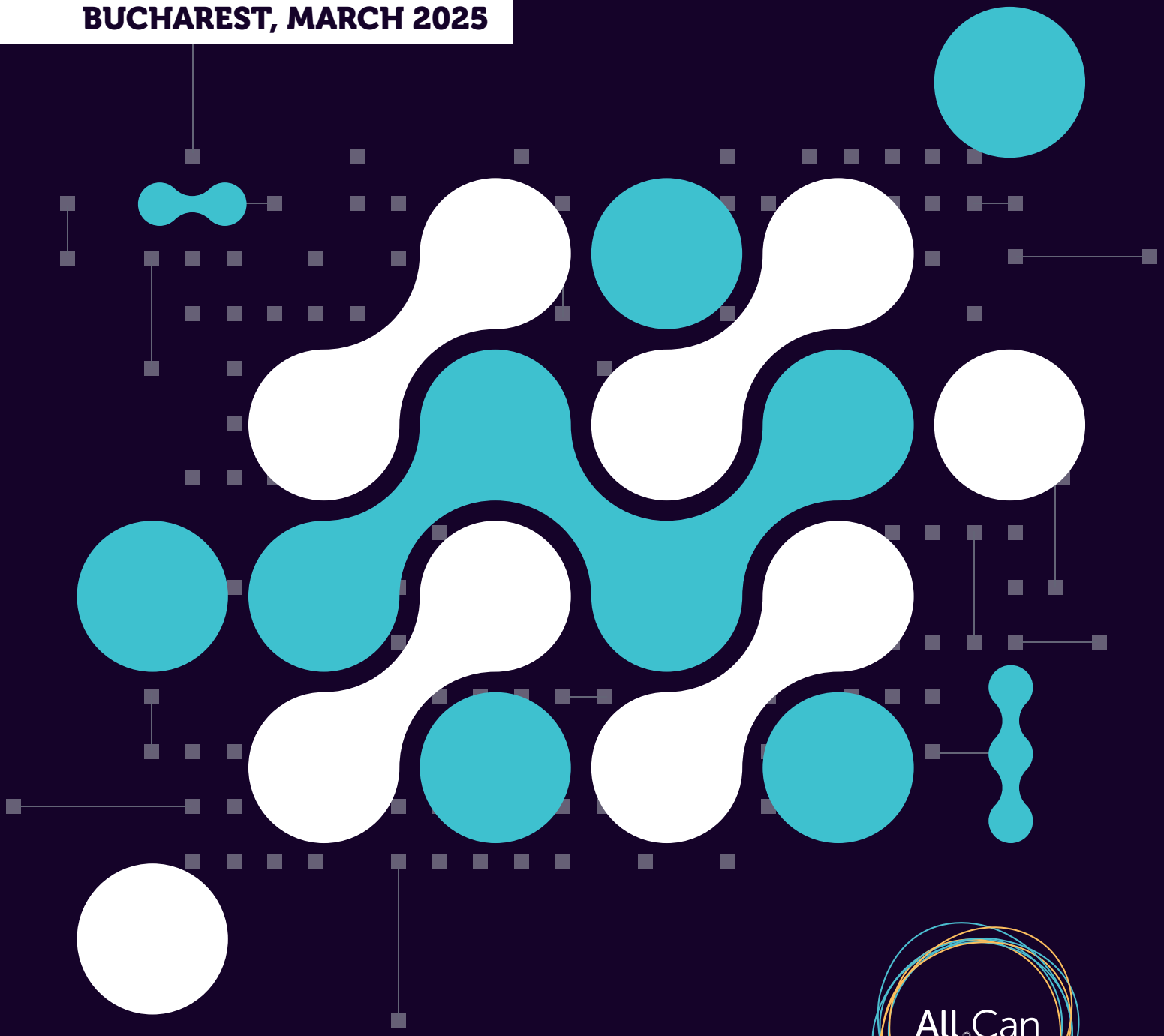
Improving Financing Mechanisms for Cancer Care in Romania,

supporting the implementation of the National Plan for Cancer Prevention and Control

BUCHAREST, MARCH 2025



REPORT PREPARED
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SUMMARY

This report analyzes the financing framework for healthcare services aimed at cancer patients and individuals exposed to modifiable cancer risk factors in Romania. The objective of the analysis is to present public authorities with proposals designed to enhance the efficiency and sustainability of the financing framework, as well as to improve access to and quality of services.

The assessment of the current situation covers the entire oncological clinical pathway, including health promotion and disease prevention measures (primary prevention), screening and early diagnosis (secondary prevention), curative measures to reduce disease complications and improve patients' quality of life (tertiary prevention), as well as palliative care. The topics addressed are specific to the healthcare system's financing component, namely budgeting and fund allocation mechanisms from payers to providers, the benefits included in service packages, and contracting and payment mechanisms.

At the same time, the analysis focuses on an international model of financing preventive and curative health services in oncology, namely the Netherlands, whose good practices were taken into account when developing the recommendations for our country.

Key Findings

The objectives and main action directions for cancer control and prevention in Romania are outlined in the National Plan for Cancer Prevention and Control (PNPCC)[1]. The implementation tools, namely medical services and the conditions for contracting, access, and payment, are established through the framework contract[2], national health programs[3], and their implementation norms[4]. The care included in these service packages covers the entire clinical pathway of patients, aiming to prevent cancer, reduce its incidence, morbidity, and mortality, and improve patients' quality of life. These services are funded by the National Health Insurance Fund (FNUASS) and, to a lesser extent, by the Ministry of Health's budget.

1. Adopted by Law no. 293/2022.
2. G.D. no. 521/2023 for the approval of the service packages and the Framework Contract regulating the conditions for providing medical assistance, medicines and medical devices, within the social health insurance system, with subsequent amendments and completions.
3. G.D. no. 423/2022 on the approval of national health programs, with subsequent amendments and completions.
4. WHO/NACO no. 1857/441/2023 on the approval of the Methodological Norms for the application of Government Decision no. 521/2023 for the approval of the service packages and the Framework Contract regulating the conditions for providing medical assistance, medicines and medical devices, within the social health insurance system.
OCNAS no. 180/2022 on the approval of the technical norms for the implementation of the national curative health programs, with subsequent amendments and completions.
WHO no. 964/2022 on the approval of the Technical Norms for the implementation of national public health programs, with subsequent amendments and completions.

The specific objectives of the PNPCC most relevant for the financing of services during the cancer therapeutic path are:

1. Early access to innovative therapies is authorized, but not yet included in the reimbursement list, for patients without therapeutic alternatives.

2. Reducing the time intervals between the authorization of new oncological therapies at the European level and their availability for patients in Romania.

3. Development and expansion at national level of population screening programs for the most common cancers, namely breast, lung, colorectal, uterine and prostate.

4. Development of care coordination mechanisms by:

a. Developing and approving standardized clinical pathways for the most common types of cancer;

b. Establishment of functional communication networks between the providers involved in the clinical pathways;

c. Use of patient navigators and case managers.

5. Developing the capacity for early diagnosis of suspected cases, involving a minimum logistical effort of the patient.

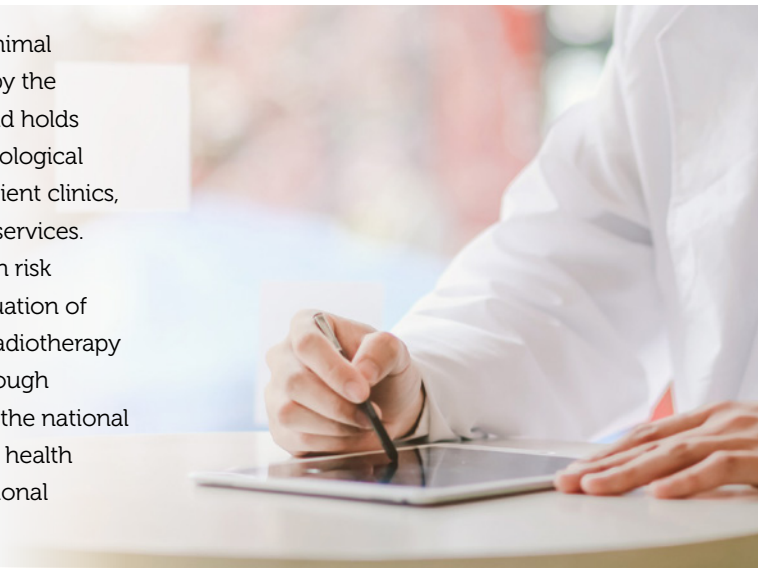
6. Increasing access to antineoplastic therapies and reducing the time between diagnosis and first administration.

7. Development of palliative care in an integrated framework at the territorial level with provision in health units with beds, outpatient and home care

8. Increasing the vaccination coverage anti-HPV and anti-HBV.

9. Development of radiotherapy services in terms of technology and territorial coverage.

The framework contract sets out the content of the basic and minimal packages of services, financed from the FNUASS and contracted by the health insurance funds. The first is available to insured persons and holds preventive and curative services that cover a large part of the oncological clinical pathway in primary health care, specialized clinical outpatient clinics, specialized paraclinical outpatient clinics, hospitals and palliative services. In 2024, there was a major development of the two packages with risk assessment services and grouped services for diagnosis and evaluation of cancer extension for over 30 types and localizations. Medicines, radiotherapy services, genetic testing and PET-CT monitoring are provided through national curative health programs. Starting with September 2024, the national palliative care program was regulated, within Law no. 95/2006 on health reform[5], which is to be detailed by the technical norms of the national curative health programs.



Starting with 2024, uninsured persons are also entitled to the same cancer care services as insured persons. Within the minimal package of services, they can receive help from risk assessment services and grouped services for diagnosis and evaluation, and in case of a positive result, they are included in the National Oncology Program. During the period of inclusion in the program, patients are insured in the social health insurance system.

In primary and secondary prevention, two interventions financed from the budget of the Ministry of Health are distinguished: the National Program for Health Evaluation and Promotion and Health Education and the National Program for Population Screening. They are implemented through the National Institute of Public Health.

The report found and quantified the expenses made from public sources in 2023 with the services provided along the clinical pathway in oncology. The analysis adopted the perspective of the payer, respectively FNUASS or MoH. The expenses included in national health programs were traceable in the reports of the implementing institutions. Expenditure on day or continuous hospitalization services was found by the diagnostic code associated with each minimum set of data reported by the health units and relevant information was obtained from the National Institute for Health Services Management. As regards primary health care, specialized clinical and paraclinical outpatient clinics and home palliation, the amounts reimbursed for services provided to patients with suspected or diagnosed cancer could not be isolated from the total but were estimated. The payments from the FNUASS for hospital services in public health units were adjusted with amounts broken down directly proportional from the subsidies to cover the cost of salary increases and from the amounts transferred on a contract basis for supplementing the food allowance, holiday vouchers and allowances paid to specialized personnel with clinical integration.

In 2023, payments worth 1 bln. RON for the National Program for Health Evaluation and Promotion and Health Education and payments worth of 2 bln. RON for the subprogram for population screening of cervical cancer were made from the national public health programs.

In 2023, payments worth 6.3 bln RON were made from the national curative health programs for cancer patients. The funds came from the National Oncology Program, from the separate allocations for antineoplastic drugs included in cost-volume contracts and from PET-CT investigations. Of the total amount, drugs accounted for 93% of the funds, radiotherapy 5%, and the rest for PET-CT investigations, genetic testing and breast reconstruction. The genetic testing subprograms, which were significantly expanded in 2023, attracted reduced resources, probably requiring a longer period to adapt the offer of health units.

5. By G.E.O. no. 106/2024 on the amendment and completion of Law no. 95/2006 on health reform, as well as for amending and supplementing certain normative acts with an impact on health.

Given that in national curative health programs "funding follows the patient", the territorial distribution of expenses on medicines and radiotherapy services shows where patients are going and where the most frequented treatment centres are located. In 2023, for medicines, only seven counties recorded values higher than the national average per capita, of which Bucharest, Cluj and Timiș stood out. For radiotherapy, less than half of the health insurance houses have contracted services with providers located in their territory. Among them, Bucharest, Ilfov, Cluj and Timiș stood out.

In 2023, 1.1 billion services were provided in day hospitalization for 185 thousand patients diagnosed with cancer. The adjusted payments for services were estimated at 610 bln. RON, respectively 18% of the total adjusted payments of the FNUASS with day hospitalization services. The average unit cost of FNUASS with a day hospitalization service for oncology patients was 565 RON.

In 2023, 370 thousand episodes of care were performed in continuous hospitalization for 205 thousand patients diagnosed with cancer. Of these, 96% were acute cases and 4% were chronic. On average, each patient had 1.8 episodes of hospitalization; for chronic cases, the value was lower, at 1.5 episodes per patient. The episodes lasted an average of 6 days for acute cases and 15.5 days for chronic cases. In the structure of chronic cases, palliative services numbered 11.4 thousand, with an average duration of hospitalization of 16 days. The adjusted payments from the FNUASS with continuous hospitalization services were estimated at 1.45 bln. RON, of which 92.5% of the expenses went to acute care, 6.5% to palliative care and 1% to other chronic care. These amounts represent 6% of the total adjusted payments of the FNUASS with continuous hospitalization services.

The average unit cost of the FNUASS with an episode of hospitalization for oncology patients was 3,928 RON.

In 2023, the adjusted payments summed up from the FNUASS for day hospitalization and continuous hospitalization services totalled 2.06 bln. RON. In terms of structure, the top 10 tumour locations used more than half of the amount, with the largest shares being cancers of the female genital organs, breast, lung and colon cancers.

In 2023, following the sum of the expenses from the national health programs, with those of hospital services and with those estimated at other levels of medical assistance, the estimated total financial effort of the FNUASS and MoH for the entire clinical pathway in oncology stood at 9.4 bln. RON, of which the quasi-unanimity was covered by the social health insurance system. The projections regarding the financing needs indicate expenses of approximately 10.5 bln. RON in 2024 and 12.3 bln. RON in 2025. Under these conditions, the shares of costs with the clinical pathway in oncology in the total FNUASS and GDP would stand at 17% and 0.6%, respectively.

So, de jure, Romanians enjoy benefits throughout the oncological clinical pathway, provided through the national health programs, the basic service package and the minimal service package. However, the analysis of the financing of the clinical pathway allowed the comparison between the provisions of the regulatory framework and the payments made, which are an indirect indicator of the development and real access to services and of the distribution of human and technological resources. The following findings were made:

1

Public health promotion programs are underfunded and poorly developed.

2

Oncology risk assessment in primary health care is insufficient, due to the low number of preventive consultations.

3

Systematic testing of asymptomatic people and early detection are underdeveloped, amid the almost total lack of national population screening programs[6]**.**

4

Service packages are fragmented. The amounts allocated at the national and county levels are difficult to access. The contracting conditions, the payment mechanisms and the payment terms provided by them are different, which amplifies the administrative burdens, complexity and opacity of the clinical pathway. The fragmentation jeopardizes (i) the PNPCC's objective of developing "one-stop-shop(s), through which sets of related services are performed by the same provider in the same episode of care and reimbursed by payment per grouped service", as well as (ii) the establishment of integrated oncological disease management networks, as provided for in the National Health Strategy.

5

Some services are incompletely developed at the national level (e.g. health promotion, population screening, genetic testing, radiotherapy, palliative services), others have uneven coverage at the inter-county level (chemotherapy administration and monitoring, radiotherapy), and specialist doctors are unevenly distributed at the territorial level (oncologists, radiotherapists, radiologists and pathologists).

6

The coordination of providers and the therapeutic conduct prescribed by them is deficient because neither the family doctors nor the attending oncologist are being paid for this role. The clinical pathway lacks two functions that could systemically remedy the fragmentation of providers, namely the case manager and the patient navigator. The lack of completion of the electronic health file and the lack of concrete clinical pathways, of the electronic referral and appointment system contribute to the poor coordination.

6. The report noted the implementation, in 2020-2023, of regional population screening projects for cervical, breast and colorectal cancer, co-financed by non-reimbursable external funds. However, they were not followed by the national expansion until the date of the analysis.

7

Payment mechanisms do not encourage providers towards the behaviours and capacities necessary to meet national health objectives. Proven expertise, previous performance, use of good practices provided in guides and protocols, and extension to unserved areas are missing from the conditions of supplier selection and are not encouraged by charging systems. Payments from FNUASS to public hospitals are extremely fragmented and a large part of them are independent of the medical activity performed.

8

Access to new cancer medicines is delayed for multiple reasons, including the marketing pricing mechanism, methodology for health technology assesments, capping the annual value of cost-volume/cost-volume-result contracts negotiated and signed, capping the volume of medicines dispensed through closed-circuit pharmacies.

9

The bureaucracy is excessive, and the process of purchasing sanitary materials and medicines is too long, either because of the regulations in force or because of the lack of support staff.

10

The patient wastes the longest time during the diagnosis process because the list of healthcare providers who have funds available for the tests to be carried out is not clear and there are cases where doctors do not know where to redirect patients.

11

There are areas without doctors and with an uninsured population, where an important role is played by community nurses, but either their number is insufficient or they are not sufficiently motivated to remain in those positions.

RECOMMENDATIONS

Cancer prevention and control is a particularly complex pillar of the health system which uses all of its components, from governance, to service delivery, provision of human, informational and technological resources and financing. The pillar does not exist independently of the rest of the health system, but interferes with its mechanisms at all stages of the clinical pathway.

Under these circumstances, the recommendations regarding the financing of the oncological clinical pathway presented in this report can be classified into two categories: (1) general, with potential effects broader than the prevention and fight against cancer, perhaps even at the level of the health system, and (2) specific, with effects at the level of the analyzed pathology. The recommendations concern the established components of health services financing: their allocation revenues, the content of service packages, contracting and payment mechanisms. From the point of view of the purpose pursued, the recommendations are likely to improve the efficiency of the organization and provision of services on the clinical pathway, the sustainability of the available financial resources and patients' access to preventive interventions and curative care. Although some of these will require additional financial resources - such as those related to patient navigators, case managers, population screening, and contracting all drugs with a conditional inclusion decision - they will create premises for efficiency gains in other phases of the clinical pathway.

The following recommendations are proposed for implementation in the short term (2024-2025):

1. Improving the budget management of the FNUASS by

a. approving the limits of the budget allocations for the FNUASS to be made for at least 3 months instead of one month, as currently provided for in G.E.O. no. 34/2023;
b. publication on the National Health Insurance House (CNAS) website of the updated budget sheets approved for each territorial health insurance house, as well as the amounts contracted by them on budget programs, subdivisions of the budget classification, including details on national health programs and their subprograms;
c. substantiating the financing needs of the national curative health programs and by taking into account the medicines with a decision of reimbursement, but which are not yet in the Reimbursed List at the time of preparing the draft budget.

2. Revision of the list of consultations reimbursed by service tariff in primary health care, by transferring those for simple monitoring of patients with chronic diseases to the list of consultations reimbursed by the per capita tariff, which can also be carried out remotely. In this way, family doctors will be incentivized to replace them with preventive consultations and other services that they do not currently provide on a large scale (case management, home consultations, diagnostic and therapeutic services).

3. Establishing the annual ceiling for contracting conditional medicines through a dialogue mechanism between NHIH, MoH and the Ministry of Finance, taking into account the contractual value of therapies that are already in cost-volume/cost-volume-result contracts, as well as those that have received a conditional inclusion decision, but have not yet been the subject of negotiation.

4. Setting a maximum deadline from the issuance of the decision to inclusion in the List of 3 months for medicines with an unconditional inclusion decision and 6 months for those with a conditional inclusion decision.

5. Consultation of all stakeholders on the mechanisms for selecting, financing and implementing the protocols for early access to reimbursement, regulated by G.E.O. no. 106/2024.[7]

6. Transfer of the vaccination service for vaccines from sublist E (compensated vaccines) to the package of basic services in primary health care or in the specialized clinical outpatient clinic, where the vaccinator is located. In primary healthcare, the vaccination service would be associated with preventive consultations offered to eligible patients, and their rates would be updated accordingly. We also propose to grant a bonus for vaccination performance, similar to the one granted for performing risk assessments in adults aged at least 40 years.

In the medium term, the following recommendations are proposed to be implemented:

Most of the measures promoted by the National Plan for Preventing and Combating Cancer, as well as the recommendations formulated in this report, **involve increasing the financial resources allocated from the FNUASS and the budget of the Ministry of Health for oncological care.** These additional needs are in addition to those arising from other high-prevalence therapeutic areas (e.g. diabetes, cardiovascular diseases, neurological diseases) and other components of the health system (increase in service tariffs, reimbursement of new medical technologies, expansion of the package of basic services, etc.). To meet them, Romania could capitalize on the fiscal potential represented by informal work and people who earn income, but benefit from health insurance without contributing. According to reports by the World Bank and the Fiscal Council, **improving the collection of direct taxes, including social health insurance contributions,** and expanding the tax base are some of the solutions that can ensure the long-term sustainability of the social health insurance system[8].

The selection of providers with which health insurance companies contract health services should also include criteria for evaluating results – for example, cases, waiting times, previous clinical outcomes - and the implementation of good practices (in cancer, these could be the establishment of therapeutic conduct in the multidisciplinary commission - tumour board - and the hiring of patient navigators and case managers).

7. G.E.O. no. 106/2024 on the amendment and completion of Law no. 95/2006 on health reform, as well as for amending and supplementing certain normative acts with an impact on health.
8. Ministry of Finance, Report on the tax system in Romania, including benchmarking and recommendations for the reform of the tax framework, prepared by the World Bank, 2023, RaportprivindsistemulfiscaldinRomania_BM.pdf (gov.ro).
Fiscal Council, Fiscal Consolidation and Tax Revenue Growth – Vital Necessity for Romania's Economic Stability and Security, 2022, Fiscal Consolidation and Tax Revenue Growth – Vital Necessity for României.pdf's Economic Stability and Security (consiliulfiscal.ro).

Developing the capacity for program management, management of supplier networks and access to alternative sources of investment financing. These capacities must be developed in particular by the hospitals that are at the centre of the regional/territorial disease management networks, but also by the health insurance houses, the National Institute of Public Health, the National Health Insurance House and the Ministry of Health.

Integration of future population screening programmes into the basic service package and the minimal service package. Within this framework, the health insurance houses will contract services grouped with networks (consortia) of vertically integrated providers at the level of a region or a county, depending on the case. The financing will be made through two mechanisms: (i) capitation, for the management expenses of the networks, and (ii) payment per service, respectively per tested patient, to cover the expenses with goods and services for recording, informing, mobilising, consultations, referrals, sampling and processing of tests. We also propose to apply a **performance bonus** that incentivizes network members to achieve high test rates.

Implementation of the reform of public hospital financing, as also provided for in the National Health Strategy 2023-2030. Its key components are the consolidation of as many sources of revenue as possible in the tariff per solved case, the sizing of the tariff according to the real costs of the services, the standardization of the staff according to the activity, not the approved beds, and the reduction of the number of contracted beds if the Health Insurance House finds their underutilization in practice. Thus, **the financing of hospitals will be correlated with the activity provided,** which will determine them to adapt their service offer to national health objectives, such as population screening, early diagnosis, genetic testing and palliative care. The revenues from tariffs for services/episodes of care may be supplemented by bonuses for performance, for example, for the provision of the grouped cancer diagnosis service within the 30 day term from the firs consultation, recommended in the framework contract.

Financing the coordination of cancer care and clinical management activities: patient counselling, monitoring adherence to treatment, management of adverse effects, avoidance of drug interactions, avoidance of polypharmacy, interdisciplinary coordination between the different service providers with whom the patient interacts, etc. This role can be played by a **case manager, with specialized training,** who can be a nurse paid by the hospitals provided in the oncology clinical pathways. The implementation of this function requires national preparation, enrolment and a funding plan.

Improving the unbalanced distribution of radiotherapy capacity by means of a preferential pricing scheme, which would grant in the medium term a bonus of 15% - 20% for the services provided in the currently underserved counties, included by the Ministry of Health in programs for the development of infrastructure and specialized human resources.

Integrated development of palliative care (i) as a consequence of the reorganization of public hospitals with low addressability for acute conditions and (ii) by integrating palliative care providers into county networks/consortia with which health insurance funds conclude contracts for complete interventions in continuous hospitalization, outpatient clinics and home care.

Conceiving a map of the providers under a contract with the National Health Insurance House by types of services provided, to facilitate patients' quick access to the necessary services.

The existence of a community nurse in each city and / or village, who is a medical professional with medium training, can help to guide patients on the diagnostic and treatment paths and can be actively involved in the development of prevention and screening programs.

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