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ENGLISH

ESTABLISHING ACCOUNTABILITY INSTITUTIONS IN HEALTH CARE

Contents

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Executive summary

The scope of the report is to analyze the existing accountability mechanisms in the health sector. Specific objectives include: a review on corruption perception by households, an analysis of the existing accountability mechanisms and discussion on their possible improvements and finally an outline on institutionalized way of measuring corruption in health care system.

Several methods are used for the analysis. Comprehensive review of the existing household perception surveys, meta-review of the secondary researches and studies, additional analysis and discussions of the presented information were carried out.

The report concludes that the existing accountability mechanisms are weak and underdeveloped. The key finding is that the availability and transparency of the (performance) information is limited. This creates a disruption in the functioning of the accountability mechanisms in the health care system. The society, the households as customers are unaware of the quality and of use of the health public expenditures. Assessing the quality of services and the efficiency of expenditures, providers self-evaluation through customer perception of the quality of services, the report recommends the establishment of the budget transparency mechanisms at providers level and across the sector for the comparison, involvement of the rayon health authorities.

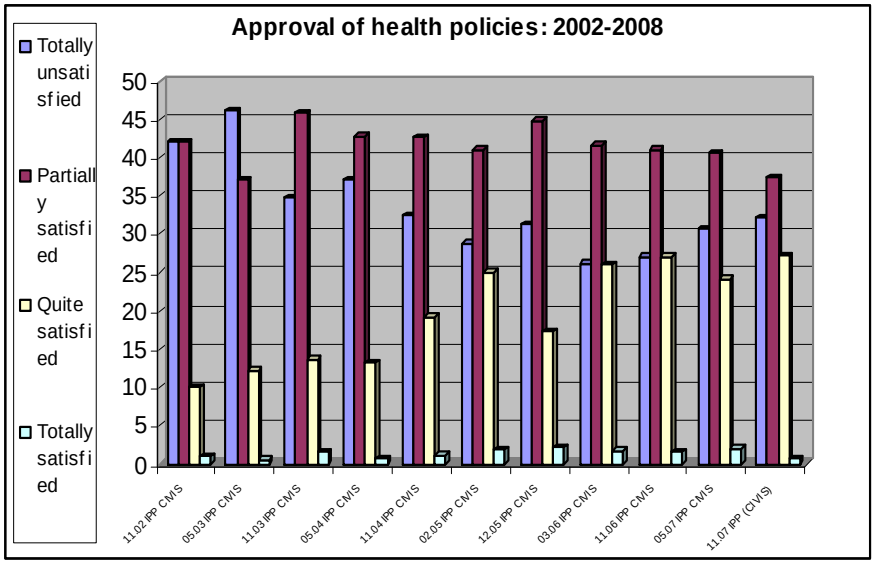
The report outlines the household perception measurement indicators.

The first one intends to present *the results of surveys* among households perception on the current health policy and on the quality of health services. The second section contains *information on the perception of corruption by households*. It has the purpose to offer a picture on the past and present interest for public health and corruption issues. Next section contains concise information on household health expenditure pattern, followed by description of the current accountability mechanisms as well as the challenges for the improvement of the accountability mechanisms. The last section deals with the *identified challenges for the improvement of the accountability links.* The final section provides a sketch for the systematic survey to find out the households' perception on the functioning of the health care system.

1. Public perception on health care policies and services

Moldova's health care sector has undergone significant reforms and changes over the past years. The turning point has been in 2004-05 after the introduction of the compulsory health insurance system. Based on the perception of the households, one can see the change and the shift in the public perception about the health policies and about the quality of services prior and after the introduction of the mandatory health insurance.

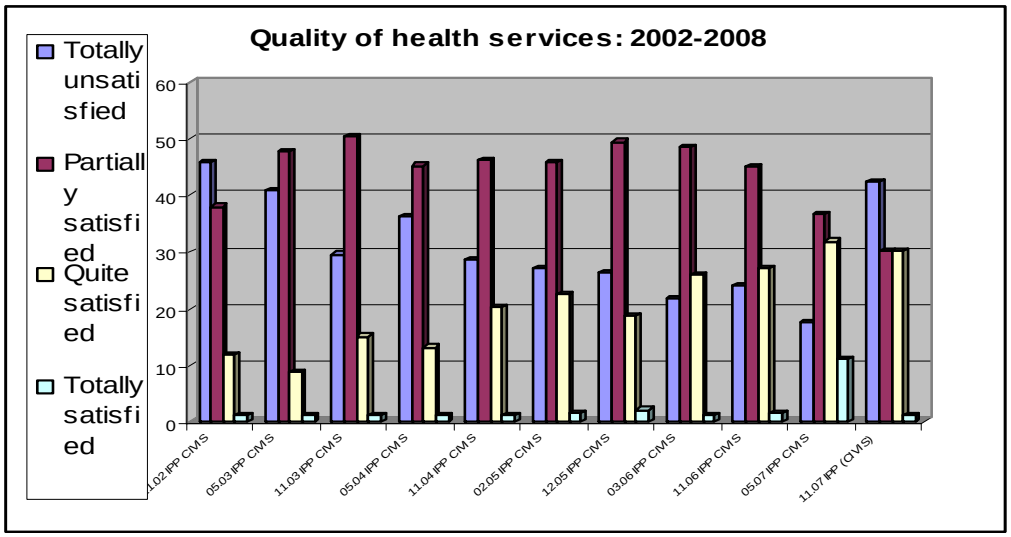
Graph 1: Perception and approval of health policies



Source: IPP/CIVIS, 2001-2007

The shift to compulsory health insurance resulted in a positive perception on policy among the households. In November 2004 and in February 2005, after introducing health insurance, there is an obvious increase of people that were having quite satisfied attitude towards the health policy. February 2005 data show a double increase (25%) compared to February 2004 (12%) of policy approval. The trend of people that are totally unsatisfied decreases starting from the beginning of 2005. The percentage of persons that are partially satisfied remains the same with some oscillations. Finally, the percentage of persons that are totally satisfied has several percents increase. Overall, the introduction of the health insurance system has been perceived positively by the households.

Graph 2: Quality perception of health care system

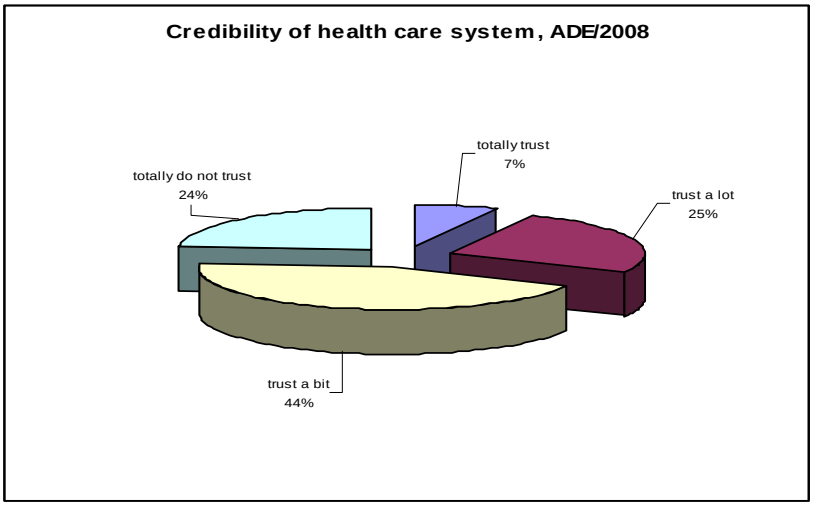


Source: IPP/CIVIS, 2001-2007

Perception of quality of health services similarly grows. A similar analysis of the perception of the quality of health services reconfirms the positive trend as a result of the introduction of the health insurance. The percentage of persons that are totally unsatisfied decreased twice, from 28% in later 2004 to 14% in 2007, the percentage of persons who are quite satisfied increased more than twice, from 12% in 2004 to 30% in 2007. One can see even a very modest increase of the totally satisfied persons.

A recent survey (MCC/AED in 2008) shows the overall trust in the health care system at present times. Around 32% of the households trust to some extent, with 24% totally distrusts the system. Overall, the households are quite reluctant in trusting the public health care system. This information is generally consistent with the IPP/CIVIS opinion poll results.

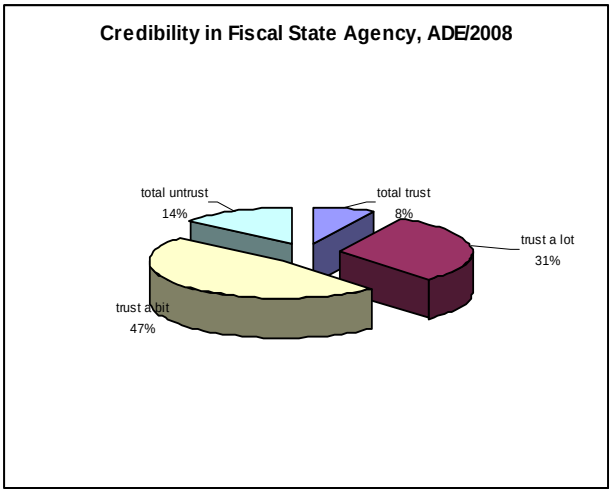
Graph 3: Credibility in health care system

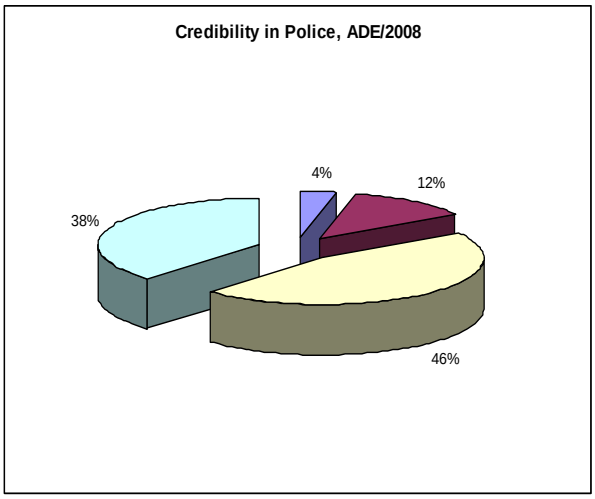


Source: ADE/TI-Moldova/2008

Even if the distrust rate is not as high as distrust in health policy (38%), there is a suggestive rate of 25% respondents that totally do not trust health care system. Comparative figures for fiscal and police authorities, show that health system trust is comparable to the fiscal system, whereas the police system trust lags substantially behind.

Graph 4, 5: Credibility in health system





Source: ADE/TI-Moldova/2008

A comprehensive analysis of the reasons and motives that determines household trust in the system is yet to discover, however, the following elements should play an important role:

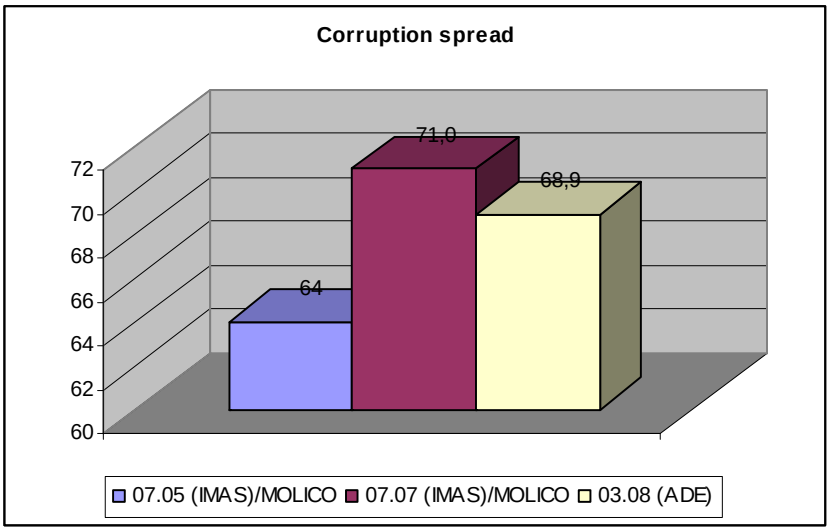
1) direct perception of the quality of health service,
2) accountability of the system before the citizens, referring to the quality information about the system and its performance,
3) leadership and opinion-makers acceptance.

The systematic institutionalized survey should inquire on the approval by the households of the current health policy as well as the household perception of the health services quality. Preferably, the survey should detail for various types and levels of health services (by levels of diseases, of health care sectors, etc.), including accessibility of health services.

2. Corruption incidence and pressure

This part illustrates the level of corruption in health care sector as perceived by households. The corruption in health care system is substantially present and more than half of the households believe so. Notwithstanding the reasons and explanation for it, the households' perception of corruption has not decreased after the introduction of mandatory health insurance system. The corruption perception is substantially more than 60%.

Graph 6: corruption spread



Corruption is a cost and a constraint in the development and for the quality of health services. One has to understand the motives that determine the corruption spread perception as well as the real causes of the corruption spread. Household perception might capture to some degree the understanding of the causes of corruption, yet, an expert insight into various aspects is necessary to determine such substantial degree of the corruption spread. The current perception of corruption spread is very high, and should this be true, the whole health insurance system would be under the jeopardy. Most experts assess the financial aspects of the current health insurance system as more than satisfactory and present the Moldovan system serves as a positive example for other countries in the region. The financial aspects of the system are just part of the system, the quality of services that are directly experienced by the households depend on many other factors. Still, the corruption spread perception most possibly exaggerated due to the misunderstanding of corruption phenomenon, and tendency to attribute other phenomenon to the notion of corruption[1].

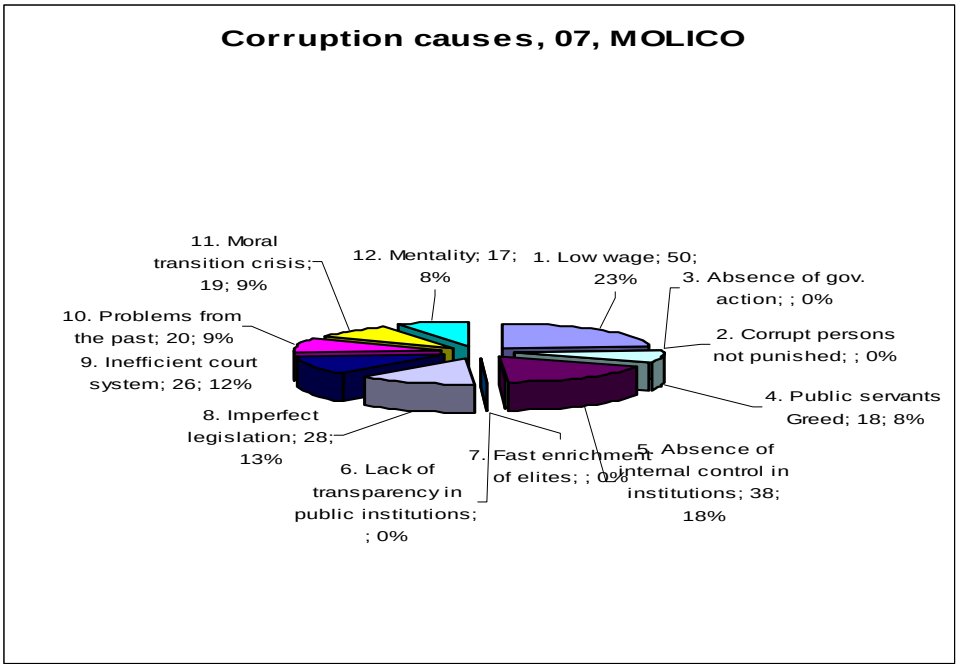
Based on these arguments, an institutional survey should address explicitly situations and cases where households directly experience corruption, include different questions that help distinguishing cases of corruption.

Household perception of reasons for corruption is diverse. A recent study on corruption causes reveals that the households believe that the main causes of corruption are: low payment of public servants (23%), followed by the absence of internal control in institutions (18%) and imperfect

[1] Recent information (June 2007-March 2008) released by the Center for Analysis and Prevention of Corruption (www.capc.md) based on the hot-line calls denouncing the cases of corruption, demonstrates that 80% of the cases are wrongly qualified as corruption cases.

legislation (13%). Many respondents think the causes of corruption pertain also to the transition crisis and the legacy of political system (around 18%).

Graph 7: Corruption causes



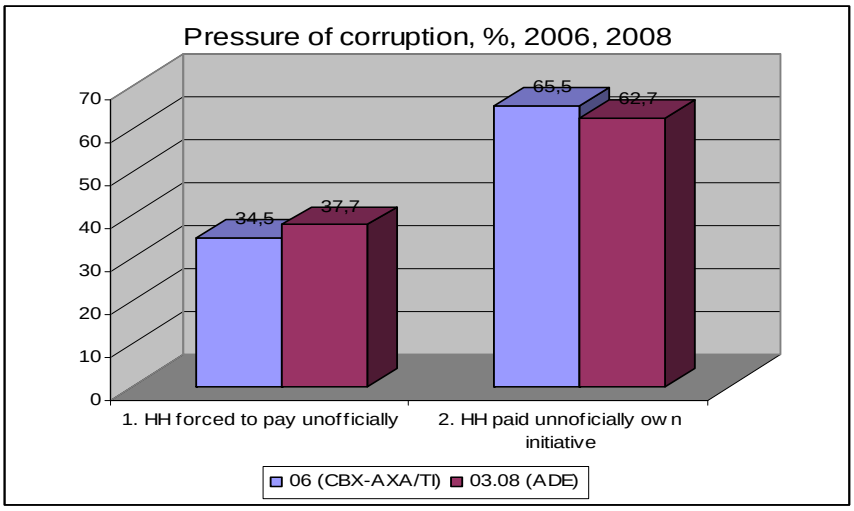
Source: MOLICO/2007

It is noticeable that absence of institutional accountability is cited as one cause (18%), at the same time more than a quarter (22%) assign it to the behavior and value system: mentality (8%), moral crises of transition (9%), public servants greed (8%). Institutional weakness of low salary (23%) and imperfect legislation (13%) are a significant factor. A more recent study (AED, 2008) cites absence of institutional control, insufficient transparency as institutional causes as well. Low wages and punishment of corruption cases are the causes as well.

Although the perception of causes of corruption is important and indeed the perception reveals important information, in many cases expert opinion is helpful to understand better the causes of corruption. Moreover, the perception of households depends on the media reflection, popular opinion-makers opinions. These sources are often subject of constraint given the insufficient quality of media reporting skills, limited degree of media independence, and very limited availability of quality expertise on the level/type of corruption.

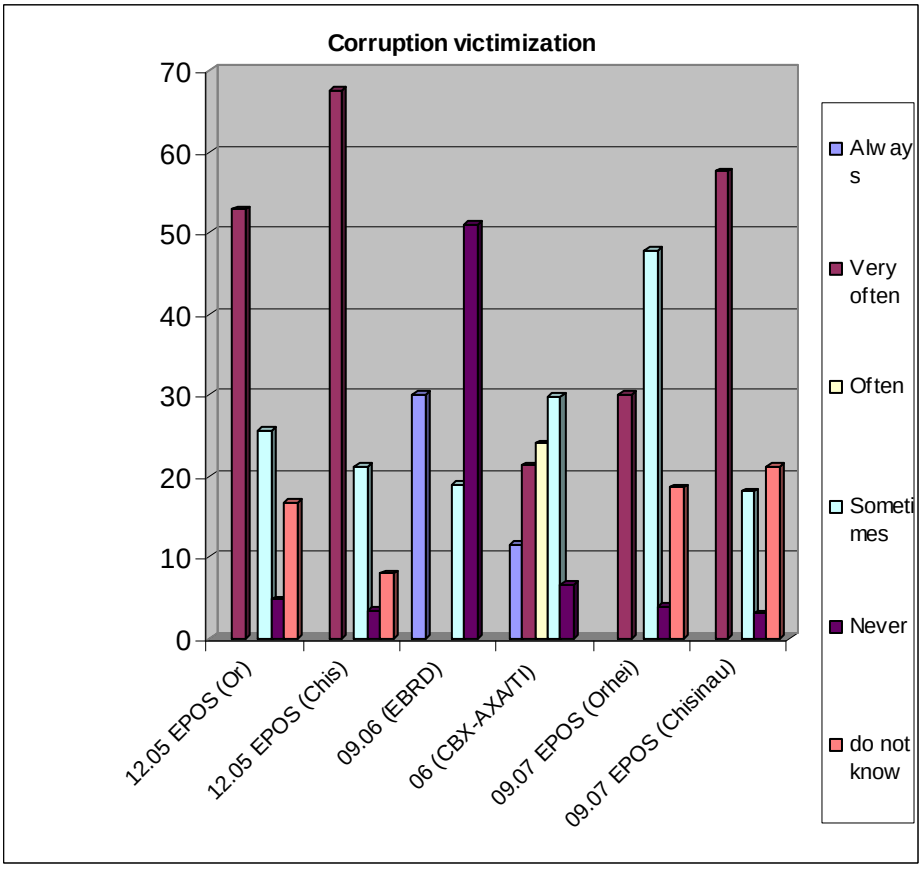
The implementation of the mandatory health insurance did not contribute to the diminishing the corruption pressure. According to the latest survey (ADE/TI-Moldova, 2008), more than a half of population paid unofficially either by their own initiative or were forced to. The corruption rate almost doubled since 2006. These results might be due to greater awareness of the population of corruption cases, economic evolution and other factors.

Graph 8: Corruption pressure



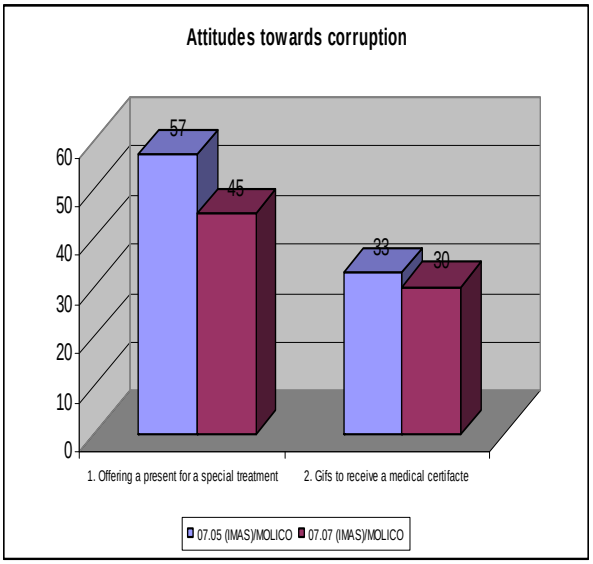
Around 35% of the households' surveyed were under the pressure to pay unofficially. It also demonstrates a considerably high level of tolerance towards corruption. The household availability to pay bribe is substantial. Almost 35% will definitely bribe a doctor/medical assistant, 50% will pay the doctors/medical assistant depending on the situation. This will be done in situations when being treated specially with care by the doctor, or when there is the need of processing a medical certificate, which can take long time to obtain.

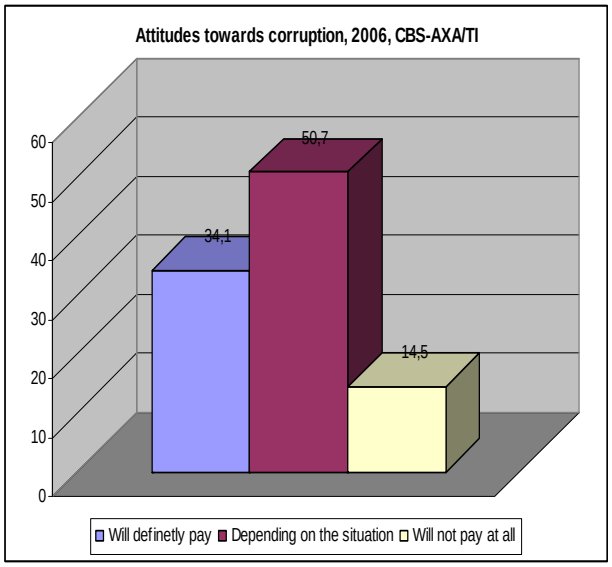
Graph 9: Corruption victimization



There is a very high degree of availability to pay for the medical services, more than 75% consider paying and only 15% will not pay at all. However, as compared to 2005, the extra-payments for special treatment or medical certificates decreased by averagely 10% in 2007.

Graph 10, 11: attitudes towards corruption





Based on the above, it is clear that the pressure for payment exist in around 30-35% (demand for payment), the rest around 60-65% have paid out of pocket upon own initiative, the later is perfectly in tune with the 60-70% of the availability to pay anyway (supply for extra-payment). The availability to pay including on household own initiative is substantial and a further investigation to understand the nature of this is required.

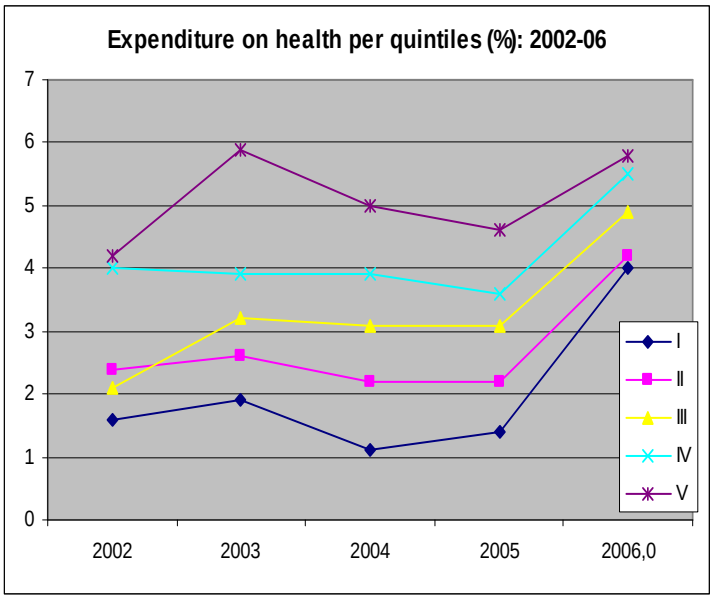
On the basis of the comparison of the corruption spread (60-65%), corruption pressure (30-35%) and availability to pay – supply (60-70%), one can promote hypotheses that if there is the situation of need, almost a half of the households are available to bribe.

The institutionalized survey should inquire about the nature of the payments, what are the households' motivations, how much the household is willing to pay. The survey should also ask questions on the pressure of corruption by understanding the frequency, amount paid and for what type and category of health services.

3. Household health expenditure pattern

The current pattern of the expenditure on health is almost similar across the quintiles, within 4-6%. The Households' Budget Survey most probably reflects additional payments apart from the mandatory health insurance payments – perceived by most as tax[2].

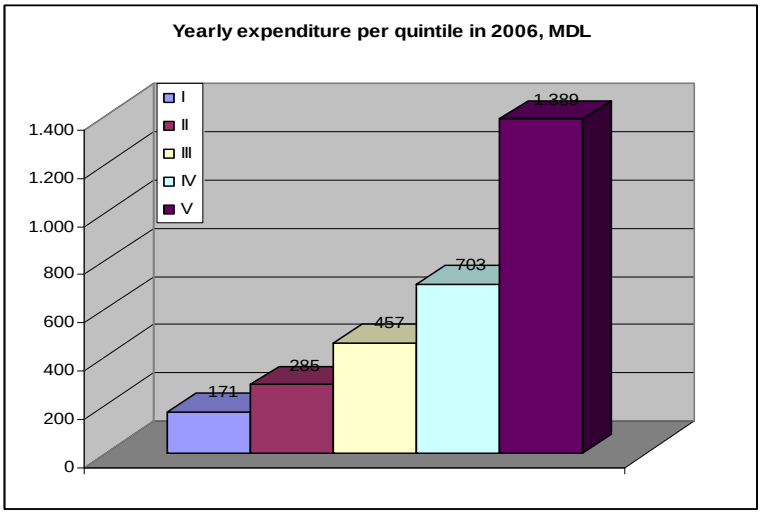
Graph 12: expenditure on health per quintiles[3]



Source: HBS/2002-06

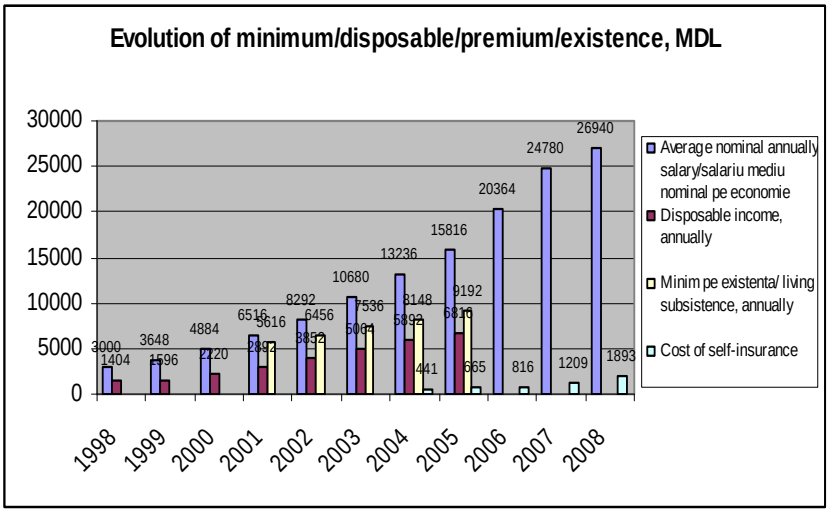
The most rapid increase experienced the poorest quintile: from a bit more than 1% to 4% (almost four times more); the richest quintile experienced a most increase from 4.6% in 2005 to 5.8% in 2006. Specific figures for 2006 indicate annual payments by quintile, where the richest quintile pays 1 380 MDL, while the poorest only 171 MDL.

Graph 13, 14: household expenditure on health per quintile and insurance premium evolution



[2] It is essential to mention that the HBS carried out in 2002-2005 is not comparable with the latest ones, due to different sample, methodology, questionnaire applied. More close information to reality can be found in HBS from the year 2006.

[3] As soon as the data from HBS from 2007 becomes available it will be included in the graph for further interpretation

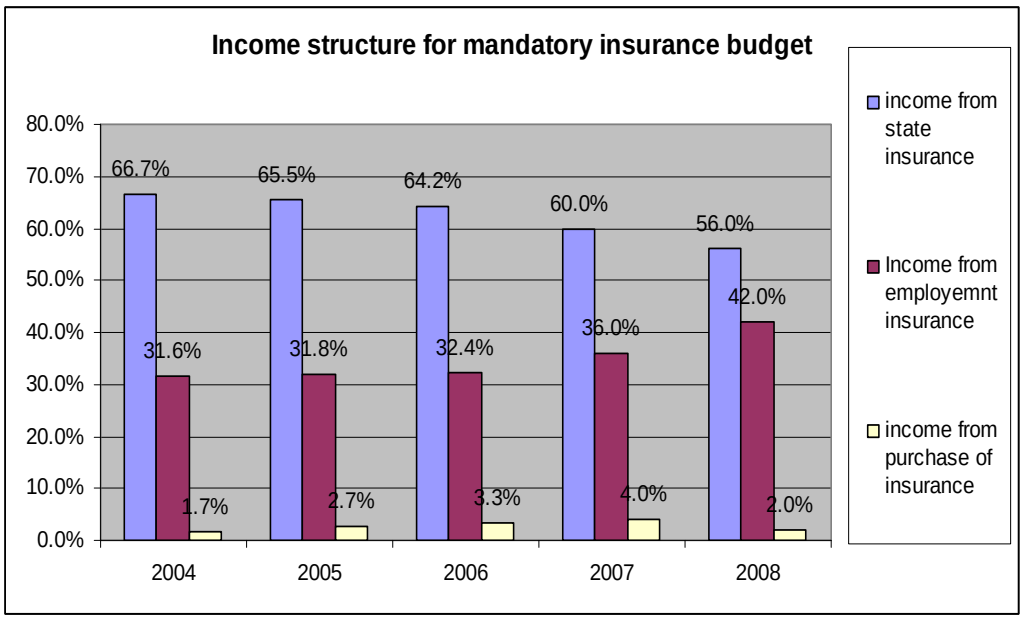


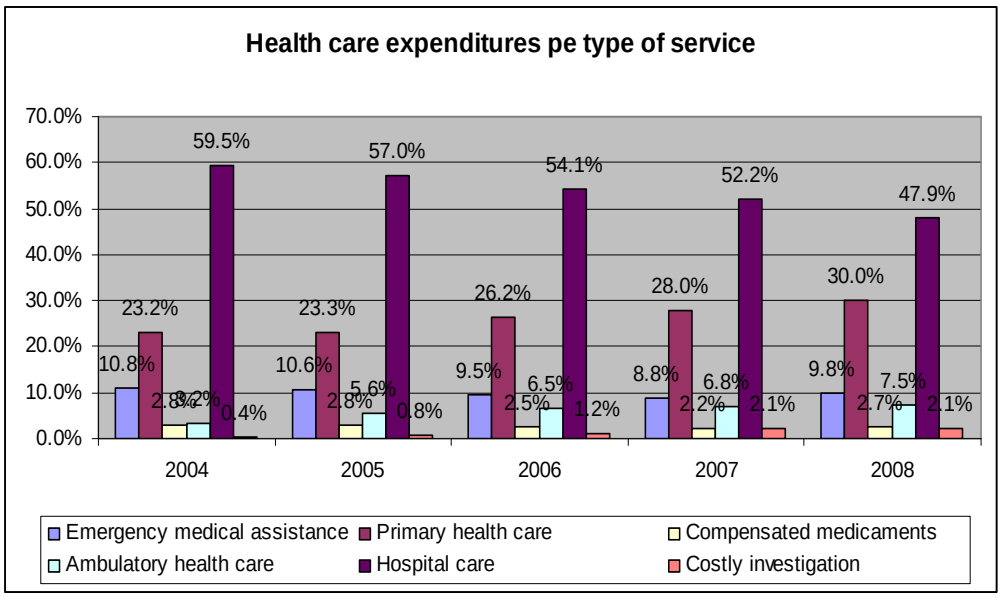
Source: HBS/2006

The absolute value of the insurance premium has grown considerably over the last 2 years. Since 2005, it grew 3 times (from 685 MDL in 2005 to 1893 MDL in 2008). As graphs below show the health insurance system income budget grew almost 3 times over the same period of time. The income from the state budget (state insured groups) remains preponderant while slightly decreasing to the expense of the income from the employed (obviously due to the increase of the insurance premium).

The health authorities adopted a strategy to broaden the type of medical services included in the insurance basket. The distribution of insurance money across types of medical services has not changed since 2004. Even if the shift to primary health care is of a main concern, the hospital service remains the top priority.

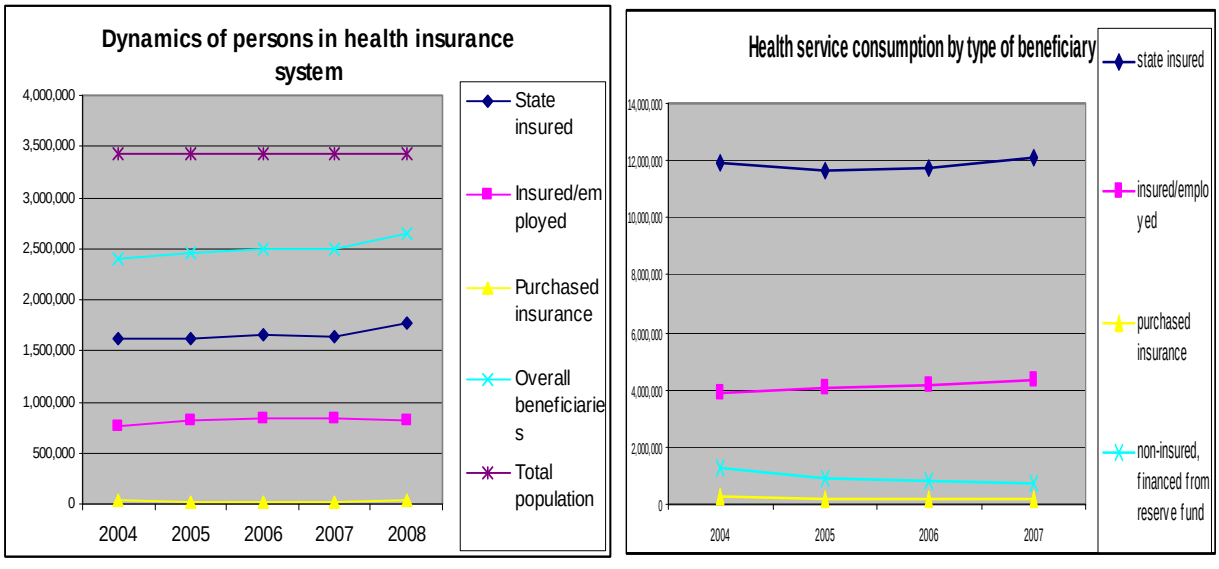
Graph 15, 16: income structure and expenditure of health system





A further analysis of the categories of persons in the system shows that state insured beneficiaries slightly increase. The state paid insurance premium is 10 times smaller than of the insurance premium charged to self-insured, or to those who are insured, through the employment. The analysis shows that the net beneficiaries of the insurance health system are the persons who are insured by the state (4 times more service consumption as compared to those who are insured through the employment). A comparative analysis of the frequency of medical service consumption by categories of persons in the insurance system shows that state insured persons consume 3-4 times more services as compared to those who are insured through the employment. This statistics shows that persons who are insured through the state dominate consumption of the health insured services as numbers and as users.

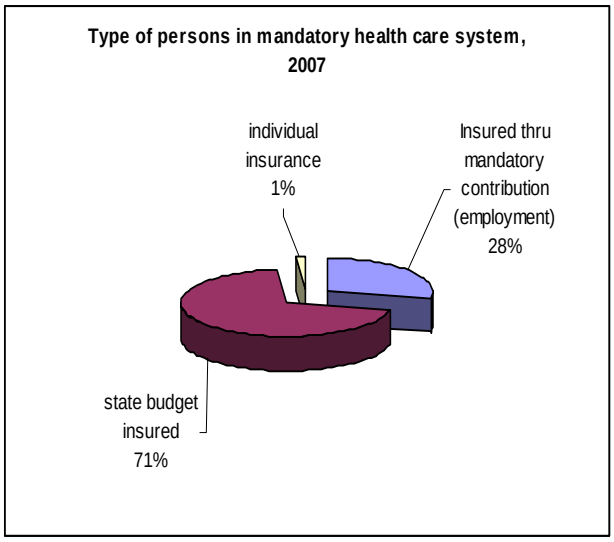
Graph 17, 18: dynamics of persons and frequency of service consumption



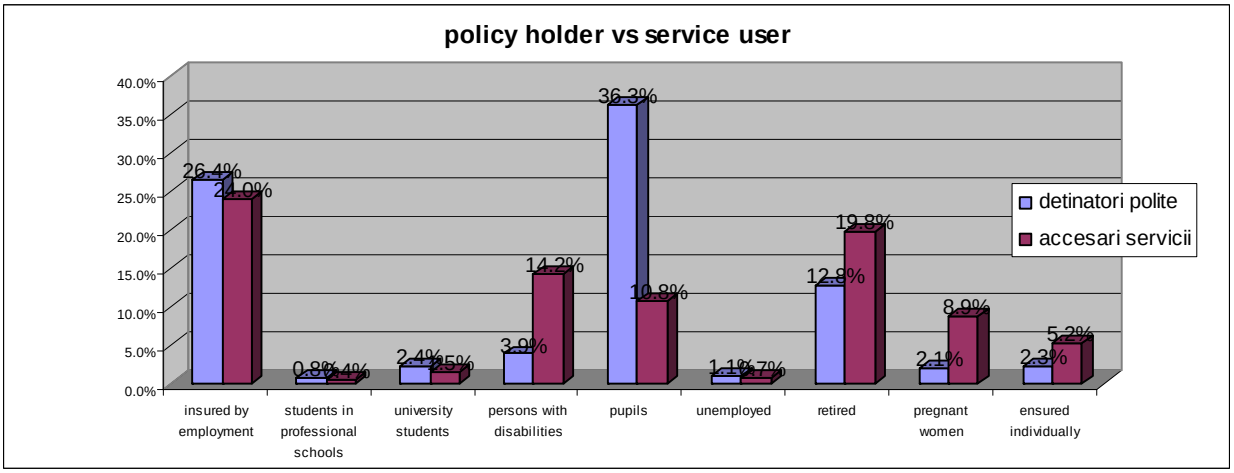
The fact that the bulk of the services goes to the persons that receive state insurance can have an important impact on the institutional and organizational culture of the provision and consumption of insured health services. The profile of persons that have state insurance will be most probably quite different from those who have self-insurance or insured through the

employment[4]. Surveys carried out so far have not distinguished the perception of health insurance system or performance from different types of beneficiaries. The provision of services to the low pay customers (given state insurance is 10 times less than self-insurance and at least 4-5 times less than of the insurance through the employment) whose service financially most likely does not cover service production probably stretches and drives the system into the pattern of the chip, low quality medical services. There is no evidence and information on whether the service is over-demanded by the state insured clients or if the production of services suffers through the use of the improper technologies or inefficient procedures in service production[5]. These aspects should be dealt with in the institutionalized survey and further researched.

Graph 19, 20: types of beneficiaries of health care insurance



Graph 20: categories of beneficiaries of health care insurance



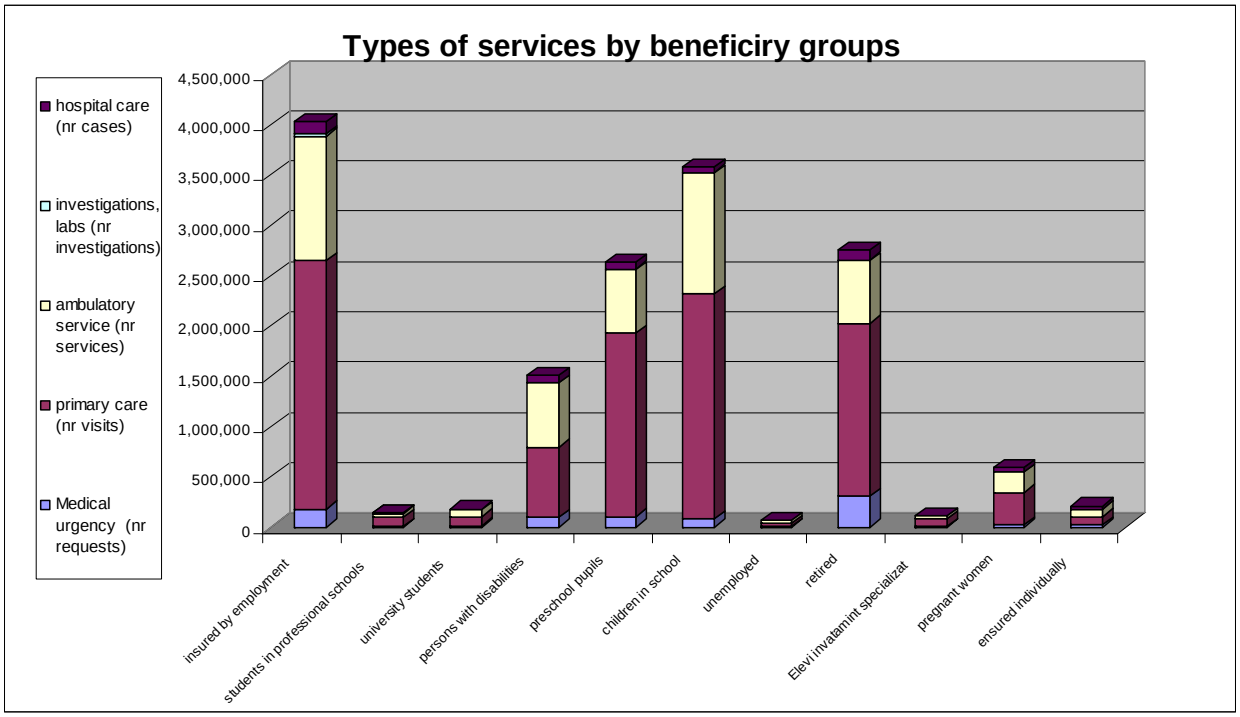
Source: Budget Analysis of health care sector, 2008

Based on the data from 2007, one can see that there are a substantial number of state insured beneficiaries. The percentage is around 60-70% and therefore the system is driven by the perception of the state running money rather than by the insured based contribution. The health bureaucracy understands the large portion of state money that come to fill in the financial

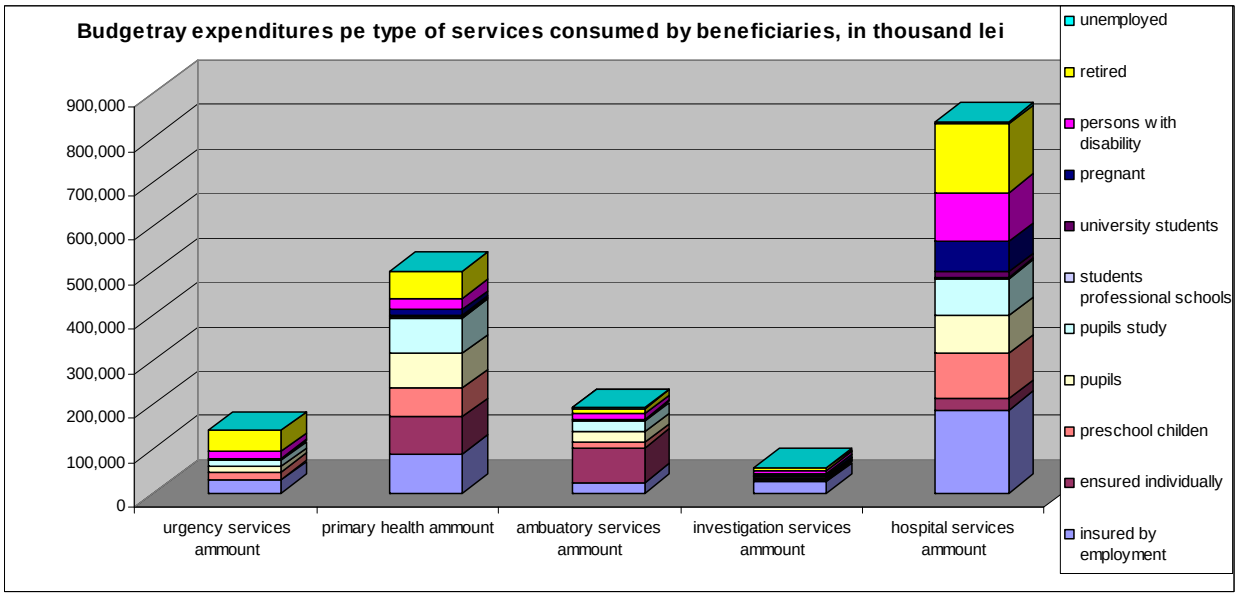
[4] A further analysis is needed in the type of self-insured persons, types of persons ensured through the employment from the perspective of type of service consumption and contribution amount.
[5] There is a widespread perception of the improper allocation of time by he family doctors, who are required to manually fill in a number of information.

functioning of the system anyway, currently the system only partly depends on the contribution mechanisms. The insurance system is preponderantly used by those who are state insured (67%).

Graph 21, 22: types of beneficiaries in health care



Source: Budgetary Analysis of Health sector, 2008



Source: Budgetary Analysis of Health sector, 2008

The institutionalized survey could discriminate the respondents based on the type of the beneficiary of the health insurance (state insured, self-insured, etc), income level as well as additional payments different types of medical services.

4. Existing accountability mechanisms

Mechanisms of the accountability in health care system

In this section we discuss the existing accountability mechanisms.

Accountability – the obligation to account for responsibilities conferred, establishing the right of citizen to know what the government intends to achieve on behalf of the citizens and how well it has met its intentions. Performance accountability is the duty of the public officials to report their actions to the citizens. Overall, it includes: who is accountable, what information should be reported, how much information, what is the quality of information, how and when information is provided.

Agencies and specifically the providers of the services are accountable by clear targets, provision of business plans and performance. The provision of the insurance based health care at hospital level faces the situation of the complete monopoly at regional level or for some type of specialized services. Therefore, the situation resembles the case of the health care providing bureaucracy that engages in the maximization of their institutional budgets formulating take-it-or-leave it position. The assumed monopoly will drive costs and budgets higher reducing from the performance accountability of the health care providers. Virtually monopolistic providers tend to hide true functional costs and concentrate on the process indicators to justify the increase of the costs and budgets.

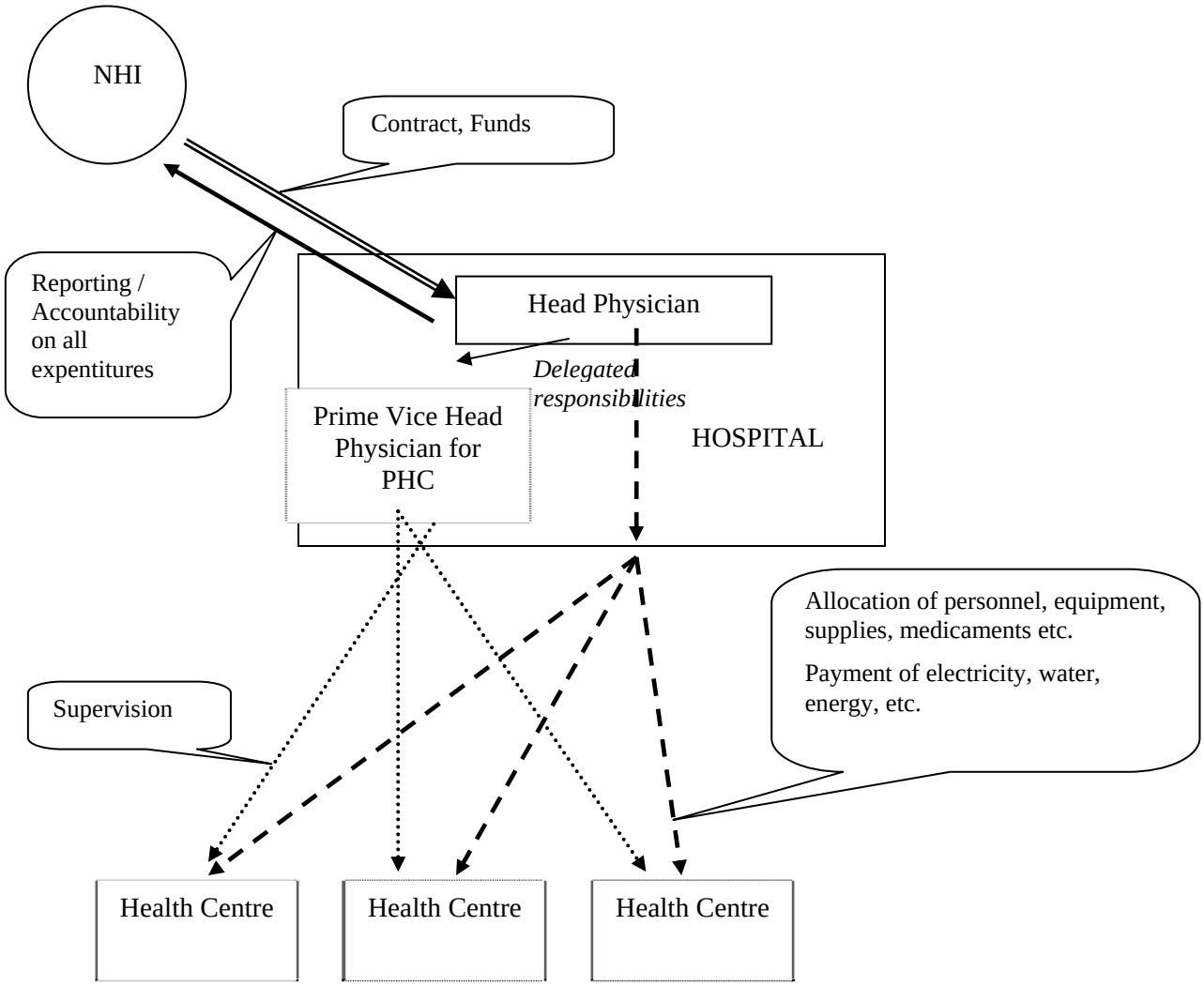
The accountability of the health care providers becomes defuse when the buyers of services and the public is unaware or incapable to monitor the providers performance. The diffusion of the accountability claims becomes even more emphasis if there is a significant number of beneficiaries become the clients of the system through the state covered system of insurance. Te state insurance also transfers a type of mentality and treatment for the “minority shareholders” of the insurance based system.

The structure of the competition of the health care market for different type of services has traditionally been seen as a market accountability approach. The state policies tend to narrow the access of the alternative providers of the health services, raise barriers to access the market or provide subsidies (in kind or in cash) for the state providers of the health services. This could also take the form by artificially lowering the capacity of the policy-making competences concentrating resources (given large health bureaucracy and powerful extensive health care providers) in the extensive health care providers. The later continue to exercise lobby for the resources and prevent the consolidation of the effective policy-making functions.

Current health accountability system

This section will discuss the existing institutional system of the health care, including flow of funds and finances, contractual arrangements between the providers of services, contractors and policy accountability actors resulting from the health insurance system.

Graph 23: Present situation: flow of funds, accountability and performance for Primary Health Care (PHC):



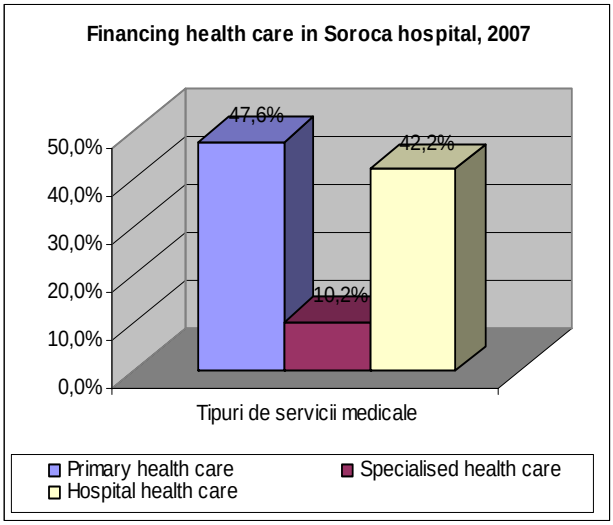
The functioning of the presented system creates the situation where National Health Insurance Company (NHIC) enters a direct contract with rayon hospital (subject to licensing from Health Accreditation Council – not enforced universally) that provides services subcontracting family doctors for the provision of the primary care services. NHIC contract contains 2 annexes where for hospital services, the payment is done by intervention (a number of interventions is planned and monitored), and for primary care the payment is done per capita (based on the number of patients per territorial jurisdiction)[6]. Indirect costs for the primary care are spent by the hospital.

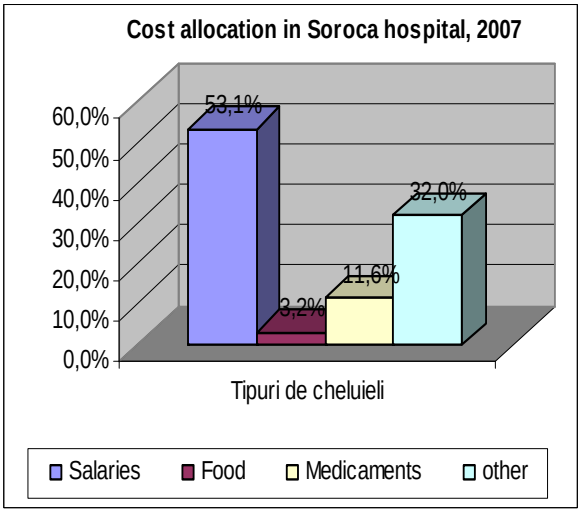
Hospital head physician is the primary administrator of the funds received for Hospital Services (HS) and Primary Health Centers (PHC). The direct supervision of the PHC is done by the prime vice-head physician of the hospital. The de facto subcontract for the provision of primary health services takes place between the hospital and the primary health centers' family doctors who form the core part of the primary health centers. The hospital allocates salaries for the family doctors that work on the ground, and pays the utility services, supplies with the medical and other equipment. In the essence it is the employment of some doctors to perform certain medical services on behalf of the hospital under fixed salary rule. The family doctors have to serve a

[n]Annex 1 of the contract refers to the primary health services based on the number of persons that are to be served of which some have insurance with one tariff and some are uninsured but paid by the state with tariff that is several times smaller. The contract also contains quality allocation of around 10% of the sum contracted for the health care services.

fixed number of persons within its territorial mandate for which they receive a fixed salary and paid indirect costs, thus they receive it as in kind contribution for the provision of medical services. The family doctors have to report on the number of cases consulted, this being the key contractual indicator. The salary is the only economic motivator for the family doctors.

Graph 24, 25: Example of expenditure distribution in Soroca hospital, 2007

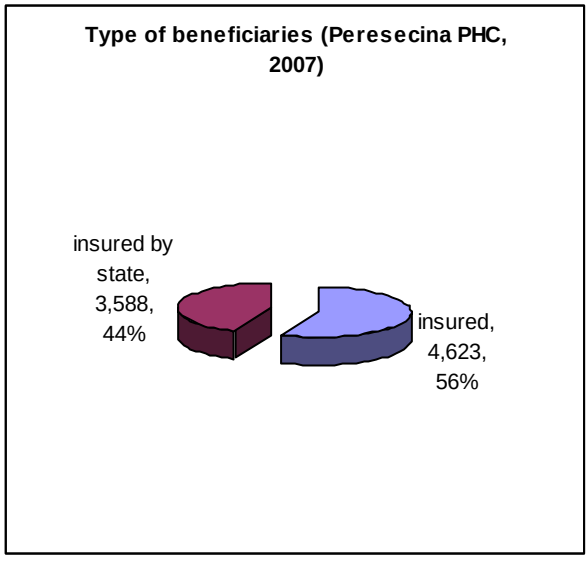




Source: DAI-Europe: Functional Analysis, 2006

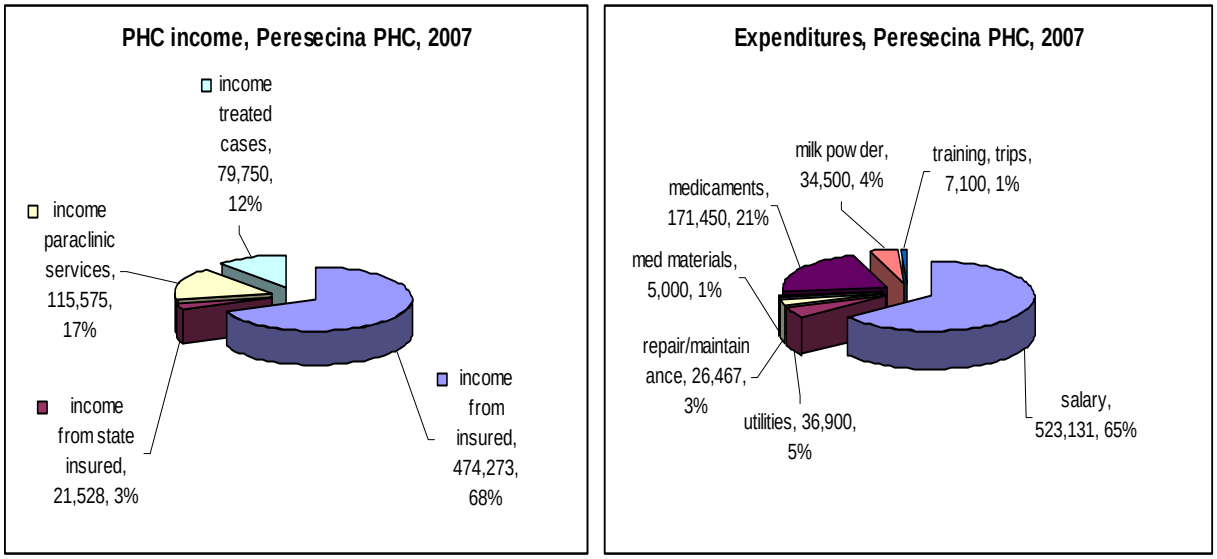
The individual contracts between NHIC and the hospitals are not published either by NHI or by the hospitals, nor the annual reports of the contract execution. Therefore, the interested household cannot scrutinize this information for their own purposes on the costs and expenditures. The contract provides that the hospitals will be reimbursed on semester basis provided they report number of cases and interventions as well as have proof for the expenditures for the indirect costs. Interested media and professional think tanks do not have the possibility to scrutinize the finances and the reports across jurisdictions.

Graph 26: Example of the income-costs for the primary health center



Source: EPOS report on finances in health sector, 2007

Graph 27, 28: Example of the income-expenditure for the primary health center



Source: EPOS report on finances in health sector, 2007

An insured person brings a bit more than 100 MDL as income into the budget of Primary Health Cener (PHC), while state insured person brings only 6 MDL. The insured people's contribution to the PHC budget is about 70%, with the state insured less tan 5%. At the same time if to compare with the actual rate of use of the services, one can see that around 70% of services are provided to the persons that are state insured.

Another aspect of the principal-agent relationship between NHIC and the hospitals is that the contract contains input only indicators (number of cases – primary care) or process only indicators (number of interventions – hospital services). These contractual arrangements might drive undesirable consequences for the quality of treatment and the interests of the households. One should consider putting in place a number of institutional accountability mechanisms through proper contract indicators (a combination of input-process-output and outcome indicators as well as benchmarks for the productivity and te use of technology), obligation of accessibility and publication of the annual financial and performance reports as well as a more hand-on approach from NHIC in managing contracts. The contracts should contain the stimulus through NHIC specialized programs and indirect higher allocations for discretionary use by the providers for the health services, should the providers of services perform better on the conracts.

This secondary layer of principal-agent relationship is not accessible and transparent for the NHIC and the households and violates the principle of the principle-agent relationship. This relationship lacks the necessary institutional accountability mechanisms.

Conclusions regarding accountability performance mechanisms:

1) absence of direct principal-agent relationship between the principal (buyer of services) and agent (provider-family doctors),
2) hospital administrator is biased towards the greater allocation of contracted sums to the provision of hospital services,
3) contractual indicators provide reporting simply input indicator of persons served,
4) primary health is financed based on the principle of the fixed sum allocation and in kind allocation for the support of provision of medical services that creates disincentives for quality and results,
5) there is no direct accountability line between the provision of primary health services and the household,

6) there is no accountability line between the provision of primary health services and the local/regional constituencies,
7) absence of the information to the public on the performance of the primary health services,
8) households cannot hold accountable primary health service as it lacks legal personality and therefore civil and another responsibility; in the rural settings, the households cannot exercise market accountability of the primary health provider (in urban areas the situation is better),

For the hospital care, there are 34 rayonal hospitals and 11 municipal hospitals (for the Municipality of Chisinau and Balti). The contractual relationship with the providers differ and information is available that some hospital providers are more advantaged as compared to the others, simply the institutional contracts are to be based on the clear criteria that combine indicators related to the potential beneficiaries, technology used, prior performance and the challenges faced by the specific regions.

Institutional capacity of the Ministry of Health (MoH) and National Health Institute (NHIC)

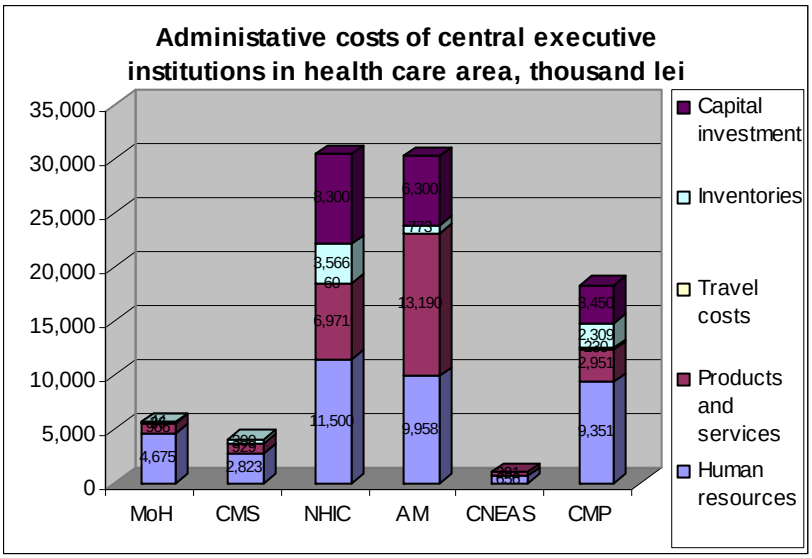
The institutional capacity of the MoH to hold accountable NHIC and the providers of the health providers as well as capacity of NHIC to hold accountable the providers of the health services are essential for the improvement of the accountability mechanisms in the health care system.

Currently MoH has one vice-minister and 3 directorates that deal with the health insurance policy: Directorate on medical insurance, Directorate on individual medical services and Directorate on mother and child health. The vice-minister of MoH responsible for the health insurance is a former deputy director general of the NHIC, who maintains direct contacts and links with the NHIC. The Directorate on medical insurance is responsible for the health insurance policy and the functioning of the NHIC[7]. This directorate has just 3 staff employees, the head of the directorate ha medical background and some experience in working with the health insurance system; the other two persons do not have any experience in health insurance system. One person is a recent graduate of the legal department and another one is in pre-pension age. The directorate responsible for the individual medical services has the mandate over the provision of all individual medical services; insurance based provision of services is also considered as included. The later has 4 employees; all have medical background. The directorates lack competences in the area of health insurance, health economics and finances, institutional economics, management by institutional contracts. De facto, the two directorates seeded the insurance policy functions to NHIC. Policy-wise NHIC is accountable directly to the Cabinet of Ministers where, there is only one councilor responsible for the health area reporting to the prime-minister.

Major policies in health insurance, in practice, are drafted and lobbied by NHIC. The key policies: law on insurance funds, health insurance service basket, insurance premium, and cost of compensated medicaments are drafted by the NHIC and presented to the Cabinet. The role of MoH is very modest, de facto MoH presents only opinions. Based on the law on NHIC, MoH does not hold accountability instruments towards the administrative budget of NHI; there is only one representative (out of 12) of MoH in the governing Board of NHIC.

Graph 29: Administrative costs in health care sector

[7] Additionally head of the Financial and Economic Directorate of the MoH is the chair of the Censor Commission of the NHIC



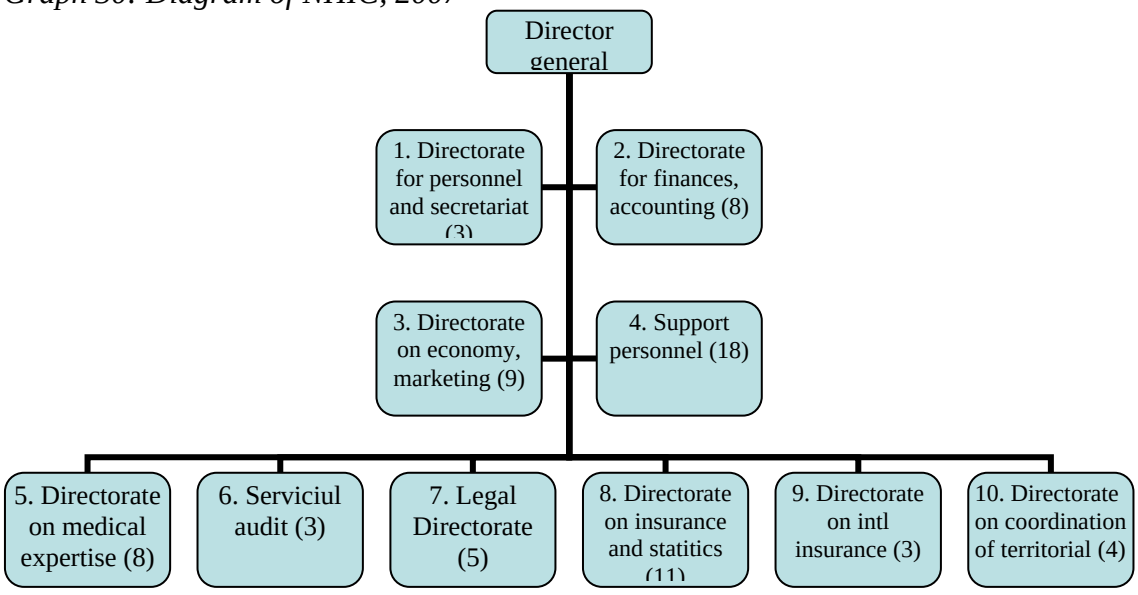
Source: Budgetary analysis in health care sector, 2007

The administrative costs of the NHIC is about 25% of all administrative costs of central public institutions.

Governance of the providers of the health care services is another issue. Hospitals founding members are regional (rayon) authorities, while the appointment of the director of the hospital is the priority of the MoH based on some competitive procedure. The bulk part of the finances comes from the NHI, with rayon authorities supporting some less than 5% going to indirect and repair needs. The performance of the hospital is the competence of the NHIC.

While looking at the organizational structure of NHIC one can see absence of the strong mission center that manages the individual institutional contracts by joining the financial considerations with the results and outcome considerations.

Graph 30: Diagram of NHIC, 2007



Source: DAI-Europe: Functional Analysis, 2006

NHIC has 10 territorial branches, each has a staff of 4-6 persons that manage and supervise the providers in 3-4 rayons. The capacity of NHIC to hold accountable health care providers is reasonable well developed. There is considerable experience, knowledge, and expertise in the

area of statistics, economics and management. There are a sufficient number of persons given the amount of work and the responsibility. Yet, NHIC mandate is narrow and is limited to the financial performance of the system.

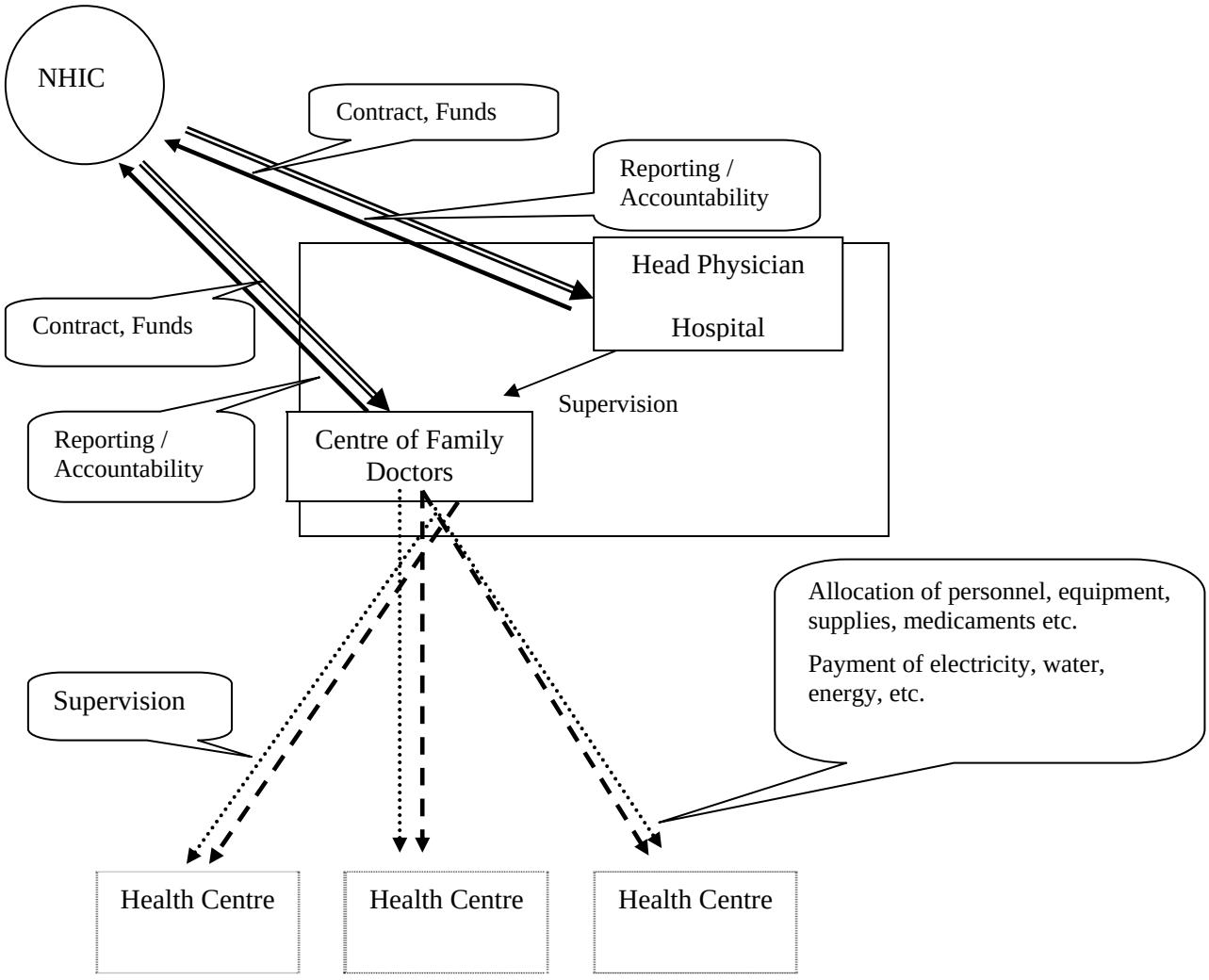
Therefore, the institutional accountability mechanism should be improved by building the relevant capacities in NHIC as well. An institutionalized survey explores direct citizen accountability mechanism on the quality and availability of the information on the functioning of each health care provider.

Decentralization of primary care: Orhei and Chisinau experience in 2007 and decentralization reform starting 2008

This section discusses the decentralization reform of the primary care health providers.

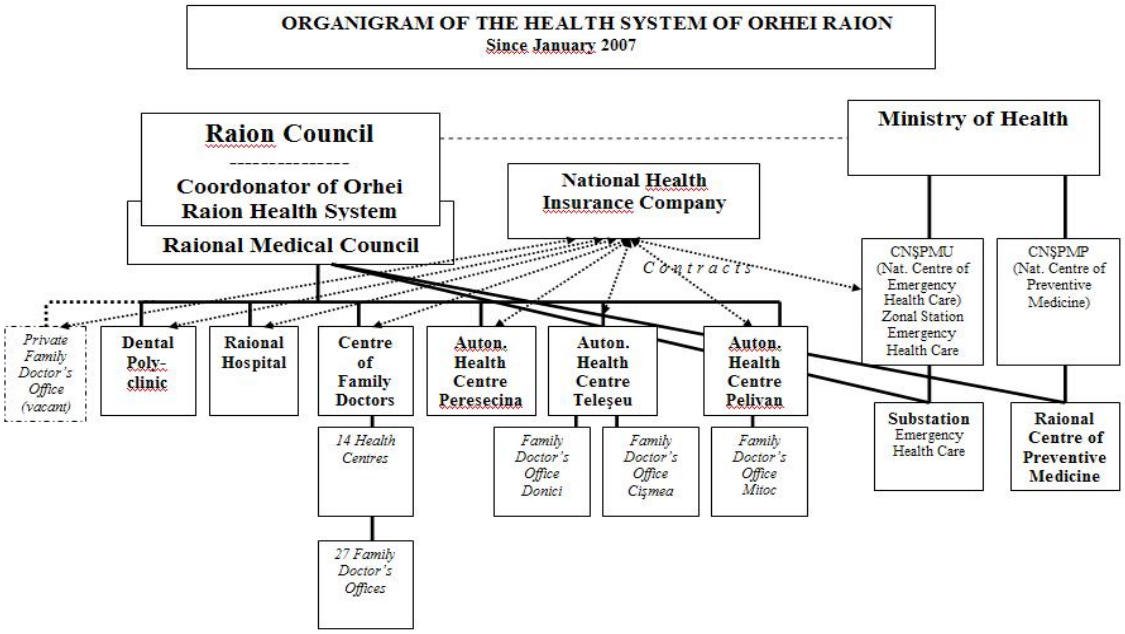
A project on decentralization of primary care is illustrated in the following graph the organigram of the health system as functions Orhei rayon, based on the pilot project since January 2007. As shown in the graph, the most prominent changes are the creation of various autonomous health care providers, new contractual relations between various autonomous providers and NHI, the establishment of a health council as co-coordinating body and finally the appointment of a Rayonal Health Co-ordinator.

Graph 31 Decentralization of primary health care provision



To date, based on the information from the MoH, there are 26 centers have been contracted by NHIC. The new system improves some accountability mechanisms. Primarily this refers to direct principal-agent relationship between NHIC and the primary health care center, avoiding hospitals.

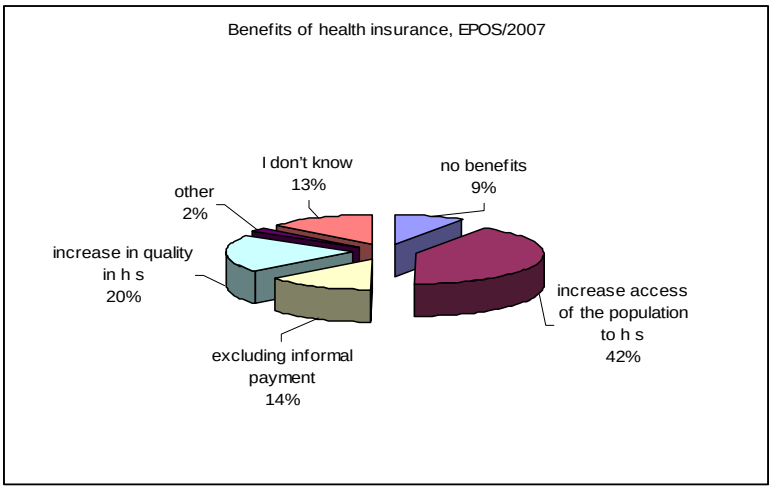
Graph 32 Decentralization at rayon level administration



The diagram shows greater decentralization of the primary care health system. Direct contracts are to be concluded with the primary care providers avoiding the intermediation of the hospitals. The pilot project, however, has not explored the mentioned improvements of the institutional contracting with the indicators of performance, greater institutional transparency and household accessibility. Based on the existing pilot project a number of household perceptions evidence is presented below.

The opinion polls results are valuable due to the fact that it was carried out in two important regions of Moldova after implementing the pilot decentralization reform, making them valuable case studies of the population attitude towards the reform and corruption in health.

Graph 33: perception of benefits of decentralization of primary health care pilot project

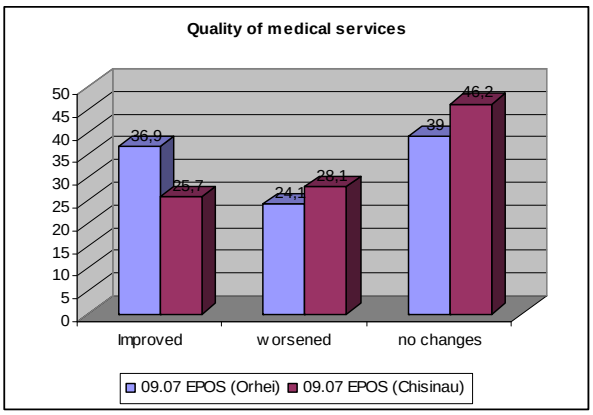


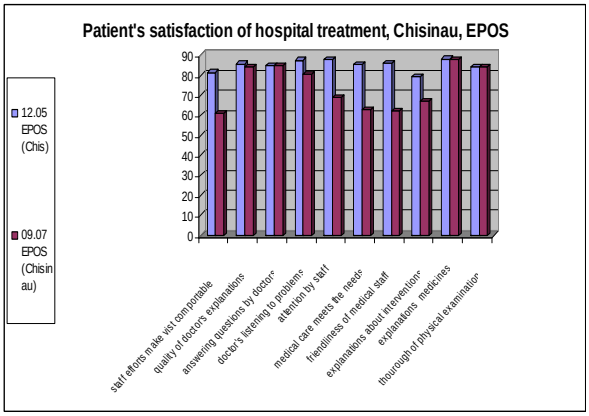
Source: EPOS report on PHC opportunities for reform, 2007

Referring to the carried out poll in both regions, implementation of obligatory health insurance increased the access of the population to the medical services, as well as in the quality. Around 15% thinks it helps excluding informal payment. Some people believed it did not bring any benefits, while others did not know how to appreciate this question.

As shown in the graphs below, almost a half of the population believes that there were no changes in the quality of medical services (with 10% difference in Orhei and Chisinau). The population in Orhei seems to be more satisfied with their medical services.

Graph 34, 35: perception of quality and satisfaction prior and after the project

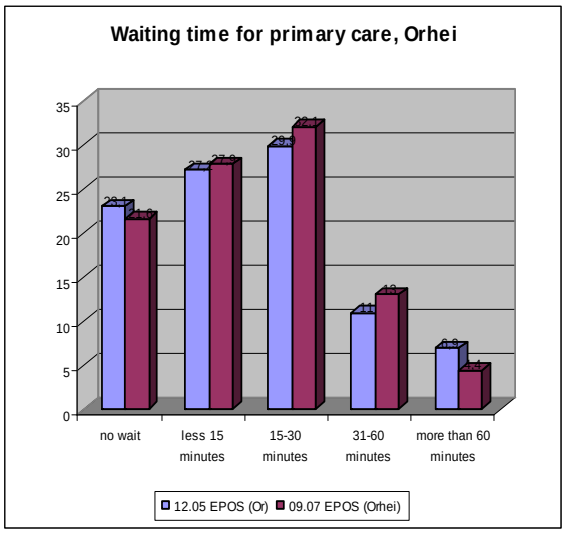


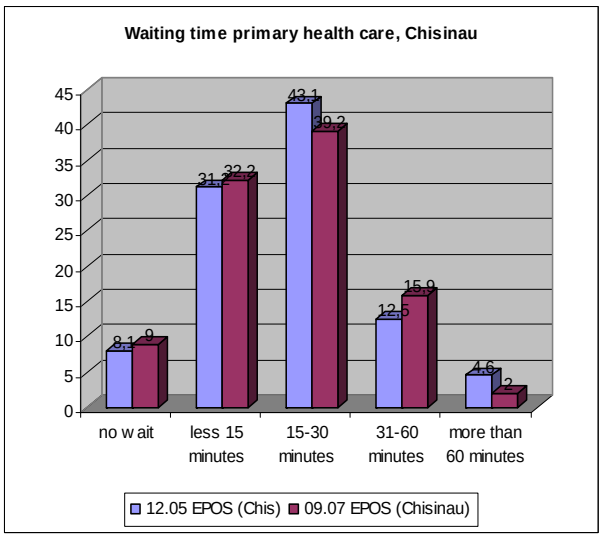


Source: EPOS report on PHC opportunities for reform, 2007

There are some differences in medical service provision in primary health care sector in Orhei and the capital. Patients in Orhei stay in queue less than those in Chisinau. In Orhei a high percentage almost not waits to have a consultation with their family doctor. Both in Chisinau and Orhei, almost a half of the patients wait (registered or life queue) 15-20 minutes to access their medical doctor, regardless before or after the experiment.

Graph 36, 37: waiting time performance in primary care improvement

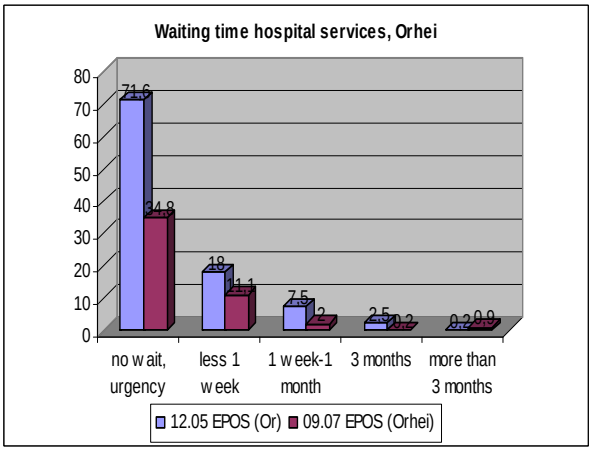


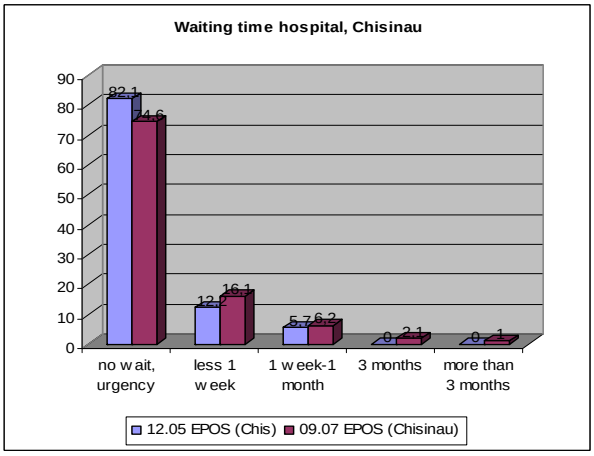


Source: EPOS report on PHC opportunities for reform, 2007

In hospitals, the situation is not very much different. It slightly changed from 2005 to 2007. There are a high percentage of patients that wait for their hospital services for less than a week, in Orhei the patients are in a more favorable situation than those in Chisinau, being assisted faster in hospitals.

Graph 38, 39: waiting time performance in hospitals improvement

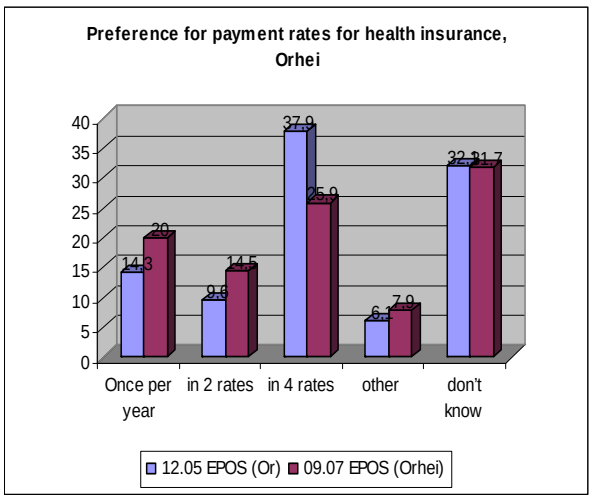


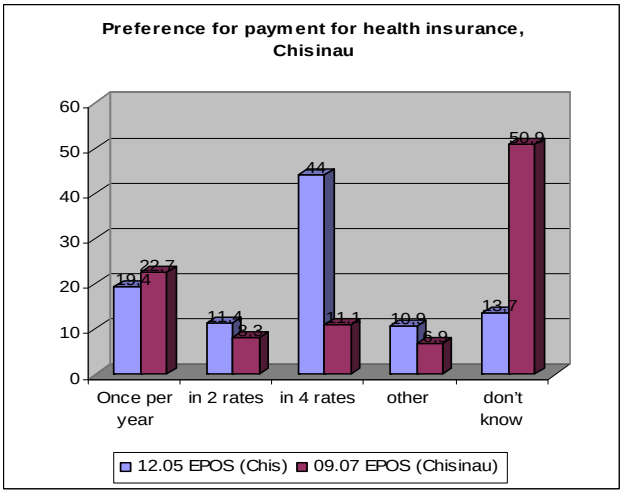


Source: EPOS report on PHC opportunities for reform, 2007

When discussing the health insurance and the payment preferences, in 2005 the majority in both regions preferred partially in 4 rates, while in 2007 in Chisinau would prefer to buy it once while in Orhei it remained the same. Noticeable is the high number of respondents that did not answered or did not know what to answer to this question (more in Chisinau than in Orhei!), which can be related to the reduced informative channels on health insurance and its purchase.

Graph 40, 41: preference for insurance premium payment

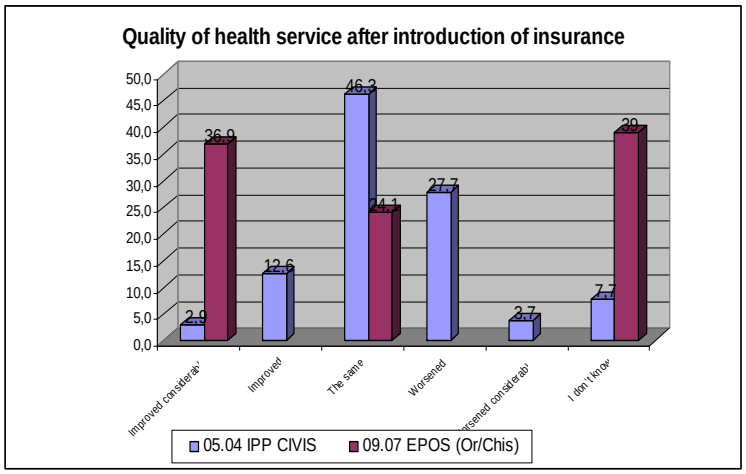




Source: EPOS report on PHC opportunities for reform, 2007

In conclusion, comparing the patients' satisfaction in this region and at national level after introduction of the compulsory health insurance, the quality was appreciated as higher in EPOS piloted regions of Chisinau and Orhei. At national level, shortly after implementing the insurance, the quality of services was appreciated as the same or worsened.

Graph 42: perception of health service quality after introduction of insurance



Source: EPOS report on PHC opportunities for reform, 2007

Based on the pilot project in Orhei region one can see that in the perception of the households, the quality and accessibility of insured health services has improved. The institutionalized survey should measure the household perception of the accessibility and quality of health services for various types of services, including pricing policy, purchasing policy. Another aspect of the survey could be the existence and functioning of the redress and complaints mechanisms within the system.

5. Challenges of strengthening accountability mechanisms

This section discusses options for the strengthening of the accountability mechanisms in Moldovan health care system.

From the stakeholder perspective, accountability requires availability and provision of the information. The key stakeholders of the health care system and the indicator of the accountability include:

Graph 43: Opportunities for accountability lines strengthening in health care sector

Stakeholder (interest, influence)	Accountability indicators	Accountability mechanisms
Households – consumer of quality health services, utility maximization, weak influence	Accessibility, quality of service, flexible choice of service provider, minimized out-of-pocket payment, satisfaction	Relation to service provider through insurance policy, informed volume and cost of services and
Society – quality of health services, public value for money, efficiency of services, weak influence	Corruption decreased, health system transparent and accessibly, cost is paid for the best value available	Transparency of policy process, transparency of financial information
Rayon administration – founders of hospital, coordination of health services at local level, maximization of electoral visibility, maximization of influence over hospital administration (staffing), weak influence	Health providers keep rayon consumers happy, use of funds by the hospital	Approval of the non-insurance part of the budget, transparency of the total hospital budget,
MoH – health policy holder, maximization of electoral visibility, maximization of control over health sector institutions, including NHI and service providers, moderate to strong influence	Trust in health policy and health service quality, decreased corruption,	Important and key role in the financial health policy, participation in the health policy elaboration,
NHI – health financial policy developer and implementer, efficiency and sustainability of insurance health financing, maximization of role in health policy, maximization of financial resources in health, strong influence	Money spend by providers as contracted,	Individual contracts
Centers for primary health care – provider of health services, maximization of professional reputation and cost		Customer accountability

of services, competes with specialized and hospital care, weak influence		
Hospitals – provider of health services, maximization of professional reputation and cost of services, competes with specialized, moderate influence		Customer accountability
Private providers of health services - provider of health services, maximization of professional reputation, access to insurance funds, competes with public providers, weak influence	Accessibility and efficiency in health insurance, price and cost responding to market rules, contracting is clear, predictable and fair	Customer accountability
Medical professional groups – maximization of professional reputation, financial resources, technology, moderate influence	Health finances pay adequately for the medical profession	Cost of labour comparable and attractive

The analysis shows that most influential members of health policy elaboration and implementation community are NHIC (finances, technology, extended autonomy) followed by MoH (non-insurance finances, administrative appointments of hospital administrators, accreditation policy), Hospital providers and medical profession groups (major beneficiaries of health expenditures). These actors drive the current health policy framework. With low technological and professional competences within MoH, the policy is misbalanced towards the financial interests of NHIC and hospitals (and related medical groups). Customer accountability mechanisms are absent, as well as market accountability mechanisms. The qualitative performance indicators are almost absent from the policy-making health agenda.

Based on this analysis, the report proposes the development of the additional accountability mechanisms. Institutional accountability mechanisms should include:

- NHIC contracts should be negotiated for each category of health insurance (hospital, family doctors, etc),
- NHIC contracts with providers of health services include input-process-output-outcome indicators,
- NHIC institutional contracts and their execution published and accessible for the public review and cross institutional comparison,
- NHIC contracts to be based on the justifiable criteria of beneficiaries per region, technology and quality used, past performance, stimuli for innovation, as well as to retain additional income for investment in the provision of services,
- NHIC capacity to supervise the contracts' performance, look into the content of the services and not only the finances of the contracts.

Public accountability mechanisms should include:

- Transparency and reporting on the overall budgets of the health providers, including performance by the medical service providers (hospitals, family doctors, etc),
- MoH substantial role in health policy (law on insurance budgets, insurance service basket, administrative budget of NHIC),

- MoH policy-making capacity in the insurance area strengthened and greater involvement of the private-public partnerships,
- Rayon health authorities should play important role in overall hospital budgeting process and review of the performance,
- Health care providers patients' satisfaction surveys and evaluations (to be taken into consideration for the accreditation and budget allocation),

Market accountability mechanisms should include:

- Cost-by-service and value created by the current contracted providers of medical services (hospitals and family doctors),
- Clear eligibility of private providers into the insurance market (primary family doctors and the providers of specialized services).

6. Household perception measuring (outline)

This section outlines the hypothesis that should be measured by household perception and show the links to the accountability mechanisms within the system. Based on the report discussions, findings and conclusions, we recommend the measurement of the household perception of the following:

- approval of health care policy (per types/category of medical service),
- quality of health care services (per types/category of medical service),
- institutional transparence and openness in the operation of the service provision,
- availability of the performance information (per types/category of medical service),
- corruption incidence and reasons (per types/category of medical service),
- corruption victimization (per types/category of medical service),
- out-of-pocket amounts paid (per types/category of medical service),
- accessibility of service, waiting time for services (per types/category of medical service),
- preference for the amount and schedule of payment for the insurance policy,
- types of medical service consumed,
- perception of cost paid and value received (per types/category of medical service).

The measurement should differentiate between the types of the household:

- status and type of insurance,
- similar questions regarding the non-insurance based medical services.

The proposed perception measurement can provide the policy-makers with a comprehensive systematic review of the health care system performance.

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