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Improving the hospital system in the Republic of Moldova



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Abstract

This report examines the next steps in planning changes to the hospital system in the Republic of Moldova following the completion of a master planning exercise in 2009. The scale of the improvements required means that large investments need to be made but to make the most of these a number of other policy changes are needed. The report details these and identifies the steps that should be taken to ensure their successful implementation. These go beyond changes in hospitals and include changes in payment, regulatory, social care and primary care policy. The report sets out recommendations for the next steps in the reform process. Particular attention is given to the risks and benefits of using public private partnerships as a method of financing capital projects.

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This publication expresses the author's personal views and opinions, which do not necessarily reflect the views of the institutions with which he is or was affiliated.

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Executive summary

In 2009, the Ministry of Health, Republic of Moldova, produced a National Hospital Master Plan for the period 2009-2018, with World Bank support. The Master Plan proposed several options for changes to the way hospital services are organized.

Specifically, the Master Plan proposed the creation of nine Regional Hospitals to replace the existing network of 34 rayon (district) hospitals and the development of two larger centres ('specialized hospitals') at Cahul and Balti. Three types of hospitals were envisaged for Chisinau: municipal hospitals responsible for general treatment of the capital's own population, centres of excellence consisting of national single-specialty hospitals, and university hospitals that would provide the most complex treatment and medical education.

In 2010, in an effort to accelerate reforms in the hospital sector, the Ministry of Health requested the assistance of the World Health Organization (WHO). Using the National Hospital Master Plan as the starting point, WHO conducted a review of key documents; discussions with the Minister of Health, officials of the Ministry of Health, the National Health Insurance Company, hospital directors, the National Council for Evaluation and Accreditation in Health, the World Bank, the Delegation of the European Union and the Ministry of Finance; and a two-day round table policy discussion involving a broad section of stakeholders to discuss future reforms.

This report is the conclusion of this technical work, and discusses a range of issues relating to the implementation of the National Hospital Master Plan, including:

- the importance of change management processes and the need for vision and leadership;
- the need for a clear clinical vision to guide changes in the way hospital (and other) services are organized;
- the need for enabling and supporting policies particularly in health finan-

cing and human resources to support the implementation of the Master Plan;

- the need to clearly define the relationship between hospitals and other levels of care (particularly primary health care); and
- the importance of clarifying future ownership and financing arrangements.

The report concludes that a number of important questions about the content and direction of reforms remain unanswered. The recommendations from the National Hospital Master Plan may have to be revisited. The importance of the development of a clear clinically-based strategy for investment, as a first step, is strongly emphasised. The report provides a range of specific recommendations to the Ministry of Health, including that:

- a core group of leaders is established to lead the process of change;
- a financial investment plan and timeline is specified; and
- a workforce strategy and hospital reform communications plan are developed.

1. Introduction

Ambitious plans are being made to reform the hospital system in the Republic of Moldova. This report sets out some background to these proposals, reviews the Hospital Master Plan and the associated planning of a road map for reform and makes some suggestions about the design and implementation of the reforms. It is based on a review of documents, meetings with the Minister of Health, officials from the Ministry of Health, Health Insurance Company (CNAM¹), Hospital Directors, the National Council for Evaluation and Accreditation in Health (CNEAS²), World Bank, Delegation of the European Union and Ministry of Finance and a two day policy round table to discuss the proposed reforms.

There are a number of issues that will need to be addressed in the development of a roadmap for the future of the hospital system and where further work is required to ensure its success, these include:

1. The Hospital Master Plan provides a high level of analysis of how hospitals should be structured but it is a largely top down planning exercise. There is more to do to take account of how the delivery of health care needs to change now and how it may change in future. Without a strong clinically based vision of the future there is a danger of creating services that will be already out of date or insufficiently flexible to respond to progress in medicine.
2. Changes are required in other parts of the health care system – in particular primary and social care – which will be important in helping the hospitals adapt and change their performance. New regional hospitals will need to be very efficient and only be used for patients that really require hospital care. They will not be able to perform their role if it is not possible to discharge patients effectively and prevent the admission of patients, particularly those with chronic disease, who should be managed in primary care.

1 Compania Națională de Asigurări în Medicină

2 Consiliul Național de Evaluare și Acreditare în Sănătate

3. Supporting policies need to be in place to ensure that the changes can be successfully implemented, these include, further development of the accreditation process, the hospital payment system, human resources policy and mechanisms for financing capital investment.
4. Most large scale change programmes tend to fail because of the approach taken to change management rather than because the technical components of the change are not properly designed. Unless the leadership, at all levels of the system, convey a clear vision of how the system will look in the future and how different actors need to adapt and change there are very significant risks.
5. The new system and the transition towards it will require high quality leadership and project management. There is a need to develop capability and capacity in this area and to quickly identify the group who will act as the leaders of the changes.

2. Background

The changes proposed for the hospital system need to be seen against the background of a more general case for change in Moldova. This was articulated by the Minister of Health at the policy round table. The urgent pressures for change come from:

- The impact of the economic crisis, the aging of the population, the escalating costs of medicines and the demands for new technology all require the health system to become much more efficient. The health system must be able to demonstrate it can make good use of the funds if the aim of maintaining the current share of health spending is to be achieved.
- Satisfaction with health services in Moldova is falling.

There is a need to change the balance of spending so that at the very least future growth in spending is directed towards areas other than hospital care.

The Hospital system in Moldova consists of 82 organizations with over 21,000 beds, out of which 71 are contracted by CNAM:

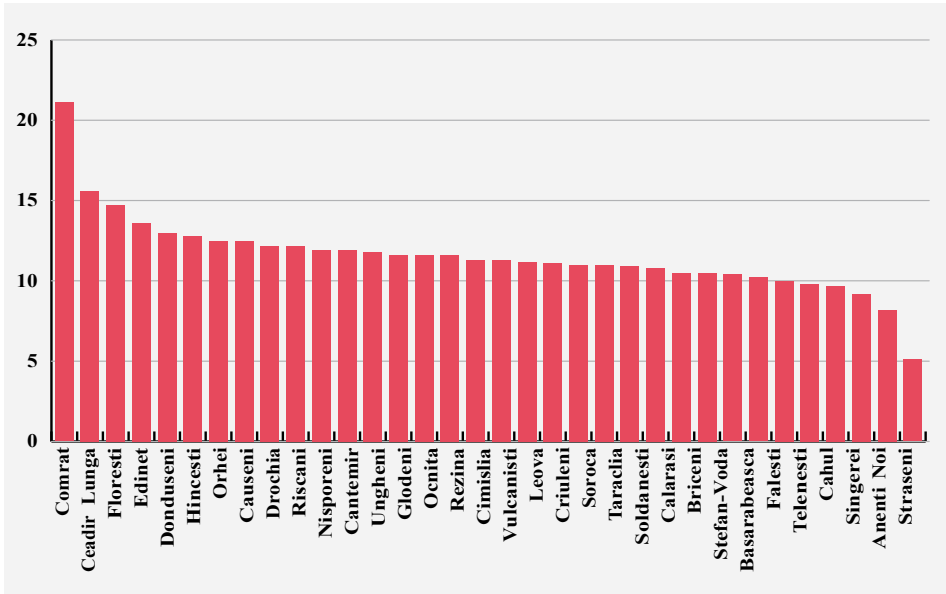
- 17 Republican Hospitals
- 10 Municipal Level Hospitals
- 34 Rayon Level Hospitals
- 5 Departmental Hospitals
- 4 Private Hospitals

Moldova has previously undertaken a very substantial rationalization of small hospitals but it still has many very significant issues that need to be resolved and until recently progress has been slow. These include:

- The physical state of the hospitals is very poor and much of the equipment is very out of date. This means that the cost of operating these buildings is very high and they provide a poor environment for patients and staff. The safety of some of the laboratory, imaging and anaesthetic equipment in use is a concern.

- There are a large number of hospitals particularly in the capital which has over 50% of the total and 56% of beds and there are some variations in the rates of utilization that require attention.

Figure 1: Hospitalisation rates per 100 population

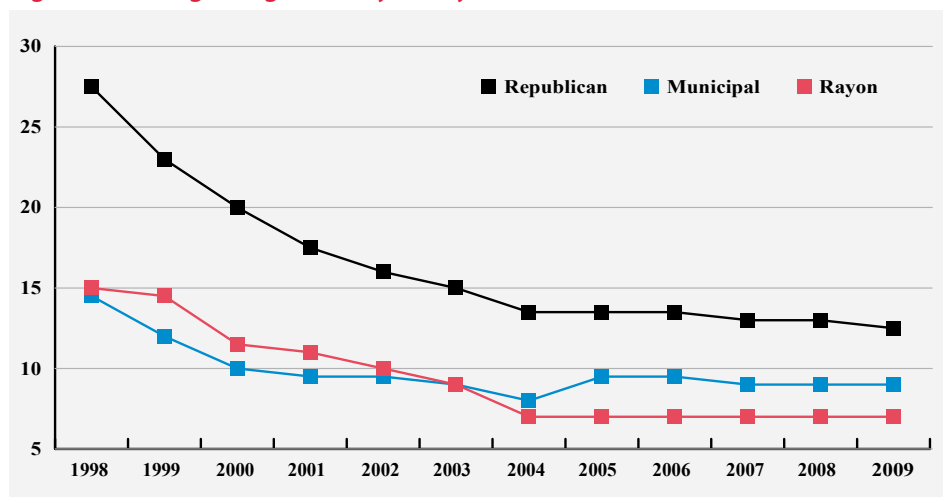


Source: CNAM: unstandardized data

- Although hospitalization rates are close to the EU average there is a concern that a significant number of patients are admitted for conditions that are not hospitalised in other European countries. This seems to be obscuring areas in which patients who are not getting access for procedures that would be more available elsewhere in Europe.
- Specialist institutions are concentrated in Chisinau and many of these are organized for single conditions (so called monopofile hospitals that include trauma, cancer, cardiology, TB, neurology & neurosurgery, and dermato-venereology). There are also separate hospitals for mothers and children and childhood infectious diseases. The persistence of this model means that multidisciplinary care is made much more difficult and there is duplication of resources.
- There is a lot of overlap and duplication between the specialist institutes, the municipal hospitals and the Departmental Hospitals.

- There is agreement that the hospital system needs to make major improvements in efficiency and quality. Length of stay has fallen but recently this trend has stalled. There are opportunities to increase the use of day treatment and to use home care and social care to improve the discharge of patients once their treatment is complete.

Figure 2: Average length of stay in days



Source: CNAM unstandardized data

- There is concern about the small number of surgical cases and deliveries undertaken in some hospitals. This partly reflects the fact that the distribution of hospitals means that some serve very small populations. This raises important questions about quality and safety. This is part of a growing challenge of how to staff and operate rural services.
- At present there is a view that too much work that should be dealt with in primary care is seen in specialized ambulatory care.
- Specialized ambulatory care has been provided separately from the hospitals and so there is a concern that some of these doctors have become out of date and have lost some of their skills.
- Ambulance services have been regionalised and improved and are an important part of the system. The state of Moldova's roads and long travel times are an issue that needs to be considered as part of planning. Major

investment to improve the road network is being planned which will help to deal with some of the worst problems.

A National Health Policy 2007-21, and a Healthcare System Development Strategy 2008-17 are currently in place. The very detailed Hospital Master Plan developed in 2009 provides options for further restructuring of the hospital infrastructure to respond to these problems and ensure a better configuration of hospitals based on the needs of the population and able to address the problems detailed here. There now seems to be a clear consensus about the way forward for further reforms of the hospital system at the central level.

3. The hospital master plan

The approach underpinning the Hospital Master Plan is based on sound principles which appear to be in line with those used in largescale strategies in other countries:

- Centralize or retain central provision in the capital city or, if appropriate, regional centres where it is necessary to ensure a critical mass of services for reasons of quality, safety, workforce constraints or economies of scale. Examples include major cancer surgery, major vascular surgery, cardiac surgery, the treatment of rare metabolic diseases. In the medium term retaining some services such as complex joint replacement, angioplasty, major paediatric surgery etc regionally would be wise.
- increase the size of population served by smaller general hospitals to create regional hospitals to ensure high quality and cost-effective care
- decentralize some services where this is appropriate and affordable
- create multispecialty centres of excellence to bring mono-profile hospitals together
- strengthen the supporting infrastructure and services
- invest to create modern facilities capable of delivering 21st century health care
- move the orientation of the health care system towards primary and community care and reduce the overall share of hospitals in the health budget
- improve the quality and efficiency of hospital services with shorter lengths of stay, increased day case work and other more efficient practices.

This is a very ambitious programme. It will require a change not just in the hospital sector, but also in primary care, social care and emergency/ambulance services. It represents a very significant leadership challenge as well as having some very demanding managerial and technical requirements.

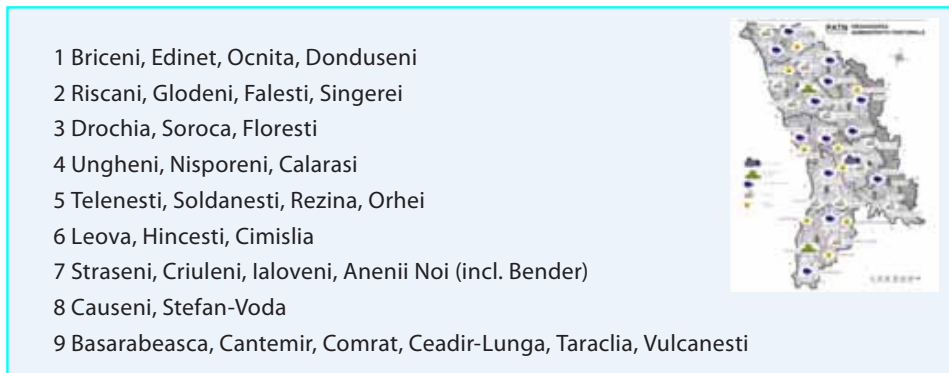
While the Hospital Master Plan sets out a broad direction it does appear that, despite the very large amount of detail that it contains, there is further work to

do to set out the changes in the way hospitals and health care will operate and to turn the plan into a set of actions that can be implemented. The complexity of the project and the interrelation with other parts of the health system means that a detailed implementation roadmap is required. In particular, it will be important to develop detailed local plans. The proposals in the Hospital Master Plan are a starting point for planning rather than providing the answer.

Regional hospitals

The proposal is to create 9 regional hospitals to replace the current network of 35 rayon hospitals.

Figure 3: Proposed Regions under the Hospital Master Plan



This will create hospitals serving an average of around 230,000 population, similar to the populations covered by general hospitals in a number of other European countries. The scale of this change and other constraints such as the need for development in other parts of the health care system and transport infrastructure means that any further centralization would be very difficult. There seems to be a high level of support for this concept amongst those responsible for health policy and it appears to be the right direction.

There is a proposal to develop larger centres at Cahul and Balti which may have some specialties currently only provided in Chisinau. This makes sense as a medium

term goal. The incentives for the Republican hospitals to ensure that there are vibrant and successful services in these regions will need some thought.

As noted above, because of the need to create a more comprehensive and forward looking clinical vision there are some important questions that are yet to be determined. There is more work to do to define the size and scope of the regional hospitals, which specialties they will offer and the nature of their relationship with the community hospitals, with specialized ambulatory care and with the specialist hospitals in Chisinau. They will have to work in a much more intense and efficient way. It is to be hoped that this pattern of care will shift significantly over the next 10-15 years as services move from hospital to ambulatory or primary care and as more specialist work becomes possible outside of specialist centres. This means that the plans for regional hospitals will need to be highly flexible.

Community hospitals

The decision to change the role of the existing rayon hospitals is the right direction. Exactly what role these hospitals will have in future needs some further clarification. At the round table it was clear that there is not yet a consensus on this but it does seem clear that these institutions will not be undertaking any emergency internal medicine that requires the support of a full acute hospital, major surgery or other major acute work. Some will be providing support to the regional hospitals, looking after patients that require rehabilitation or palliative care and providing a base for specialist outpatient consultation and diagnosis. Others may have a role in providing social care and long-term nursing support for older people. This has implications for how these hospitals are owned and managed (whether it is the regional hospitals, the rayons or some other body) which is considered below.

An important question which has been identified by the Ministry and Health Insurance Company is who will be responsible for paying for people who use the community hospitals. Since a significant amount of the care that they will be providing will not be the responsibility of CNAM, the support of the Ministry of Labour, Social Protection and Family, local authorities and other possible payers (for example, NGOs) will need to be obtained.

Municipal and republican hospitals

In common with most other countries across the region the capital city is over-endowed with both hospitals (48 institutions) and beds (over 12,000) and this position is unsustainable. The capital is also where the mono profile and departmental hospitals are located and there is a great deal of duplication between the municipal hospitals and republican hospitals. The proposal is to reduce the number of hospitals and to merge the management of many of the separate institutions. The new configuration of hospitals (still on multiple sites) for the capital will be:

- 7-8 Centres of Excellence providing complex and tertiary care
- 2 Community Hospitals
- 8 Monoprofile Specialized Hospitals under common management
- 8 Municipal Hospitals under common management

It is clear that a lot of thought has gone into the future shape of municipal hospitals, specialist services, the reorganization of mono profile hospitals and how Moldova can create centres of clinical and academic excellence. It is fortunate that a number of these institutions are reasonably close together.

The proposed new configuration of hospitals is still generous and means that the general hospitals will be covering a much smaller population than those serving the regions. There will still be a large number of health care sites for a city the size of Chisinau. This suggests that a more ambitious plan for change could be developed to reduce further the number of separate sites and overall level of hospital provision. This would also be desirable as a way of improving multidisciplinary working and reducing the risk of duplicating expensive diagnostic equipment. The round table heard about plans to reduce the number of beds from over 12,000 to 5,500 by 2020. Further discussion on how to achieve this, the new ways of working that will be required and whether further change might be possible should take place.

The separation of emergency care from other specialties is likely to have a negative impact on the outcomes of care for multiple trauma but also potentially for elderly people with fractures whose main problem may be their medical condition. Removing this separation will reduce the need for patients or

staff to be moved or for facilities to be duplicated. Further examination of the organization and management of these services would seem to be required.

The incorporation of infectious diseases treatment into general hospital care is a direction that is being followed in many countries. Multidisciplinary care of diseases will significantly improve outcomes. A beneficial side effect of this is that it will provide opportunities for cost savings and the sale of buildings. Attention will need to be given to the control of infection practices where these services are brought together.

The long term future of children's infectious diseases and whether such a large and centralized capability is required should be examined. The participants in the round table suggested that strengthening primary care services for children could significantly reduce demand for admission for paediatric infectious disease.

The proposal to partly decentralize chemotherapy, and in the future radiotherapy, is a good example of where improved efficiency and reduced costs are also likely to create major benefits for patients. There are some education and training issues that will need to be addressed. There will also be a need to ensure that the regional hospitals are able to deal with the emergency management of patients with complications resulting from chemotherapy.

As indicated above an important question will be how the expertise at the specialist hospitals can be used to support the development of services in regional hospitals. For example, in the hospital that we visited there is no capability for joint replacement, which could be decentralized if the facilities were better, but they were attempting intensive care for children which should be regionalized. The temptation will be for hospitals to try and develop new techniques and services and while this should be encouraged it will be important to ensure that this is done in a rational way. Some services are centralized now because the resources are not available elsewhere (e.g. major vascular surgery). Other health systems have fought to create this level of regionalization, the Republic of Moldova should allow decentralization where it makes sense but it would be wise to resist the temptation to develop highly specialist services serving suboptimal populations. Developing some clear regulatory and accreditation criteria to manage this would be sensible.

To be most effective, regional hospitals will need to be able to rapidly discharge their patients either to home with appropriate support, or to hospitals that can provide after-care, or to rehabilitation/palliative care hospitals and sometimes to social care. This type of network management is relatively difficult and will need to be supported by the design of appropriate incentives.

Outpatients and specialist consultation

As hospitals are centralized and become more distant from the populations they serve it will be even more important that specialist ambulatory and diagnostic services are available close to where patients live.

How ambulatory care fits into the overall care system in Moldova needs some further thought. It is potentially very important in supporting primary care, particularly in the management of chronic disease and reducing the risk of admission to hospital for many patients which will release capacity to allow other patients to be treated.

Ambulatory specialists can lose their skills and become out of date over time unless they have a well established connection to colleagues working in hospital. Some systems for ensuring this, perhaps by allowing rotation, should be considered. The proposal for specialist ambulatory care to be managed and provided by the hospitals will address this but it will be important to ensure that primary care can get access to advice from their specialist colleagues that will assist them in the management of their patients and also help keep them up to date.

Primary care

Primary care is the subject of a separate policy development process but it is very important that plans for primary care are aligned with those for hospital and ambulatory care. A more accessible and skilled primary care service has an absolutely vital role to play in reducing the admission of some patients and creating capacity in those areas where there is a need to improve access to care. As hospitals improve and become more efficient it will be important to ensure that

their spare capacity is used effectively and does not simply allow the threshold for admission to fall: in other words it must not be too easy for primary care to shift work to hospitals. Improving the capability, diagnostic abilities and reputation of primary care will be important.

There do seem to be some registries in use in primary and specialist ambulatory care. It is not clear that these are being used to their full potential. In time there should be contracting to encourage both the development and use of registries to ensure compliance with best practice evidence based disease management

There is also a need for some decisions to be made about the methods for providing out of hours emergency support, particularly to people in rural areas. The emergency ambulance service does operate a system in which patients can speak to a doctor and ambulance crews can provide care without taking the patient to the hospital. The implications of regionalising the hospitals for the ambulance service will need some careful planning. There are other options for providing out of hours primary care and some discussion of these may be worthwhile.

There is some reason to be concerned about the introduction of co-payments for ambulatory and primary care for both insured and uninsured patients from 2013. The rationale is that this will encourage the use of primary care and incentivise the uninsured to take insurance. However, it is not clear that this policy is consistent with the overall aim of reducing hospital use and without some studies of the potential impact on this there is some reason to be concerned about the potential to prevent appropriate attendance at the family doctor, particularly for patients with chronic disease. Copayment can be effective as a method for reducing informal payments but it is not clear to what extent this was a problem in primary care.

One point which might merit further investigation is the role primary care plays in the management of mild and moderate mental illness. Hospitalization for cancer, chronic disease and problems of old age are often linked to the way that the associated depression these patients often have is treated.

4. The need for a more challenging clinical vision

The Hospital Master Plan models the future shape of the hospital system based on assumptions on hospitalization rates, changes in performance, some change in treatment modalities and other factors such as travel time. There is a concern that it does not consider the potential for major shifts in where the population may be living in future.

The plan concentrates on the changes to the pattern of hospitals and hospital buildings. However, there is much more to be said about how the practice of medicine and the organization of care needs to change, the way that primary care and ambulatory care works with the hospitals and manages chronic disease and how new techniques and technology will create new ways of providing care. As far as it is possible to tell the Hospital Master Plan does not deal with this.

An important lesson from other major rebuilding programmes is that before any design or procurement is undertaken there is a large and very important task to redesign elements of care. For Moldova this will include:

- Rethinking the role of primary care and ambulatory care and how this can reduce the demand for hospital admission and improve the health status of the population
- Changes in the approach taken to areas of medicine where there are opportunities to modernize the approach. For example, the integration of infectious diseases or trauma into more general hospital services.
- How reductions in length of stay will be achieved and the interface of health services with social care and home care
- The future pattern of some specialist services that are currently centralized but which could be devolved or developed in the new larger regional hospitals needs to be discussed. Examples might include: joint replacement, complex imaging, some complex surgery, etc. Understanding how these may change over time will be important. As noted above, the Republic of Moldova has already centralized some services into larger centres, some-

thing which other countries are still trying to do – it will be important to ensure that this advantage is retained.

- Dealing with known deficits in the current system – for example in the area of stroke care
- What other changes in medicine need to be planned for – for example, a move away from a hospital based model of care in a number of specialties: e.g. admission for dermatology conditions, the administration of simple medication, etc.
- One notable gap in the clinical vision and the Hospital Master Plan is mental health. This represents a huge burden of disease and the model of care requires very serious attention. Increasingly it is understood how important mental health problems, particularly dementia, are in the treatment of general medical conditions. Proposals in the plans for Chisinau to reduce hospitalization for mental health problems including addiction is an important step that will improve services to patients assuming that capacity is available in other settings.

Being able to describe how the proposed changes will translate into improvements in care will not only provide a basis for designing new systems locally but will also be useful in helping to gain support for the proposals.

It is not clear what the balance between upgrading and new building will be. If Hîncești hospital is typical then rebuilding is likely to be the only way to create facilities capable of dealing with more acutely ill patients. This makes the forecasting task much more demanding as hospitals will need to be developed that are the right size for 20 years time when medicine in Moldova may be unrecognisable from where it is today and when there may be significant staff shortages.

Changes at the level of the system need to be supported by micro level changes in health care at the front line. Involving front line staff in rethinking some elements of how care is organized can have a rapid and impressive impact if it is combined with teaching relatively simple improvement and implementation techniques. Developing projects that could demonstrate how front line clinical staff could make improvements in outcomes for patients could be very useful in creating future leaders of change.

5. Supporting the change

Financial strategy

Major change programmes of this type require a sophisticated financial framework to deal with the inevitable costs of transition and on some occasions the need to run services in parallel. Developing a financial profile for the next few years of the implementation of the roadmap will be very important.

The implementation of DRGs will produce a number of benefits in terms of being able to improve efficiency and deep management of hospitals. However, the extent to which a DRG system will really drive very significant change in the hospital system in the short to medium term is limited. Not only does it require sophistication in the price setting process, which takes time to develop, but also well developed management processes within hospitals.

There are a number of lessons from other DRG systems which will need to be incorporated into the design of the system. But, one important issue given that the DRG system will be being introduced during a period of significant change is that there needs to be a mechanism to deal with hospitals that start to accumulate deficits and an appropriate failure/insolvency regime. Experience in a number of other countries suggests that hospitals have not proved very agile at adjusting to the signals sent by the payment system – or indeed, any budget constraints tend to be “soft” and readily over-ridden.

One important mechanism for creating change will be the use of selective contracting by the Health Insurance Company. This means that contracts need to be fully enforceable and the Company needs to be allowed to make decisions not to contract with particular hospitals. Regulations based on capability, quality and safety can be helpful in this (see below).

Capital financing

It will be important that the way that equipment purchase, renovations, investment and maintenance is funded supports the implementation of the overall service delivery strategy and ensures that the correct incentives are in place. Having a separate financial method in which the owners are allocated budget from central funds is not very satisfactory. Whether or not the construction and renovation of hospitals is funded through public private partnerships (PPPs) there will be a need to have a method for paying for the capital – this means that payment to hospitals must contain an element that allows capital costs to be repaid.

In time it might make sense to move to a system where capital is dealt with through the DRG payment system but this is likely to be a long term goal. The design of this type of system is difficult both technically and because so much of the hospital capital is in such a poor state that any attempt to do this will create very significant distortions and unintended consequences. However, until a method for paying for capital and a relatively stable pricing system is developed it may be difficult to attract PPP partners. A simple formula based method of payments to providers which is transparent and that reflects the true costs of capital could be developed. The lesson is to ensure that hospital directors realize that capital is a real cost and that there are consequences from capital spending in terms of servicing the cost of the capital, maintenance as well as important opportunity costs.

There is interest in PPPs as a method of developing capital investment, based on initial work carried out by IFC and a few small schemes under way. Some of the issues relating to PPPs were discussed at the policy round table. These are complex instruments and require significant expertise to design contract structures. To get the best of them it is critically important to have a developed service strategy and have a detailed understanding of the way that processes and ways of working will change in any new building.

Regulation and accreditation

The Republic of Moldova operates an accreditation scheme for health care providers. This is done on a rolling five year cycle with annual updates. It includes inspections of

facilities, a review of documentation, an assessment of management, compliance with clinical guidelines and a wide range of other process and structure criteria. The agency is able to partially accredit providers or impose a condition on them if some or all of their services fail to meet the criteria. Conditional accreditation allows providers time to comply. This is a potentially powerful tool for facilitating change, as the Health Insurance Company is not permitted to contract with hospitals or departments which do not hold an accreditation certificate. In practice, however, it is not easy for the company to comply with this due to the globally very poor quality of buildings and equipment. This limits the power of accreditation as a way of driving change as until hospitals have improved, significantly enforcing the regulator's decisions would lead to the closure of hospitals that the Hospital Master Plan needs to retain.

However, having an explicit set of standards for the provision of care means that decisions on the role of hospitals, which are inevitably highly political, may be made more easily where it is clear that the hospital is not meeting the correct standards of safety and quality. Using regulation rather than laws is also more flexible and allows the regulatory framework to adapt to changes in medicine and practice more easily. There is of course a significant danger of creating a highly burdensome and bureaucratic process and so the regulatory system needs to be carefully designed. Some further discussion of the role of regulation in the system in Moldova would be worthwhile to determine just how far it can be used as a lever for change.

In developing regulatory and payment policy it will be important to ensure that there are mechanisms that will prevent hospitals from continuing to provide medical care that will no longer be appropriate.

Workforce strategy

Hospital managers will need the freedom to shape the workforce and steps should be taken to ensure that the legal framework is fair but gives them sufficient freedom to do this.

A new pattern of hospital, ambulatory specialist consultation and primary care provision is an opportunity to improve medical education and training.

In particular, it would be valuable to create systems to share knowledge and expertise more evenly around the country and to help doctors in rural areas and small hospitals keep up to date. The extension of resident placements to regional hospitals could also be considered.

The use of protocols and clinical standards for the delivery of care, like regulation, is a potentially useful mechanism for creating change and improving standards. Moldova has undertaken a lot of work in this area and extending this could provide a useful lever for encouraging change.

The development of a strategy for quality and safety in the Moldovan health care system could be a useful way of promoting change.

Ownership and governance

The size of the change programme and the fact that 24 – 25 rayon hospitals will be effectively downgraded raises a question about who should be responsible for the ownership and management of these hospitals while the changes are taking place. The options for this need some discussion. One is for the Ministry of Health to take responsibility for running the hospitals and overseeing the planning process. The designated regional hospitals could be given managerial responsibility over the other rayon hospitals and be asked to manage their change of role. However, it is clearly not satisfactory for the Ministry of Health to be responsible for the detailed management of hospitals and it should not be the owner in the future. The options for the future ownership of hospital should be considered but they do not necessarily have to be returned to the rayons or municipalities. One option would be to create autonomous hospitals in which rayon councils were stakeholders. There are a number of models available in Europe which could be adapted for use in Moldova, the approach used in Estonia might be worth considering but it will require significant investment in management capacity.

There is also a question about whether in future the community hospitals should be under the management of the Rayon or the Regional Hospitals. The answer may vary depending on the types of services provided in the community hospitals.

6. Planning the future

Experience suggests that it would be desirable to engage the designated regional hospitals in planning their clinical strategies and therefore their content. The same applies in the hospitals in Chisinau. This is a difficult task as it means that people will be asked to look well beyond how the hospital currently works. This means that they will need technical help, the opportunity to learn from others and some parameters set by the Ministry to ensure that they are making appropriate assumptions about what work will be delegated to community hospitals, what new services can be developed and to ensure that the profile of services is affordable.

There is a significant capability issue about delegating this type of planning, developing the skills to manage complex networks and managing large investment programmes, establishing and contracting PPPs as well as the redesign of internal clinical processes and ways of working that will be necessary for regional hospitals to operate within the number of beds that will be affordable. It is vital that serious effort is put into the redesign of clinical work processes, patient flows and other aspects of delivery before serious work on the design of any new buildings is undertaken.

Action should be considered to create additional capability in these areas both centrally and locally.

Leadership and management development

The implementation of the roadmap at local level will require very high quality leadership and management. We also know that stability in the top leadership team is important for the creation of high performing hospitals. We suggest that a selection process for identifying the top leadership of the new regional hospitals should be carried out and that the selection should be made against a set of objective criteria which identifies the skills and knowledge required. Top leaders do need to have a capable team to support them.

To support the development of hospitals that work in more efficient and effective ways some capacity building will be required focusing on:

- managing complex networks
- the redesign of clinical processes
- using DRG and costing information
- managing change

While traditional classroom methods of teaching have an important role, a number of these skills can really only be learnt by doing. This means that education methods based on mentoring, collaboratives (a series of short events where clinical staff and managers from different organizations come together to plan solutions to shared problems) and other practical and experience based approaches are required.

7. Change management

Change programmes of this sort are more likely to fail because of the approach taken to communication, the management of change and the recruitment of support rather than the technical content of the changes themselves.

We met a number of very able senior people during the mission. The question is always whether there is capability and capacity beneath the top level in the ministry and hospitals.

Creating a coalition in favour of change including the hospital directors of the designated regional hospitals, opinion leaders in the medical profession and other influential people will be very important. The formation of a Hospital Association or Hospital Directors Association might be a useful way of supporting the changes.

There is a strong argument for identifying the leadership teams who are going to be responsible for developing the ideas for their local hospitals. This selection should be on the basis of a rigorous assessment process looking at the skills, knowledge, change management abilities and openness to new ideas. This group then need to increase their knowledge by examining systems in other countries and identifying high quality practice in other countries. They should work together to ensure cross-fertilization of ideas. Examples of this approach in other countries suggest that it is worthwhile to invest serious effort and resources. This process should also be used to identify changes in the practice of medicine or the organization of care that could be quickly implemented and would have a big impact on health care outcomes or costs.

The presence of a leadership group with well established processes for learning, planning, criteria for determining the pattern of investment and service provision and supported with 1) high quality policy advice from the Ministry 2) rigorous project management and 3) dedicated support to develop their work will be important in demonstrating to donors and other funders that there will be progress and that the proposals should be taken seriously.

Managing staff in the transition

Complex change programmes need a simple story that can be used to explain why changes are necessary and why the outcome of the process will represent an improvement. In general it is almost impossible to over-communicate in this area and much more needs to be done to tell this story in a way that staff will find engaging and compelling.

The implementation of the Hospital Master Plan will inevitably mean that the workforce will need to be reprofiled and some staff will need to be made redundant. A special plan for managing staff during the transition is needed. This should have the aim of ensuring that talented staff are retained and can see a good future for themselves. It should also cover how any staff reductions are to be carried out. A 'last in first out rule' for redundancy selection is not necessarily the most appropriate method for ensuring the right balance of skills and tends to reinforce the problem of an ageing workforce, which is an important issue.

8. Timetable

One of the most important tasks for the next few months is to develop a timetable for the different components of the reform. There are still a lot of unanswered questions about how hospitals have to adapt and the scale of the task could put a major strain on the capability of the ministry and hospital management if all of the change is attempted at once.

It is very important that the development of a clear clinically based strategy is determined before any major capital investment is made or PPP contract is signed. There are a number of other elements of the road map also that need to be put in place before changes in the hospital system. These include decisions about the development of primary care, changes in outpatient care and changes in social care.

We suggest that the programming of where the investment might benefit from some further thought. For example, consideration could be given a competitive process in which there is some competition for the management team that will lead the change in a particular area – this would be based on an assessment of the quality of the team but also the quality of their vision for change. The teams could be given technical support access to study tours etc.

9. Summary of recommendations

A large number of issues were addressed in the policy round table and in our discussions. There are a large number of actions that are needed to drive change in the hospital sector and in the wider health system. Amongst the many actions the following emerged as the main priorities:

1. The system needs to move away from thinking in terms of beds, and particularly beds by specialty or professor, and look at the productive capacity of hospitals.
2. A core group of leaders should be established and provided with high quality support to implement the Hospital Master Plan.
3. The Ministry of Health needs to establish a planning process involving the leadership group and other stakeholders. A clinical vision should be developed which lays out criteria for determining which services are required at which level of the health system, and how this might change over time. This should then be used to refine and update the Hospital Master Plan.
4. A programme for change needs to be defined over the next six months with a financial investment plan and a timeline for the different components required to manage the change.
5. Strategies for primary care, ambulatory care, social care and other key policies need to be in place in order to support the programme, together with the necessary coordination mechanisms.
6. Develop the payment, accreditation system and other contracting instruments to allow CNAM to play its part in supporting the change process.
7. Consider whether the Hospital Master plan proposals for the capital are far reaching enough and more rapid progress could be made to create multidisciplinary care.

8. The future management and ownership arrangement of regional hospitals needs to be defined by the Ministry of Health.
9. Additional central expertise in health planning, new clinical models, public-private-partnerships and other aspects of the change programme should be created.
10. A workforce strategy needs to be developed; this should consider the implications of the planned reforms for medical and nursing education and training.
11. Capital investment is needed to improve the current poor state of hospital assets. One option would be to take a framework loan from one of the international financial institutions (e.g. Council of Europe Development Bank, European Investment Bank), and allocate these resources flexibly across the system to create new capacity where hospital and other management are willing to do things differently, in order to incentivise change.
12. The most difficult part of this type of exercise is the communication of the vision, explaining how the changes proposed will improve the health system. A communications plan to create public debate and a role for the leadership group discussed above is very important.
13. There is a need to develop managerial capacity across the health system, including skills in the management of change, service planning and improvement.

Annex 1: Lessons from Estonia

The experience of Estonia was presented at the policy round table and was found to be useful by the delegates partly because the reform journey Estonia has taken is similar to that required in the Republic of Moldova. Many of the problems experienced in Estonia are similar to those in Moldova now, including:

- Fuzzy ownership and legal status of hospitals
- Too many fragmented providers in the hospital sector
- Over-capacity of acute beds
- Poor hospital building conditions
- Poor hospital management quality
- Lack of access to capital
- Blurred distinction between acute care, rehabilitation, long term and nursing services/beds
- Little coordination with primary health care and outpatient specialist care

In Estonia, the first response was to close many small hospitals followed by the development of a detailed hospital master plan based on performance targets from Sweden. This aimed to:

- Reduce acute hospitals from 68 to 13
- Reduce acute beds from 6,500 to 3,100
- Make the case for renovating the acute hospital network (estimated cost 300 million EUR)

There are a number of important policy lessons from this experience:

1. Reform of financing, hospital payment and budgeting, primary care, hospital ownership and governance and health improvement policy are all required to successfully reform the hospital sector

2. A detailed hospital plan is an important part of the reform process.
3. This needs to be developed with the cooperation of leaders from within the country but it is important to look outwards to other health care systems to ensure that appropriately challenging benchmarks for performance and change in clinical practice are set
4. Clear criteria for determining the distribution of services including emergency travel times are important. These also need to incorporate quality and affordability issues.
5. The master plan is a dynamic document and will need to be revised. It has proved to be difficult to sustain surgery and some emergency services in the smaller hospitals and further centralization, beyond that originally planned, has become necessary.
6. The creation of hospitals as self governing bodies with managerial freedoms on investment, hire and fire decisions and pay and conditions for staff has been an important step in this process.
7. An extensive programme of mergers has been necessary to make the process of change work. Mergers have their own risks, however, and can be disruptive.
8. Hospitals in the capital city need a coordinated development plan.
9. Increased efficiency, reduced stays and increased day cases are important
10. The planning process was overseen by a wide group representing different stakeholders

Annex 2: Public private partnerships (ppps)

What are PPPs?

PPPs are a risk-sharing relationship based upon a shared aspiration between the public sector and one or more partners from the private and/or voluntary sectors to deliver a publicly agreed outcome and/or service. Essentially there are four activities in any investment project – Design, Build, Finance and Maintain/Operate: a PPP always has “M/O” as well as some or all of the others.

PPPs tend to use long term contracts, 20-25 years, and longer periods are common. A core characteristic is the need to ‘bundle’ the construction and operating parts of the contract. Bundling the facilities management with other aspects of the contract is an important way of ensuring that the constructors have the right incentives to build new facilities in a way that is cost effective to maintain rather than just cheap to construct. The same logic extends to applying to other services beyond the management of the buildings. Contract payments are generally linked to the availability of the spaces constituting the hospital buildings – with penalties and pay for performance elements when standards fall below the specified level of the contract. The objective is to achieve the management of risks (including but by no means limited to risks such as design failures, construction completion date or cost, utilities usage, subcontractor performance, inflation or the catch-all “force majeure”) by passing them to the party in the best position to accept them or requiring the least risk premium, the incentivization of long-term quality by ensuring that incentives are properly aligned, and ‘clean’ debt and procurement methods. ‘Clean’ in this context means that there are uncontested rights over the assets in the project, and that there is clarity over who is responsible to deliver and manage the project.

As the definition above implies, PPPs should be driven by public sector imperatives, and use private sector resources and skills to deliver them. Objectives behind the use of PPP as a finance and procurement mechanism include improving access to those services where the public sector is currently failing to de-

liver adequately (such as rural health care), encouraging the development of services requiring high levels of investment beyond that available in the country or to the public sector, importing high technology facilities, and improving the quality of services or management in the sector. It is only when the private sector can do one or more of these things better or more cheaply than the public sector that it is worth attracting private sector partners.

PPPs and flexibility

As progress in health care technology and to a certain extent social change is rapid, the use that is made of buildings changes over time. It is important that, as far as possible, buildings can adapt easily to this changing environment. Often this has not been done very successfully due to the tight or rigid contractual nature of PPPs such as those being used in the United Kingdom's private finance initiative.

Managing PPP contracts

It is impossible to write contracts which are "complete" (i.e. account for all the contingencies which can occur during a long life). Conceptually and practically, there is a trade-off between future efficiency gains (particularly in terms of cost savings) and quality improvement. This is because the incentives for the contractor to aim for cost reduction are strong, because they tend to be contractible and the gains can be captured by the contractor, but the pressure to aim for quality improvements (including all-important future flexibility of the estate) are relatively weak, and the consequences of this – inflexible and inappropriate buildings – are left with the public sector.

The solutions to this include developing contracts which more explicitly allow for renegotiation of later service configurations. Beyond this, there should preferably be recourse to arbitration rather than litigation for the disputes which will inevitably occur. It is also important to re-orient the contractual culture so that "partnership" is real rather than rhetorical and incentivizes flexibility. More radically, it is possible to reposition the contract envelope more broadly than

just accommodation, in order to foster whole-hospital or whole-system health care evolution – that is, still more ‘bundling’.

Some misconceptions

The funding cost of PPPs is unlikely to be cheaper than conventional finance, as governments can always borrow at more advantageous rates than banks and other commercial financing channels. Equally, PPPs are not necessarily more efficient unless they are carefully specified and professionally managed. Setting up and managing these complex mechanisms is a challenging task.

PPPs financing should not be treated as ‘off balance sheet’ borrowing. The rules set by Eurostat only allow PPPs to be treated in this way in exceptional circumstances, and it should be recognized anyway that economically an obligation has been incurred, even if accounting treatment were to allow it to be off balance sheet.

Different types of PPP

There are a range of possible types of PPP actually being used in Europe at present for large projects:

Model	Advantages	Disadvantages
1. "Public-public"	Point responsibility Easy to renegotiate building provision	FM not always bundled Artificial separation of public entities
2. Accommodation PFI	Point responsibility Very well developed Many variants	Rigid contracts
3. Hospital JV	Point responsibility Alignment of building & services	Contractual complexity
4. Privatization	Off state balance sheet Efficiency/quality gains	Loss of public control
5. Population full service	Integration of primary & hospital Cost certainty	Loss of transparency, cost information, control

The impact of the economic crisis

The world economic crisis has some significant implications for the financing of capital and the development of public private partnerships (PPPs). Both equity and debt finance through this route may be more difficult to find. It is presently more expensive, particularly as banks are less willing to lend for the longer periods required for hospital building programmes. The state of economies in Europe mean that the very high levels of national fiscal debt will take a long time to pay off, and there is a strong likelihood that this will inhibit economic growth. Further, beyond the current crisis, European economies will have to divert increasing state resources to fund the “baby boomer” generation’s pensions, health care and social care. All this will inhibit the availability of public finance, including for capital investment in the health care sector and elsewhere, which will make private capital very useful. The assets created by PPP will in their turn be attractive to, for example, pension funds. In sum, the future for PPP is bright.



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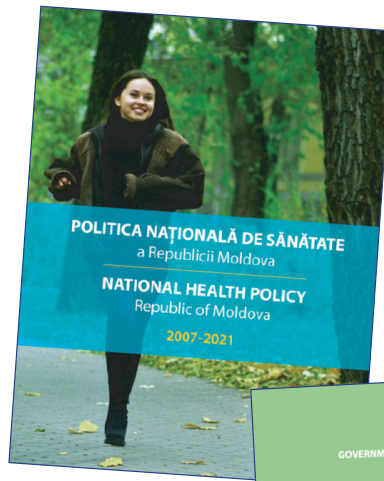
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