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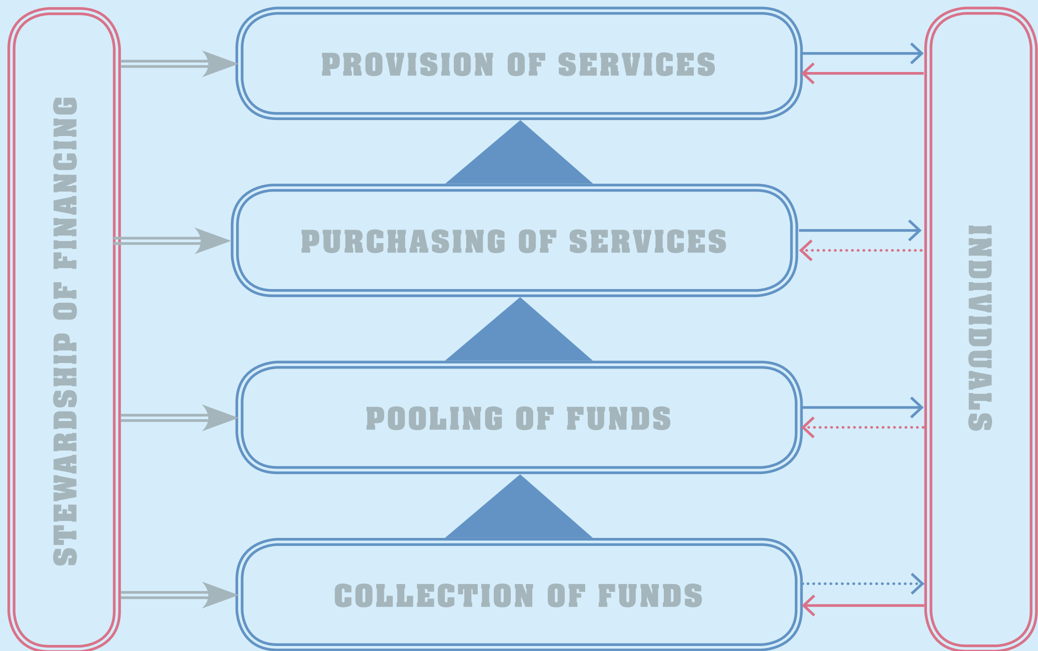

EXTENDING POPULATION COVERAGE IN THE NATIONAL HEALTH INSURANCE SCHEME IN THE REPUBLIC OF MOLDOVA

Health Financing Policy Paper 2010/1

EXTENDING POPULATION COVERAGE IN THE NATIONAL HEALTH INSURANCE SCHEME IN THE REPUBLIC OF MOLDOVA

STRATEGIC OPTIONS

BY: MATTHEW JOWETT AND SERGEY SHISHKIN

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ABSTRACT

The Republic of Moldova introduced substantial reforms to its health system in 2004 with the establishment of a mandatory system of health insurance, and a single pool of funds combining both payroll contributions and budget transfers. Under this system, however, around one-quarter of the population makes no insurance contribution, and hence has very limited financial risk protection when accessing health services. The subsequent National Health Policy 2007–2021 clearly articulated the goal of ensuring equal and adequate access to health services for all citizens of the Republic of Moldova, and this report recommends three possible courses of action to the Minister of Health to move towards this goal given the country's current fiscal capacity; first to use insurance subsidies in a more poverty-focused way, secondly to strengthen various aspects of the design and management of the insurance programme, and thirdly to strengthen the link between citizenship and entitlement to health care.

Keywords

INSURANCE, HEALTH
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EXECUTIVE SUMMARY

The introduction of a system of mandatory health insurance in the Republic of Moldova in 2004 represented fundamental reform to the organization of the health system and led to significant improvements in health system performance. However, one negative consequence of the reforms was the creation of an explicitly uninsured segment of the population, estimated in 2009 to be 27.6%. Under this system, the uninsured have access only to life-saving services and a limited number of consultations with primary health care providers; for all other services, direct out-of-pocket payment must be made.

In the Republic of Moldova, the uninsured population is heavily concentrated among rural agricultural workers, and hence any successful strategy needs to ensure increased coverage among this group. Significant increases in enrolment are, however, highly unlikely under the current approach to health financing; a large proportion of those individuals the Government expects to self-insure live below the absolute poverty line while being asked to pay a premium which has increased dramatically in recent years. Furthermore, there is only one premium for the self-insured despite this group being heterogeneous in its economic status, ranging from farmers to notaries and lawyers. Some positive amendments are planned for 2010 but are still expected to have a limited impact on overall levels of coverage.

Between 2004, when the Mandatory Health Insurance Company (MHIC) was established, and 2008 its revenues increased more than three-fold but the percent of population covered under the insurance scheme remained largely unchanged. The de facto priority has been to increase funding for facilities and salaries and to ensure good financial protection for those who are already insured under the scheme, rather than to expand coverage.

One significant recent change in policy was the approval of Law No. 22–XVI on 2 February 2009, which amended the existing Law on Mandatory Health Insurance to ensure that all those registered as poor under the recently approved Law on Social Support would automatically receive fully subsidized health insurance; this is a very positive move which targets subsidies directly at the poor.

This report presents **three strategic options**, or policy proposals, which the Government of the Republic of Moldova should consider with a view to extending population coverage under the mandatory health insurance scheme. Note that the focus of this report is the extension of population coverage i.e. membership or enrolment, rather than the two other dimensions of coverage namely the scope of health services included in the benefit package, and the depth of financial protection for patients. The three strategic options that follow are not mutually exclusive and can be implemented simultaneously:

OPTION A: serious consideration should be given to **changing the way in which subsidies for insurance are targeted**. While the approval of Law No. 22–XVI is positive, a more fundamental overhaul of the way subsidies are used is proposed. At present, insurance subsidies do not specifically target poor households (see Section 2.4), with only 19% of those currently receiving fully subsidized insurance falling below the extreme poverty line, and approximately 41% falling below the absolute poverty line. Section 3.3 of this report proposes an alternative use of subsidies under which the use of priority groups is maintained, at least in the short to medium term, but only those individuals below the absolute poverty line within each group

would continue to receive fully subsidized health insurance. Those above this threshold would receive a partial subsidy and would thus be obliged to pay part of the premium themselves.

By allocating insurance subsidies in a fairer and more poverty-targeted way, the Government has the potential, even in the current fiscal context, to simultaneously achieve the following: increase population coverage, respond to current and future budget reductions in a pro-poor manner and make public spending more poverty-focused. In doing this fair financing would be improved in the health system overall. Given the likely implementation challenges of this approach, however, the benefits would only be realized in the short to medium term.

The main risk in this approach, in which a large number of individuals would move from receiving full insurance subsidy to receiving partial subsidy, is that some individuals would drop out of the insurance scheme in an attempt to avoid making a financial contribution. This is a risk that needs managing in two separate ways:

- First, by clearly reaffirming the mandatory nature of the scheme i.e. that by receiving a subsidy, even if partial, the citizen has an obligation to contribute – this is also true of the premium discount offered to the self-insured which should not be marketed simply as an incentive, but as a subsidy that comes with an unequivocal obligation to contribute. Without a 'stick' to accompany the 'carrot' these measures will have only a limited effect in terms of extending population coverage.
- The second action required for this approach to work is the strengthening of systems to enforce contributions; while this will not be easy at this time of financial crisis, it is essential for both efficient risk-sharing and a solidarity-based system, that those who can afford to pay do so. Expanding the number of people contributing through automatic deductions should also be a priority.

OPTION B: measures should be taken in the short and medium term to **improve the design and management of the mandatory health insurance scheme**. Proposed measures include the introduction of more than one premium level for the self-insured; making it as easy as possible for people to make contributions, for example through the accreditation of a network of financial institutions as collecting agents; allowing greater flexibility in contribution payments (e.g. monthly) for the self-insured if they make automated payments through the banking system; and shifting away from individual-based and towards family-based enrolment. Furthermore, as already mentioned, enforcement of contributions from those currently evading payment needs to be strengthened, for example through cross-government initiatives – this task should not fall on the MHIC alone. Finally, continual investment in database management will be required both to manage membership and to provide good information for analytical and policy development purposes. These measures are expected to have a low to medium impact on levels of insurance membership, but are critical for the professional and effective management of a modern health insurance scheme.

OPTION C: The third policy option proposed is to further **extend the package of health services provided as a universal guarantee** for all Moldovan citizens, irrespective of their health insurance status. This approach weakens the link between contributions and entitlements, in turn strengthening the rights of citizens to essential health services. There are strong arguments for reinforcing universal access to health services, in particular primary health care, at a time when unemployment is rising rapidly. While not directly increasing the number of individuals enrolled under the mandatory health insurance scheme, this strategic

option would have a **high positive impact** on access to services and financial protection for the population, "…ensuring the equal and adequate access to health services for all citizens of the Republic of Moldova." being a stated goal of National Health Policy 2007–2021, and progress could be made in the **short term**.

Finally, the entire issue of increasing levels of insurance coverage needs to be viewed in the context of the broader health system. There is ample scope for greater efficiency in the way services are delivered, and the need to make progress on this front will understandably increase as pressure on public finances grows. Indeed, finding savings and efficiency gains in the way services are organized, delivered and financed is likely to be crucial to ensuring greater population coverage under the mandatory health insurance scheme without a substantial deterioration in the quality of health services.

1. OBJECTIVES OF THE REPORT

1.1 Rationale

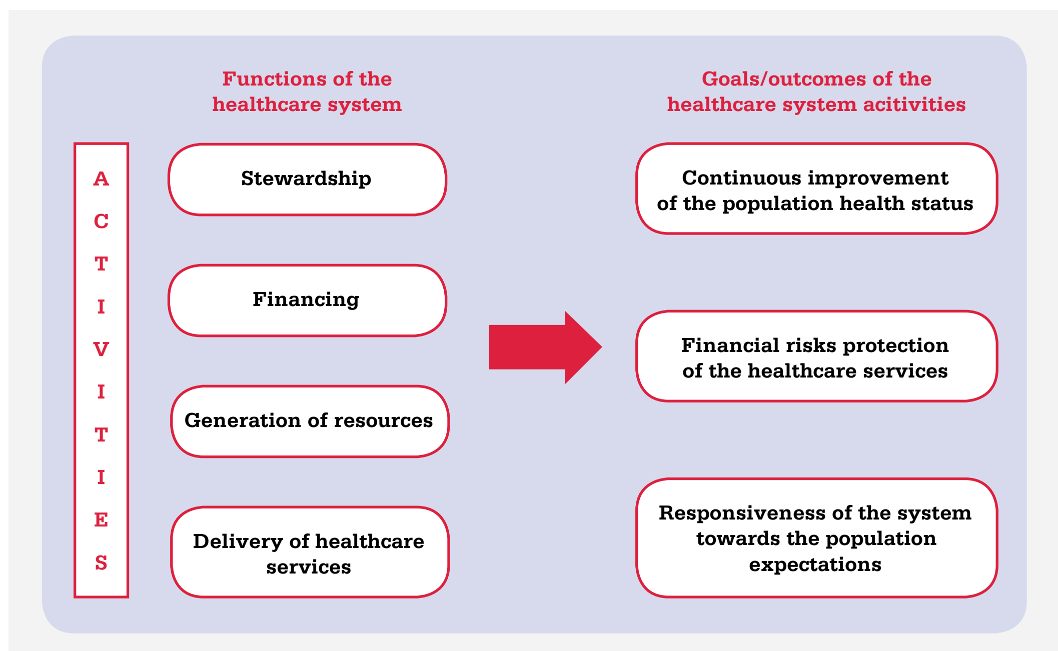
The Republic of Moldova introduced a national system of mandatory health insurance in 2004 through the approval of a law stipulating that the economically active population is obliged to make contributions through a payroll tax or alternatively, if self-employed, to pay a flat rate contribution. The remainder of the population, including those officially registered as unemployed or non-working, is exempt from making contributions and insured by the Government of the Republic of Moldova who makes a contribution on their behalf through a budgetary transfer. The principal shortcoming of the reform, and hence the main challenge it currently faces, is that the fundamental shift in the basis of entitlement away from being a citizen of the Republic of Moldova to being an individual who makes a premium contribution payment has meant that approximately one quarter of the population are now explicitly uninsured and as a result face inferior access to health care.

This report proposes three broad strategic options available to the Ministry of Health to reduce gaps in population coverage under the mandatory health insurance scheme, with a view to improving both access to health services and financial protection for the population. On the positive side, many countries around the world have faced a similar health challenge over the past two decades, and as a result there is considerable evidence and experience on which to draw. One interesting point of note is that in many countries financial and economic crisis has provided the trigger to introduce fundamental changes to health policy, for example in Thailand where the so-called "30-Bhat Scheme" was introduced in 2001 to ensure universal health insurance coverage during a period of growing unemployment (*1*).

1.2 Health policy goals

This report presents some clear practical choices and recommendations to the Ministry of Health on how to extend insurance population coverage, and does so in a way consistent with stated health systems goals. It is important to be clear that insurance coverage is not an end in itself, but is rather a means to an end or ultimate goal; that goal is defined through the 'National Health Policy 2007–2021' (*2*) which sets the broad vision for the evolution of the health system, with greater detail provided in the 'Healthcare System Development Strategy 2008–2017' (*3*). These documents clearly specify three overriding goals for the health system as shown in Figure 1, namely improved health, financial risk-protection, and responsiveness to the population. An important message here is that data on insurance coverage is only part of the story, with the value of that insurance in terms of access to health services and financial protection ultimately what matters.

Figure 1: Functions and goals of health care systems specified in the "Healthcare System Development Strategy 2008–2017"



The introduction of mandatory health insurance in 2004 in the Republic of Moldova is the core health system reform of recent years, and the central strategy to achieving the health policy goals set out by the Government of the Republic of Moldova. For example, the way in which funds are raised for the health system is an important element of fair financing and influences access to health services; similarly, the establishment of a single payer provides the Government with greater leverage over service provision in terms, for example, of quality and efficiency. Empirical evidence of the impact of being insured on access to health services is generally positive, with recent analysis showing that the insured are far less likely to suffer catastrophic levels of out-of-pocket spending on health (see Section 2.2.3).

2. INSURANCE COVERAGE

2.1 Estimates of population insurance coverage

2.1.1 Overview

According to Law No. 1585 on Mandatory Health Insurance of the Republic of Moldova, signed on 27 February 1998, those individuals insured under the scheme include citizens of the Republic of Moldova, foreign citizens, and persons without citizenship living permanently on the territory of the Republic of Moldova. Law No.1593–XV (dated 26 December 2002) under which the Mandatory Health Insurance Company (MHIC) was established stipulates that the economically active population is obliged to contribute according to their wage levels (through a payroll tax) or to make a flat-rate contribution if self-insured. This latter group is further defined in Box 1.

Box 1: Defining the self-insured[1]

a) Residents of the Republic of Moldova who are:

- Owners of agricultural land, regardless of whether these are leased out or used on the basis of a contract, except invalids or pensioners;
- Founders of individual enterprises, except invalids or pensioners;
- Individuals renting or using agricultural land based on a contract;
- Holders of business patents, with the exception of pensioners and invalids;
- Individuals who receive income from the rental of transportation, facilities/buildings, equipment and other material goods, with the exception of agricultural land.

b) Private notaries and barristers, regardless of organizational legal form, possessing a legal license.

c) Other individuals resident in the Republic of Moldova, who are not assigned to any of the above-mentioned categories and are not insured by the State in accordance with part (4) article 4 of the Law on Mandatory Health Insurance.

1

The role of monitoring and enforcing the timely payment of contributions by the self-insured lies with the MHIC alone but is not strictly enforced. Territorial State Tax Inspectorates, for example, only have the right to enforce contributions made through payroll taxation by those in formal employment. Any violation in health insurance contributions whether non-payment, late-payment, or incomplete payment, may be sanctioned in accordance with the Code on Administrative Violations and the Criminal Code. The power to act under these provisions lies with State prosecution agencies and the police. More recently, there have been cross-government initiatives to strengthen audit of small businesses to ensure that all employees have been declared and the appropriate contributions made.

Those officially registered as unemployed (or "non-working") are exempt from making insurance contributions and are automatically insured by the Government of the Republic of Moldova which makes transfers to the MHIC on their behalf as payment of the premium contribution. Law No. 22–XVI 'On the amendments in the Chapter 4 of the Law on Mandatory Health Insurance' was adopted on 2 February 2009. As a result, members of households eligible for social benefits as defined by the Law 'On Social Benefits' No. 133–XVI signed on 13 June 2008, will automatically be insured with the Mandatory Health Insurance Company. This is a major step forward in terms of extending health insurance coverage to a priority group previously with

1 The text in this box is translated from the annex to Law No. 1593-XV, dated 26 December 2002.

very limited access to health services. The number of individuals currently insured by the State, defined in terms of priority population categories, is presented in Table 1.

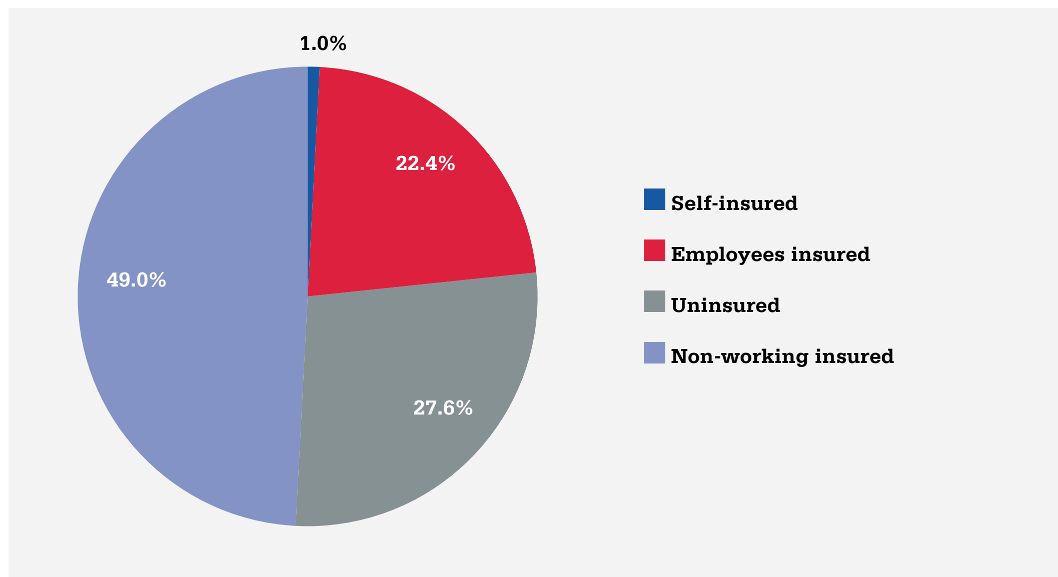
Table 1: The number of individuals insured by the State by defined category (thousands)

	2008	2009 (planned)
1. Pre-school children	261.0	259.6
2. Primary and secondary school children. Children in gymnasiums and lyceums	491.5	461.0
3. Students of secondary vocational schools, colleges.	53.9	55.7
4. Students of higher, university education institutions,		
full-time.	128.0	122.9
5. Postgraduate students in residence	1.4	1.5
6. Children not enrolled in school up to 18 years old	-	0.1
7. Disabled	128.0	129.7
8. Disabled from childhood	4.8	10.1
9. Pensioners	507.0	489.7
10. Unemployed, officially registered	20.4	18.9
11. Pregnant women and post birth	37.1	38.1
12. Mothers with 4 or more children	146.0	146.0
13. People from disadvantaged families receiving of social support under Law No. 133–XVI of 13 June 2008	-	16.2
Total insured by the State	**1779.1**	**1749.5**

Source: (4)

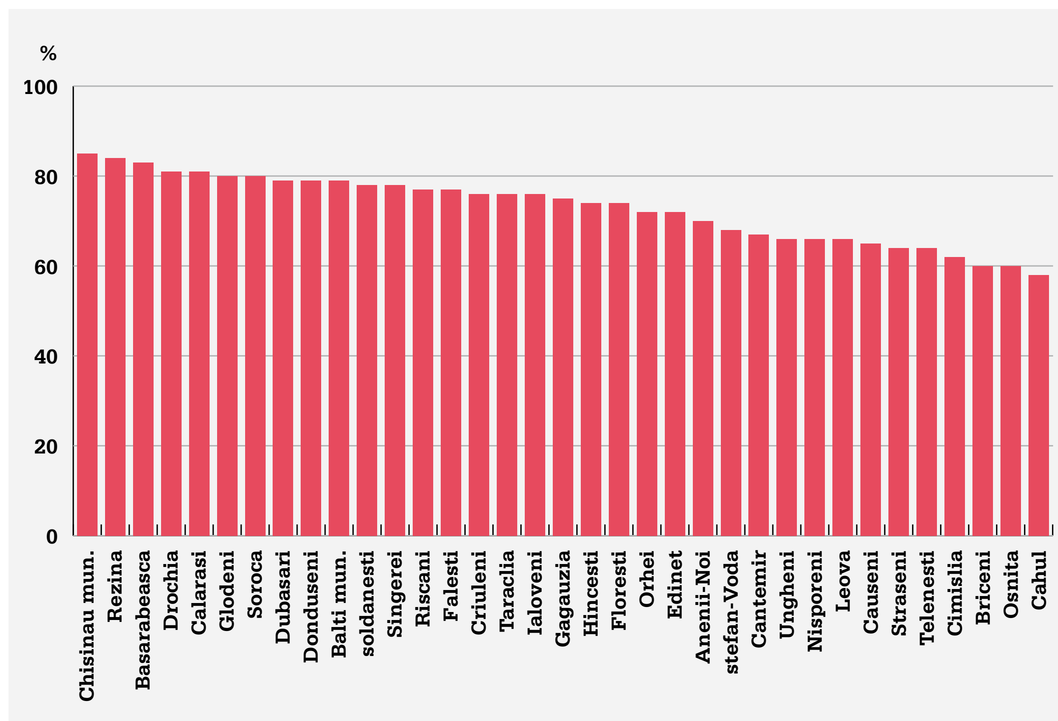
In 2009 the total number of insured individuals was 2 584 600 of whom 800 100 were employees, 1 749 100 were non-working persons insured by the State and 35 000 were self-insured citizens. More than one in four Moldovans were thus uninsured in 2009 (see Figure 2). Substantial variation does exist in coverage rates across Rayons and Municipalities (see Figure 3), which to some extent reflects the fact that the uninsured are heavily concentrated in rural communities (see Figure 6 and Figure 7).

Figure 2: Insurance status of citizens in the Republic of Moldova (including those not living permanently in the country) in 2009 (%)



Source: (4)

Figure 3: Health Insurance Coverage Rates by Rayon and Municipality in 2006



Source: (5)

The number of uninsured has decreased in recent years, but in 2009 there was a slight increase (see Table 2). The current financial and economic crisis has led to an increase in the number of

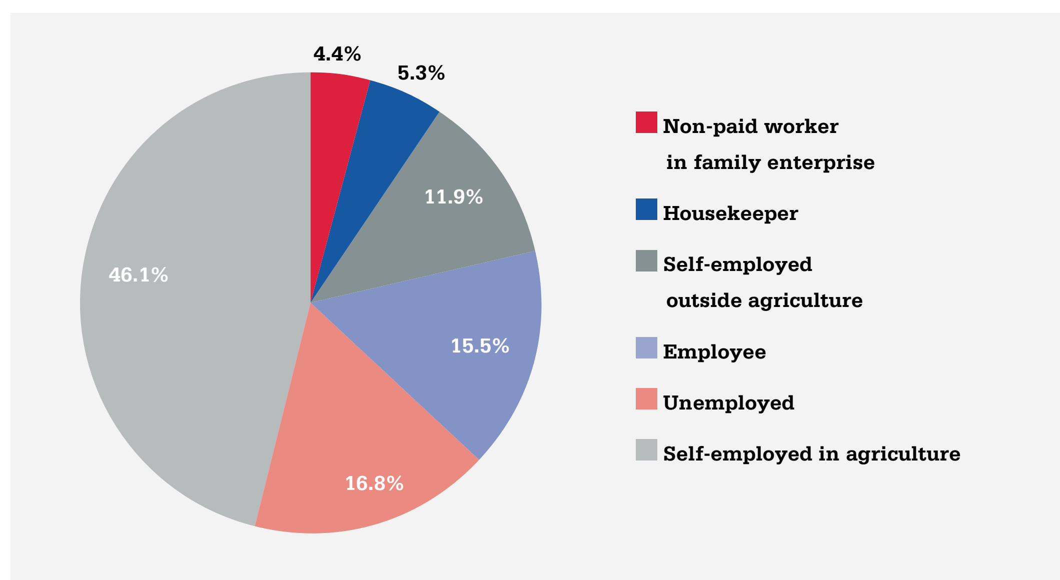
unemployed, some of whom are not officially registered. The World Bank reports that unemployment levels in the Republic of Moldova in 2009 have grown 60% over 2008 levels (*6*). As a result there has been a substantial reduction in the number of employees making payroll contributions. Around half of the uninsured are self-employed in agriculture, 12% are self-employed outside agriculture, and almost 17% are unregistered unemployed (see Figure 4).

Table 2: Number of individuals insured in social health insurance system by category (thousands) 2006–2009

Category	2006	2007	2008[2]	2009	
Non-working persons insured by the State	1627.4	1645.1	1779.1	1749.5	*49.0%*
Employees	811.5	830.6	835.3	800.1	*22.4%*
Self-insured	27.3	29.0	34.5	35.0	*1.0%*
Total insured	2466.2	2504.7	2648.9	2584.6	*72.4%*
Uninsured	1123.1	1076.4	923.8	982.9	*27.6%*
Total population	**3589.3**	**3581.1**	**3572.7**	**3567.5**	**100.0%**

Source: (7)

Figure 4: Occupational status of the uninsured (%) mid 2009

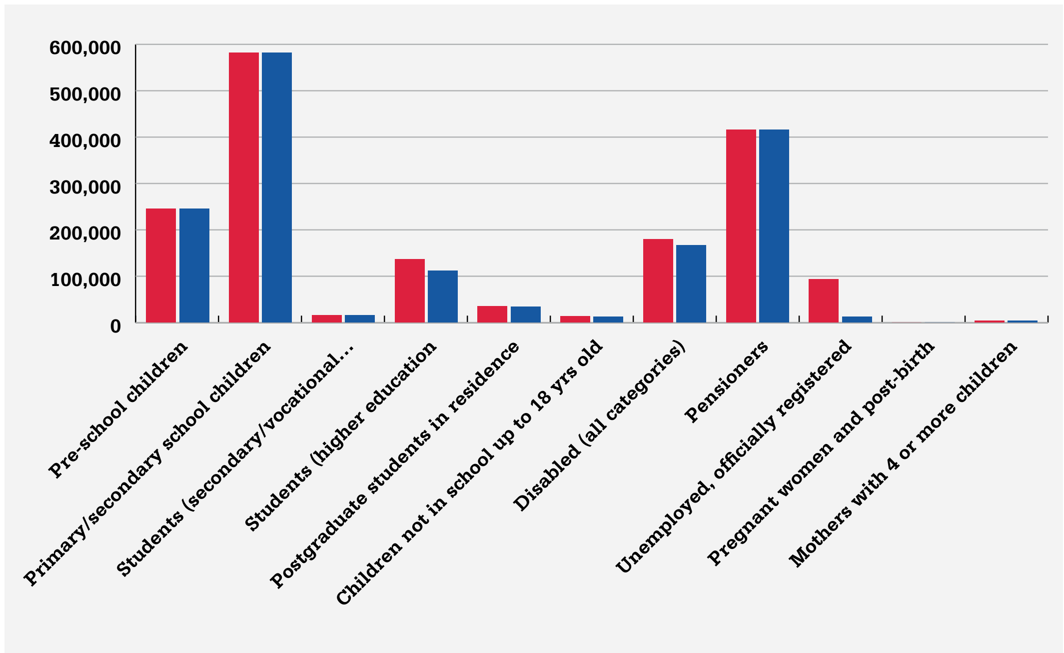


Source: (8)

2 A 50% premium discount for the self-insured was first introduced in 2008, and only applicable if policies were bought during the first three months of the year. This approach has since been further refined and is discussed elsewhere in this report.

In some cases, those who are eligible for health insurance coverage may not actually be registered. We cross-check official administrative data[3] using Household Budget Survey (HBS) data to estimate this uptake gap, matching priority categories targeted for insurance subsidy with HBS categories as accurately as possible.[4] Figure 5 juxtaposes two estimates of actual coverage, and suggests that not all those eligible for fully subsidized health insurance are covered in practice. Non-uptake appears to be largest for the unemployed, those in higher education and the disabled. Non-uptake among the unemployed can be explained by the fact that the HBS estimate of unemployment includes both officially registered and non-registered unemployed, while MHIC databases only include those officially registered.

Figure 5: Two estimates of actual coverage within categories eligible for fully-subsidized insurance



Sources: (7) and (9)

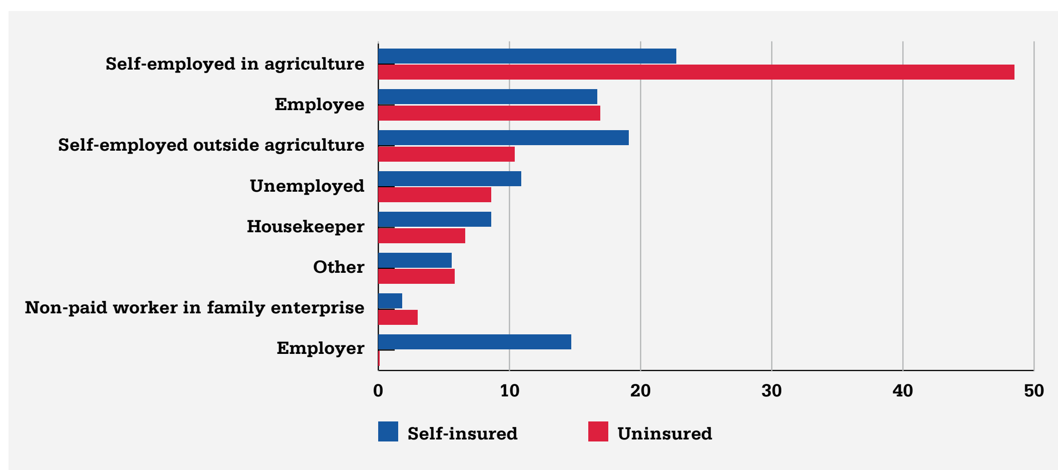
2.1.2 Coverage by occupation

A comparison of the uninsured and self-insured in terms of their occupational status and main source of income (Figs. 6 and 7) shows that the self-employed in agriculture are least likely to self-insure: their share in the group of all self-insured (22.7%) is less than half their share in the group of all uninsured (48.5%).

3 The number of people enrolled under MHIC is itself an estimation obtained by applying the relative weight of the population categories in the total population receiving fully subsidized MHIC policies in 2009, to the total population receiving fully subsidized MHIC policies in 2007.

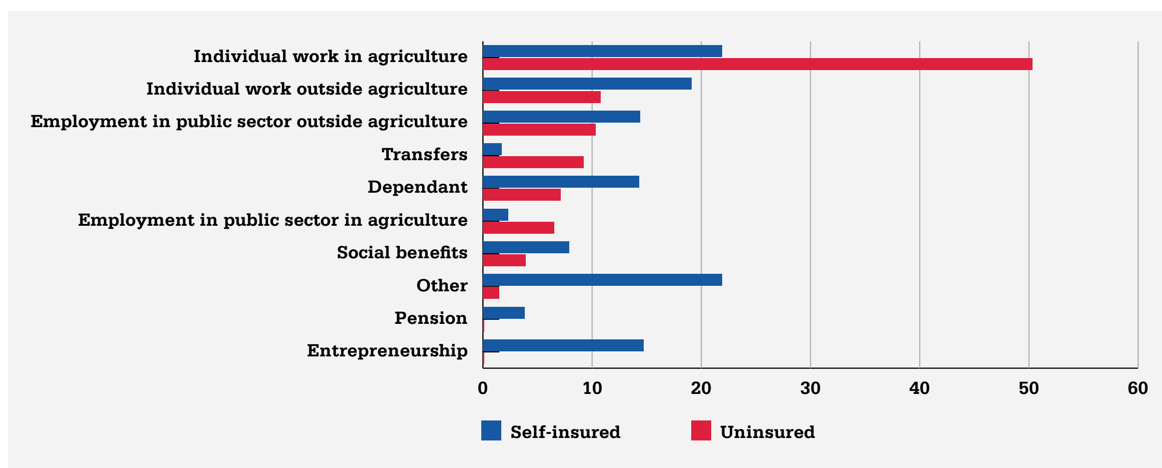
4 Where precise matching variables are not available we use proxies. Note that there is no estimate of “pregnant women” in the HBS dataset.

Figure 6: Occupational status of uninsured and self-insured (%) mid 2008



Source: (10)

Figure 7: Main sources of income for uninsured and self-insured (%) mid 2008



Source: (10)

The policy implication here is that any strategy to increase coverage must be effective in reaching agricultural workers. This is problematic in the sense that any administrative system that needs to reach out to a dispersed population in rural areas, with seasonal income etc. will face significant challenges in identifying individuals, measuring their income, and collecting the appropriate contributions. Furthermore, Annex 1 projects the rural population to decline more slowly in the future than the urban population, and hence will be relatively more dominant in the future. Given that many of the individuals in this category fall under the absolute poverty line (see Section 2.3) the use of subsidies to support their enrolment is justifiable.

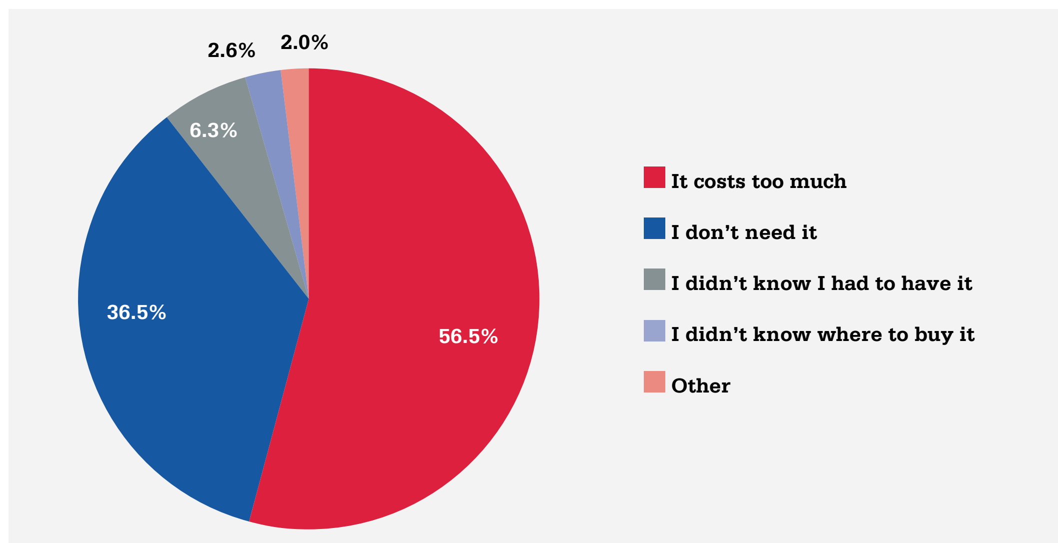
2.2 Non-purchase among the self-employed

2.2.1 Reasons for non-purchase

The main stated reason for not being insured is a lack of money. It is interesting that data from different surveys are very similar on this issue. According to a Transparency International

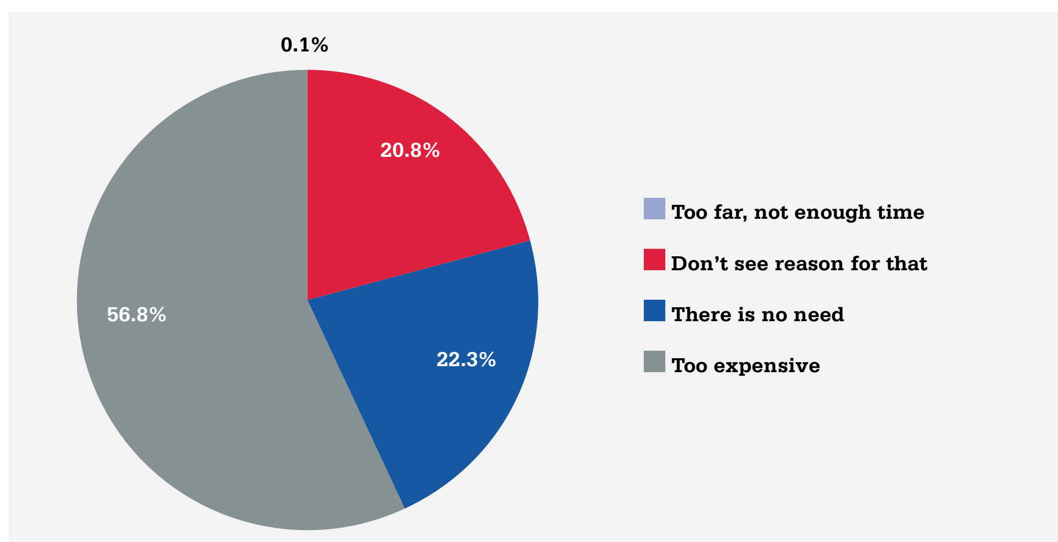
survey conducted in 2006,[5] 56.5% of the uninsured stated economic problems as the reason (see Figure 8). According to data from the National Budget Survey (NBS) 56.8% of uninsured in 2008 indicated that it was too expensive (see Figure 9). This problem has been exacerbated by the significant increase in flat-rate contributions in recent years (see Table 4).

Figure 8: Reasons for not self-insuring in 2006



Source: (11)

Figure 9: Reasons for not self-insuring in 2008



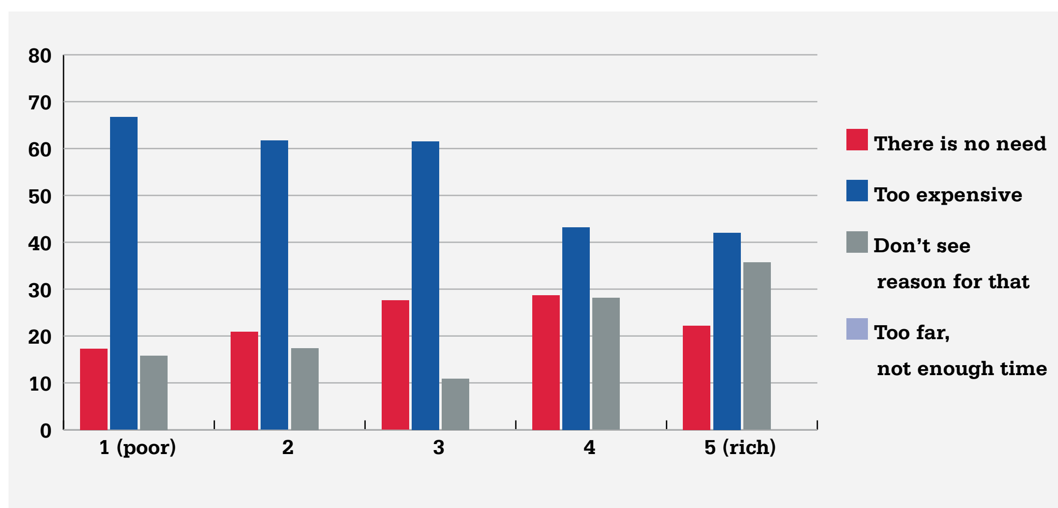
Source: (10)

The way in which health insurance is currently financed is equitable for employed persons, but regressive for the self-employed due to the flat rate premium, although the proposed introduction of a tiered discount for 2010 would rectify this to some extent. This is one factor which

5 A nationally representative survey with a sample of 1375 adult respondents conducted in May-June 2006.

explains less than full coverage; see Figure 10 which shows responses to the question '*Why don't you have health insurance?*. More than 60% of the uninsured from the first three economic quintiles[6] indicated "too expensive" as the main reason with around 40% from the two richest quintiles giving the same answer. NBS data also show that around one third of uninsured from these two quintiles see no reason to purchase health insurance with one quarter saying they have no need for it. It is likely therefore that more than half of those in the two richest quintiles will not be sensitive to a further decrease in the contribution level.

Figure 10: Reasons for not self-insuring by income group (%)

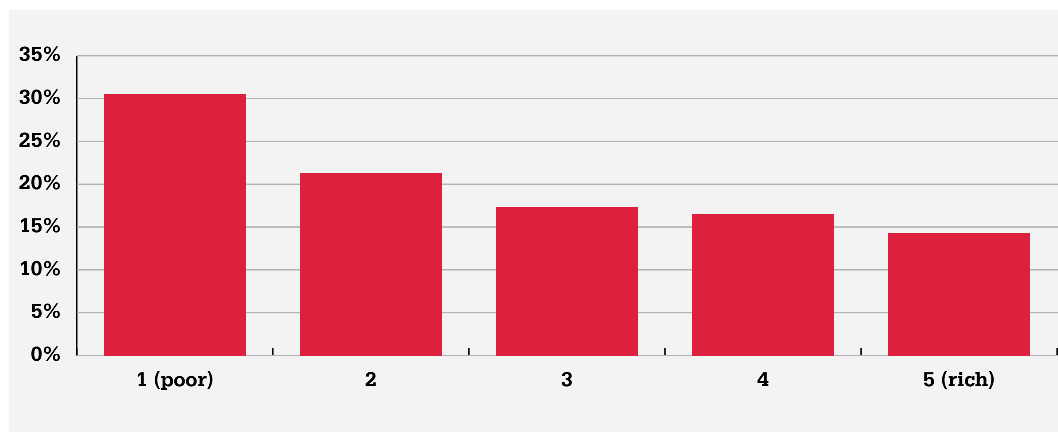


Source: (10)

Economic status is a significant barrier to purchasing health insurance with around one-third of the uninsured belonging to the poorest economic quintile group (Figure 11). Figure 12 plots economic status (measured in terms of average adult equivalent consumption expenditure) by deciles, against the proportion of self-employed individuals stating that the premium level is a reason for not purchasing health insurance. The trend is clear, that the lower the economic status of an individual, the more likely that 'premium level' is stated as a reason, which is not surprising given that there has been only one premium level for this economically heterogeneous group, and given the substantial increases in recent years.

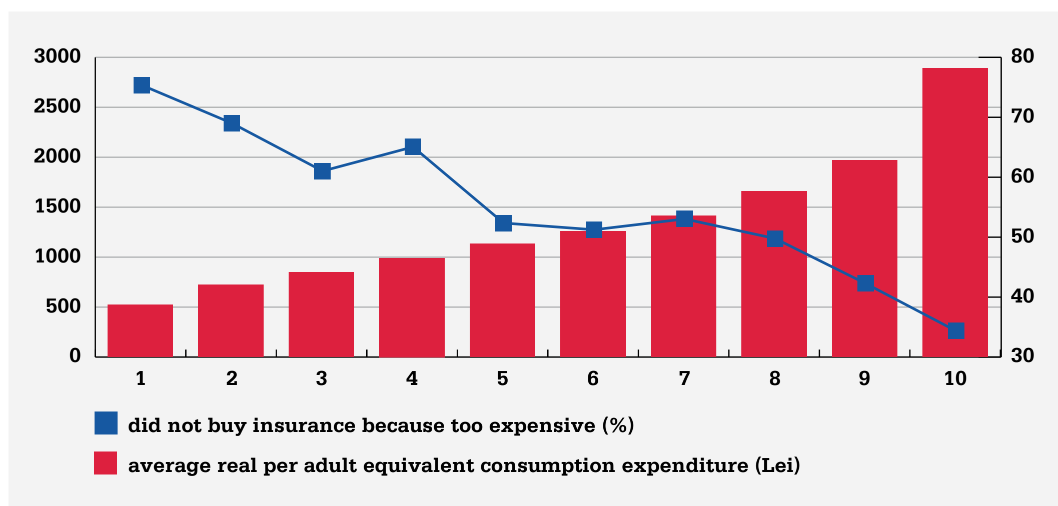
6 Based on consumption expenditure data rather than reported income.

Figure 11: Distribution of uninsured by per capita household's economic quintiles (%) mid 2009



Source: (8)

Figure 12: Importance of premium level as cause of non-purchase across groups of different economic status 2008



Source: (10)

While stating "too high a premium" as a reason for not purchasing health insurance is a common response in countries around the world, unlike many good and services demand for health insurance is more complex than simply the price of the insurance policy. Indeed, empirical evidence from the Republic of Moldova shows that enrolment was increasing slightly prior to the introduction of a discount. According to Ministry of Health data, the number of self-insured individuals was 29 000 in 2007 and 34 500 in 2008. This indicates that the rate of growth was 19% only and that the price elasticity of demand for insurance is very low at 0.38. The message here is that lowering the premium level alone will have only a small impact on levels of enrolment into the scheme; many other factors drive the voluntary purchase of health insurance, in particular an individual's health status.

Furthermore, this approach will not achieve the Government's own stated policy goals, with the self-insured being asked to pay the same relatively high premium, and many of those expected to purchase insurance themselves living on incomes below the absolute poverty line. Currently there is a proposal to introduce three separate discounts in 2010 if a policy is bought in the first three months of the year, with the highest at 75% for agricultural workers, no discount for lawyers and notaries, and a 50% reduction for all others; while this is an improvement on the previous use of incentives, it will still have a limited effect on population coverage levels without some practical measures to enforce the mandatory nature of the scheme.

2.2.2 International experience

Before discussing specific options to extend population coverage in the Republic of Moldova, it is worth reviewing some key messages from international experience. First, there is clear evidence that when the decision to purchase health insurance is a voluntary one either officially, or de facto within a mandatory scheme, universal coverage will not be achieved and indeed it is unlikely that coverage will approach anywhere close to universal.

Thailand provides a useful example, where efforts to expand coverage to informal sector workers included community-based financing schemes which started in 1983, and subsequently the launch of a national voluntary health card scheme (VHCS) in 1991 (*1*). Neither programme was successful, however, with the VHCS reaching a high point of only 12% population coverage in certain parts of the county despite intensive marketing and advertising campaigns. By 2001, 25% of the population remained without insurance coverage (a level similar to the Republic of Moldova today) prompting the launch of the Universal Coverage Act, which effectively enrolled all the self-employed through public subsidies, and required only a small co-payment of 30 Baht at the point of service – the scheme became known as the 30 Baht Scheme. While this approach puts considerable stress on public finances it led to universal coverage overnight by extending insurance coverage to the informally employed. Similarly in China, the Government is extending coverage to the rural population through the New Rural Cooperative Medical Scheme, under which the Government subsidies 80% of the premium with the beneficiary expected to pay the remaining 20%, as well as a co-payment at the point of service.

It can be argued that as those in formal employment receive a matching contribution from their employer, and priority groups receive a full subsidy, that the self-employed should also receive some matching contribution. Incentive-based measures such as reduced premia typically have a limited impact and may actually exacerbate adverse selection and the financial stability of an insurance scheme. Other lessons include shifting away from individual enrolment and towards some form of group-based enrolment, most obviously the family, but potentially larger groups e.g. members of rural financial associations (see Box 2). Finally, any measures which strengthen the mandatory aspect of entry into a health insurance scheme, either through legislation or more effective collection of contributions through administrative measures, will be critical to ensuring substantial increases in population coverage.

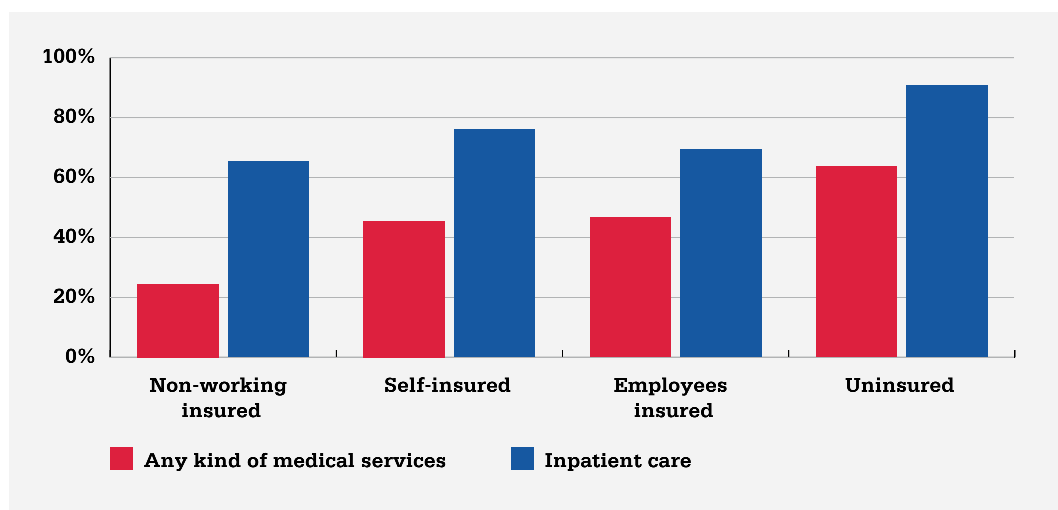
2.2.3 The impact of being uninsured

According to NBS survey data, approximately one third of uninsured patients received only free health care while 64% paid for medical services. This last figure ranges from 1.4–2.6 times higher than for the various categories of insured (see Figure 13). Only 9% of hospitalized unin-

sured persons were treated for free. However the difference between the share of insured and uninsured patients who paid for inpatient services is less.

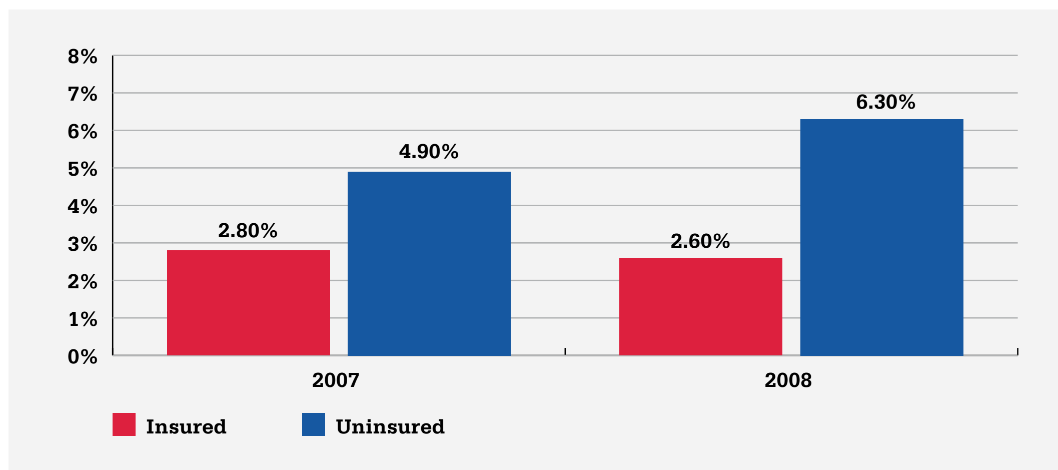
A recent analysis of levels of catastrophic health expenditures in the Republic of Moldova (*12*), estimated the extent to which the uninsured are more vulnerable to such expenditures than the insured, and the results are presented in Figure 14. This is positive evidence of the effect that being insured has on financial protection although for all patients, expenditures on outpatient medicines can be considerable. These costs are not included in the benefit package under the health insurance scheme and are estimated to constitute 72% of all out-of-pocket spending nationally. This is a priority policy issue which needs to be addressed in the future in order to further strengthen financial protection for patients.

Figure 13: Share of patients by insurance status who paid for health care in 2008 (%)



Note: Data on use of all types of medical services encompass four months in year (one month in each quarter). Data on use of inpatient care encompass 12 months
Source: Author calculations based on (10).

Figure 14: The effect of being insured on patient financial protection



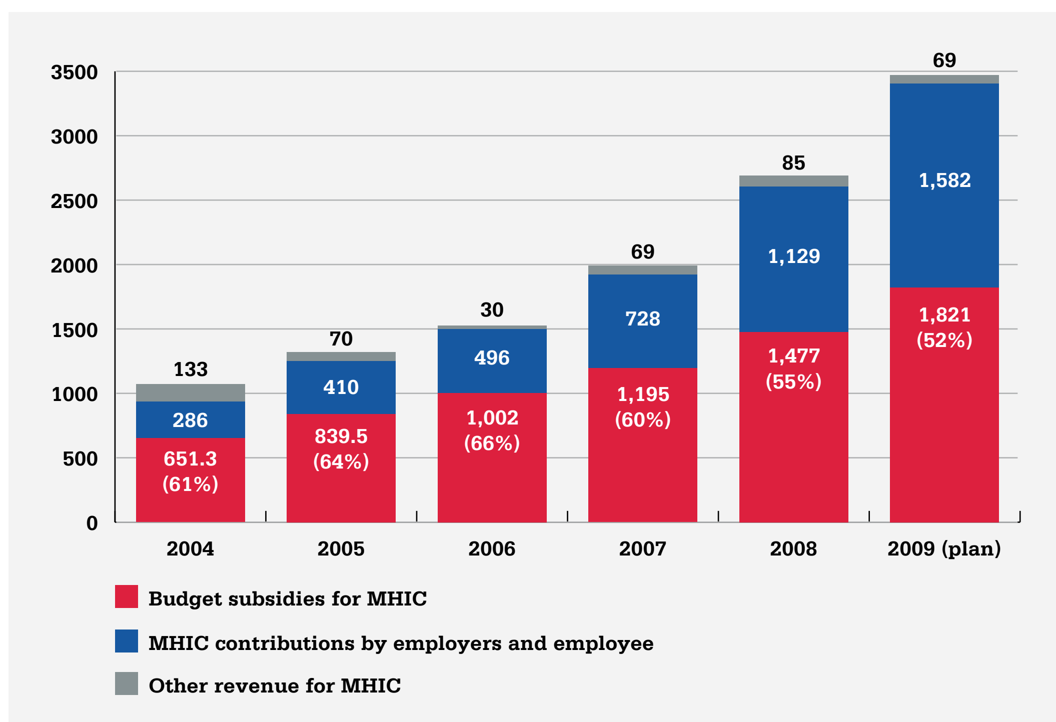
Source: Author calculations based on (12)

2.3 Sources of MHIC funding

Considering sources of MHIC funding in some detail is important for at least three reasons; first, as highlighted above, given the way the health system is financed in the Republic of Moldova, subsidies play an important part in determining insurance coverage levels and access to health services; secondly, sources of funds are important from the perspective of fair financing which is an important policy goal; thirdly, sources of funds are important from the perspective of revenue stability and the future sustainability of overall health system funding.

Budget transfers to the MHIC have grown considerably since its establishment in 2004 (see Figure 15), although the share of budget transfers in total MHIC revenues has fallen from 60.8% in 2004 to an expected 52.4% in 2009. This is consistent with the desire of the Government to reduce the extent to which the MHIC is dependent on budget transfers for its revenues – the sense in the Government, however, is that this was not happening quickly enough. According to the Law on Mandatory Health Insurance, formally adopted in 2003, premium contributions made by the employed, contributions from the State for non-working populations, and contributions by those self-insuring, should be equivalent to each other and to the average per capita cost of the package of health care benefits guaranteed by the MHIC.

Figure 15: Sources of mandatory health insurance funding 2004–2009 (million Lei)



Source: (7)

This mechanism stipulated a clear financial responsibility for the Government with respect to those they insured, but at the same time forced a rapid increase in budget contributions

as average wages rose in the economy.[7] The solution to this growing problem was to disconnect budget contributions from payroll contributions. Changes in legislation were made[8] and, starting from 2007, budget contributions for those insured by the Government were fixed at the three-year (2004–2007) average ratio of public health expenditures to the basic fund of the national public budget[9], calculated to be 12.1%. Following the adoption of this rule, the share of budget subsidies in MHIC revenues decreased from 66% in 2006 to 55% in 2008, although the absolute amount has continued to increase substantially.

The issue of reducing dependence on budget transfers has understandably been overtaken by more pressing issues as a result of the financial crisis. Table 3 and Figure 16 show how plummeting tax receipts have led to a 22% downward revision of planned funding for 2009, with actual transfers running at a further 18% lower for the first three quarters of the year. Furthermore, unemployment growth has meant a 7% downgrade in expected revenues from payroll taxes, with actual receipts running 13% lower than these estimates.

Table 3: Sources of mandatory health insurance funding 2009 (million Lei)

	2009	January–September 2009	
		Planned	Actual
Budget subsidies for MHIC	1 820 800	1 061 900	870 200
MHIC contributions by employers and employees	1 582 000	1 103 506	962 837
MHIC contributions by other categories of population	53 081	46 319	37 289
Other revenues	15 609	14 617	44 017
Total revenues	**3 471 490**	**2 226 343**	**1 914 344**

Source: (4)

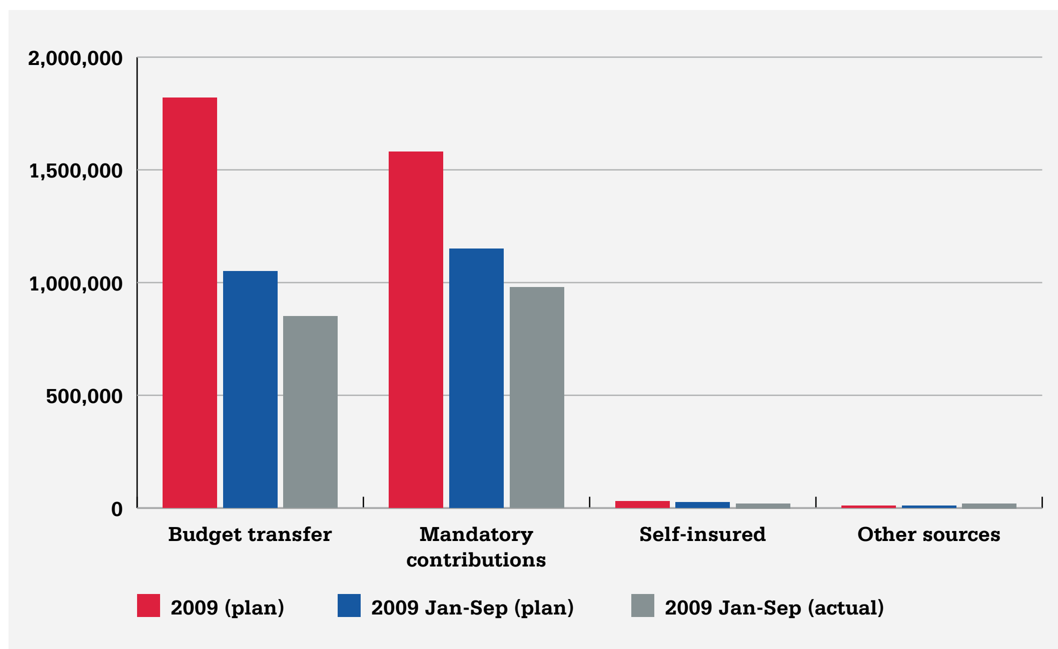
The flat rate premium applies to all those who self-insure, and has increased substantially in recent years as shown in Table 4. However, the basis for calculating the flat rate contribution of the self-employed also changed in 2007; previously the rate was defined as equal to the average per capita cost of the benefit package guaranteed by MHIC. Since 2007 it is calculated as the average per capita salary expected in the coming year multiplied by the payroll tax rate used for contributions by those in formal employment. The direct link between the contribution amount for each insured and the average per capita cost of the benefit package has thus been removed. As a result there is now substantial variation in actual premium contributions across different types of insured person, and across time (see Table 5 and Figure 17). Contributions to MHIC per employee and flat rate contributions for the self-employed increased by a factor of 2.2 between 2006 and 2009. Meanwhile per capita budget contributions for the non-working population have increased by a factor of 1.2.

7 At the birth of the scheme, contributions by the government for the non-working was based on the 4% payroll contribution made by the employed (2% employer and 2% employees), which was then applied to the average monthly income, multiplied by 12 months, and calculated to be equal to 480 Lei. During 2005 and 2006 the premium increased as average monthly salaries rose.

8 Under Law No. 268–XVI from 28.07.2006, the rule that premium contributions made by the employed, contributions from the State for non-working populations, and contributions by those self-insuring, should be equivalent to the average per capita cost of the package of health care benefits guaranteed by the MHIC, was removed from paragraph 5 of the law on the rules of contributions (No. 1593–XV from 26.12.2002).

9 Defined as the national public budget minus expenditures for special purposes.

Figure 16: Impact of the financial crisis on budget transfers for the non-working population 2009



Source: (13)

Table 4: Premium for the self-insured 2004–9 (Lei)

Currency	2004	2005	2006	2007	2008	2009
Lei[a]	441	665	816	1209	1895	2638
USD	36	52	62	100	172	245

Source: (14)

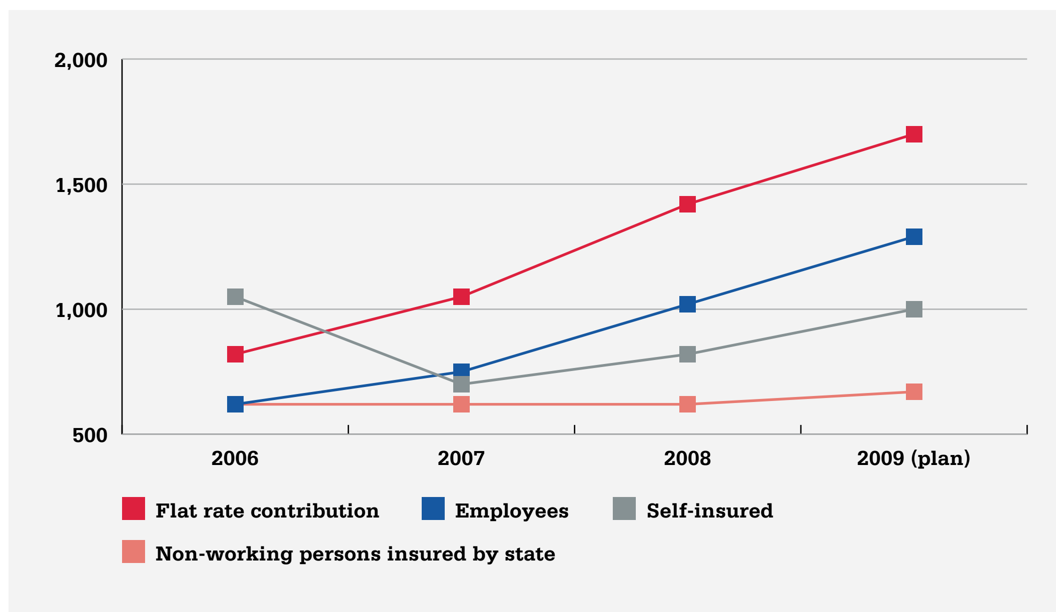
Table 5: Actual premium contributions by insured category (Lei)

	2006	2007	2008	2009 (planned)	increase 2006–2009
Non-working persons insured by the State	615.4	726.4	830.3	1050.5	+ 70%
Employees[10]	611.3	876.5	1351.6	1977.3	+ 223%
Self-insured	1046.2	827.6	1102.3[11]	1516.6	+ 45%
Average premium contribution per insured person	619.5	795.3	1016.0	1351.6	+ 118%

Source: Author calculations based on (7)

10 Payroll tax rates have increased from a total of 4% (shared equally between employer and employee) when the scheme was introduced to 7% in 2009. No further increases are envisaged at present.
11 The 50% premium discount was introduced in this year and explains this figure, vis-à-vis the non-discounted full premium amount shown in Table 4.

Figure 17: Per capita MHIC contributions by categories of insured in 2006 prices (Lei)



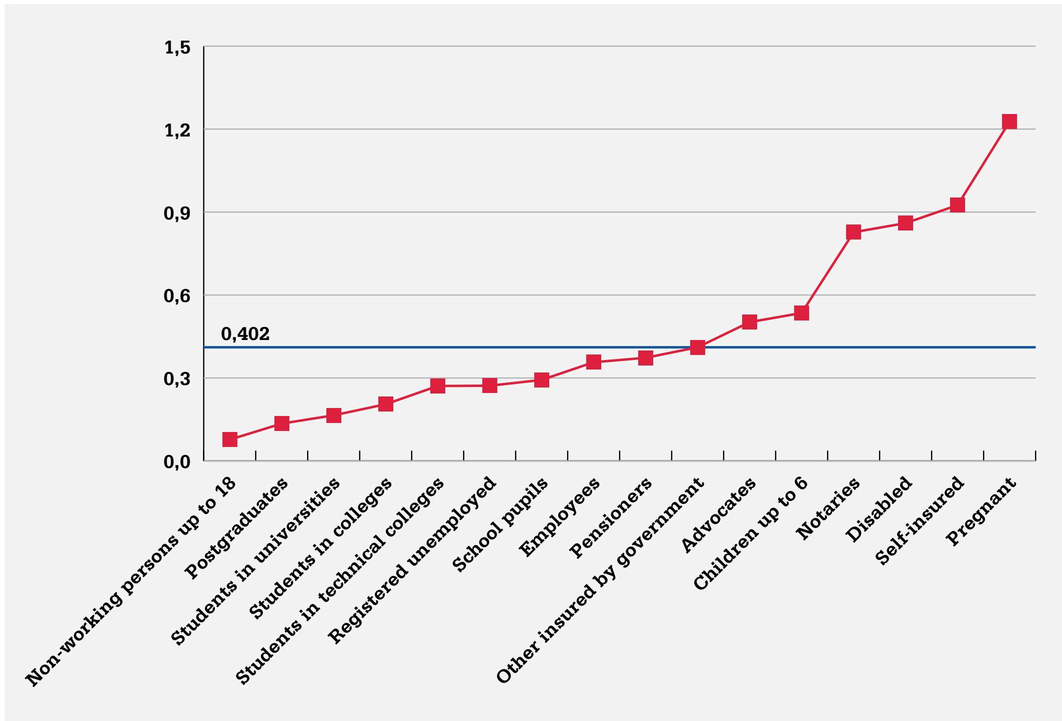
Source: Author calculations based on (10) using a GDP index-deflator calculated from (15).

The de facto voluntary nature of contributions for the self-insured has, predictably, resulted in the presence of adverse selection. The substantial increase in the flat-rate exacerbates this problem. According to estimates the utilization of health care was 2.3 times higher among the self-insured in 2005–2006 then the average figure for all insured (see Figure 18). Those formally employed (and their employers) thus cross-subsidize other categories of insured, which again is common in non-profit insurance schemes and broadly consistent with a fair financing approach.

A 50% discount on the premium for the self-insured was introduced in 2008 as an incentive to encourage those without insurance to purchase a health insurance policy. Those not taking advantage of the policy, available for the first three months of the year, had to pay a penalty including a lump sum of between 120 and 340 Lei plus 0.1% of the cost of the MHIC policy for each day following the end of the first three-month period. The effectiveness of these bonuses and penalties seem to be quite modest. According to Ministry of Health data, the number of individuals insured by purchasing a policy was 29 000 in 2007 and 34 500 in 2008. This indicates a growth rate of 19% and a very low price elasticity of demand of 0.38.

It could be argued that the discount has had a negative effect on fair financing, with those taking advantage of the discount being of a better economic status than those who did not, according to HBS data. In recognition of this, the 50% discount in 2009 is no longer available for self-employed individuals with high incomes e.g. lawyers, notaries. The proposed 2010 revisions referred to earlier in this section improve the design of the scheme, but are not expected to substantially increase enrolment levels.

Figure 18: Relative utilization of health services by category of insured (average for 2005–2006)



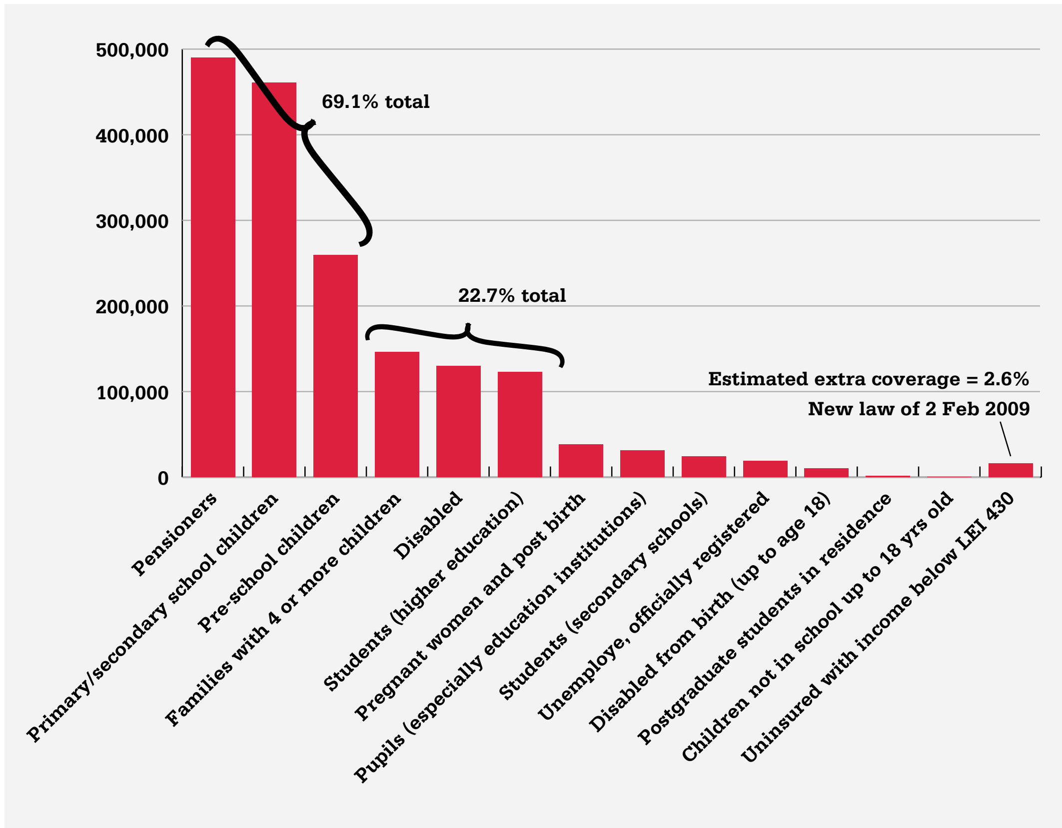
Source: (16)

It is interesting that while MHIC funding has increased rapidly in recent years, coverage rates have not increased significantly. This is largely due to the defined group approach towards subsidized enrolment introduced in 2007 following legislative amendments. Secondly, it is becoming clearer that the upward trend in funding will not continue in 2010 and most likely for a number of years to come; the dominance of budget subsidies has softened in recent years as payroll tax rates increased, and this will now accelerate on the back of lower budget transfers. Weak enforcement of contributions by those who should self-insure is the largest gap in revenue sources, and explains the fact that one quarter of the population remains uninsured.

2.4 How poverty-focused are current insurance subsidies?

Currently, public subsidies for insurance contributions are targeted according to a number of population subgroups, as shown in Figure 19. By far the largest single group are pensioners, followed by children in primary education and children of pre-school age. Together these three groups account for almost 70% of all recipients of free health insurance. The next three groups, families with four or more children, the disabled, and students in higher education account for a further 23%.

Figure 19: Those eligible for fully subsidized health insurance by defined population group 2009



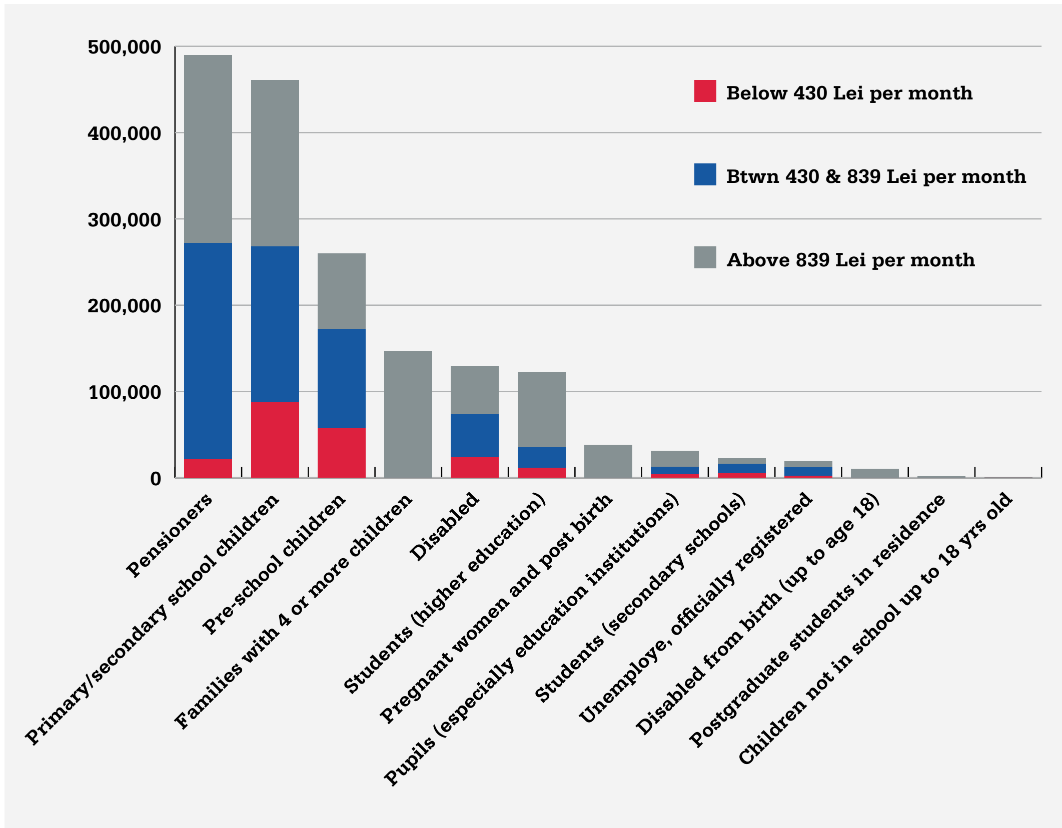
Source: Author calculations based on (4) and (8)

Here, we look at insurance coverage from the perspective of how poverty-focused the use of subsidies currently is. There are two thresholds commonly used in the Republic of Moldova to measure poverty as follows:

- **Extreme Poverty Line:** estimated at 430 Lei for 2009 – this threshold is currently as part of the process of defining those individuals eligible for cash support under the new Law on Social Support.
- **Absolute Poverty Line:** official poverty line calculated by the National Bureau of Statistics, and defined at the level of 945.9 Lei per capita per month for 2009.

In order to assess how poverty-focused the defined group approach is, we split out each of these recipient population groups using the first two of these thresholds. Data were generated from the Household Budget Survey for the third quarter of 2008 to allow this analysis, although for three of the categories this disaggregation was not possible.

Figure 20: How poverty-focused are population subgroups currently receiving fully subsidized health insurance?



Source: Author calculations based on (4) and (8)

It is clear from this initial analysis that insurance subsidies are not particularly targeted towards the poor, with only 19% of all recipients falling below the minimum per capita monthly income threshold, and approximately 41% falling below the absolute poverty line. As a result a substantial number of the poor remain uninsured, consistent with the data in Figure 11, which shows that in mid-2008 one-third of all the uninsured were in the lowest economic quintile. While overall levels of insurance coverage are very important, so too is the distribution of that coverage, and this initial analysis shows that progress could be made towards broader health policy goals by targeting insurance subsidies in a more poverty-oriented way.

3. STRATEGIES TO INCREASE POPULATION COVERAGE

The following paragraphs propose some guiding ideas for policy makers when addressing the issue of extending health insurance coverage for the population. These ideas are based largely on international experience in countries facing problems similar to the Republic of Moldova and also on conceptual and theoretical works.

3.1 Guiding ideas

Any system of health insurance in which the decision to buy insurance is a voluntary one will result in substantial gaps in coverage. As a result, **any opportunity to make both participation and contributions mandatory should be taken** which may, for example, require the amendment or clarification of legislation. If this is not possible, then the second guiding principle becomes particularly relevant.

Move away from individual enrolment. In for-profit health insurance schemes the insurance provider typically tries to enrol all employees of a firm. This approach which targets and captures a group of individuals has several advantages. First, it is far more efficient to enrol a group of individuals en masse than to enrol each one individually – the administrative costs are considerably lower. Secondly, this approach mitigates adverse selection by capturing a mix of risks, fundamental to a successful insurance scheme i.e. one which is financially stable; such an approach is equally relevant for a non-profit health insurance scheme. The key message is that when enrolment is based on individuals, the higher risks will be more likely to join.

Incentives must be accompanied by **effective regulation and enforcement**. Few systems function well on incentives alone; only when enforcement of contribution payment is improved will significant progress towards universal coverage be made.

3.2 Policy tools

The Ministry of Health has a number of policy tools at its disposal to increase levels of insurance coverage above current levels, as outlined below. Many of these tools can be used simultaneously.

Regulation

- Subsidy (full or partial) together with the condition of mandatory enrolment
- New legislation e.g. recent amendment to the Law on Mandatory Health Insurance
- Enforcement of existing legislation e.g. increases frequency of audit of small businesses

Incentives

- Subsidy without the condition of mandatory enrolment
- Differential benefits / prices for those who sign up early / regularly i.e. do not drop out.

Administration of the health insurance system, for example:

- Flexible payment systems
- Varied flat payment rates to reflect ability to pay

- Improved marketing and awareness
- Partnerships with organizations to facilitate payments e.g. microfinance

The use of a premium discount is a good illustration. It is essentially an incentive (a form of subsidy without the condition of mandatory enrolment), and is having only a limited effect, something recognized by the Government in 2009. The principle of moving away from voluntary enrolment and towards compulsion is particularly relevant here, and as such we advise that any use of discounts, which can be viewed as a form of subsidy, should be viewed not simply as an incentive but a contribution by the Government which comes together with an obligation on the members side to also contribute.

Many of the poor are located in rural areas and are often in casual, seasonal or informal employment, which makes it very difficult to compel them to contribute to health insurance, simply due to the challenge of measuring their income and physically collecting payments. In addition to ensuring that administrative systems make it as easy as possible for members to contribute, it is likely that much of this group would be covered under a reallocation of subsidies towards the poor i.e. a far greater level of subsidies would automatically flow to the agricultural population; if this were to happen, then other strategies to boost insurance coverage are likely to be more successful, on the basis that it should be easier to measure income and collect contributions from those living in urban areas, who would then dominate the uninsured population to a greater extent.

3.3 Option A: Reallocating subsidies towards the poor

One clear strategic option for the Government is to ensure that all those categorized as poor are insured something which has not happened since the establishment of the MHIC despite rapid growth in public subsidies. Insurance coverage for this group should be subsidized by the Government, and indeed this is the aim of the amendment under Law No. 22–XVI adopted on 2 February 2009. There are two possible sources of subsidy for the poor: i) additional subsidies allocated from the national budget, and ii) retargeting of existing budget subsidies. Some initial calculations on the subsidy required to fund this mandate are presented below.

3.3.1 Targeting subsidies using poverty thresholds

Under the Law on Social Support adopted on 26 September 2008, households identified as vulnerable, under a three-stage evaluation process, become eligible for cash benefits. A new mechanism has been established to assess applicants in terms of their income, assets etc. Law No. 22–XVI, which amends the existing law on health insurance (adopted on 2 February 2009), provides for the automatic inclusion into the MHIC of those found eligible for support under the Law on Social Support (i.e. those individuals with an income of less than 430 Lei per month) with full subsidy from the Government. According to household survey data from the fourth quarter of 2008 (*10*) it is estimated that 431 500 individuals now qualify. Out of these it is estimated that 160 000 or 31.1% are currently uninsured. In fact the number of people who applied for the social support during first nine months of 2009 was around 20 000 of which 16 208 were uninsured at the time they applied.

While it is up to each individual to come forward and apply for benefits under the Law on Social Support, if all those eligible were to actually apply, and were subsequently enrolled into the MHIC, and using the planned per capita contribution of 1050.5 Lei for 2009 (see Table 4),

total subsidies in the region of 168.1 million Lei would be required. Overall population coverage would increase from 72.4% in 2009 to 76.9%.

The minimum per capita income threshold of 430 Lei is particularly low at half the absolute poverty line. There is a case that all those below the absolute poverty line (currently 945.9 Lei per capita per month) should receive a full subsidy. According to HBS data from the second quarter of 2009, the number of individuals living in a household with a monthly per capita income of less then 945.9 Lei was 1 184 900; out of these it is estimated that 488 500 are uninsured.

If health insurance subsidies were introduced using the absolute poverty line, some individuals who currently self-insure would begin to receive fully subsidized insurance i.e. an estimated 46.4% (16 200 individuals) of all those currently self-insured.[12] Hence, the total number of individuals eligible for full subsidies under this option would be up to 504 700 with additional funding of 530.2 million Lei required.

Table 6: Ensuring the poor received fully subsidized insurance: estimated impact on the budget and on coverage levels

Policy option	**Budget required (using 2009 planned per capita contributions)**	**Estimated impact on coverage**
Full subsidy for all those under the "minimum per capita income" threshold of 430 Lei (2009)	168.1 million Lei	Increase from an estimated national insurance coverage level of 72.4% in 2009 to 76.9%
Full subsidy for all those under the "absolute poverty line" of 945.9 Lei (2009)	530.2 million Lei	Increase from an estimated national insurance coverage level of 72.4% in 2009 to 86.1%

Source: Author calculations

3.3.2 Targeting subsidies at poor self-employed agricultural workers

Targeting could also be based on both the economic status of an individual and their occupation. The occupational category considered a priority by the Government for greater insurance coverage is self-employed workers in agriculture. According to NBS survey data (second quarter 2009) there were 401 500 such workers living in a household with a per capita monthly income below the absolute poverty line, and of these 269 100 were uninsured. If subsidies were targeted at self-employed workers in agriculture in households below the absolute poverty line, contributions amounting to 282.7 million Lei would be required.

12 This estimate is based on the share of all insured individuals (rather than only the self-insured) below the absolute poverty line at the mid-point of 2009.

Table 7: MHIC coverage of self-employed in agriculture with per capita monthly income less than 945.9 Lei

Policy option	Budget required (using 2009 planned per capita contributions)	Estimated impact on coverage
Full subsidy for all self-employed agricultural workers, with a per capita monthly income less than 945.9 Lei.	282.7 million Lei	• 65% of all self-employed in agriculture would be enrolled • 87% of all those living in a household with a per capita monthly income of less 945.9 Lei would be covered • Increase from an estimated national insurance coverage level of 72.4% in 2009 to 80.0%

Source: Author calculations

Given that the agricultural sector is of particular importance politically, and is disadvantaged in many respects regarding access to health services, we consider here the scenario of fully subsidizing the enrolment of all self-employed agricultural workers. This group amounted to 614 900 individuals at the mid-point of 2009, of which 246 700 were insured. The number of self-employed in agriculture voluntarily self-insuring in 2009 amounted to 7900.[13] The balance of 238 800 individuals was insured through State subsidy by virtue of belonging to other priority groups. In order to cover all the self-employed in agriculture, this would imply an additional 376 100 individuals, and contributions amounting to 395.1 million Lei at current per capita estimates.

3.3.3 Retargeting subsidies towards the poor within existing priority groups

Given the substantial budget reductions during 2009, and possible further reductions, using existing subsidies more efficiently by making them more poverty-targeted is the most realistic option for the Government to further extend the population covered by health insurance. Here, we examine how the refocusing of subsidies towards the poor within the existing structure of priority population groups might be implemented.

The option considered here is to use full subsidy only for those individuals in each of the priority population categories (see Figure 19) who fall below the absolute poverty line (see Figure 20). For those who do not fall below this threshold, partial subsidies are proposed i.e. move towards coinsurance. Figure 20 showed that most individuals currently receiving fully subsidized insurance are not poor. Using NBS 2009 survey data the number of people from these groups falling below the absolute poverty line is estimated to be 983 200 with 766 300 having a higher income. The NBS survey data doesn't allow estimates to be made for families with four or more children, pregnant women, those disabled from birth, and those resident in post-university education, who amount to 195 600 individuals. While such a change appears drastic it does allow the Government to potentially do the following:

13 According to NBS survey data, the number of self-employed in agriculture contributing voluntarily into MHIC in mid 2008 amounted to 22.7% of all those self-uninsured. Applying this share to the number of self-insured in 2009 we estimate that 7900 self-employed individuals in agriculture contributed voluntarily into the MHIC.

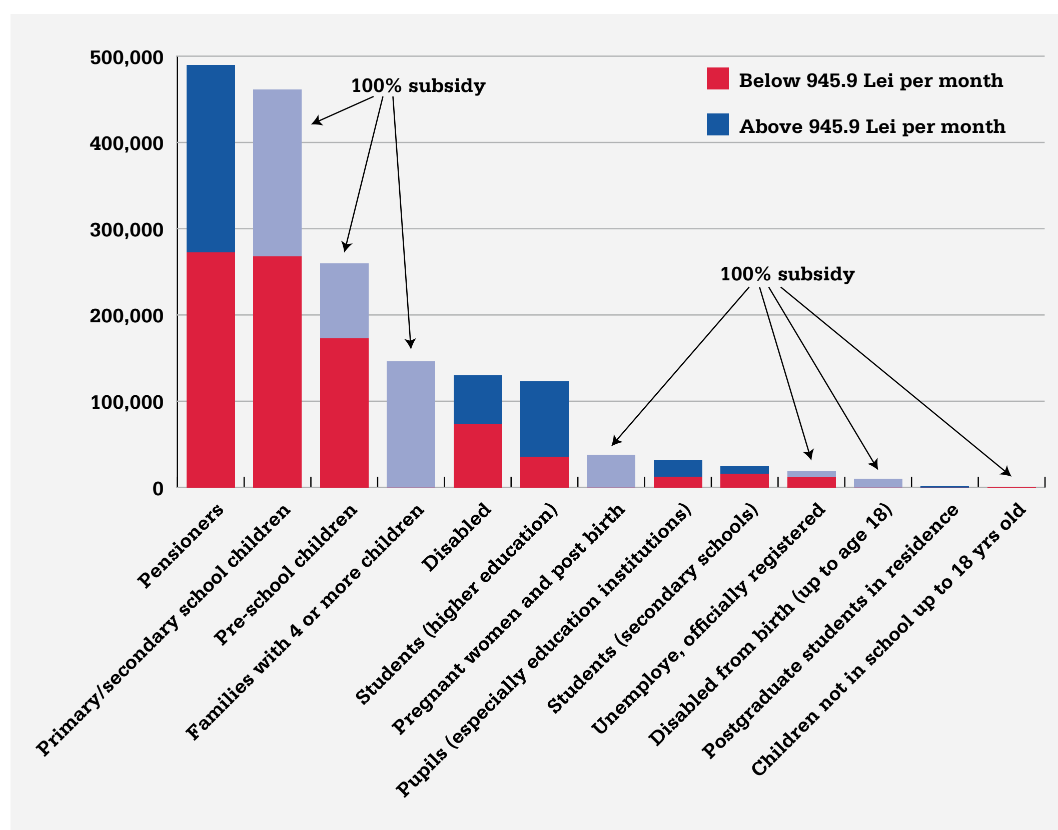
» respond to any reductions in the planned 2010 budget funding in a pro-poor manner;
» increase insurance coverage, by moving towards the use of partial subsidies for the non-poor and spreading these more widely, and
» improve the poverty-focus of public spending, and improve fair financing within the health system.

Based on discussions with the Ministry of Health and MHIC officials the following scenario of rearranging insurance subsidies with the existing thirteen priority groups is considered first:

» all persons from priority groups with per capita monthly household's income less then the absolute poverty level (945.9 Lei) receive full subsidy;
» persons from these groups with per capita monthly household's income more then 945.9 Lei receive a partial subsidy from the State, and hence have to co-finance health insurance contributions, and
» health insurance subsidies vary for different targeted groups.

Many scenarios can be considered with respect to using full versus partial subsidy, and certain groups may still merit full subsidy for a variety of reasons. In the following scenario, shown in Figure 21, we consider the following scenario as an example, again based on discussions with Ministry of Health and MHIC officials:

Figure 21: Retargeting subsidies using the absolute poverty threshold



Source: Author calculations based on (4) and (8)

- 100% subsidy for all those falling below the absolute poverty line
- also, 100% subsidy for those above the absolute poverty line in the following categories: school pupils, children of preschool age, families with four or more children, pregnant women, officially registered unemployed, those disabled from birth, and children below 18 years not involved in education institutions, and
- all others in one of the defined priority groups to receive a 50% subsidy and would thus have to contribute a further 50% themselves.

The total amount of subsidies required to fund this scenario is estimated as follows:

- for those in targeted groups with a per capita monthly household's income lower than absolute poverty level (862 500 individuals, 100% subsidy) = 905.7 million Lei
- for families with four or more children, pregnant women, and those disabled from birth (194 100 individuals, 100% subsidy) = 203.9 million Lei
- for school pupils, children of preschool age, children below 18 years not involved in education institutions, and officially registered unemployed with per capita monthly household's income more than the absolute poverty level (372 400 individuals, 100% subsidy) = 391.1 million Lei, and
- for other citizens, with a per capita monthly income above the absolute poverty level (461 800 individuals, 50% subsidy) = 242.5 million Lei.

The total amount of required subsidy under such a rearrangement is 1 619 million Lei. As mentioned several times in this report, these estimates are based on maintaining the 2009 planned per capita contribution, which is unlikely to be possible. These figures will need revisiting once the impact on budgets in the coming years is clearer.

3.3.4 Risks, concerns and opportunities of Option A

The question now is whether the technical proposal to refocus insurance subsidies on the poor is politically feasible, even with the precedent of the new Law on Social Support; there are strong arguments to move in this direction from a policy perspective. Secondly, as raised above, any new proposal needs to be administratively feasible or else it will remain little more than a technical idea.

One very real risk is that during the process of process an individual moving from a position of receiving a 100% subsidy to receiving a partial subsidy, may prefer to drop out of the system and avoid contributing. It is conceivable that insurance coverage could fall slightly in the short term. Hence it is essential that a public campaign stresses the mandatory nature of the scheme, that enforcement of contribution collections is strengthened, and that the premium contribution structure is considered fair by the population.

Importantly, the way in which budget subsidies to the MHIC are now calculated means that neither increases nor decreases in the budget directly affects population coverage levels. Just as insurance coverage has hardly changed since the establishment of the scheme, despite a rapid increase in revenues, population coverage will not necessarily fall as the budget reduces dramatically. What does vary from year to year is the per capita subsidy which is essentially a function of the number of people covered by the budget available.

One major challenge with the ideas presented in this section, is how to apply an income-based targeting mechanism given that there is no comprehensive database with such information on it in the Republic of Moldova. While there is now a legal link between the targeting mechanism used for the Law on Social Support, the threshold is very low, and only a very small number of households have been assessed under the scheme since implementation began.

The reallocation of subsidies based on poverty criteria is also likely to increase the effectiveness of strategies to increase insurance coverage among the self-insured, as discussed in the following section.

3.4 Option B: Strengthening the strategies and performance management of the MHIC

Some ideas have already been put forward in this report on how to improve the current design of the mandatory health insurance scheme, for example the fact that if subsidies were more poverty targeted the uninsured population would be more concentrated in the urban population; the advantage of this from an implementation or administrative feasibility perspective, is that it should be easier, or at least cheaper, to identify the uninsured and enforce contributions from them.

Several other measures have already been proposed as good practice for any health insurance scheme, namely regularly audit of small business to ensure they are complying with their obligations to contribute on behalf of their employees, improving awareness of the scheme and its benefits for the population, and making it as easy as possible for people to make payments, for example by expanding the network of collecting agencies (i.e. banks, microfinance agencies can be accredited as premium collection agencies, and may receive commission on this) as well as allowing, for example, monthly payments rather than the large one-off annual payment. Another measure previously mentioned is to move towards family enrolment which would significantly reduce administrative costs and help to close the gaps in coverage that currently exist.

One additional idea is to **introduce more than one flat rate for the self-insured**, rather than maintain one premium and to apply discounts to it. The motivation for this is similar to that of the new premium discount approach i.e. to adjust the premium to bring it more in line with ability to pay. The main difference is that one is a temporary adjustment with limited 'sticks' attached, while the other approach would be a permanent reflection of ability to pay, and could be backed up by the systems to ensure compliance. If more than one premium were to be generated, professional employment categories can be used as a proxy for income (see Table 8) although there is a trade-off between the number of groups selected and ease of administrative implementation; initially it would be advised to group these categories into two or three categories and to set a flat premium for each, taking into account the actual contributions of formally employed individuals.

Table 8: Average monthly income by labour force category 2008

Professional group	Average income per month (Lei)	Median income per month (Lei)
1 High level management	2500	2300
2 Professional	1986	1800
3 Technician and other professionals	1526	1400
4 Clerk	1317	1200
5 Service worker	1387	1200
6 Skilled worker in agriculture, forestry and fishery	982	900
7 Trade and related worker	2017	1900
8 Operator, assembler etc.	1882	1800
9 Unskilled worker	1063	850
10 Army	2296	2050
Average	**1667**	**1500**

Source: (17)

Finally, it needs to be stressed that any of the policy options presented in this report ideally require a well managed and accurate **database** of members. This is no small task, and there is considerable potential, for example, of double counting and duplication of enrolment; investing in a high quality database of members of the national health insurance scheme is hence worthy.

The mechanisms of **enforcement** of self-employed persons to make insurance contributions should be further strengthened. The state social insurance system which provides pensions and other social benefits in cash has also faced the problem of collecting contributions from self-employed workers, despite using quite developed enforcement mechanisms. The Law "On the budget of the social insurance system in 2009" (Nr. 262 from 11.12.2008) defines very clear not only the duty of all self-employed to pay social insurance contributions (3708 Lei per year), but also the duty of public administration bodies to ensure these payments. Local public administration bodies should give notice to those agricultural self-employed in arrears for contributions for state social insurance, and are obliged to collect them and then transfer the state social insurance budget. Territorial Tax Inspectorates issue business patents only after confirmation that the applicant has made the mandated state social insurance contributions for the entire period relating to activities based on the patent business. The same mechanisms should be used for the collection of mandatory health insurance contributions, with the corresponding amendments made in the annually adopted law "On the amount, manner and timing of payment of mandatory health insurance contributions".

The following tools are suggested for consideration:

» To introduce the automatic enrolment of legal dependants when a person is enrolled e.g. a person who is formally employed. Such family-based enrolment is common practice in many countries, some of which vary premium contributions according to family size, but most of which do not. This approach is consistent with the principle of enrolling groups rather than individuals. The current approach of marketing to individuals is highly inefficient in that it is expensive, delivers relatively few new

members, and exacerbates problems of adverse selection i.e. higher risk individuals are the most likely to purchase. Group enrolment, on the other hand, can lower per-new-member administrative costs while mitigating adverse selection (unless the group which is targeted is itself high risk e.g. a patient's group). The family is the most basic type of group.

» To introduce mandatory health insurance contributions as part of the taxation of patent holders. According to the estimation of the Head of Parliamentary Commission on Social Policy, the patent holders would accept the increase of taxation of patent if they know for what purpose this surplus would be spent (*16*).

» Make automatic deductions from any new income received by certain groups under Option A, for example pensioners. The same rate of taxation could be used for pensioners as that for formal sector employees i.e. 3.5% of the monthly pension in 2009. These contributions could be easily collected by social security agencies administering pension payments. In this case the contributions on social health insurance by pensioners might be estimated as following. At the date of 1 January 2009, the total amount of pensioners, including retired, disabled and other kinds of persons having right for state pension stood at 621 400, with an average monthly pension calculated as 646.4 Lei (*17*). The total amount of insurance premium contributions by all pensioners would be in the order of 168.7 million Lei in 2009.

» To collect mandatory health insurance contributions from car owners when they ensure their cars against civil responsibility. There will be a number of ways in which mandatory contributions can efficiently piggy-back on existing systems of taxation, or on other payment systems such as the electricity bills, which reach almost every household in the country.

» To introduce more flexible contribution payment systems i.e. allowing the self-employed to break the annual premium up into several payments, in the way that formal sector employees contribute every month. This builds on the premise that for many, the annual premium may not be too high, it is just too high to pay in one go. The disadvantage of this system is that it creates greater administrative costs, and can lead to instability in payments (e.g. members who pay one month, then miss a month, and then pay the following month). Such an option would have to be managed carefully and may for example only be offered to those setting up an automatic payment from a bank account.

» To develop partnerships with rural financial institutions (see Box 2). In certain countries, most notably the Philippines, the Government's health insurance agency has entered into partnerships with microfinance institutions. The rationale for initiating these partnerships was that while membership in the national health insurance programme was mandatory, it was de facto voluntary given the large informal nature of the economy and weak government regulatory capacity. Microfinance institutions typically provide financial services to those in the population who are not served by the formal banking sector. Members were often informal economy workers who were also uninsured, and as such targeting clients of microfinance institutions was an effective strategy in boosting insurance coverage.

Box 2: Two microfinance institutions in the Republic of Moldova

Corporatia de Finantare Rurala (CFR)

- Active in the Republic of Moldova since 1997.
- Private-for-profit but aims to contribute to rural development.
- Provides credit only to legal entities, not individuals. Clients are mostly savings and credit associations, of which there are 460 in the country. Other clients include small and medium-size enterprises.
- Savings and credit associations, in turn, provide small loans (on average 8000–9000 MDL, approx. US$ 800, but can range from 3000 to 30 000 MDL) mostly to farmers in rural areas.
- The total number of beneficiaries in the entire network is approximately 110 000–120 000. The network, including CFR, was created within the World Bank supported project on rural financing.
- RFC does not view the lack of mandatory health insurance among its members as a credit risk, and as such this is not a prerequisite for making a loan. Criteria for approving loans are very simple and based on the moral values/reputation of applicants; risk is viewed a mutual responsibility.
- RFC does not know what proportion of their beneficiaries are insured, but assume it to be very low. Most clients are the active and healthy part of the rural population with few health problems that could involve catastrophic expenditures. They also experience few cases of failure to repay loans, with most associations having life insurance policies.

MICROINVEST

- Active in the Republic of Moldova for six years.
- Private-for-profit.
- Have 4000 active clients and a portfolio of 250m Lei.
- Lend only to businesses, not individuals. Most are small businesses, including many small farmers. Most clients are in rural areas who they see as the ‘entrepreneurial poor’.
- Have few problems in terms of portfolio-at-risk. Unsure about levels of insurance coverage among members, but estimate it to be low.

This approach also took advantage of the group approach, with several thousand new members being enrolled under one contractual agreement. Microfinance institutions also had an incentive to promote or insist that their members had health insurance coverage, as in most cases portfolio-at-risk was explained to a significant degree by members becoming sick and not being able to repay loans due to high out-of-pocket health expenditures. Two examples of such microfinance institutions in the Republic of Moldova are profiled in Box 2.

» Apart from public policy actions, some spontaneous health financing initiatives have also evolved in the Republic of Moldova. One example is the creation of informal sickness funds by policemen; while they have their own departmental health care system they have access to only one tertiary facility in Chisinau. They have to pay for admission to tertiary care hospitals in Chisinau as well as for admission to other public hospitals not included in the departmental system, and hence to cover expenditures for treatment in public non-departmental hospitals, informal pooling of money has evolved. The amount of informal contribution is 30 Lei per month. Such a scheme could be integrated within the national scheme with little increased risk to the national pool but with substantial gains to the police.

3.5 Option C: Expanding the universal package of services

The third policy option takes a different strategic approach to that underlying the various ideas outlined in this report, and proposes further extending the package of health services provided as a universal guarantee to all Moldovan citizens, irrespective of their health insurance coverage. This approach weakens the link between contributions and entitlements, in turn strengthening the rights of citizens to essential health services. There are strong arguments for reinforcing universal access to health services, in particular primary health care, at a time when unemployment is rising rapidly.

One major advantage of this approach is that the administrative challenges and costs involved in developing and implementing strategies to close gaps in population coverage, for example through the identification of particular population subgroups, or those individuals below a certain income threshold, establishing how much they should pay, and then enforcing the collection of contributions, would be entirely avoided. It is estimated (see Table 9 for further details) that 202 Lei per capita would be needed to extend primary health care to all the uninsured as follows:

- 96 Lei for ambulance care that would equalize guarantees for free ambulance care for insured and uninsured persons, and
- 106 Lei for enlargement free primary care provision for uninsured.

Table 9: Per capita expenditure of MHIC for different types of care for insured and uninsured (Lei)

	Insured	Uninsured	
	2009 planned	**2009 planned**	**Enlarged benefit package**
Primary care	385.1	16.9	122.9
Specialized outpatient care	94.9	-	
Ambulance care	114.5	18.5	114.5
Inpatient care	656.8	-	
Total	**1251.3**	**35.4**	**237.4**

Source: (4)

This approach would change the way in which the MHIC pays primary care providers i.e. no longer on the basis of the number of individuals enrolled into the MHIC, but rather based on the number of individual citizens registered at the primary health care facility. Further calculations would need to be made to establish the impact on internal reallocations within the Ministry of Health budget.

While this approach would not directly increase the number of individuals enrolled under the mandatory health insurance scheme, this strategic option would have a **high positive impact** on access to services and financial protection for the population, "…ensuring the equal and adequate access to health services for all citizens of the Republic of Moldova." being a stated goal of National Health Policy 2007–2021, and progress could be made in the **short term**.

4. CONCLUSION

The entire focus of this report, which is to propose strategic policy options to the Government of the Republic of Moldova to further increase levels of population coverage under the national mandatory health insurance scheme, needs to be seen in the context of the broader health system, and health system reforms. For example, there remains considerable room for improvements in the way that health services are organized, managed, funded and delivered, and reforms which support such changes may also deliver savings and efficiency gains, something which is now a top priority. Indeed, the need to make savings is will understandably increase as the financial crisis depends and pressure on public finances grows, and are likely to be crucial to ensuring greater population coverage under the mandatory health insurance scheme without a substantial deterioration in the quality of health services.

Finally, this report was prepared between November 2008 and November 2009, a period when the global financial crisis deepened, severely affecting the fiscal situation in the Republic of Moldova. While the most up-to-date figures have been used in the analysis presented the situation is changing rapidly. Any new policy based on this report would be wise to revisit the specific figures; however, the principles underlying the recommendations and the three broad options proposed, remain relevant to the current challenge facing the Moldovan health system to move towards universal population coverage under the mandatory health insurance scheme.

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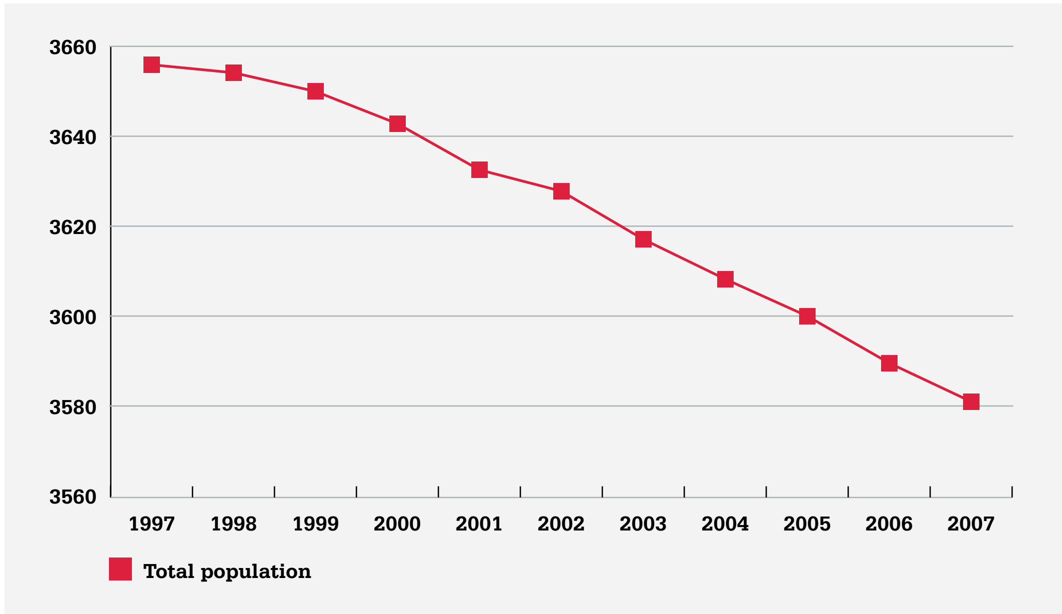
ANNEX 1. DEMOGRAPHIC TRENDS

Population changes impact heavily on health insurance systems in different ways:

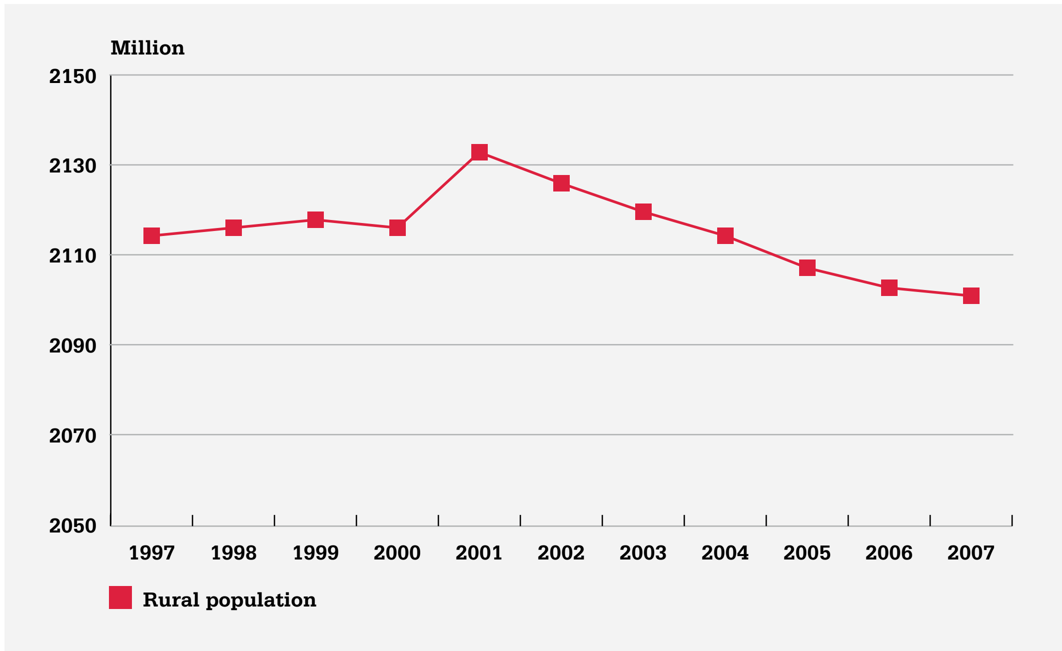
- The size of the population determines the scope of the population to be covered;
- The age composition of the population impacts directly on the dependency ratio;
- The sex-age composition of the population impacts on the population health risk-profile of the population to be covered by the MHIC.

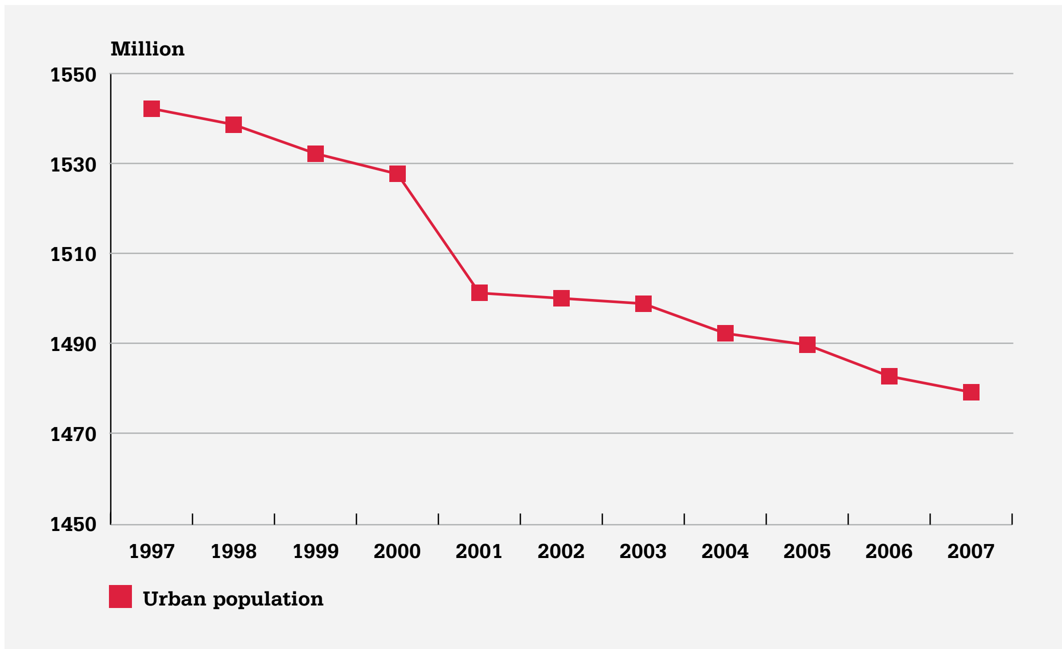
Each of these factors is discussed in turn.

Historic patterns: Demographic evolution 1997-2007



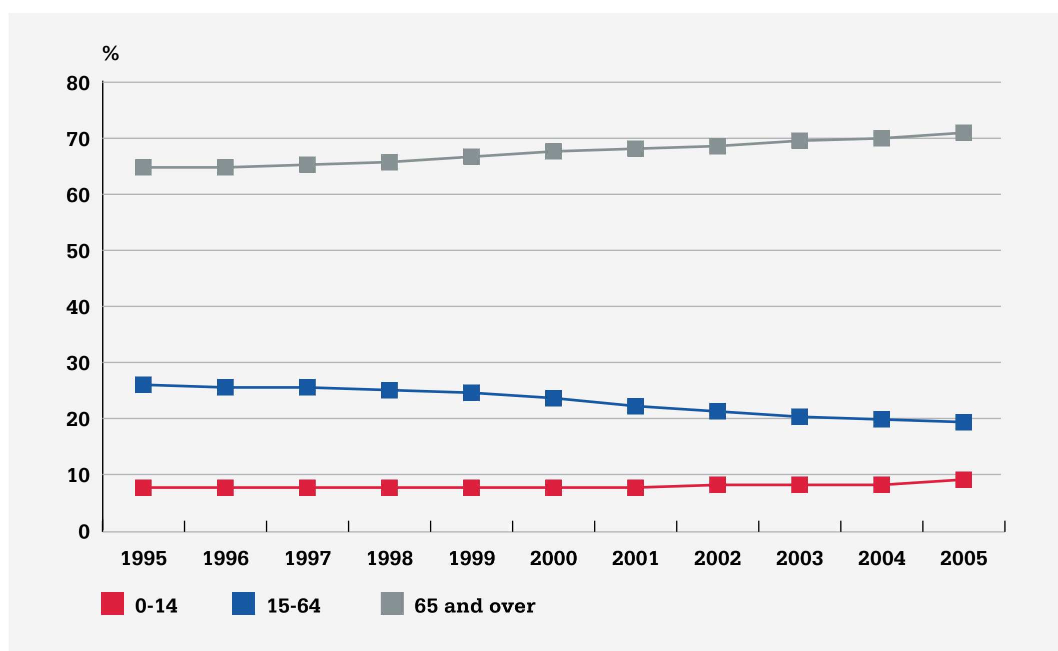
The population in the Republic of Moldova has been decreasing at an accelerating rate since at least 1997. Between 1997 and 2007 the population contracted by 2.1%. The decrease was sharper in urban (-4.3%) than in rural (-0.5%) areas.





While the relative proportion of females and males in the population remained stable over the period 1997–2007, the age structure changed considerably with the proportion of 15–64 years and 65 and over increasing at the expense of the 0–14 years old.

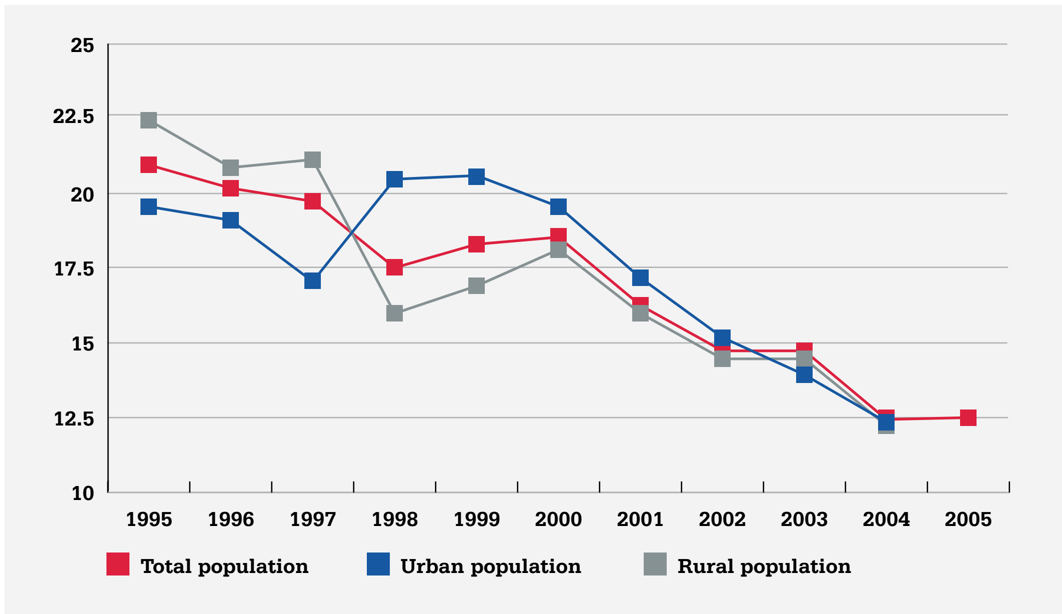
Age structure 1995-2005



The main driver of this relative shift in importance between age groups is a decreasing birth rate over that period. As a higher proportion of active individuals take care of a smaller share of inactive individuals the dependency ratio has also decreased over the period 1995 – 2005. The dependency ratio in rural areas is higher than the one in urban areas. The age structure is similar for men and women in 2004.

The general mortality rate (number of deaths per 1000 population) has been relatively stable over the reference period, although significantly higher for men compared to women. Infant mortality, however, has decreased significantly and more so in rural compared to urban areas, and stood at 12.2 infant deaths per 1000 live births in 2005.

Infant mortality rate 1995-2005



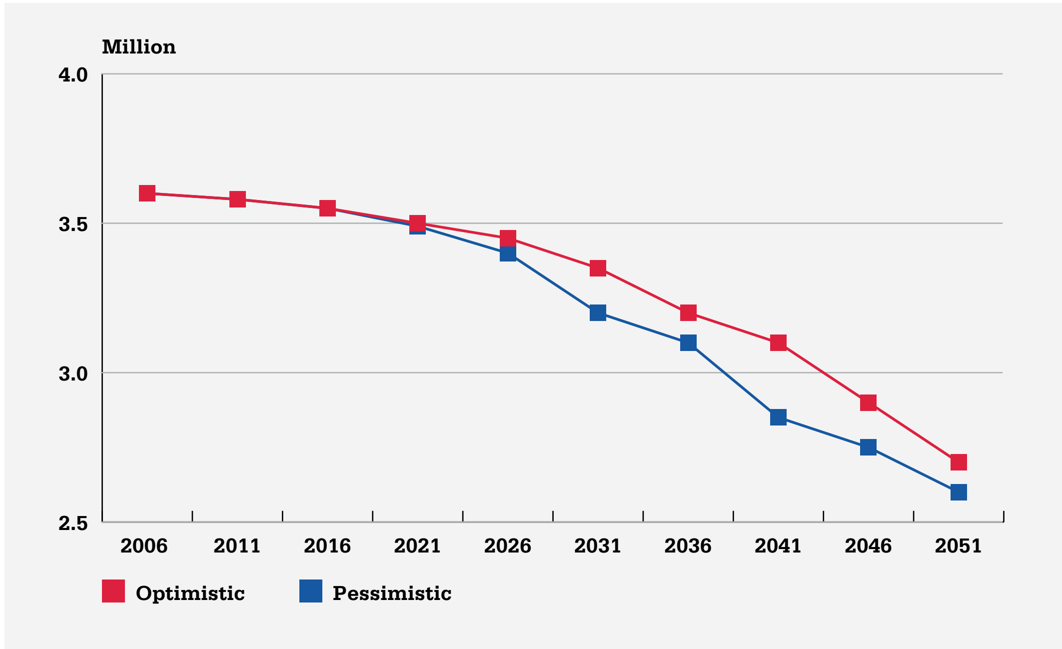
The Republic of Moldova experienced a substantial reduction in its overall birth rate between 1995 and 2005. The birth rate was one of the lowest in the world in 2005 and not sufficient to maintain current population levels, resulting in a negative population growth rate.

Population forecast

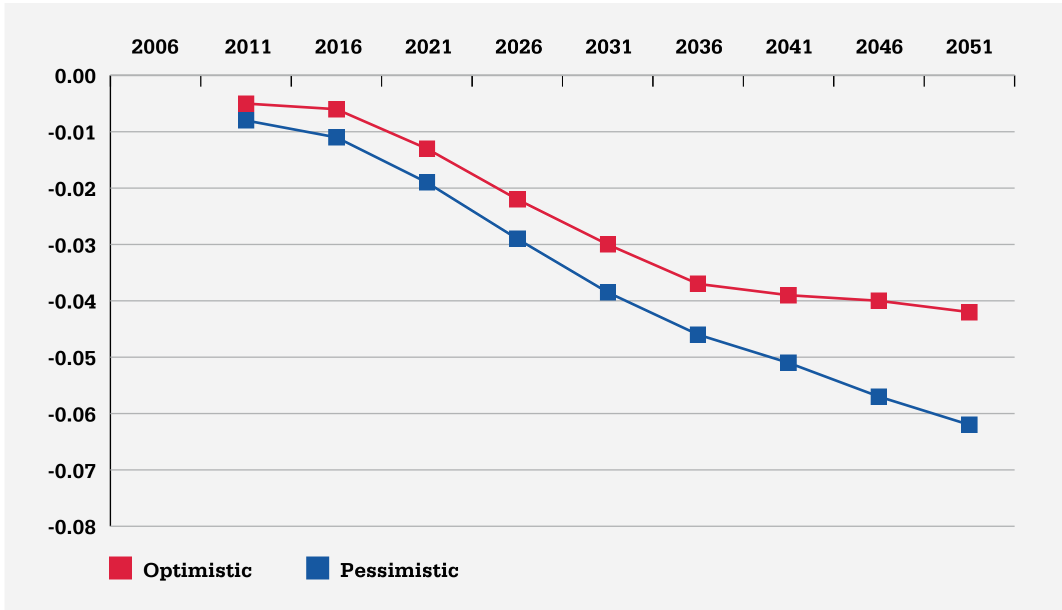
The Academy of Science recently completed a population forecast distinguishing between different scenarios, including a pessimistic and an optimistic scenario. The two scenarios differ in their assumption regarding the evolution in the total fertility rate in the period 2006 – 2051, but the declining trend in total population observed since the 1990's persists in all scenarios.

The following graphs and tables show the population forecast, the population growth rate and its rate of decline.

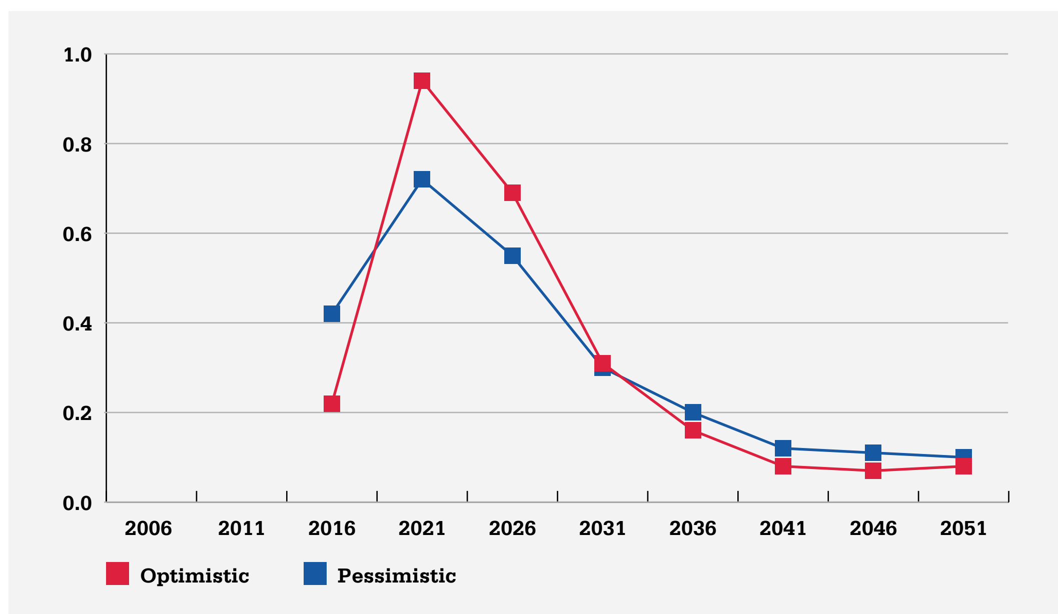
Population forecast



Population growth rate



Rate of decline (2nd derivative)



Population forecast

	Pessimistic	Optimistic
2006	3 585 523	3 585 532
2011	3 557 858	3 564 526
2016	3 518 746	3 538 967
2021	3 451 891	3 489 754
2026	3 350 504	3 408 496
2031	3 222 337	3 303 794
2036	3 075 582	3 186 138
2041	2 918 230	3 064 387
2046	2 752 908	2 940 029
2051	2 580 822	2 812 841

Population growth rate

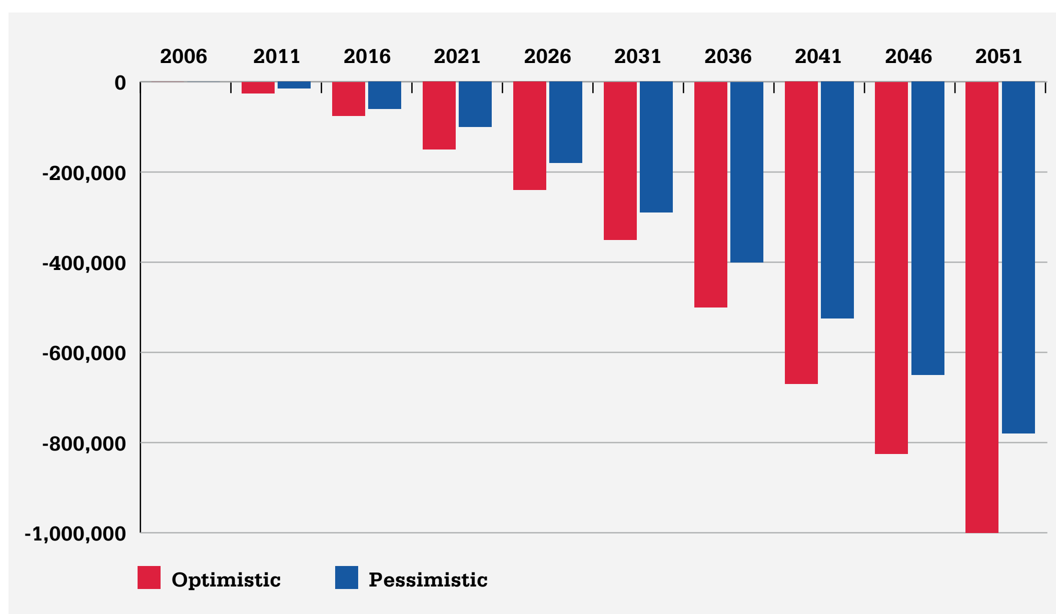
	Pessimistic	Optimistic
2006		
2011	-0.77%	-0.59%
2016	-1.10%	-0.72%
2021	-1.90%	-1.39%
2026	-2.94%	-2.33%
2031	-3.83%	-3.07%
2036	-4.55%	-3.56%
2041	-5.12%	-3.82%
2046	-5.67%	-4.06%
2051	-6.25%	-4.33%

Population rate of decline

	Pessimistic	Optimistic
2006		
2011		
2016	0.42	0.22
2021	0.73	0.94
2026	0.55	0.67
2031	0.30	0.32
2036	0.19	0.16
2041	0.12	0.07
2046	0.11	0.06
2051	0.10	0.07

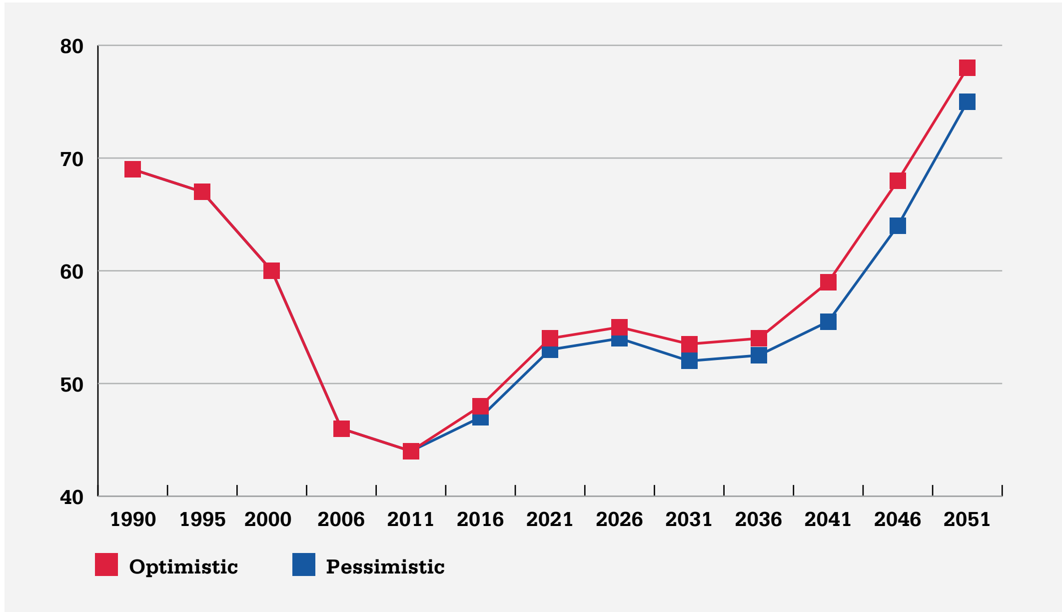
Total population is projected to decline in all scenarios; from 3.58 million in 2006 to 2.58 million in the pessimistic scenario, and to 2.81 million in the optimistic scenario. The population growth rate is increasingly negative over the years. While the growth rate is negative throughout the forecast period the rate of decline accelerates between 2016 and 2021 and decelerates in the years after. An immediate effect of the population forecast is that the target coverage population for the MHIC declines dramatically, with about 1 million individuals fewer to cover in 2051 compared to 2006 under the pessimistic scenario, and 800 000 in the optimistic scenario.

Cumulative population decline 2006 baseyear



However, perhaps more important than total population for the MHIC in the Republic of Moldova, is the age composition of the population as this directly impacts on the dependency ratio. The total dependency ratio, obtained by dividing the number of youth and elderly by the number of economically active, is a measure of the financial burden for upbringing and social security measures including health insurance that falls on the economically active population. The erratic evolution of the dependency ratio points at offsetting growth rates in the youth and elderly population segment, but from 2031 onwards the dependency ratio changes adversely under both scenarios. The evolution suggests that up to 2011 there is increasing opportunity for a positive balance between MHIC revenue and expenditure, which is likely to be eroded away from then onwards.

Total dependency ratio



Dependency ratio

	Pessimistic	Optimistic
2006	68.7	68.7
2011	66.4	66.4
2016	59.7	59.7
2021	46.5	46.5
2026	44.1	44.3
2031	47.6	48.4
2036	52.7	54.4
2041	53.4	55.5
2046	51.2	53.6
2051	51.6	54.2

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