

HiT profile in brief

Moldova

The health reform programme in Moldova was delayed for a number of years due to the severe fiscal difficulties faced as the country embarked on political, economic and social transition. However, despite the limited resource base, real progress has been made in rationalizing the health system and reducing the dominance of inpatient care through the restructuring of hospital stock and the development of primary health care on the basis of family medicine. The stabilizing of health care financing through the successful introduction of mandatory social health insurance (SHI) is a notable achievement which has also had the effect of reducing the level of informal payments within the system.

Introduction

Geographical, economic and political context

Moldova is a landlocked country situated in south-eastern Europe, bordered by Ukraine to the east and Romania to the west. Following the collapse of the Soviet Union, Moldova was established as an independent state in 1991 and a parliamentary republic in 2001. Since Moldova claimed independence there has been civil strife in the breakaway region of Transnistria (1). The conflict has not yet been resolved and, although the self-proclaimed Transnistrian Moldovan Republic has never been recognized internally or internationally as an independent state, it currently has its own parliament, president, constitution, economic system and currency (2,3). The region remains effectively outside of central government control, and its status is still being negotiated (1).

Since 1991 Moldova has faced serious economic challenges. Agriculture and food processing dominate the economy and the country is dependent on imports for its energy needs. Following downturns in the 1990s, when gross domestic product (GDP) fell by 60% (4), GDP growth resumed and reached 43% during the period 2000–2005 (5). As a result of pro-poor economic reforms, poverty rates and the level of inequality have also been decreasing, as reflected in the Gini coefficient which changed from 0.38 in 2000 to 0.36 in 2004 (6).

Notwithstanding recent growth, Moldova remains the poorest country in Europe (defined geographically), with an estimated per capita gross national income of US\$ 1100 in 2006 (7). It is estimated that levels of open and hidden unemployment were approximately 8.3% at the end of 2005 (1). Following independence there has been large-scale labour migration and about a quarter of the economically active population now work abroad. While remittances account for 20–25% of GDP and have boosted the economy, the social impact of such large-scale migration is cause for concern (8).

Health status

Moldova is the most densely populated country of the former Soviet Union (127 people per km²), with a population of approximately 4.2 million (1). Approximately 46% reside in urban areas, while 54% of the population live in rural areas. Unfortunately, there is a significant gap in the basic population data for Moldova because, from 1997, national data do not include data for Transnistria. Consequently, the health status of that region is not really known (9).

Economic transition caused great socioeconomic hardship in the country and the health status of the population fell initially; however, in 2006 life expectancy at birth in Moldova was 64.6 for men and 72.4 years for women (9). The infant mortality rate has been decreasing and officially reached 11.8 per 1000 live births in 2006. The maternal mortality rate remains high at 16 deaths per 100 000 live births in the same year (9). Moldova has a double epidemiological burden of communicable and noncommunicable diseases. The main causes of mortality are currently cardiovascular diseases, neoplasms, diseases of the digestive system and external causes (injuries and poisonings). Increasing tuberculosis (TB) and human immunodeficiency virus (HIV) infection rates are also cause for concern (9).

Organizational structure

Historical origins of the system

Before independence, Moldova's health system was

organized in line with the Soviet centralized health system based on the Semashko model, consisting of an extensive infrastructure with a curative focus and a large number of health professionals. The Soviet period saw an overall expansion in both the funding and provision of health care, but the centralized management and rigid budgeting systems allowed little flexibility for improvements in efficiency. From 1991, new socioeconomic conditions threatened the population health status and could not sustain the inherited expensive health system. The resulting growth in formal and informal payment requirements deterred the poorest sections of the population from accessing services. To address problems related to access and efficiency, the Government has introduced reforms to reorganize primary and secondary care and their financing mechanisms (1).

Organizational overview

The Ministry of Health (MoH) is responsible for the population's health, but the financing of most services has been recentralized to the National Health Insurance Company (NHIC) and the organization of primary and secondary care is now devolved to the regional/municipal level. Tertiary services, highly specialized hospitals and public health institutes are the responsibility of the MoH and funded directly from the MoH budget. The Ministry of Finance works with the MoH to advise Parliament on a suitable level of funding for health care services and to agree on the annual health budget, while the Ministry of Education is responsible for the provision of undergraduate medical education for health care professionals. A range of international organizations operate in Moldova, providing help in the form of technical assistance, training and aid, with a special focus on health system development, maternal and child health, immunization, HIV/AIDS (acquired immunodeficiency syndrome) prevention and TB control. Local nongovernmental organizations (NGOs) are also becoming increasingly important actors in the provision of health services (1).

Decentralization and centralization

Since independence, there have been ambitious steps towards decentralizing the Moldovan health system (1). Between 1991 and 1999 Moldova was reorganized, using a series of different administrative divisions, but since 2003 32 local districts (*rayons*) have existed, along with three municipalities and two territorial autonomous units (10).

Health care financing

Health expenditure

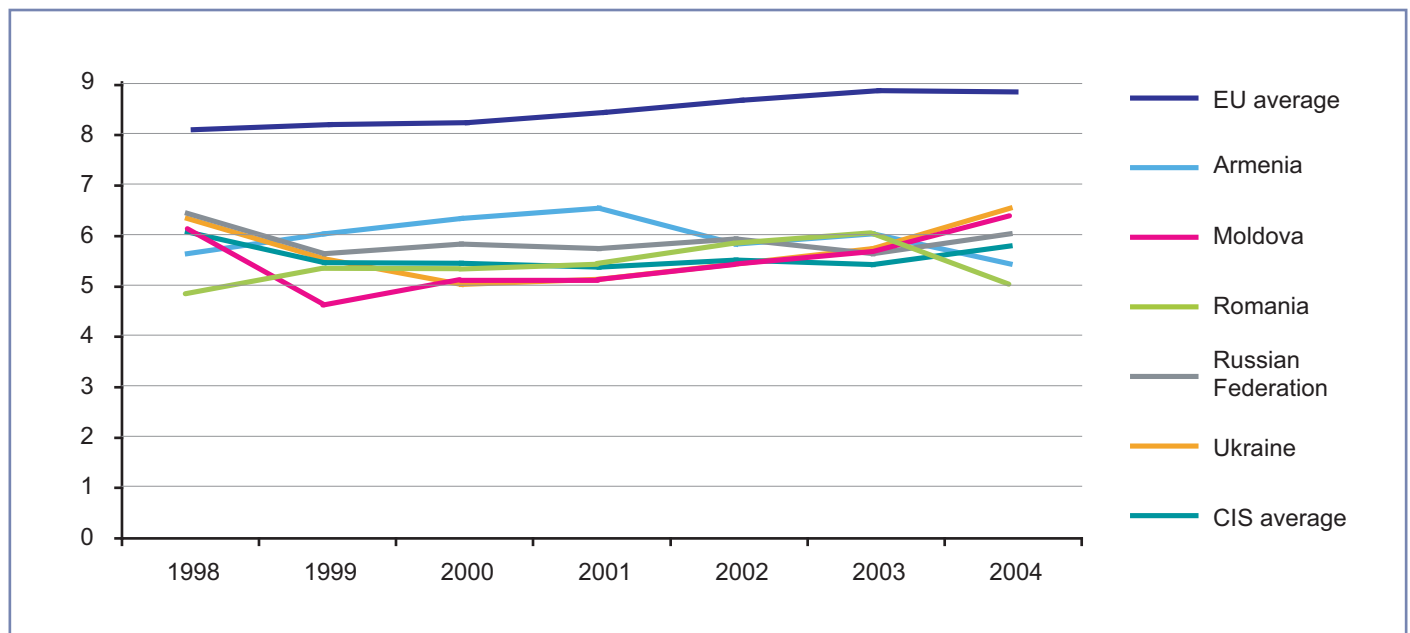
State budget allocations to health care suffered a serious decline between 1993 and 2003 and have only stabilized with the introduction of mandatory SHI. Following the period 1999–2001, when government expenditure on health as a percentage of GDP fell from 7.1% to approximately 6.0%, total health expenditure has been steadily increasing (see Fig. 1), reaching 7.4% in 2004 (9). Central budget transfers to the MoH cover preventive medicine services, national programmes, teaching institutions and system administration, while the NHIC purchases health care services (1).

Benefits and coverage

The 1994 Constitution of the Republic of Moldova guarantees a minimum provision of health services to the population free of charge and regardless of insurance status. The state-guaranteed Minimum Package of Services includes primary health care services; consultations with specialists in polyclinics and hospitals; a limited range of diagnostic tests and elementary investigations conducted in ambulatory laboratories; immunization; urgent and emergency services for life-threatening situations; and hospital care for the treatment of mental disorders, cancers, asthma, diabetes, HIV/AIDS, TB and some other infectious diseases (11). Additional services, defined under the Basic Benefits Package of Health Care Services under Mandatory Health Insurance (BBPMHI) include emergency pre-hospital medical assistance; primary medical assistance; specialized ambulatory medical assistance; and outpatient medical assistance (1).

Initially the State committed to insure the following categories, which were considered to be vulnerable population groups: children of preschool age; children in full-time education; students in full-time vocational or higher education; and postgraduate students on mandatory study programmes. In 2004 this was expanded to include pensioners, pregnant women and those in post-partum care, and officially registered unemployed individuals – in essence, the State pays the contribution for all the registered non-working population. However, while ensuring coverage of the whole population has been a key aim of implementing mandatory SHI, some vulnerable population groups are covered neither through payroll contributions nor government transfers (1). Taking into account wide regional variations in insurance coverage, the overall proportion of uninsured

Figure 1: Trends in health expenditure as a percentage of GDP in Moldova and selected countries, 1998–2004, WHO estimates



Source: WHO Regional Office for Europe, (9).

Notes: CIS: Commonwealth of Independent States; GDP: Gross Domestic Product; WHO: World Health Organization.

people among the population was found to be 24.3% (10). Coverage is worst for the “self-employed”, who are poor subsistence farmers in rural areas.

Revenue

In 2005, 48.1% of total health expenditure came from compulsory sources of funding (general taxation and mandatory SHI contributions), 42.3% came from direct out-of-pocket payments, 7.8% from international aid agencies and 1.7% from voluntary health insurance (VHI) contributions (12). The economically active resident population are obliged to contribute a proportion (currently 2%) of their wages through payroll tax, or pay a flat rate lump sum if they are self-employed. Employee contributions are matched by a 2% contribution from employers. Contributions for the rest of the population are paid by the Government from the state budget. Out-of-pocket payments include direct payments for goods and services not covered by mandatory SHI; co-payments or official user charges for goods and services covered by mandatory SHI; and informal payments. External sources of funding are also significant in the Moldovan health sector and usually come from international partners in the form of grants, loans and technical assistance (1).

Pooling

The NHIC acts as the main pooling agency, collecting resources from Government, employers and employees and transferring them to its territorial branches, which are the purchasing agencies (13). The Government has delegated to the NHIC all budget funds targeted towards the purchasing of health care services, including those for uninsured individuals. The NHIC estimates the coverage rate to be 80%, and this is the basis used to calculate the allocation of money intended for the reimbursement of services provided for both the insured and uninsured population. However, this blunt formula means that poorer rural areas – which have a higher proportion of uninsured, but also greater need – are significantly underfunded (1).

Payments

From 2001 there was a shift away from historical budgeting, based on number of beds and staff, towards more output-oriented payments and budgets. The introduction of contracting has created a new incentive environment for service providers, in particular for inpatient hospital care and emergency medicine services, with the introduction of payment per case for inpatient hospital care

and payment per visit for ambulance services, significantly improving productivity. From 2004, the NHIC has agreed an annual contract with the *rayon* health authorities with pre-specified prices and volumes of services to be provided. At the local level, branches of the NHIC contract with the chief doctors and hospitals are paid according to block volumes of services based on their number of cases, with additional performance indicators regarding quality, user satisfaction and organizational change. Hospitals can levy additional formal charges for services not included in the state-guaranteed Minimum Package of Services or the BBPMHI on a fee-for-service basis at prices set by the MoH. Another important factor for improving productivity has been the stabilization of financial flows, including the introduction of advance funding and shortening transaction procedures (1).

Nevertheless, despite recent increases, salaries for medical personnel are still low by international comparison. In the transition period, the widening wage differentials between the public and private sectors led many public health sector employees to leave their positions and work in the private sector (14). Despite efforts to reduce salary arrears and increase wages based on each doctor's annual performance, years of experience and location (urban versus rural), the basic salary scale has not changed. Since salaries are not usually linked to group or individual performance, they are not yet used as incentives for improving the quality of care or efficient use of resources (1).

Planning and regulation

Regulation and governance of the health system is within the remit of the MoH and its subordinates, particularly the National Centre for Preventive Medicine (NCPM) and its network of local agents. However, since the introduction of contracting arrangements for the purchasing of publicly funded health services, the NHIC now also has a significant regulatory role. The organizational relationship between purchasers and providers has been based on contracts since the introduction of the BBPMHI in 2004. The NHIC is a wholly state-owned organization, although it has considerable autonomy; it is answerable to the Government and the Minister of Health is its chairperson (1). In terms of planning, a new National Health Policy for 2007–2021, which emphasizes the importance of intersectoral collaboration in improving population health (15), has been a significant step towards increasing capacity for strategic planning

in the Moldovan health system (1).

Health care services are provided through a mix of public sector hospitals and health centres, with smaller doctor's surgeries and health centres in more remote rural regions. Private health service provision is relatively limited. Specialized tertiary level hospitals are directly governed by the MoH and managed by chief doctors, who are appointed by and answerable to the local government. Given greater autonomy and responsibility over their own budgets, the health centres are now independent actors. The accreditation and governance of health care providers in Moldova is currently fragmented and insufficiently rigorous. The licensing of doctors is also currently inadequate. However, a Quality Assessment Authority is being developed at the time of writing in order to improve regulation of providers. Further, a Pharmaceuticals Agency has now been set up in the MoH for market authorization and licensing of new pharmaceuticals. An accreditation or medical auditing system to enforce quality standards for health services or pharmacies is yet to be established (1).

The National Centre for Health Planning and Management (NCHPM) is responsible for health monitoring, but its efforts are hindered by excessive reporting requirements and resource constraints. The NCPHM datasets and indicators are not harmonized with internationally accepted datasets to allow inter-country comparisons. In addition, although the NCPHM provides detailed statistics on demographics, morbidity patterns, mortality, health service activity and financing to the MoH, there is inadequate analytic capacity at the MoH to further analyse these and also incorporate the emerging information into strategic planning decisions. There is currently no health technology assessment (HTA) agency in Moldova, although a department with responsibility for HTA has been established in the newly restructured MoH. Outdated technologies and the absence of evidence-based treatment protocols present serious concerns about the quality of care. Thus, there is a need to improve information systems so that data and analysis can inform policy and planning (1).

Physical and human resources

Physical resources

Moldova inherited one of the most extensive health care systems in Europe with extreme overcapacity in the hospital sector. The financial hardships experienced during transition meant that maintaining the scale of this

Table 1 Selected health care resources (physicians, nurses, acute hospital beds) per 100 000 population, 2006

	Physicians	Nurses	Acute care hospital beds
Moldova	311.1	702.7	506.3
Armenia	345.6	418.2	385.5
Romania	192.1	397.4	505.2
Russian Federation	430.9	805.9	930.9
Ukraine	308.4	783.4	711.9
CIS average	377.4	794.9	797.1
EU average	315.0	741.6	410.2

Source: WHO Regional Office for Europe, (9).

Note: CIS: Commonwealth of Independent States

system was both impossible and undesirable. Until the late 1990s, all towns or settlements with a population of over 3000 people had a polyclinic and settlements with a population of under 3000 had a combination of health centres, health posts and feldsher services. In total the delivery network included more than 305 hospitals, 1011 health posts and 189 health centres. However, nearly 30% of hospital spending was directed into the (approximately) 20 republican institutes that provide highly specialized care, located in the capital Chisinau. Hospital rationalization focused on rayonal hospitals and many of the reductions have been carried out through the closure of rural hospital facilities; for this reason, restructuring has been uneven across the country and many hospitals still operate at less than half of their operational capacity. The restructuring process to date has focused on cutting costs by reducing overcapacity, but this has not necessarily involved a strategic effort to improve efficiency (1).

Between 1995 and 2004 the total number of hospitals declined from 265 to 120 and the number of beds fell from 42 000 to approximately 23 000 (16). In 2006 there were 506 acute care hospital beds per 100 000 population, which is higher than the European Union (EU) average of 410 per 100 000, but well below the

Commonwealth of Independent States (CIS) average (see Table 1). Despite these developments, the majority of hospital and primary health care infrastructure is in poor condition, and routine maintenance of capital stock has not been a priority. Throughout the 1990s investment in and maintenance of medical equipment was lacking and equipment purchased or received through donations more recently has not always corresponded to national priorities. A significant proportion of Moldovan health care centres contain obsolete equipment or lack essential pharmaceuticals (1).

Human resources

Between 1990 and 2006, the number of physicians declined from approximately 15 500 to 11 100 and the total number of nurses has declined from 48 000 in 1995 to 25 200 in 2006 (9). The number of doctors working in the health system only fell after restructuring reforms in 1998, and the number of doctors per capita in 2006, while comparable to the EU average of 315 per 100 000, was considerably lower than the CIS average of 377 per 100 000 (see Table 1). However, despite the substantial fall in the numbers of health workers, due to migration and other factors, there is an excess of human resources in the health system, in particular the number of

(narrow) specialists. Meanwhile, due to low salaries, it is very difficult to attract doctors and nurses to rural areas and retain them. Low wages may also contribute to the prevalence in the system of unofficial charges to patients as a means of supplementing professionals' income. For this reason, there have been changes to the salary model used in Moldova in order to improve incentives. Consequently, to address the lack of coverage in rural compared with urban areas, higher remuneration rates now reflect higher demand (1).

Following recent reforms, the training of family doctors and health care managers has received particular attention and training programmes have developed considerably. Between 2000 and 2006, approximately 500 doctors graduated from a three-year specialist residency programme in family medicine. However, it has been difficult to attract young doctors to this programme. Family medicine's low status in the health system, along with low salaries, has dampened the enthusiasm of doctors to enter residency or retraining programmes in family medicine, despite the demand in this area. With very few of the young residents entering the field of family medicine, the prevailing attrition rate and the looming retirement of the existing cadre of doctors points to a substantial shortage of family physicians relative to needs. Training in health system administration and management is another important area that currently lacks capacity. In Moldova, although there is no formal licensing or registration of health professionals, all staff are obliged to undergo regular performance reviews and training following the old Soviet model of attestation. Every five years reviews and training courses in continuing medical education are undertaken (1).

Provision of services

The strengthening of primary care is an important priority in Moldova. This requires continued shifts in resource allocation away from the traditional emphasis on inpatient care, so that ambulatory health centres are resourced and empowered to deal with the vast majority of the population's health care needs, which can indeed be met at the primary health care level. There is also a need to increase the efficiency of the system and to ensure that the health financing system has appropriate incentives for health care providers. For example, the current hospital payment system provides highly-specialized Republican hospitals with an incentive to treat simple cases, which could be treated equally well in a *rayon* hospital, because the "profit margin" (the

difference between reimbursement and average case cost) is greater for the Republican hospitals and they are discouraged from treating more "expensive" (complex) cases – that is, exactly those cases Republican hospitals are designed to treat (17). Meanwhile, apart from family support and only few projects that provide home care and community care, long-term care provision is most often institutional. In terms of palliative care, the majority of the services are provided by charitable NGOs and funded mostly by the international hospice movement and international donor agencies (1). There have been some improvements in emergency care, and there were new investments in ambulances and emergency equipment in 2003 (16). Following the introduction of the new payment methods under mandatory SHI, activity levels and the number of people hospitalized via emergency services have increased significantly, while the treatment of surgical emergencies has improved and the rates of post-surgical complications and adverse events have fallen (1).

Public health

The main public health facilities in Moldova maintain a vertical organizational structure and are accountable directly to the MoH through the NCPM, which has a network of 40 territorial branches throughout the country based on the Soviet sanitary-epidemiological service network. Despite current epidemiological trends in the country, such as the rising noncommunicable disease rate and the disease burden from tobacco and alcohol consumption, the main emphasis of public health services remains on the implementation of sanitary norms in all public facilities (including health care facilities); the notification and surveillance of communicable disease outbreaks; environmental health monitoring; and health promotion. The National Health Policy called for a broader focus on public health to ensure that noncommunicable disease and chronic conditions are adequately addressed in future health planning, and reforms of public health structures and organization have aimed to strengthen public health capacity. So far, only the immunization programme is fully integrated into the health care delivery system and the rayonal health authorities. A national immunization programme covers eight target diseases (polio, diphtheria, tetanus, measles, pertussis, TB, hepatitis B and mumps) and provides vaccination to all children free of charge. Official routine figures report immunization coverage for children of over 90% for all vaccines, although there are significant regional variations (1).

Primary health care

The primary care network in Moldova now consists of four types of providers: Family Medicine Centres (FMCs), based in the former district polyclinics and often serving large populations of over 50 000 people; Health Centres, based on former rural medical points; Family Doctor Offices, based on former rural medical points which had only one doctor, covering populations over 1000, and; Health Posts for doctors' assistants (feldshers) covering villages/areas with populations of less than 1000 people (10). The primary health care services include general and paediatric consultations and referrals; paediatric development checks and immunization; antenatal and postpartum care; nutrition clinics; chronic disease management; mental health services; family planning; hepatitis and TB care; acute respiratory illness care; diarrhoea care; home visits; nursing care; ambulance services; and health promotion and prevention clinics (11).

As the introduction of mandatory SHI in 2003 has removed or reduced barriers in access to care, the number of visits to family doctors, which in 2003 represented 63% of total visits, increased in 2005 to 66%, which would indicate increasing utilization of primary health care services (10). In the same period, the total number of outpatient visits (*rayonal* facilities excluding highly specialized Republican institutions) also increased. Although the primary health care network is extensive and access to services is good, there are still significant variations and geographical inequities in the distribution of staff, the range of services provided, the availability of equipment and essential pharmaceuticals between the rural and urban regions (1).

Hospital care

At the secondary care level, *rayon* general hospitals in rural areas and municipal general hospitals provide a relatively broad profile of services to the local population. In 2005, there were 64 hospitals in Moldova, with almost 40% of all inpatient facilities and hospital beds located in the capital (17). Following the introduction of SHI, the legal status of hospitals has changed to allow them more autonomy – all MoH hospitals were converted into state enterprises and funding is received through the NHIC rather than the budget (10). However, although the declared aim was to reorient the system towards a primary care-based model as funds for primary care were not ring fenced they could be used to cross subsidize inpatient care, and this would appear to

have happened in many areas. The role of the chief doctor of *rayon* hospitals vis-à-vis primary care providers was therefore rethought. Although the chief doctors themselves were resistant to changes, which would weaken their local power base, the FMCs were given autonomy from 1 January 2008. In terms of reform priorities for secondary care, there is also a need to develop both long-term care solutions and new care modalities, such as home care and day surgery (10).

Mental health care

Mental health policy has not yet been fully implemented in Moldova, but various programmes and pieces of legislation to improve psychiatric services and to protect the rights and interests of people with mental health problems have been adopted. The first point of contact for people with mental health problems is most often the family doctor in a primary care setting, but more complex cases are referred for outpatient consultation with a psychiatrist or psycho-neurologist, working either in a psycho-neurological outpatient clinic or a psychiatric hospital. There are no community care facilities for people with mental health problems, although the number of mental health day-care places in hospitals is increasing (1). Both outpatient and inpatient mental health care is intended to be free of charge, but the cost of pharmaceuticals is a serious barrier to patients with mental health problems (18).

Health care for specific populations

As the Transnistria region remains effectively outside central government control and its status is still being negotiated, it has not been included in the Moldovan reform programme or the recent introduction of mandatory SHI, although there was some interest in introducing a similar system in 2006. Basic health and demographic data for the region have not been available since 1997, but it would seem that the region has maintained a largely unreformed, wholly state-owned health system based on the Semashko model, with polyclinics and a large hospital sector (1). The region has not had access to Moldovan government funds or to funding from international donors organizations working with Moldova, which has meant restricted access to, for example, anti-retroviral therapies for the region's 1000–1500 people living with HIV/AIDS (19).

Health care reforms

The Moldovan health reform programme faced severe delays due to fiscal constraints throughout the 1990s,

and many of the reform ideas, which were passed into national law, could not be implemented. However, the extra time did enable the MoH to work closely with international organizations so that the reform initiatives could be refined before implementation and some of the pitfalls encountered in other countries with inherited Semashko health systems have been avoided. The key reform areas have related to the privatization of some health care services (most notably dental services and pharmacies); hospital restructuring; reorientation of the system in support of primary care services; and most recently, the successful introduction of mandatory SHI. The focus for future reform is on improving the quality, efficiency and performance of the health system. Other efforts include reducing health inequalities between socioeconomic groups and geographical regions within the country and improving overall population health status through health promotion and disease prevention, control of both communicable and noncommunicable diseases, ensuring access to services and support for vulnerable populations, improving environmental health and protection, and improving the quality of mental health services (1).

Assessment of the health system

The Moldovan health system aims to provide the entire population with universal access to a basic package of health care services. Although regional differences in per capita funding for health care have decreased following the recentralization of resource pooling, more remote regions are still underserved and the rural poor population are less likely to gain access to services. While recent reforms have had a very positive impact on equity in the health system's overall costs and benefits, the current system of health financing does not yet ensure effective protection of the entire population from financial risks. Out-of-pocket payments are still high, and a sizeable proportion of the population are not covered by SHI, with many of these people belonging to the country's poorest households (1).

Profound hospital restructuring has taken place and much of the excess capacity in the Moldovan health care system has been reduced. The current focus has been on developing primary health care, substantial investment in the training and retraining of personnel, and reallocation of resources away from inpatient care. However, there are still problems regarding attracting and retaining staff to work in primary care, particularly in rural areas. There are also still few incentives to improve

quality and consumer satisfaction in the Moldovan health system. The system is not accountable to the people and responsive to their needs and it continues to be run according to a centralized, command-and-control system whereby the patient as the end-user has little participation in the system's management. In many respects it is still too early to assess the contribution of the current health system to health improvement, as the latest round of reforms introducing SHI and boosting primary and emergency health care services only took effect in 2004. However, there is evidence that the reform programme has delivered some improvements in the perceived quality of care (particularly in primary health care services), in efficiency of resource allocation and in more equitable distribution of the health systems costs and benefits across the population. Falling infant and maternal mortality rates, and consistently high levels of child immunization seem to indicate that programmes to improve the quality of certain services have been effective (1).

References

1. Atun R et al. (2008). Health systems in transition: Moldova. *Health Systems in Transition*, 10(5):1–160.
2. Protsyk O. (2006). Moldova's dilemmas in democratizing and reintegrating Transnistria. *Problems of Post-Communism*, 53(4):29–41.
3. Roper SD (2005). The politicization of education: Identity formation in Moldova and Transnistria. *Communist and Post-Communist Studies*, 38(4):501–514.
4. World Bank (2004). *Moldova Country Assistance Evaluation*. New York, World Bank Operations Evaluation Department.
5. International Monetary Fund (2006). *Republic of Moldova: Statistical Appendix*. Washington DC, International Monetary Fund.
6. International Monetary Fund (2006). *Republic of Moldova: Poverty Reduction Strategy Annual Evaluation Report 2005*. Washington DC, International Monetary Fund.
7. World Bank (2007). *World Development Indicators*. New York, World Bank.
8. International Monetary Fund (2005). *Republic of Moldova: Selected issues*. Washington DC, International Monetary Fund.
9. WHO Regional Office for Europe (2007). European

Health for All database (HFA-DB) [offline database]. Copenhagen, WHO Regional Office for Europe (November edition).

10. Government of the Republic of Moldova & World Bank (2006). *Health policy note* [draft]. Chisinau, Government of the Republic of Moldova & World Bank.

11. Atun RA (2007). *PHC development strategy for Moldova*. London, Primary Care and Social Assistance Project, Grant 55808.

12. Ministry of Health and Social Protection / National Bureau of Statistics data, cited in Shishkin, Kacevicius & Cocianu 2006 (16).

13. World Bank (2003). *Moldova health policy note: The health sector in transition*. Washington DC, World Bank.

14. Grant H (2001). *Moldova salary survey report*. Consultant report for the State Chancellery of Moldova, Washington DC, International Monetary Fund.

15. Government of the Republic of Moldova (2007). *Politica națională de sănătate Republic of Moldova 2007–2021 / National Health Policy, Republic of Moldova 2007–2021*. Chisinau, United Nations Children's Fund (Moldova).

16. World Bank (2005). *Review of experience of family medicine in Europe and central Asia*. Washington DC, World Bank Human Development Sector Unit, Europe and Central Asia Region.

17. Shishkin S, Kacevicius G, Cocianu M (2006). *Evaluation of health financing reform in the Republic of Moldova*. Copenhagen, WHO Regional Office for Europe.

18. Interminds (2004). *A long road: A country report, mental health services in the Republic of Moldova*. Edinburgh, Interminds (http://www.interminds.org/contents/countryreports/cr_moldova.doc, accessed 26 November 2007).

19. Medecins sans Frontieres (2007). *MSF opens first HIV/AIDS clinic in breakaway region of Transnistria*. MSF Press Release. Geneva, Medecins sans Frontieres (http://www.msf.org/msfinternational/invoke.cfm?objec tid=499E9128-15C5-F00A-25F02FDB85DB4CA9 &component=toolkit.pressrelease&method=full_html, accessed 11 December 2007).

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