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Framework for addressing out-of-pocket and informal payments for health services in the Republic of Moldova

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Taryn Vian, Frank G Feeley, Silviu Domente

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LIST OF ABBREVIATIONS

BCA	biennial collaborative agreement
CBO	community-based organization
CNAM	National Health Insurance Company
CSO	civil society organization
ERP	external reference pricing
GDP	gross domestic product
GP	general practitioner
INN	international non-proprietary name
LSL	Lesotho loti
MDL	Moldovan lei
MNT	Mongolia tugrik
NAC	National Anticorruption Center
NBS	National Bureau of Statistics
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
OOP payments	out-of-pocket payments
PACA	Project Against Corruption in Albania
PAS Center	Center for Health Policies and Studies
PHC	primary health care
RTIA	Right to Information Act (India)
SPR	single payer reform
THE	total health expenditure
UNDP	United Nations Development Programme
US$	United States dollars

EXECUTIVE SUMMARY

The Government of the Republic of Moldova is committed to ensuring access to affordable high-quality health care for all citizens through health reforms which promote universal coverage, reduce inequities, improve efficiency and expand financial protection. There is concern that high out-of-pocket (OOP) payments and the presence of informal payments may be hindering achievement of these goals. This report presents a discussion of how OOP and informal payments in the Republic of Moldova are affecting health sector objectives; a framework for understanding the drivers; and suggestions for policy options to reduce these payments.

Previous analyses have provided background on formal OOP payments and proposed a range of policy options, some of which are already under implementation. Reforms targeting informal payments are high on the agenda of the Government and civil society, yet this sensitive issue has not yet been addressed comprehensively. While this study touches on all types of OOP payments, the aim is to provide more detail on informal payments and to focus recommendations in this area.

Methods
Data were collected between August and October 2013 through review of documents, health laws and regulations; key informant interviews; focus groups with providers and patients; and analysis of quantitative data on salaries and household care seeking behaviour and expenditures. A policy workshop for 45 participants was held at the Ministry of Health of the Republic of Moldova on 31 January 2014 to present the draft framework and discuss policy options. The final report incorporates input from this workshop.

Definitions
OOP payments are defined as "any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent" is to enhance or restore health status. OOP payments include both formal and informal payments. Formal payments are user fees paid to private health-care providers; officially approved user fees charged in public facilities; and purchases of medicines. Informal payments are defined as "a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to." In the Republic of Moldova, people refer to three types of informal payments: (i) conditioned payments – payments demanded by providers or which patients feel obliged to pay in order to access good-quality care; (ii) facilitation payments – payments which patients pay voluntarily (e.g. to obtain specialist care without a referral or to skip a queue); and (iii) gifts – in-kind or cash amounts given freely to express gratitude.

Findings
Over the past 10 years, the Government of the Republic of Moldova has engaged in reforms to improve the quality and use of medical services and to provide financial protection and equitable access to care. These include national pooling of funds managed by the National Health Insurance Company (CNAM) to reduce

fragmented and inequitable health financing allocations; universal coverage for primary health care (PHC) services; and incentives to increase insurance coverage among self-employed people. Insured people are entitled to free inpatient medical care services listed in the benefit package without co-insurance, deductibles or co-payments. For outpatient care, insurance covers the cost of consultations and some ancillary testing, also without co-insurance, deductibles or co-payments. Certain outpatient medicines listed on CNAM's compensated or reimbursed medicines list are covered in full or in part. Outpatients have to purchase any medicines that are not on the compensated medicines list, and pay any portion of the price not covered by insurance. These medicines are sold at private pharmacies. Facilities are allowed to charge user fees for services to uninsured patients and for services which are not part of the insurance benefit package, following a nationally approved price list.

Implementation of these reforms has expanded health insurance coverage to almost 80% of the population and increased use of services. In 2010, Moldovans had 6.5 outpatient contacts per person per year; exceeding the European Union (EU) average of 6.3 contacts per person per year. In addition, reforms have reduced financial barriers to accessing care. Over the past four years, the proportion of people who said they did not seek care when they needed it due to financial reasons fell by half: from 29.2% in 2008 to 14.8% in 2012. Still, data show that people who are in the lowest consumption quintile, lack health insurance and live in rural areas are more likely to have financial problems in accessing care.

Health expenditures and OOP payments

In the Republic of Moldova, total health expenditure (THE) as a proportion of gross domestic product (GDP) is currently 11.4%, showing a 70% increase between 2000 and 2011. This level of spending was the highest in the European Region in 2009. At 13.1%, the share of government budget allocated for health is also high, yet absolute spending on health is low at US$ 341 total health spending per capita – 48th in the WHO European Region. Private health expenditures comprise 54.4% of THE, an increase of 5.6% between 2000 and 2011, and OOP payments comprise the largest share of private expenditure (82.6%). Compared to other countries in Europe and central Asia, the Republic of Moldova is an outlier in terms of the relative importance of OOP payments as a percentage of THE, of average total household spending, and of OOP spending on medicines. Heavy reliance on OOP payments for health financing can lead to more frequent catastrophic expenditure episodes; greater inequity of utilization of health-care services across socioeconomic groups; and more people falling below the poverty line because of medical bills. Households can be protected from catastrophic health expenditures by reducing the health system's reliance on OOP payments.

Proportion of patients who paid out of pocket

According to 2012 data from the National Bureau of Statistics (NBS), the proportion of patients who report making an OOP payment when seeking care is lower in outpatient facilities (16.2%) than in inpatient facilities (30.2%). The proportion of people making an OOP payment for outpatient care has declined by almost 19% since 2009, but has not changed for inpatient care. In addition, 70.7% of people who sought care with a provider in 2012 also reported paying for medicines, an increase of 9% since 2009.

Informal payments

Among those who paid anything out of pocket for care, 36% of outpatients and 82% of inpatients reported paying informally in 2012. These rates are, respectively, 12% and 37% higher than in 2009. A more in-depth survey of patients hospitalized in the past 12 months found that 62% of informal payments were gifts, 23% were imposed (conditioned) and 15% were both gift and conditioned payment. Taking into account that the majority of patients reported making no OOP payment at all, this means that overall 5.8% of outpatients and 24.6% of inpatients reported making an informal payment in 2012.

OOP payments and insurance

For outpatient OOP payments, insurance is clearly protective: uninsured patients were 3.8 times more likely than insured patients (49% vs. 13%) to pay out of pocket in 2012. However, the data for inpatient care are less clear. In 2011, uninsured inpatients were almost twice as likely to pay out of pocket as insured patients (59% vs. 31%); in 2012, insured patients were more likely to pay out of pocket (31% of those with health insurance vs. 18% of those without).

OOP payments and consumption quintiles

Poor people are less likely to make facility-based OOP payments when seeking outpatient care. In 2012, less than 10% of patients in quintile 1 (poorest quintile) paid out of pocket for outpatient facility-based care, compared to 29% in quintile 5 (least poor quintile). However, no obvious trend can be seen for hospital-based care. In 2012, the proportion of inpatients paying out of pocket was virtually the same in quintiles 1 (36%) and 5 (35%).

Average OOP payment amount for inpatients

In 2010 the average OOP payment among inpatients who reported making a formal payment was MDL 1449/€90 (median MDL 700/€44).[1] Those who underwent surgical interventions were 70% more likely to pay than all other patients, while those with higher incomes tended to pay more, officially, than those with lower incomes.

Of the 38% of patients who reported making an informal payment, the average amount paid was MDL 1193/€74 and the median was MDL 400/€25. Patients who said they had made a conditional informal payment were more likely to be rural (40% vs. 32–36% for urban residents), female (46% vs. 30% for males), to have had a surgical intervention (42% vs. 36% for non-surgical care) and have no health insurance (46% vs. 37% for insured patients).

Perceptions of patients

Many of the drivers of formal OOP payments identified by patients were related to the health insurance system: financial disincentives to buying insurance; meagre benefits covered by insurance (i.e. a limited list of compensated medicines); desire to receive better treatment than that covered by health insurance; and waiting lines caused by rationing of insured services (which push patients to pay in the private sector). Some of the poorest patients said they were able to see a doctor without paying, but OOP

[1] Moldovan lei (MDL) were converted to euros (€) using XE Currency Charts, taking the mid-point of the relevant year (http://www.xe.com/currencycharts/?from=MDL}&to=EUR&view=5Y, accessed 1 February 2014).

payments for medicines and laboratory tests were unavoidable. Drivers of informal payment mentioned by patients included the desire for faster care (skipping the queue); fear of poor-quality treatment if no payment was made; and gratitude for a good health outcome such as the birth of a child. Some patients described friends who had had to make conditioned payments for surgical care.

Perceptions of providers

Providers mentioned several reasons for formal OOP payments, including high-tech diagnostic tests which public hospitals are not able to perform or which are rationed due to cost; patients who need a second- or third-line medication not covered by insurance, or who prefer a different medicine from the one on the compensated list; and the health needs of uninsured and non-referred patients. Providers were reluctant to discuss any kind of informal payments except gifts, described as token presents (chocolate, flowers) or small amounts of cash given after discharge. Most providers thought that gift giving is a strong cultural value and does not cause harm. When asked about the underlying causes of OOP payments, providers mentioned low salaries; low reimbursement rates from the insurance fund; ceilings on the number of cases that the insurance fund will reimburse; over-utilization of services (too many referrals for testing, over-prescribing by doctors); drug advertising and inappropriate self-treatment by patients; poor quality medicines; and patient attitudes toward gift giving.

The following table summarizes the drivers of formal and informal payments in the Republic of Moldova.

	Drives which kind of OOP?				
	Formal Private	Formal Public	Condi-tioned informal	Facili-tation informal	Gift
Medicine-Related Factors					
Limited list of compensated medicines and/or only partial reimbursement	✓				
Prescribers shift patients to uncompensated medicines	✓				
Poly pharmacy (use of too many medicines in treatment)	✓	✓			
Few family doctors in rural areas, so patients can't get compensated meds	✓				
High unit price of medicines	✓				
System-Related Factors					
Waiting time and referral system	✓			✓	
Low quality of care/lack of supplies		✓	✓	✓	
Inadequate reimbursement rates/doctor pay		✓	✓	✓	
Disincentives for insurance enrollment	✓	✓			
Physician conflict of interest, induced demand	✓				
Impunity			✓	✓	
Organizational culture of acceptance of IP			✓	✓	✓
Patient-Related Factor					
Desire to choose provider	✓				
Lack of knowledge of entitlements		✓	✓		
Cultural desire to pay for service, gift				✓	✓
Perceived necessity to pay			✓		
Inappropriate self-medication	✓	✓			

Adequacy of existing law

The current law and regulations on provider contracts allow for sanctions against providers for failure to provide covered services to Moldovans who are beneficiaries in the health insurance system. While this provision could be used to discipline those who demand illegal payments from insurance beneficiaries, it is not specifically targeted for that purpose. In addition, the law and contract do not explicitly make contracted health providers responsible for informal payments demanded by employees or consultants. It would be desirable to revise the health insurance law and contract in order to provide a specific definition that any demand for informal payments is a refusal to provide covered services (because a patient who does not pay is denied the service). Such a revision could also make a contracted provider responsible for the conduct of any employee or consultant who demands informal payments. Penalties described in the health insurance act and Type Contract could then be assessed against the provider and recovered from amounts that the insurer owes the provider. This would create a powerful economic deterrent to demands for informal payments without requiring the insurer to terminate the contract and expel the provider from the insurance system.

Policy options

The major driver of private health expenditures is OOP spending on medicines: MDL 1687.4 million/€102.8 million in 2010. Over 70% of patients who reported seeing a provider in 2012 also purchased medicines, and many patients purchase medicines without seeing a provider. Most Moldovans did not have to pay out of pocket at a facility in order to access outpatient or inpatient care: only 16% of outpatients and 30% of inpatients reported having to make a facility-based OOP payment. Informal payments are also infrequent: reported by less than 6% of all outpatients who sought care, and 25% of all inpatients. The majority of these payments appear to be gifts. Nevertheless, data suggest that some patients are being forced (or feel obliged) to pay for services – mainly at the hospital level and for surgical care. Depending on how the patients find the funds to pay informally, these payments may be threatening financial security.

A range of options may help to reduce such payments. Some options (e.g. option 1 below) work exclusively on reducing formal OOP payments, others mainly target informal payments (3 and 5), and others could help to reduce both types of OOP payments (2, 4, 6, 7). The option of increasing the proportion of the population covered by insurance is not included here as it already forms part of the Government's strategy and is under implementation.

1. Implement measures to reduce medicine prices and households' expenditures. Build capacity for more efficient procurement, more successful price negotiation, and implementation of other initiatives to reduce medicine purchase prices. Reduce conflict of interest in prescribing and increase price transparency. Reduce over-prescribing and inappropriate self-medication. Increase insurance coverage for medications.

2. Improve accountability of health-care workers and managers through administrative controls. Clearly define roles and procedures for official fee collection and financial management, audit and supervision systems.

3. Lessen impunity through regulatory reform, detection and enforcement. Revise and strengthen CNAM contractual provisions to ban informal payments and deduct payment from providers whose employees continue to accept them. Revise the health insurance law in order to provide a specific definition that any demand for informal payments is a refusal to provide covered services (because a patient who does not pay is denied the service). Make a contracted provider responsible for the conduct of any employee or consultant who demands informal payments. Assess penalties against the provider and recover from amounts that the CNAM owes to that provider.

4. Implement a community monitoring mechanism to strengthen social accountability. Develop social audit mechanisms using facility report cards combined with joint meetings of facility staff and community members to develop improvement plans.

5. Increase individual provider incentives and improve organizational incentives for performance. Reduce the pressure on providers to demand, and on patients to offer, informal payments through options such as reform of base salaries for staff most likely to accept informal payments; implementation of a grant programme to incentivize hospitals to test interventions to reduce informal payments; programmes to shift patient gift-giving practices from individual to facility-level gifts; and increased transparency of waiting lists.

6. Formalize unofficial payments through the introduction of formal user fees and/or private wards in public facilities. Increase revenue retained by facilities which can be used to supplement salaries and replace informal payment. This strategy may also reduce the need to ration services (itself a driver for informal payment).

7. Improve transparency and implement information strategies. Increase patient knowledge of entitlements and conduct analyses of complaints to determine patterns and propose systemic solutions.

Participants in the policy workshop favoured options 1, 2, 5, and 7 for reducing formal OOP expenditure, and options 3–7 inclusive for reducing informal payments. Many participants favoured expanding the compensated medicines list and increasing the proportion of cost covered as a way to reduce OOP payments, but recognized the need to control irrational use of medicines. The group also acknowledged the need to enhance incentives for individual providers and provider organizations to offer high-quality care and control informal payments.

Proposed options should be discussed and further analysed by the Ministry of Health and the CNAM to determine administrative and technical feasibility and the likelihood of success. Additional analysis may be needed to assess frequency and trends in hospital-based conditional payments, and to determine other baseline indicators, before implementing policy changes. No single option is likely to be effective and it may be necessary to adopt a range of strategies.

1. Introduction

The Government of the Republic of Moldova is committed to ensuring access to affordable high-quality health care for all citizens and is actively engaged in a process of health reform to move towards universal coverage, reduce inequities, improve efficiency and expand financial protection. There is concern that high OOP payments and the presence of informal payments may be hindering achievement of these goals. The Global Corruption Barometer survey (Transparency International, 2013) shows that 38% of respondents in the Republic of Moldova said that they had paid a bribe for health-care services in the past year. The study shows high concern over corruption in the public sector (see Annex A).

Legislation introduced in 2009 and 2010 provides all citizens with access to free primary health-care services provided by family doctors. Citizens enrolled in the Unified Programme of Mandatory Health Insurance (79.7% of population in 2011) have access to a defined benefits package and a limited list of covered or compensated medicines (Shishkin & Jowett, 2012). The Unified Programme benefits package includes emergency care; primary care; secondary and tertiary care including rehabilitation services, termination of pregnancy, emergency and preventive dental care, medical transportation, laboratory/radiology and other diagnostic testing and home care (Turcanu et al., 2012). Inpatient services are available without co-insurance, deductible or co-payment. Inpatients are also entitled to free medicines; medicines outside the benefit package are purchased from a private pharmacy. Covered outpatient services (except medicines) also do not require any co-insurance, deductible or co-payment. Outpatient medicines are covered at different levels depending on the drug: 50%, 70%, 90% and 100%. Private pharmacies charge outpatients any portion of the medicine cost not covered by insurance and apply to the CNAM for reimbursement of the covered portion. Outpatients also pay the full price for any medicines that are not included on the compensated medicines list. Hospitals can charge user fees for services provided to non-insured patients, and for services outside the Unified Programme benefits package. Prices for these services are approved at national level.

Approved in late 2012, the CNAM's institutional strategy for 2013–2017 sets clear targets to improve financial protection and reduce OOP and informal payments (CNAM, 2012). The baseline for indicators was 2010 data; targets are set for 2017.

The indicators include:

- decrease in the share of patients making an informal payment in primary and outpatient care (of those who paid anything at all) from 37% to 20%;
- decrease in the share of patients making an informal payment in inpatient care (of those who paid anything at all) from 94% to 45%;
- decrease in the share of OOP payments within THE from 46% to 36%, with gradual increase of public funding available for health care;
- decrease in the share of expenditures for medicines in total OOP expenditure of households from 72% in 2010 to 65%.

The purpose of this document is to discuss how OOP and informal payments in the Republic of Moldova are affecting health sector objectives, and to create a framework for understanding the drivers and policy options to reduce such payments.

The report will:

- define OOP and informal payments in the Moldovan context;
- describe the problems posed by high OOP and informal payments;
- explore perceptions of formal and informal payments;
- identify drivers of OOP and informal payments on both supply and demand side;
- suggest short-, medium-, and long-term actions which could reduce OOP and informal payments.

2. Methods

Methods included desk review of policy documents, key informant interviews, focus groups with providers and patients, a legal review, and analysis of quantitative data. Each data source and collection method is described below.

Desk review and key informant interviews

The study began with a desk review of policy documents and data from the Republic of Moldova and other countries in the WHO European Region, in order to develop a preliminary analytical framework. This framework was reviewed and revised in consultation with representatives of the WHO Country Office in the Republic of Moldova during an in-country trip in August 2013. A set of key informant interview questions was then devised (Annex B) and used to interview officials from the Ministry of Health, CNAM, NBS, the National Anticorruption Center (NAC), development partners, civil society organizations (CSOs), and health facilities.

Focus groups

During a second visit in October 2013, the authors conducted seven focus groups: three with providers/administrators; four with patients (see Annex C and D for guides). Two large (>500 bed) hospitals and a family medicine center in the Chisinau area and one district hospital (<450 beds) were visited. A total of five administrators and 24 providers (23 doctors and one nurse) participated in the provider focus groups; 17 patients or caregivers participated in the patient focus groups. Patient focus groups were relatively small (2–6 patients each). All participants were informed that findings would be anonymous. It was explained that the aim was to gain greater understanding about any payments for hospital care that people might have to make outside of what was covered by insurance, including formal and informal payments. Questions included whether, where and why these payments happen; advantages and disadvantages of the payments for the providers and patients; and ideas for reform. The WHO-funded study on barriers and facilitating factors in access to health services, conducted with assistance from the Center for Health Policies and Studies (PAS Center), hereafter referred to as the Barriers Study, also provided qualitative data on patient perspectives on OOP payments[2] (see Annex E for abstract, background and methodological details of this study).

Legal review

Analysis of policy reports and empirical studies was combined with a review of pertinent laws and regulations governing the insurance reimbursement and patient

[2] All quotations are from WHO Regional Office for Europe, 2012:75–115.

payment processes. These included English translations of the Law on Compulsory Health Insurance (No 1585—XIII, dated 27 February 1998) as amended through 2012, and Government Decision No 1636 Regarding the Approval of the Type Contract for Health Care Provision within the Compulsory Health Insurance, dated 18 December 2002.

Quantitative data

Two sources of data on the rates of OOP payments for health-care services were reviewed. The first is the Household Budget Survey conducted by the NBS of the Republic of Moldova each month, with data summarized by quarter and by year. The nationally representative survey interviews members of randomly selected households, stratified by residential area and consumption quintile. The health module of the survey asks about health care seeking behaviour in the last four weeks, including care sought from inpatient and outpatient care providers. Respondents are queried on OOP spending related to outpatient care (primary care doctors, specialist doctors, diagnostic testing centres), inpatient care (hospitalization experience), dental care, and medicines (purchased through pharmacies and excluding medicines received free of charge during hospital stay). Data from 2008 to 2012 were examined. The second data source was a study conducted in 2011 by the PAS Center, a Moldovan independent non-profit-making organization. The study approached 5600 households to select 1204 people who had been admitted to hospital in the past 12 months. The longer recall period and other methods in this study provide a larger sample of hospitalized patients than the NBS budget survey. In addition, data on medical staff salaries obtained from the Ministry of Health were reviewed.

Report review and policy workshop

The preliminary report was reviewed by staff of the WHO Country Office in the Republic of Moldova and of the WHO Regional Office for Europe. A policy workshop was held at the Ministry of Health in Chisinau on 31 January 2014 to present the revised framework and discuss the policy options. Participants included the Minister of Health, Vice Ministers of Health, heads of services, facility directors, other government agency representatives and CSOs. The final report incorporates feedback received during this workshop.

3. Definitions

OOP health expenditure is defined as "any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent" is to enhance or restore health status (World Bank, 2014). Fig. 1 and the explanations which follow define the types of OOP expenditures, including formal payments in the public and private sector and different categories of informal payments. Later sections of the report will provide data on the proportion of spending by category, where data are available.

Formal payments include official payments in the private sector and the public sector.

- *Private payments* are user fees to pay for health goods or services (e.g. consultation, laboratory exams) delivered in a private facility or by a privately employed health-care professional, such as inpatient treatment in a private hospital, consultation with private doctor, testing at a private diagnostic centre, or purchase of medicines from a private pharmacy without reimbursement through health insurance. In the Republic of Moldova, the majority of private payments are for medicines purchased from a pharmacy which are not covered through the CNAM, or medicines purchased by a non-insured individual.

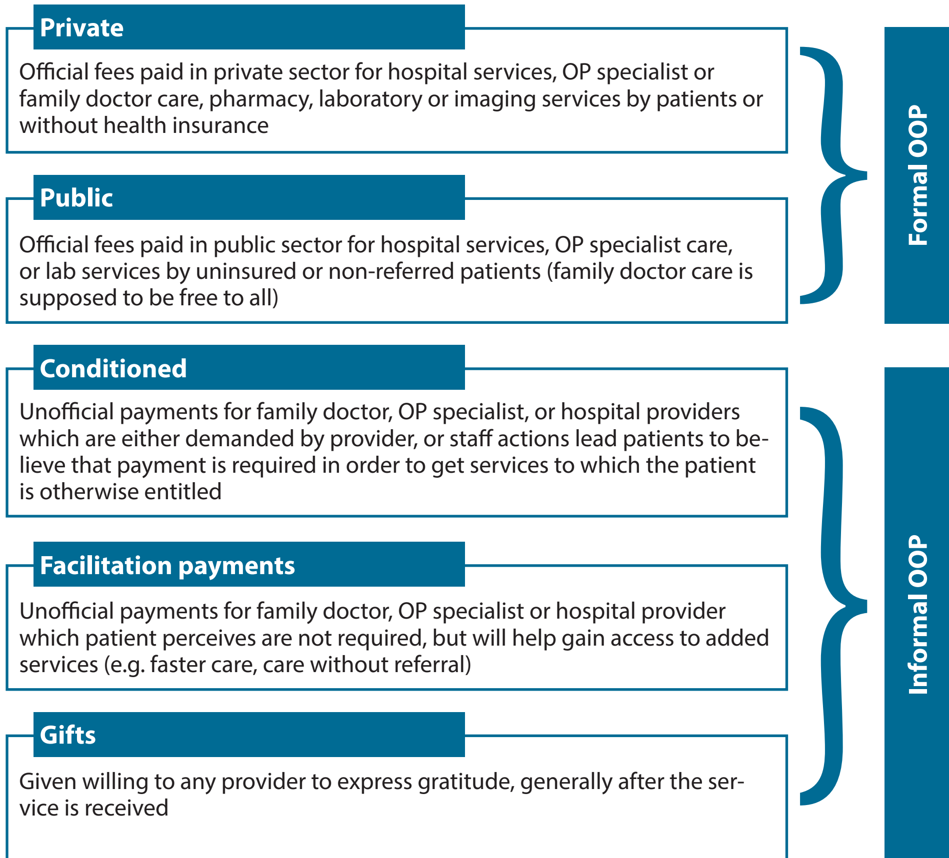
- *Public payments* include official user fees which a public facility is allowed to charge for services, with tariffs fixed nationally. Public hospitals may charge fees for care provided to uninsured patients; care for an insured patient who is not properly referred (e.g. has not first seen a primary care doctor); care for an insured patient who seeks services not covered by insurance (e.g. acupuncture). See Annex F for an illustrative list of user fees.

Medicines consumed by insured patients in inpatient settings incur no formal user fees because they are fully covered and should be provided to patients free of charge. It is possible that a doctor in a public hospital could ask a patient to pay for covered medicines, claiming that budget shortages have resulted in stock-outs and the doctor has used his or her own money to purchase the medicines. Key informants and survey evidence suggest that if this does happen, it does so infrequently. It was noted that occasionally patients are told a medicine is not available and are advised to purchase it from a private pharmacy outside the hospital.

In the Republic of Moldova, most official payments in public facilities occur in hospitals due to the policy for universal free coverage of PHC services (whether or not a patient is insured). However, an individual might pay officially for an outpatient visit to a specialist doctor if the individual was not referred.

There may be other official user fees. For example, hip replacement surgery for insured patients is fully covered by insurance. However, the limited budget for purchasing hip implants means that the waiting list may be long. An insured person could choose to purchase the implant device in order to obtain the surgery faster (all other costs would be free of charge). [3]

Fig. 1. Types of OOP payments in Republic of Moldova



Note: OP = outpatient.

Informal payments. An informal payment for health care is defined as "a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to" (Gaal et al., 2006:276). Informal payments are, by definition, unofficial. The authors were informed that small informal payments are sometimes paid at the PHC and specialist level, mainly to

[3] Moldovan lei (MDL) were converted to euros (€) using XE Currency Charts, taking the mid-point of the relevant year (http://www.xe.com/currencycharts/?from=MDL}&to=EUR&view=5Y, accessed 1 February 2014).

reduce waiting time, by-pass the appointment system, obtain a referral to a higher level and/or improve the quality of interaction with providers (WHO Regional Office for Europe, 2012). In hospitals, informal payments are sometimes paid to physicians, nurses and support staff to access diagnostic tests or procedures, surgical interventions or other medical care. Patients may also make informal payments for hotel services (e.g. cleaning).

Informal payments can be divided into three categories: conditioned payments, facilitation payments and gifts. These are ordered from most problematic to least concerning and, although conceptually distinct, in practice these categories overlap and payments are not always clearly classifiable. It is likely that conditioned payments and facilitation payments are made most often in the public sector, while gifts may occur in either the private or public sector.

- *Conditioned payments:* informal payments made by patients who perceive that such payments are necessary in order to receive services which should have been provided free of charge according to official policy (e.g. services covered by insurance). This term is also applied to the situation of a patient who feels obliged to pay something informally in addition to an official fee which has already been paid through official channels. Conditioned payments may be requested directly by a staff member, or the patient may be acting on the strong sense that the payments are necessary. These payments have the most serious effects in terms of eroding patients' financial protection.

- *Facilitation payments:* informal payments made voluntarily by a patient to obtain something which is outside the basic service package entitlement, for example jumping a queue or obtaining a referral without first seeing a primary care doctor. As with gifts, these payments can create financial burden and can influence care-seeking patterns in ways that reduce efficiency or increase costs. Policy-makers may be less concerned about these types of payments because the patient perceives that he/she has a choice, and the amounts involved are not large (e.g. MDL 10–100/€0.63–6.34) (WHO Regional Office for Europe, 2012). [4]

- *Gifts:* informal payments made voluntarily by patients to express gratitude or thankfulness for a good health outcome. Gifts may be cash or in-kind; the value can vary but is usually small and, generally, they are given after the service has been received. They can create a financial burden for patients but, if the gift is truly voluntary and providers do not give better care to those who pay, the impact on the health system may be benign or even beneficial if the gifts improve responsiveness (Gaal et al., 2006).

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[4] Conversion to euros using Xe.com tables for midpoint of 2012.

4. Trends in OOP payments and evidence of barriers to access

Over the past 10 years, the Government of the Republic of Moldova has engaged in health-sector reforms to improve the quality and use of services and to provide financial protection and equitable access to care. Reforms include national pooling of funds managed by the CNAM to reduce fragmented and inequitable health financing allocations; universal coverage for PHC services; and incentives to increase insurance coverage among self-employed people. More detailed description of the reforms is available in other documents (see Shishkin & Jowett, 2012; Turcanu et al., 2012; WHO Regional Office for Europe, 2014).

Increased use of services

Evidence suggests that reforms have increased the use of health services. In the Republic of Moldova, the number of outpatient contacts per person per year was below the EU average in 2007. By 2010, Moldovans had 6.5 outpatient contacts per person per year, exceeding the EU average of 6.3 contacts (Turcanu et al., 2012).

Compared to other former Soviet Union countries, the Republic of Moldova is rated highly in terms of access to health care. In 2010, a nationally representative sample survey of 1800 Moldovan respondents found that 70% saw a doctor when they felt they needed to, more than any of the other countries analysed in the study – Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Russia, and Ukraine (Balabanova et al., 2012).

According to a household survey conducted by the NBS in 2010, during a four-week recall period 32.7% of survey participants reported consuming medicines for health reasons. Most (68.6%) used medicines prescribed by a medical provider and the rest (31.4%) self-treated. Compared to previous years, there was a reduction in self-treatment and increasing use of drugs prescribed by a doctor (NBS, 2013a).

Improvements in financial protection

In addition, NBS data suggest that health reforms since 2008 have improved financial access to care. Table 1 shows that the proportion of people who said that they did not seek care when they needed it, due to financial reasons, fell by half: from 29.2% in 2008 to 14.8% in 2012. Poorer people are more likely than people in higher income brackets to be deterred from seeking care, but the number of extremely poor people who said they did not seek care

because of financial reasons fell by one third between 2008 and 2012: from 43.6% to 29.1%. People with health insurance and in urban areas are less likely to say that they did not seek care for financial reasons: only 12.7% of those insured (versus 20.6% of uninsured) and only 6.2% of urban residents (versus 22.3% of rural residents).

Table 1. People who experienced a health problem but did not seek care due to financial reasons, 2008–2012 (selected years)

Characteristic	2008	2010	2012	% change 2008-2012
Overall	29.2	20.9	14.8	-49.3
Residence				
Urban	20.9	11.3	6.2	-70.3
Rural	36.4	28.3	22.3	-38.7
Income Quintile				
1	43.6	40.4	29.1	-33.3
2	35.4	28.3	24.2	-31.6
3	28.0	20.1	16.6	-40.7
4	28.3	11.2	7.1	-74.9
5	13.4	11.5	5.0	-62.7
Insurance Status				
Insured	26.5	17.4	12.7	-52.1
Not insured	37.6	28.9	20.6	-45.2

Source: Household Budget Survey data (NBS, 2013b).
Note: income quintile 1 = poorest; 5 = least poor.

Financial access problems for poor and large households

Although health reforms since 2008 have improved financial access, access is still a problem for very poor people. In 2012, among those who had not sought care in the past four weeks when they felt it was justified, 29.1% of those in the poorest quintile said they could not afford either services or drugs (Table 1). Larger households also appear to be less likely to seek care: in 2010, 53% of households with three or more children said that they did not approach health-care providers due to financial difficulties (WHO Regional Office for Europe, 2012).

Trends in total, public and private health expenditure

The Republic of Moldova has high levels of THE as a proportion of GDP – currently 11.4%, a 70% increase from 2000 to 2011 (Table 2). This level of spending was the highest in the European Region in 2009. The share of government budget allocated for health is also high – 13.1% in 2010 (Turcanu et al., 2012).

Table 2. Trends in health expenditure in Republic of Moldova, 2000–2011

Characteristic	2000	2005	2006	2007	2008	2009	2010	2011	% change 2000-2011
Total Health Expenditure (THE) as % GDP	6.7	9.2	10.6	10.9	11.4	12.5	11.7	11.7	70.1
General government expenditure on health (GGHE) as % THE)	48.5	45.6	44.4	45.2	47.2	48.5	45.8	45.6	-6.0
Private expenditure on health as % THE	51.5	54.4	55.6	54.8	52.8	51.5	54.2	54.4	5.6
Private household OOP as % private expenditure on health	83.3	82.1	82.9	83.3	85.4	84.8	82.8	82.6	-0.8
Private household OOP as % of THE	42.9	44.7	46.1	45.6	45.1	43.7	44.9	44.9	4.7

Source: WHO global health expenditure database (WHO, 2014).

Yet in absolute terms, spending on health is low at US$ 341 per capita, or 48th in the WHO European Region (Turcanu et al., 2012). Only Armenia, Kyrgyzstan, Uzbekistan, Turkmenistan and Tajikistan spend less per capita on health.

High private expenditure

Private health expenditures comprised 54.4% of THE in 2011, an increase of 5.6% between 2000 and 2011 (Table 2). OOP payments account for the largest share of private expenditure, at 82.6%. This includes both formal payments and informal payments. Table 3 presents comparative indicators for other countries in 2008, indicating that only Azerbaijan, Georgia and Armenia were more reliant on OOP payments than the Republic of Moldova at that time.

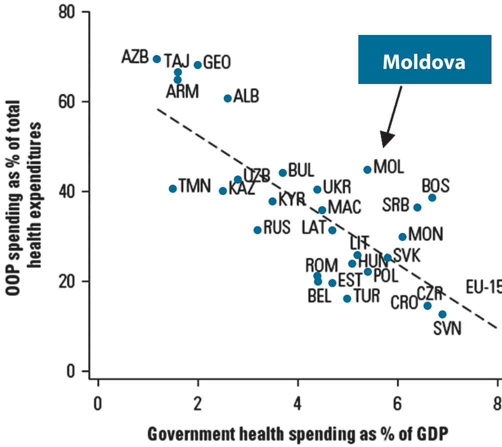
Table 3. Key health system indicators in eight former Soviet Union countries

Country	GDP per Capita PPP (Current intl $, 2009)	Total Government Expenditure as % of GDP, 2008	Public Expenditure on Health as % of Total Govt Expenditure, 2008	Public Expenditure on Health as % of Total Health Expenditure, 2008	Private HH's OOP on Health as % of Total Health Expenditure, 2008
Armenia	5 279	21.5	7.6	43.7	50.9
Azerbaijan	9 638	34.0	2.6	24.0	67.8
Belarus	13 040	49.5	9.9	75.3	17.4
Georgia	4 774	36.4	4.9	20.7	66.3
Kazakhstan	11 510	22.3	10.8	65.7	33.7
Moldova	2 854	41.6	13.0	50.5	48.4
Russia	18 963	33.6	10.2	65.5	28.3
Ukraine	6 318	44.5	8.6	56.1	40.7

Source: Balabanova D, Roberts B, Richardson E, Haerpfer C, McKee M. Health care reform in the former Soviet Union: Beyond the transition. *Health Services Research*. 2012:47(2), Table 1, p 842.

Fig. 2 shows the relative importance of OOP spending as a percentage of THE, and government spending as a proportion of GDP, for the Republic of Moldova and other countries in Europe and central Asia (Smith & Nguyen, 2013). Again, the Republic of Moldova is an outlier when compared to the linear trend line.

Fig. 2. Balance between OOP spending and government budgets



Source: WHO National health accounts database, 2012
Source: Smith & Nguyen, 2013

Fig. 3 shows how the Republic of Moldova compares to other countries in Europe and central Asia in terms of OOP expenditure as a percentage of average total household spending, and OOP spending on medicines. These data highlight the fact that, compared to the Republic of Moldova, households in EU15 countries spend proportionately less on health and that Moldovan OOP spending is largely driven by spending on medicines.

Fig. 3. OOP payments in Europe and central Asia: total payments and payments on drugs

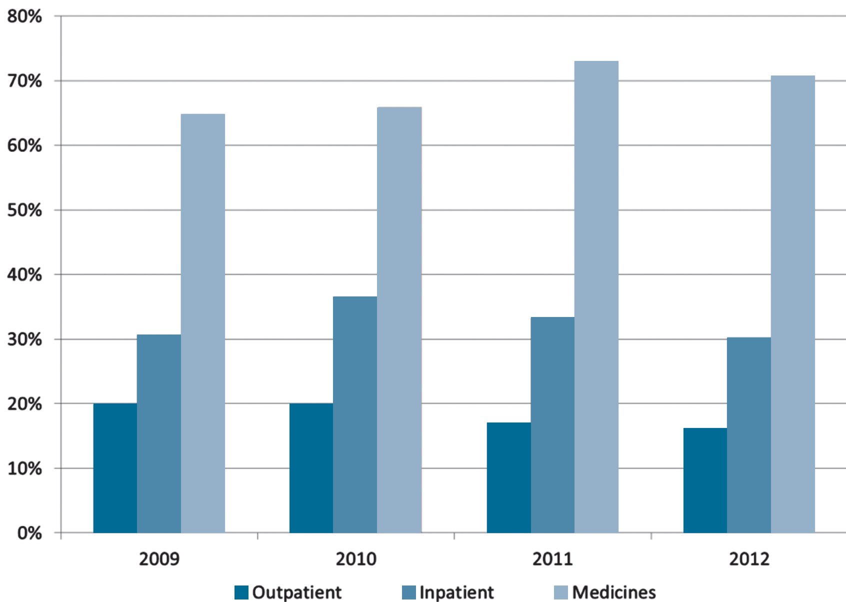
Source: OECD (2011)
Source: Smith & Nguyen, 2013.

Heavy reliance on OOP payments for health financing can lead to more frequent catastrophic expenditure episodes; greater inequity in utilization of healthcare services across socioeconomic groups; and more people falling below the poverty line because of medical bills (Falkingham, 2004; Smith & Nguyen, 2013). To the authors' knowledge, this analysis has not yet been conducted in the Republic of Moldova. Households can be protected from catastrophic health expenditures by reducing the health system's reliance on OOP payments (Xu et al., 2003).

Proportions of patients who paid out of pocket

NBS data were used to analyse the proportion of Moldovans making payments when seeking inpatient or outpatient care at a health-care provider such as a PHC practice, diagnostic test centre, or hospital (Fig. 4). These show what percentage of patients paid (combining formal and informal payment) at the primary care level, at hospital level, or for medicines purchased as part of their care. Because of the way that data were collected in the budget survey, they do not include people who only sought self-treatment care at a pharmacy (as already noted, an estimated 31.4% of patients self-treat). As such, the total proportion of people making any OOP payments for medicines may be underestimated.

Fig. 4. Percentage of patients making any OOP payment when seeking care in past four weeks (excluding self-treatment at pharmacy), 2009–2012



Source: Household Budget Survey data (NBS, 2013b).

Outpatient OOP payments

Fig. 4 shows that the percentage of people making OOP payments at outpatient facilities has declined by 18.6%: from 19.9% in 2009 to 16.2% in 2012.

Inpatient OOP payments

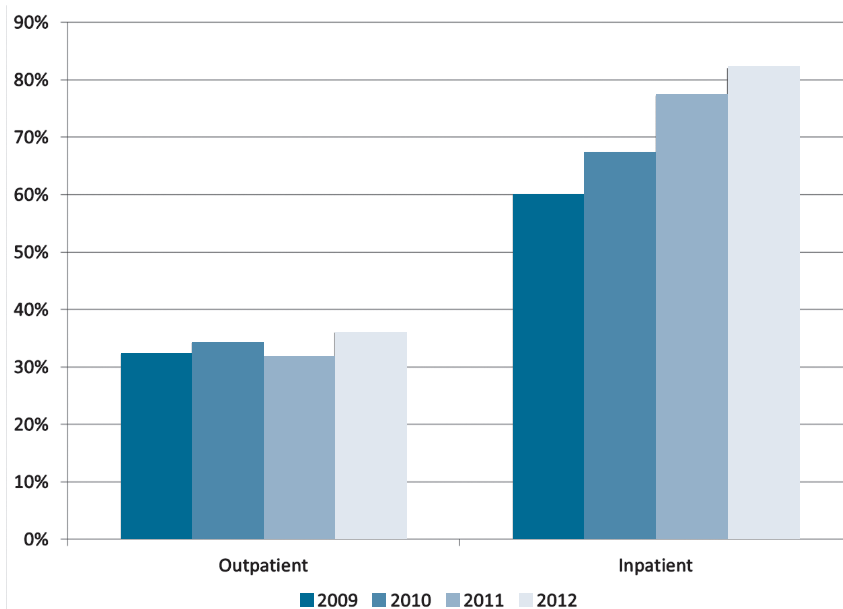
The rate of OOP payments at inpatient facilities has remained relatively steady,

at 30.6% in 2009 and 30.2% in 2012. Data from the PAS Center hospitalized patient survey showed a somewhat lower rate of formal OOP payments in hospitals, but a high rate of any hospital-based OOP payments if both formal and informal payments are counted. The PAS Center study in 2011 found that 22.2% of inpatients had made formal payments for services provided (defined as payments made at the cash desk of the inpatient unit), while 37.9% had made an informal payment directly to a health worker. The combined percentage of patients making any OOP payment appears to be 60.1% but there is some overlap between these categories.[5]

OOP payments on medicines, for those who sought care from any provider
The percentage of people who sought care with a provider and also paid for medicines increased by 9%, from 64.8% in 2009 to 70.7% in 2012.

Rate of informal payment, among those who paid out of pocket
Fig. 5 draws on the data from the NBS study to drill down on the informal component of OOP payments from 2009 to 2012. Informal payments may have been given for any reason but the sample is restricted to those patients who reported making some OOP payment for care at an inpatient or outpatient provider in a four-week recall period. The figure does not include people who only purchased self-treatment medicines at a pharmacy. However, this is unlikely to be a major issue for informal payments (unlike in Fig. 4).

Fig. 5. Percentage of patients making an informal payment in last four weeks, of those who made any OOP payment, 2009–2012



Source: Household Budget Survey data (NBS, 2013b).

[5] This study was duplicated in 2013, but the report had not been published as of June 2014. The questionnaires were not modified in 2013 because the scope of questioning aimed to show the share of formal and informal payments in hospitals, not the total OOP payments made in hospitals by patients.

Outpatient informal payments
The data show a fairly steady rate of informal payment in outpatient settings: about 32% of patients in 2009 reported making an informal payment, compared to 36% of respondents in 2012.

Inpatient informal payments
The rate of informal payment for inpatient care is increasing steeply over time: from 60% in 2009 to 82% in 2012: a 37% increase.[6]

Types of informal payment
The PAS Center study provides additional detail on the types of informal payments. Of those who made an informal payment:

- 61.6% said they had given willingly (i.e. a gift, such as money or a present, to thank staff);
- 23.2% said the payment was imposed by a health worker (conditioned payment);
- 14.7% said they had given both (gift and conditioned payment).

Combining categories would suggest that **over three quarters of patients had given a gift, and 37.9% of inpatients surveyed had been obliged to make an informal payment** for services to which they were entitled. The study did not ask specifically about facilitation payments (i.e. payments given willingly, but not a gift).

Rates of informal payment among general population seeking care
The data cited above show that (of those patients who reported making any OOP payment when seeking care at a provider location other than a pharmacy) 36% of outpatients and 82% of inpatients said that they made an informal payment in 2012. Taking into account that the majority of patients reported making no payment at all, this means that, overall, 5.8% of outpatients and 24.6% of inpatients reported making an informal payment (see Table 4).

Table 4. Share of Moldovans making informal payments when seeking care, 2012

Outpatient care		
Proportion of people who made OOP	16.2%	
Of those who paid, % making IP	36.0%	
Proportion of people who made IP		5.8%
Inpatient care		
Proportion of people who made OOP	30.0%	
Of those who paid, % making IP	82.0%	
Proportion of people who made IP		24.6%

Source: Household Budget Survey data (NBS, 2013b).

[6] Fig. 5 shows that the rate of inpatient informal payment in 2010 (67.4%) is lower than the baseline figure CNAM used to set its strategic objectives related to informal payment reduction (94%). The difference is due to CNAM using data from only the first quarter of 2010; full-year data are used here.

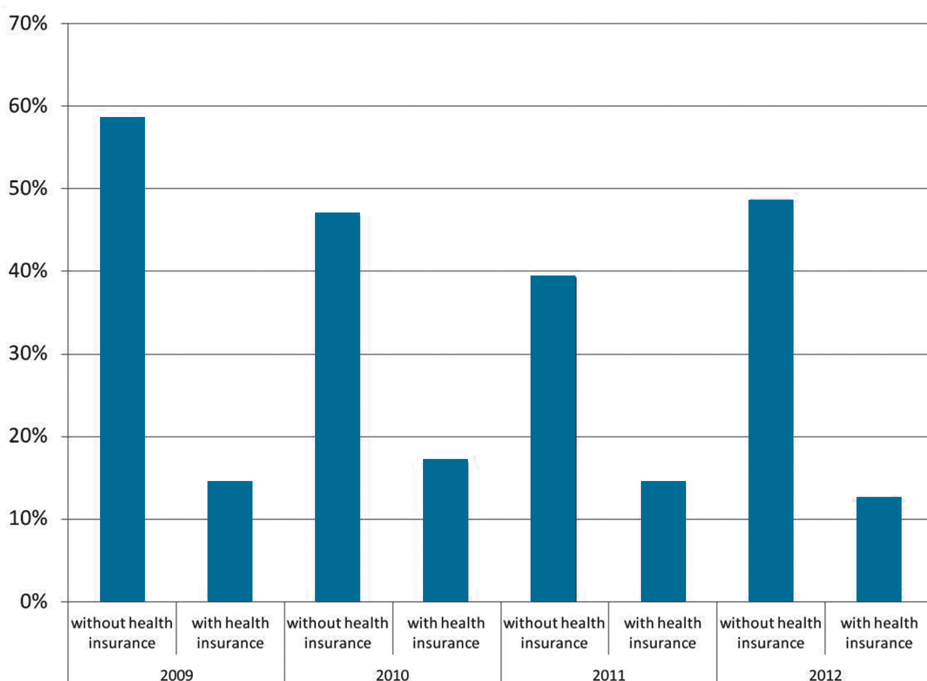
These data suggest that the situation regarding informal payment may be improving over time, and that informal payments are mostly focused in the hospital sector. A previous study showed higher rates of informal payment. For example, a survey conducted by the European Bank for Reconstruction and Development in countries in transition in 2007 found that 48% of Moldovans reported always or sometimes paying informally (WHO Regional Office for Europe, 2012).

Rates of OOP payments by insurance status

As mentioned earlier, nearly 80% of citizens are covered through the mandatory health insurance programme. Fig. 6 shows the proportion of patients who sought outpatient care and made an OOP payment at a facility, by insurance status, from 2009 to 2012. Fig. 7 shows the same data for hospitalized patients. These data do not include the proportion of patients who also had to pay for medicines at an outside pharmacy.

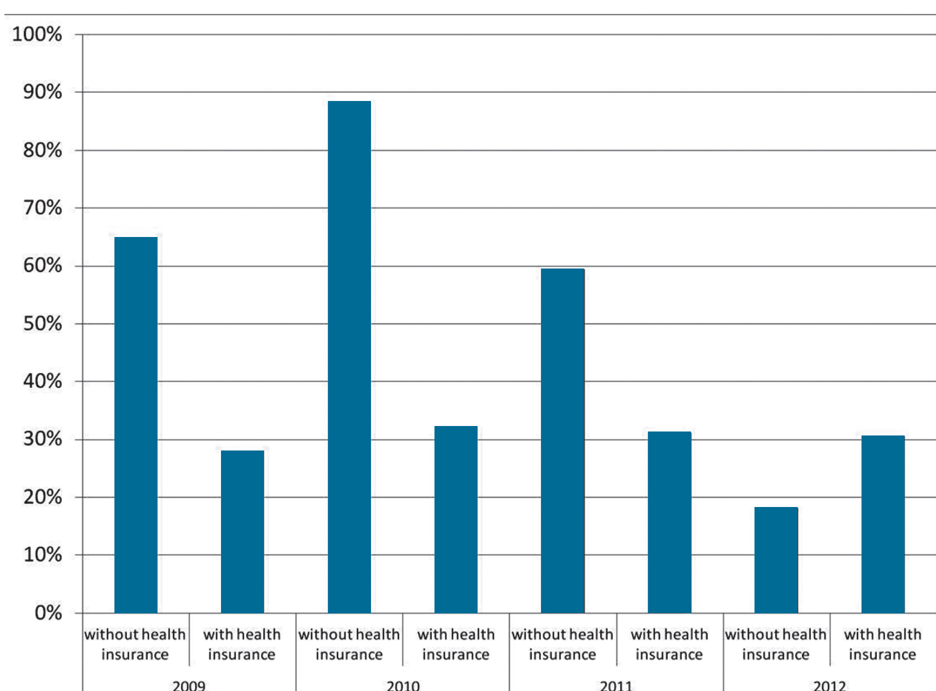
Insurance is clearly protective for outpatient facility-based OOP payments: uninsured patients were 3.8 times more likely than insured patients to make an OOP payment in 2012. The interpretation is less clear for inpatient care, especially in 2012, where data seem to suggest that people with insurance actually paid more frequently out of pocket.

Fig. 6. Percentage of uninsured and insured outpatients making an OOP payment when seeking care in last four weeks, 2009–2012



Source: Household Budget Survey data (NBS, 2013b).

Fig. 7. Percentage of uninsured and insured inpatients making an OOP payment when seeking care in last four weeks, 2009–2012



Source: Household Budget Survey data (NBS, 2013b). Note: sample size is 127 hospitalized patients, so data should be interpreted with caution.

According to Shishkin and Jowett (2012), the rate of informal payment among insured patients varied from 27% of those with employer-based insurance to 57% with state insurance, while 22% of uninsured individuals made informal payments.[7] It is not clear why those with employer-based insurance made fewer informal payments as the benefit package is, in theory, the same. However, people with employer-based insurance may be more empowered than people who are entitled to insurance through a state entitlement (i.e. because they are unemployed, veteran, etc.). Uninsured people may make lower informal payments because they have to pay higher formal user charges anyway, and either are not asked or do not offer to make additional informal payments.

In the PAS Center study of 1204 patients hospitalized in 2010, 15.2% of insured and 27.9% of uninsured patients reported personally procuring medicines (formal OOP payment) at a pharmacy. This was mainly because a doctor had told the patient that the hospital did not have all the necessary medicines or those that the hospital did

[7] State insurance refers to non-working individuals (e.g. unemployed people, students, children) who qualify for insurance coverage paid for through the state budget. The economically active population must pay for insurance either through payroll tax, or a flat rate contribution (self-employed). See Shishkin & Jowett, 2012.

have were "not good" and the patient should buy medicines recommended by the doctor (PAS Center, 2011).

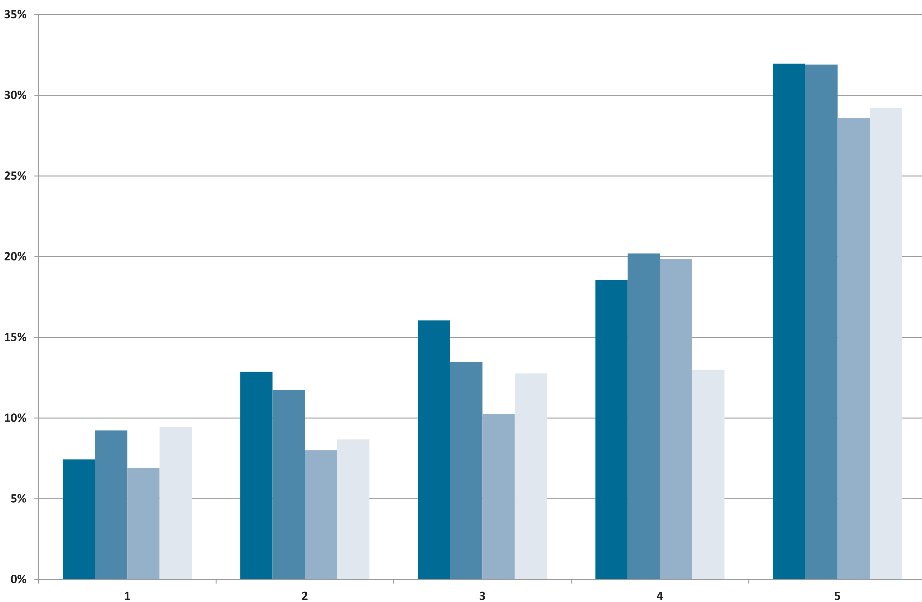
The same study noted that 42% of uninsured versus 19% of insured made formal OOP payments at the hospital, and 46% of uninsured versus 37% of insured made a conditioned informal payment. Patients who said they made a conditional payment were also more likely to be rural (40% vs. 32–36% among urban residents), female (46% vs. 30% among males), and to have had a surgical intervention (42% vs. 36% among those who received non-surgical care) (PAS Center, 2011).

OOP payments by consumption quintile

The NBS survey data allow analysis of the rates of OOP payment by consumption quintile, a measure used to distinguish the population according to their welfare.[8] Fig. 8 shows the percentage of patients who sought care and reported making an OOP payment from 2009 to 2012, with separate graphs for each location of payment (outpatient facility, inpatient facility, medicines purchased in a pharmacy by those who sought facility-based care). Data are shown by consumption quintile.

Fig. 8. Percentage of patients who sought facility-based care and made an OOP payment, by consumption quintile and type of care, 2009–2012

Outpatient facility-based care

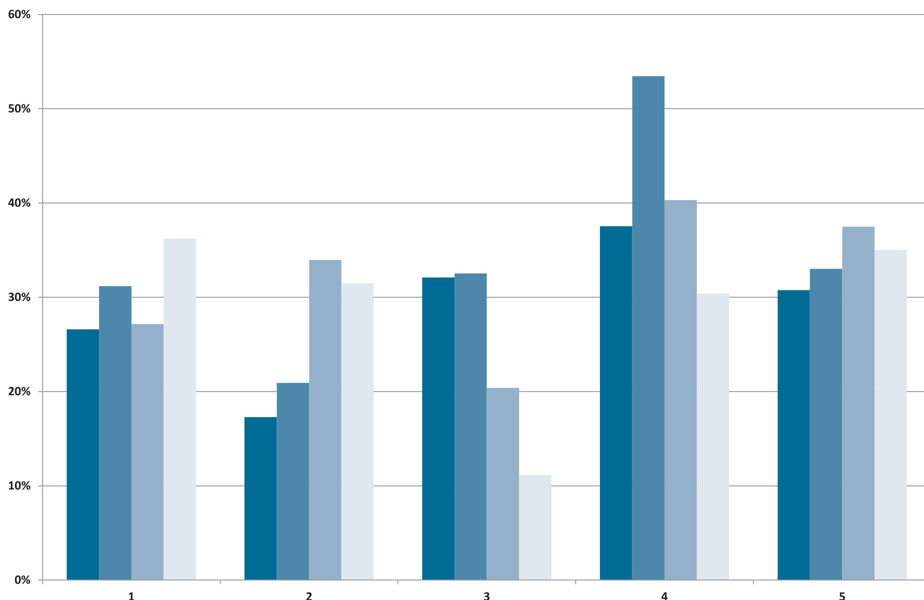


Source: Household Budget Survey data (NBS, 2013b). Note: 1=most poor, 5=least poor.

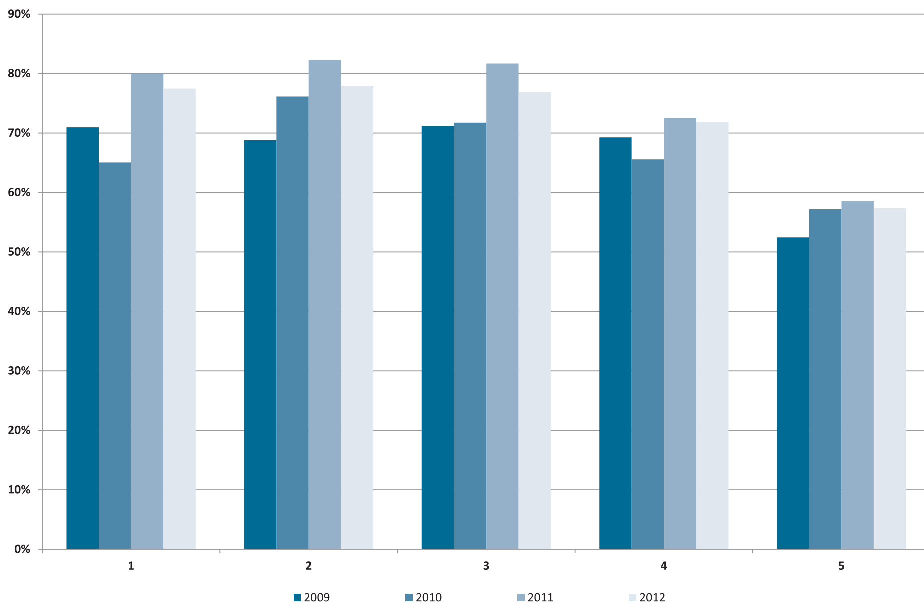
8 Five quintiles rank the population from the poorest 20% to the 20% who are least poor. Poorest households are in quintile 1, while those with higher consumption go into the second quintile, and so on.

Fig. 8, continued. Percentage of patients who sought facility-based care and made an OOP payment, by consumption quintile and type of care, 2009–2012

Inpatient facility-based care



Medicines



Source: Household Budget Survey data (NBS, 2013b). Note: 1=most poor, 5=least poor.

There is a clear tendency for the percentage of patients making outpatient facility-based OOP payments to rise with consumption level (i.e. 1 through 5). In 2012, less than 10% of patients in quintile 1 made an OOP payment for outpatient facility-based care, compared to 29% in quintile 5.

However, hospital-based care shows more variability and no obvious trend. In 2012, the proportion of patients making an OOP payment was virtually the same in quintile 1 (36%) and quintile 5 (35%). And for medicines, it seems that rich people may even pay less often than poor people: over 77% of the patients in the poorest quintile who sought facility-based care also purchased medicines in 2012, compared to only 57% of patients in quintile 5. Again, it is necessary to exercise caution in interpreting data as sample sizes are small.

Average amounts of OOP payments for inpatients

In the PAS Center study, among inpatients who reported paying a direct payment (2010 data) the average amount paid was MDL 1449/€ 90, and the median MDL 700/€44 (PAS Center, 2011).[9] Those who underwent surgical interventions were 70% more likely to pay than all other patients, while those with higher incomes tended to make more formal payments than those with lower incomes.

Of the 38% of patients who reported making an informal payment directly to health staff, the average amount paid was MDL 1193/€74 and the median was MDL 400/€25 (PAS Center, 2011).[10]

[9] This is somewhat higher than data reported in the Barriers Study (WHO Regional Office for Europe, 2012) which found that the average OOP payment for a hospital stay was MDL 1100.
[10] Converted to euros using Xe.com data table, mid-point for relevant year (http://www.xe.com/currencycharts/?from=MDL}&to=EUR&view=5Y, accessed 1 February 2014).

5. Perceptions of patients and providers regarding OOP and informal payments

Patient perspectives

The authors of the Barriers Study state that "OOP payments are by far the most emotional and important topic for users of health services."[11] Interestingly, the focus groups with 17 patients conducted for this study in 2013 did not document the same level of concern. This could be because the focus groups were conducted in facilities where patients were being treated or had just received care, and patients may not have felt comfortable sharing their opinions in this setting. Or, it could simply be because numbers were small. The results of the Barriers Study are described below, followed by the results of the 2013 focus groups.

Barriers Study results

Some of the drivers of OOP payments identified by patients interviewed in the Barriers Study included financial disincentives to buying insurance, meagre benefits covered by insurance, desire to receive better treatment than that offered under health insurance benefits, and waiting lines.

> *I have no health insurance and I do not need it. Whenever you go, it's not helping you….I made some mathematical calculations and I realized there is no point in paying for it.* (Male, 19)
>
> *Health insurance covers only the expenses for the bed, all the rest should be paid for. They have some aspirin or other cheap medicines, but sometimes they lack the cheapest vitamins; as for the rest, you usually have to pay MDL 500–600 (€32–38).* (Male, 28)
>
> *If you go to the doctor and show your health insurance, you are considered weird, as if you fell from the moon. Health insurance is shameful.* (Female, 40)
>
> *Having health insurance does not mean you have priority. If it were so, and if people with the policy were paid attention to, everyone would buy the policy.* (Female, 28)

Some patients paid out of habit, such as a woman who paid MDL 100 (€6.34) to the ambulance driver who came to take her to a maternity hospital because it was, "as though I was calling a taxi."

Some of the poorest patients did say that they were able to see a doctor without paying, but OOP payments for medicines and laboratory tests were unavoidable (WHO Regional Office for Europe, 2012). One patient suspected she was being charged at the pharmacy for drugs which should have been free:

> *Actually, [the medicines] should be free because on the network they are registered as free, but when you go to the drugstore they say it is not for free and they can provide it for half the price.* (Female, 56)

---

[11] All quotations are from WHO Regional Office for Europe, 2012:75–115.

Others suspected conflict of interest on the part of doctors:

> *The pharmacy at the corner of the hospital belongs to the head of the outpatient specialized service. They write prescriptions that need to be filled at that specific pharmacy, so that he has a profit.* (Female, 39)

Table 5 reviews the major reasons patients described for making informal payments. These are discussed in more detail below.

Table 5. Patients' perceptions of reasons for informal payments

Faster care	*I said 'I can pay.' The physician is happy and I am happy. And I did not stay in line.* (Male, 21, insured) *They start by saying there is a schedule and you have to wait for your turn, but when you pay things move very fast. When I go to the children's hospital with my child I pay for all the services, but I can also leave some money on the table. If you go downstairs to the payment office, when you come back the doctor is already busy and you have to wait. It is easier to pay him/her directly.* (Male, 42, uninsured)
Fear of poor quality	*When I was hospitalized, there were some people coming from the city who were telling us we shouldn't even have thought to pay, since we had health insurance. There was a sort of campaign; everybody was signing an informed consent [therefore aware that they should not pay out of pocket for anything]. But I was paying anyway to assure myself that everything would be fine. I was very worried and I just wanted to know that everything would be OK.* (Female, 31, insured) *Unless you put some cash in their pockets, they don't even look at you…they don't even come close to you and don't even check on you…I noticed an immediate change after we paid, they looked after her and came regularly to check on [my wife]. She stayed a week…and the workers from there expected to be paid…* (Male, 42, insured)
Gratitude	*For the birth of my two children, I gave money. Nobody forced me and I gave MDL 5000–6000 (€317–380) with all my heart.* (Male, 42, insured)

The Barriers Study provides evidence that patients are making **voluntary informal facilitation payments** to speed up care or get a referral. For example, patients with insurance coverage sometimes reported paying out of pocket to receive faster care, presenting this as a win–win situation. Other patients perceive the need to see a family doctor in order to get a referral as an unnecessary bureaucratic barrier, therefore they are willing to pay out of pocket to gain direct access to specialized care (WHO Regional Office for Europe, 2012). Some patients admitted that they paid informally to avoid the trouble of going to the cashier (which would increase waiting time). The study also documented voluntary gift-giving, such as a payment to clinical staff to recognize a birth.

In other situations, patients reported that payments were conditioned or requested directly. Some noted that if a patient does not make a payment for the first visit,

the specialist will refuse a second appointment (WHO Regional Office for Europe, 2012).

Yet, even those who saw payments as necessary also perceived that they were willing participants in the practice. One woman told of how she paid so that she could feel she had done all she could to ensure a good health outcome. Ironically, she did this even during a campaign against informal payments which sought to educate patients about their rights to free care. This suggests that patients' fears about quality and their desire to assure accountability of providers is a deep-seated driver of informal payments.

2013 focus groups with patients

Formal payments. In the four focus groups held with patients (3 in hospitals, 1 at a primary care facility), several patients reported paying formally for care or knowing others who paid. Reasons for formal payments include the examples listed below.

- *No referral.* One patient had paid officially for a service because she did not have a referral. She knew that she could avoid the fee by obtaining a referral but did not want to spend the time. Another patient said she waited a week to see a specialist, but that "if I wanted to see the specialist right away, I would have had to pay."
- *Medicine or supplies* not on compensated list. Often, patients said that they paid for medicines or supplies which were not compensated through the insurance programme. One patient said she paid officially for one medication that was not on the compensated list, and she also purchased a different cough medicine (on the recommendation of another doctor) when the one she had been given in the hospital did not seem to be working. Two patients reported purchasing compression stockings to wear after surgery. An outpatient said she sometimes goes to the pharmacy to buy drugs to self-treat. She explained that medicines for neurological disorders were no longer on the compensated list. Some illustrative quotes are shown below.

  > If you don't want [the hospital's] drugs, but you want your own drugs, then you have to purchase them. For example, they didn't have magnesium.
  >
  > I saw the gastroenterologist who prescribed very expensive medicines, 7 drugs. She didn't take into account that I am retired… I don't qualify for discounts.

- *Added service.* One patient paid to get an ultrasound at a private diagnostic centre because she wanted a print-out of the picture (the hospital's machine lacked this capacity). Another patient purchased outpatient acupuncture services, "The acupuncture treatment I received from this clinic really helped me. It is expensive and not covered by insurance, but I got better."
- *Lack of understanding of insurance.* One patient thought that some people pay out of pocket because they are not aware of the value of having insurance. She told the story of her godmother who preferred to pay for a hospitalization and medicines rather than purchasing insurance.

Several patients complained about the high cost of medicines purchased formally at the pharmacy. One mother said, "If you have 4–5 children, you cannot afford it. The hospital gives you some medicines, but [depending on the child's illness] you might need an expensive one [the hospital doesn't have]." Another said "If you want your child to be healthy and get well, you need to pay a lot for medicines."

Informal, conditioned payments. None of the patients or caregivers who participated in a focus group said that they had given an informal payment that was conditioned (required or demanded) or for facilitation (i.e. to skip queue or get a rationed service). However, one patient described how a friend had been forced to pay for surgery:

> I know someone who had surgery [at the Cancer Institute] and had to pay. They demanded money before the surgery. This person had medical insurance but he still had to pay before the surgery. That was in May 2013…. I know many other people treated at the Cancer Institute: my godmother… my cousin (two years ago) …also my niece. The majority of them paid. There was a case, eight years ago, a colleague of friends. The doctors asked for payment. I dared to say 'Since it is final stage, why are you asking for so much?' But they still wanted payment. I refused to pay. They told us to take her home.

Another patient also had a story about informal payment at the Cancer Institute. Though she described the payment as "voluntary" she also asked the rhetorical question, "How can you refuse?"

> My teacher went to the Cancer Hospital. Her husband purchased a computer for the department. It was voluntary. The doctor said 'We need a computer for the department.' How can you refuse? When you take into account the doctor, the auxiliary staff who are treating the patient [there are many to pay]. But the lady passed away.

One patient reported making informal payments at the Trauma Hospital in order to assure prompt attention in a situation of under-staffing:

> My husband broke his leg and we went to Trauma Hospital. They had only two auxiliary staff. The relatives pay the staff to tend to their patient since there aren't enough staff and the staff can't take care of all the patients. The staff aren't asking for these payments, but the relatives are paying. My husband stayed one week. I have seen it.

Some patients acknowledged that it is a "human attitude" to think that "if you give something you will get better care."

Informal gifts. Several patients admitted **giving a gift** when they or someone they knew had given birth. People would not say how much they paid, but they said everyone does it and it is definitely a thank you. The quotes below suggest the reasoning behind gift giving.

When I gave birth, everyone thanks, so I thanked as well. I wasn't asked to pay. I wanted to thank the doctor for the attention.

I think it is normal, not forced. I gave as much money as I wanted.

My doctor found medicines for me on another unit when they weren't available on my unit [so I thanked her].

About informal payments, I think it is something about individuals giving flowers and candies. No one is imposing this. If I like the doctor's approach and

I am satisfied and I want to thank him with coffee or autumn fruits, I should do it.

Everyone decides for himself. If I want to, why can't I thank my doctor?

Medical provider perspectives

Medical providers participating in the 2013 focus groups described the following reasons why people make OOP payments.

- **High-tech diagnostic tests which the hospital is not able to perform**, but which the patient needs. The patient is advised to have the test at a public or private testing centre elsewhere. For insured patients these tests might be rationed (i.e. insurance fund reimburses only a certain number). This means that a patient may have to wait some days, those who do not want to wait can pay out of pocket.

- **High-tech diagnostic tests which the hospital is able to perform**, but which may be discretionary (i.e. not essential patient care). Hospitals limit the number of investigations to control costs as the insurance fund reimburses a set amount per treated case. If a patient wants a test that the hospital determines is not essential care, the patient can pay out of pocket.

- Patients may need **second-line and third-line medicines unavailable** in the hospital or in the country. Patients may purchase these medicines personally and bring them to the hospital.

- Patients may want a **medicine not on the compensated medicines list**. One doctor said that some of the "cheap" medicines are not good. "How can a drug be good if it costs 10 times less than another medicine?"

- **Uninsured patients** (including those from the Transnistrian region) must make OOP payments. However, hospitals in the Republic of Moldova charge tariffs that are lower than the real cost of care for these patients.

- **Non-referred patients.** According to one focus group participant (a hospital administrator) up to 30% of patients may attend a district hospital without a

referral. These patients must pay to see the specialist. If tests are needed, they will also pay, unless they return to their family doctor to obtain a referral for a specialist and free tests.

- **Gifts** given after a service, to thank the provider (see informal payments, below).

Informal payments. Often medical personnel and facility managers are reluctant to discuss informal payments. The Barriers Study suggests that providers do not like being perceived as corrupt (WHO Regional Office for Europe, 2012). A manager of a rayon-level specialized outpatient service stated, "There is a stereotype in the society that physicians are the most corrupt, and it is painful because we are not the most corrupt." A similar attitude was found during the 2013 focus groups.

Gifts. In the 2013 focus groups, most doctors at hospital and primary care level said that gifts were the only kind of informal payment. These include small token gifts of candy, flowers, a bottle of cognac, or a small amount of cash given after discharge or after care is delivered. A hospital patient might give a gift because the doctor came in on the weekend or at night to check the patient's status, for example. In the focus group held at the primary care practice, most providers thought that there is a low rate of informal payment, comprising mostly gifts. Providers described most informal payments as "simple acts from patients to say thanks," such as flowers and presents. One provider mentioned MDL 100 (€6.34) as a cash gift. A primary care doctor justified accepting gifts by comparing it to other service providers: "Doctors should get tips. Waiters get tips, so why not?" Doctors believed that gifts are proportional to the means of the patient (i.e. can be small or nothing if the patient cannot afford it). According to one informant, a doctor cannot take a gift before the service has been delivered because there is no guarantee of a good outcome.

Doctors in two of the 2013 focus groups made reference to Stalin's adage, "A good doctor is fed by the people." This was meant to convey that **gift giving is culturally acceptable** to patients as they think it necessary to say thank you. Patients also understand the economic situation of the country; are aware of how little doctors earn; and are willing to contribute to the livelihood of providers. One doctor said, "It is a custom that has existed for decades. It is how they say thank you for the attention."

Conditioned or facilitation payments. Doctors thought that no forced or conditioned informal payments were required by medical staff, "No-one puts his hand in the patient's pocket." Similarly, the doctors did not believe that patients made facilitation payments to skip waiting lines in hospitals. At primary care level, no-one spoke of facilitation payments. Primary care providers said that the problem of informal payments is not as bad as it used to be, and that it is mostly in hospitals rather than at the primary care level.

Yet, in the Barriers Study, some medical providers admitted that patients who pay formally or informally are given better service, and that long waiting times influence OOP payments and create inefficient care-seeking patterns.

> Those who are insured [are supposed to] have priority…but in reality those who are willing to pay are privileged, they do not stay in lines…If a client comes with cash, he is received with open arms compared to those with health insurance. (Manager, rayon-level specialized outpatient service)
>
> To avoid waiting for hospitalization, patients prefer to call the ambulance, to avoid all the referrals, and then we have the situation that about 50% of hospitalizations are based on emergency...In these cases the ambulance prefers to over-diagnose and hospitalize overnight, to avoid repetitive calls. (Manager, rayon-level specialized outpatient service)
>
> Health insurance is only formal; if you do not have money you do not get treated. (Social assistant, rayon-level)

One doctor in a 2013 focus group mentioned that informal payments are widespread in other sectors and that it did not make sense to single out the health sector. This doctor thought that payments in the health sector are minimal compared to other sectors, "The hidden economy is large in Moldova."

Provider perceptions of underlying causes

Doctors mentioned the following causes or drivers of OOP and informal payments in general. Primary care providers focused on low salaries; hospital-based providers suggested other systematic drivers too.

Low salaries/lack of appreciation. Most providers at the hospital and primary care level thought that the major driver of conditioned informal payments is low pay and a sense that receiving payment makes one feel appreciated. Many doctors expressed discontent with the current salary structure.[12] A doctor might make MDL 4000/€225 per month before taxes (MDL 3500/€197 after taxes). A nurse might make MDL 2500–3000/€141–169 per month before taxes. Another doctor said that a new specialist doctor (not a resident) will earn only MDL 1300 (€74) per month. Some doctors thought that society is aware that doctors in the Republic of Moldova have very low salaries, while a doctor in Europe may earn US$ 15 000 or US$ 16 000 (€11 121–11 862) per month. Other doctors thought that patients may not realize how low doctors' salaries are. The low salaries of doctors in the public sector may lead providers to work additional hours in the private sector. They can make additional revenue by seeing patients after their public sector shift has ended.

> If doctors have decent wages, the informal payments will disappear. (Family doctor)
>
> How can a doctor finance a family with three or four children? The average salary we earn is not enough to pay for a flat. (Administrator)
>
> I am a specialist, I have no complaints against me, I want to feel appreciated. (Hospital doctor)

[12] See also Tables 8 and 9, which contain salary information, and related discussions.

Low reimbursement provided to the facility on a per-case basis by the national insurance fund. Doctors reported being unhappy with the diagnosis related group (DRG) reimbursement rates because they do not cover costs, yet the hospital still has bills to pay. Hospitals cope by paying bills late and by rationing care: patients who do not want to wait may go elsewhere. At the primary level, doctors did not think that waiting lines were a driver of informal payments: "We don't have long waiting lines, so that's not a driver." Yet, primary care doctors and administrators also agreed that their facility lacked adequate resources to provide for all the patients who come for treatment.

Ceilings on the number of cases that the insurance fund will reimburse. Once the ceiling has been reached, the hospital may either refuse to treat patients (put them on a waiting list) or ask them to pay. If the hospital continues to treat patients for free, it may not have adequate funds to pay providers.

Over-utilization. One doctor thought that costs were being driven up by too many investigations and too many referrals for testing. Some providers at the primary care practice felt that there were too many diagnostic centres in Chisinau, and that patients attending private clinics or diagnostic centres without referral are having many unnecessary tests. Also, as the insurance fund reimburses some care sought at private centres, there is less money to finance the public centres. "The majority of patients are going to private medical centres [first]. Then they come back to the public sector because they can't afford it anymore." This highlights the importance of regulating standards in both the public and private sectors to protect value in CNAM spending.

Advertising, self-treatment with medicine. Providers thought that patients are accessing the Internet to look up how to treat their illness, are swayed by adverts for medicine and are buying expensive vitamins and other products that they do not need. "There are nine drug stores in our neighbourhood. Patients are asking the pharmacist what they can take. They purchase a lot of drugs, maybe MDL 600 (€34)." Doctors thought that patients are having tests they do not need but think will benefit them.

Prescribing practices of doctors. In the primary care focus group, providers mentioned that some doctors may be over-prescribing, and suggested that doctors, "need to be more careful about how they prescribe. It is increasing costs without any better results, and the pharmaceutical companies are benefiting."

Poor quality medicines. One provider suggested that public facilities sometimes dispense drugs that are not of good quality (e.g. medicines procured by tender from suppliers in China). Concern about the quality of medicines may drive people to pay more in private pharmacies to get what they perceive to be higher quality drugs.

Patient attitudes towards both gift-giving and self-treatment are driving OOP and informal payments. Providers explained that it is hard to refuse if a patient wants to give, and that it is traditional for people to give something to the person who has

treated them. Another patient attitude is the tendency to self-treat before attending hospital.

> In some cases the patient is ready to give everything they have to survive. (Hospital doctor)

> You should understand patient psychology: patients give flowers - if you don't accept the 'thank you', the patient will doubt you. (Hospital doctor)

> [Patients] uselessly pay MDL 1000 (€56) for medicines. Then they come here. (Hospital doctor)

One primary care practice administrator reported that many measures are in place to deter informal payments, including:

- training on anti-corruption for providers, conducted by staff from the NAC
- opinion polls, toll-free numbers and complaint registers in each department
- posters on doctors' office doors to say that patients do not have to pay
- policies in place for punishment of those who accept payments.

Given the circumstances (conducting focus groups, not performing a control visit), the existence of posters, complaint registers or other policies to deter informal payment could not be confirmed.

Advantages of informal payments

Participants mentioned only one advantage of informal payments: they help the system to survive in a situation of severe under-funding. This also includes professional development as doctors have to pay from their own pockets for attendance at congresses, conferences and seminars abroad.

Disadvantages of informal payments

Medical providers focused on several disadvantages of informal payments. One is that doctors do not pay taxes on gifts and a larger informal economy makes it difficult for the government to invest in public goods such as roads. Doctors also mentioned that the need to make an informal payment places an additional burden on the family of an ill patient.

Finally, doctors were concerned that informal payments are affecting society's view of the medical profession. One doctor said it is humiliating for a doctor to condition a payment: "You would have to be the worst kind of person to demand payment." Doctors felt that the press and different household survey reports have exaggerated the problem of informal payments, making it look as if doctors in general are very corrupt when this is not true, "The image of the doctor in society is being destroyed because of the image created by government through these surveys." If the medical profession is tarnished, people will begin to leave for other professions, leading to shortages of doctors. Moreover, the focus on doctors accepting informal payments diverts attention from potential wrongdoing

by senior health officials (i.e. high-level corruption which might involve much greater sums of money).

Reform ideas
Doctors considered that the following actions might help to reduce formal and informal payments.

- **Increase official tariffs** (fees for services charged by hospital to patient) or **institute co-payments** (paid by patient to hospital). Prices charged to uninsured people may need to be increased. Co-payments contributing to the cost of care may need to be introduced for insured patients.

- **Increase insurance reimbursement** rates (amounts paid to hospital per case by the insurance fund). Reimbursement rates need to be closer to real costs per case.
- Create **private wards** in public hospitals to allow private practice within public facilities and enable people to buy extra amenities (e.g. luxury room, higher nursing ratio). Another option is to rent space to private physicians and/or allow them to offer private clinics at times when public clinics are closed (e.g. late afternoon or evening). The rent would cover the private physicians' use of the space and some hospital support services (e.g. security, maintenance, cleaning).

- **Increase salaries of doctors** and provide better working conditions (i.e. housing, equipment, continuing education, participation in conferences, medical books for direct benefit of doctors).

- **Improve management and physician-management communication.** There may be ways to reduce costs through proper management and oversight. One doctor thought it might help to create medical councils. Another suggested reviewing annual financial statements and patterns in use of medicines to identify any potential for improvement. Some doctors disagreed, believing that, "management can't help if you have nothing (no funds) to manage." Some doctors thought that the situation would only improve in line with improvements in the general economic climate in the country.

- Create some **transparency around the amount of gifts people** receive. This idea caused some disagreement: it might create tension "if we show all our thank yous." In addition, one doctor questioned the fairness of the high tax rate that would apply to formalized payments.

Other key informant perspectives
Other stakeholders interested in this issue include the NAC and the CNAM. The NAC noted that complaints and prosecutions in the health sector are increasing (see Table 6). Although the organization could assist with detection and enforcement, NAC suggested the need for a sectoral approach to prevention through health systems strengthening. NAC staff and CNAM officials have met to discuss enforcement issues.

Table 6. NAC investigative data, health sector

	2012	2013	Percentage change
Complaints in first 6 mo.	123	176	43.1%
Prosecutions per month*	1.1	2	84.6%
2013 is projected based on 6 months of data, Jan–June			

Source: data obtained on request from NAC, 2013.

According to NBS household survey data from 2012, 39% of respondents said that they would not raise any complaint if they were asked to pay extra for services in a public facility. However, 17% of the population said they would address a complaint directly to the physician concerned and 15% said they would complain to the Ministry of Health. Compared to 2008, there was increased public confidence in the Ministry of Health and medical staff (NBS, 2013a).

CNAM officials presented many explanations for high OOP payments, several of which were related to medicines (see section on drivers). They felt that thank-you payments were acceptable, because they were traditional, but conditional payments were not. They considered that problems were rare in emergency services. The CNAM has plans for several initiatives which should help to increase transparency, including a call centre to make it easier for patients to lodge complaints and better information materials on insurance benefits.

Provider contracts contain no specific provision concerning acceptance of any informal payment, but clause 5.6 forbids the provider to ask for payment for a service covered. One clause requires the CNAM to reimburse the patient if a service is not available and he/she needs to go elsewhere; the organization sends an investigator to scrutinize such requests. Any complaints about conditional payments are passed to the NAC because the legislation does not allow the CNAM to investigate individuals.

The CNAM plans to create a new **subdivision for beneficiary protection** which will include the aforementioned call centre for complaints. The office will also create a rating system based on the number of complaints that institutions accrue. With World Bank support, the CNAM plans to undertake a more detailed study of informal payments in order to understand the weaknesses and gaps in

patient information. In addition, they will develop documents to help patients understand the benefit programme and insurance provisions more easily, and are intending to introduce surprise audits of facilities.

The CNAM has proposed systems-level reforms which they believe may also help to reduce OOP and informal payments. These include modernizing payment methods and introducing digital prescriptions. The latter is intended to help the CNAM to detect doctors who are prescribing more expensive drugs (with same active ingredient) and to identify other inefficiencies or irrational prescribing which may affect OOP payments.

6. Drivers of OOP payments

This section presents a synthesis of the quantitative and qualitative data to provide a summary of causes and drivers of OOP payments organized in three broad categories: (i) medicine-related drivers; (ii) system-related factors; and (iii) patient-related drivers (Table 7). Note that medicine-related factors generally relate to formal payments only, so the last three columns of the table are less relevant.

Table 7. Drivers of formal and informal OOP payments

	Drives which kind of OOP?				
	Formal Private	Formal Public	Conditioned informal	Facilitation informal	Gift
Medicine-Related Factors					
Limited list of compensated medicines and/or only partial reimbursement	✓				
Prescribers shift patients to uncompensated medicines	✓				
Poly pharmacy (use of too many medicines in treatment)	✓	✓			
Few family doctors in rural areas, so patients can't get compensated meds	✓				
High unit price of medicines	✓				
System-Related Factors					
Waiting time and referral system	✓			✓	
Low quality of care/lack of supplies		✓	✓	✓	
Inadequate reimbursement rates/doctor pay		✓	✓	✓	
Disincentives for insurance enrollment	✓	✓			
Physician conflict of interest, induced demand	✓				
Impunity			✓	✓	
Organizational culture of acceptance of IP			✓	✓	✓
Patient-Related Factor					
Desire to choose provider	✓				
Lack of knowledge of entitlements		✓	✓		
Cultural desire to pay for service, gift				✓	✓
Perceived necessity to pay			✓		
Inappropriate self-medication	✓	✓			

Medicine-related drivers

Payments for medicines are usually **formal OOP payments.** The reasons for these payments include factors related to the compensated medicines policy and limits on coverage; prescribing practices that shift patients to medicines which are not compensated; polypharmacy (prescription and use of too many medicines in treatment); barriers to access in rural areas; high unit price of medicines arising from procurement practices and other policies. Inappropriate self-medication is also a problem, discussed under patient-related factors.

Factors related to compensated medicines policy
All drugs dispensed in hospitals are covered 100% for insured patients but only a very limited number of medicines are covered 100% in outpatient settings. This means that patients have to pay out of pocket in a private pharmacy, or (as some have suggested) try to get hospitalized so that the drugs will be free (Sautenkova et al., 2012).

Many medicines prescribed in outpatient settings receive only partial reimbursement (i.e. 50%, 70%, 90%), requiring patients to pay the balance as a formal user charge. Public facilities impose no formal user charges for outpatient prescription drugs.

Prescribing practices that shift patients to uncompensated medicines
Some doctors in public practice are reportedly prescribing medicines which are not covered by insurance. Lack of confidence in (or knowledge of) standard treatment guidelines, or doubts about the quality of medicines on the compensated list, may lead doctors to suggest that a different (generally more expensive and/or branded) medicine is better. Laws permit doctors to hold ownership stakes in pharmacies so these prescribing patterns may be influenced by financial benefit to the prescriber who owns a pharmacy, or there could be a kickback relationship between prescriber and pharmacist.

Polypharmacy, self-treatment and other prescribing issues
Polypharmacy can drive up OOP payments through unnecessary prescribing and self-treatment. A study which examined prescriptions written in 2011 found that 7.8% of cases showed evidence of over-prescribing by physicians. In addition, despite an attempt to introduce prescribing by international non-proprietary name (INN) in 2012, doctors still prescribe using brand names and pharmacists are not allowed to make generic substitutions. Hence, patients pay higher prices than necessary for prescribed medicines (Sautenkova et al., 2012).

Patient attitudes may also be contributing to polypharmacy. For convenience, or because they do not believe that doctors consider all possible treatment options, patients may seek medicines at private pharmacies or public pharmacies in PHC units without first consulting a clinician. Sometimes, antibiotics and injectable medicines are sold to patients without a prescription, and a nurse or pharmacist may prescribe prescription-only medicines (Sautenkova et al., 2012). In addition to increasing OOP payments, polypharmacy and self-treatment can have negative consequences for health. Patients find it harder to adhere fully to instructions when they are taking multiple medicines, and may take incomplete or insufficient treatments (possibly fuelling antimicrobial resistance) or suffer side effects or drug interactions (Pavin et al., 2003). Sautenkova et al. (2012) suggest that polypharmacy and irrational prescribing are exacerbated by inadequate supervision of prescribing and lack of monitoring by government, civil society and professional bodies.

Barriers to access in rural areas
According to one key informant, insufficient numbers of family doctors in rural areas mean that patients are prevented from obtaining prescriptions which would allow insurance reimbursement. Instead they go to pharmacies and pay out of pocket.

High price of medicines
Medicines are expensive for a variety of reasons. For example, procurement agents have limited skills in price negotiation; restrictive TRIPS Plus intellectual property rules;[13] small size of the country limits bargaining power (see Sautenkova et al., 2012).

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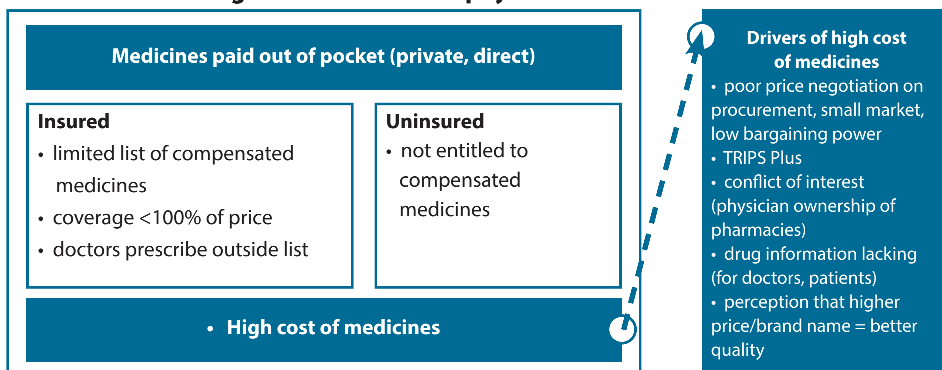
[13] The Agreement on Trade-Related Aspects of International Property Rights (TRIPS Agreement) sets minimum standards for intellectual property protection (such as copyrights, patents, trademarks) that all World Trade Organization Member Countries have to respect. TRIPS Plus sets more restrictive conditions such as extending the term of a patent beyond the 20-year minimum, or introducing provisions that limit the use of compulsory licences or restrict generic competition. Some countries are required to adopt TRIPS Plus restrictions as part of trade agreements with the United States of America or the EU. See http://apps.who.int/medicinedocs/en/d/Jwhozip18e/2.html for discussion.

Fig. 9. Drivers of OOP payments for medicines



System-related factors

System-related factors can drive up both formal OOP and informal payments. These include long waiting times; low quality of care and lack of supplies; low compensation or reimbursement of providers; disincentives for insurance enrolment; conflict of interest; and impunity. These are discussed in more detail below. There is also an organizational culture of acceptance of informal payments as gifts, as discussed in Section 5 on perceptions.

Waiting time and referral system

Patients who do not want to join a waiting list to receive treatment, or to be referred to a specialist, may either make a facilitation payment to jump the queue (thus driving up informal payments) or obtain the service from a private facility (increasing formal OOP payments). A distal causal factor may be that facilities lack equipment and supplies (e.g. implant devices), thus increasing waiting time for a procedure. In this event, the patient again has a choice: either opting to pay formally for the device or supply, or trying to make an informal payment to reduce waiting time for what should be a free device. For an outpatient specialist consultation, people who pay are seen more quickly than those who have insurance and so patients pay to be seen quickly (increasing formal OOP payments).

Low quality of care and lack of medical supplies

Facilities lack consumables so patients are asked to pay either formally (at a store) or informally (e.g. a doctor may say that although no syringes are available, they can be purchased directly from the doctor). Patients pay informally, or shift to the private sector, to try to assure that they will get the best possible care. In addition, some informants reported that doctors who are overloaded with work do not have time to spend with patients, resulting in poor diagnosis and treatment. Patients pay informally to get more attention, or to be sure that the doctor will allow them to make another appointment.

Inadequate rates for reimbursement and doctors' pay

Some people have suggested that the insurance reimbursement to facilities is not adequate to cover the full cost of services and salaries. They claim that doctors, especially young doctors, are not paid well enough and this could be a driver affecting mainly informal payments. Inadequate reimbursement of fixed facility costs may also be a factor. For example, a manager may need to ration services because the facility cannot afford to purchase adequate supplies to conduct diagnostic or surgical procedures. In this case, the manager or individual doctors may ask patients to pay formally for medical devices and consumables, or may solicit informal payments for surgical procedures or medical testing.

To evaluate claims of inadequate salaries, average salary data for physicians, nurses and other personnel were obtained from the Ministry of Health. The 2013 data for physicians were adjusted to account for 15% added vacancy pay,[14] and compared to the estimated average salary in the national economy (Table 8). The comparison shows that physicians are earning about 41% more than the estimated average salary in the Republic of Moldova. This ratio has improved from Soviet times, when primary practice doctors were paid less than the average wage. However, the ratio is lower than the average in other European countries.

Table 8. Dynamics of monthly salaries (in MDL) in medical institutions, 2006–2013

	2006	2007	2008	2009	2010	2011	2012	2013 first 6 mo
Average salary per one uccupied vacancy for all medical institutions (financed by the National Health Insurance Fund)*	1 125	1 442	1 918	2 310	2 479	2 509	2 838	2 958
Physicians	1 821	2 357	3 117	3 707	3 981	3 962	4 494	4 730
Physicians with 15% added vacancy pay **	2 904	2 710	3 585	4 263	4 579	4 556	5 168	5 440
Nurses	1 122	1 447	1 963	2 366	2 553	2 579	2 905	3 001
Nurses (lower level)	546	808	1 027	1 240	1 325	1 348	1 550	1 584
Other personnel (service personnel, administrative)	955	1 207	1 589	1 957	2 088	2 118	2 346	2 556
Estimated average salary in national economy ***	1 697	2 015	2 630	2 925	2 950	3 300	3 550	3 850
% Difference between Physician Salary w/ Added Vacancy Pay and National Average Salary	23%	34%	36%	46%	55%	38%	46%	41%

Source: data obtained on request from Ministry of Health of the Republic of Moldova, 2013. Notes: *hospitals, health-care centres, ambulatory services, emergency service. ** The regulation permits a doctor to occupy (accumulate) up to 2.0 vacancies and, very often, based on statistics a doctor occupies on average 1.25 vacancies, with corresponding increases in the monthly salary. For example, in 2012 the average monthly salary is MDL 2838 without vacancies, but MDL 3275 (about 15% more) if accumulated vacancies are included. The physicians' salary is therefore shown with and without vacancy pay. ***Calculated by the Ministry of Economy and approved annually by the Government.

For comparison, Table 9 shows the annual salaries of primary care and specialist physicians in several Organisation for Economic Co-operation and Development (OECD) countries. In most of these, a general practitioner (GP) would earn at least US$ 29 000 per year (US$ PPP); the annualized salary for a physician in the Republic of Moldova, including 15% vacancy pay, is US$ 8 774 (US$ PPP).[15] A 2008 study comparing GPs' remuneration to the average wage in 14 OECD countries found that this varies from being twice the average wage in Finland and the Czech Republic to 3.5 times greater than the average wage in the United States of America and Iceland. Remuneration of specialists varied more: from 1.5–2 times more than the average

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[14] Physicians may be paid additional salary for assuming the responsibilities of other unfilled positions, within limits. See notes to Table 8.

[15] MLD 5440 per month x 12 months, divided by MLD 12.4 per US$1 X 0.6 for conversion to US$ PPP as of October 2013. Exchange and conversion rates obtained from Ministry of Health.

wage of all workers for salaried specialists in Hungary and the Czech Republic, to 5–7 times higher for self-employed specialists in the Netherlands, United States of America, and Austria (Fujisawa & Lafortune, 2008). By contrast, resident doctors in Romania earn substantially less than the national median wage. According to one study, in 2010 resident doctors in Romania earned €250 per month and specialist doctors earned €495 per month. This compared to the country's median wage of €492 per month. Moreover, the economic crisis led to a 25% cut in doctors' salaries after 2010 (Puţan, Ivan & Topor, 2013).

Table 9. OECD salary data for GPs and specialists, selected countries, 2009–2012

General Practitioner Annual Salaried Income in US$PPP				
	2009	2010	2011	2012
Estonia	33 416	32 347	32 314	32 500
Hungary	31 019	29 593	29 353	NA
Mexico	39 902	41 025	43 178	NA
Poland	NA	45 899	NA	NA
Slovak Republic	37 346	38 223	37 517	NA
Slovenia	80 637	79 016	79 325	NA
Specialist Doctor Annual Salaried Income in US$PPP				
	2009	2010	2011	2012
Estonia	42 563	41 017	42 565	44 347
Hungary	34 716	34 182	33 862	NA
Mexico	50 742	51 217	53 869	NA
Poland	NA	33 807	NA	NA
Slovak Republic	NA	NA	NA	NA
Slovenia	90 837	85 214	82 898	NA

Source: OECD, 2014. Search for: health, health care resources, remuneration of health professionals.

A cost analysis has not been performed therefore it cannot be determined whether or not reimbursement rates for facilities are inadequate.

Disincentives for insurance enrollment

When this study was undertaken, patients were allowed to buy insurance at the time of seeking care, with no waiting period. This policy has since changed and there is now a five-day waiting period. A short waiting period may be an incentive for relatively healthy self-employed individuals to remain uninsured. Those needing to access care would then make formal OOP payments for basic services while retaining the option to enrol in the insurance programme if more intensive care was required (assuming no emergency and the ability to wait five days). In addition, hospitals' official tariffs (formal OOP payments) for uninsured people are low. This makes it economical to opt out of insurance and just pay the fees if a person becomes ill.

Conflict of interest

Patients may be sent for lab tests in private laboratories in which the referring doctor works part time. This could drive formal OOP payments higher. In general, doctors who work in both private and public sectors have incentives to shift patients

to private practice. Doctors may be inducing demand for high-tech services which are not covered by insurance or have waiting lists which patients pay to avoid; or encouraging patients to make private formal payment. A doctor who is part-owner of a device company may direct the patient to purchase from that company (formal OOP payments) which then releases the device to the doctor.

Impunity
Some facilities are not providing the care required by contract, and yet are not penalized. For example, rather than providing urgent care and then seeking reimbursement, a facility might deny care unless a patient makes a payment. In addition, the CNAM contract does not include incentives for facilities to control informal payments. It is difficult to prosecute doctors for accepting informal payments as this requires an investigator to observe the act of payment, must involve the NAC and requires the patient's cooperation and use of informants (see Section 7).

Organizational culture
There is an attitude of acceptance of informal payments which allows the practice to continue. Most providers perceive informal payments as gifts (see Section 5).

Patient-related drivers

Choice
Some patients are willing to pay to be able to choose their provider. In order to receive care covered by insurance, they must go to the specialist or hospital to which they are referred by the family doctor. If they want to go elsewhere, they make a formal OOP payment.

Lack of knowledge
Patients may not know what their insurance covers. Doctors could abuse this lack of knowledge by requiring patients to pay for services that should have been free. These could be formal public payments or informal payments that the patient believes are formal. Lack of knowledge may also be a factor driving patients' preference for expensive, proprietary and uncompensated medicines over the generic medicines included in the insurance benefit package. This results in higher formal OOP payments.

Cultural desire to pay for a service rendered, or to give gifts
Some key informants reported that patients are used to paying for a service, and believe they should be paying something for their medical care. Despite having insurance, and even if they have paid their own premium, they may still feel that they have not paid. This perception drives informal payments. In addition, some people want to express their gratitude with a gift (flowers, chocolate).

Perceived necessity
In some cases, patients may feel that they must make an informal payment in order to be seen or to receive quality care. They may fear the possible outcome if they do not make a payment.

7. Review of adequacy of existing law for control of informal payments in Republic of Moldova

The following analysis is based on the review of English translations of the Law on Compulsory Health Insurance (No 1585—XIII, dated 27 February 1998) as amended through 2012, as well as Government Decision No 1636 Regarding the Approval of the Type Contract for Health Care Provision within the Compulsory Health Insurance, dated 18 December 2002. The language of these documents, as translated, has been compared with what would be necessary to sanction providers within the Moldovan health-care system in the event that they demand informal payment for services already covered by national health insurance.

Statutory structure

Article 11 of the health insurance law provides that an insured person is entitled to, "benefit from health services according to the volume and quality stipulated in the Unified Programme, regardless of the amount of paid insurance premiums." In other words, everyone enrolled in the national health insurance programme is entitled to the same benefits and quality of service and, presumably, is entitled to such covered benefits without additional payments, beyond co-payments or fees specified in the Unified Programme.

Article 14.4 of the health insurance law states, among other obligations of health providers, that they "… are liable within the legislation and clauses of the contract … for the refusal to provide health care to insured persons …." So if a provider or its employee demands an informal payment as a condition of providing a covered service, the provider should be liable for refusing the service.

Section 5.3 of CNAM's Type Contract [16] states that, "where there is a confirmation of the refusal to provide health care set forth in the Contract, the provider shall pay a 10% penalty of the estimated value of the services which should have been provided." If the courts interpret the demand for an informal payment as a denial of service, then the provider can be penalized 10% of the value of all such services for which an informal payment is demanded. Of course, the provider may use the defence that the services were ultimately provided – when the patient made the informal payment. The penalty under section 5.3 of the Type Contract would then be much less, because it would apply only to the services that might have been obtained by the patients turned away due to their refusal to make the informal payment. Where patients routinely make informal payments, the amount of care denied because the patient refuses to make the informal payment could be quite small.

[16] The Type Contract and any modifications are approved by Government Decision – see Government Decision No.1636 dated 18 December 2002 "Regarding the approval of the Type Contract for delivery of medical services under the mandatory health insurance", including the last modifications to it published in the Official Gazette Nr. 311 on 27.12.2013, art. Nr.: 1158

If the section 5.3 sanction is applied to all services for which an informal payment is demanded (whether paid or not), the total could be substantial. However, this still may not be enough to deter the conduct, especially if the informal payments exceed 10% of the insurance payment. The clause would be more effective if the penalty were larger, and if the provider was also required to return to the insurer, or the insured, all amounts earned through informal payments.

Weaknesses in the statutory structure

While it can be argued that a demand for informal payments is a denial of covered services within the insurance benefit, the existing language is not specific on this point. It is desirable to amend the language in the health insurance law to state specifically that any demand for payments other than those authorized under the Unified Programme is an attempt to violate the rights of the insured. The amendment would further state that such violation of rights is subject to penalties under section 5.3 of the Type Contract, whether or not the patient made the informal payment and received the service. Of course, the health insurance programme will need further strengthening of its information resources so that insured members can readily determine what services or drugs are covered, and the permitted level of user fees for these services or drugs. In addition to informational mailings and posters at provider sites, information programmes might be strengthened by SMS applications that would enable a patient to make a benefit query at the time of service. Another mechanism might be to require insurers to install dedicated computer terminals in each provider. Such networked computers would have an easy-to-use interactive query function to answer queries about payments authorized within the Unified Programme.

The structure for recovery of penalties under Section 5.3 of the Type Contract should be expanded by increasing the percentage of the penalty for services denied above 10% of the value of such services. The amendment should also bar the defence that these services were ultimately received after the insured made the informal payment. In addition, the penalty should be expanded to provide for the insurer to recover all informal payments in addition to a percentage of the value of the services for which an informal payment was requested. The Type Contract simplifies the recovery of such penalties because they can be deducted from amounts payable to the provider, rather than going through a cumbersome process to collect a criminal fine. Such a recovery mechanism is very much preferred to the alternatives of the criminal fine or termination of the contract, which may not be feasible, as discussed below.

Of course, the law could simply require the informal payments to be returned to patients, but this would be hard to monitor and enforce. In part, patients make informal payments for their own advantage (e.g. facilitation payments to jump the queue or assure better services), so forfeiting the recoveries to the insurer would provide another reason for patients to avoid making informal payments. Patients would not get their money back following the insurer's successful pursuit of the provider demanding such payments.

Finally, the health insurance law should be strengthened by adding to Section 14 the statement that a provider shall be liable, "for any action by its employees or agents which shall have the effect of denying the patient a covered service as provided under the Unified Programme." Currently, a provider could claim that it has no knowledge of the fact that employees are demanding informal payments. As the law is currently written, providers have little interest in learning if employees or agents are demanding such payments. With the law changed to impose strict liability for demands made by employees, providers are more likely to deploy systems to control such demands.

The suggested reforms will work only if there is an effective programme to educate beneficiaries on their rights and formal payment obligations under the Unified Programme. At least initially, patients may be unwilling to complain so the insurer will need to deploy multiple techniques to document demands for informal payments, including mystery patient programmes,[17] complaint hotlines and exit surveys of patients when they complete treatment. With such systems in place to inform insured members and measure violations, the existing statutory structure and suggested amendments should provide a framework for deterring informal payments.

The law and regulations on provider contracts provide sanctions for providers failing to provide covered services to Moldovans who are beneficiaries under the health insurance system. This provision might be used to discipline those who demand illegal payments from insurance beneficiaries but it is not intended for that purpose. In addition, the law and contract do not explicitly make contracted health providers responsible for informal payments which are demanded by employees or consultants. It would be desirable to revise the health insurance law and contract to specifically define any demand for informal payments as a refusal to provide covered services (because the patient who refuses to pay is denied the service). Such a revision should also make a contracted provider responsible for the conduct of any employee or consultant who demands informal payments. Penalties provided in the health insurance act and the Type Contract could then be assessed against the provider and recovered from amounts owed the provider by the insurer. This would create a powerful economic deterrent to demands for informal payments without requiring the insurer to terminate the contract and expel the provider from the insurance system – a result which may not be feasible when the provider is used by a large number of patients or is the only contracted provider of a service in a given area (e.g. the only hospital in an isolated district).

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[17] An agent of the insurer visits a suspect provider and requests the service, documenting any request for an informal payment.

8. Policy options for reduction of OOP and informal payments

The following policy options may help to reduce OOP and informal payments.

1. Implement measures to reduce households' medicine costs and expenditures.
2. Improve accountability of health workers and managers through administrative controls.
3. Lessen impunity through legal reform, detection and enforcement.
4. Implement a community monitoring mechanism to strengthen social accountability.
5. Increase individual provider incentives and improve organizational incentives for performance.
6. Formalize unofficial payments through the introduction of user fees and/or private wards in public facilities.
7. Improve transparency and implement information strategies.

Participants in the policy workshop favoured options 1, 2, 5, and 7 for reducing formal OOP payments, and options 3–7 inclusive for reducing informal payments. They suggested expanding the compensated medicines list and increasing the percentage of medicine costs reimbursed as a way to reduce OOP payments. This would entail more government spending. Workshop participants also noted the need to control irrational use of medicines as a way to achieve efficiencies. This could be achieved through education of providers and patients, and better management of conflicts of interest affecting prescribing. Finally, the group noted the need to enhance incentives for individual providers and provider organizations to offer high-quality care and control informal payments.

Evidence and possible drawbacks for each of the options is discussed in more detail below. Given that pharmaceutical expenditure comprises the majority of OOP payments, policy options for reducing unit costs and household spending on medicines are presented first. This is the most urgent area if the Republic of Moldova is to reduce the proportion of OOP spending within THE.

1. Implement measures to reduce households' medicine costs and expenditures

- Conduct capacity building in procurement. This would include developing skills in price negotiation for tendering; rules to allow government to benefit from discounts negotiated between pharmacists and distributors (for drugs reimbursed by the CNAM); and putting in place conflict-of-interest policies for medicines procurement and purchase of technology.
- Create regulations to prevent doctors, facility managers and their close relatives from owning pharmacies in order to avoid self-referral conflict of interest.
- Support the CNAM and the Medicines and Medical Devices Agency in

implementation of an electronic prescribing system. Support analysis of prescribing data by the CNAM or nongovernmental organizations (NGOs) to detect patterns of over-prescribing or other irrational prescribing issues.
- Increase medicine price information available to patients. For example, via computer screens in pharmacies or cell phone apps which allow price checking (Lithuanian example).
- Support reforms to encourage prescribing by INN.
- Engage in activities to empower patients and change consumer attitudes regarding brand name versus generic drugs and drug prices (e.g. Estonian commercials using famous actors).

Evidence
In Mexico, capacity building in price negotiation contributed to a 41% reduction in the price paid for antiretrovirals (Adesina, Wirtz & Dratler, 2013). Other important factors in the reduction of procurement prices included clarifying the roles and responsibilities of procurement staff (Woodle, 2000), improving the collection of data related to supply and integrating these data within the forecasting process; and creating systems to monitor use of medicines (Adebiyi Adesina, Wirtz & Dratler, 2013). Accurate information regarding regional procurement or pooled procurement options is also important (Chaudhury et al., 2005).

Several studies have shown that separation of drug prescribing and dispensing can reduce drug prescription rates and expenditures on medicines. In east Asia, Chou et al. (2003) found that the probability of prescription was 17–34% less among visits to clinics without an on-site pharmacist, compared to control sites, while drug expenditure per visit was 12–36% less without an on-site pharmacist, compared to the control. Jeong (2009) found that a similar reform was very successful in reducing prescription rates and costs in the Republic of Korea. For example, the claims containing antibiotics within the total claims from doctors' clinics dropped from 55.7% in 2000 to 29.6% in 2008, and the number of drugs per claim from 5.9 in 2000 to 4.2 in 2008. This type of finding has implications for situations where the physician may have a financial stake in a pharmacy.

Interventions to promote prescribing according to INN, including generic substitution, have proven effective at saving costs. In addition to avoiding potential corruption and influence from pharmaceutical marketing, it may be that doctors in the Republic of Moldova do not know that a generic medicine is available or do not know the generic name. In the American state of Massachusetts a physician must sign the prescription form a second time if a brand name is prescribed. Finland saved 5% of total medicines sales in the first year following a generic substitution reform initiative (Heikkilä et al., 2007). The introduction of generic substitution in Sweden was associated with a shift in trend from an increase to a decrease for both patient-level and national medicine expenditures (Andersson et al., 2007). In Australia, the Minimum Price Policy set a government subsidy for therapeutically interchangeable brands at the level of the lowest-priced brand. This put downward pressure on medicine prices, but it was not until the introduction of generic substitution at pharmacist level that patients

showed a marked shift to the lower-priced brands. Researchers concluded that containing the rate of increase of drug costs by increasing market penetration of cheaper generics, or by encouraging price reduction of innovator brands, requires the introduction of generic substitution in order to have significant impact (McManus et al., 2001). A regulatory reform used extensively in OECD countries, external reference pricing (ERP) is a type of direct price control in which the regulator sets a maximum reimbursement level for drugs based on the prices of similar drugs in other countries. Researchers correlated pharmaceutical sales revenue with ERP reforms in 16 OECD countries, concluding that reference pricing reduced pharmaceutical revenues by 10.8% (Sood et al., 2009). [18]

Lithuania has introduced an electronic database of prescription data containing reimbursed prescription medicine history for all patients, diagnosis, and names of the prescribing physician and the dispensing pharmacy. This database is monitored frequently and has helped to identify results of changes in medicine policy. Lithuania was able to achieve considerable reduction in reimbursed expenditures for generics in 2009: 42–65% below originator 2001 prices. This was achieved by requiring all prescriptions to be written by INN, and pharmacists to provide pricing information to patients on computer screens, and by imposing sanctions on pharmacists who do not stock the cheapest generics (Garuoliene et al., 2011). At least 22 EU States monitor physicians' prescription patterns, benchmarking against the prescription patterns of other physicians in similar specialties, in order to identify large and unexplained deviations. Physicians may be asked to explain such deviations and those who cannot do so may be subject to fines, legal action or suspension of their prescribing rights (Carone, Schwierz & Xavier, 2012).

The Republic of Moldova could learn from in-depth analysis of alternative cost containment strategies from Europe, such as those defined in Carone, Schwierz & Xavier (2012). However, it is important to assess their relevance to the local context.

Discussion
Short-term reform. As the largest area of OOP payments, medicine costs are worth a focused plan of intervention. In the short-term, medicine policy experts should work with the Ministry of Health, CNAM and the appropriate drug regulatory agencies to develop a strategic plan for policy reform to reduce medicine prices.

Improve accountability of health workers and managers through administrative controls

Evidence of options 2–4 will be discussed together, after option 4.

Evidence
Hierarchical internal control systems define roles and procedures for key management functions such as purchasing and fee collection, and assure appropriate oversight of

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[18] See Jeong, 2009 for more detailed analysis of the benefits and potential problems with reference pricing.

management decisions. Once standard operating procedures and controls (checks and balances) have been defined, it is possible to measure through supervision and/or audit whether procedures are being followed and to enforce consequences for compliance failures.

With the support of the United Nations Development Programme (UNDP), in 2006–2007 Mongolia implemented the project: Strengthening ethics and integrity for good governance in the health sector of Mongolia (UNDP, 2009). Project activities included review of laws, regulations and procedures in the health sector to ensure efficient and transparent procurement, financial management processes and human resources practices, and the creation of benchmarks at sectoral, organizational and individual level to measure transparency, integrity and accountability in the health sector. Examples of sectoral benchmarks included a well-defined finance policy, revised implementation guidelines and public reporting of expenditures; organizational benchmarks included public access to information on fee schedules and government financial accounting reports; individual benchmarks included establishing an ethical code of conduct and following established rules for fee collection, among others. However, adoption of the benchmarks on paper did not directly lead to implementation, and some senior health officers did not believe there was a need for open procedures and reporting. Though implementation was slow, the project was thought to have raised awareness and a follow-on project is continuing the work.

2. Lessen impunity through legal reform, detection and enforcement

Evidence
A study of 22 hospitals in Venezuela found that the probability of detection and sanction appeared to play a large role in explaining corruption (the study looked specifically at theft and absenteeism). The probabilities of detection and sanction were associated with the existence of administrative controls (Jaén & Paravisini, 2001).

Implemented by the Council of Europe, the Project Against Corruption in Albania (PACA), reviewed the framework of the health insurance law and related by-laws. The review found that the regulatory structure of the Albanian national health insurance system was vulnerable to corruption by health-care providers demanding informal payments, and identified where clarification of statutory or regulatory language might reduce the risk of illegal or informal payments by increasing the probability of detection and enforcement (Feeley, 2012).

3.Implement a community monitoring intervention to strengthen social accountability

Evidence
Allowing communities to have monitoring power over providers may help to improve service delivery and reduce informal payments or other forms of corruption (Accountability and Monitoring in Health Initiative, Open Society Foundation, 2011). Such interventions give community members an opportunity to

observe and assess providers' performance and provide feedback to providers and politicians. Components may include information campaigns, score cards or citizen report cards, social audit and grievance redress mechanisms (Molina et al., 2013). Social audit is defined as "an ongoing process by which the potential beneficiaries and other stakeholders of an activity or project are involved from the planning to the monitoring and evaluation of that activity or project"(Puri & Lahariya, 2011). A social audit conducted by Mazdoor Kisan Shakti Sangathan, a community-based organization (CBO), uncovered corruption in the Food for Work Programme implemented in Rajasthan, India. The government responded by making an annual social audit conducted by villagers a formal requirement of the National Food for Work Programme.

Social audit methodologies are sometimes used simply to collect information on citizens' perceptions of services, including the practice of informal payments. Paredes-Solís et al. (2011) summarize lessons learned from social audits conducted in the health sector in Bangladesh, Pakistan, Uganda, South Africa and the Baltic States. The authors found that social audits use a variety of methods such as household interviews, focus group discussions, institutional reviews of health facilities, interviews with service providers and discussions with health authorities. The audits collected views about perceived corruption in the services, and details about how service users make official and unofficial payments, amounts paid, service delivery indicators and satisfaction with services. They found that the audits were helpful in revealing reasons why citizens were abandoning public services to seek other health-care options, and what factors were driving them away. They also helped to identify different patterns of informal payments. For example, in Uganda payments were most often demanded by providers; in the Baltic States they were more often offered by patients who wanted to be assured better quality of care.

When combined with more active community monitoring, social audit has been shown to be successful in improving health outcomes through joint action with health providers. A community-based monitoring programme in Uganda sought to increase the quantity and quality of PHC provision in 50 rural communities (Björkman & Svensson, 2009). Within this intervention, CBOs collected not only data to contrast community members' and health workers' perceptions of quality, but also objective data on health outcomes and health facility performance. Key findings were summarized into a report card. The CBOs then facilitated three different meetings. First, a meeting in each community to disseminate the report card. Community members then developed a set of recommendations for improvement which could be achieved without further resources. Second, a meeting at the health facility to disseminate the report card and discuss the community's views and proposals. Third, a meeting to provide an interface between community members and health workers. The final meeting resulted in a shared action plan or community contract with agreements on what needed to be done, when and by whom.

After one year, the communities that implemented the intervention had 33% lower child death rates and 20% higher utilization of services. Absence rates were lower by 13%, waiting time was lower by 10%, and drug stock-outs were less frequent

despite increased utilization. Researchers were able to confirm that members of the community engaged in monitoring health workers after the contract was developed and without the CBO facilitator. Monitoring tools such as numbered waiting cards, suggestion boxes and duty rosters were used more often in intervention communities. The process of developing the report cards also helped communities to improve existing governance structures (such as health unit management committees) that had been ineffective.

Expert-Grup, a Moldovan CSO, recently won one of the first grants awarded by the Global Partnership for Social Accountability, a coalition of donors, governments and CSOs working together to improve governance (World Bank, 2013a).[19] The grant will be used to monitor the quality of public education services in the Republic of Moldova; lessons learned can help to inform other social audit interventions.

Discussion of options 2–4

Medium-term actions in the Republic of Moldova could focus on strengthening CNAM's contractual provisions to ban informal payments and to deduct payment from providers whose employees continue to accept them, as detailed in Section 7. Such actions could include:

- amending the health insurance law to specify that any demand for payments other than those authorized under the Unified Programme is an attempt to violate the rights of the insured, and is subject to penalties under section 5.3 of the proforma contract;
- increasing the percentage of the penalty for services denied (currently 10% of value of such services);
- making provision for the insurer to recover all informal payments;
- strengthening the health insurance law by adding a provision stating that a provider is liable for any action by its employees or agents which shall have the effect of denying the patient a covered service as provided under the Unified Programme.

Activities to implement these reforms will include strengthening information resources so that insured members know what co-payments are permitted and services covered, and various methods to document demand for informal payments (e.g. complaint mechanisms, exit surveys, mystery patient programmes).

The Ministry of Health should also clarify facility managers' roles in disciplining employees (i.e. ability to place a written warning on an employee's file on the basis of a patient's complaint or to sanction employees who have many complaints), and the roles of the Ministry of Health, municipal councils, CNAM and NAC in relation to complaint mechanisms, investigation and enforcement.

Currently the PAS Center is collaborating with private industry on a web application to enable patients to rate their satisfaction with hospitals and provide feedback on their experiences. This model could be evaluated and the data used in improvement plans.

[19] See also World Bank, 2013b.

Long-term actions to consider include the development and use of a social audit mechanism using facility report cards combined with joint meetings of PHC staff and community members to develop improvement plans to reduce waiting times and informal payments. If the quality of primary care (and to some extent hospital care) can be improved through such means, then patients are less likely to pay out of pocket to jump queues or to assure quality. A social audit might also create standards for the financial transparency of facilities. Another method to consider is a written exit questionnaire (3–4 questions) for patients.

4.Increase individual provider incentives and improve organizational incentives for performance

- Increase individual incentives for providers through higher wages, bonuses and other incentive payments.
- Improve organizational incentives to control informal payments, such as creating a grants programme for hospitals to fund proposed interventions to reduce informal payments, or linking insurance reimbursement or bonus payments to an indicator showing that a facility is acting to control informal payments.
- Create incentives to reduce waiting times for procedures, which will reduce risk of facilitation payments and of patients diverting to private practice.

Evidence

Individual incentives

It is reasonable to expect that someone who is not well paid may feel tempted to engage in corruption in order to increase their income. The Director of the 300-bed University Maternity Hospital Tirana, Albania, used official fee revenue to supplement staff salaries, effectively quadrupling doctors' compensation and doubling the salaries of other staff. This was introduced in tandem with actions to prohibit informal payments: posting official fee schedules, creating a complaint hotline and streamlining systems to achieve better control of cash collection. According to independent exit surveys conducted with patients, this reduced the rates of informal payment and increased hospital utilization (Miller & Vian, 2010). In Mongolia, a doubling of the salary of health sector employees reportedly resulted in "less interest in receiving under-the-table payments" (UNDP, 2009:7). Staff reported high satisfaction with the pay increases and asserted that fair compensation had directly improved the integrity of the health sector.

Conversely, a study of 33 hospitals in Argentina showed that, although procurement managers were paid higher monthly wages (US$ 1295, or about US$ 375 more than a manager of that age and experience would earn elsewhere), there was no statistical relationship between pay and corruption, even after adjusting for hospital size, experience and other factors (Savedoff, 2010). The authors believed that wage increases alone were not effective in reducing corruption, they needed to be supplemented with increased discipline and stronger oversight to reinforce accountability.

Several hospitals in Mongolia have implemented individual incentive programmes to promote integrity, including providing bonuses on salaries (e.g. 10%) to reward the most ethical employees.[20] One hospital initiated a programme to encourage patients to thank employees more publicly in lieu of individual gifts. For a small fee (MNT 500, around US$ 0.30), patients can purchase a heart-shaped card on which they name the employee they wish to thank before posting the card on a gratitude board. At the end of each quarter, hospital staff collect and tabulate the cards. The staff member with the most gratitude postings is awarded a cash prize funded by the collected contributions (UNDP, 2009). At Queen 'Mamohato Memorial Hospital in Lesotho, a monthly prize is given to the ward with the highest (or most improved) patient satisfaction survey scores. Each staff member in the winning ward is given a gift card (LSL 100, around US$ 10) for a local grocery store (Vian, McIntosh et al., 2013).

Organizational incentives

UNDP projects in Mongolia and Viet Nam have implemented special grants programmes to encourage organizations to improve service delivery and combat corruption. The Ministry of Health in Mongolia introduced an annual award for the most ethical health-care organizations. The hospitals used these grants to introduce programmes such as the aforementioned gratitude board and to provide performance-based bonuses to staff. In Viet Nam, the World Bank and a group of about 10 development partners have sponsored the annual Innovation Day programme since 2003. This contest promotes small-scale change initiatives which have the potential to improve public sector service delivery and achievement of public goals. In 2009, awards were given to several hospitals (see example below on waiting time reduction) (Vian, 2009). In 2013, the Vietnam Anti-Corruption Initiative also created an innovation competition to award 24 organizations proposing initiatives to increase transparency and integrity (Talkvietnam, 2013).

Reducing waiting time

The National Hospital of Pediatrics in Hanoi, Viet Nam, introduced a patient feedback system in 2009 as a way to improve service delivery after their project won an Innovation Day award. The hospital had had serious problems with overcrowding and waiting times of four to five hours which were seen as a driver of informal payments. The intervention team developed tools to collect feedback from doctors and patients; patients responded positively to being asked their opinions and were eager to participate. Data from the study were used to set benchmarks and to identify specific issues for problem solving. The feedback included information on whether patients felt compelled to pay informal fees, and has contributed to increased transparency about this practice (Vian, Brinkerhoff et al., 2012).

The strategy of publishing waiting lists has been tested in Croatia as a means of reducing the practice of patients bribing doctors to jump the queue. Waiting lists in two major hospitals in Zagreb were made available in hard copy and on the Internet in 2004 and 2005 (Transparency International, 2006). An independent organization

[20] The Mongolia assessment did not provide details on the criteria used to determine these awards, but (for example) patient exit survey data could be used.

established a hotline to collect complaints; in the first few months, 90 complaints were received about one of the hospitals. One patient who had been waiting two years for heart surgery was operated on within two weeks of lodging the complaint. It seems that the combination of the independent complaint mechanism and the transparency of waiting lists may have been important (Ringold et al., 2012).

Discussion

In the medium term, the government might consider enabling facility managers to reward individual providers through bonus payment mechanisms tied to the quality of care or other performance measures. Facility managers may also need to be given authority to make other decisions (such as downsizing total staff and paying more to remaining staff) to motivate staff and discourage abusive practices such as informal payments.

Medium-term efforts to reduce waiting time (a driver of informal payment) could include measuring times at baseline and training hospital staff in quality improvement techniques which can be applied to this operational problem. Hospitals that reduce waiting times could be rewarded with a bonus payment or additional medical equipment. This might also help to make waiting lists more transparent to patients. The government might also support the creation of electronic, online hospital appointment systems that would also make waiting lists more transparent.

Reform of base salaries would be difficult, but should be discussed as a long-term measure.

5. Formalize unofficial payments through user fees and/or private wards

- Consider official user fees for selected procedures in hospital.
- Create private wards in public hospitals.

Evidence

Official fees

Revenue retained by facilities can be used to supplement salaries and increase quality of care, resulting in greater patient satisfaction and overall use of services. Examples include University Maternity Hospital Tirana in Albania (described earlier), health reform in Kyrgyzstan and hospital reform in Cambodia. The latter two examples are summarized below; in both, official fees were part of larger reforms involving other strategies such as fee retention (Kyrgyzstan) and increased salaries (Cambodia).

As a result of scarce resources and budget constraints, patients in Kyrgyzstan were being asked to pay for medical supplies and drugs which should have been free or included in co-payments, and even to subsidize providers' salaries. Informal payments were also collected for admission to a particular hospital or for admission without referral, and for non-medical supplies (sheets, light bulbs, pens) and food (Baschieri & Falkingham, 2006). In 2001, the government introduced a single payer reform (SPR) that addressed the key reasons for making informal payments: low pay and confusing

entitlements. The SPR clearly defined a specific free care benefits package and a formal co-payment schedule for hospital referrals, allowing hospitals to retain co-payments and use them to supplement salaries (20%) and pay for medicines and patients' food (80%). By introducing a clear system of payments to providers, allowing co-payments to be retained by hospitals, and increasing the transparency of the system, the designers of the reform expected that funding would be improved and informal payments reduced.

In 2004, after three years of implementation, the reform showed qualified success. An evaluation found that an increased percentage of people seeking care at the primary level were given receipts for official payments, and fewer respondents reported giving a gift to health personnel. In hospitals, there was a decrease in the proportion of patients that reported making payments for medicines, laboratory tests and other supplies. At least half of all inpatients did not pay more than required according to the fee schedules (Baschieri & Falkingham, 2006).

But the reform experienced challenges too. The evaluation found that the proportion of all patients who reported paying for primary care (which should have been free) rose from 10% to 17% between 2001 and 2004. In hospitals, an increased proportion of families were helping to give injections (i.e. supplementing nursing care) and, despite decreased proportions of inpatient contributions for some services, the paying proportions remain high (70% for medicines, 39% for laboratory tests, 47% for other supplies). Also, even though some health professionals discount informal payments charged to poor people, the expenditure still represents a greater share of total household resources for poor people than for wealthier patients.

Reform experts in Kyrgyzstan also observed an increase in incorrect charging of co-payments. Recorded revenue was less than patients' reported payments, which in turn were less than the expected patient revenue (based on co-payment price multiplied by quantity of services provided). These findings highlight the importance of monitoring payment systems to identify weaknesses, as new ways may be found to manipulate the system for private gain.

Cambodia had a deeply rooted system of corruption in its health sector. Pay was low and civil servants relied on coping strategies such as demanding informal payments or taking second jobs in the private sector. In 1999, informal payments were so high that OOP spending was 20 times higher than government health expenditure, representing 82% of THE (World Bank, 1999). The Cambodian Ministry of Health has tried to improve health-care access and rationalize health-care financing by introducing the national Health Coverage Plan, referral networks and the National Charter on Health Financing. The latter introduced official user fees while supplementing staff salaries and creating incentives for expanded provision of care.

Takeo Provincial Referral Hospital participated in these reforms with success. In 1996, monthly under-the-table revenue at the 176-bed facility was estimated at US$ 13 750: more than five times the monthly hospital payroll and 45% of the total monthly revenue. Unpredictable public funding, low salaries, few sanctions for

misconduct and no rewards for individual initiative all created systemic problems in resource management and informal payments posed a significant barrier to care-seeking behaviour (Barber, Bonnet & Bekedam, 2004).

These problems were addressed through a new financing scheme based on a transparent and official fee schedule introduced in 1997. Inpatient fees represented 65% or less of previous inpatient informal payments and an exemption process identified patients who should not be required to pay. The formal fee schedule was intended to increase utilization and regain public confidence in the health system by assuring predictability and reducing provider subjectivity in assessing the payment due. Increased utilization would benefit providers because bonuses would be linked to the volume of hospital activity.

After one year of the financing reform, data from patients showed that they were paying less than they had before the reforms were introduced. In other words, formal fees had replaced informal fees and were not an additional financial burden to patients. Partly because of the lower official fees, utilization levels of inpatient and surgical services increased by more than 50%. Performance-based salary supplements were comparable to the previous average revenue from informal payments. By 2001, Takeo Provincial Referral Hospital was able to phase out external donor support as central government funding and official user-fee revenue continued to increase over time. Similar reforms were accomplished in the National Maternal and Child Health Center in Phnom Penh, Cambodia, thereby demonstrating that formalization of user fees and implementation of organizational change have the potential to produce drastic improvement in hospital utilization and equity (Akashi et al., 2004).

Private wards

In Ireland, beds in publicly-funded hospitals may be designated as either public or private, with a goal of reserving 80% of beds for public patients and 20% for private patients – over 50% of the population is covered by private insurance which would be used to pay for this care (McDaid et al., 2009). In practice, hospitals often use more than 20% of beds for private patients, thus increasing the waiting time for public patients seeking elective procedures. The government initiated an additional reform to combat this problem: the National Treatment Purchase Fund allows public patients to purchase care anywhere (including the private sector or the United Kingdom of Great Britain and Northern Ireland) if their wait is longer than three months. The state is also contracting for the construction of eight new private hospitals within the grounds of public hospitals in an effort to free up an additional 1000 public hospital beds and to maximize potential use of public hospital sites (McDaid et al., 2009).

Romania is currently considering a proposal to create private wards. These have the potential to generate additional hospital revenue and to operate at a surplus which could be used to cross-subsidize public care. Studies of private wards in public hospitals suggest that substantial capacity is needed to undertake this type of reform. Well-developed costing systems are essential, and policy-makers must carefully

monitor cost sharing and the direction of cross-subsidies between the public and private wards. Revenue collection from private patients (funded by private insurance or self paying) may not reach targeted levels. This can result in the public sector subsidizing private care instead of the reverse. [21]

Discussion

Medium-term reform. Facilities would be allowed to charge official fees in addition to receiving insurance reimbursement, with the intention of replacing informal payments. The success of this reform option depends on combining the introduction of fees with stronger enforcement of rules against informal payments and on educating patients that they need not pay informally. Official fees could be state regulated, either by creating a standard national price list or by allowing individual facilities to establish fees, but either case would require each patient to be given a receipt to document payment. [22] Official fees would be lower for insured patients, and fee revenue could be shared between a facility and doctors/other staff. Provision would need to be made to exempt the vulnerable population (i.e. pay their fees through an equity fund or other reimbursement mechanism). Such an intervention would need to be carefully monitored and evaluated to assure that official user fees replaced informal payments, instead of being an additional cost to patients.

Longer-term reform. The specific model of private wards would need to be further developed and pre-conditions assessed. For example, it may be that the success of this reform depends on a large proportion of the population being covered by private insurance, which is not the case in the Republic of Moldova. Updated data from countries which have implemented this reform are needed to fully appreciate possible implementation concerns and how to mitigate risks. Strong regulation and monitoring are required to avoid incentives to displace public wards with private beds, increased waiting times in public wards, or to pressure patients to pay for private beds when they cannot afford them.

6. Improve transparency and implement information strategies

- Support CNAM plans to **improve patient information** on the Unified Programme (insurance benefits package). Technology could be incorporated, such as a texting-based frequently asked question (FAQ) list.
- Produce an **annual analysis of patient complaints** and their resolution.

Evidence

Access to information in different forms has been shown to help empower citizens and control corruption in several studies. Reinikka and Svensson (2004) show that diversion of budgetary allocations for Ugandan schools was reduced from 80% to less

[21] See, for example, Wadee & Gilson, 2007; OECD, 2004:194 on Ireland's experience; McPake et al., 2004.

[22] In Kenya, patient receipts were introduced – along with use of electronic point-of-service cash registers for fee collection – as a way of increasing accountability and tight control of revenue. This reform resulted in a 400% increase in revenue collection from user fees because cashiers could no longer pocket cash or allow friends to avoid paying (see Vian, 2006).

than 20% after the government started publishing information on public spending on education in national and local newspapers, and in the schools themselves (Reinikka & Svensson, 2004).

Information has been shown to increase the rate at which disadvantaged citizens received social benefits without having to pay a bribe in India. The study measured the time it took for slum dwellers in Delhi to obtain a ration card. Researchers divided slum dwellers into four groups: (i) requested information about the eligibility criteria for the ration card under the national Right to Information Act (RTIA) prior to making the request for a card; (ii) included a letter of support from an NGO with the request; (iii) paid a bribe; and (iv) requested ration card using standard procedures alone. The researchers found that while those who paid a bribe had the fastest median processing time (2½ months) for the ration card, virtually all of those who filed the RTIA request received a ration card with a median processing time of four months. Of those who did not file an RTIA request or pay a bribe, very few received a ration card (Peisakhin & Pinto, 2010).

Discussion

Short-term reform. The Ministry of Health, CNAM and NAC should collaborate to produce an annual analysis of complaints data including how complaints were resolved, the number of complaints formally investigated and/or leading to prosecution, and possible administrative changes or systems improvements which may be identified by reviewing complaints as a whole.

Medium-term reform. The government and development partners should support CNAM initiatives to improve patients' knowledge of entitlements. To support the introduction of SMS technology to educate patients, the Republic of Moldova might try to tap into international resources such as the Bill and Melinda Gates Foundation's Grand Challenges in Global Health initiative.

9. Conclusion

Moldovan policy-makers, CSOs and development partners need to consider ways to reduce OOP spending, especially spending on medicines and informal payments during hospitalization. The Policy Workshop on the Drivers of Out-of-Pocket Payments and Causes of Inefficiencies in the Republic of Moldova was held in Chisinau on 31 January 2014. The diverse set of stakeholders attending voiced support for all the policy options, favouring options 1, 2, 5, and 7 for reducing formal OOP payments, and options 3–7 inclusive for reducing informal payments.

The major driver of private health expenditures in the Republic of Moldova is spending on medicines: MDL 1687.4 million (€104.8 million) in 2010. Over 70% of patients who sought care in 2012 purchased medicines, not including individuals who self-treated at the pharmacy without seeing a provider. These facts suggest that immediate steps should be taken to reduce medicine expenditures by households. Participants suggested expanding the compensated medicines list and increasing the percentage of insurance reimbursement to reduce OOP payments. These options would not reduce overall expenditure on medicines, but would shift the cost burden from consumers to the government. At the same time, participants acknowledged the need to control irrational use of medicines through educational interventions and better management of conflicts of interest or other incentives leading to polypharmacy and over-prescribing. Attacking the problem from this side would reduce overall expenditures, not just shift the cost burden from households to the government.

Most Moldovans do not have to pay out of pocket at a facility to access outpatient or inpatient care: only 16% of outpatients and 30% of inpatients reported having to make a facility-based OOP payment. Informal payments are also infrequent in outpatient care – less than 6% of all outpatients who sought care made an informal payment, although 25% of inpatients reported making informal payments. While some informal payments are intended as gifts, other patients feel forced to pay. Depending on how the patients find the funds to pay informally, these payments may be further threatening financial security and increasing poverty.

The policy workshop participants noted the need to enhance the incentives for individual providers and provider organizations to offer high-quality care and control informal payments. As a first step, the Ministry of Health and CNAM will need to work with providers to define good performance. If possible, incentives based on performance should be integrated into existing funding formulas rather than creating a separate programme. Workshop participants also supported enforcement activities to help end informal payments.

While some countries have introduced formal user fees as a strategy to replace informal payments, the Government of the Republic of Moldova should be cautious about adopting this approach. Formal payments in public facilities are not consistent with the current approach of universal primary care access. Also, the strategy could increase OOP payments if it is not implemented as part of a larger package of reforms including increased provider financial incentives and stronger monitoring and control mechanisms.

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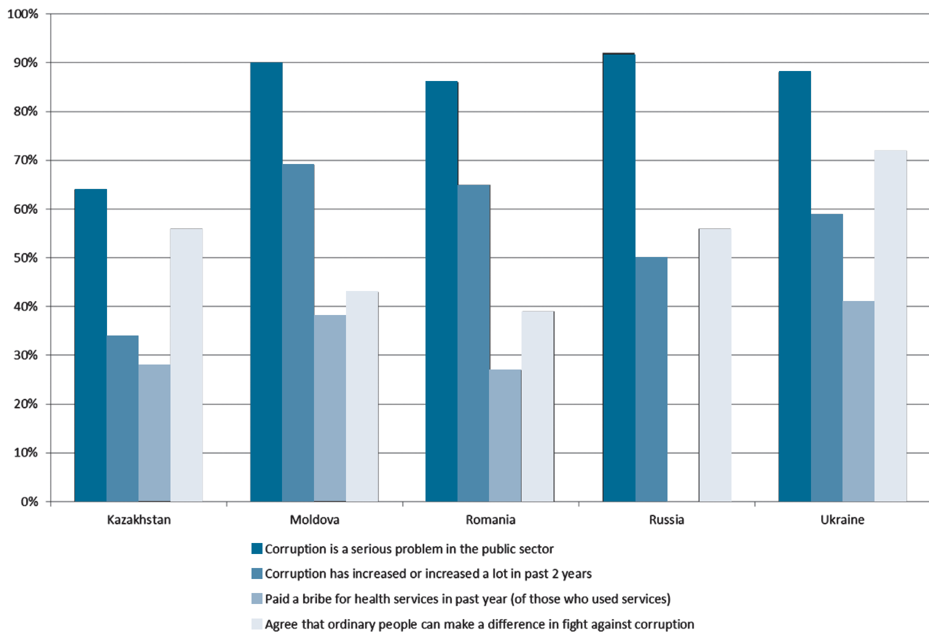
Annex A.
Transparency International (TI) Global Corruption Barometer 2013

The following graph from the Transparency International (TI) Global Corruption Barometer shows that 38% of respondents in the Republic of Moldova said that they had paid a bribe for health-care services in the past year. The study shows that 90% of Moldovans believe that corruption is a serious problem in the public sector; 69% believe that corruption has increased in the past two years; but less than half of citizens believe that ordinary people can play a role in the fight against corruption.



Source: Transparency International , 2013. [23]

The percentage of respondents who paid a bribe (among those who used services) shown in this table is higher than the NBS survey data: the latter showed that 5.8% of outpatients and 24.6% of inpatients had paid informally for services. Two differences are salient: recall period and respondent. The recall period in the NBS survey is one month for outpatient care and one year for inpatient care, but the recall period in the TI survey is one year for both outpatient and inpatient care. In addition, the NBS survey asks individual respondents about their own behaviour only; the TI survey asks about the respondent and/or anyone living in the respondent's household. At the same time, the TI survey also asks only about paying a "bribe in any form"; the NBS survey asks about any informal payment, including gifts. The direction of bias due to these differences would have pushed TI data higher than NBS data.

[23] Transparency International (2013). Global corruption barometer [website]. Berlin (http:// www. transparency.org/gcb2013, accessed 3 June 2014).

Annex B.
Key informant question guide

The Government of the Republic of Moldova is committed to ensuring access to affordable quality health care for all citizens and is actively engaged in a process of health reform to increase universal coverage, reduce inequities and improve efficiency and financial protection.

In 2010, 25% of Moldovans reported making a payment for some type of health care, and 68% of those who had been hospitalized made an OOP payment. More than 70% of OOP payments on health are related to pharmaceuticals. Of those who made an OOP payment, many made informal payments. Studies have shown that high rates of OOP payment can erode financial protection, increasing the percentage of families that face catastrophic health spending which can push them below the poverty line.

The purpose of our study is to dig deeper into this problem to assess the drivers of OOP and informal payments in the Republic of Moldova, to document how these payments are affecting health sector goals, and to create a framework for developing policy options to reduce OOP and informal payments.

1. Do you think OOP payments are a problem in Moldova? Why? What kinds (formal, informal)?

2. Why are people making these payments? Are providers demanding or patients offering? Are they gifts?

3. Studies show that uninsured people sometimes pay out of pocket. But some people with insurance are paying out of pocket, both formally and informally. If they have insurance why are they paying out of pocket?

4. Studies show that inpatients are more likely than outpatients to make an OOP (and also an informal) payment. Why might this be so?

5. What are some of the drivers and underlying causes, systems issues, and incentives we have to think about in trying to develop policy options to reduce OOP and informal payments? Who is most interested in this issue? Who are the stakeholders with influence?

6. What options do you think we should consider? What are barriers to reform? What are facilitators?

Annex C.
Focus group guide: providers

This discussion is about your experiences with, and opinions about, informal payments. Informal payments are any payments made to government medical staff for services that are supposed to be offered free of charge to community members or patients based on the national insurance programme.

There is no one right answer, so please feel free to agree or disagree with what other participants say.

1. What are the main problems that currently affect your ability to deliver good quality health-care services?

2. Why do you think informal payments take place in the health sector?

3. What are the good things about informal payments?

4. What are the bad things about informal payments?

5. Do informal payments affect the way patients and providers relate to each other? If so, how?

6. Do informal payments affect the nature of services provided? If so, how?

7. How do you think the health reform process might affect informal payments?

8. What do you think should be done about informal payments? Who should do the things you suggest?

9. Do you have any other thoughts about informal payments?

Do you have any questions for me?

Thank you very much for your participation.

Annex D.
Focus group discussion guide: general public

This discussion is about your experiences with, and opinions about, informal payments. Informal payments are any payments or gifts made to government medical staff for services that are supposed to be offered free of charge under the national insurance programme.

There is no one right answer, so please feel free to agree or disagree with what other participants say.

1. Where do people make informal payments for health-care services?
   - Probe – Does everyone make payments? What kinds of services or providers do people give payments to?
2. What are the ways by which people make these payments?
   - Probe – How do people make the informal payment? How do people learn how much it should be? What kinds of things do people use to pay, and when do they pay?
3. What do you think about these payments?
   - Probe – How have services changed over time and how have payments changed over time? What would happen if people didn't make the payments?
4. What are the advantages and disadvantages of the payments?
   - Probe – What are the advantages and disadvantages of making or not making the payments? Accepting or not accepting the payments?
5. What do you think should be done about the payments in the future?
   - Probe – What should providers, administrators, community members, and patients do?
6. Do you have any other thoughts to add about informal payments, or any questions for us?

Annex E.
Abstract, background and methodological details for WHO report: Barriers and facilitating factors in access to health services in the Republic of Moldova

Abstract

In the context of global efforts to move towards universal coverage in health systems, this report identifies barriers and facilitating factors in accessing health services in the Republic of Moldova. The domains of the Tanahashi framework (availability, accessibility, acceptability, contact and effective coverage) underpin the research and analysis of findings in this report. This framework is particularly useful for ascertaining challenges to universal coverage – defined by the WHO as access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The study looks in particular at how the population's access to health services has been affected by the recent efforts (2009–2011) to extend health services coverage.

This is the first comprehensive research carried out in the Republic of Moldova that identifies bottlenecks and facilitating factors for access to health care by using the Tanahashi dimensions of health coverage as the assessment framework. While many of the qualitative findings are common knowledge for both providers and users of health services, the added value of the Tanahashi dimensions is that they allow assessment of the interlinkages and symbiotic nature of access barriers, the role of wider social determinants of health, human interaction and motivating factors between providers and users; going beyond the pure technical assessment of the inputs and outputs of health system analysis.

Background and methodological details

This report was produced through the Biennial Collaborative Agreements (BCAs), covering 2010–2013, between the Ministry of Health of the Republic of Moldova and the WHO. The publication forms part of the Health Policy Papers series launched in 2011 with the aim of strengthening the health system in the Republic of Moldova in line with the national health policy and strategy for the development of the health-care system. It has been prepared under the guidance of Andrei Usatii, Minister of Health of the Republic of Moldova and Jarno Habicht, WHO Representative in the Republic of Moldova.

This document was produced with the financial assistance of the EU within the technical assistance programme coordinated by the WHO. The objectives of the programme include strengthening the stewardship of health sector investments,

better monitoring of performance, and ensuring greater use of evidence in policy decisions. The WHO Regional Office for Europe commissioned this study and report from the Center for Health Policies and Studies (PAS Center).

The research methodologies, instruments and report content lines were elaborated by a joint team of WHO and PAS Center staff and consultants. PAS Center staff – Stela Bivol, Ghenadie Turcanu, Andrei Mosneaga and Viorel Soltan – oversaw data collection, performed analysis and wrote the report. WHO staff and consultants (listed alphabetically) Silviu Domente, Jarno Habicht, Matt Jowett, Theadora Koller and Jeanette Vega conceptualized the research using the Tanahashi framework; provided orientations for the study instruments and data analysis; and gave technical input to the final report. Theadora Koller, from the WHO European Office for Investment for Health and Development, coordinated WHO's contribution for this BCA activity. The initial literature search and tables were produced by Inga Pasecinic and all qualitative interviews were conducted and transcribed by the Centre for Sociological and Marketing Studies (CBS AXA) team. Translation was performed by AQA Logistics.

The full report can be found online (http://www.euro.who.int/__data/assets/ pdf_file/0018/183510/e96775-final.pdf?ua=1, accessed 29 April 2014).

Annex F.

User fees charged for procedures and services in public hospitals (for uninsured or non-referred patients or services not covered by insurance)

Service		Price range (MDL)	(€)
Dental services	**Basic**	140–300	7.5–16.2
	Prosthetic	1441–2 200	78.0–119.2
General profile medical services	**Genetic examination**	490–652	26.5–35.3
	Retinal angiofluorography	1 054	57.1
	Biometry	386	20.9
	Retinal photocoagulation	430	23.3
	Functional diagnostics	150–400	8.1–21.7
	Digital radiography	100–150	5.4–8.1
	Computerized tomography	600–4 000	32.5–216.6
	Magnetic resonance imaging	500–5 800	27.1–314.1
Physiotherapy	**Treatment session**	60–100	3.2–5.4
Laboratory	**Diagnostic test**	60–560	3.2–30.3
Inpatient services	**Bed day in cardiology or hepatology unit**	360	19.5
	Endoscopy	2 400	130.0

Source: data from Government Decision No.1020 dated 29 November 2011 “regarding the tariffs for medical services”, including the last modifications to it, published in the Official Gazette Nr. 290 on the 10.12.2013, art. Nr. 1084

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