Expansion of health insurance in Moldova and associated improvements in access and reductions in direct payments

### Authors

Thomas Hone1

Jarno Habicht2

Silviu Domente3

Rifat Atun4

1 Department of Primary Care and Public Health, Imperial College, London, UK

2 WHO Country Office in Kyrgyzstan, World Health Organization

3 WHO Project Office in Greece, World Health Organization

4 Harvard T.H. Chan School of Public Health, Boston, MA, USA

### Conflicts of interest

None to declare

### Word Count

4700

### Acknowledgements

We are grateful to the Moldovan National Center for Health Management (CNMS) and the Moldovan National Bureau of Statistics (NBS) for providing data to support the analysis, and the WHO regional office for Moldova for hosting a research visit in 2013.

The views expressed in the article are those of the authors alone and do not necessarily reflect the decision or stated policy of the World Health Organization

# Abstract

## Background

Moldova is the poorest country in Europe. Economic constraints mean that Moldova faces challenges in protecting individuals from excessive costs, improving population health and securing health system sustainability. The Moldovan government has introduced a state benefit package and expanded health insurance coverage to reduce the burden of healthcare costs for citizens. This study examines the effects of expanded health insurance by examining factors associated with health insurance coverage, likelihood of incurring out-of-pocket (OOP) payments for medicines or services, and the likelihood of forgoing healthcare when unwell.

## Methods

Using publically available databases and the annual Moldova Household Budgetary Survey, we examine trends in health system financing, healthcare utilisation, health insurance coverage, and costs incurred by individuals for the years 2006-2012. We perform logistic regression to assess the likelihood of having health insurance, incurring a cost for healthcare, and forgoing healthcare when ill, controlling for socio-economic and demographic covariates.

## Findings

Private expenditure accounted for 55.5% of total health expenditures in 2012. 83.2% of private health expenditures is OOP payments – especially for medicines. Healthcare utilisation is inline with EU averages of 6.93 outpatient visits per person. Being uninsured is associated with groups of those aged 25-49 years, the self-employed, unpaid family workers, and the unemployed, although we find lower likelihood of being uninsured for some of these groups over time. Overtime, the likelihood of OOP for medicines increased (OR=1.422 in 2012 compared to 2006), but fell for healthcare services (OR=0.873 in 2012 compared to 2006). No insurance and being older and male, was associated with increased likelihood of forgoing healthcare when sick, but we found the likelihood of forgoing healthcare to be increasing over time (OR=1.295 in 2012 compared to 2009).

## Interpretation

Moldova has achieved improvements in health insurance coverage with reductions in OOP for services, which are modest but are eroded by increasing likelihood of OOP for medicines. Insurance coverage was an important determinant for healthcare costs incurred by patients and patients forgoing healthcare. Improvements notwithstanding, there is an unfinished agenda of attaining universal health coverage in Moldova to protect individuals from healthcare costs.

# Introduction

Moldova is the poorest country in Europe. Following independence from the Soviet Union in 1991, Moldova experienced rapid economic decline and has faced economic challenges since, hampering government efforts aimed at health system strengthening, financial sustainability, and universal health coverage (UHC)[1](#_ENREF_1),[2](#_ENREF_2) – the sustainable development goals (SDGs) for health[3](#_ENREF_3).

The economic downturn in Moldova led to health system funding shortages, reductions in service provision, increased out-of-pocket payments for users[4](#_ENREF_4), and a rise in tobacco and alcohol use. Life expectancy at birth fell from 69 years in 1989 to 66 years in 1995, and the health burden from infections (particularly tuberculosis) and chronic illness rose[5](#_ENREF_5),[6](#_ENREF_6). Adverse economic conditions led to emigration, with the resident population of Moldova falling from 3.62 million in 2003 to 3.56 million in 2013[7](#_ENREF_7). In 2006, around 20% of the population lived on less than US$2 (purchasing power parity) a day[8](#_ENREF_8), whilst gross domestic product (GDP) per capita was $1967 in 2011 – the lowest in geographical Europe[5](#_ENREF_5). The GDP has increased from $1.3 billion in 2000 to $7.3 billion in 2012[9](#_ENREF_9), but approximately one quarter comes from remittances from Moldovan population working abroad[8](#_ENREF_8).

The government of Moldova has embarked on health system reforms aimed at rationalising excess hospital capacity[6](#_ENREF_6), reducing service duplication and developing primary health care (PHC)[4](#_ENREF_4) in order to improve health outcomes, provide financial protection and achieve financial sustainability. *The Health Sector Strategy for 1997–2003*[4](#_ENREF_4) set out plans to develop an efficient, effective, responsive and equitable health system[10-12](#_ENREF_10). Following the 1994 Constitution, which guaranteed a right to health, a state-funded free health service package was introduced in 1999[4](#_ENREF_4),[6](#_ENREF_6), followed by the Law on Mandatory Health Insurance (MHI) in 2001, and the establishment of the National Health Insurance Company (CNAM) in 2004.[4](#_ENREF_4)

The MHI is compulsory for Moldovan citizens – and aims to provide complete insurance coverage – but in reality individuals may chose their own insurance or not to purchase any[4](#_ENREF_4). Certain individuals (non-working groups including students, children, pensioners, disabled etc.) receive insurance coverage without payment covered by the government according to equalized groups.[4](#_ENREF_4) MHI coverage entitles individuals to a benefits package of covered services – including selected primary and secondary care services, emergency care, and dental services. In 2009, primary care services were extended, free of charge, to all irrespective of insurance status, and in 2012, services covered by the benefit package were further extended[4](#_ENREF_4). None-the-less, many medicines are not covered and patients incur informal payments due to limited financing of the benefit package.[4](#_ENREF_4),[13](#_ENREF_13) The *National Health Policy 2007-2021*[*14*](#_ENREF_14)wasfollowed by *the Healthcare Development Strategy 2008-2017*[*15*](#_ENREF_15) which, alongside wider health system reform, specifically aimed to expand insurance coverage through financial incentives and mandating an insurance policy when renewing government issued licences[4](#_ENREF_4).

Earlier studies highlight the significant burden of OOP incurred for hospital services (mostly due to informal payments) and for medicines[13](#_ENREF_13) (Panel 1). This study uses routine administrative data on insurance coverage and healthcare utilisation and household surveys to explore the effect of health system reforms on OOP, and applies robust econometric methods to analyse the likelihood of being uninsured, incurring an OOP for medicines or health services, or forgoing healthcare by socio-economic and demographic characteristics.

**Panel 1 | Health System Financing in Moldova**

|  |
| --- |
| **Trends in health system financing**Total health expenditure (THE) as a percentage of GDP rose from 8.1% in 2002 to 11.72% in 2012. Whilst higher than the EU average of 9.61% in 2012, the absolute level of health expenditure per person (PPP$) is the lowest in Europe at $344, compared with the EU average of $3,307.[5](#_ENREF_5)In 2012, health expenditure from public sources was 45.5% of THE compared to the EU average of 76.0%, illustrating the large role private sources play. Public sector expenditure on health as a proportion of total government expenditure rose from 11.7% in 2007 to 13.3% in 2012 – similar to the EU average of 15.2%.[5](#_ENREF_5) The majority of private health expenditures (83.2% in 2012) is OOP and has risen from 79.9% in 2003. Pharmaceutical expenditures accounted for 72% of the OOP payments in 2010.[16](#_ENREF_16) **Purchaser-provider split**In 2003, the creation of CNAM introduced a purchaser-provider split in Moldovan health system by separating health financing and service delivery. CNAM is responsible for direct contracting of hospitals and PHC providers, and for 85% of the government expenditure on health[17](#_ENREF_17). Of this expenditure, around 49% was spent on hospitals, 29% on PHC, 9% on ambulance services, 7% on specialized outpatient care, 4% on compensated outpatient medicines, and 2% on complex healthcare services (2011 data), with little variation in these proportions since 2007[17](#_ENREF_17). **Geographical variation in health system financing**Healthcare spending across regions (rayons) has been uneven, with per capita funding across rayons in 2003 differing by a factor of 4.6. Urban rayons received a substantially greater share of funds due to concentration of hospital and specialist care. Following financial reorganization in 2004 that centralised pooling of funds with CNAM, in 2010 the difference fell to 3.8.[17](#_ENREF_17) |

# Methods

## Analytical framework

The study uses a health systems framework[18](#_ENREF_18),[19](#_ENREF_19), to guide the analysis (Panel 2). The framework builds on *earlier* approaches used to analyse health system reforms[*20*](#_ENREF_20)*,*[*21*](#_ENREF_21). The national Healthcare Development Strategy 2008*-*2017 follows a similar structure to the health systems framework used in the study, enabling analysis of changes in health system goal of financial protection following health system reforms aimed at expanding insurance coverage to explore association of actual insurance coverage with service utilisation, OOP payments incurred and forgone healthcare.

##### Panel 2 | Health System Framework used for analysis

|  |
| --- |
| **Health system functions** We identify four key health system functions which the policy makers can modify to achieve health system goals: (i) **governance and organisation** - the policy and regulatory environment, stewardship function of the ministry of health and its relationship with other levels of the health system, and structural arrangements for insurers/purchasers, healthcare providers and market regulators; (ii) **financing** - how the funds are collected, funds and risks pooled, finances allocated within the health system and how healthcare providers are remunerated; (iii) **resource management** – how physical, human and intellectual resources – are generated and allocated, including their geographic and needs-based allocation; and (iv) **service delivery** that includes both public health services and individual health services provided within the community, PHC, hospitals, and other health institutions. Health services are produced using governance and organisation, financing and resource management functions. **Health system objectives** We define four objectives which the policy makers need to balance when designing or financing a health system, and in relation to individual and public health services: **equity** (including access and use of services by different population groups), **efficiency** (efficient allocation of resources to right interventions and producing them at low cost), **effectiveness** (the extent to which interventions provided are evidence based and safe) and **responsiveness** (of care providers to user needs, including choice of providers).**Health system goals** There are three health system goals in our framework which the system aims to achieve. The first goal is **health**, both the level and distribution of population health as measured by morbidity and mortality. The second goal is **financial protection**, for which we examined level and distribution of health expenditures (targeting of health insurance), levels of health insurance coverage, and levels of financial protection (out of pocket expenditures, and catastrophic health expenditures) for different population segments. The third goal is **user satisfaction**, specifically the satisfaction of the population with the health system. |

## Data Sources

Two main sources of data were used for the years 2006-2012. Firstly, publically available datasets the Moldovan National Center for Health Management (CNMS) were collected. CNMS collates data from public healthcare provider reports. We extracted health service utilisation information relating to number of hospitalisations, average number of visits per person, and emergency calls per 1,000 residents.

Secondly, the monthly collected annual Household Budget Survey (HBS) was used. HBS based on an internationally validated survey and is undertaken by the Moldovan National Bureau of Statistics (NBS)[7](#_ENREF_7). The HBS is nationally representative and is undertaken through two-stage sampling based on regional areas and a random selection of households. Approximately 5,500 households (15,000 individuals) are surveyed annually on a wide range of questions relating to the economic situation of the household and individuals. Responses for the years 2006-2012 were obtained from the NBS. We selected questions relevant to this analysis including demographic, socio-economic, health and healthcare-related questions. Our outcome variables of interest were calculated from survey questions: “If individuals currently have health insurance”; “if individuals paid for any service (inpatient or outpatient) either formally or informally when using care in the last four weeks”, and “if you were unwell in the last four weeks, but did not use healthcare”. Because of issues of non-response (up to 40% in some years), the age and gender distribution of the HBS was compared to national population data (from NBS[7](#_ENREF_7)) showing high similarity (See Supplementary Appendix).

## Analysis

Using the health system analytical framework14,15, we examine elements of financial protection in the context of the health system objectives. Equity is a key health system objective for this analysis. We examine equity in insurance status, OOP payments, and foregone health across demographic groups. We demonstrate the interactions between insurance status and equity in other financial protection elements such as OOP. Additionally, we also explore the health system objectives of responsiveness in terms of preferred healthcare provider, effectiveness through forgone healthcare, and efficiency in terms of national utilisation trends. We triangulate these findings to understand how factors contributing to financial protection are being met.

### *Descriptive analysis*

CNMS data on healthcare utilisation are shown over time. Individual responses on preferred of healthcare provider, for those with healthcare use in the last four weeks, were stratified by provider and year.

For insurance coverage, CNMS data was compared with individual HBS responses (stratified by employed status and age groups) over time.

Insurance coverage trends were compared between individual HBS responses and from administrative data (CNMS) sources. Furthermore, we stratified the insurance status of the respondents in the HBS by occupation and age group.

The percentages of individuals reporting OOP payments were described by consultative services, inpatient services and drugs, and by each year. Mean incurred costs by individuals were shown. Additionally, mean costs were compared to average monthly earnings.

### *Logistic regression*

We employed logistic regression to calculate the likelihood of: being uninsured, incurring an OOP for medicines or any healthcare service from healthcare used in the last four weeks, and not using (foregoing) healthcare when reporting a health problem in the last four weeks. Logistic regression was employed as the most appropriate method for binary outcomes.

Covariates from the HBS survey were used to control for and highlight explanatory factors. We included in all models: age group (0-17 year, 18-24, 25-34, 35-49, 50-59, 60-74 and 75+); gender; chronic disease status (yes or no); and employment status (employed, self-employed (non-agriculture), self-employed (agriculture), unpaid family worker, unemployed (including those of not working age); and educational attainment (pre-school or no education, primary, secondary, and college or university). We also included year (2006-2012) to look for time trends.

For the regressions on the likelihood of an OOP and forgone healthcare, we included disability (yes or no) and uninsured (yes or no) as covariates. Additionally, for the regressions on the likelihood of an OOP we included first choice of healthcare provider (family doctor’s office, home visit, polyclinic (health centre), hospital or other (e.g. pharmacy). For the regression of foregone healthcare, we only examined the years 2009-2012, as the question was not in earlier surveys. Analyses were carried out at the individual level, with adjustments for the clustered nature of the survey. All individual responses were included for analyses, except the likelihood of being uninsured. The regression was restricted to those aged over 18 and under the age of 60 years, as individuals outside these ages are eligible for free insurance coverage. We report adjusted odds ratios and 95% confidence intervals. Interaction terms between covariates and year (linear trends) were additionally tested.

# Results

Table 1 shows the descriptive statistics, which categorises the respondents by socio-economic and demographic covariates, and additionally overall responses to key variables of interest.

***Insert here Table 1***

***<Table 1 – Numbers and percentage distribution of Household Budget Survey (HBS) respondents by year (2006-2012), socio-economics and demographics, and key variables of interest >***

## Service utilisation

We examined average healthcare utilisation rate at national and preferred first contact provider from HBS respondents. The healthcare utilisation rate at national level rose between 2006 and 2012 (Table 2), with the hospitalization rate (per 100 residents) increasing from 16.7 in 2006 to 18.4 in 2012 and the average number of outpatient visits per person rising from 6.02 to 6.45. These numbers are broadly in line with European averages (of 18.04 hospitalisations and 6.93 outpatient visits per person in 2012)[5](#_ENREF_5).

Individual respondents in the HBS who sought healthcare in the last four weeks show the majority sought healthcare in former polyclinics (centers that in majority of cases include both family doctors and out-patient specialists) (48.0% in 2012) with family doctor offices (32.6%), home visits (8.9%) and hospitals (5.2%) the next most popular. These trends have remained fairly constant since 2003 (Figure 1).

***Insert here Table 2***

***<Table 2 | Healthcare utilization (2006-2012)>***

***Insert here Figure 1***

***<Figure 1 | Choice of healthcare provider for individuals who sought medical care in the last 4 weeks prior to household budget survey (2006-12)>***

## Insurance Coverage

Approximately 75% of HBS respondents reported having health insurance during the period 2006-2012 (Table 3). National statistics suggest rising coverage of health insurance from 76.1% to 80.3%. In 2012, only 60% of the working age population (18-59 years) had insurance coverage, with the self-employed and those working in family business having lower coverage levels: 24% of self-employed agriculture workers, 57.8% of self-employed non-agriculture workers, and 53.8% of unpaid family workers had insurance. In 2012, the main reasons for being uninsured were unemployment (27.9%), cost (26.2%), they would pay anyway (13.9%), working informally (13.1%), belief that it would not be needed (8.5%) and working abroad (8.1%).

The odds of not having health insurance were examined using multivariate logistic regression (Table 4). Age was an important determinant of being uninsured, with those aged 25-43 and 35-49 years of age 2.9 (OR=2.898, p<0.000) and 2.3 times (OR=2.261, p<0.000) respectively more likely to be uninsured than those aged 18-24 or 50-60 years of age.

Females were less likely to be uninsured than men (OR=0.599, p<0.000), as were those with chronic health conditions (OR=0.303, p<0.000). All categories of employment were substantially more likely to be uninsured than those employed. The self-employed, and unpaid family workers were all more than 20 times more likely to be uninsured. Unemployed were 5 times more likely (OR=4.915, p<0.000). All categories of education were more likely to be uninsured than those with only pre-school or no-education with primary, secondary, and college or university educated individuals 7.7, 6.1 and 3.2 times more likely to be uninsured.

Generally over time, there was no evidence of a trend in change in likelihood of being uninsured. Model with interactions with time (results not shown) suggest that the likelihood of being uninsured declined over time for those with chronic conditions (compared to those without), females (compared to males), and the self-employed (agriculture) and unpaid family workers (compared to employed). There was an increased likelihood in being uninsured for the unemployed over time (compared to other employment categories).

***Insert Table 3 here***

***<Table 3 | Insurance coverage national and occupational groups (2006-2012)>***

***Insert Table 4 here***

***Table 4 | Multivariate Regression Results on Likelihood of being Uninsured for individuals aged 18-60 years (2006-2012)>***

## Private and Out of Pocket Expenditure

Around 15% of HBS respondents who sought healthcare reported a payment for consultative services and 2% for inpatient care in 2012 (Table 5) compared with 20% and 3% in 2006 respectively. The average costs for both consultative services and medicines had increased since 2006.

The factors affecting the likelihood of an OOP payment for both medicines and healthcare services were analysed separately using multivariate logistic regression (Table 6).

Although low numbers and fluctuations in reported costs make conclusions difficult, there appears to be only modest reductions in costs incurred relative to average monthly earnings over time (Table 7).

### *Out of Pocket Payment for Drugs*

Older individuals (aged over 50 years), who sought healthcare in the last four weeks, were more likely to incur a cost than those aged under 34 years. Females were 13% most likely to pay (OR=1.133, p=0.013), whilst those with chronic conditions were nearly 1.9 times as likely to incurring a cost (OR=1.911 p<0.000).

Unpaid family workers and the unemployed were less likely to incur costs for medicines, as were those with primary and secondary education. Those without health insurance were 1.3 times more likely (OR=1.297, p=0.004) to incur an OOP for medicines compared to than those with insurance. Individuals were only less likely to incur a cost for medicines at hospitals or other services (such as pharmacies).

Over the period 2006-2012, the odds of incurring a cost for medicines have increased (up to 1.8 times more likely to incur a cost in 2011 (OR=1.772, p<0.000) compared to 2006. The only significant interaction with time (results not shown) was insurance status with those without insurance increasingly more likely to pay for medicines OOP over time.

### *Out of Pocket Payment for Healthcare Services*

Individuals who sought medical care in the last four weeks and incurred OOP payments (informally or formally) for consultative or inpatient services showed different trends to costs for drugs. Older individuals and those under 18 were least likely to incur a cost than those aged 18-24. Those with chronic conditions were 1.3 times more likely to pay (OR=1.296, p<0.000), but those with disability were nearly 40% less likely to pay (OR=0.634, p<0.000).

Uninsured individuals were 3.8 times (OR=3833, p<0.000) more likely to incur an OOP payment for health services. There was no difference between employment categories whilst only those with college or university education were more likely to pay (OR=1.391, P=0.008)

Those using hospitals and polyclinics respectively were 7.2 times (OR=7.205, p<0.000) and 2.8 times (OR=2.723, p<0.000) more likely to incur a cost than at family doctor offices. Home visits were less likely to incur a cost than family doctor office (OR=0.415, p<0.000).

There was a general decline in the likelihood of incurring an OOP expenditure cost for services, although the difference was not significant every year. The only interaction with time (results not shown) was age with those aged 50-60 years having an increased likelihood of incurring a cost over time compared to other ages.

***Insert here Table 5***

***<Table 5 | Percentage of individuals reporting costs for healthcare services and average costs incurred (2006-12)>***

***Insert here Table 6***

***<Table 6 | Odds of Incurring OOP for either drugs or healthcare services for those who sought medical care in last 4 weeks>***

***Insert here Table 7***

***<Table 7 | Average reported healthcare costs compared to average monthly earnings>***

## Foregone Healthcare Utilisation

Using multivariate logistic regression the likelihood of not visiting a healthcare provider when being sick in the last four weeks was examined (Table 8). Older individuals were more likely not to seek healthcare with those 75 years or more 2.4 times (OR=2.379, p<0.000) more likely than 0-24 year olds. Females were 9.8% less likely to forego care (OR=0.902, p=0.003).

Employed and self-employed (non-agriculture) individuals were most likely to not seek healthcare when sick. The disabled were less likely to forego healthcare when sick (OR=0.819, p<0.001).

Those without insurance were 1.7 times (68%) more likely not to seek healthcare when sick (OR=1.680, p<0.000).

Over average there is an increasingly likelihood of forgoing healthcare when sick with individuals on average 1.3 times (30%) more likely in 2012 than 2009. There were no significant interactions between covariates and time suggesting the increasing trend in likelihood of foregoing healthcare applies to all individuals.

***Insert here Table 8***

***<Table 8 | Results from multivariate logistic regression on odds of not utilizing healthcare when unwell>***

# Discussion

Our results indicate that aspects of financial protection in Moldova are improving, albeit slowly, but with different trajectories for certain demographic groups.

Health service utilisation has gradually increased from to 6.45 visits per person in 2012– now in line with the European average of 6.93 – and whilst the majority of individuals use some form of PHC (former polyclinics or family doctor offices), there has been little change over time in utilisation levels for PHC services. The inefficient hospital network[17](#_ENREF_17), needs to be rationalised to encourage greater use of PHC services and to develop a more efficient and effective health system.

The challenging economic environment is slowing efforts to improve financial protection – particularly in terms of equity. Our finding that insurance coverage is still not universal – impacting accessibility of services – particularly in older individuals, unemployed, agriculture workers and those of working age is in line with earlier studies[22](#_ENREF_22). Our findings illustrate that despite the government efforts to expand coverage through financial incentives to purchasing coverage and as a requirement during certain licence renewals, not enough progress has been made.

Limited public finances for health are misallocated due to slow progress in tackling the inefficient hospital network which reinforces inequitable provision of healthcare services[17](#_ENREF_17), and limits the ability of the government to further incentivise insurance coverage and expand the benefit package. Although overall there was no significant improvement over time in insurance coverage, the finding that particular groups – the self-employed (agriculture) and unpaid family workers – had reduced likelihood of being uninsured suggests attempts to expand coverage to these groups are having some success.

Our findings confirm earlier studies[13](#_ENREF_13) that reveal the large burden OOP payments – particularly for medicines. Our results indicate the likelihood of incurring a payment has increased over time for medicines, but declined for healthcare services. Notably insurance status is a strong determinant of likelihood of incurring an OOP payment. The fact that many medicines are not covered by the MHI package[4](#_ENREF_4) is clearly contributing to OOP burdens. The high average cost for drugs, which have both increased since 2006, is resulting in the unaffordability of medicines and high prices in both the public and private sectors[16](#_ENREF_16). Financial protection is still not being met in terms of access to medicines, but on the other hand, we see that efforts to curtail informal payments and reduce OOP in services have had some success. Earlier studies in Moldova suggest that cost as a reason for not seeking care when experiencing a health problem has fallen in x to y, but is still a major factor especially in poorer income groups[13](#_ENREF_13).

The finding that healthcare is still being foregone suggests the minor improvements for some groups in insurance coverage and OOP for services, are not translating to improvements in healthcare utilisation. Individuals are increasingly likely to forego healthcare – notably the uninsured, older, and certain groups of employed individuals. Challenges in expanding insurance coverage are clearly impacting on healthcare utilisation. But healthcare utilisation is also likely affected by the limited benefit package, health service quality and non-financial barriers to access [4](#_ENREF_4). Evidence indicates health insurance is key to protecting individuals against OOP payments and promoting healthcare utilization[23](#_ENREF_23),[24](#_ENREF_24), although for those in the informal sector the effects may be weaker[25](#_ENREF_25).

## Strengths and Limitations

The HBS only provides limited insight into financial protection in Moldova over time. As a survey certain populations – e.g. travelling communities or homeless – will be not represented. The high non-response rate (~40%) raises the issue of reliability of the survey, although the concordance of results with earlier studies and representativeness of age and sex distributions could mean the impact of the high non-response rate is low. There are also potential issues of recall or selective reporting possible. There are limitations for the questions asked in the survey. For example, we do not know individuals’ utilization patterns of healthcare – only if they have used a healthcare provider in the last four weeks. Healthcare utilisation could confound the results reported here. None-the-less, whilst we must acknowledge certain groups (for example those with chronic conditions, older or the disabled) are likely to use healthcare more, true financial protection should be equitable across groups. Further research into the exact costs and fees incurred by individuals and explanatory demographic variables is also needed.

Other data sources employed – including CNMS – are from administrative sources that may be prone to errors and issue of data quality. Additionally, as administrative data are only from public facilities, the study is not able to analyse private providers in the health system.

The analyses undertaken may also introduce potential errors. Logistic regression identifies associations through predictive probabilities between groups and outcomes, but cannot prove causality. Our results must be interpreted with this limitation in mind. Additionally, assumptions about grouping of outcomes – including OOP from informal and formal sources and between different services – may obscure finer trends and patterns, but due to small sample size it was not possible to analyse these subgroups separately. Even so, we use multiple covariates not to just examine potential inequities between demographic groups, but also to control for potential effects and elucidate clearer associations than descriptive trends. This allows us to identify whether it is age or employment status, for example, which is the stronger determinant of an outcome. Furthermore, we take into account the clustered nature of the survey design further strengthening the validity of our findings.

## Conclusions

There is clear evidence that many elements of financial protection are not being met in Moldova. Whilst in some areas – insurance coverage and OOP for services – there is slow improvement, the increase in OOP for medicines counteract the improvements observed. Healthcare is potentially being foregone due to limited protection from costs. Progress towards UHC is an integral to the SDGs[3](#_ENREF_3), and removing financial barriers to access is key to attaining UHC. To reduce financial access barriers the Moldovan government should focus on three areas: further expansion of health insurance coverage, tackling costs of medicines and healthcare services, and improving the efficiency of health system financing. The first, further expansion of insurance coverage and access to services centres, can be achieved by further targeting of coverage to the uninsured, by utilising incentives (both financial and using legal requirements), and by streamlining the enrolment process[26](#_ENREF_26). Our results indicate that these efforts in the past may have had only small gains, and marginal returns may be low. Alternatively, building upon the expansion and free entitlement to primary care services for all in 2009, insurance coverage could be extended free of charge maintaining inputs from taxation and insurance premiums. Moldova must weigh up the marginal costs of targeted insurance premiums versus expanding free entitlement on the pathway to UHC.

Second, costs for medicines and services could be reduced by: i) introducing regulations to prevent informal payments and to regularise formal cost-sharing[27](#_ENREF_27); ii) increasing, through allocated funding and legal powers, the powers of the Moldovan Medicines and Medical Devices Agency (MMDA) and CNAM, in procuring medicines, negotiating prices, and regulating quality, to reduce costs for those who purchase drugs and the cost burden of medicines in the benefit package[16](#_ENREF_16),[28](#_ENREF_28); iii) strengthening the provision of PHC, where the majority of health needs can be dealt with cost-effectively, in resource allocations for both services and medicines[27](#_ENREF_27);

Third, health system financing trends indicate that although Moldova commits a proportion of public sources to health inline with EU averages, the actual amount is very low. The government fiscal space for increased funding of health system could be improved by: (i) increasing tobacco and alcohol taxes – which will not only reduce consumption and tackle the health burden of these substances, but generate revenues for the government, (ii) optimizing and consolidating the inefficient hospital sector (iii) investing in new infrastructure using EU development financing and private sector funding to improve health system efficiency.

# References

1. World Health Organizaton. The World Health Report 2013: Research for Universal Health Coverage. Geneva, Switzerland: World Health Organization, 2013.

2. World Health Organization. The World Health Report 2010: Health System Financing - The path to universal coverage. Geneva, Switzerland World Health Organization, 2010.

3. Tangcharoensathien V, Mills A, Palu T. Accelerating health equity: the key role of universal health coverage in the Sustainable Development Goals. *BMC Medicine* 2015; **13**(1): 1-5.

4. Turcanu G, Domente S, Buga M, Richardson E. Republic of Moldova: Health System Review. *Health Systems in Transition* 2012; **14**(7): 1-151.

5. World Health Organization Regional Office for Europe. European health for all database (HFA-DB). 2013. <http://data.euro.who.int/hfadb/> (accessed 8/11 2013).

6. Atun R, Richardson E, Shishkin S, Kacevicius G, Ciocanu M, Sava V. Republic of Moldova: Health Sytem Review. *Health Systems in Transition* 2008; **10**(5): 1-140.

7. National Bureau of Statistics of the Republic of Moldova. StatBank. 2013. <http://www.statistica.md/> (accessed 11/12 2013).

8. The World Bank. Migration & Remittances Data. 2013. <http://go.worldbank.org/092X1CHHD0> (accessed 8/11 2013).

9. The World Bank. DataBank: Country: Moldova. 2013. <http://data.worldbank.org/country/moldova> (accessed 07/11 2013).

10. Atun R. What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services. Copenhagen, WHO Regional Office for Europe; 2004. p. 1-18.

11. Starfield B. Is primary care essential? *The Lancet* 1994; **344**(8930): 1129-33.

12. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank quarterly* 2005; **83**(3): 457-502.

13. Vian T, Feeley FG, Domente S, Negruta A, Matei A, Habicht J. Barriers to universal health coverage in Republic of Moldova: a policy analysis of formal and informal out-of-pocket payments. *BMC Health Serv Res* 2015; **15**: 319.

14. Government of Republic of Moldova. National Health Policy 2007-2021. Chisinau, Republic of Moldova: Government of Republic of Moldova, 2007.

15. Government of Republic of Moldova. Healthcare System Development Strategy for the period 2008-2017. Chisinau, Republic of Moldova: Minsitry of Health, 2007.

16. Sautenkova N, Ferrario A, Bolokhovets G, Kanavos P. Availability and Affordability of Medicines and Assessment of Quality Systems for Prescription of Medicines in the Republic of Moldova. Republic of Moldova Health Policy Series 6. Copenhagen, Denmark: World Health Organization Regional Office for Europe; 2012.

17. Shishkin S, Jowett M. A Review Of Health Financing Reforms In The Republic Of Moldova. Copenhagen, Denmark: WHO Regional Office for Europe, 2012.

18. Atun R, de Andrade LOM, Almeida G, et al. Health-system reform and universal health coverage in Latin America. *The Lancet* 2014.

19. Atun R, Aydın S, Chakraborty S, et al. Universal health coverage in Turkey: enhancement of equity. *The Lancet* 2013; **382**(9886): 65-99.

20. World Health Organization. Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, Swtizerland: World Health Organization, 2007.

21. Roberts M, Hsiao W, Berman P, Reich M. Getting health reform right: a guide to improving performance and equity: Oxford university press; 2003.

22. Richardson E, Roberts B, Sava V, Menon R, McKee M. Health insurance coverage and health care access in Moldova. *Health Policy and Planning* 2012; **27**(3): 204-12.

23. Spaan E, Mathijssen J, Tromp N, McBain F, Have At, Baltussen R. The impact of health insurance in Africa and Asia: a systematic review. *Bulletin of the World Health Organization* 2012; **90**(9): 685-92.

24. Ekman B. Community-based health insurance in low-income countries: a systematic review of the evidence. *Health Policy and Planning* 2004; **19**(5): 249-70.

25. Acharya A, Vellakkal S, Taylor F, et al. The Impact of Health Insurance Schemes for the Informal Sector in Low- and Middle-Income Countries: A Systematic Review. *The World Bank Research Observer* 2012.

26. Vilcu I, Mathauer I. State budget transfers to Health Insurance Funds for universal health coverage: institutional design patterns and challenges of covering those outside the formal sector in Eastern European high-income countries. *International journal for equity in health* 2016; **15**(1): 1-19.

27. Ferrario A, Chitan E, Seicas R, et al. Progress in increasing affordability of medicines for non-communicable diseases since the introduction of mandatory health insurance in the Republic of Moldova. *Health Policy Plan* 2016.

28. Ferrario A, Sautenkova N, Bezverhni Z, et al. An in-depth analysis of pharmaceutical regulation in the Republic of Moldova. *Journal of Pharmaceutical Policy and Practice* 2014; **7**(1): 4.