**Programme for Results**

**Health Transformation Project**

**Moldova**

**Environmental and Social Systems Assessment**

1. **SECTOR CONTEXT AND PROGRAMME DESCRIPTION**

The Government of Moldova and the World Bank are currently engaged in the preparation and development of a Program-for-Results (PforR) loan named *“Health Transformation Project”.*

Health sector development in Moldova is guided by the 2007-2021 National Health Policy that was developed in accordance with WHO recommendations and involved the active participation of all relevant ministries, authorities and institutions; civil society; professional organizations in the field of health; and international development partners. Discussion in society around the National Health Policy has been encouraged by the Government of Moldova.

The policy is further elaborated and operationalized by the 2008-2017 National Health System Development Strategy. This PforR operation is in line with the National Health Policy and National Health System Development Strategy that form together a robust reform agenda for the coming years with the following objectives (i) continuous improvement of population health; (ii) financial risk protection; (iii) reducing inequalities in the use and distribution of health care services; (iv) enhancing user satisfaction; and (v) restructuring the health system to improve performance and population health regardless of limited resources. To achieve reform objectives, the National Health System Development Strategy identifies four sub-programs of activities (also known as “sections”)

**Section 1**: Improve the management/stewardship of the health system. This sub-program includes interventions to: (i) increase the capacity of the MOH, MOH-affiliated institutions and local health authorities, (ii) improve communication mechanisms, (iii) strengthen multi-sectoral collaboration for better health, (iv) increase the involvement of civil society, and (v) bring national health legislations to the level of EU standards.

**Section 2:** Improve the funding and payment mechanisms for health services. This sub-program includes interventions to improve: (i) health funding, (ii) mechanisms for payment and contracting of services and (iii) equity and transparency of resource allocation as well as financial protection.

**Section 3:** Organize and provide health care services to meet the people’s health care needs. This sub-program includes interventions to (i) promote integration and continuity of health services, (ii) develop priority sectors of the health system with large impacts on population health, and (iii) improve quality of care and level of patients’ satisfaction.

b Generate and ensure the necessary resources of for the health system. This sub-program includes interventions to: (i) efficiently manage human resources for health through rational use of existing staff as well as other pre-service and in-service activities; (ii) strengthen the technical and material base of the institutions and facilities; and (iii) rationally manage the drugs provision.

The reform objectives in healthcare sector have been outlined in the Policy Roadmap for Acceleration of Healthcare Reforms[[1]](#footnote-1) aimed at fostering reforms implementation within 2012-2014 and are aligned to priority interventions stipulated in the Government Action Plan – European Integration: Freedom, Democracy, and Welfare (2011 – 2014).

In November 2013 the Government of Moldova embarked upon extending the scope of and lifting the significance of the Roadmap by developing a new Healthcare Reforms Strategy paper 2020 incorporating the main priorities set out in the Policy Roadmap aligning it to the WHO Health 2020 policy framework. The new Healthcare Strategy paper 2020 is being finalised and shall be passed through the Government in the first half of 2014.

Besides the above-mentioned key planning documents, there are some 16 ongoing specific national programmes and policies in healthcare sector. In addition to the above, in November 2012 the National Health Insurance Company (hereinafter as CNAM) has approved its institutional development strategy which encompasses important interventions in the area of health financing, thus greatly affecting the health system in general.

A Medium-Term Budgetary Framework (MTBF) is prepared by the Government on a rolling basis to finance the implementation of all the Strategies and programmes in the healthcare sector.

**The Program Development Objective** of this bank-supported PforRis to contribute to the reduction of population health risks (with a strong focus on non-communicable diseases) and improved efficiency of health services in Moldova[[2]](#footnote-2).

The proposed four-year operation will be aligned to the National Health System Development Strategy 2007-2021 (hereinafter as the Strategy and support the first three sections of the Strategy and is envisioned to correspond to 6 sub-programs of the MTBF, namely:

1) Health Policies and Management;

2) Administration of National Health Insurance Fund;

3) Monitoring and Evaluation of Health System;

4) Public Health,

5) Primary Care and

10) Hospital Care.[[3]](#footnote-3)

A set of Disbursement-linked Indicators (DLIs) which corresponds with the sub-programs is developed to form the basis of disbursement.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Indicators** | | **Unit** | **Baseline** | **Target Values** | | | |
| **Yr 1** | **Yr 2** | **Yr 3** | **Yr 4** |
| **PDO Indicator 1:**Reduction in smoking prevalence amongst young people | | % | 13.4% (2008)  (to be updated with GYTS data available early 2014) |  | 12.0% |  | 10.0% |
| **PDO Indicator 2:**Increase in the percentage of adults with hypertension whose blood pressure is under control | | % | 10%  (to be updated with STEPS data available early 2014) |  | 12% |  | 15% |
| **PDO Indicator 3:**Reduction in out-of-pocket expenditure as percentage of household expenditure in the poorest 40% of the population | | % | 6% |  | 5% |  | 4.5% |
| **PDO Indicator 4:**Reduction in annual hospital admissions/discharges for acute care per 100,000 persons | | # | 17.64 (2012) | 17 | 16.5 | 16 | 15 |
| **PDO Indicator 5:**Reduction in the number of acute hospital beds per 100,000 persons | | # | 494 (2012) | 490 | 480 | 450 | 420 |
| **Intermediate Results Indicator 1:**Percentage of primary care centers implementing full-feature primary care information system (including e-prescription, noncommunicable disease management, and pay for performance features) | | # | 0 | 20% | 40% | 60% | 80% |
| **Intermediate Results Indicator 2:**Increase in the average reimbursement rate of generic, first line medications for the three main categories of antihypertensive drugs in the drug benefit package from 50% to 70% | | % | 50% | 70% |  |  |  |
| **Intermediate Results Indicator 3:**Revised performance-based incentive scheme in primary care, including (i) performance indicators and (ii) counter-verification methods | | Y/No | No | Revised scheme | Counter-verification of a random subset of FM providers carried out by NGO | Counter-verification of a random subset of FM providers carried out by NGO | Counter-verification of a random subset of FM providers carried out by NGO |
| **Intermediate Results Indicator 4:** Introduction of performance-based incentives to improve (i) efficiency and (ii) quality of care in hospitals | | Y/No | No | Incentive program designed: Yes | Pilot of incentive program: Yes | Contracts signed with all hospitals: Yes | Contracts signed with all hospitals: Yes |
| **Intermediate Results Indicator 5:**  Use of updated DRGs for hospital payments | Y/No | No | Updating DRG using country data | Updated DRG accounting for 50% of hospital payment | Updated DRG accounting for 60% of hospital payment | Updated DRG accounting for 70% of hospital payment |
| **Intermediate Results Indicator 6:** Increase in the proportion of public hospitals in Chisinau which are under common management | % | 0 | 10% | 20% | 30% | 50% |
| **Intermediate Results Indicator 7:** Approval of the new strategy which concerns (i) regionalization of hospitals (ii) common management for public hospitals in Chisinau and (iii) establishment of a university hospital | Y/No | No | Approval of the strategy |  |  |  |

Furthermore, the PforR operation is aligned with priority interventions in healthcare identified by the Government in the relevant specific healthcare programmes, such as: NCD control strategy, Tobacco control programme, Healthcare Reforms Acceleration Roadmap, e-Health strategy, CNAM institutional development strategy, etc.

1. **ENVIRONMENTAL AND SOCIAL SYSTEM ASSESSMENT.**

To inform preparation of the PforR operation, the World Bank conducted a comprehensive Environmental and Social System Assessment (ESSA) of the existing country environmental and social management systems.

This report presents the findings and recommendations of the ESSA exercise. The report is organized in seven sections, as follows:

**Section I** presents the general background to the Program and the ESSA exercise as well as provides a description of the proposed Program for Results Operation.

**Section II** describes the scope and methodology of the Environmental and Social Systems Assessment process conducted to inform design and preparation of the Program for Results Operation.

**Section III** providesa brief introduction to the key elements of the health sector in Moldova and the roles of the key stakeholders Program

**Section IV** examines the potential environmental risks of the proposed Program.

**Section V** examines the potential social effects of the proposed Program.

**Section VI** describes existing environmental and social systems currently in use in the health sector to address the environmental and social effects of the proposed Programme for Results.

**Section VII** presents the ESSA actions proposed for inclusion in the overall Program Action Plan.

## Scope

The Program for Results financing instrument is a new form of World Bank financing that aims to help countries design and deliver their own development programs. To do this, PforR links disbursement to verified achievement of results.

Associated with the PforR financing modality is a different approach to assessing and addressing environmental and social effects related to the Program. With standard Bank investment lending operations, the Borrower is required to comply with the set of World Bank Safeguard Policies applicable to the project or program and prepare the relevant safeguard instruments to avoid, mitigate and manage the environmental and social impacts of a project or program.

For PforR operations, rather than having the Borrower apply the standard set of Bank environmental and social safeguard policies, early in Program preparation, the Bank task team is responsible for conducting a comprehensive assessment of the country systems in place for managing environmental and social effects (defined as benefits, impacts and risks) associated with the proposed set of Program related investments. This assessment, called the Environmental and Social System Assessment (ESSA), also assesses government’s institutional capacity to plan, monitor and report on environmental and social management measures. The findings of the ESSA inform preparation of the Program Action Plan that government will use to bridge any significant gaps in the existing environmental and social management system with respect to the sustainability principles of the PforR Operating Policy (OP/BP 9.00)[[4]](#footnote-4). The Bank provides implementation support as warranted for the implementation of agreed program action plan.

Specifically, the ESSA exercise is designed to consider the consistency of the existing country systems with the proposed PforR operation along two dimensions: (1) systems as defined in the legal and regulatory framework of the country; and, (2) capacity of the Program institutions to effectively apply the environmental and social management systems associated with the Program’s environmental and social effects as well as the proposed set of actions in the Program Action Plan that attend to the major gaps in the system as identified in the ESSA with respect to the six core principles of OP/BP 9.00.

The six core principles that guide the ESSA analysis are presented in the Program-for-Results financing guidelines (OP/BP 9.00) and include:

**Core Principle 1: General Principle of Environmental and Social Management**. This core principle aims to promote environmental and social sustainability in Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program’s environmental and social impacts.

**Core Principle 2: Natural Habitats and Physical Cultural Resources**. This core principle aims to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program.

**Core Principle 3: Public and Worker Safety**. This core principles aims to protect public and worker safety against the potential risks associated with: (i) construction and/or operation of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

**Core Principle 4: Land Acquisition**. This core principle aims to manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist affected people in improving, or at the minimum restoring, their livelihoods and living standards.

**Core Principle 5: Indigenous Peoples and Vulnerable Groups**. This core principle aims to give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.

**Core Principle 6: Social Conflict**. This core principle aims to avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

In analyzing a program for consistency with the sustainability principles of OP/BP 9.00, the ESSA is intended to ensure that programs supported by PforR financing are implemented in a manner that maximizes potential environmental and social benefits and avoids, minimizes or mitigates any and all adverse environmental and social impacts and risks. Essentially, the ESSA process seeks to improve institutional performance related to the program’s development objectives.

For this PforR operation, the ESSA examines Moldova’s existing environmental and social management systems as applicable to the heath sector and, in particular, to the set of activities supported by the Health transformation Pfor R.

The ESSA describes the potential environmental and social effects associated with the PforR supported activities. The ESSA also assesses institutional roles and responsibilities as related to Health Transformation PforR implementation and describes current capacity and performance to carry out those roles and responsibilities. The ESSA also considers public participation, social inclusion, and grievance redress mechanisms in place and as applied in PforR activities.

It is important to note that the ESSA will get updated based on the feedback received from stakeholders and implementation experiences of the Program for Results operation. The following sections present the steps undertaken in the ESSA preparation process to date and what the forthcoming steps include (e.g., Stakeholder consultations).

## Methodology

In order to assess the existing systems as well as to analyze how these systems are applied in practice, the process of preparing the ESSA has drawn on a wide range of data, some of which are ongoing as the ESSA is further refined.

Inputs analyzed for this ESSA have included the following elements:

***Desk Review of policies, legal framework and program documents****:* The review examined the set of national policy and legal requirements related to environment and social management in the health sector. The review also included supervision documents from previous and ongoing World Bank project and programs in the health sector, namely the Health Services and Social Assistance Project.

***Institutional Analysis***: An institutional analysis was carried out to identify the roles, responsibilities and structure of the relevant institutions responsible for implementing the PforR funded activities, including coordination between different entities at the national, regional and local levels. Sources included: existing assessments of key institutions focusing on environmental and social assessment and management processes. Available literature and documents were also consulted to assess health care waste management system’s capacity and performance and access to health care services.

***Interviews****:* Interviews were held with various GoM ministries and authorities, including those at the national and regional level, as well as technical experts involved with environmental and social impact assessment and management in the health sector. Specifically, formal interviews were conducted with relevant personnel in the MoH, CNAM, and key staff in the Ministry of Environment, experts in the NCPH. In addition, interviews were held in primary health care facilities to assess strengths and gaps in effectively managing environmental effects in the sector at the regional and local level.

1. **Stakeholder Consultation Process**

The ESSA process includes stakeholder consultations and disclosure of the ESSA Report following the World Bank’s Access to Information Policy[[5]](#footnote-5). At present, the ESSA consultation process has just begun and is embedded in the Program consultation process.

Going forward, the Program team will develop a comprehensive consultation process for the ESSA report. Likely aspects of such a process will include a stakeholder workshop which participants drawn from civil society, program implementers at different levels and development partners supporting health sector.

1. **KEY STAKEHOLDERS MAPPING**
2. **The lead partner and main coordinator of the PforR implementation is Ministry of Health**

The measures under the PforR operation are to be implemented by both, the Ministry of Health and the National Health Insurance Company (CNAM) who are equally important project partners.

The Ministry of Health is responsible for health policy and the development of legislation regulating the organization and provision of health services. It is also responsible for (i) quality assurance and establishment of minimum quality criteria, (ii) the definition of the benefit package, (iii) resource planning and the use of capital investments, (iv) surveillance of population health, (v) setting public health priorities, (vi) managing of national health programmes (including medical education), as well as (vii) promoting Health in All Policies.

A series of basic functions of the Ministry of Health relates to ensuring the preparedness of the health system for efficient response to public health emergencies, to implementing international health regulations and to collaborating with international organizations and structures in the field of health.

The Ministry of Health is also tasked with ensuring transparency and responsibility in the health system in order to achieve measurable results; with executing the Ministry of Health budget and the budgets of the subordinated institutions, including providing systematic and published information on budget execution and performance; and with improving the management of public finances in the field of health. For this purpose, from 2009, the Ministry of Health has had its Internal Audit Service, which conducts audit activities in subordinated institutions.

**2. National Health Insurance Company (CNAM)**

The CNAM is a state not-for-profit organisation with financial autonomy that was created by the government in 2001. Its main responsibility include (i) Mandatory Health Insurance (MHI) of the population; (ii) contracting health service providers for the provision of services to insured people; (iii) verifying that the provisions of the contracts correspond to the actual volume, terms, quality and costs of health care provided, as well as managing MHI resources within the limits of the contracted services; (iv) protecting the interests of insured individuals; (v) case validation; and (vi) concluding re-insurance contracts.

The CNAM pools payroll and state budget contributions into a single pot for the reimbursement of health services provision. CNAM’s resources are distributed between five funds:

1. The Main Fund for Reimbursement of Health Services
2. The Reserve Fund
3. The Fund for Prophylactic Measures
4. The Fund for the Development and Modernization of Public Health Service Providers
5. The Administrative Fund for the MHI system.

The CNAM as an independent state agency has an Administrative Council, Executive Department and Control Council. The composition of the Administrative Council is approved by the government and includes 15 members: one representative from parliament, one representative from the President’s Office, five representatives from the government (including one each from the Ministry of Finance, the Ministry of Health and the Ministry of the Economy), three representatives from the National Confederation of Employers, three representatives from the National Confederation of Trade Unions, one representative from the health workers’ professional organization and one representative from a patient rights organization. The activities of the Administrative Council are led by its chair, who is usually a government representative.

The Executive Department is responsible for the CNAM’s operational and ongoing administration within the limits of competencies given to it by the Administrative Council and by the Regulations of the CNAM, which are approved by government. The activity of the Executive Department is led by the Director General, who is appointed for a five-year period by government decree on the recommendation of the Administrative Council, which selects him (or her) on a competitive basis. The CNAM covers the whole territory of the Republic of Moldova through 12 territorial agencies, coordinating and supervising their activity within the existing legal framework.

**3. Other key implementing agencies**

***3.1 National Centre of Health Management (NCHM)***

The NCHM is financed by and subordinated to the Ministry of Health. It was created by the government in 2007 through the reorganization of the Scientific and Practical Centre of Public Health and Sanitary Management.

NCHM’s basic functions include (i) collection, standardization and analysis of statistical information on public health; (ii) provision of the scientific strategy underpinning development of the health system; (iii) development of standards, norms and regulations for health care; (iv) monitoring of health service markets and the technical and material basis necessary for the provision of health services; and (v) creation of automated systems for the collection of operational information on the population’s health.

The NCHM is the primary source of statistical information on most of health system indicators in Moldova.

**4. Other relevant stakeholders in the reform process**

***4.1 Parliament of the Republic of Moldova***

According to the Constitution of the Republic of Moldova (1994), parliament establishes the structure of the national health system and the means for protecting the physical and mental health of individuals. Through legal acts, parliament has the power to reorganize the national health system and pharmaceutical activity as per the Law on Health Protection (No. 411-XIII, 28 March 1995). Parliament approves the annual Law on State Budget (which includes the budget of the Ministry of Health) and the annual Law on Mandatory Health Insurance Funds.

The *Parliamentary Commission on Social Protection, Health and Family* examines draft laws and proposals as related to the health sector, develops reports or commentaries, conducts parliamentary investigations and debates, and takes decisions on cros-sectoral health issues.

***4.2. The Government***

The Government of the Republic of Moldova promotes state policy for population’s health, secures socioeconomic conditions and creates the technical and material basis as well as special funds for the development of health care.

The Government also manages, coordinates and approves regulations and regulates the activities of the Ministry of Health, the National Health Insurance Company (CNAM) and any other government structures that have their own parallel health networks[[6]](#footnote-6).

***4.3. Other ministries and government agencies***

*The Ministry of Finance* has a strong influence on the process of developing the health system budget through departments that examine state budget proposals for health and forecasts for MHI indicators, which are identified, developed and submitted by the Ministry of Health.

The Ministry of Finance has the key role to play in ensuring the PforR funding to the Health Sector.

*The Ministry of Education* coordinates and monitors methodological and educational activity at higher, postgraduate and vocational training institutions in medicine and pharmacy. It approves overall curricula structure and ensures its compliance with general educational standards. The Ministry of Health approves the content.

The Ministry of Education also promotes healthy lifestyles in statutory education institutions as a compulsory subject within the civic education curriculum and through “education for health” and “education for family life”, which are optional subjects in secondary schools.

*At the current time, there are several key governmental actors in health: Parliamentary committee on health and social protection (Mr. V. Hotineanu – one of the founders of the Liberal-Democratic party), Ministry of Health (Mr. A. Usatii), National Health Insurance Company (Mr. M. Buga) and the Health Trade Union (Mr.Benu).*

***4.4. Regional/local administrative units (or local health authorities)***

Three of the thirty-five administrative authorities in the Republic of Moldova (Chisinau municipality, Balti municipality and Gagauz-Yeri) have local health authorities responsible for local regulatory aspects, but they are not empowered to procure health services for local population and the service providers are not directly subordinated to them. However, being the founders of healthcare institutions, the Municipalities are partly involved their governance.

Overall, the legal framework regarding the competencies of local authorities in health is confusing and contradictory so the efficacy of health authorities in Chisinau, Balti and Gagauz-Yeri is not optimal.

***4.5. The Health Department under the Mayor’s Office***

The Health department under the Mayor’s office is a department of the Chisinau Municipality Council aimed at implementation of the following objectives: (i) administration of the health system in Chisinau while promoting Government policy in the field of ensuring population with healthcare services, (ii) healthcare policy development and planning in Chisinau Municipality (iii) ensuring implementation of prevention activities and early identification of diseases by healthcare providers, (iv) co-ordination of the Municipal healthcare providers in case of natural disasters, epidemics, other accidents, etc.

Being the founder of some number of primary and secondary healthcare institutions in Chisinau Municipality, the day-to-day activity of the Healthcare Department rests with capital investment planning, co-ordination of health services provision by these medical institutions and implementation of decisions, orders and instructions of the Chisinau’ Mayor. In its activity, the healthcare department is guided by the existing Government strategies and programmers in the healthcare sector.

***4.6. National Centre of Public Health (NCPH)***

A new Law on State Surveillance of Public Health (No. 10-XVI) was approved in 2009, marking a shift from the old-style sanitary-epidemiological system focusing on communicable disease control and sanitary inspection to a more modern approach for public health, with more emphasis on non-communicable disease control, health promotion and disease prevention. The NCPH[[7]](#footnote-7) is located in Chisinau, 2 municipal centres of public health (in Chisinau and Balti) and 34 district centres of public health, plus 7 departmental cent res of public health in the parallel systems. NCHP’s 36 territorial centres of public health, which are located in all districts across the country, are supervised by the Chief Sanitary Doctor, who is a Deputy Minister of health and also heads the State Surveillance of Public Health Service (SSPHS).

The NCPH coordinates technical and methodological activities in the health sector directed at the development and implementation of strategies for health protection and promotion, prevention and control of communicable and non-communicable diseases, as well as specific public health policies at the national level. The territorial centres of public health have similar responsibilities at the local level.

The NCPH has a special unit responsible for environment and health issues and the surveillance of environmental factors influencing health. Data collection on environmental factors is carried out as part of “socio-hygienic monitoring”. The NCPH prepares an annual report on environment and health.

In July 2007, the Chief Sanitary Doctor approved a decision banning the advertising of calorie-dense products in institutions for children.

The SSPHS monitors the observance of occupational health legislation and evaluates temporary disability and occupational diseases.

The NCPH has a special registry of occupational diseases. The NCPH produces an annual report on workers’ health in relation to risk factors at their workplaces, which is published in the journal Labour Security and Hygiene and on the NCPH web site. The report is also sent to the National Social Insurance Fund.

***4.7. National Council for Evaluation and Accreditation in Health***

The National Council for Evaluation and Accreditation in Health was created by the government in 2002 and is a self-financing institution. Basic functions of the Council include (i) evaluating compliance of health and pharmaceutical institutions and the activity of enterprises with the relevant standards and, (ii) based on this evaluation, providing official recognition that a health and pharmaceutical unit and its personnel are competent to conduct activities specific to its profile, in accordance with the standards and legal provisions in the field of medicine and pharmacy.

***4.8. The State Medical University “N. Testimiteanu”***

The Medical University is the only one medical education institution that provides graduate and post graduate and further continuous professional training to healthcare professionals in Moldova. The University together with the Ministry of Health are the founders of the School for Public Health that provides continuous training for health workers. Most of professors and resident students of the Medical University exercise medical practice in the clinical and research departments established under tertiary healthcare institutions thus contributing to a stronger linkage between the network of health professionals and academic society. Furthermore, University professors are part of specialised expert committees established under the Ministry of Health.

***4. 9. Organizations representing patients/consumers***

There are some organizations representing patients’ interests in the Republic of Moldova. Most are active in the field of chronic and rare diseases, such as diabetes, arthritis, haemophilia, cystic fibrosis, phenylketonuria and others.

There are also organizations promoting access to information and protecting the rights of patients and disabled people, but these are mostly oriented around services for people living with HIV, TB or mental illness. The focus and results of their activities depend heavily on the individuals leading them and on the financial resources available – most of which come from international partners.

***4.10. Professional and providers’ associations***

The *Association of Nursing of the Republic of Moldova*, is the most active professional association which represents nurses from different fields: paediatric nursing, oncology, psychiatry, community nursing and others. The association was founded in 1994 and has 34 branches across the whole country. Since 1997, it has been a member of the WHO European Forum of Nursing Associations.

The *League of Doctors of the Republic of Moldova* was created in 1999 and aims to protect the professional interests of doctors and to define the criteria for fulfilling clinical functions. The League has a delegated member in the Administrative Council of the NHIC.

There are also specialized associations for family medicine, surgery, oncology, psychiatry and narcology, rheumatology, orthopaedics and traumatology, ophthalmology, and so on. The ability of such organizations to promote members’ interests and the participation of these bodies in decision-making processes depends heavily on how active the leadership of the association is and on the financial means available to them.

In November 2013 the Parliament approved the *Law on the establishment of Medical Collegium*. The Law provides for some controversies and overlaps in terms of delegated functions, such as exercising the responsibilities of some public institutions (e.g. the National Council for Evaluation and Accreditation in Health, Ministry of Health), or duplicating functions of other professional associations. The Medical Collegium also intends to act as sanctioning body for medical malpraxis, however there have been not yet developed administrative procedures in respect of this mandate.

The Law is enforced since January 1, 2014 and shall have in place all related by-laws and regulatory acts by end April 2014.

The ***Sanatatea*** (the health trade union), which has sufficient resources and a well-organized structure at national and local levels. Sanatatea plays an important role in protecting the rights of its members as well as promoting their working, professional, economic and social interests.

***4.11. Civil Society Organizations (CSOs)***

A large network of CSOs is active in HIV/AIDS and TB control and in supporting children’s health, particularly for those with disabilities. CSOs are active participants in the development of health policy and their contribution to the development of partnerships with the civil society and in monitoring health reform is increasing.

There are some think tanks such as Centre for Health Policies and Studies (NGO PAS) and Centre for Strategic Policy and Analyses in Health involved in advocacy for policy reforms and implementation of health outcomes monitoring, as well as generating knowledge on specific issues related to reform implementation.

In addition, the media has an increasing role in raising awareness about the reform process, which greatly influences public opinion on reforms, particularly in rural areas. There are frequent TV programs or interviews on various problems related to health reforms.

***4.12. Private Healthcare Providers***

Since 2009 when national legislation eliminated barriers to attracting private investors in healthcare sector (e.g. adoption of a Law on public-private partnerships, etc) the number of private healthcare providers has been steadily growing. Although private medical institutions are not participating in the mandatory health insurance scheme, CNAM is legally empowered to purchase healthcare services from the accredited private providers using the same fee rates as for public hospitals. Currently the range of healthcare services provided by private companies is limited mainly to ambulatory care, diagnostics and pharmacies. Although being relatively small-size, many of private healthcare providers have strong linkages with public sector thus all together being in the ability to affect significantly healthcare policy pathways.

**5. International Development Partners**

There are many international organizations active in the health sector of the Republic of Moldova and their role was and is essential in the promotion and support of health system reform.

In 2011, Moldova received US$ 51.9 million in official development assistance for health; of which, 20-30% was in the form of technical assistance.

The EU, WHO, World Bank, Swiss Development Cooperation Agency, Japan International Cooperation Agency (JICA) and Government of Austria are currently the key development partners active in the health sectors. An important counterpart in the reform process is WHO, who recently implemented EU-funded TA attached to budget support in healthcare for 2011-2012. WHO has committed to assist the Republic of Moldova in selecting and applying best practices and strategies of tobacco control at the country level. WHO plans also to lead the way for development of strategic legal and policy frameworks, like new tobacco control legislation.

The Bank’s team will continue its close collaboration with WHO and other Development Partners active in the health sector to coordinate policy dialogue and TAs for the country.

1. **POTENTIAL ENVIRONMENTAL RISKS**

Potential adverse environmental effects of the Program are likely to be related mostly to: (a) the generation of health care wastes (HCWs) which are not managed properly[[8]](#footnote-8); and (b) improper disposal of pharmaceutical wastes (PhWs) which would have direct impacts on population health and the environment.

**1. Health care waste management**

The scale of the problem. Based on available data about 75-90% of HCW (of a total of 15.7 thousand tones) are similar to communal wastes and only about few per cent of about 2.75 thousand tones are infectious and 314 tones – toxic . Furthermore annually about 90 million of syringes and 6 million of perfusion systems are used in medical institutions in the country. These wastes are extremely harmful for the health of population and for the environment.

* 1. ***National policy with regard to HCW.***

The GoM and MoH, being aware of the HCW problem during last decade made a real effort to improve the HCW Management (HCWM) and align it to the best international practices. Along with the necessary regulatory framework (see point 24) it has adopted a series of National Strategies and Action Plans which direclty relate to HCWM. The National Program for the Valorisation of Industrial and Domestic Waste adopted by GoM in 2000 was aimed at minimizing domestic waste generation and valorising waste with the introduction of a recycling system and contains a special section on HCWM, specifying several priority activities. This Program was recently replaced by a new Strategy, which also has a section dedicated to HCWM, based on what the MoH issued Order No. 652 from 06.06.2013 “Concerning implementation of National Strategy for waste management in the Republic of Moldova for 2013-2027”. The main issues of HCWM are specified in other adopted policy documents and in particular in the National Action Plan for syringes safety in the Republic of Moldova (2004-2010). These issues are also periodically discussed at the MoH Board, where relevant decisions on improving the situation in the domain are taken. Such discussions have been organized in January, 2001; August, 2004; July, 2006; and in May, 2011.

* 1. ***Local and HFs HCWM action plans.***

Based on mentioned above GoM Strategies and Action Plans as well as per adopted in 2001 special Regulation on HCWM, the rayon and local medical institutions have to develop local action plans on HCWM. The last analysis done by the MoH in 2011 show in most of the rayons (27 out of 34) such program have been developed. At the same time, as it was presented at the MoH Board meeting in 2011, in terms of allocated financial resources for their implementation there are serious problems, - in most cases have been provided with just several thousand or ten thousand Moldovan Lei. The key issues reflected in those action plans relate to dividing responsibilities and ensuring necessary segregation of produced HCWs.

*Study on HCWM done by Regional Office of WHO.* In January 2004, the Regional Office for Europe of the World Health Organization (WHO) supported the MoH to develop an integrated Health-Care Waste Management (HCWM) Plan for the Republic of Moldova. The document is a comprehensive one and contains a detailed analysis of the situation in the domain, including different aspects: regulatory framework, policies, existing practices, and identifying priority activities to be undertaken. While it contains for some activities the magnitude of their costs, it didn’t provide clear understanding of all associated expenditures. This was the reason why the document wasn’t officially approved by the GoM. At the same time it is necessary to mention the main conclusions of the study and several proposed activities are still relevant to the current HCWM situation in the country.

* 1. ***Regulatory framework on HCWM*.**

The GoM has developed a substantial legal and regulatory framework for the safe management and disposal of HCW. Among most important regulatory documents in this regard are the following: (a) Law on industrial and domestic wastes (1997); (b) Law on sanitary-epidemiological control (1993); (c) Regulation for Medical Waste Management, approved by MoH and registered by the Ministry of Justice in January 2002 ; (d) Guidelines for supervision and control of noozomical infectious (2009); and (e) Sanitary Regulation in hygienic conditions for HCFs approved by the GoM (No. 663 from 2010).

*Regulation on Medical Waste Management.*

This document is divided into 8 chapters and provides requirements for hygienic and technical standards for hazardous HCW collection, temporary storage, transportation and disposal. The “Health-Care Waste” is defined as waste hazardous or not, generated by medical activities and include the following types: the anatomo-pathological waste, the infectious waste, chemicals and pharmaceutical waste (gathered into the same group), sharps and radioactive waste. The Regulation presents different disposal technologies but no details are provided on the standards that these technologies should meet. According to the Regulation all medical institutions in the country and their and staff must comply with this regulation. In particular they: (a) are accountable for the safe handling and disposal of HCW; (b) have the responsibility to identify adequate financial resources; (c) elaborate management strategies to prevent the production of hazardous HCW or minimize as much as possible the quantities generated; (d) implement HCWM plans setting-up internal rules and codes of procedures; and (d) precise duties and responsibilities of medical and ancillary staff, which include: (i) the minimization of the amount of HCW generated; (ii) the reuse and the recycling when it is possible; (iii) the segregation at source of hazardous HCW from non-risk HCW, (iv) the reduction of the costs associated with the management and disposal of HCW using single use items appropriately. Overall, as it is specified in the study done by the European office of WHO, this Regulation is simultaneously normative and informative, being at the midpoint between a Law and a Technical Guidelines. Although HCWM is thoroughly addressed in the Regulation, the document is not well structured and not adapted to the real economic situation of the Republic of Moldova. Based on that it was proposed it should be revised, taking into consideration mentioned issues.

*Hospital Regulations on HCWM.*

The proper management of HCW depends to a large extent on good administration and organization but also requires that adequate instructions be consigned in a formal document (e.g. a HCWM plan) and that the medical and paramedical staff be fully aware of their duties and responsibilities. The responsibility of the different components of the HCWM system is shared between the Hospital (or other medical facility) Director, who is directly in charge of the overall implementation of a safe HCWM system inside the HCFs; the Hospital Epidemiologist and the Hospital Head Nurse, who have the responsibility to supervise at hospital level the HCWM plan, the Medical Doctors and Nurses who directly ensure an immediate segregation of the HCW. The medical staff is personally accountable for the application of the Regulation for Medical Waste Management. They can be fined an amount of money, directly taken from their salary, if they do not respect the instructions contained in the plan.

*National Standards Related to HCWM.*

A significant number of standards exist in the Republic of Moldova, most of them were inherited from the Soviet Union period: standards for buildings design, hospital ventilation, natural and artificial lights, equipment and furniture, work of medical staff, maintenance or rooms, personal hygiene norms for patients and medical staff, sanitary conditions for food units, construction of new HCFs. Specific standards exist also for HCWM, providing instructions on: the location of HCW incinerators; the cleaning of hospital compound, the design of waste containers, and waste collection services. However, many of them are outdated and should be revised by the MOH because they are either obsolete or not practical. In this regard it would be necessary to have a long term strategy and an action plan for updating them and/or for designing new ones, harmonizing them with the EU legislation.

*Overall Conclusion on the existing regulatory framework.*

The legal and regulatory framework to ensure a safe management of HCW in the Republic of Moldova is relatively well developed. Although not complete, it can provide the necessary legal basis for a well-organized HCWM plan in each HCF as well as efficient control and monitoring procedures. At the same time it should be more specific to the Moldovan context and should be reviewed to stipulate more clearly the HCWM procedures that each HCF and each medical and paramedical staff should comply with, harmonizing it with the requirements of the EU legislation. One of important step in this regard would be revising the existing Regulation on HCWM and approving it at the GoM level.

* 1. ***Institutional capacity.***

The country has a clear institutional setup in the domain. The main responsibilities with regard to state policies and regulatory framework are assigned with the MoH and its division – National Centre for Preventive Medicine. The main controlling functions are delegated to the rayon Centers for Preventive Medicine which has to conduct necessary inspection of all HCFs in the country and provide relevant conclusions and recommendations. The implementation of the HCWM is full responsibility of the HCF staff. The conducted by the WB mission meetings and field visits show all involved parties have clear understanding about their roles and responsibilities as well as technical knowledge to deal with the HCWM. A very important role in this process plays the system of human capacity building organized by the MoH (see point below).

*HCWM capacity building.* Presented to the WB mission information shows MoH keeps in its attention the capacity building for HCWM, organizing periodically training for HCFs staff. Last such trainings have been organized on 16.12.2011; 30.11.2012. Relevant training was organized also in 2009 and 2010, with the main focus on the implementation of newly adopted Ghidelines for supervision and control of noozomical infectious (2009) and, of the Sanitary Regulation in hygienic conditions for HCFs. Simultaneously the HCFs management require from its staff to improve their knowledge on HCWM individually, based on self-learning. Based on provided training and self-learning the MoH and HCFs management periodically organize staff examination on HCWM requirements. The data presented by the MoH show for 2010 shows about 28,3 thousand of medical staff received training and about 73% of them proved adequate knowledge in this regard.

* 1. ***Efficiency of HCWM.***

The overall conclusion of the WHO study concerning implementation of HCWM is that the practices that are currently applied in the different HCFs of the country are still risky and should be more in accordance with the international procedures recommended by the World Health Organization and that remains many things to be done to reach acceptable international standards for HCWM in the Republic of Moldova. This is mainly due to the lack of affordable handling equipment and disposal infrastructures within the medical institutions. Sometimes the HCFs experience lack of means (waste containers, colour plastic bags, transportation means adequately equipped, disposal facilities, etc.) which jeopardizes significantly the safe implementation of HCWM requirements. Furthermore, the staff, in charge of the waste collection and/or the on-site disposal is under-equipped (no apron, mask or sometimes gloves). To similar conclusions came also WB representatives conducted missions in 2009, 2011 and 2013 in Anenii Noi, Hincesti and Nisporeni rayons. The missions have seen generally the HCFs follow up on good measures practiced in Moldova for safe management of sharps (discarded needles/syringes, scalpel blades, empty glass vials, or other sharp objects), collecting them in special containers (the mission has seen such containers in all visited facilities), after what they are burned in a stove outside the facility and then disposed on the landfill. At the same time the WB representatives have been informed about the lack of necessary equipment and suppliers as well as of strong need for addressing the infectious wastes. As known HCFs may generate a stream of non-infectious solid and liquid waste, which if improperly handled these materials can negatively affect terrestrial and aquatic ecosystems and expose local residents to health hazards. This issue, as recognized by practically all health care specialists in the country as well as by WHO study represent one of most critical problem in the HCWM. For the neutralization of infectious wastes in the country currently the HCFs use in some cases their autoclaving, burring or burning. While all these means are generally accepted, the existing practice in Moldova is still quiet dangerous as: (a) the existing autoclave equipment is outdated, doesn’t exist and doesn’t have enough capacity to cover the current needs in all HCFs; (b) HCWs burring at municipal cemeteries is well organized only in Chisinau HCFs, while in most other localities is done from time to time and using not specially equipped transportation means, and, in some cases, burring of the anatomo-pathological wastes is done on special burial pits for animal carcases; (c) in the country there no one well-functioning HCW incinerator, being used in most cases improvised stoves, located on the territory of HCFs which do not correspond to national environmental requirements. Sometimes in an attempt to mitigate the lack of equipment and infrastructures for HCWM, the medical and paramedical staff conducts disinfection of hazardous HCW before throwing them together with the domestic waste or storing them into cardboard boxes. These practices remain incorrect and the basic aseptic measures fail to be applied: no systematic hand washing once the bins are handled and transported within the wards; use of garbage chutes (a nest for pathogens) in the largest hospitals, waste containers not lined with adequate bags; lids of the waste bins manipulated with no specific precaution.

*Overall conclusion regarding HCWM in the country.* Moldova has in place relatively well developed policy and legal framework on HCWM along with an institutional system which is generally adequate. There is a clear regulation for the safe management of HCW with standardized definition, as well as segregation, handling, transportation, storage and disposal procedures. Based on this framework the HCFs transposed its main requirements into hospital/medical institution rules that medical and paramedical staff attempts to respect and apply in the best way they can. Although the regulatory framework exists, it needs to be updated, taking into consideration of the best international practices and EU legislation in the domain, adapting it to the country’s conditions. At the same time the lack of adequate funding necessary to ensure the safe management of HCW jeopardizes the application of the HCWM requirements. The HCFs quite often lack necessary equipment - no adequate bag holders, no yellow PE bags or HDPE waste containers, no safety boxes, no adequate transportation equipment and sometimes, - necessary protective equipment for responsible for HCWM staff. Furthermore, there is no single disposal or treatment facility throughout the country to safely dispose the HCWs.

**2. Pharmaceutical wastes management (PhWM)**

***2.1. The scale of the problem*.**

Based on data provided by the National Agency for Drugs and Medical Equipment (NADME) annually in the Republic of Moldova are identified large amount of such wastes. The provided data show for 2012 there have been identified the following types and amount of PhWs: (a) 90.000 pills; 42886 solution; (c) 63036 injections; (d) 42518 capsules; (e) 13372 greases; (f) 43269 specie; (g) 60777 samples with dust; etc. The general trend is the amount of PhWs is slightly growing.

***2.3. Regulatory framework.***

The PhWM is done in accordance with the Ordinance Nr. 9 from 06.01.06 **"**on the Safe Disposal of Outdated, Falsified and Unidentified Pharmaceuticals”. By this ordinance it was approved a special Regulation, which specifies the procedures, roles and responsibilities for disposal of pharmaceutical waste in a very strict manner, providing also guidelines for their encapsulation and final disposal at the municipal landfill. Per stipulations of the Regulation, all pharmaceutical owners have to assess the need for PhWs disposal individually in each concrete case, transporting them in about that in 2 months’ time to NADME which is located in Chisinau city with all associated documents. The decision concerning their disposal is the responsibility of a specially created under the NADME Commission. The Regulation also specifies that a strict monitoring system has been set-up to avoid any misuse of pharmaceutical wastes. All pharmaceutical waste that is outdated or does not respect standards and must be disposed of is listed by the hospital pharmacy or by the drugstore in a specific sheet. Among requested information which should be specified in that sheet are the following: the name of the pharmaceutical unit where it is generated, the name of the drug, the type of pharmaceutics, the concentration, the packaging type, the serial number, the quantities, the cause for unused. The pharmaceutical administration must organize the transportation to NADME, present the request and must pay for it. NADME verifies and confirms the necessity to dispose of the drug.

***2.4. Institutional setup and capacity.***

According to its approved by the GoM (no 71 from January 23, 2013) the NADME has as one of its main responsibility “organization, supervision and/or safe disposal of pharmaceutical wastes”. As the main decision body with regard to PhW disposal is assigned a special Commission, composed by the Chief of Quality control of NADME (as chairman); representatives from NADME, Chisinau Ecological Agency, from permanent Drugs Commission of the Republic of Moldova, and National center for Preventive Health. The Commission has in its responsibilities to analyze presented for disposal PhWs and to decide and approve disposal methods, carrying a strict evidence of disposed wastes, as well as to supervise the collection and disposal of the wastes. The main controlling institution in the domain it is the Pharmaceutical Inspectorate which in direct subordination of the NADME Director. For the purpose practical PhWs disposal in NADME structure was created a special division which is composed by 3 staff members. This unit is also responsible also to keep in its files all relevant information about the existing PHWs and their disposal.

***2.5. Payment for PhW disposal.***

The legislation in the domain specifies the PhWs disposal is done against relevant payment. In this regard, the MoH has adopted in 2006 a special Decision (no. 9 from 06.06.2006) where are specified the tariffs for different types of PhW disposal which should be covered by the owner of the wastes. As informed by the Chief of Waste Disposal Division of the NADME, while the current tariffs level is not high enough to provide opportunities for collecting necessary revenues for additional investments in the domain, they are sufficient to cover associated costs for Division’s staff costs and operation.

***2.6. The effectiveness of PhWM.***

The overall impression of the WB mission is the country has an efficient system in this regard. Pharmaceutical wastes are collected separately from the other categories of HCW, are under strict evidence and monitoring and quiet efficiently disposed. Furthermore, as was seen by the mission, by using cement and 15% of water they are well encapsulated in paper boxes (initially in plastic and/or metallic drums which was not practical and currently in cardboard boxes) in a central place in NADME facilities. After encapsulating the wastes are buried in a landfill located 30 km from Chisinau. The waste burring is observed at the site at landfill by the Chief of Division which makes sure after PhWs disposal at landfill they are covered by a soil cover. While in NADME the mission was presented with the information about all steps of PhWs disposal, starting from identifying them, until final disposal. In this regard the Division keeps in e-format all necessary documents: about the received quantity of wastes; their composition; all decisions of NADME PhWs Commission; about provided by waste owners payments; about type and quantity of disposed wastes; about made payments to municipality landfill administration, etc. Thus it is possible to conclude overall the system of PhWs disposal works quite efficiently in the country.

1. **PROGRAM’S POTENTIAL SOCIAL IMPACTS**
2. **The scale of the impact**

Major healthcare reforms were undertaken in the early 2000s, including a large reduction in hospital overcapacity (from approximately 300 hospitals in 2001 to 73 in 2012) and the introduction of mandatory health insurance and family medicine in 2004 and 2005 respectively. However, the reform agenda remains unfinished: there is still substantial overcapacity in the hospital sector that requires further optimization, primary care does not fully execute its gatekeeping functions, out-of-pocket expenditures remain high and non-communicable diseases continue to expand rapidly.

*Resettlement*: The reform process supported in the framework of the PforR is not supposed to cause any physical or economic displacement as it is focused mostly on the changes in the management systems. Land acquisition is not going to be required as the result of the Bank-supported reform.

1. **Social Risk Screening Exercise** was structured around the four main themes. **The first relates to potential internal and external resistances to changes foreseen by the Program**, notably, the PforR foresees system changes and upgrades in the ways of providing the health care services (following the defined healthcare path protocols and procedures) and accountability for them (e.g. quality monitoring and control).

Managing this change will require stakeholders at central level to handle the complexity of the processes: evaluating, planning and implementing actions; adopting appropriate tactics and strategies; making sure that the change is worthwhile and relevant.

As a rule, even if a change is endorsed, those affected by it want to understand why change is happening, when and how they will be affected.

All reform areas outlined in the PforR operation will ultimately lead to higher overall healthcare quality for the patients and better organized and managed system for the employees. Although these changes are overall in favour of patients the employees within the system may oppose to some specific changes, as overall improvements often come at the cost of some objective local loses.

Given that there is no culture of preventive visits to the doctor and general perception that to be treated efficiently one needs to be in a hospital, the reduction of the days patients spend in the hospital and moving to more efficient outpatient practises may create the perception of denial of medical assistance in the population.

The introduction of performance-based payment and cross checking on the quality of services delivered with patients may create the feeling of uncertainty and thus resistance in medical professionals.

Efficient change management planning, which includes also competent communication of the planned reforms measures and their overall advantages and fairness to different stakeholders, will be of critical importance for the Program success, i.e. for the success of the reforms supported by the Program.

1. **The second group of potential social impacts is related to social inclusion and equity in access to the health care services**.

*Health Financing.* Since 2004, health financing in the Republic of Moldova has been organized as MHI. Total health expenditure in 2010 was 11.7% of GDP. Based on revenue source, 40.3% of total health expenditure was from MHI contributions and 44.9% from OOP payments (WHO, 2012). Contributions from the working population come predominantly through payroll contributions of a fixed percentage of salary (7% in 2011 and 2012: 3.5% to be paid by the employee and 3.5% to be paid by the employer); the self-employed are expected to purchase their own cover for the year at a fixed price. The non-working population (14 categories including pensioners, students, children, registered unemployed, etc.) is covered through transfers from the central budget to the CNAM, which is the pooling agency for prepaid health care funding[[9]](#footnote-9).

Despite this significant inequalities in access to healthcare services on the basis of socio-economic status exist in Moldova with studies showing that low income groups use significantly less specialist services than higher income groups. Equity issues are also raised by the growth in out of pocket payments which are disproportionately paid by lower income groups sometimes reaching the level of catastrophic expenditures in their household budget. Main groups at risk in terms of low access to quality health services are those being self-employed (particularly in agriculture), unemployed (or unofficially employed), younger age and low income, large families, the elderly and people living in remote areas. The main reason of non-accessing healthcare by vulnerable social groups would be high cost of drugs or lack of awareness. From 2010, households registered as being below the poverty line automatically receive MHI cover. However, this may not drastically improve equity in the system as 73.1% of all OOP payments in 2010 were for pharmaceuticals, and the list of medicines that can be reimbursed through MHI is extremely limited T and only drugs prescribed in an inpatient setting are covered. Consequently, nearly all drugs prescribed in outpatient care are purchased directly by patients at full cost, even for those vulnerable groups which get their insurance contributions paid from the budget. Those patients with chronic conditions are likely to be most disadvantaged by this, but it should also be noted that pharmaceuticals are also much more expensive in rural areas than in the cities.

*Gender Aspects*. Household budget survey (HBS) for health conducted in 2012 revealed that women are accessing healthcare services 1.6 times more often than men. Therefore enabling environment for men to turn for health services need to be created.

More than 80% of healthcare workers in Moldova are women therefore any major changes in the work schedules, timing and venues of the suggested training courses need to be tailored respectively to their personal safety requirements and family obligations. The communication campaign for health care workers also needs to take into account the gender composition of the work force.

A study conducted by ***European Centre on the Health of Societies in Transition*** in 2008 found that 22% of population had no health insurance cover (19% of the women surveyed and 25% of the men surveyed). Health insurance cover for citizens under 15 years and over 65 years was 100%, as insurance contributions for these groups are paid directly by the government. Similarly, those registered as disabled had high rates of insurance coverage as the government also funds their health insurance premiums directly. When the analysis is restricted to the working age population without disability, over one-third (35%) of respondents had no health insurance cover (30% of the women and 41% of the men surveyed).

• Factors associated with being uninsured include being self-employed (particularly in agriculture), unemployed, younger age and low income.

* Both insured and uninsured face high additional costs of obtaining care, in particular due to payments for pharmaceuticals.
* As a consequence, insurance coverage has only a limited impact on seeking care when ill.

Even among those with health insurance, 30% cited inability to afford care as a reason for not using it, a figure that increased to 41% among those without insurance. This was the second most frequently cited reason, after a belief that they would get better using the drugs they already had, for both groups. While being uninsured had some additional impact on utilization, there were still considerable financial barriers facing those with insurance. This is likely to reflect the known high level of out-of-pocket expenditure, which poses a significant barrier to access.

*Roma population*. -There are no routine health care and statistical research on the condition and health care of Roma, therefore the estimates are given based on data produced by UNDP (2007)[[10]](#footnote-10). Data on infant mortality in Roma, though incomplete, show great differences when compared to non-Roma population, and estimated life expectancy index of Roma population is lower than in the non-Roma population.

The barriers to joining the health insurance and to access to the healthcare are the same as for general population: lack of awareness, lack of employment, lack of habit to go to the doctor and high out of pocket payments for medications. The only additional barrier identified specific for Roma population is lack of the identification documents. So particular attention shall be paid to raising awareness of the Roma population the on steps necessary to get health insurance and eligibility for free coverage for the most vulnerable categories to which many of them belong. It is also important to work with Roma NGOs to access the illiterate and non-Romanian speaking share of the Roma.

*National Health System Development Strategy 2008-2017* under Section 2 sets the objective to enhance equity and transparency in allocation of resources and financial protection of the citizens. This objective is reiterated and further expanded in the CNAM Institutional Development Strategy 2013-2017.

One of the main goals of the Strategy and the PforR support is to address existing inequalities and inequities in health. Program activities, primarily planned deepening the health insurance coverage through (i) increasing the average reimbursement rate of generic, first line medications for the three main categories of antihypertensive drugs in the drug benefit package from 50% to 70% and (ii) reduction in out-of-pocket expenditure as percentage of household expenditure in the poorest 40% of the population. The MoH is committed to reducing informal payments in the system and it is expected that adding performance-related payment mechanisms, together with improvements in transparency through external auditing, will help to achieve this aim.

1. **The third group of potential social impacts is related to social accountability of the health care system.** Improvements related to social accountability and transparency are ongoing. For example, the new Regulation introduced in 2009 has improved transparency, timeliness and methodology of decision making by the CHIF’s Committee for Medicines. Since 2010, patients’ representatives are members of county health councils. Since 2012, some positive changes have been implemented: participatory approach has been applied in the preparation and development of the National Health Strategy 2012-2020 with a series of consultations meetings and public debates held country wide. Also, regular weekly meetings are being held between various patients’ associations and Minister of Health. Additionally, the website of the Ministry of Health is a good example of transparency with all relevant health information posted and communicated to the public. The weekly meetings and website could also serve as communications channels to voice and address any negative social impact of the Program activities.
2. **The fourth group relates to potential impact on the employees – medical and non-medical staff within the reformed system**. Given that the rightsizing of the medical institutions have mostly been completed during the previous phase of the reform the proposed PforR is not focusing on the optimization of the network of the institutions. The programme is not likely to affect employment of medical or-non medical staff in the system. However it will pose significant training and self-learning requirements that will have to be advocated to the personnel as well as supported by the time and resources and properly communicated to the staff.For example P4P in hospitals will require re-engineering of internal business processes. Without proper improvement in the staffing level, work environment, salaries there might be a shift in the workload to nurses who will be also blamed for non-compliance, if any. So new business processes shall be developed in an inclusive manner with having a say, communicated to the personnel with necessary training if required.

Overall, it is difficult to identify specific winners and losers at this stage given that the various reforms supported by the new PforR will involve agencies across the sector and have various implications for each of the key actors.

The key actors in healthcare sector can be grouped in three categories: (a) at central level: policy-makers at MoH and other related agencies, and MPs advocating for their electorate interests (b) at meso-level: public and private healthcare providers affected by reforms, i.e. managers and staff in health facilities, (c) at micro level: the general public benefitting from improved equity and quality of healthcare services.

The Project will affect all three groups, yet the immediate effects will be felt more by the first two categories. Hospitals and primary care facilities will face internal reorganization in order to comply with reform requirements, as well as to ensure their economic and operational efficiency, and technocrats and policy-makers must obtain support in order to implement difficult reforms. However, MPs and other political actors in the short-run may face lobbying from the academic and/or medical society who are negatively impacted by the reform process (hospitals managers forced to reduce acute care beds, medical personnel paid based on the new P4P schemes, better accountability and transparency of medical institutions and reduced OOPs, etc).

In the longer term, end-users will benefit from improved quality of healthcare services as a result of enhanced services and better monitoring of population’s health outcomes.

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| --- | --- | --- | --- |
| **DLI focus areas vs. impact on the affected stakeholders** | **NCD risks reduction:**   1. Reduction in smoking prevalence amongst young people 2. Increase in the percentage of adults with hypertension whose blood pressure is under control[[11]](#footnote-11) | **Financial protection:**   1. Reduction in out-of-pocket expenditure as percentage of household expenditure in the poorest 40% of the population 2. Increase in the average reimbursement rate of generic, first line medications for the three main categories of antihypertensive drugs in the drug benefit package from 50% to 70% | **Quality and efficiency in healthcare:**   1. Reduction in annual hospital admissions/discharges for acute care per 100,000 persons 2. Reduction in the number of acute hospital beds per 100,000 persons 3. Percentage of primary care centers implementing full-feature primary care information system (including e-prescription, noncommunicable disease management, and pay for performance features) 4. Revised performance-based incentive scheme in primary care, including (i) performance indicators and (ii) counter-verification methods 5. Introduction of performance-based incentives to improve (i) efficiency and (ii) quality of care in hospitals 6. Use of updated DRGs for hospital payments 7. Increase in the proportion of public hospitals in Chisinau which are under common management 8. Approval of the new strategy which concerns (i) regionalization of hospitals (ii) common management for public hospitals in Chisinau and (iii) establishment of a university hospital |
| **Public institutions and agencies at central level: MoH, CNAM,** | 1. In the short-term agencies at central level will face the administrative challenges related to the enforcement of tobacco control measures and monitoring of their implementation; 2. Monitoring population with hypertension is a challenge and may require funding of the specific survey conducted by MoH or outsourced to CSOs/WHO. | a). The primary importance would stand with enrolment of the poorest population in the MHI. Currently most of uninsured (cca 40%) are in the first population quintile, for whom procurement of MHI is too expensive and who are not entitled to free HI as they are not AS beneficiaries, often being employed in informal economy .  b). The revision of free drugs list under MHI coupled with better identification of hypertensive patients by FDs may lead to some increases in the CNAM’s expenditures from the Base Fund. To sustain them CNAM shall eliminate inefficiencies within MHI.  It is advisable to calculate the total cost of this measure per annum.  b). Starting 2014 CNAM has amended legislation governing contracting of healthcare providers to apply formal sanctions upon those medical institutions that recommend patients to procure drugs while being treated in the hospital. In order for this measure to be effective (i) population shall be aware of how to claim their rights (ii) CNAM shall develop capacity to properly administer the scheme. | b). Reduction of acute hospital beds would primarily be conducted by transforming acute into long-term care beds (rehabilitation or geriatric). The co-operation and coordination with MoLSPF to avoid overlaps shall be ensuresd.  c) implementation of fully-fledged PHC information system means not only development of electronic health record and computerising PHCs throughout the country, but also enacting relevant legislation and training both, physicians but also patients on how to deal with this new procedure. Thus, creation of enabling environment, training doctors and educating patients on the primary care information system and e-prescription are key prerequisites for a successful result.  g). creation of common management in Chisinau Municipality requires effective communication and co-operation with Chisinau Municipality, which has its own health budget (45 mln lei in 2014) and which can develop its own local healthcare strategy.  d) &e). Monitoring of P4P schemes for hospital and primary care would require further strengthening of CNAM’s capacity. Despite the fact that it is being intended to outsource this activity to CSOs for the period of PforR implementation, it shall be institutionalised and sustained by public institution rather than by CSO.  h) MoH does not have in-house capacity to complete drafting of the strategy due to high staff turnover issue. |
| **Healthcare providers (hospitals, primary care centres, etc)** | b). PHCs could be confused on the reporting and would tend to cheat as similar indicator is included in the P4P public payment scheme | a). Hospitals staff will apply adverse selection to charge OOPs from patients belonging to higher quintiles than the poorest first quintile.  b). Some pharmaceutical companies could be against introduction of generic drugs as these are less expensive and could potentially reduce the demand for more branded second-line drugs. | f) & a). DRG-based payment implies that some hospitals will receive lower annual budgets for their services and will have to optimise their expenditures which may have negative effect on the quality of medical practice in the short-term.  Also, rolling out of DRGs payment mechanism will force hospitals to reduce ALOS and increase the beds rotation (more admissions), which can potentially offset the reduction of hospital admissions.  e). P4P in hospitals may be ineffective unless implemented with some support for re-engineering of internal business processes, i.e. there is a concern that without proper improvement in the staffing level, work environment, salaries there might be a shift in the burden to nurses who will be also blamed for non-compliance, if any. |
| **Population/ Patients** | a). Population will benefit from the ban of smoking both in the short-run and long-term period.  b). Unless large public awareness campaign is conducted and there is also free drugs provided to those identified with hypertension, a relatively low screening coverage could be observed as people are reluctant to check their health status if they would have to pay for drugs to keep their health condition under control. | a) Population that does not value public healthcare services will continue to offer informal payment in public institutions, or will go to private physicians as an option of ensuring better quality of medical practice and treatment thus undermining the attempts to reduce OOPs.  b) Extension of generic drugs list provided for free shall also combine public awareness campaign aimed at raising accountability of patients for their health by lifestyle changes to prevent health conditions. Otherwise, a stand-alone measure risks to develop population’s expectation of any healthcare responsibility shifted to doctors and MHI. | e). P4P will improve health outcomes for patients and may also lead to a decrease in overall healthcare costs.  g). common management or such other hospital reforms in Chisinau municipality would not hinder access to hospital care by population as there are sufficient secondary and tertiary medical institutions in Chisinau, including private outpatient care providing similar services.  c). Implementation of PHC information system at its early stage of implementation may lead to longer time spent by physician per patient’s visit (reviewing paper records, intaking the new records in the system, registering new patients etc) yet in the longer-term the benefits would offset the initial shortcomings. |

**V. ASSESSMENT OF THE MANAGEMENT SYSTEM IN THE SECTOR**

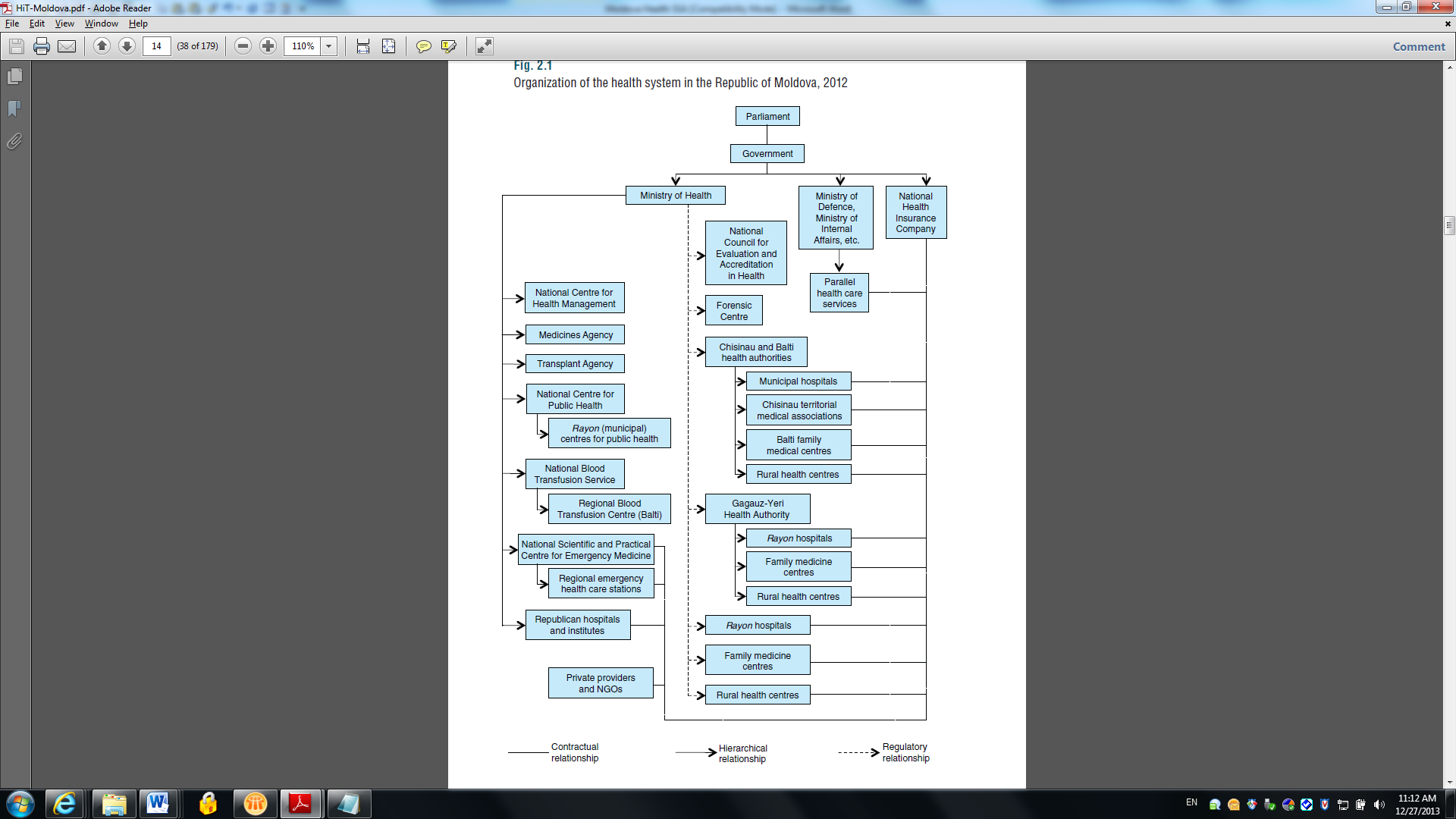
**1. Overall assessment of Environmental Management System (EMS) in the country.**

Overall Moldova has in place relatively well functioning EMS[[12]](#footnote-12). Its operation is based on a series of Environmental policies which cover both sectors - environmental protection and health care. The National Program for Environmental Security for 2007-2015 specifies necessary actions for ensuring environmental protection, including issues which have direct implications for human health and relates to prevention of environmental pollution, wastes and toxic wastes management and enforcing EA rules and procedures. The Government of Moldova (GoM) has also in place several other national documents related in particular to health and environmental issues, including a Health and Environment Action Plan, approved in 2001[[13]](#footnote-13) and recently adopted National Strategy for waste management which contains also a section devoted to HCW[[14]](#footnote-14). Furthermore, Moldova during last 20 years developed a comprehensive new regulatory framework that covers all and environmental and health sector issues, including EA for planned and for existing enterprises, solid waste management, ensuring compliance with the national environmental legislation and standards etc. Overall, the quality of designed policy and regulatory documents are adequate, especially of those approved in recent years. They have been prepared based on best international practices and recommendations proposed by various International Development Institutions as well as Multilateral Environmental treaties. Furthermore, recently the country has started to harmonize its legislation with the EU Directives. At the same time implementation of approved policy documents and environmental legislation overall is qualified as at medium to low level, mostly due to inadequate funding as well as enforcement capacity of the MOH and the Ministry of Environment.

**2. Assessment of the applicable health management systems**

Political will: Instability within the ruling coalition is one of the major factors affecting implementation of reforms in many sectors in Moldova. However at the sectoral level both the Ministry of Health and CNAM recognize the importance of improving service delivery, enhancing efficiency and improving financial protection. The current Minister of Health was involved in the first wave of hospital reforms in the early 2000s. Similarly, the current management of the CNAM was actively promoting the introduction of mandatory health financing scheme and, along with ownership of these reforms, possess solid institutional memory. Overall, on the side of MoH and other relevant government stakeholders, there is common understanding and support for the declared reform agenda .

**Picture 1[[15]](#footnote-15).**



The Ministry of Health had approved a roadmap for accelerating health reforms in February 2012 that emphasized, inter alia, hospital sector optimization and networking. Subsequently, in December 2012, CNAM approved its new institutional development strategy that was not solely aimed at institutional strengthening and reorganization, but also included reforms in the field of health financing, access and quality of healthcare .

The Prime-Minister has re-confirmed the commitment to hospital reform, yet in a careful and gradual manner. MPs have advocated for a stronger communication policy to mitigate the risk of non-support of reforms by population and political parties in opposition.

*Institutional capacity*: Another important factor is a lack of clear definition of the mandate and coordination of responsibilities between different institutions in the health sector (as well as roles and responsibilities within particular institutions). In particular, CNAM is currently going through its institutional restructuring, the National Centre for Health Management is acting without a Director and furthermore in summer 2013 the MoH proposed its reorganisation.

There is an issue of managerial capacity related to prioritizing reform measures and coordinating their implementation across the sector. Weak institutional capacity in the health sector is mainly caused by the lack of robust motivation instruments (i.e. salary scheme and career development mechanisms) to retain healthcare management professionals in the sector.

*Intergovernmental Relations*: Whilst the PforR as designed will have no direct effect on Local Public Administrations (LPAs), the hospital reform implementation largely depends on co-operation between MoH and LPAs, who are the founders of Rayon and Municipal hospitals. The strong associations between Rayon’s and Municipal local authorities and the political elite in Chisinau have to be taken into account, particularly as major hospital overcapacity is concentrated in Chisinau, where these connections are even stronger.

Furthermore, the PforR’s targeting hospital beds reduction that at least in the short-run will lead to re-profiling of acute care beds into long-term rehabilitation. That will require better cooperation with the Ministry of Labour, Social Protection and Family in view of delineating social and medical long-term care and avoiding any possible duplication.

*Regulatory and fiscal issues*: The existing laws and regulations aimed at ensuring the division of policy stewardship, service provision and service contracting functions are not fully enforced, which is hindering the implementation of healthcare reforms[[16]](#footnote-16). The Law on healthcare as of 1995 despite many amendments remains outdated and needs upgrading and alignment to the EU best practice.

The state budget is experiencing a large fiscal deficit that has implications for the financing of national public health programs. Graduation from the Global Fund and GAVI in the coming year will transfer the financial burden of disease control [provision of free drugs, vaccines etc.] to MoH and CNAM, which may create a significant budget deficit in health for the forthcoming years[[17]](#footnote-17).

The government and the Ministry of Health do have all the tools for planning capital investments in the public infrastructure of the health system, but because of resource constraints at the national level, capital investments are minimal. It shall be mentioned that the Court of Accounts audit of CNAM’s resources for 2012 noted under-collection of funds by the Health Insurance Fund to the amount of 61.2 mln MDL from the state budget as a result of budget deficit. Furthermore, arrears accumulated from the economic entities to the amount of 17.8 mln MDL affected budget under-execution and created pressures in managing financial resources. However, starting 2014 the Government increased health insurance premium by 1% (from 7% to 8% equally from employer and employee) which increases the global CNAM budget.

*Information System and Data Collection*: The PforR operation is very much linked to and dependant on the country’s data collection mechanisms: for effective monitoring of payment-for-performance in primary care and hospitals, as well as accurate costing of DRGs availability of computerised data collection is imperative.

In May 2013, the MoH embarked upon development of PHC software that inter alia will be a data source to monitor achievement of expected results. The software should be operational within two years, yet the Ministry has committed to deploy it in fall 2014.

CNAM also committed introducing of smart cards for patients in 2015 that if implemented could significantly improve the information flow between institutions and enhance monitoring of health indicators.

Compared to other sectors, Health sector is better positioned in terms of institutional capacity for reforms. However, concerns remain regarding the technical and managerial ability within institutions to implement reforms. Therefore, it is imperative for the proposed PforR operation to include high quality TA activities.

*Communications and capacity to communicate reforms:* Implementation of sensitive reforms in social sectors which require strong communications support has been difficult in Moldova. Though the government and the Ministry of Health in particular have a communications strategy, the overall capacity to communicate reforms is not sufficient. It is critical that a strong focus in the proposed Operation is placed on building the Health Ministry's capacity to communicate reforms, explain and highlight the rationale and benefits of specific actions. It would be also important to identify the champion in the government who could take the lead in communicating health reforms. It would be important to prominently include building communications capacity of the Ministry of Health in the TA component of the project.

Knowing public opinion is instrumental for successful communications campaign. Though no special public opinion polling has been done recently for the health sector, a Citizen Report card done a few years ago by the Bank, and regular general public opinion surveys carried out every six months provide some useful insights into priorities of the population and should be taken into account for the design of the communications strategy. Going forward, it could be also useful to conduct several focus groups with different stakeholders to learn more about the existing perceptions, fears, and aspirations. This would be very useful for crafting messages about the proposed reforms that would resonate with the population. Additional public opinion surveys and focus groups could also be considered as part of the TA component.

**3. Coordination Mechanisms among Stakeholders**

In 2009, the Ministry of Health set up the Health Sector Coordination Council for External Assistance, and from 2010 it has operated in line with the Governmental Regulation on the Institutional Framework and Coordination Mechanism of the External Assistance provided to the Republic of Moldova by International Organizations and Donor Countries. Similar councils exist in all ministries and their purpose is to increase the efficiency, efficacy and sustainability of external assistance through better coordination throughout the process of planning and implementing programmes.

*The Health Sector Coordination Council for External Assistance* is a consultative organ created on the partnership principle and responsible for the planning and monitoring of external assistance projects and programmes in the health sector. The Minister of Health chairs the Council and the WHO representative is co-chair. The heads of Ministry of Health subdivisions responsible for the development, monitoring and evaluation of policies and directives for European integration are members of the Council, as are representatives of donors active in the health sector and representatives of other relevant institutions. The Council meets as often as necessary, but at least once per quarter. At the Council meetings, priorities for assistance to the sector (including project proposals) are formulated, ensuring complementarity and avoiding duplication. Draft strategies and action plans are discussed, as well as health expenditure strategies related to the integration into the national public budget of planned actions and financial resources under external support. The Ministry of Health develops annual monitoring reports on externally funded projects and programmes implemented in the health sector, which are presented and approved at the Council’s meeting.

In terms of inter-sectorial cooperation with other line ministries, in implementation of its policy reforms the Ministry of Health co-operates with the Ministry of Labour, Social Protection and Family, the Ministry of Agriculture, Ministry of Education, and the results of MoH activity are often dependant on how well this cooperation works.

In spite of having long-standing relations with the Ministry of Labour, Social Protection and Family (in the past it was a single Ministry covering health and social sectors) there are still significant overlaps in terms of provision and reimbursement of long-term and rehabilitation care. For instance, some rehabilitation services for patients are being contracted by CNAM, whereas the same services are covered by the MoLSPF budget. Alternatively, implementation of many public health programme like tobacco control programme if to be successful shall combine joint efforts of the Ministry of Education, Ministry of Finance and Ministry of Health. Consequently, strengthening of cross-sectoral co-operation and coordination mechanism is imperative for implementation of many activities in the field of health care.

In order to implement the new public health legislation, a working group was set up in 2010 to evaluate the epidemiological situation regarding noncommunicable diseases and to identify priority conditions having a negative impact on public health. Altogether, 13 conditions have been prioritized and became part of the surveillance system[[18]](#footnote-18).

A biannual National Report on the Environment and Health is prepared jointly by SSPHS and the Ministry of Environment. Apart from this, the results of air quality monitoring are made public quarterly by the joint monitoring system of the SSPHS and the “Hydrometeo” service under the Ministry of Environment. The monitoring of water quality is also carried out jointly by the SSPHS, “Hydrometeo” and the Ecological Inspectorate of the Ministry of Environment. SSPHS is responsible for monitoring the quality of drinking-water[[19]](#footnote-19), surface water and water in recreational areas.

The surveillance of occupational health and workplace safety is carried out by the SSPHS in collaboration with the Labour Inspectorate under the Ministry of Labour, Social Protection and Family.

In 2012 the Government of Moldova established a Sanitary-veterinary and Safety of Products of Animal Origin Agency under the Ministry of Agriculture and Food Industry (Food Security Agency). The surveillance of food safety and quality is carried out jointly by the SSPHS, the Food Security Agency, and the State Inspectorate for Consumer Protection. At present, there are many overlaps between the mandates of the Institute of Public Health and this newly created Food Security Agency with regard to health protection.

1. **Brief consideration of the borrower’s more recent experience relevant for the Program.**

Major structural reforms of the health care system started in 2001 with creation of CNAM and introduction of Mandatory Health Insurance at national level in 2004, followed by primary care reform, family medicine promotion and hospital network optimization. Although, there is still much to be done and in recent years the reform pace has been rather slow.

The Ministry of health was along with the Ministry of Labour and Social Protection the implementing partner of the Bank supported Health Services and Social Assistance project (2007-2014) the primary objective of the project is to support the Government's program to increase access to quality and efficient health and improve efficiency of social assistance services for the Moldovan population in line with the MTBF for 2007-09.

Under the ongoing Health Services and Social Assistance project, the Bank has conducted three rounds of survey (Health Module based on household budget survey: 2008, 2010, 2012) aimed at monitoring public satisfaction with healthcare services, access to healthcare etc. The Bank’s team will consider how to best monitor these healthcare indicators in the future. The current project implementation has been ranked as moderately satisfactory.

In addition to the IDA credit provided by the Bank, several donors including IDA, EU, SIDA, DFID, CEB and relevant UN agencies, through coordinated but parallel financed operations, support the Government initiatives in this area.

There was no formal assessment of the achievements so far; but generally speaking, key achievements of the first stage of its implementation include: (i) widening the services available to the uninsured and increasing financial protection for vulnerable groups, (ii) implementing modern provider payment mechanisms (diagnostic-related groups) for hospitals, (iii) improving PHC infrastructure and granting autonomy and gate keeping functions to PHC providers, (iv) introducing public-private partnerships, (v) introducing reference pricing and centralized (pooled) procurement of essential medicines for public facilities and (vi) approving the National Programs for Tobacco Control and Reduction of Alcohol Consumption[[20]](#footnote-20) after several years’ delay due to industry pressure. These programs are in line with, respectively, the WHO Framework Convention for Tobacco Control and the WHO European action plan to reduce the harmful use of alcohol 2012–2020.

The results reported by the Ministry of Health at the Annual Health Forum (November 2013) are the following: in 2008 about 78% of the population of Moldova had MHI, which represented a small increase since the introduction of social health insurance in 2004.

As of 2013 health insurance coverage of the population increased to 87%. Through further strengthening and increasing the autonomy of the primary health care sector, 192 health centres out of 262 across the country have signed financial contracts directly with the National Health Insurance Company. In 2013 year, 78 primary health centres were repaired and equipped with medical equipment. This has allowed access to quality health services for one million people. In 2013 policy dialogue among health sector stakeholders and development partners focused on priority issues related to tobacco control policies and hospital sector governance and regionalization. Also on the agenda were decentralization of public services, health services efficiency and quality, health financing and local authorities’ and community involvement.

In the past the Ministry of Health has been benefitting from healthcare budget support assistance provided by the European Commission and is therefore familiar with some features pertaining to the PforR instrument. Furthermore, in the last two years the World Bank launched two results-based financing projects in social assistance and education sectors in Moldova. However, the transition from an input-based to a results-based operation could still be an issue particularly given that healthcare sector is governed by a specific funding allocation mechanism of health insurance and the budgetary rules for funds allocation are subject to change. Furthermore, the EU direct budget support was underpinned by the EU-funded technical assistance component channelled through WHO.

**5. Current practices, legal and institutional framework securing social accountability on the Health Sector**

* 1. ***Public participation***

According to the 2005 Law on Patient Rights and Responsibilities, all decisions of economic, administrative or social character with a potential influence or impact on the population’s health status, at the national or local level, should take into consideration public opinion. Patients have a collective right to be represented at all levels of health system and to be involved in the process of decision-making regarding the planning and evaluation of services, including the breadth, quality and delivery mode of services provided. Citizens of the Republic of Moldova, patients’ organizations and NGOs can participate in the development of health policies and programmes, as well as in setting priorities and criteria for resource allocations.

The means for public participation in the health system was only developed in 2010, when, in order to increase transparency in the development of legal and regulatory documents, the Ministry of Health, along with other government authorities, developed internal rules for ensuring transparency in the decision-making process, in line with Governmental Decision On the Actions for the Implementation of Law No. 239-XVI from 13 November 2008 Regarding the Transparency in the Decision-making Process (No. 96, 16 February 2010). These rules include the regulation of information, consultation and participation in the process of developing and approving decisions, the contact details of the coordinator of the public consultation process, and the list of interested and informed parties, which includes most of the NGOs active in the field of health.

The websites of the Ministry of Health and the CNAM are a good examples of transparency with all relevant health information posted and communicated to the public. This provides a good start for real public dialogue on the impact of the Programme.

Furthermore, the Government-wide initiative to disclose all data, except the sensitive one, to general public is being implemented and by now the Ministry of Health made available more than 180 datasets for free use by CS on the website: <http://data.gov.md/raw/category/3>.However, due to inconsistency with some data caused either by different calculation modalities of the same indicator and different data collection modalities, or unavailability of computerised records, some data remains undisclosed.

Further improvements in social accountability in the health care system, both in implementation of the foreseen reforms and in the functioning of the reformed system are needed. Some initiatives to that effect are already underway. For example, participatory approach has been applied in the preparation and development of the National Health System Development Strategy 2008-2017 with a series of consultations meetings and public debates held country wide. This practice has been replicated through a series of policy consultations on the elaboration of the new Healthcare Strategy 2020.

The Ministry of Health with support from WHO have organised public consultation workshops aimed at raising public awareness on hospital regionalisation concept and getting feedback on the proposed hospital reform plans. In particular, during October – November, 2013 MoH have organized three regional field trips to the north, south and the centre of Moldova and involved in the policy consultation process about 300 persons representing local authorities, medical institutions, CSOs and mass media.

The results of this consultation process identified a need to have a complex planning for capital investments, regulatory adjustment and human resource strategies, but also a need for greater empowerment to the change agents and for implementation support.

* 1. ***Grievance mechanism (mediation, claims) and Responsiveness in the healthcare***

Moldovan legislation has sufficient provisions for petitions and complaints submission and the Ministry of Health established the channel for complaint submission in electronic format. However the Ministry of Health has neither specialized unit for dealing with patient complaints nor it has system in place to monitor cases of infringement of patient rights and their review in courts. Furthermore, the current approach to complaints handling within the Ministry of Health as stipulated in the Law on Petitions (no 190 of 19.07. 1994) has a deleterious effect on MoH’s institutional capacity as in some cases it leads to up to 70% of staff working day being devoted to dealing with petitions. The situation is similar in other Ministries, so the elimination of this inefficiency shall be lifted to and adopted at a higher governmental level.

According to the 1995 Law on Health Care, the patient has the right to request a professional review to be conducted in the established way and to compensation for moral and material prejudice following inadequate health care. Patients’ requests or complaints are examined in the framework of the Law on Petitions (1994) according to which both the patient or his/her legal representative and the health care provider against which the complaint is being made are informed about the outcome of the review and the decision taken. If the patient or his/her legal representative disagrees with the outcome, they can address their complaint to an independent commission for professional medical expertise, which is created ad hoc by ministerial order.

The 2005 Law on Patient Rights and Responsibilities stipulates also that the patient or his/her legal representative may institute legal procedures against health service providers where their actions have led to the infringement of the individual rights of the patient, as well as against public authorities and responsible individuals involved in decisions or actions leading to the infringement of his/her social rights as provided by the legislation. De jure, the patients are entitled to have their complaints examined and resolved in a prompt way. In reality, often many of patient’s rights are being infringed and the telephone green line established by the Ministry of Health is the only way to file a claim, if any.

Although the legislation stipulates the rights of patients to complain to territorial health authorities (which only exist in Chisinau, Balti and Gagauz-Yeri), the CNAM, medical and pharmaceutical facilities, professional doctors’ associations, patients’ associations and public associations for the protection of health service users’ rights, due to non-existence of integrated claim processing mechanism patients prefer to address their petitions directly to the Ministry of Health.

Patients usually address their petition in writing, but it is now possible to do this electronically. Petitions are examined by the relevant bodies within 30 days, or within 15 days from the registration date for those that do not need an additional review and analysis; the final decision should be communicated immediately to the petitioner. In exceptional cases, the examination term can be prolonged by the manager of the respective body for up to one more month and the petitioner is informed of this.

Some patients address complaints regarding inadequate health care to public associations for the protection of the rights of health service users. These associations draft a petition to the Ministry of Health and/or the other health authorities or medical/pharmaceutical facilities involved, and bring the matter to court where there is a disagreement with the results of review and the decision taken. Therefore, the role of public associations for patient rights is increasing; moreover, there are cases when, based on such appeals, the courts have issued sanctions (including financial ones) for harm to the petitioner’s health.

In 2009, the Ministry of Health developed a draft Law on Civil Liability Insurance that was examined and commented on by the other ministries involved, but its progress was stopped because the implementation of such a law might have generated legal and financial problems.

In 2008 USAID project supported the Ministry of Health in drafting a law on malpraxis which provided for the creation of a special fund to cover compensation awards to patients affected by medical mistake has also been discussed, but this idea was abandoned as well because of the fiscal constraints resulting from the global economic crisis in 2008–2009 and some political aspects.

Currently, the Ministry of Health has no system in place to monitor cases of infringement of patient rights and their review in courts.

Patient satisfaction surveys as part of the HBS Health module funded under the ongoing Health Services and Social Assistance project have been conducted and the results of the last survey conducted in 2012 showed that the majority of patients dissatisfaction is associated with a physical conditions (sanitary block, rooms, water supply, food) of the medical facilities and out of pocket payments.

The recently adopted Law on the creation of Medical Collegium that is entitled to receive malpraxis claims and to initiate sanctioning against them. However, the regulatory by-laws and other implementation arrangements are to be drafted and approved by early spring.

In addition to the above-mentioned complaint mechanism, CNAM is installing a hotline service that will provide various information for the patients, including claims with regard to quality of care or out-of-pocket payments starting from January 2014 (a project financed by Estonian government).

* 1. ***Accountability***

Accountability in the health sector and the public scrutiny of the resources spent in the health sector need to be strengthened. Overall capacity of the civil society and population to monitor and systematically hold health providers accountable for the quality of health services provided is limited. The health sector is characterized by the existence of different interest groups lobbying for certain reforms. In terms of political economy, the health sector is largely influenced by the key players from Liberal-Democrat party (PLDM) who occupy important positions across the health system: sectoral parliamentary committee, Ministry of Health, Drugs Agency, Prime-Minister’s advisor on health and social protection, important opinion-makers from medical society etc.

Vested interests play a major role in the implementation of health reforms. Reforms that may lead to profits for private businesses tend to be implemented with more vigor: e.g. implementation of PPP schemes even in areas where the use of public funding would be more cost-efficient, or undertaking activities that require infrastructure construction and/or procurement of medical or IT equipment etc.

In case of corruption at medical institutions of any level, the complaint is usually being submitted to the National Anticorruption Centre (CNA) that in case of solid facts takes it further for investigation. Since 2013, the National Anticorruption Centre has launched 11 penal cases related to informal/illegal payments in healthcare.

Interesting is the fact that 39.9% of population in case of bribe request would not file a claim to the respective institution, and those 16.9% of population that are willing to complain would rather do so by addressing relevant request to a doctor, and 15.1% - by contacting the Ministry of Health.

**RECOMMENDATIONS**

*Recommended measures to improve HCWM*. To improve situation in this domain it is necessary to undertake a series of activities which related to both capacity building as well as to providing necessary funds and investments in the sector (all concrete measures are specified in the table 1 below). With regard to HCWM regulatory framework it is necessary to revise and update the regulation on HCWM, as well as to update existing Guidelines and relevant national standards. Concerning providing the HCFs with adequate equipment, suppliers and to building up adequate disposal facilities the GoM may prepare and adopt a special action plan in this regard. Considering relatively highcosts the GoM may therefore use part of the crediting resources from the WB or formulate a well-targeted project, requesting assistance from multilateral or a bilateral donor.Such project should be based on a feasibility study which would demonstrate the needs for the HCWM sector and, in particular, for regionalization of relevant services and including options for developing public-private partnerships. This study can be financed under the current P4R project. The preliminary estimations specified in the National Waste Management Strategy for 2013-2025 specifies it might be needed about 3-4 regional autoclaves in this regard with a total cost per unit of about Euro 0.5 million, including the costs associated for creation of regional networks for providing these services.

*Areas and options for improving PhWM.* While overall this system is well functioning, based on received information it is possible to conclude the NADME PhWs Disposal Division is understaffed and periodically has difficulties in conducting timely its activities. In this regard it would be necessary to increase on temporary or permanent basis the number of its staff. Another possible option in this regard might be commercializing these services, by creating necessary regulatory basis, by increasing the current level of tariffs to a feasible level and/or by creating a public private partnership in this domain. For the latest it would be good to conduct a feasibility study and assess this option, proposing necessary recommendations.

*Ensuring political support to the reforms*

The new project will commence in FY 15, which coincides with the pre-election period. During this time, the MoH leadership and some MPs may be reluctant to embark upon unpopular reforms, or conversely will try to introduce some measures that are not necessarily cost-effective and efficient. It is therefore important to address capacity strengthening and accountability measures and ensure that the project design includes inter alia some “low-hanging fruit“ measures.

*Enhancement of access to health care services*

Policy NGOs shall be involved in the promotion of structural reforms at central level, whereas advocacy organizations such as health trade unions would be helpful in providing information on the reforms in health institutions. Social networks and media shall be used to communicate the reform to the patients. Roma NGOs might be involved to improve awareness on the entitlements and the changes related the reform.

The Bank has tailored second round of GPSA initiative to the healthcare sector and linked it to the PforR project scope. It is, however, important to ensure that social accountability practices developed and piloted by the CSOs under GPSA programme are further institutionalised by the relevant sector players.

*Improvement of the current practices in securing social accountability*

The project shall adopt measures aimed at strengthening quality management and ensuring accountability mechanisms to better deliver on the Bank’s fiduciary responsibilities: involvement of the Court of Accounts, CSOs and mass media throughout the project cycle, especially in verification of project DLIs, use of Bank’s staff for awareness raising amongst medical society and the general public about the need and benefits of reforms, etc.

It is of crucial importance to ensure consolidation of MoH’s capacity to deal internally with complaint monitoring and resolution.

In order to ensure trust and common use of the CNAM’s hotline by the patients it is important to monitor its performance and adjust the information supplied by it to the patients as well as responses to the complaints received through it.

*Communicating reform efficiently to the key stakeholders*

The communication campaign for health care workers needs to take into account the gender composition of the work force (80% women).

The communication campaign for the patients has to take into account language diversity (Russian materials might be needed for Gagauz Yeri and Transnistria population) access to various channels of communication by different target groups. High level of adult illiteracyamong the Roma population has to be taken into account when trying to reach this vulnerable group.

**Table 1. Main environmental and social issues and risks for the PforR and proposed activities to address them**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Issues and risks** | **Actions** | **Responsibility** | **Timeframe** | | **Costs (USD)** | | **Indicator** |
| 1. ***Improving regulatory framework and building capacity*** | | | | | | | | |
| 1 | Lack of relevant guiding documents and outdated Regulation on HCWM | Updating the HCWM regulatory framework and preparing the guidance documents:  - Revising the Regulation on HCWM;  - Preparing Technical Guidelines on HCWM;  - Designing National Guidelines on syringes safety | MH;  NCPH | 2013-2014 | | Within allocated budget | | Noted documents adopted by the GoM and MoH |
| 2 | Weak HCFs human capacity for sustainable HCWM | Continue HCWM awareness and training programs for medical and paramedical staff | MoH;  NCPH;  Rayon CPH and Local Public Authorities | Permanently | | Within allocated budgets | | Number of conducted trainings and participants |
| 3 | Weak National Drugs Agency capacity to dispose collected pharmaceutical wastes | Strengthening NADME human capacity to conduct activities for safe and timely disposal of accumulated pharmaceutical wastes and ensuring adequate conditions for their encapsulating; | 2014 | NADME | | Within the existing budget and using funds received from provided services | | Number of additional staff hired |
| 4 | Lack capacity of the MoH to deal with patient’s complaints and monitor their resolution. | Creation of an integrated complaint mechanism and consolidation of MoH capacity to deal internally with complaint resolution. | 2015 | MoH | | Within the existing budget | |  |
| 5 | Emerging capacity of CNAM to analyse grievances and inform the population | Strengthen capacity of the hot-line by developing information and training the staff | 2014 | CNAM | | Within allocated budgets | | Number of conducted trainings and participants |
| 6 | Low awareness of the population of existence of the hot-lines administered by CNAM and MoH | Wide public information campaign on the hot-lines and issues to be addressed to them | 2014 | MoH, CNAM | | Within allocated budgets | | Number of calls to the hot-lines and nature of requests addressed |
| 7 | Need to prepare the population to use of primary care information system and e-prescriptions | Wide and proactive dissemination of information on how to use primary care information system among the patients | Continuously | MoH & CNAM (development of information materials) PHCs, CSOs (dissemination and councelling) | | TA Funding | | Materials developed and disseminated |
| 8 | Low awareness of the patients on their rights and entitlements in terms of secondary and tertiary medical services | Hospitals develop in collaboration with the patients’ associaions public charters that can be easily accessed by the patients and inform on their entitlements and rights as well as expected quality of services. | 2015-2016 | MoH, Hospital Management, patients’ associations | | TA Funding | | Charters developed and place in the hospitals |
| 9 | Insufficient monitoring of use of public funding for health Care | Involve the Court of Accounts and CSOs in monitoring of RforR related performance | Annually | MoH | | Within allocated budget | | Reports produced by the Court of Accounts |
| 1. **Feasibility studies** | | | | | | | | |
| 10 | Inadequate collection, treatment and disposal of infectious wastes and associated health and environmental risks | Carry out a detailed feasibility study on the options, costs and technical issues of the creating regional networks for separate collection of infectious wastes and their treatment before disposal. | MoH | 2014-2015 | 100.000 | | Study conducted and alternative scenarios developed and approved by the GoM/MoH | |
| 11 | Lack of capacity to timely and efficiently conduct disposal of PhWs | Analyzing current legal basis, economic incentives and tariffs and proposing necessary adjustments and actions for involving private service providers in the area of PhWs disposal | NADME | 2014 | Within the existing budget and using funds received from provided services | | Study conducted and necessary legal documents approved by GoM/NADME | |
| 12 | Lack of funding for adequate HCWM and associated risks | Conducting an analysis and estimating the HCWM needs in terms of relevant equipment, goods and suppliers and proposing an action plan for short and medium terms | MoH | 2015 | 100.000 | | Costs estimated and action plan developed and adopted by the GoM | |
| 13 | Outdated DRGs for hospital payments | CNAM to carry out the out DRG costing study | CNAM | 2014-2015 | TA Funding | | Study conducted and hospital payments adjusted accordingly | |
| 14 | No system of performance-based incentives to improve (i) efficiency and (ii) quality of care in hospitals | Develop performance-based incentives for hospitals to be included in the contracts between CNAM and hospitals | CNAM, MOH |  | TA Funding | | System of incentives developed and piloted | |
| 1. **Necessary investments and funding for HCWM** | | | | | | | | |
| 15 | Lack of facilities for treatment and disposal of infectious wastes and associated health risks | Purchasing of autoclave equipment for major hospitals in the country (based on the results of the feasibility study specified under line 5 above) | MoH | 2015-2016 | To be estimated within the Feasibility study (see line no.4 above)[[21]](#footnote-21). | | Number of autoclaves purchased | |
| 16 | Inadequate segregation, collection and transportation of HCWs for disposal due to lack of equipment and necessary goods and associated risks of contamination of workers and of the environment | - Ensuring segregation of MWs in all HCFs by using a three bins system;  - Supplying HCFs with all necessary goods and containers for separate collection of medical and domestic waste as well as for their temporary storage before disposal (per action plan specified under line 7 above); | MoH,  Local Public Administration | 2016-2017 | To be estimated within the feasibility study see line No. 6 | | HCWs segregation is ensured in 100% of public HCFs;  Number of provided containers and other suppliers and protective equipment for HCWM; | |

1. “Boost up the reforms: addressing health needs through investment policies” approved through Ministerial Order dd. February 2012 [↑](#footnote-ref-1)
2. Other sector issues (like financial protection) are being addressed through a variety of instruments. [↑](#footnote-ref-2)
3. The subset of activities will be further elaborated during project preparation. [↑](#footnote-ref-3)
4. http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/EXTPOLICIES/EXTOPMANUAL/0,,contentMDK:23101116~menuPK:4564185~pagePK:64709096~piPK:64709108~theSitePK:502184,00.html [↑](#footnote-ref-4)
5. http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTANDOPERATIONS/EXTINFODISCLOSURE/0,,menuPK:64864911~pagePK:4749265~piPK:4749256~theSitePK:5033734,00.html [↑](#footnote-ref-5)
6. \*\* See http://web..org/WBSITE/EXTERNAL/PROJECTS/EXTPOLICIES/EXTOPMANUAL/0,,contentMDK:23101116~menuPK:4564185~pagePK:64709096~piPK:64709108~theSitePK:502184,00.html

   As per the Law on Government (No. 64-XII, 31 May 1990) [↑](#footnote-ref-6)
7. In 2010, the regulation setting up the SSPHS and its staffing was approved (Government Decision No. 384, 12 May 2010) [↑](#footnote-ref-7)
8. The issue of medical radioactive wastes is not covered by the ESSA as based of the opinion of the national health and environmental specialists they are relatively well managed and do not constitute a major problem for the country. [↑](#footnote-ref-8)
9. **Health Financing Reforms Review** conducted by WHO in 2012 suggests that 20% of resident population in Moldova do not have health insurance. It is notable that the share of uninsured people with chronic disease is one half of those uninsured.

   However, out of the population with the lowest income 41.0% do not have health insurance, and every second person in this group has free medical insurance. The population with the highest income (quintile V) has the highest rate of insured persons by monthly contributions (40.1%). [↑](#footnote-ref-9)
10. http://www.undp.md/publications/roma%20\_report/Roma%20in%20the%20Republic%20of%20Moldova.pdf [↑](#footnote-ref-10)
11. Adults with hypertension is the category of 18 years and older excluding pregnant women. [↑](#footnote-ref-11)
12. This can be concluded while analyzing various papers prepared by different international organizations and in particular by UNECE (Moldova: Environmental Performance Review, 2005 and 2013 – see: (<http://www.unece.org/fileadmin/DAM/env/epr/epr_studies/moldova%20II%20m.pdf>); by UNDP (see: National Report for UN CSD 2012 Rio+20. Chisinau, 2012. http://www.mediu.gov.md/images/Report\_RIO20\_ENG\_12-06-2012\_NEW\_OUT.pdf; and by Environmental Action Program for Central and eastern European countries Task Force under the OECD (see: Capacity Development for environmental management in Moldova: Drivers, links to planning and methods of assessment. Paris, 2010. <http://www.oecd.org/dataoecd/30/44/45559222.pdf>; Compliance and Enforcement Capacity Building in Moldova (<http://oecd.hybrid.pl/finfo.php?layer_id=14&object_id=160>) [↑](#footnote-ref-12)
13. Health and Environment Action Plan. GoM No. 487, from June 19, 2001 [↑](#footnote-ref-13)
14. National Strategy for waste management for (2013-2027) approved by GoM, Nr. 248 from 10.04.2013 [↑](#footnote-ref-14)
15. Source: http://www.euro.who.int/en/who-we-are/partners/observatory/news/news/2012/11/new-hit-for-republic-of-moldova [↑](#footnote-ref-15)
16. For instance, formally NHIC should be empowered to undertake strategic purchasing of healthcare services from providers, however can only do this in consultation with institutions’ founders (represented by MoH and LPAs). As a result, the existing regulatory framework creates a direct conflict of interest that sustains inefficiencies in the sector [↑](#footnote-ref-16)
17. In spite of the fact that recently GAVI agreed to allocate some grant amount in support of Moldova’s graduation from its financial assistance, there are still significant financing gaps not covered. [↑](#footnote-ref-17)
18. Ministry of Health Order No. 869, 27 December 2010 [↑](#footnote-ref-18)
19. New water quality norms, harmonized with EU norms, were approved in August 2007 (Government Decision No. 934). [↑](#footnote-ref-19)
20. The main causes of death in the Republic of Moldova are diseases of the circulatory system followed by cancer and diseases of the digestive system. Many of these deaths can be attributed to very heavy alcohol and tobacco consumption – 57.6% of total male mortality and 62.3% of female mortality in 2010 could be attributed to smoking-related causes while 18.8% of male mortality and 13.7% of female mortality were related to alcohol consumption. [↑](#footnote-ref-20)
21. Preliminary estimations done in the National Strategy for Waste Management for 2013-2025 show the need for about Euro 4.0 million. [↑](#footnote-ref-21)