors suggest different payment systems. Others propose different classification and payment systems for services, such as direct payment from the patient.

A smaller number of respondents suggest additional changes, such as reforming the contract's negotiation process to allow for more input from family doctors, decreasing red tape, changing the rating scale for patients (decreasing the number of enrolled patients), and giving the NHIH more responsibilities.

Others doctors suggest the need for providing facilities and training (such as in the use of medical equipment and computers) and having a better reporting system. Fewer than 1% asks for more benefits for employees (for example, paid vacations or sick leave, working hours, and tax exemptions for health services) and no more changes in regulations. Others request that the NHIH website be updated and ask for better collaboration with the NHIH. Some ask for help facilitating sponsorships with companies, tax reduction, and facilitated credit.

TABLE 14. HOW FAMILY DOCTORS THINK THE NHIH CONTRACT SHOULD BE CHANGED TO IMPROVE IT

Suggested improvements	Number of family doctors	Percentage
Increase payment amount for service provision	1,115	91.8
Increase the capitated rate	1,045	86.0
The contract period should not be limited to one year	702	57.8
Increase payment ratio in favor of service provision	476	39.2
Increase payment ratio in favor of capitated services	360	29.6
Use money, rather than points, to evaluate services provided under the contract	301	24.8
Other	322	26.5
Total	**1,215**	*

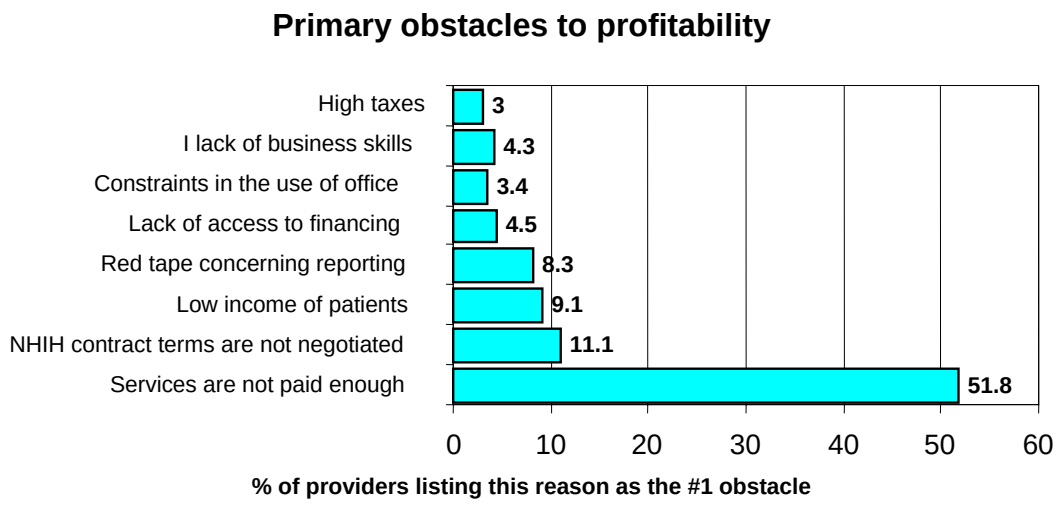
** The question allowed multiple answers.*

4.7 PROFITABILITY AND EXPANSION PLANS

4.7.1 OBSTACLES TO PROFITABILITY

The survey asked family doctors to identify the primary obstacles to profitability. Over half (51.8%) of the family doctors believe that they are underpaid for their services and that this situation is the main obstacle to running a profitable business. This barrier stands out above the others. Other obstacles that were cited include that the NHIH contact is not negotiated (11.1%), the low income of patients (9.1%), excessive red tape in reporting and deductions (8.3%), lack of access to funding (4.5%), lack of business skills (4.3), constraints in the use of the office (3.4%), and high income taxes (3.0%).

FIGURE 10. FAMILY DOCTORS' PRIMARY OBSTACLES TO PROFITABILITY



4.7.2 PLANS TO EXPAND AND GROW THEIR BUSINESSES

Despite these constraints almost all family doctors in the sample (94.6%) intend to expand their practices. Only 5.4% do not intend to do so.

Family doctors have a number of expansion plans, including purchasing medical equipment (77.5%), buying property (66.7%), expanding or refurbishing their clinic (52.9%), adding new services (50.5%), purchasing computers (37.8%), and hiring new staff (23.2%).

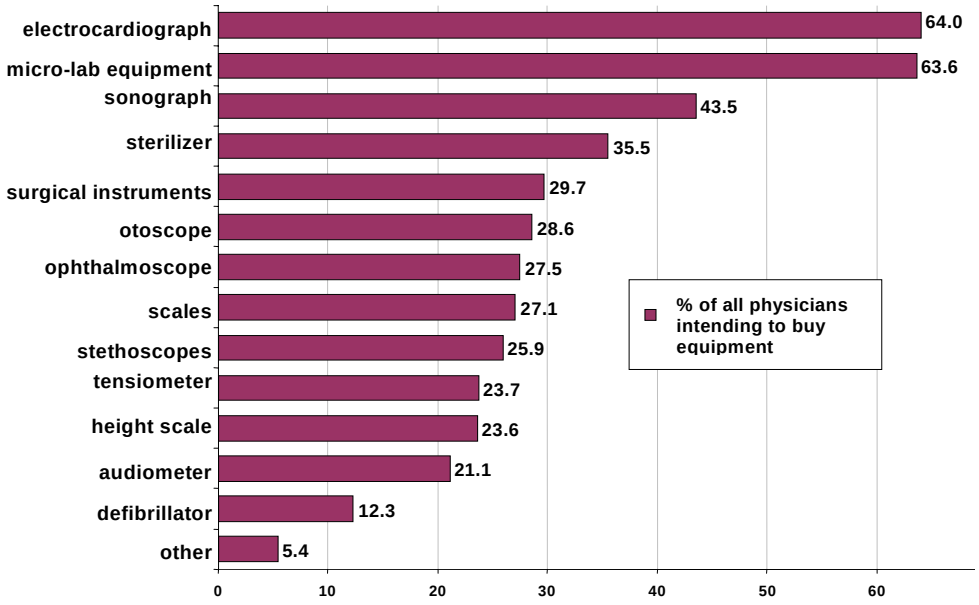
TABLE 15. HOW FAMILY DOCTORS PLAN TO GROW AND EXPAND THEIR BUSINESSES

Planned expansion activities	Number of family doctors	Percentage
Buy equipment	942	77.5
Buy property (present location or other)	810	66.7
Expand or refurbish clinic	643	52.9
Offer new services	613	50.5
Buy a computer	459	37.8
Hire staff	282	23.2
Purchase land	57	4.7
Expand space (office or new clinic)	8	0.7
Buy a car for house calls	4	0.3
Partner for private practice	3	0.2
Do not intend to expand activity	66	5.4
Total	**1,215**	*

** The question allowed multiple answers.*

Of the 942 family doctors with plans to expand their practice by buying equipment, two-thirds choose an electrocardiograph (64%) and micro-lab equipment (63.6%), followed by a sonogram (43.5%) and a sterilizer (35.5%). Please refer to following figure for a more detailed list of equipment that family doctors are interested in purchasing.

FIGURE 11. TYPE OF EQUIPMENT DESIRED BY FAMILY DOCTORS WANTING TO EXPAND THEIR BUSINESSES



** The question allowed multiple answers.*

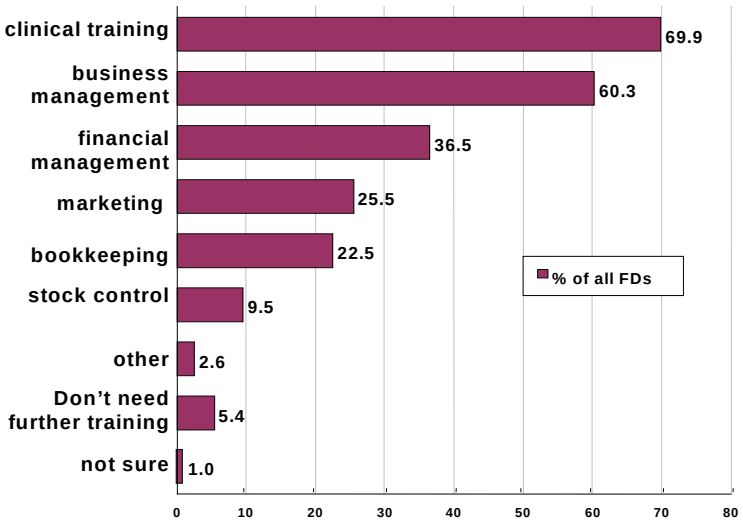
It is clear from the doctors' ideas about business growth and the use of possible loan proceeds that they would like to add services the contract does not cover. The equipment they seek would allow them to perform non-NHIH contracted services. One possible reason for this desire is that in rural areas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

4.8 TRAINING NEEDS ASSESSMENT

4.8.1 INTEREST IN FUTURE TRAINING

Of the 1,215 family doctors, 93.6% feel the need for further training,

FIGURE 12. FURTHER TRAINING DESIRED BY FAMILY DOCTORS



** The question allowed multiple answers.*

As a group the doctors choose clinical training as their most wanted instruction. The second most commonly desired training is in business management (60.3%). More than a third (36.5%) feel the need for financial-management training, while about a quarter would like more marketing (25.5%) and bookkeeping training (22.5%).

4.8.2 PREPARATION OF FINANCIAL STATEMENTS

Over a third of the family doctors state that they have an employee who prepares their financial statements. Only 21.1% of the family doctors do the bookkeeping themselves, while 28.2% use an outside accountant. A tenth of the time (10.5%) a friend or relative who is not a certified accountant performs the financial record keeping.

4.8.3 PREVIOUS TRAINING

In the past five years, family doctors have received training primarily in the medical field, including family planning courses (49.8%) and courses in other medical competencies (48.4%). Only four of them attended financial-management training.

TABLE 16. TYPE OF TRAINING RECEIVED IN THE PAST FIVE YEARS

Type of training	Number of family doctors	Percentage
Continuous medical-education classes	709	58.4
Family planning	605	49.8
Medical competency training	588	48.4
Did not attend any courses	57	4.7
Financial management	49	4.0
Family medicine	32	2.6
Medical management or business management	30	2.5
Personal computer operation	2	0.2
Total family doctors	**1,215**	*

* The question allowed multiple answers

4.9 FINANCING NEEDS ASSESSMENT

4.9.1 CREDIT EXPERIENCE

In the past 10 years, more than half of the family doctors (51.1%) took loans, while the rest had not borrowed money. About a third (33.9%) had taken between one and two loans, a tenth (9.8%) had taken three to five loans, and 7.5% had borrowed more than five times.

TABLE 17. BORROWING FREQUENCY OF FAMILY DOCTORS IN THE PAST 10 YEARS

Borrowing frequency in the past 10 years	Number of family doctors	Percentage
Never	593	48.9
One to two times	411	33.9
Three to five times	119	9.8
More than five times	91	7.5
Total	**1,214**	*

Among doctors who had borrowed money, more than three-quarters (77.3%) had outstanding debt at the time of the survey. From this finding one may be able to deduce that borrowing is a recent phenomenon among this sub-sector. If most doctors have had only one or two loans and the majority of these doctors have a loan now, then it is likely that they only began borrowing in the past two to three years.

4.9.2 OUTSTANDING LOANS

Those doctors who have outstanding loans have an average debt of 23,471 RON ($8,970), with a range from 184 RON ($70) to 201,715 RON ($77,076).

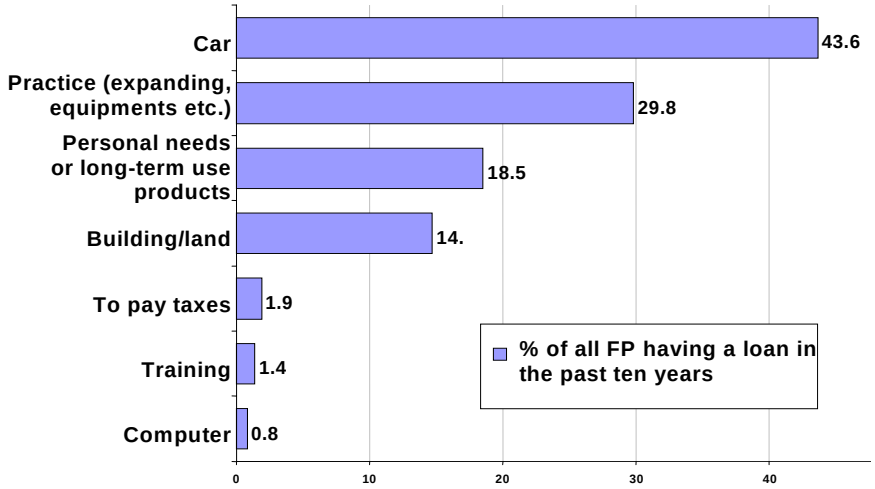
TABLE 18. INDICATORS OF THE PRESENT OUTSTANDING AMOUNT OF LOANS[21]

Outstanding loan amount	RON	EUR
Mean value	23,471	6,649
Minimum value	184	52
Maximum value	201,715	57,143
First quartile (25%)	5,295	1,500
Second quartile (50%)	14,120	4,000
Third quartile (75%)	31,770	9,000

4.9.3 USE OF PREVIOUS LOANS

Of the 621 family doctors who had taken out a loan, over two-fifths (43.6%) used their last loan to buy a car. About a third (29.8%) used the loan to invest in their practice or office, and about a fifth of the borrowers (18.5%) used it for personal needs.

FIGURE 13. USE OF MOST RECENT LOAN



4.9.4 SOURCE OF PREVIOUS LOANS

Of the 621 family doctors who took loans in the past 10 years, almost two-thirds (63.6%) had borrowed from a bank, a quarter (23%) from a leasing company, a tenth (10.1%) from family or friends, and 6.1% from the House of Mutual Support.

[21] The exchange rate at the time of this report was $1 to 0.74 euro.

TABLE 19. LOAN SOURCES FOR FAMILY DOCTORS WHO TOOK A LOAN IN THE PAST 10 YEARS

Loan sources	Number of family doctors	Percentage
Bank	395	63.6
Leasing company	143	23.0
Family or friend	63	10.1
House of Mutual Support	38	6.1
MFI (such as CHF, CAPA/World Vision, or the Economic Development Center (CDE))	6	1.0
Monthly installments at a store	7	1.1
Financing cooperation	3	0.5
Non-financial institutions (such as city hall)	2	0.3
Total who obtained a loan in the past 10 years	**621**	*

* The question allowed multiple answers.

Among the 621 family doctors who borrowed from a financial institution in the past 10 years, almost a fifth (18.4%) obtained their loan from the Romanian Commercial Bank. Another 13.7% received their loan from Raiffeisen Bank, 9% from Libra Bank, 7% from Banc Post, and 6.2% from Banca Transilvania. Other financial institutions, including all of the MFIs, appear to be minimal players in the health care market.

TABLE 20. SOURCE OF PREVIOUS LOAN BY FINANCIAL INSTITUTION

Institution name	Number of family doctors	Percentage
Romanian Commercial Bank	114	28.4
BRD Romanian Development Bank	74	18.5
Raiffeisen Bank S.A.	55	13.7
Libra Bank S.A.	36	9.0
Banc Post S.A.	28	7.0
Transilvania Bank S.A.	25	6.2
Volksbank Romania S.A	14	3.5
Romanian Bank S.A.	11	2.7
Ion Ţiriac Commercial Bank	10	2.5
Finansbank (Romania) S.A.	8	2.0
Alpha Bank Romania S.A.	7	1.7
The House for Savings and Investments C.E.C. S.A.	7	1.7
HVB Bank Romania S.A.	5	1.2
Unicredit Romania S.A.	4	1.0
Piraeus Bank Romania S.A.	3	0.7
Carpatica Commercial Bank S.A.	2	0.5
Citibank Romania S.A.	2	0.5
Romexterra S.A. Credit and Development Bank	1	0.2
CHF România	1	0.2
Emporiki Bank–România S.A.	1	0.2
ING Bank N.W	1	0.2
Mindbank S.A – The Bank for Small Industry and Free Initiative	1	0.2
Procredit Bank	1	0.2

Institution name	Number of family doctors	Percentage
Romanian International Bank S.A.	1	0.2
ABN Amro (Romania) S.A.	1	0.2
Robank Commercial Bank	0	-
Microfinance MIRO SA	0	-
CAPA World Vision	0	-
Eurom Bank S.A.	0	-
CDE	0	-
Banca Italo-Romena Spa Italia Treviso	0	-
MISR Romanian Bank	0	-
OMRO	0	-
National Bank of Greece S.A.	0	-
Commercial Bank Sanpaolo IMI Bank Romania S.A.	0	-
Other	9	-
Unspecified	3	-
Total obtaining a loan in the past 10 years from a bank or MFI	**401**	*

4.9.5 VALUE AND TERM OF RECENT LOANS

When asked the amount of their most recent loan, the average amount the family doctors report is 25,603 RON ($9,783). Fifty percent of family doctors borrowed between 5,295 and 35,300 RON ($2,023 and $13,488).

Concerning loan terms, almost two-fifths (38.6%) of the family doctors that took a loan in the past 10 years had a term between 3 to 5 years for repayment. Almost a third (29%) borrowed the last time for a period of one to three years. Less than a tenth borrowed for a term of less than a year.

TABLE 21. TERMS OF PREVIOUS LOAN

Term of the last loan	Number of family doctors	Percentage
Less than a year	59	9.5
1–3 years	180	29.0
3–5 years	240	38.6
5–10 years	90	14.5
10v20 years	40	6.4
Over 20 years	6	1.0
No specific term (loan from a relative or friend)	6	1.0
Total borrowing money in the last 10 years	**621**	**100**

4.9.6 ATTEMPTS AT BORROWING

Among family doctors who did not obtain a loan in the past 10 years, the vast majority had not tried to get one. Only about a sixth (15.9%) attempted to borrow but were unsuccessful in securing credit.

TABLE 22. BORROWING ATTEMPTS IN THE PAST 10 YEARS, AMONG FAMILY DOCTOR WITH NO PREVIOUS CREDIT EXPERIENCE

Attempted to borrow in the past 10 years?	Number of family doctors	Percentage
Yes	94	15.9
No	499	84.1
Total	**593**	**100**

Among the 94 family doctors who tried to borrow but were not successful in doing so, the primary reason is that the loan application was rejected, which almost two-thirds of the respondents (61.7%) mention. It is possible that the respondents who claim they had attempted to borrow but do not cite their application as being rejected, consider "attempted to borrow" to mean "researched the possibility of borrowing" or "began but didn't finish the loan application." These interpretations would explain the following answers. A quarter (24.5%) mentions the fear of being unable to repay the loan, and almost two-fifths (19.1%) feel that the process of obtaining a loan involves too much red tape.

TABLE 23. REASONS FOR NOT BORROWING IN THE PAST AMONG THOSE WHO ATTEMPTED TO BORROW

Reason	Number of family doctors	Percentage
The loan application was rejected	58	61.7
Afraid of being unable to pay it back	23	24.5
The process of obtaining a loan involves too much red tape	18	19.1
Do not like to borrow money	8	8.5
Bad experience with borrowing in the past	8	8.5
Do not want to offer collateral	3	3.2
Do not know who to ask for a loan	2	2.1
Other	6	6.4
Reason unspecified	5	5.3
Total who did not take a loan in the past 10 years	**94**	*

4.9.7 INTEREST IN A FUTURE LOAN

Of all 1,215 respondents, two-fifths (42.3%) claim that they are interested in having a loan now. Around half stated that they would rather not have one. About a tenth (9.5%) are not sure.

TABLE 24. FAMILY DOCTORS' INTEREST IN HAVING A LOAN NOW

Interested in a loan	Number of family doctors	Percentage
Yes	514	42.3
No	584	48.1
Not sure	116	9.5
Non-responses	1	0.1
Total	**1,215**	**100**

The family doctors who would rather not have a loan or are not sure were asked why they may not want a loan and given an opportunity to cite multiple answers. Among them, fewer than a tenth (9.4%)

say that they do not need a loan. More than half (57.7%) says the main reason was that they could not afford it. Although mentioned by only 21%, the second most common reason for not wanting a loan is that the respondent does not like to borrow money. Only 6% said that they do not want to offer collateral. Between 4 and 5% said that they or their acquaintances had bad experiences with loans, or that they have their own financing resources.

TABLE 25. MAIN REASONS FAMILY DOCTORS WOULD "RATHER NOT" TAKE A LOAN OR ARE "NOT SURE"

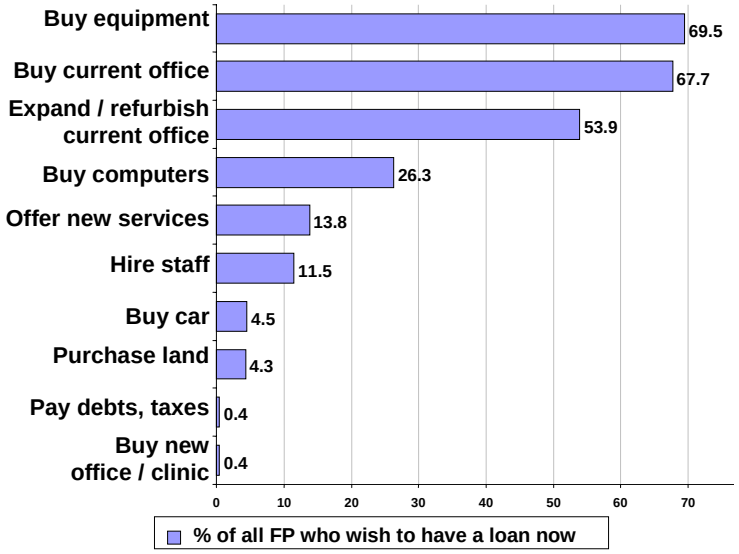
The main reason for not wanting to borrow	Number of family doctors	Percentage
Cannot afford it financially	404	57.7
Does not like to borrow money	148	21.1
Does not need a loan	66	9.4
Does not want to offer collateral	42	6.0
Has other sources of financing	32	4.6
Knows somebody who got into trouble after taking loan	31	4.4
Had a bad experience with borrowing in the past	30	4.3
Monthly revenue (the NHIH contract) is insecure	20	2.9
Does not own office space	9	1.3
High interest rates	7	1.0
Harsh contract terms	6	0.9
Close to retirement age	6	0.9
Personal reasons (such health or leaving the country)	4	0.6
Complicated loan application procedures (red tape)	3	0.4
Unclear judicial status	3	0.4
Does not have any collateral	2	0.3
Job insecurity	2	0.3
Total answering "rather not" or "not sure"	**700**	**100**

** The question allowed multiple answers.*

4.9.8 FUTURE LOAN PURPOSES

Seventy percent of those who would like to borrow in the future would use the loan to purchase medical equipment, and 68% said they would like to buy their current office. Over half (53.9%) would use the loan to refurbish or expand their private practice. And more than a quarter of the respondents (26.3%) would buy computers with the loan. A smaller percentage would provide other services (13.8%) or hire staff (11.5%). Multiple answers were allowed.

FIGURE 14. HOW FAMILY DOCTORS WOULD USE A LOAN IN THE FUTURE



Of the 357 family doctors who would use a loan to purchase medical equipment, almost-two thirds (65%) would buy an electrocardiograph. The second most frequent type of desired equipment was micro-lab, mentioned by over half (59.7%) of respondents. Over two-fifths (44.3%) would buy a sonogram, less than a third (30%) a sterilizer, and a quarter (25.5%) surgical instruments.

TABLE 26. MEDICAL EQUIPMENT FAMILY DOCTORS WOULD PURCHASE WITH A FUTURE LOAN

Equipment	Number of family doctors	Percentage
Electrocardiograph	232	65.0
Micro-lab equipment	213	59.7
Sonograph	158	44.3
Sterilizer	107	30.0
Surgical instruments	91	25.5
Otoscope	70	19.6
Ophthalmoscope	69	19.3
Scales and balances (any type)	64	17.9
Tensiometer	60	16.8
Audiometer	59	16.5
Height scale	58	16.2
Stethoscopes (any type)	57	16.0
Defibrillator	36	10.1
Other	15	4.2
Total who would use the loan to purchase medical equipment	**357**	**100**

4.9.9 LOAN AMOUNTS AND TERMS DESIRED

Fifty percent of family doctors intending to borrow and specifying the amount they want would borrow between 3,000 and 10,000 RON. The average desired loan is 11,221 RON. The most frequently wanted amount is 10,000 RON, stated by 107 respondents, or a fifth of those who indicated a loan amount desired.

On average family doctors are willing to make monthly loan payments of 583 RON. Fifty percent of the family doctors said that they can afford monthly installments of between 304 and 530 RON. Only 7 respondents claimed that they could afford monthly installments of 3,530 RON or more.

4.9.10 COLLATERAL

Out of the 514 respondents, about three-quarters (73.5%) claim to be able to offer a guarantee or collateral to secure a loan. A tenth (11.1%) report they do not have any security to offer, and 15.4% do not want to offer collateral.

TABLE 27. COLLATERAL OR GUARANTEES AMONG FAMILY DOCTORS INTERESTED IN HAVING A LOAN

Collateral or guarantee	Number of family doctors	Percentage
Yes, I have collateral or another guarantee	378	73.5
I do not offer collateral or another guarantee	57	11.1
I do not want to offer collateral or another guarantee	79	15.4
Total who want to borrow now	**514**	**100.0**

Of the 514 family doctors interested in a loan, almost half (47.9%) could offer as collateral the item purchased with the loan (that is, equipment, a building, or land). Fewer than a fifth (17.3%) can offer a building they currently own as collateral, fewer than a tenth have a guarantor, and 6% to 7% could use land (6.8%) or equipment (6.2%). Over a quarter (26.1%) mentioned "other types" of collateral not listed in this paragraph.

5. ANALYSIS BY LOCATION (URBAN VERSUS RURAL)

5.1 SERVICE PROVISION, BY LOCATION

5.1.1 CLIENT VISITS PER MONTH, BY LOCATION

Regardless of their location, most family doctors had between 301 and 600 client visits in the last month. City dwellers had more visits in general, with 50% of them reporting between 600 and 1,200 visits in the past month, higher than the average of 581 among all family doctors.

5.1.2 FAMILY PLANNING CONSULTATIONS AND SERVICES OFFERED, BY LOCATION

The highest number of family planning consultations is in the rural areas, with correspondingly higher numbers of doctors in those areas offering these services. Those in rural areas are twice as likely to have provided family planning consultations in the last month. And of those that did have these consultations in the last month, they are likely to have offered more consultations. Sixty-seven percent of rural doctors who provide family planning counseling and services had more than 10 visits in the previous month and over 35% had more than 20. In contrast to urban areas, where among those that had consultations only 41% had more than 10 visits, and only 16% had more than 20.

Significantly, family doctors in rural areas provide more than two times as many family planning consultations than doctors in urban areas. This finding is due in part to the fact that the USAID-funded RFHI focused most of its family planning training in rural areas. Thus, if more urban family doctors were offered this training, they could add to the number of women with access to family planning in urban areas.

TABLE 28. FAMILY PLANNING CONSULTATIONS IN LAST MONTH, BY LOCATION

Number of family planning consultations last month	Urban		Rural		TOTAL	
	Number of doctors	Percent	Number of doctors	Percent	Number of doctors	Percent
0	386	61.5	197	33.6	583	48.0
1-10	142	22.6	129	22.0	271	22.3
11-20	43	6.9	121	20.6	164	13.5
21-30	25	4.0	81	13.8	106	8.7
31-40	7	1.1	22	3.8	29	2.4
41-50	10	1.6	18	3.1	28	2.3
51-100	9	1.4	15	2.6	24	2.0
101-350	6	1.0	4	0.7	10	0.8
Total	**628**	**-**	**587**	**-**	**1,215**	**-**

5.2 REVENUE, EXPENSES, AND REINVESTMENT, BY LOCATION

5.2.1 MONTHLY REVENUE, BY LOCATION

Based on the averages extrapolated from revenue ranges respondents indicated, family doctors earn an average of 3,387 RON ($1,388) per month with little variation between urban and rural practices.

TABLE 29. MONTHLY REVENUE (RON) OF FAMILY DOCTORS, BY LOCATION

Location	NHIH contract revenue	Non-contract revenue	Sponsorship or other source	Total revenue
Urban	3,137	225	53	3,415
Rural	3,193	131	32	3,356
Total	**3,164**	**180**	**43**	**3,387**

Rural family doctors tend to receive less of their income from revenue outside of the NHIH contract.

5.2.2 BUSINESS EXPENSES, BY LOCATION

Similarly to the calculation of total revenue, mean business expenses were extrapolated from the ranges respondents indicated. The following table shows the mean business expenses for urban and rural locations.

In spite of having similar revenues as their counterparts in urban areas, doctors in rural settings appear to have higher expense levels, indicating a slightly lower net income for the doctor.

TABLE 30. AVERAGE MONTHLY BUSINESS EXPENSES (RON), BY LOCATION

Location	Monthly business expenses
Urban	2,044
Rural	2,120
Total average	**2,080**

5.3 FAMILY DOCTORS' ATTITUDES TOWARD THE NHIH CONTRACT, BY LOCATION

5.3.1 IMPACT OF THE NHIH CONTRACT BY LOCATION

Family doctors with rural practices are more likely to believe the NHIH contract has a positive impact on their practices, with over 50% indicating so, and they are less likely (14%) to consider the contract as having a negative effect. These attitudes are compared to urban doctors of whom 43% think that the impact is positive and 20% believe that the contract negatively affects their practice.

The reasons doctors believe that the contract helps their practice are constant among urban and rural doctors with no significant variation among locations.

TABLE 31. FAMILY DOCTORS' PERCEPTIONS OF HOW THE NHIH CONTRACT IMPACTS THEM POSITIVELY, BY LOCATION

Category	Urban		Rural	
	Number	Percent	Number	Percent
Total monthly revenues	290	46.2	292	49.7
Constant monthly revenues	310	49.4	311	53.0
Number of patients	227	36.1	208	35.4
Expanding the private practice	140	22.3	134	22.8
Access to training	193	30.7	168	28.6
Access to financing	91	14.5	90	15.3
Access to facilities	101	16.1	98	16.7
Total	**628**	*	**587**	*

**The question allowed multiple answers.*

Doctors in all locations believe that the contract inhibits their access to finance, facilities, and ability to expand their practice.

TABLE 32. FAMILY DOCTORS' PERCEPTIONS OF HOW THE NHIH CONTRACT IMPACTS THEM NEGATIVELY, BY LOCATION

Category	Urban		Rural	
	Number	Percent	Number	Percent
Total monthly revenues	165	26.3	127	21.6
Constant monthly revenues	145	23.1	108	18.4
Number of patients	228	36.3	211	35.9
Expanding the private practice	315	50.2	285	48.6
Access to training	262	41.7	251	42.8
Access to financing	364	58.0	329	56.0
Access to facilities	354	56.4	321	54.7
Total	**628**	*	**587**	*

5.3.2 CHANGES DESIRED IN THE NHIH CONTRACT, BY LOCATION

Doctors in urban and rural locations have similar ideas on how to improve the contract. In rural areas, doctors are more likely to favor increases in payments per services over capitation payments than their urban counterparts.

TABLE 33. HOW FAMILY DOCTORS THINK THE NHIH CONTRACT SHOULD BE CHANGED TO IMPROVE IT, BY LOCATION

Suggested improvements	Urban		Rural	
	Number	Percent	Number	Percent
Increase payment amount for service provision	538	85.7	507	86.4
Increase the capitated rate	562	89.5	553	94.2
The contract period should not be limited to one year	210	33.4	150	25.6
Increase payment ratio in favor of service provision	345	54.9	357	60.8
Increase payment ratio in favor of capitated services	232	36.9	246	41.9
Use money, rather than points, to evaluate services provided under the contract	154	24.5	147	25.0
Other	178	28.3	126	21.5
Total	**628**	**100**	**587**	**100**

5.4 PROFITABILITY AND EXPANSION PLANS BY LOCATION

5.4.1 OBSTACLES TO PROFITABILITY, BY LOCATION

Surprisingly, family doctors in urban and rural locations have similar thoughts on what the main obstacles are to running a profitable practice. Urban family doctors have more concerns that their activity is not compensated adequately than rural doctors. Rural doctors tend to cite the low income of patients' more than urban doctors, but agree with their urban counterparts in most ways on this point.

TABLE 34. FAMILY DOCTOR'S PRIMARY OBSTACLES TO PROFITABILITY, BY LOCATION

Main obstacle	Location					
	Urban		Rural		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
Lack of business skills	31	4.9	21	3.6	52	4.3
Partners and employees lack business skills	1	0.2	1	0.2	2	0.2
Increased competition (such as from other family doctors or specialists)	6	1.0	5	0.9	11	0.9
Low demand from other reasons than financial	0	-	1	0.2	1	0.1
Lack of professionalism or dedication in some employees	0	-	2	0.3	2	0.2
Constraints in the use of the office	28	4.5	13	2.2	41	3.4
Low income of patients	33	5.3	77	13.1	110	9.1
The activity is not paid accordingly or enough	336	53.8	291	49.7	627	51.8
The terms of the NHIH contract are not actually negotiated	72	11.5	63	10.8	135	11.1
Excessive red tape concerning reporting and deductions	44	7.0	57	9.7	101	8.3
Lack of access to financing	31	5.0	23	3.9	54	4.5
There are no obstacles	1	0.2	3	0.5	4	0.3
Total	**625**	**100**	**586**	**100**	**1,211**	**100**

5.4.2 PLANS TO EXPAND AND GROW THEIR BUSINESSES, BY LOCATION

Both urban and family doctors want to buy equipment and property for their practices. Family doctors in rural areas, however, are more likely to want to refurbish their clinic than doctors in towns and cities. Urban family doctors seem to have more interest in offering new services.

TABLE 35. HOW FAMILY DOCTORS PLAN TO GROW AND EXPAND THEIR BUSINESS, BY LOCATION

Category	Urban		Rural	
	Number	Percent	Number	Percent
Expand or refurbish clinic	301	48.0	322	54.9
Purchase land	28	4.5	29	4.9
Buy property (present location or other)	435	69.3	375	63.9
Buy equipment	491	78.2	451	76.8
Buy a computer	236	37.6	223	38.0
Hire staff	142	22.6	140	23.9
Offer new services	334	53.2	279	47.5
Do not intend to expand activity	35	5.6	31	5.3
Expand space (office or new clinic)	5	0.8	3	0.5
Buy a car for house calls	0	-	4	0.7
Partner for private practice	1	0.2	2	0.3
Total	**628**	*	**587**	*

Among those who wanted to expand by purchasing equipment, the trends among rural and urban family doctors are similar. Rural family doctors seem to have more equipment needs and are more likely to want to purchase micro-labs, sterilizers, and surgical instruments, suggesting that these items may be needed because of a lack of diverse facilities in rural areas (such as hospitals and labs).

TABLE 36. TYPE OF EQUIPMENT DESIRED BY FAMILY DOCTORS WANTING TO EXPAND BUSINESS, BY LOCATION

Category	Urban		Rural	
	Number	Percent	Number	Percent
Electrocardiograph	315	64.2	288	63.9
Sonograph	210	42.8	200	44.3
Micro-lab equipment	295	60.1	304	67.4
Stethoscopes (any kind)	92	18.7	127	28.2
Scales (of any type)	117	23.8	126	27.9
Surgical instruments	103	21.0	177	39.2
Otoscope	130	26.5	139	30.8
Tensiometer	114	23.2	109	24.2
Sterilizer	157	32.0	177	39.2
Ophthalmoscope	132	26.9	127	28.2
Audiometer	106	21.6	93	20.6
Height scale	113	23.0	109	24.2
Defibrillator	41	8.4	75	16.6
Height scale	36	7.3	30	6.7
Defibrillator	8	1.6	4	0.9
Total	**491**	*	**451**	*

5.5 TRAINING NEEDS ASSESSMENT, BY LOCATION

5.5.1 INTEREST IN FUTURE TRAINING, BY LOCATION

The vast majority of urban and rural family doctors (92% and 95% respectively) would like to have more training. And the types of training desired are similar. When asked for the most important training needed, the trends are the same with rural family doctors more likely to site clinical training (54%) than their urban counterparts and urban family doctors more likely to site business management than their rural colleagues.

TABLE 37. FURTHER TRAINING DESIRED BY FAMILY DOCTORS, BY LOCATION

Type of training	Urban		Rural	
	Number	Percent	Number	Percent
Stock control	6	1.0	5	0.9
Bookkeeping	19	3.3	25	4.4
Business management	174	29.8	148	26.2
Marketing	31	5.3	24	4.3
Financial management	52	8.9	45	8.0
Clinical training	288	49.3	304	53.9
Not sure	4	0.7	6	1.1
Personal computer operation	6	1.0	2	0.4
Project management	0	-	1	0.2
Total	**584**	*	**564**	*

5.5.2 PREVIOUS TRAINING EXPERIENCE, BY LOCATION

Rural family doctors are more than twice as likely as those in urban locations to have received training in family planning.

TABLE 38. TYPE OF TRAINING RECEIVED IN THE PAST FIVE YEARS, BY LOCATION

Type of training	Urban		Rural	
	Number	Percent	Number	Percent
Family planning	203	32.3	64	68.5
Medical competency	323	48.5	59	45.1
Financial management	32	5.1	5	2.9
Did not attend any courses	36	5.7	7	3.6
Continuous medical education classes	364	58.0	86	58.8
Family medicine	11	1.8	4	3.6
Personal computer operation	1	0.2	1	0.2
Medical management or business management	11	1.8	2	3.2
Total	**628**	*	**137**	*

5.6 FINANCING NEEDS ASSESSMENT, BY LOCATION

5.6.1 CREDIT EXPERIENCE, BY LOCATION

Differences among urban and rural family doctors related to their previous credit experience are negligible.

5.6.2 OUTSTANDING LOANS, BY LOCATION

Rural family doctors are more likely to currently have a loan outstanding (80%) than those in urban areas (74%). The uses of previous loans follow general trends for both urban and rural borrowers.

5.6.3 SOURCE OF PREVIOUS LOANS, BY LOCATION

Rural borrowers were more likely to borrow from friends and family and less likely to borrow from a bank than their urban counterparts, but generally the trends in borrowing sources are similar.

TABLE 39. LOAN SOURCES FOR FAMILY DOCTORS WHO HAD TAKEN OUT A LOAN IN THE PAST 10 YEARS, BY LOCATION

Loan sources	Urban		Rural	
	Number	Percent	Number	Percent
Bank	207	65.5	188	61.6
MFI	5	1.6	1	0.3
Leasing company	70	22.2	73	23.9
House of Mutual Support	18	5.7	20	6.6
Family member or friend	29	9.2	34	11.1
Monthly installments at a store	4	1.3	3	1.0
Non-financial institutions (such as city hall or OMNIASIG)	2	0.6	0	0.0
Financing cooperation	1	0.3	2	0.7
Total	**316**	*	**305**	*

Among those that borrowed from a bank in the past, the sources according to location are listed in the following table.

TABLE 40. SOURCE OF PREVIOUS LOAN BY FINANCIAL INSTITUTION, BY LOCATION

Name of bank	Location					
	Urban		Rural		Total	
	Number	Percent	Number	Percent	Number	Percent
BANCA COMERCIALĂ ROMÂNĂ S.A.	49	23.1	65	34.4	114	28.4
BRD–BANCA ROMÂNĂ FOR DEZVOLTARE	41	19.3	33	17.5	74	18.5
RAIFFEISEN BANK S.A.	27	12.7	28	14.8	55	13.7
LIBRA BANK S.A.	18	8.5	18	9.5	36	9.0
BANC POST S.A.	19	9.0	9	4.8	28	7.0
BANCA TRANSILVANIA S.A.	16	7.5	9	4.8	25	6.2
VOLKSBANK ROMÂNIA S.A	9	4.2	5	2.6	14	3.5
BANCA ROMÂNEASCĂ S.A.	5	2.4	6	3.2	11	2.7

BANCA COMERCIALA ION ŢIRIAC	6	2.8	4	2.1	10	2.5
FINANSBANK (ROMÂNIA) S.A.	4	1.9	4	2.1	8	2.0
ALPHA BANK ROMÂNIA S.A.	3	1.4	4	2.1	7	1.7
C.E.C. S.A.	4	1.9	3	1.6	7	1.7
HVB BANK ROMANIA S.A.	3	1.4	2	1.1	5	1.2
UNICREDIT ROMANIA S.A.	1	0.5	3	1.6	4	1.0
PIRAEUS BANK ROMANIA S.A.	1	0.5	2	1.1	3	0.7
BANCA COMERCIALA CARPATICA S.A.	1	0.5	1	0.5	2	0.5
CITIBANK ROMÂNIA S.A.	1	0.5	1	0.5	2	0.5
BANCA DE CREDIT ŞI DEZVOLTARE ROMEXTERRA S.A.	1	0.5	0	-	1	0.2
CHF ROMÂNIA	0	-	1	0.5	1	0.2
EMPORIKI BANK–ROMÂNIA S.A.	0	-	1	0.5	1	0.2
ING BANK N.V	1	0.5	0	-	1	0.2
MINDBANK S.A–BANCA FOR MICĂ INDUSTRIE ŞI LIBERA INIŢIATIVĂ	1	0.5	0	-	1	0.2
PROCREDIT BANK	1	0.5	0	-	1	0.2
ROMANIAN INTERNATIONAL BANK S.A.	1	0.5	0	-	1	0.2
ABN AMRO (ROMÂNIA) S.A.	0	-	0	-	0	-
BANCA COMERCIALĂ ROBANK	0	-	0	-	0	-
BANCA DE MICROFINANŢARE MIRO S.A.	0	-	0	-	0	-
CAPA WORLD VISION, CDE, or OMRO	0	-	0	-	0	-
EUROM BANK S.A.	0	-	0	-	0	-
MISR ROMANIAN BANK	0	-	0	-	0	-
NATIONAL BANK OF GREECE S.A.	0	-	0	-	0	-
BANCA COMERCIALĂ SANPAOLO IMI BANK ROMANIA S.A.	0	-	0	-	0	-
ALTA	5	2.4	4	2.1	9	2.2
Total	**212**	*	**189**	*	**401**	*

5.6.4 INTEREST IN A FUTURE LOAN, BY LOCATION

There is no significant difference between rural and urban family doctors in their desire for future financing. Among those who say that they do not want a future loan, their reasons are similar.

5.6.5 FUTURE LOAN PURPOSES, BY LOCATION

Urban family doctors are more likely to intend to purchase facilities than their rural counterparts (70% and 66% respectively). Rural family doctors are more likely to need medical equipment (71%) than those in urban areas (68%).

TABLE 41. HOW FAMILY DOCTORS WOULD USE A LOAN IN THE FUTURE, BY LOCATION

Category	Urban		Rural	
	Number	Percent	Number	Percent
Expand or refurbish office	143	53.8	134	54.0
Buy land	9	3.4	13	5.2
Buy current office space	185	69.5	163	65.7
Buy medical equipment	180	67.7	177	71.4
Buy computer	58	21.8	77	31.0
Hire staff	31	11.7	28	11.3
Offer new services	30	11.3	41	16.5
Buy a car	13	4.9	10	4.0
Buy new office or clinic	0	0	2	0.8
Pay debts or taxes	1	0.4	1	0.4
Total	**266**	*	**248**	*

5.6.6 LOAN AMOUNTS AND TERMS DESIRED, BY LOCATION

The average monthly instalment that those willing to have a loan would pay is 530 RON ($203) in rural areas and approximately 635 RON ($244) in urban areas.

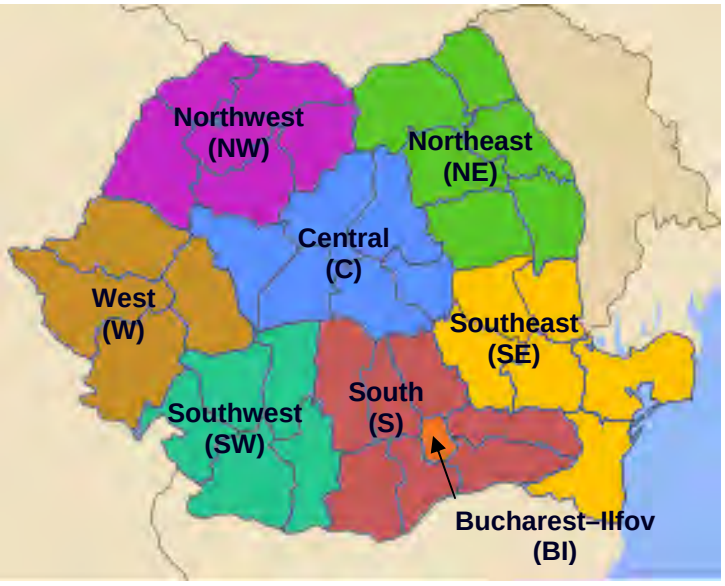
5.6.7 COLLATERAL, BY LOCATION

Both urban and rural family doctors appear to have collateral to offer (approximately 74% are willing to do so), with rural family doctors more likely to say they do not have collateral to offer (14%) and urban doctors more likely to say they do not want to offer it (17%).

TABLE 42. COLLATERAL OR GUARANTEES AMONG FAMILY DOCTORS INTERESTED IN HAVING A LOAN, BY LOCATION

Category	Urban		Rural	
	Number	Percent	Number	Percent
Yes, I have collateral	197	74.1	181	73.0
I do not have collateral	23	8.6	34	13.7
I do not wish to offer collateral	46	17.3	33	13.3
Total	**266**	*	**248**	*

6. ANALYSIS BY REGION



Abbreviations—The following abbreviations for regions are used.

BI—Bucharest-Ilfov, a Romanian development region encompassing Bucharest and the Ilfov county. This area is also referred to as the capital region.

C—Central, a Romanian development region encompassing six counties (Alba, Brasov, Covasna, Harghita, Mures, and Sibiu)

NE—Northeast, a Romanian development region encompassing six counties (Bacau, Botosani, Iasi, Neamt, Suceava, and Vaslui)

NW—Northwest, a Romanian development region encompassing six counties (Bihor, Bistrita-Nasaud, Cluj, Salaj, Satu-Mare, and Maramures)

SE—Southeast, a Romanian development region encompassing six counties (Braila, Buzau, Constanta, Galati, Vrancea, and Tulcea)

S—South, also known as South-Muntenia, a Romanian development region encompassing seven counties (Arges, Calarasi, Dimbovita, Giurgiu, Ialomita, Prahova, and Teleorman)

SW—Southwest, a Romanian development region encompassing five counties (Dolj, Gorj, Mehedinti, Olt, and Valcea)

The survey data was analyzed to find significant correlations and cross tabulations related to the location of the family doctors' practices by development region. Although the data was collected at the district level, results were combined into the eight development regions to facilitate the comparison of regional differences in the findings[22]. In most cases significant differences were not found when comparing the regions to each other. What follows is a description of some findings that are notable.

6.1 CHARACTERISTICS OF PRIVATE PRACTICE, BY REGION

6.1.1 TYPE OF BUSINESS, BY REGION

The highest presence of individual private practices is in the South, where 98.9% of 188 family physicians are registered as individual private practices, and only 1.1% are partnership private practices.

The lowest percentage of individual practices is in the Northwest, where out of the 127 family physicians, 84.3% are registered as individual private practices. The Northwest also has the highest percentage of practices registered as group practices (10.2%) out of any region.

[22] For data pertaining to a specific district, contact the Banking on Health project by visiting www.bankingonhealth.com.

TABLE 43. PRACTICE TYPES OF FAMILY DOCTORS, BY REGION

	Region																Total	
Business type	**BI**		**C**		**NE**		**NW**		**SE**		**S**		**SW**		**W**			
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Individual private practice	108	97.3	162	90.5	193	94.6	107	84.3	133	93.0	186	98.9	141	89.8	96	90.6	1,126	92.7
Partnership	2	1.8	9	5.0	5	2.5	3	2.4	4	2.8	2	1.1	4	2.5	2	1.9	31	2.6
Group practices	0	-	6	3.4	0	-	13	10.2	3	2.1	0	-	1	0.6	3	2.8	26	2.1
Medical civil society	0	-	0	-	2	1.0	1	0.8	0	-	0	-	0	-	1	0.9	4	0.3
Limited liability company	1	0.9	2	1.1	4	2.0	3	2.4	3	2.1	0	-	11	7.0	4	3.8	28	2.3
Total	**111**	**100**	**179**	**100**	**204**	**100**	**127**	**100**	**143**	**100**	**188**	**100**	**157**	**100**	**106**	**100**	**1,215**	**100**

6.1.2 PARTNERS, BY REGION

As mentioned previously family doctors in the Bucharest-Ilfov region have a high rate of individual private practices, so it is no surprise that 96.4% of them have no partner in their business. In the Central region, 11.7% of the doctors work in a partnership with one other doctor, the highest rate of dual-partner practices in the country. Also, the Central region has the greatest number of doctors with multiple business partners, with up to seven of them in some instances.

TABLE 44. NUMBER OF PARTNERS, BY REGION

Partners	Region																Total	
	BI		**C**		**NE**		**NW**		**SE**		**S**		**SW**		**W**			
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
0	107	96.4	132	73.7	190	93.1	119	93.7	128	89.5	181	96.3	147	93.6	96	90.6	1,100	90.5
1	3	2.7	21	11.7	7	3.4	4	3.1	14	9.8	7	3.7	7	4.5	10	9.4	73	6.0
2	0	-	12	6.7	2	1.0	0	-	1	0.7	0	-	0	-	0	-	15	1.2
3	0	-	5	2.8	1	0.5	3	2.4	0	-	0	-	0	-	0	-	9	0.7
4	1	0.9	1	0.6	3	1.5	0	-	0	-	0	-	3	1.9	0	-	8	0.7
5	0	-	2	1.1	1	0.5	0	-	0	-	0	-	0	-	0	-	3	0.2
6	0	-	4	2.2	0	-	1	0.8	0	-	0	-	0	-	0	-	5	0.4
7	0	-	2	1.1	0	-	0	-	0	-	0	-	0	-	0	-	2	0.2
Total	**111**	**100**	**179**	**100**	**204**	**100**	**127**	**100**	**143**	**100**	**188**	**100**	**157**	**100**	**106**	**100**	**1,215**	**100**

6.2 SERVICE PROVISION, BY REGION

6.2.1 CLIENT VISITS PER MONTH, BY REGION

The average number of client visits per month was highest in the region of Bucharest-Ilfov, with a mean of 668 visits. The fewest visits on average were reported in the Southwest, with a mean of 528 per month.

TABLE 45. MONTHLY CLIENT VISITS, BY REGION

Number of Visits	Region																Total	
	BI		C		NE		NW		SE		S		SW		W			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0–300	3	2.7	8	4.5	20	9.8	11	8.7	15	10.5	17	9.0	25	15.9	17	16.0	116	9.5
301–600	45	40.5	88	49.2	110	53.9	54	42.5	96	67.1	96	51.1	92	58.6	53	50.0	634	52.2
601–900	52	46.8	64	35.8	60	29.4	50	39.4	27	18.9	64	34.0	28	17.8	24	22.6	369	30.4
901–1,200	9	8.1	17	9.5	14	6.9	9	7.1	4	2.8	10	5.3	11	7.0	9	8.5	83	6.8
1,201–1,500	2	1.8	1	0.6	0	-	3	2.4	1	0.7	1	0.5	1	.6	2	1.9	11	0.9
1,500+	0	-	1	.6	0	-	0	-	0	-	0	-	0	-	1	0.9	2	.02
Total	**111**	**100**	**179**	**100**	**204**	**100**	**127**	**100**	**143**	**100**	**188**	**100**	**157**	**100**	**106**	**100**	**1215**	**100**

6.2.2 FAMILY PLANNING CONSULTATIONS AND SERVICES OFFERED, BY REGION

The average number of family planning consultations in the past month was lowest for the capital region of Bucharest-Ilfov, with a mean of only five consultations. That number rises to 7.5 in South, 7.8 in West, and 7.8 in Central. Higher rates of consultations were seen in the Northwest (13.2%), Southwest (13.8%), and the Southeast (14.7%). The region with the greatest average number of family planning visits was the Northeast with 17.2. (These averages take into consideration those who do not offer any family planning.)

Family planning provision among family doctors is directly tied to training in that area they receive (sponsored by USAID and the MoPH). Only doctors with training in family planning are allowed to offer such consultation and services. The focus of the USAID training was on rural areas, the results of which can be seen in the following data and urban and rural analysis.

TABLE 46. FAMILY PLANNING CONSULTATIONS PER MONTH, BY REGION

FP visits	Region																Total	
	BI		C		NE		NW		SE		SM		SW		W			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0	81	73.0	104	58.1	110	53.9	46	36.2	29	20.3	114	60.6	45	28.7	54	50.9	583	48.0
1–5	3	2.7	12	6.7	10	4.9	20	15.7	24	16.8	13	6.9	16	10.2	22	20.8	120	9.9
6–10	13	11.7	16	8.9	16	7.8	8	6.3	36	25.2	18	9.6	30	19.1	14	13.2	151	12.4
11–15	2	1.8	15	8.4	10	4.9	7	5.5	17	11.9	13	6.9	16	10.2	4	3.8	84	6.9
16–20	4	3.6	10	5.6	19	9.3	13	10.2	9	6.3	5	2.7	15	9.6	5	4.7	80	6.6
21–25	0	-	5	2.8	6	2.9	11	8.7	4	2.8	10	5.3	7	4.5	1	0.9	80	6.6
26–30	3	2.7	6	3.4	11	5.4	12	9.5	6	4.2	6	3.2	1	0.6	3	2.8	48	4.0
31–35	0	-	2	1.1	1	0.5	5	3.9	3	2.1	0	-	3	1.9	0	-	14	1.2
36–40	1	0.9	1	0.6	1	0.5	3	2.4	4	2.8	2	1.1	4	2.5	1	0.9	17	1.4
41–45	1	0.9	0	-	2	1.0	1	0.8	3	2.1	2	1.1	2	1.3	0	-	11	0.9
46–50	1	0.9	5	2.8	3	1.5	0	-	2	1.4	2	1.1	4	2.5	0	-	17	1.4
51–55	1	0.9	0	-	0	-	0	-	0	-	0	-	0	-	0	-	1	0.1
56–60	0	-	3	1.7	3	1.5	0	-	2	1.4	0	-	0	-	0	-	8	0.7
61–65	0	-	0	-	1	0.5	0	-	0	-	1	0.5	0	-	1	0.9	3	0.2
66–70	1	0.9	0	-	0	-	0	-	1	0.7	0	-	0	-	0	-	2	0.2
71–75	0	-	0	-	0	-	0	-	1	0.7	0	-	0	-	0	-	1	0.1
76+	0	-	0	-	10	4.9	3	2.4	2	1.4	2	1.1	1	0.6	1	0.9	19	1.6
Total	**111**	**100**	**179**	**100**	**204**	**100**	**127**	**100**	**143**	**100**	**188**	**100**	**157**	**100**	**106**	**100**	**1,215**	**100**

6.3 REVENUE, EXPENSES, AND REINVESTMENT, BY REGION

6.3.1 MONTHLY REVENUE, BY REGION

There is not a great degree of variance in revenue among the regions. Family doctors in the Northeast development region have the highest total revenues from their practices on average, earning approximately 3,540 RON ($1,451) per month. The lowest total revenue is in the West, where total monthly earning averaged 3,036 RON ($1,244).

While there is some variation in income source regardless of region, the NHIH contract is the most significant source of revenue for family doctors. Other sources are minimal. Doctors in the Northeast earned the most from their NHIH contract, and those in the West earned the least from it. Non-contract services were a more significant source of income for family doctors in the Central region (311 RON or $127), while doctors in the capital region earned only 114 RON ($47) a month from non-contract services. Although sponsorship funds were minimal, those in the Southeast earned a monthly average of 93 RON ($38), while only 3 RON ($1.23) per month was the average received in sponsorship funds in the Southwest.

TABLE 47. MONTHLY REVENUE (RON) OF FAMILY DOCTORS, BY REGION

Region	Revenue source			Total monthly revenue
	NHIH contract	Non-contract services	Sponsorship	
BI	3,331	114	66	3,511
C	2,871	311	78	3,260
NE	3,333	176	31	3,540
NW	3,201	199	37	3,438
SE	3,281	124	93	3,498
S	3,111	158	15	3,284
SW	3,329	129	3	3,461
W	2,806	198	32	3,036
Total	**3,164**	**180**	**43**	**3,387**

* These means have been extrapolated from data for income source and region.

6.3.2 BUSINESS EXPENSES, BY REGION

The average amount in RON for monthly business expenses was calculated for each region as shown in the following table. Doctors in the Central region had the lowest average business expenses at 1,825 RON ($748) monthly. In the Northwest expenses were the highest at 2,326 RON ($953) per month.

TABLE 48.MONTHLY BUSINESS EXPENSES (RON), BY REGION

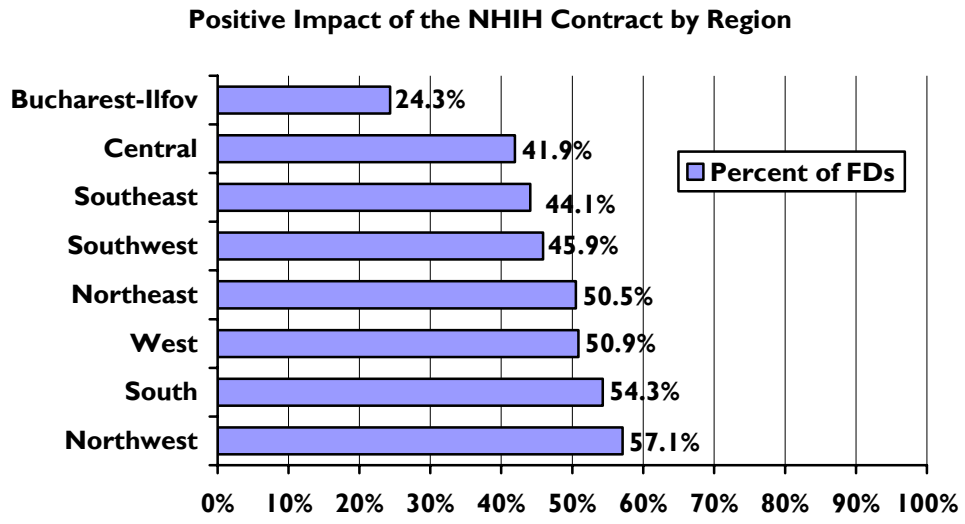
Region	Monthly business expenses (mean)
BI	2,031
C	1,835
NE	2,175
NW	2,326
SE	2,155
S	2,058
SW	2,186
W	1,854
Total	**2,080**

6.4 FAMILY DOCTORS' ATTITUDES TOWARD THE NHIH CONTRACT, BY REGION

6.4.1 IMPACT OF NHIH CONTRACT, BY REGION

The largest percentage of doctors who believe that the NHIH contract has a positive impact on their business activity is in the Northwest (57.1%), while the smallest percentage is in Bucharest-Ilfov (24.3%).

FIGURE 15. PERCENTAGE OF FAMILY DOCTORS WHO FEEL THE NHIH CONTRACT HAS HAD A POSITIVE IMPACT ON THEIR PRACTICE, BY REGION



In the Northeast family doctors mention most frequently that the stability of monthly income was a positive effect of the NHIH contract (55.4%), as did doctors in the Northwest (65.4%) and the South (58.5%). The most frequently reported positive impact from the NHIH contract by doctors in Bucharest-Ilfov is the number of patients (42.3%). Total monthly revenue is mentioned in the Southeast as the main positive benefit of the contract (51.1%). And although 27.3% of doctors in the Southeast say access to facilities was positive, only 6.3% of doctors in Bucharest-Ilfov indicate the same.

TABLE 49. FAMILY DOCTORS' PERCEPTIONS OF HOW THE NHIH CONTRACT IMPACTS THEM POSITIVELY, BY REGION

Category	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Total monthly revenues	34	30.6	74	41.3	111	54.4	69	54.3	66	46.2	96	51.1	72	45.9	60	56.6
Stability of monthly revenues	40	36.0	75	41.9	113	55.4	83	65.4	63	44.1	110	58.5	70	44.6	67	63.2
Number of patients	47	42.3	47	26.3	68	33.3	49	38.6	57	39.9	73	38.8	45	28.7	49	46.2
Expanding the private practice	13	11.7	35	19.6	51	25.0	33	26.0	40	28.0	43	22.9	28	17.8	31	29.2
Access to training	31	27.9	39	21.8	76	37.3	50	39.4	51	35.7	57	30.3	18	11.5	39	36.8
Access to financing	6	5.4	23	12.8	28	13.7	30	23.6	35	24.5	35	18.6	14	8.9	10	9.4
Access to facilities	7	6.3	17	9.5	29	14.2	24	18.9	39	27.3	45	23.9	20	12.7	18	17.0
Total	**111**	*	**179**	*	**204**	*	**127**	*	**143**	*	**188**	*	**157**	*	**106**	*

The question allowed multiple answers.

When asked what the main negative impact of the NHIH contract is on their practice, 62.2% of family doctors in Bucharest-Ilfov quote a lack of access to financing. This same reason also is mentioned by 63.7% of doctors in the Northeast, 68.5% in the Northwest, and 64.2% in the Northeast. In the Northwest family doctors feel that the contract limits their access to facilities (73.2%), which also is reported by 61.3% of their counterparts from Bucharest-Ilfov. And while only 10.4% of doctors in the West said that the contract jeopardizes the stability of their monthly revenue, 31.5% of family doctors in the capital region believe it is a concern.

TABLE 50. FAMILY DOCTORS' PERCEPTIONS OF HOW THE NHIH CONTRACT IMPACTS THEM NEGATIVELY, BY REGION

Category	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Total monthly revenue	41	36.9	38	21.2	47	23.0	48	37.8	24	16.8	44	23.4	32	20.4	18	17.0
Consistent monthly revenue	35	31.5	37	20.7	45	22.1	34	26.8	27	18.9	30	16.0	34	21.7	11	10.4
Number of patients	28	25.2	65	36.3	90	44.1	68	53.5	33	23.1	67	35.6	59	37.6	29	27.4
Expanding the private practice	62	55.9	77	43.0	107	52.5	84	66.1	50	35.0	97	51.6	76	48.4	47	44.3
Access to training	44	39.6	73	40.8	82	40.2	67	52.8	39	27.3	83	44.1	86	54.8	39	36.8
Access to financing	69	62.2	89	49.7	130	63.7	87	68.5	55	38.5	105	55.9	90	57.3	68	64.2
Access to facilities	68	61.3	95	53.1	129	63.2	93	73.2	51	35.7	95	50.5	84	53.5	60	56.6
Total	**111**	*	**179**	*	**204**	*	**127**	*	**143**	*	**188**	*	**157**	*	**106**	*

6.4.2 CHANGES DESIRED IN THE NHIH CONTRACT, BY REGION

When asked about the changes they would like to see in the NHIH contract, 97% of doctors in the West region would like the payment amount for services to be increased; 95% of respondents in the Northwest region share this sentiment. In Bucharest-Ilfov, 90% would like to have the amount for capitated services increased. Sixty-seven percent of doctors in the Southwest would like to see the contract period changed.

TABLE 51. HOW FAMILY DOCTORS THINK THE NHIH CONTRACT SHOULD BE CHANGED TO IMPROVE IT, BY REGION

Suggested improvements	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Increase the capitated rate	100	90	151	84	172	84	112	88	120	84	162	86	136	87	92	87
Increase payment amount for service provision	103	93	154	86	191	94	120	95	133	93	171	91	140	89	103	97
Increase payment ratio in favor of capitated services	27	24	64	36	69	34	37	29	38	27	49	26	44	28	32	30
The contract period should not be limited to one year	70	63	94	53	109	53	68	54	83	58	104	55	105	67	69	65
Increase payment ratio in favor of service provision	33	30	80	45	87	43	48	38	48	34	66	35	65	41	51	48
Use money, rather than points, to evaluate services provided under the contract	19	17	54	30	58	28	34	27	33	23	33	18	39	25	31	29
Other	37	33	35	20	33	16	30	24	42	29	81	43	21	13	25	24
Total	**111**	*	**179**	*	**204**	*	**127**	*	**143**	*	**188**	*	**157**	*	**106**	*

6.5 PROFITABILITY AND EXPANSION PLANS, BY REGION

6.5.1 OBSTACLES TO PROFITABILITY, BY REGION

Regardless of region most family doctors believe that the main obstacle to profitability is that they are underpaid for their services. Other issues, however, were voiced, such as a lack of business skills, reported by 11.9% of respondents in the Northwest. The terms of the NHIH contract are considered an obstacle by 15.4% of those in the Southeast, and the excessive red tape of the contract is a hindrance to 12.6% as well. In the Northeast 13.2% of family doctors mention low-income patients as an obstacle. Constraints in the use of the office are mentioned as an obstacle by 7.1% in both the Southwest and the Northwest regions.

TABLE 52. FAMILY DOCTORS' PRIMARY OBSTACLES TO PROFITABILITY, BY REGION

Obstacle	Region																	
	BI		C		NE		NW		SE		S		SW		W		Total	
	No.	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%	No	%
Lack of business skills	2	1.8	4	2.2	10	4.9	15	11.9	6	4.2	6	3.2	3	1.9	6	5.7	52	4.3
Lack of professionalism in employees	0	0	0	0	2	1.0	0	0	0	0	0	0	0	0	0	0	2	0.2
Constraints in the use of the office	2	1.8	6	3.4	2	1.0	9	7.1	7	4.9	3	1.6	11	7.1	1	0.9	41	3.4
Low income of patients	2	1.8	11	6.1	27	13.2	6	4.8	18	12.6	20	10.7	19	12.2	7	6.6	110	9.1
Activity is not paid accordingly or enough	63	57.3	103	57.5	107	52.5	61	48.4	53	37.1	94	50.3	82	52.6	64	60.4	627	51.8
NHIH contract terms are not negotiated	10	9.1	20	11.2	20	9.8	12	9.5	22	15.4	20	10.7	18	11.5	13	12.3	135	11.1
Excessive red tape for reporting and deductions	10	9.1	18	10.1	13	6.4	11	8.7	18	12.6	17	9.1	12	7.7	2	1.9	101	8.3
Total	**110**	**100**	**179**	**100**	**204**	**100**	**126**	**100**	**143**	**100**	**187**	**100**	**156**	**100**	**106**	**100**	**1211**	**100**

6.6 TRAINING NEEDS ASSESSMENT, BY REGION

6.6.1 INTEREST IN FUTURE TRAINING, BY REGION

Throughout the regions interest in additional clinical training is ranked the highest, ranging from 53.6% of doctors in the Central region to 78.7% in the South. In every region the second most cited need for training is in business management, with a high of 73.2% of doctors in the Southwest interested in this topic, to a low of 52.0% in the Northwest. Financial management is also a major concern in the Southeast (46.9%) and South (41.5%). Doctors in the Northeast have the highest demand for marketing training (30.9%) among the regions. Doctors in the capital region have the highest demand for training in bookkeeping (27.0%). They are also more likely than other regions to say they did not need further training (16.2%).

TABLE 53. FURTHER TRAINING DESIRED BY FAMILY DOCTORS, BY REGION

Category	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Stock control	12	10.8	13	7.3	20	9.8	10	7.9	11	7.7	24	12.8	13	8.3	13	12.3
Bookkeeping	30	27.0	36	20.1	47	23.0	25	19.7	38	26.6	45	23.9	30	19.1	22	20.8
Business management	58	52.3	94	52.5	125	61.3	66	52.0	100	69.9	116	61.7	115	73.2	59	55.7
Marketing	16	14.4	36	20.1	63	30.9	41	32.3	31	21.7	54	28.7	43	27.4	26	24.5
Financial management	30	27.0	53	29.6	80	39.2	46	36.2	67	46.9	78	41.5	48	30.6	42	39.6
Clinical training	70	63.1	96	53.6	142	69.6	93	73.2	100	69.9	148	78.7	120	76.4	80	75.5
Not sure	1	0.9	-	-	1	0.5	3	2.4	2	1.4	4	2.1	-	-	1	0.9
Do not need further training	18	16.2	19	10.6	7	3.4	7	5.5	3	2.1	5	2.7	1	0.6	6	5.7
Total	**111**	*	**179**	*	**204**	*	**127**	*	**143**	*	**188**	*	**157**	*	**106**	*

6.6.2 PREVIOUS TRAINING EXPERIENCE, BY REGION

There is significant variance in the regions according to those who have attended training in family planning. The highest percentage is in the Southeast, where 65.7% of family doctors have been trained in family planning during the last five years. Bucharest-Ilfov has a low rate of family planning training, with only 13.5% of doctors having been trained. The central region has the highest percentage of doctors recently attending medical competency courses (66.5%), and the Southeast was second with 65.7%. Doctors in Bucharest-Ilfov are the most likely to have attended continuing medical education courses (70.3%), which fewer than half that amount attended in the Central region (32.4%). Financial-management courses are universally infrequent, with the highest rate in the Northeast (6.4%) and the lowest in Bucharest (1.8%). The Northeast has a larger amount of doctors who have been trained in medical or business management (7.8%).

TABLE 54. TYPE OF TRAINING RECEIVED IN THE PAST FIVE YEARS, BY REGION

Category	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Family planning	15	13.5	77	43.0	100	49.0	76	59.8	94	65.7	90	47.9	94	59.9	59	55.7
Medical competency training	60	54.1	119	66.5	58	28.4	50	39.4	94	65.7	81	43.1	64	40.8	62	58.5
Financial management	2	1.8	4	2.2	13	6.4	10	7.9	4	2.8	7	3.7	3	1.9	6	5.7
Did not attend any courses	6	5.4	14	7.8	5	2.5	2	1.6	3	2.1	8	4.3	9	5.7	10	9.4
Continuing medical training	78	70.3	58	32.4	119	58.3	87	68.5	66	46.2	153	81.4	88	56.1	60	56.6
Family medicine degree	1	0.9	3	1.7	9	4.4	8	6.3	2	1.4	7	3.7	1	0.6	1	0.9
Operating computer	-	-	-	-	-	-	-	-	-	-	-	-	2	1.3	-	-
Medical or business management	-	-	7	3.9	16	7.8	-	-	5	3.5	1	0.5	-	-	1	0.9
Total	**111**	*	**179**	*	**204**	*	**127**	*	**143**	*	**188**	*	**157**	*	**106**	*

6.7 FINANCING NEEDS ASSESSMENT, BY REGION

6.7.1 CREDIT EXPERIENCE, BY REGION

Although the majority of all doctors have had a previous loan, the region with the most doctors with credit experience is the Northwest, where 81.2% of respondents have an outstanding loan. The lowest percentage is in the West where only 58.7% have a loan.

TABLE 55. FAMILY DOCTORS WITH OUTSTANDING LOANS, BY REGION

Loan?	Region																Total	
	BI		C		NE		NW		SE		S		SW		W			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	28	70.0	53	71.6	110	79.7	56	81.2	59	81.9	86	81.1	61	80.3	27	58.7	480	77.3
No	12	30.0	21	28.4	28	20.3	13	18.8	13	18.1	20	18.9	15	19.7	19	41.3	141	22.7
Total	**40**	**100**	**74**	**100**	**138**	**100**	**69**	**100**	**72**	**100**	**106**	**100**	**76**	**100**	**46**	**100**	**621**	**100**

6.7.2 OUTSTANDING LOANS, BY REGION

The highest mean value of the outstanding debt is in the Northwest region (37,519 RON or $13,514), followed by the South (28,026 RON or $10,729). The lowest average outstanding debt amount is in the West region (13,287 RON or $5,086).

TABLE 56. AVERAGE VALUE OF CURRENT OUTSTANDING DEBTS (RON), BY REGION

	BI	C	NE	NW	SE	S	SW	W
Mean value	17,272	17,634	22,316	37,519	21,036	28,026	21,356	13,287

6.7.3 USE OF LOAN, BY REGION

Among the doctors who have taken out a loan, a large number of them use it to purchase a car: 50.0% in Central, 49.3% in Northwest, and 46.1% in Southwest. Of those who invest the funds in the practice, the largest percentage is in the Southeast (36.1%). Doctors in Bucharest and the Northeast are more likely than other regions to use the loan for personal needs and consumer goods, such as appliances. Building or purchasing land is most frequently found in the Northeast (21.0%).

TABLE 57. USE OF MOST RECENT LOAN, BY REGION

Category	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Practice (such as for refurbishment or equipment)	11	27.5	17	23	45	32.6	24	34.8	26	36.1	20	18.9	25	32.9	17	37
Building or land	4	10.0	10	13.5	29	21.0	12	17.4	9	12.5	14	13.2	8	10.5	5	10.9
Car	16	40.0	37	50.0	50	36.2	34	49.3	32	44.4	47	44.3	35	46.1	20	43.5
Personal needs or appliances	11	27.5	7	9.5	38	27.5	9	13.0	12	16.7	21	19.8	12	15.8	5	10.9
Training	1	2.5	-	-	5	3.6	-	-	1	1.4	1	0.9	-	-	1	2.2
To pay taxes	-	-	2	2.7	2	1.4	1	1.4	-	-	4	3.8	-	-	3	6.5
Computer	-	-	2	2.7	1	0.7	-	-	1	1.4	1	0.9	-	-	-	-
Other personal needs	-	-	1	1.4	3	2.2	2	2.9	1	1.4	1	0.9	1	1.3	-	-
Total	**40**	*	**74**	*	**138**	*	**69**	*	**72**	*	**106**	*	**76**	*	**46**	*

6.7.4 SOURCE OF PREVIOUS LOANS, BY REGION

The source of the family doctors' recent loans varies by region, with those in the Northwest (73.9%) and Bucharest-Ilfov (72.5%) more likely to use a bank compared to their counterparts in the West (50.0%). The Northwest also has the highest percentage of those borrowing from an MFI (13.0%). Doctors in the Northwest (14.5%) and the Northeast (15.9%) are more likely to borrow from friends and family than other regions.

TABLE 58. SOURCES OF THE LAST LOAN

Loan source	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Bank	29	72.5	50	67.6	81	58.7	51	73.9	38	52.8	72	67.9	51	67.1	23	50.0
MFI	-	-	2	2.7	1	0.7	9	13.0	-	-	-	-	2	2.6	1	2.2
Leasing company	12	30.0	15	20.3	25	18.1	1	1.4	26	36.1	22	20.8	22	28.9	12	26.1
The House of Mutual Support	-	-	5	6.8	14	10.1	10	14.5	2	2.8	10	9.4	3	3.9	3	6.5
Family or friend	1	2.5	4	5.4	22	15.9	-	-	11	15.3	7	6.6	2	2.6	6	13.0
Store credit (monthly payments)	-	-	-	-	3	2.2	-	-	2	2.8	1	0.9	-	-	1	2.2
Non-financial institution	-	-	1	1.4	-	-	-	-	-	-	-	-	-	-	1	2.2
Financing cooperation	-	-	-	-	1	0.7	-	-	-	-	1	0.9	1	1.3	-	-
Total	**40**	*	**74**	*	**138**	*	**69**	*	**72**	*	**106**	*	**76**	*	**46**	*

6.7.5 ATTEMPTS AT BORROWING, BY REGION

For doctors without previous loans who claim that they tried to get one, 100% of the doctors in Bucharest-Ilfov say that the reason was that their loan application was rejected, as do 87.5% of the respondents from the South.

6.7.6 INTEREST IN A FUTURE LOAN, BY REGION

Of those without a current loan, an average of 42.3% are interested in borrowing right now, with the highest rate in the Southwest (52.9%). Among those not interested in a loan right now, the highest proportion is in the Central region (60.9%). Among those not sure, the most doctors are in the Northwest (25.4%).

TABLE 59. FAMILY DOCTORS' INTEREST IN HAVING A LOAN NOW, BY REGION

	Region																Total	
Interested in a loan	BI		C		NE		NW		SE		S		SW		W			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Yes	47	42.3	63	35.2	103	50.5	40	31.7	58	40.6	75	39.9	83	52.9	45	42.5	514	42.3
No	57	51.4	109	60.9	75	36.8	54	42.9	77	53.8	88	46.8	69	43.9	55	51.9	584	48.1
Not sure	7	6.3	7	3.9	26	12.7	32	25.4	8	5.6	25	13.3	5	3.2	6	5.7	116	9.6
Total	**111**	**100**	**179**	**100**	**204**	**100**	**126**	**100**	**143**	**100**	**188**	**100**	**157**	**100**	**106**	**100**	**1214**	**100**

Those who were not interested in a loan or not sure where asked why, with the most frequent answer being that they could not afford a loan. This is the response of 68.8% of family doctors in Bucharest-Ilfov and 64.9% in the Southwest. Those saying they did not need a loan are most frequently found in the Northwest (17.4%). Over a quarter (25.9%) of the respondents from the Southeast say they do not like

to borrow money, but only 16.2% in the Southwest felt likewise. Doctors in the Southwest and West mentioned they had other sources of financing (9.8% and 9.5% respectively).

TABLE 60. MAIN REASONS FAMILY DOCTORS WOULD "RATHER NOT" TAKE A LOAN OR ARE "NOT SURE", BY REGION

Reason	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Do not need a loan	4	6.3	12	10.3	7	6.9	15	17.4	9	10.6	6	5.3	7	9.5	6	9.8
Do not like to borrow money	11	17.2	27	23.3	20	19.8	19	22.1	22	25.9	24	21.2	12	16.2	13	21.3
Have own sources of financing	-	-	8	6.9	2	2.0	4	4.7	1	1.2	4	3.5	7	9.5	6	9.8
Do not want to offer collateral	2	3.1	8	6.9	8	7.9	4	4.7	8	9.4	7	6.2	4	5.4	1	1.6
Had bad experience with borrowing in the past	1	1.6	5	4.3	5	5.0	5	5.8	3	3.5	7	6.2	4	5.4	-	-
Knows somebody who got into trouble after taking loans	3	4.7	2	1.7	3	3.0	7	8.1	6	7.1	2	1.8	3	4.1	5	8.2
Can not afford it	44	68.8	55	47.4	64	63.4	43	50.0	47	55.3	70	61.9	48	64.9	33	54.1
Other	5	7.8	15	12.9	10	9.9	2	2.3	10	11.8	12	10.6	-	-	5	8.2
Total	**64**	*	**116**	*	**101**	*	**86**	*	**85**	*	**113**	*	**74**	*	**61**	*

6.7.7 FUTURE LOAN PURPOSES, BY REGION

Among the family doctors interested in taking out a loan in the future, the most frequently cited use for the loan is buying equipment by doctors in Central (63%), Northeast (82%), Northwest (77%), Southeast (80%), South (79%), Southwest (89%), and West (78%). Only doctors in the Bucharest-Ilfov region rank buying property (74%) ahead of buying equipment (70%). In the West and the Northeast, 60% would use the funds to expand or refurbish their clinics. Sixty percent in the Northeast also would expand the range of services they offer. Doctors in the Southwest mention buying computers most frequently (57%).

TABLE 61. HOW FAMILY DOCTORS WOULD USE A LOAN IN THE FUTURE, BY REGION

	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Expand or refurbish clinic	50	45	74	41	123	60	63	50	83	58	100	53	86	55	64	60
Purchase land	9	8.1	2	1.1	12	5.9	8	6.3	9	6.3	6	3.2	10	6.4	1	0.9
Buy property	82	74	104	58	131	64	91	72	107	75	126	67	101	64	68	64
Buy equipment	78	70	113	63	167	82	98	77	115	80	149	79	139	89	83	78
Buy computer	41	37	44	25	73	36	46	36	59	41	75	40	89	57	32	30
Hire staff	32	29	37	21	41	20	32	25	22	15	57	30	35	22	26	25
Offer new services	64	58	65	36	122	60	64	50	70	49	94	50	87	55	47	44
Other	1	0.9	8	4.5	7	3.4	8	6.3	4	2.8	7	3.7	2	1.3	1	0.9
Do not intend to expand activity	11	9.9	15	8.4	6	2.9	5	3.9	5	3.5	12	6.4	3	1.9	9	8.5
Total	**111**	*	**179**	*	**204**	*	**127**	*	**143**	*	**188**	*	**157**	*	**106**	*

Those family doctors who would use their loan to buy equipment say most frequently that they would buy an electrocardiograph, as did 86.7% in the West, 75.0% in the South, and 68.4% in the Southwest. Micro-lab equipment is chosen most frequently by doctors in the Southwest 78.9%, whereas only 33.3%

mention it in the West. The Southeast has the highest demand for scales (28.2%). Sterilizers are mentioned by 43% of doctors in the Northeast, but only 16.7% in the Northwest.

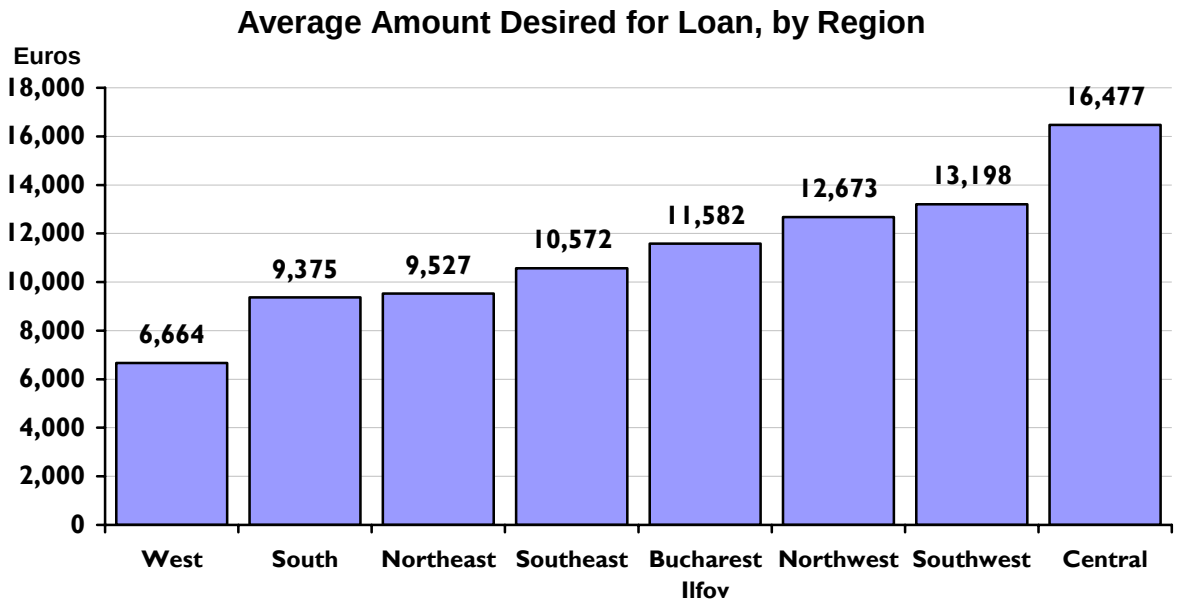
TABLE 62. MEDICAL EQUIPMENT FAMILY DOCTORS WOULD PURCHASE WITH A FUTURE LOAN, BY REGION

Equipment	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Electrocardiograph	17	56.7	13	48.1	49	62.0	16	66.7	20	51.3	39	75.0	52	68.4	26	86.7
Sonograph	14	46.7	10	37.0	30	38.0	9	37.5	22	56.4	24	46.2	37	48.7	12	40.0
Micro-lab equipment	13	43.3	16	59.3	40	50.6	16	66.7	28	71.8	30	57.7	60	78.9	10	33.3
Stethoscopes (any kind)	7	23.3	5	18.5	17	21.5	3	12.5	7	17.9	3	5.8	13	17.1	2	6.7
Scales (of any type)	3	10.0	3	11.1	17	21.5	2	8.3	11	28.2	8	15.4	18	23.7	2	6.7
Surgical instruments	6	20.0	8	29.6	21	26.6	7	29.2	8	20.5	10	19.2	28	36.8	3	10.0
Otoscope	7	23.3	5	18.5	20	25.3	4	16.7	4	10.3	5	9.6	19	25.0	6	20.0
Tensiometer	4	13.3	6	22.2	19	24.1	5	20.8	6	15.4	6	11.5	11	14.5	3	10.0
Sterilizer	8	26.7	10	37.0	34	43.0	4	16.7	9	23.1	13	25.0	23	30.3	6	20.0
Ophthalmoscope	5	16.7	5	18.5	20	25.3	4	16.7	4	10.3	7	13.5	18	23.7	6	20.0
Audiometer	2	6.7	8	29.6	12	15.2	5	20.8	5	12.8	7	13.5	17	22.4	3	10.0
Height scale	3	10.0	7	25.9	14	17.7	3	12.5	7	17.9	7	13.5	15	19.7	2	6.7
Defibrillator	4	13.3	2	7.4	10	12.7	1	4.2	6	15.4	5	9.6	5	6.6	3	10.0
Spirometer	1	3.3	-	-	-	-	1	4.2	-	-	1	1.9	-	-	1	3.3
Oscillometer	-	-	-	-	2	2.5	-	-	-	-	1	1.9	-	-	1	3.3
Bioptron	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	3.3
Physical therapy equipment	-	-	-	-	1	1.3	1	4.2	-	-	1	1.9	-	-	1	3.3
Bioresonance equipment	-	-	-	-	-	-	1	4.2	-	-	-	-	-	-	-	-
Laser therapy equipment	-	-	-	-	-	-	-	-	-	-	1	1.9	-	-	-	-
Total	**30**	*	**27**	*	**79**	*	**24**	*	**39**	*	**52**	*	**76**	*	**30**	*

6.7.8 LOAN AMOUNTS AND TERMS DESIRED, BY REGION

The lowest average amount desired is in the West, with 6,664 RON ($2,777). This amount is followed by the South (9,375 RON or $3,906), the Northeast (9,527 RON or $3.970), the Southeast (10,572 RON or $4,405), Bucharest-Ilfov (11,582 RON or $4,826), the Northwest (12,673 RON or $5,280), the Southwest (13,198 RON or $5,499), and the Central (16,477 RON or $6,865).

FIGURE 16. LOAN AMOUNT DESIRED, BY REGION



6.7.9 COLLATERAL, BY REGION

When asked what type of collateral they have to offer, doctors in the Northwest are most likely to be able to offer land (12.5%), versus only 2.1% in Bucharest. Most family doctors are willing to offer whatever they purchase with the loan, as four-fifths (80%) of the doctors responded in the West. Guarantors are mentioned by a high of 14.7% of respondents in the South, but by none in the West. Over a quarter (25.3%) of doctors in the Southwest do not have any collateral. Those not wishing to offer any collateral are most often located in Bucharest (29.8%), followed by the Southeast (24.1%).

TABLE 63. TYPE OF COLLATERAL, BY REGION

Collateral	BI		C		NE		NW		SE		S		SW		W	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Land	1	2.1	5	7.9	8	7.8	5	12.5	2	3.4	3	4.0	7	8.4	1	2.2
Building	3	6.4	13	20.6	19	18.4	14	35.0	7	12.1	17	22.7	10	12.0	6	13.3
Equipment	2	4.3	9	14.3	5	4.9	2	5.0	7	12.1	6	8.0	4	4.8	-	-
Purchased equipment, building, or land	19	40.4	39	61.9	44	42.7	24	60.0	24	41.4	31	41.3	29	34.9	36	80.0
Guarantor	5	10.6	4	6.3	10	9.7	2	5.0	2	3.4	11	14.7	8	9.6	-	-
Do not have any collateral	3	6.4	1	1.6	14	13.6	1	2.5	8	13.8	8	10.7	21	25.3	1	2.2
Do not want to offer collateral	14	29.8	2	3.2	15	14.6	4	10.0	14	24.1	16	21.3	10	12.0	4	8.9
Total	**47**	*	**63**	*	**103**	*	**40**	*	**58**	*	**75**	*	**83**	*	**45**	*

7. ANALYSIS BY GENDER

The family doctor survey data also was analyzed by gender, with the objective of finding significant correlations related to the gender of the family doctors. The sample found that nearly 80% of family doctors are women. In most areas of analysis, however, the differences between men and women in their responses are not significant. This section is a sample of some key findings.

TABLE 64. GENDER OF THE FAMILY DOCTORS

	Absolute number	Percentage
Male	259	21.3
Female	956	78.7
Total	**1,215**	**100**

7.1 CHARACTERISTICS OF PRIVATE PRACTICE, BY GENDER

The study found that men are more likely than women to partner with others in their practice. Of women, 94% are in individual practices whereas 88% of men are in such a practice.

7.2 SERVICE PROVISION, BY GENDER

7.2.1 CLIENT VISITS PER MONTH, BY GENDER

The average number of client visits in the last month is 35 visits higher for women (589 client visits) compared to men (554).

TABLE 65. TOTAL NUMBER OF CLIENT VISITS IN THE LAST MONTH, BY GENDER

	Male	Female
Mean value	553.64	588.66
Median value	520	570
Modal value	400*	600
Standard deviation	252.679	218.876
Minimum value	71	0
Maximum value	1,700	1,685

*Multiple modes exist. The smallest value is shown.

7.2.2 NUMBER OF FAMILY PLANNING CONSULTATIONS IN THE LAST MONTH, BY GENDER

The average number of family planning consultations in the last month is 3 higher for women family doctors than for men (12 versus 9.)

7.3 REVENUE, EXPENSES, AND REINVESTMENT, BY GENDER

7.3.1 MONTHLY REVENUE, BY GENDER

Men tend to earn more than women in their medical practices. The value of revenues obtained from the NHIH contract is identical in both genders, consisting of between 2,500 RON ($1,025) and 3,499 RON ($1,434). Men are more likely than women to have revenues from non-contracted services. Nearly 74% of male family doctors and 69% of female family doctors have revenues from services the NHIH contract does not cover. The average monthly income by source was extrapolated from the data into the findings presented in the following table.

TABLE 66. AVERAGE TOTAL PRACTICE REVENUE (RON), BY GENDER

	NHIH-contract revenue	Non-NHIH services revenue	Sponsorship revenue	Total revenue
Female	3,149	163	41	3,353
Male	3,219	243	50	3,512
Total	**3,164**	**180**	**43**	**3,387**

7.3.2 BUSINESS EXPENSES, BY GENDER

The survey found that men have higher expenses than women. The extrapolated mean of practice expenses for women was 2,059 RON ($844) per month. For men the average was 2,160 RON ($885) per month.

7.3.3 HOUSEHOLD INCOME AND EXPENSES, BY GENDER

Male and female family doctors have similar household income and expenses. See the general findings for details.

7.4 FAMILY DOCTORS ATTITUDES TOWARD THE NHIH CONTRACT, BY GENDER

7.4.1 IMPACT OF THE NHIH CONTRACT, BY GENDER

Male family doctors are more likely than female ones to view the NHIH contract positively, with 50.4% of males and 45.8% of females stating that the NHIH contract has a positive impact on their private practices. When asked what are the positive benefits of the contract, men and women have the following responses.

TABLE 67. POSITIVE BENEFITS OF THE NHIH CONTRACT, BY GENDER

Category	Male		Female	
	No.	%	No.	%
Total monthly revenues	135	52.1	447	46.8
Consistent monthly revenue	141	54.4	480	50.2
Number of patients	96	37.1	339	35.5
Expanding the private practice	66	25.5	208	21.8
Access to training	81	31.3	280	29.3
Access to financing	44	17.0	137	14.3
Access to facilities	49	18.9	150	15.7
Total	**259**	*	**956**	*

** The question allowed multiple answers.*

When asked what changes should be made to improve the contract, men and women have nearly identical responses. See the general findings for details.

7.5 PROFITABILITY AND EXPANSION PLANS, BY GENDER

7.5.1 OBSTACLES TO PROFITABILITY, BY GENDER

When asked what is the main obstacle to profitability in their practices, men are more likely than women to say that they are not compensated adequately for their services. Women are more likely to find their inability to negotiate the contract with the NHIH a barrier than are men.

TABLE 68. THE MAIN OBSTACLES IN THE WAY OF RUNNING A PROFITABLE PRACTICE

The main obstacles in the way of running a profitable practice	Gender				Total	
	Male		Female			
	No.	%	No.	%	No.	%
Lack of business skills	9	3.5	43	4.5	52	4.3
Employees lack business skills	0	-	2	0.2	2	0.2
Increased competition	4	1.6	7	0.7	11	0.9
Low demand for paid services	0	-	1	0.1	1	0.1
Lack of professionalism in some employees	0	-	2	0.2	2	0.2
Constraints in the use of the office	8	3.1	33	3.5	41	3.4
Low income of patients	23	9.0	87	9.1	110	9.1
Services are not paid accordingly or enough	144	56.3	483	50.6	627	51.8
Terms of the NHIH contract are not actually negotiated	24	9.4	111	11.6	135	11.1
Excessive red tape concerning reporting and deductions	16	6.3	85	8.9	101	8.3
No obstacles	15	5.9	39	4.1	54	4.5
High wages	3	1.2	7	0.7	10	0.8
High cost of supplies	0	-	1	0.1	1	0.1
Lack of reliable suppliers	1	0.4	1	0.1	2	0.2
Insufficient continuous-training programs	1	0.4	3	0.3	4	0.3
High income taxes	4	1.6	32	3.4	36	3.0
Lack of access to financing	3	1.2	15	1.6	18	1.5
More than one obstacle	1	0.4	3	0.3	4	0.3
Total	**256**	**100**	**955**	**100**	**1,211**	**100**

7.6 TRAINING NEEDS ASSESSMENT, BY GENDER

7.6.1 INTEREST IN FUTURE TRAINING, BY GENDER

When given an opportunity to list training topics that would be important to their business, women are more likely than men (63% and 52% respectively) to be interested in business-management training. They are also more likely to cite clinical training. In other topics their interest levels are similar.

TABLE 69. FUTURE TRAINING DESIRED BY FAMILY DOCTORS, BY GENDER

Type of training	Male		Female	
	No.	%	No.	%
Stock control	21	8.1	95	9.9
Bookkeeping	49	18.9	224	23.4
Business management	135	52.1	598	62.6
Marketing	48	18.5	262	27.4
Financial management	87	33.6	357	37.3
Clinical training	165	63.7	684	71.5
Not sure	3	1.2	9	0.9
Do not need further training	30	11.6	36	3.8
Other	6	2.3	25	2.6
Total	**259**	*	**956**	*

When asked what is the most important training needed, both cite clinical, business management, and financial management in that order.

7.7 FINANCING NEEDS ASSESSMENT, BY GENDER

7.7.1 CREDIT EXPERIENCE, BY GENDER

Men and women used the last loan they received in similar ways. Men are more likely to have purchased a building or land (20%) than women (13%). Women are more likely to have purchased a car than men. Perhaps because of this behavior, women are also more likely to have received financing from a leasing company (25%) than men (16%). Men were more likely to have received a bank loan than women.

TABLE 70. HOW FAMILY DOCTORS WOULD USE A LOAN IN THE FUTURE, BY GENDER

	Male		Female	
	No.	%	No.	%
Invest in practice (such as refurbishment or equipment)	40	31.3	145	29.4
Buy a building or land	26	20.3	65	13.2
Buy a car	52	40.6	219	44.4
Personal needs or long-term-use products	20	15.6	95	19.3
Training	1	0.8	8	1.6
Pay taxes	3	2.3	9	1.8
Buy a computer	0	-	5	1.0
Other personal needs	2	1.6	7	1.4
Total	**128**	*	**493**	*

In the past men have borrowed higher amounts, with their most recent loans valuing 30,005 RON ($11,486) on average. In contrast, women's most recent loan has an average value of 24,710 RON ($9,459).

7.7.2 INTEREST IN A FUTURE LOAN, BY GENDER

Female family doctors (43%) are more likely than their male counterparts (40%) to be interested in borrowing now for their business. Of those who wish to borrow now, men would like a higher average loan amount of 13,286 RON ($5,445) compared to women who wish to borrow 10,687 RON ($4,380) on average.

Of those who wish to grow their businesses and purchase equipment to do so, women are more likely to want to purchase an electrocardiograph (66%) compared to men (58%) and men are more likely to want to purchase a sonograph (54%) than women family doctors (41%). Women have a higher demand for tensiometers (26%) than men (16%). Other levels of demand for equipment are similar between the genders. See the general findings for details.

8. FINDINGS ON OB/GYN PRACTICES, MEDICAL CLINICS, PHARMACIES, AND DISTRIBUTORS

Research on OB/GYN practices, medical clinics, pharmacies, and distributors was conducted using a literature review of public documents (when such data was available) and focus-group discussions.

8.1 OB/GYN PRACTICES

Obstetric and gynecologic physicians are specialists who focus on reproductive health, family planning, pregnancy, and delivery. As of the end of 2005, there were 1,014 private OB/GYN practices in Romania, more than 85% of which did not have a contract to provide services under the national insurance plan.[23] (See Annex A for the district distribution of OB/GYN practices.)

Focus groups held in Bucharest (a wealthy district) and Iasi (a poorer economic location), indicated that OB/GYN specialists are running profitable businesses, which they intend to grow. They primarily would like to purchase new equipment and also are interested in developing their facilities and services. OB/GYNs are interested in maintaining high standards and believe that the role of the private sector is to set the standards for quality service and care in the profession. Potential changes in requirements for facilities as a result of European Union accession may require additional investment in their practices. Some of them mentioned a desire to use existing equipment more efficiently by partnering with other professionals who also may use the equipment, thus maximizing its usefulness.

TABLE 71. NUMBER OF OB/GYN PRACTICES IN ROMANIA[24]

Status of the offices	OB/GYN offices
Under contract with the NHIH	155
Not under contract with the NHIH	862
Total	**1,014**

These OB/GYN physicians count among their main obstacles to business growth the high cost of investment for the equipment necessary for their practices, the high cost of purchasing or renting facilities, and a shortage of trained supporting health professionals.

8.1.1 GROWING OB/GYN PRACTICES

During the focus-group discussions, OB/GYN participants were asked to cite factors that allow them to become more profitable and sustainable. Participants mentioned a number of factors.

- *Creating an association between practices to use the same administrative facilities and equipment*—This approach could help their future financial health, in terms of necessary investments (some OB/GYNs have made steps towards building partnerships).

[23] The Romanian National Centre for Organizing and Providing Data and Information within the Health System, 2006.

[24] Ibid.

- *Changing the economic legislative framework*—Focus group participants would like a tax exemption for practices that reinvest profits. This policy will encourage investment in new equipment.
- *Tackling the economic constraints that are prevalent in some regions*—OB/GYNs believe that low incomes and economic development constraints hurt the underlying population, which in turn affects the medical practices. They would like the state to be more proactive in addressing these constraints.
- *Training in financial management*—Most of the participants stated that it is important to attend courses organized for physicians who manage private practices, as many physicians have to decide whether to take big loans for investment based on the financial status of their practice and the advice provided by their accountant. Almost all OB/GYNs said that this need has to be addressed soon because increasingly they will have to be managers and not only physicians.

8.1.2 CREDIT EXPERIENCE AND CURRENT FINANCING NEEDS

An important finding of the focus groups and interviews is that OB/GYN physicians regard credit as a useful and accessible tool for financing their business development. Unlike other groups of businesses, these practice owners have experience in borrowing and financing from diverse sources, including leasing companies, banks, and equipment suppliers. In terms of their attitudes toward borrowing, they recognize that lending institutions have become more competitive in their rates and terms, and they claim that the personal relationship with the banker is important to them, although they still find the process bureaucratic. OB/GYNs have optimistic outlooks on their business prospects and have hopes to purchase new equipment with loans of over 60,000 RON ($24,590), and repayment terms of more than five years.

8.1.3 OPPORTUNITIES AND THREATS

Findings from the focus groups and marketing information indicate that opportunities for OB/GYN private practices include the following.

- There is continuously increasing demand for quality private medical services coming from an ever-growing middle class. If these practices can develop a comparative advantage and carve out a market niche by adapting to demand, adding specialized services, or targeting a specific population, they will be able to grow with the market. Some providers have reacted to the changes in the market by associating with other providers, either in group practice or by sharing equipment, facilities, and services (such as administration). Knowledge of financial management is essential for those physicians and owners of private practices who would like to enter into a joint venture with other colleagues.
- The recent accession of Romania into the European Union has opened the doors for all European suppliers of medical equipment. It is expected that over the next one to two years the competition between these suppliers will increase and prices and payment terms will improve for health providers in private and public practice.

There are some important threats, however:

- Starting a practice requires a large investment. The process of a young physician establishing a private practice would be challenging financially. Without serious financial support from sources other than lending institutions, it is difficult to think that banks will be eager to offer loans of 50,000 Euro ($67,568) based only on a good business plan. This difficulty is mostly due to the disparities between the existing levels of earnings of the medical personnel and the prices of equipment and facilities.

- Competition is developing from medical centers organized as networks at the national and regional levels.

8.2 MEDICAL CLINICS

Commercial medical clinics are expanding in an increasingly competitive market. At the end of 2005, there were 291 private medical clinics and centers registered nationwide.[25] Medical clinics are private medical facilities that may be operated by an individual doctor or several doctors. Clinics may provide in-patient and outpatient services.

Medical clinics that participated in this research can be divided into two subgroups: those that specialize in family planning (also known as family planning clinics) and those that are general medical service providers. For the purposes of this study, the results are presented separately as their business models, financing and training needs, and opportunities and threats are different.

8.2.1 GENERAL SERVICE MEDICAL CLINICS

These medical clinics generally do not operate under contract with the NHIH, but rather they earn revenues from corporate subscriptions or clients paying directly for services out of pocket. Some medical clinics have OB/GYN specialists as one member of a specialist group practice. The larger facilities focus on primary health care with family planning as only a small part of their total services. The large medical centers see the family planning services as a by-product in the process of delivering OB/GYN services.

8.2.2 GROWING MEDICAL CLINICS

This subsector is an expanding, competitive, growing market, with quality goals to maintain competitiveness and meet the demand of the growing middle class.

8.2.3 OPPORTUNITIES AND THREATS

When asked what their greatest obstacles to business development are, clinic managers and owners cited the lack of qualified personnel, the unclear package of services to be supplied through the national health system, and informal payments in the public sector. There are some specific human resource needs that are not met in the Romanian health system; for example it is hard to find a well-trained medical receptionist or medical secretary. As in all sectors of the growing Romanian economy, wages are rising and qualified professionals are in high demand.

It can be difficult for the private sector to compete with the public one. As a result many private providers are looking to create market niches that do not compete with the public sector. Clinic managers would like clarification regarding the future development of the national health system from the MoPH so that they can invest with confidence in areas the public system does not cover. One example of how MoPH action affects private-sector investment is in emergency services. One of the centers explained that in 2005–2006 it was thinking of strengthening its emergency services by investing in ambulances and equipment, but management learned in due time that the MoPH was about to invest in emergency services. As a consequence the private clinic dropped all the development plans and feasibility studies.

[25] The Romanian National Trade Register Office, 2006.

Lastly private clinic owners claim that informal payments made in the public sector lure good doctors into that (tax-free) environment instead of into the formal sector of employed work with a medical clinic or a private hospital. These informal payments, which continue to haunt the system, distort public perception: some services that are meant to be free are not. Yet there is no clear way for the public to compare prices, which private clinics find to be unfair.

8.2.4 CREDIT EXPERIENCE AND CURRENT FINANCING NEEDS

Medical clinics have large credit needs, primarily to invest in facilities and equipment, with loans of over 60,000 RON ($24,590) and more than five-year terms. They have property and equipment to offer for collateral. They do not rely on supplier credit, as their use of consumables and pharmaceutical supplies is limited. They have used bank loans in the past and all were familiar with Libra Bank's specialized products for the medical sector.

8.3 FAMILY PLANNING CLINICS

Small private family planning clinics claim to be operating profitably but with low levels of revenue. These clinics, often affiliated with NGOs, have been important outlets for family planning and reproductive health products and services, particularly in the early years of health reform when access was a huge impediment to women.

8.3.1 STRUGGLING FAMILY PLANNING CLINICS

As of late 2006, there were fewer than 20 such clinics in Romania. As their incomes decrease those that historically have benefited from donor support are facing difficult choices to maintain services and their social mission while covering costs. Now, with trained family doctors in rural areas providing MoPH-supplied contraceptives and counseling and greater access even at the specialist and pharmacy levels, these clinics are less vital to women's access to family planning.

8.3.2 CREDIT EXPERIENCE AND CURRENT FINANCING NEEDS

Family planning clinics' financing needs are in the ranges of 2,500 to 5,000 euro ($3,378 to $6,757) for terms of two to five years, for working capital and facility upgrades.

8.3.3 OPPORTUNITIES AND THREATS

Family planning clinics' obstacles to business growth include increasing competition and low levels of funding. They perceive fewer prospects for business growth than the general clinics and are redefining their business models and seeking sustainable roles in women's health care. These clinics are considering adding OB/GYN services and offering laboratory services and other diverse services to provide a more complete package in the hopes of becoming financially viable.

To summarize, the following opportunities exist in the market for medical clinics.

- The medical-services field has changed dramatically in the last 10 years, with more consumers seeking the quality of services that the private sector provides.
- With economic growth ranging from 7 to 9% in recent years, incomes are rising and thus private-sector opportunities are growing.
- The minimum package of services the NHIH provides has gaps where private providers may step in.
- While private health insurance as defined in some Western countries is not yet fully developed in Romania, legislation is being debated that offers promise to private facilities for future growth.

- Private health coverage schemes that private sector employers offer are becoming popular.

The following threats exist in the market for private medical clinics.

- Legislative volatility: The legal framework applicable to companies providing medical services changes frequently.
- The absence of a defined minimum package of services by the MoPH makes it hard for them to plan.
- Private investors are hesitant to make massive investments in the sector because there is a risk of loss if the public sector should step into that area.
- There is a shortage of trained medical personnel to fuel growth.
- For family planning clinics, increased competition from public and private sources and the withdrawal of donor funding is causing some entities to rethink their business models.

8.4 PHARMACIES

In 2004, 4,772 pharmacies and 617 pharmaceutical points were registered in Romania.[26] Pharmacies are important distribution points for family planning products. Among these entities, at least 90% are privately owned (4,268 are private and 504 pharmacies are public). Among the pharmaceutical points, 592 points are private and only 25 points are public. In 2004, 8,763 pharmacists were registered, of which 8,026 were women (92%). See Annex B for a distribution at the district level of pharmacies and pharmacists.[27]

TABLE 72. THE DISTRIBUTION PHARMACIES AND PHARMACISTS

District	Public pharmacies	Private pharmacies	Total pharmacists	Female pharmacists
TOTAL	**529**	**5,282**	**8,763**	**8,026**

8.4.1 STRUGGLING INDEPENDENT PHARMACIES

In late 2006 several serious obstacles to business development plagued independent pharmacies in rural areas. Rural pharmacies, almost all of which are independently owned, are suffering from low profit margins and a challenging reimbursement and supply situation, depending on expensive supplier credit to address their cashflow needs while awaiting reimbursement for NHIH-covered medications. In focus groups, the biggest impediments described included

- *the low level of the margins in this field of activity*—this problem is related to the compensation the NHIH allows for medicines
- *the low economic status of the rural population where they are located*
- *the method in 2006 of calculating the value of stocks of medicines* this downgraded their value accepted for sale and accordingly resulted in a loss of profit for pharmacies without effecting the cost to consumers

[26] A pharmaceutical point is a temporary distribution point, usually operating on a weekly basis, often in rural areas, by pharmacy owners who travel to that area to distribute and sell medicines.
[27] Romanian National Institute of Statistics. 2005. Statistical Yearbook 2005. Bucharest.

- *the NHIH allocates the fund for compensated prescriptions using as the only criterion the number of pharmacists each pharmacy employs*—pharmacy managers suggest that an allocation of the fund should consider more than one criterion; among the most important ones to consider is the size of the population accessing the services of each pharmacy (This is particularly important for rural pharmacies; such a reform could benefit rural residents who may have to travel to urban centres to obtain medications. This measure would most easily be implemented for rural pharmacies that have a more delimited population accessing their services than their urban counterparts.)
- *the slow compensation cycle from the government*—pharmacy managers claim that the NHIH has a two-to-three-month payment cycle for reimbursing the pharmacies for medicines that are compensated under the plan
- *the high salaries newly graduated pharmacists that are entering the labour market demand*—managers put some blame on high expectations generated by big pharmacy chains (this trend is true of the average levels of salary in this subsector which are rising, as are all wages in Romania)
- *the policy and legislative environment*—pharmacists claim that legislation changes too frequently and new policies are not sufficiently promoted within the industry and among the general population

8.4.2 GROWING PRIVATE PHARMACIES

Despite many of the challenges that confront pharmacies, most pharmacists are interested in growing and developing their pharmacies, although usually to meet new compliance requirements the NHIH provides or those expected by membership in the European Union. This behavior reflects a reactive attitude where business development is seen as a means to comply with compulsory regulations.

Ideas that pharmacists have to improve their businesses include

- refurbishing or upgrading the premises or facility
- hiring new personnel
- purchasing and providing customers with new generation drugs and improving their offering of pharmaceuticals more generally
- opening a new pharmacy or pharmaceutical sales-point

8.4.3 CREDIT EXPERIENCE AND CURRENT FINANCING NEEDS

Most pharmacists claim they are not profitable because of some of the problems described in this report. They stay in business because of their professional training and, in many cases, their sense of social obligation or family tradition of running the pharmacies in rural areas. In this situation they rely on supplier credit for financing and are hesitant to borrow. Rather, most are hopeful that the policy and regulatory environment will improve and allow them better payment terms, greater margins, and eventually the possibility for business growth. If their business conditions were to improve, most would be interested in loans in the range of 2,500 to 5,000 euros ($3,378 to $6,757), with two- to five-year payment terms for fixed assets and working capital.

8.4.4 OPPORTUNITIES AND THREATS

Opportunities for private pharmacies are closely tied to the NHIH contract, which is the foundation of their revenue. Pharmacists, most of whose businesses have a contract with the NHIH, believe that the NHIH could help them by better disseminating information to the general population regarding

- differences between commercial names (brands) and names of active substances in the medicines
- differences in price for the same medicine (referring only to those medicines for which the NHIH is reimbursing the pharmacy according to the national health insurance scheme) which might arise because of the compensation system
- differences between various products (made of the same active substance) and the necessity that the patient makes an informed choice towards one or another of the products
- pharmacy managers also are concerned that the software being implemented by each of the pharmacies as a prerequisite for entering a contractual relationship with NHIH is changed too often and the cost of the software is prohibitive for rural pharmacies.

8.5 DISTRIBUTORS

Private distributors differ in needs and profitability, as many are international and only a smaller set is nationally or regionally managed. At least five international distributors of family planning products operated in Romania in 2006.[28] In the case of internationally owned distributors, most marketing and business decisions are made outside of Romania, which hindered findings at the focus group level.

8.5.1 CREDIT EXPERIENCE AND CURRENT FINANCING NEEDS

National and regional distributors use credit in the form of credit lines from suppliers. Some use credit lines from banks. Most focus group participants were removed from financing and marketing decisions, which are made at the corporate level, outside of Romania, limiting the usefulness of the findings for this subsector.

8.5.2 OPPORTUNITIES AND THREATS

In terms of business opportunities, they would like to improve relations with family doctors. As there is a general perception that MoPH supplies of family planning products may cease after USAID's departure from Romania in 2008, distributors are more interested in the possibility of working with family doctors as outlets for their products.

They all claim to face difficulties with government payment schedules. In addition, they must offer payment terms to their clients that can hinder cashflow. Another obstacle to business growth according to focus group participants is the limited types of family planning products and brands that the government is willing to reimburse under the national insurance plan.

[28] At the time of publication, public data on the numbers of distributors of family planning products in Romania was not available.

9. CONCLUSIONS

This research focused on the financing and training needs of family doctors and other private providers and distributors of reproductive health and family planning products and services in Romania. While these needs may seem removed from the care of the population, they are directly linked to the provision of sustainable, quality care under a capitated health system. Credit has been linked directly to small firm's growth, including those in the medical sector.29 Access to finance can assist private providers to expand their services and invest in quality improvements.

Family doctors are struggling under the NHIH capitated health system to reinvest and improve their practices. They are surviving financially, but need additional inputs to improve their practices by purchasing equipment, renovating facilities, and adding services. Family doctors cited access to finance, better contract terms, ownership of facilities, and training as factors that can improve their practices. In addition to clinical training, business and financial management training is needed to help medical businesses operate in the private sector. OB/GYN specialists, distributors, and larger medical clinics are poised to grow and improve their practices with financing. Independent pharmacies, distributors, and family doctors would benefit from minor policy changes that would enable their businesses to function and improve their use of external finance.

Investing in a population's health is critical for improving livelihoods and creating sustainable, long-term economic transition. Recent reports by the World Health Organization have established that investment and improvement in essential health services contribute to poverty alleviation and economic growth.30 This moment is an exciting and opportune one for Romania in many ways: energy, hope, and technical and financial investments can have a catalytic effect that will be felt for years to come.

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

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

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

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29 Earle, J, and D. Brown, et al. 2002. What Makes Small Firms Grow: A Study of Success Factors for Small and Micro Enterprise Development in Romania. Bucharest: United States Agency for International Development/CEU Labor Project.

30 World Health Organization Regional Office for Europe and the Council of Europe Development Bank. 2006. Health and Economic Development in South-Eastern Europe. Paris.

ANNEX A: DISTRICT DISTRIBUTION OF OB/GYN PRACTICES IN ROMANIA

District	Not under NHIH contract	Practices with NHIH contract	Total
ALBA	11	0	11
ARAD	22	10	32
ARGES	24	1	25
BACAU	18	0	18
BIHOR	20	0	20
BISTRITA-NASAUD	16	0	16
BOTOSANI	12	0	12
BRAILA	10	0	10
BRASOV	17	4	21
BUZAU	2	0	2
CALARASI	7	2	9
CARAS-SEVERIN	8	11	19
CLUJ	20	6	26
CONSTANTA	39	6	45
COVASNA	3	1	4
DAMBOVITA	34	0	34
DOLJ	62	0	62
GALATI	17	0	17
GIURGIU	4	0	4
GORJ	18	0	18
HARGHITA	3	19	22
HUNEDOARA	27	4	31
IALOMITA	6	1	7
IASI	28	20	48
ILFOV	6	3	9
MARAMURES	18	4	22
MEHEDINTI	9	0	9
MURES	44	5	49
NEAMT	19	3	22
OLT	8	0	8
PRAHOVA	20	3	23
SALAJ	9	0	9
SATU MARE	14	0	14
SIBIU	16	1	17
SUCEAVA	28	17	45
TELEORMAN	12	2	14
TIMIS	46	5	51
TULCEA	7	1	8
VALCEA	21	1	22
VASLUI	12	0	12
VRANCEA	12	0	12
City of Bucharest	130	25	155
TOTAL	859	155	1014

ANNEX B: DISTRIBUTION OF PHARMACIES AND PHARMACISTS AT THE DISTRICT LEVEL, 2004

District	Public Pharmacies	Private Pharmacies	Pharmacists
Bacau	8	90	215
Botosani	10	35	107
Iasi	21	264	604
Neamt	6	85	181
Suceava	10	134	261
Vaslui	12	41	77
Braila	6	78	97
Buzau	15	72	103
Constanta	14	273	430
Galati	13	115	186
Tulcea	5	30	52
Vrancea	13	62	119
Arges	19	141	185
Calarasi	6	31	45
Dambovita	11	82	113
Giurgiu	7	16	50
Ialomita	5	15	48
Prahova	25	173	274
Teleorman	12	32	111
Dolj	18	119	259
Gorj	10	37	110
Mehedinti	11	38	103
Olt	8	36	116
Valcea	10	93	129
Arad	10	164	196
Caras-Severin	10	54	75
Hunedoara	15	82	215
Timis	22	375	337
Bihor	17	151	279
Bistrita-Nasaud	5	48	115
Cluj	26	288	598
Maramures	11	131	143
Satu-Mare	7	66	128
Salaj	5	43	77
Alba	11	64	204
Brasov	19	186	254
Covasna	5	29	75
Harghita	4	18	116
Mures	14	157	333
Sibiu	12	166	183
Ilfov	5	21	80
City of Bucharest	56	1147	1380
TOTAL	**529**	**5282**	**8763**

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