HiT summary Republic of Moldova

Introduction

Government and recent political history

The Republic of Moldova became independent in August 1991 with the collapse of the Soviet Union. The country became a parliamentary republic in 2000. The head of state is the president, elected by the unicameral parliament every four years. The president nominates the prime minister who is approved by the parliament. Since 1991, there has been civil strife in Transdniestria, a region effectively outside central government control.

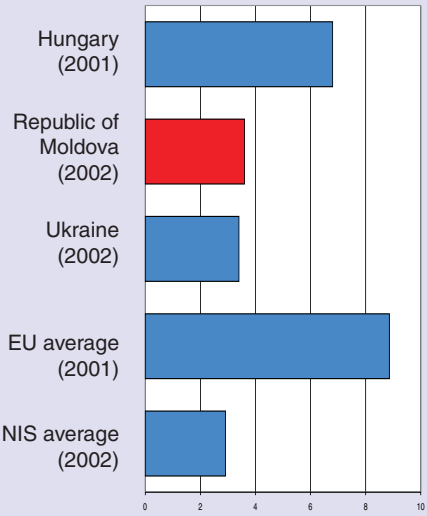
Population

The population was estimated to be 4 267 000 in 2003. Over the last decade, the birth rate has declined and the mortality rate increased, while emigration is thought to be sizeable. The serious economic decline since independence has led to decreasing living standards and widespread poverty. When measured in GDP per capita, the Republic of Moldova was the poorest country in Europe in 1999, although this does not capture the large-scale informal economy.

Average life expectancy

Trends in life expectancy have followed those of the former Soviet Union as a whole. Between 1989 and 1995, life expectancy at birth declined from 69.09 to 65.88 years, with a particular decrease in male life expectancy. Since 1996, life expectancy has increased again, although it has still not reached the level of 1989. In 2002, it was 68.11 years for both sexes, with 64.39 years male and 71.76 years female life expectancy.

Fig. 1. Total health care expenditure as % of GDP, comparing Republic of Moldova, selected countries and EU and NIS averages



Source: WHO Regional Office for Europe health for all database.

Leading causes of death

The main causes of death are diseases of the circulatory system, followed by cancer, diseases of the digestive system and external causes of death. The mortality rate of diseases of the circulatory system was the highest in Europe in 2002, with alcohol abuse as one of the likely causes. Infant mortality (14.79 per 1000 live births in 2002) has continued to fall in recent years, but maternal mortality (30.81 per 100 000

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in 2002) is still many times higher than in the European Union.

Recent history of the health care system

During the Soviet period, the health care system followed the Semashko model, with centralized planning and administration and a focus on high numbers of doctors and hospital beds rather than on outcomes. The collapse of health care funding in the beginning of the 1990s, combined with the inefficient use of existing resources and the focus on tertiary care, has threatened the provision of the most basic health services, such as vaccination.

Reform trends

The reform of the health system has proceeded at a slow pace, but some important changes have occurred in recent years. Since 1997 the institution of family doctors has been introduced in primary care. There have also been reforms of the hospital sector. In 1998, the number of hospital beds and personnel was reduced, in 1999 some planning and funding mechanism decentralized and in 2001 a new financing mechanism introduced, basing funding on the number of patients rather than the number of beds. The introduction of a compulsory health insurance scheme has been delayed by lack of funds.

Health expenditure and GDP

Total health expenditure was estimated to be 3.6% of GDP in 2002. However, this figure does not include private payments (both formal and informal), which have grown considerably in recent years.

Overview

The Republic of Moldova has started the reform process cautiously, but major steps have now been undertaken. One of these steps is the development of a minimum package of health care in 1998. The strengthening of the primary sector and the restructuring of the secondary and tertiary sector will help to make health care more affordable and efficient, although hospitals continue to consume the majority of health resources. One of the main challenges now is to overcome the funding constraints through a new system of finance, while ensuring equal access of all to a basic level of care.

Organizational structure and management

The Ministry of Health is responsible for policy development and quality control and manages national level tertiary facilities and hospitals. At the regional (judet) level, health authorities are responsible for the organization of health care services. There are also a number of facilities belonging to other ministries, including those responsible for railways, prisons and defence, which provide parallel health services.

The Ministry of Health has the overall responsibility for health care, with a shift from the provision of services towards setting guidelines, monitoring and the provisions of national programmes, such as immunisation and tuberculosis control. The regional health administrations, set up in 1999, plan and manage health services in the regions. The Scientific and Practical Centre for Public Health and Management collects data, undertakes analytical research and defines guidelines.

There are a number of professional medical associations, such as the Nurses Association, the Association of Surgeons and the League of Physicians. There are also patient groups and nongovernmental organizations and a range of international donors. The private sector has yet to develop. The majority of health facilities continue to be publicly owned and funded. Pharmacies and dental clinics, however, are almost all privatized. There are now also private outpatient clinics providing diagnostic services.

Planning, regulation and management

Planning is mainly the responsibility of the Ministry of Health, although the role of the regional health administration in this field is growing. Several republican institutions and the Scientific and Practical Centre for Public Health and Management contribute to the planning process through the provision of data and expertise. The Ministry of Health is responsible for regulating standards of medical training, while the Ministry of Education administers the training programmes. Existing guidelines on treatment contradict in some cases internationally accepted norms and are currently being revised.

Decentralization of the health care system

In the Soviet period, key decision-making and planning were taking place in Moscow. In 1991, decision-making and planning powers were moved to Chisinau and have in 1999 been further decentralized to the country's regions. The regional health authorities are now responsible for planning and administering locally collected taxes for health services in the region. However, this process of decentralization has been limited by the inadequate funding of regional administrations.

Health care financing and expenditure

Main systems of financing

Funding comes from three main sources: general taxation, regional taxation and direct private funding. General taxation continues to be the most important source of funding. Although a Law on Compulsory Health Insurance was passed in 1998, no major changes have been made in the national financing arrangements except the introduction of charges for some health services. Currently, levels of government financing are insufficient. Little is known about health care funding and performance in the region of Transdniestria.

Complementary sources of financing

Both formal and informal payments form an increasing source of financing for health care, which may at least match government funding. Official fee-for-service payments were introduced in 1999. Official fees and widespread informal payments negatively impact on the poor, many of which forego treatment due to financial constraints. It is unclear to what extent private voluntary insurance is used by the population.

The Republic of Moldova receives international assistance in the health sector from a range of donors, including UN agencies, the World Bank, the European Union and bilateral donors. The Republic of Moldova has become a member of the Stability Pact for South Eastern Europe and has developed an Interim Poverty Reduction Strategy with the World Bank, which envisages increasing the resources allocated to the health sector and improving access to health services.

Health care benefits and rationing

A law on a minimum package of health care was passed in 1998. It provides for free medical services to pregnant women and children under five years of age, who go to a family doctor for treatment or referral. In reality, however, free health care provision is very limited and a large number of patients refer themselves to higher levels of care and pay for themselves. Problems with the existing package include lack of funding, budget differences between regions, insufficient public knowledge and unclear funding mechanisms.

Health care expenditure

According to the WHO Regional Office for Europe health for all database, total health expenditure was 3.6% of GDP in 2002, amounting to only US $62.35 PPP per capita. As already

mentioned, this figure does not include the substantial out-of-pocket payments and private pharmaceutical expenditure, so that the actual health care expenditure can be assumed to be much higher.

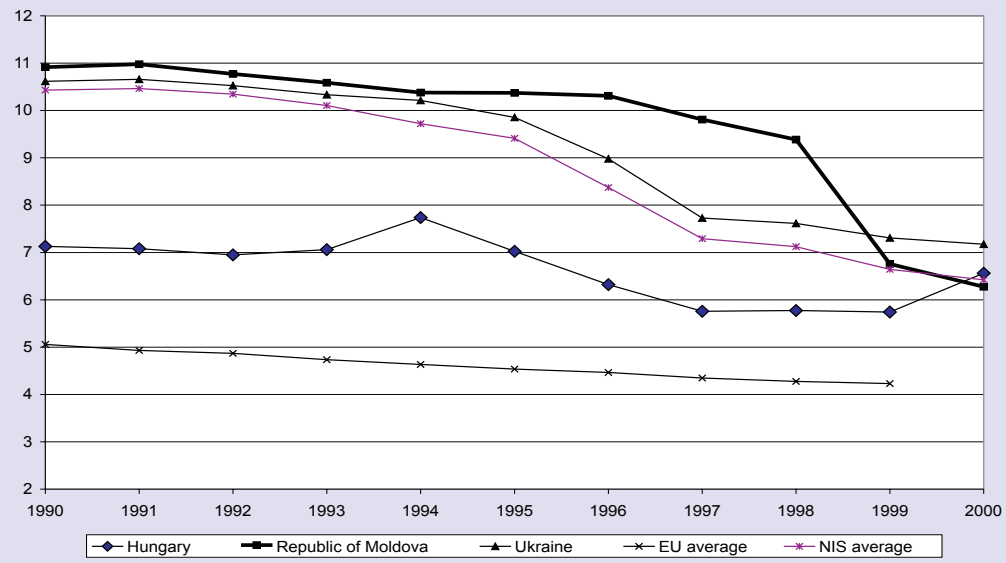
Health care delivery system

Primary health care

Despite reductions in the number of hospitals and specific allocations funds for primary care, the health system continues to be heavily weighted in favour of tertiary care. Health posts, family doctor offices, health centres (formerly ambulatories) and family doctor centres form the key elements of primary health care and are linked to local level hospitals. Primary care provision through clinics and health centres is the responsibility of the regional health administrations, which fund salaries of primary care staff. The primary health care facilities and practitioners are responsible for the delivery of the minimum package of free medical assistance, established in 1998. Although over 800 primary care facilities exist in the Republic of Moldova, they were traditionally used as referral points to higher-level treatment rather than as providers of primary care services.

Efforts are now being made, jointly with external donors, to strengthen primary care services. In 2000, primary care services were rendered by 36 family doctor centres, 366 health centres and 441 general practitioner offices. In addition, the rural population receives basic first aid in 585 doctor's assistant health posts. Although the primary care facilities are being restructured to play a key role in the health system, they are currently severely under-resourced and have difficulties providing the primary care components of the minimum package, leading to low utilization and patient dissatisfaction.

Fig. 2. Hospital beds in acute hospitals per 1000 population, Republic of Moldova, selected countries and EU and NIS averages, 1990–2000



Source: WHO Regional Office for Europe health for all database.

Progress, however, has been achieved in the training of doctors in family medicine and the expansion of family planning provision.

Public health services

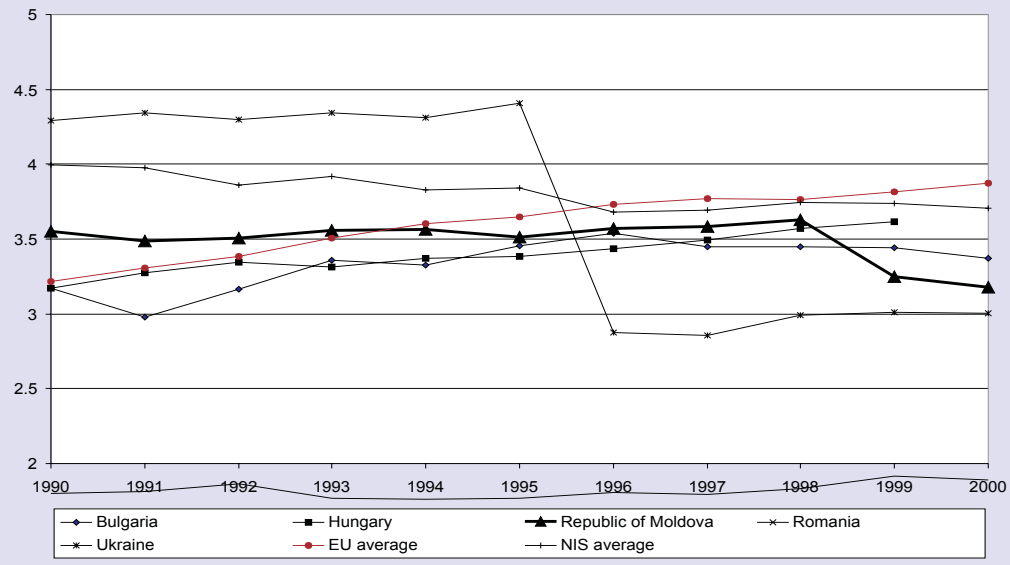
Public health remains focused on the traditional functions of the old sanitary-epidemiological (san-epid) service, with an emphasis on control of communicable disease and environmental health. These activities are run as separate vertical programmes with their own structures apart from the health care delivery system (with the exception of immunization) and the regional health administrations. However, some parts of the public health system have been reformed and expanded including efforts to introduce broader health promotion activities to address issues such as smoking and HIV prevention. The National Health Policy has also called for a broader focus on public health.

The Ministry of Health is responsible for public health services. Health promotion, epidemiological services and environmental health activities are run by the National Scientific Practical Centre of Preventive Medicine, which focuses on communicable disease control, including management of the national immunization programme, and environmental health issues. The centre now has a special section on health promotion, although this section remains severely under-funded. In 1995 a "Healthy Lifestyles" centre was developed and in 1998 a national health education programme was drawn up. A new national immunization programme was established in 1994 and has achieved good results, although it is highly dependent on support from international donors.

Secondary and tertiary care

The Soviet health care system left the Republic of Moldova with an enormous and unsustainable number of facilities and practitioners providing secondary and tertiary care. In 1994 the country had over fourteen beds and around 4 doctors per

Fig. 3. Physicians per 1000 population, Republic of Moldova, selected countries and EU and NIS averages, 1990–2000



Source: WHO Regional Office for Europe health for all database.

1000 people, almost double the number found in the central and eastern European countries as a whole at the time. Reductions in secondary and tertiary care provision began on a large scale from 1998. In 1999 a new hospital restructuring plan was developed, calling for the closure of all large hospitals in the regions except one and the transformation of polyclinics into family medicine centres. The reforms have resulted in a massive reduction of hospitals, reducing the number of beds from 13 per 1000 people in 1991 to 5.8 per 1000 people in 2002.

Despite the large provision of hospital beds until 1998, reported bed occupancy rates were over 90% at the end of the 1980s, reflecting an emphasis of clinical guidelines on long hospitalisation and incentives for hospitals to maintain high occupancy rates. Since then, there has been a decline to 75.1% in 2002, although official data are likely to be an overestimate, as hospital managers and doctors have had incentives to over-report admissions, length of stay and occupancy rates to prevent closure of their facilities.

Social care

The Ministry of Labour and Social Protection is officially responsible for the provision of social care. Social care provision takes the form of unemployment benefits, care for the disabled, elderly and other groups requiring assistance through financial or other measures and provision of a large number of child care homes. While a large part of the population requires some form of social care, the capacity of the state to provide social assistance is very limited. Provision of care for the elderly has traditionally been missing, and many hospitals have been used by elderly people no longer needing medical care, so that the Ministry of Health effectively contributes to the care of the elderly. On the other hand, there are a large number of state care homes for children with physical or mental disabilities, to which children born outside marriage were sent also.

Human resources and training

The number of medical professionals has dramatically declined since 1998 and has now fallen below the levels of the European Union. In 2002 there were 2.7 doctors, 6.3 nurses and 0.3 dentists per 1000 population. However, it has been estimated that around 15% of rural areas are not covered by doctors.

Most staff are employed by the state. Physicians are mainly described as specialists although a large family medicine training programme has begun. The Republic of Moldova uses central planning to determine how many people can enter the health workforce. This is the responsibility of the Human Resources Unit in the Ministry of Health.

Doctors from all parts of the country are trained at one of five state-certified medical colleges and at the State Medical University. Nursing training takes place through five colleges of "secondary medical training". The number of nursing colleges was reduced from eight to five in 1999 to reduce perceived overproduction. New structures for enhanced primary care training are being put in place for both doctors and nursing staff. In 1996 the Family Doctor Training Programme began. In 1998 the Faculty of Family Medicine was established at the State Medical University, and a Chair in Management Training and Public Health was established in 2000.

At present, health staff face difficult working conditions. Staff continue to be salaried employees of their institution, their salaries are very low and often delayed by three to four months. Informal payments are therefore frequently requested and make up a large part of income for many medical professionals.

Pharmaceuticals

The Moldovan pharmaceutical distribution sector underwent a major process of privatization in 1994. Today many pharmacies are privatized, although the state remains a shareholder in a

number of the privatized enterprises. The large scale privatization was undertaken to ensure an adequate and regulated drug supply in the face of economic collapse and the state's difficulties running its own drug supply and distribution system.

Regulation of the pharmaceutical sector is a responsibility of the Ministry of Health. It has set profit limits for drugs (40% on wholesale price) on pharmacies and also regulates which drugs may be sold. An essential drugs list was established in 1998. The country imports most of its drug requirements. As part of the health reform process and with certain exceptions, it moved to a system of local hospital-level purchasing. Many people, however, cannot afford pharmaceuticals.

Financial resource allocation

The national health budget is set annually. Since 1999, each region has formed a regional health budget and submitted this to the Ministry of Health. The regional budget outlines requirements for provision of the minimum package and provision of care through the regional health facilities. From 1999 onwards, health budgeting has moved from being based on bed numbers to an age-weighted capitation system.

Payment of hospitals

The hospital sector has been severely affected by the economic crisis and the inefficient management of resources. Local governments (or in the case of republican hospitals, the Ministry of Health) finance hospitals from state funds in line with the provision of inputs and hospitals in turn disburse funds to their associated polyclinics.

Hospital directors, as part of the health reforms, now have greater autonomy than under the Soviet system but are still allowed only limited discretion in varying budget allocations within their own institutions. However, they do now have the autonomy to levy charges in certain instances and are permitted to retain any income generated by their hospital to supplement state budget provisions.

However, hospitals do not always receive all the funding they requested in their budgets. As a result, hospital administrators try to cover this deficit by transferring the costs of health services to inpatients who must pay "from their pockets". The Ministry of Health plans to institute major reforms of hospital financing by introducing compulsory health insurance and extending the use of contracts to ensure that payment will be on the basis of the volume and quality of services provided.

Payment of physicians/health care professionals

Physicians and middle-level medical staff are paid a salary that reflects their hours at work rather than their levels of activity. In addition, remuneration tends not to reflect the levels of responsibility assumed by health care personnel and does not encourage them to upgrade their professional skills. The salaries of medical staff are very small, on average only US $32 per month in 2002, and this creates low morale and conditions for under-the-table payments.

The Ministry of Health plans to incorporate changes in labour remuneration into the health care reform process, seeing it as an essential step in enhancing morale and the quality and efficiency of care. Experiments with the payment of general practitioners in pilot areas, whereby a basic salary is 'topped up' by capitation fees, are underway.

Health care reforms

During the period of transition, the health care system found itself unable to provide adequate, consistent and affordable basic health care, or to sustain the enormous provision of specialist care

that was drawing funds away from the basic care level. The inherited system was highly centralized and planning was designed around funding bed numbers in specialist facilities with little opportunity for effective local level planning.

The Republic of Moldova began the health reform process cautiously. Privatization of many dental clinics and pharmaceutical services was implemented relatively early, but major efforts to address the unaffordable large provision of specialist care and channel funds from this to primary care did not really take off until 1998, when the government published the "Health Strategy 1997–2003" and initiated a medium hospital restructuring. In 1999 the government passed the law on the "Regulation on Fee for Health Services" which legalized formal payments for some health services.

One of the key reform measures undertaken so far includes the development of a minimum package of health care in 1998. Although the package is, in reality, not yet available to all due to funding constraints, it is helping guide health planning towards providing a minimum level of basic services with whatever funds are available. The move from bed numbers to a weighted population measure in planning the health budget also represents a big step in making health planning more realistic and closer to the needs of the population. In a major move to ensure more accountability and reflection of local needs in health planning, the creation of the regional health structure has brought a high level of decentralization to the health system.

Actions to respond to the call for strengthening the primary care services started in 1997 with the beginning of family medicine training. Since then, over 2000 staff have been trained in aspects of family medicine and over 500 family medicine centres have been opened.

The massive restructuring of the secondary and tertiary care has resulted in a reduction of over half in staffing and bed numbers at this level. This restructuring is supposed to have released additional funds to the primary care sector. However, whether all funds released through these reductions have been passed to the primary care sector or even remained within the health sector at all is unclear, as primary care facilities remain severely under-funded and under-equipped.

Conclusions

After independence the health system faced both worsening health indicators of the population and severely diminished resources for the health system. The health reforms are beginning to address some of the pressing issues of the system. The Republic of Moldova has started the process of rationalizing the size of its health system, both in terms of numbers of facilities and staff. It has also begun innovative training for health staff in new methods of management and care. Although the health system still has far to go in ensuring equal access of all to a basic level of care, it has started the journey towards meeting this goal.

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Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Hungary	5.9	22.9	6.9	77.8
Republic of Moldova	4.7	13.1	9.7	75.1
Ukraine	7.2	19.2	12.3	89.2[a]
EU average	4.1[a]	18.9[b]	7.7[b]	77.4[c]
NIS average	8.2	19.7	12.7	85.4

Source: WHO Regional Office for Europe health for all database.
Notes: [a] 2001, [b] 2000, [c] 1999, [d] 1998, [e] 1997, [f] 1996.

The Health Care System in Transition (HiT) profile on the Republic of Moldova was written by Laura MacLehose (European Observatory on Health Systems and Policies) and edited by Martin McKee (European Observatory on Health Systems and Policies). Martin McKee was also research director for the Moldovan HiT.

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The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

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