Can people afford to pay for health care?

New evidence on financial protection in the Republic of Moldova

Iuliana Garam
Mariana Zadnipru
Valeriu Doronin
Andrei Matei
Ilaria Mosca

Summary
The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage. It works with Member States across WHO’s European Region to promote evidence-informed policy making.

A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals.

The Office supports countries to develop policy, monitor progress and design reforms through health system problem diagnosis, analysis of country-specific policy options, high-level policy dialogue and the sharing of international experience. It is also the home for WHO training courses on health financing and health systems strengthening for better health outcomes.

Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Health Systems and Public Health of the WHO Regional Office for Europe.
Can people afford to pay for health care?

New evidence on financial protection in the Republic of Moldova

Summary
Contents

Spending on health 5

Coverage, access and unmet need 8

Household spending on health 11

Financial protection 13

Factors that strengthen and undermine financial protection 16

Implications for policy 17

References 19

Glossary of terms 20
This review assesses the extent to which people in the Republic of Moldova experience financial hardship when they use health services, including medicines. The analysis draws on household budget survey data collected annually by the National Bureau of Statistics of the Republic of Moldova (NBS) from 2008 to 2016. It focuses on two indicators of financial protection: catastrophic health spending and impoverishing health spending. It also considers the presence of access barriers leading to unmet need for health care.
Spending on health

Research shows that financial hardship is more likely to occur when public spending on health is low in relation to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of current spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

In the Republic of Moldova, public spending in general and public spending on health have not kept pace with economic growth (Fig. 1). In 2016, public spending on health accounted for 12.1% of government spending and 4.4% of GDP.

Fig. 1. Trends in the size of government and public spending on health, Republic of Moldova

National health accounts data show that public spending on health and out-of-pocket payments per person grew steadily in real terms between 2000 and 2009 (Fig. 2). Public spending on health spiked in 2004, with the introduction of the new system of mandatory health insurance, but the rate of growth in out-of-pocket payments was much faster after 2004, so that by 2009 out-of-pocket payments and public spending were once again roughly equal. Between 2009 and 2013, out-of-pocket payments fell while public spending on health remained stable. Public spending on health has fallen since 2014, so that in 2016 it was very close to the level it had been in 2008.

Fig. 2. Spending on health per person by financing scheme, Republic of Moldova

Note: OOPs: out-of-pocket payments.
The out-of-pocket payment share of current spending on health mirrors the pattern described above, falling sharply in 2004, growing again until 2008, fluctuating as public spending on health stagnated, and rising again after public spending declined (Fig. 3). The out-of-pocket payment share is lower than the average for lower-middle-income countries in the WHO European Region.

Fig. 3. Out-of-pocket payments as a share of current spending on health, Republic of Moldova and country averages

![Graph showing out-of-pocket payments as a share of current spending on health](image-url)

Note: country income groups are for countries in WHO’s European Region.

Coverage, access and unmet need

In 2018, the national health insurance fund (Compania Națională de Asigurări în Medicină, CNAM) covered 88% of those it was required to cover. The people most likely to be without CNAM coverage – the uninsured – are people living in rural areas, people aged 24–54 years, self-employed people, people employed in agriculture and the poorest households. CNAM only covers around 15% of self-employed people.

Publicly financed access to emergency services and primary care visits is available free of charge to the whole population, regardless of insurance status. Some medicines for the treatment of a range of communicable and noncommunicable diseases are also available on this basis, as well as inpatient care for people with selected communicable diseases, acute mental health and addiction-related issues, cancer and blood disorders.

All other publicly financed health services are only available to people covered by CNAM, who benefit from free access to outpatient and inpatient care with referral.

The range of medicines covered by CNAM is relatively limited and most people have to pay co-payments for the majority of these medicines.

CNAM covers a very narrow range of dental care – mainly preventive and emergency services, with some additional but still limited services for children and pregnant women. Most restorative services and orthodontics are not covered.

The main gaps in health coverage are related to:

- the fact that entitlement to CNAM benefits is based on payment of contributions; as a result, 12% of people eligible for CNAM benefits are uninsured;
- a limited positive list of outpatient prescribed medicines covered by CNAM;
- almost no coverage of dental care for adults;
- heavy use of percentage co-payments for outpatient prescribed medicines covered by CNAM, with no exemptions for poor people and no cap on co-payments; and
- informal payments, particularly for inpatient care (including medicines), but also in outpatient settings.

Voluntary health insurance (VHI) does not play a role in covering these gaps. It only accounts for 0.2% of current spending on health; provides access to services excluded from the benefits package or access to private health care providers; and is mainly purchased for employees of large companies.
There is substantial inequality in the use of specialists, partly due to a shortage of physicians in rural areas and partly due to barriers caused by distance to facilities, poor road quality and lack of public transport. There are also inequalities in the use of dentists and medicines.

While the share of people reporting unmet need due to cost and quality has fallen substantially over time, narrowing the gap between unmet need among the uninsured and people covered by CNAM, it is striking that 13% of people covered by CNAM continue to report unmet need due to cost (Fig. 4).

In contrast to the use of general practitioners, the use of dental services has fallen over time, with the sharpest fall occurring among the poorest income quintile.

**Fig. 4. Self-reported unmet need for health care by reason, Republic of Moldova**

<table>
<thead>
<tr>
<th>Year</th>
<th>Unmet need due to cost</th>
<th>Unmet need due to quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>2010</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>2012</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>2016</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Note: people reporting care foregone in the last 12 months.

Table 1. Gaps in coverage

<table>
<thead>
<tr>
<th>Coverage dimension</th>
<th>Population entitlement</th>
<th>The benefits package</th>
<th>User charges (co-payments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues in the governance of publicly financed coverage</td>
<td>Entitlement is based on payment of contributions for economically active people</td>
<td>Very limited coverage of non-emergency dental care</td>
<td>Heavy user charges for outpatient prescribed medicines, especially for adults; about half of covered medicines are subject to percentage co-payments of 30% and 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive list of covered outpatient prescribed medicines and diagnostic services is very limited</td>
<td>Weak protection from user charges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informal payments, particularly in inpatient settings</td>
<td></td>
</tr>
<tr>
<td>Main gaps in publicly financed coverage</td>
<td>Around 12% of those entitled to CNAM coverage are uninsured</td>
<td>Outpatient prescribed medicines, diagnostic tests and dental care.</td>
<td>Outpatient prescription medicines for adults</td>
</tr>
<tr>
<td>Are these gaps covered by VHI?</td>
<td>No; VHI only accounts for 0.2% of current spending on health; provides access to services excluded from the benefits package or access to private health care providers; does not cover co-payments for services covered by CNAM and is mainly purchased for employees of large companies</td>
<td></td>
<td>Dental care for adults</td>
</tr>
</tbody>
</table>

Source: authors.
Household spending on health

Household budget survey data show that:

• the share of households reporting out-of-pocket payments has increased from 65% in 2008 to 72% in 2016;

• across all years, households without out-of-pocket payments are more likely to be poor than rich, but the share of households in the poorest quintile reporting no out-of-pocket payments has decreased substantially over time; and

• out-of-pocket payments grew steadily during the study period, both in absolute terms and as a share of household budgets, with the largest growth among the poorest quintile.

These patterns are consistent with the large reduction in self-reported unmet need between 2008 and 2016 and may reflect policy changes to extend access to publicly financed health services, which increased people’s use of health care and at the same time exposed them to out-of-pocket payments.

Outpatient medicines consistently account for the largest share of out-of-pocket spending for all quintiles, followed by inpatient, dental and outpatient care (Fig. 5). The share spent on outpatient medicines is much higher among poorer households, while the share spent on dental care is negligible in all except the richest quintile. Spending on outpatient medicines grew substantially during the study period, both in absolute terms and as a share of out-of-pocket payments. The growth was largest among the poorest quintile.
Studies suggest that informal payments are a problem in the Republic of Moldova, particularly for inpatient care. The share of people reporting paying informally for inpatient care grew from 60% in 2009 to 82% in 2012 (Vian et al., 2015). Informal payments reduce transparency, increase barriers to access and increase financial hardship. They are also likely to be regressive, placing the greatest financial burden on the poorest households.

Fig. 5. Share of total out-of-pocket spending by type of health care, Republic of Moldova

- Orange: Medical products
- Purple: Diagnostic tests
- Yellow: Outpatient care
- Blue: Dental care
- Green: Inpatient care
- Red: Medicines

Note: diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: authors based on household budget survey data.
Financial protection

Financial protection is weak in the Republic of Moldova compared to many countries in Europe, including countries in which out-of-pocket payments account for a similarly high share of current spending on health (Fig. 6).

In 2016, 17% of households experienced catastrophic levels of spending on health and nearly 7% experienced impoverishing health spending.

Fig. 6. Incidence of catastrophic spending on health and the out-of-pocket share of current spending on health in selected European countries, latest year available

Notes: $R^2$: coefficient of determination. The out-of-pocket payment data are for the same year as the catastrophic spending. The Republic of Moldova is highlighted in red.

Source: WHO Regional Office for Europe (2019).
Around half of all households with catastrophic health spending are in the poorest quintile, while a fifth are in the second quintile (Fig. 7). The incidence of catastrophic spending has increased over time. It is higher in 2015 and 2016 than in all previous years of the study.

The share of further impoverished households has fallen slightly over time, while the share of impoverished households and households at risk of impoverishment has increased (Fig. 8).
Outpatient medicines are the largest driver of catastrophic spending in all quintiles; their share rises with household consumption and increased overall during the study period from 62% in 2008 to 74% in 2016 (Fig. 9). Inpatient care is the second-largest driver for all except the richest quintile. Dental care is only a significant source of financial hardship for the richest quintile.

Fig. 8. Share of households with catastrophic spending by risk of impoverishment, Republic of Moldova

Fig. 9. Share of catastrophic spending by type of health care, Republic of Moldova

Notes: OOPs: out-of-pocket payments. Diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: authors based on household budget survey data.
Factors that strengthen and undermine financial protection

The establishment of a single, national pool for transfers from the state budget (general taxes) and contributions (payroll tax); the government’s commitment to public spending on health; the expansion of population groups eligible for state contributions; and a steady increase in the number of essential medicines covered by CNAM are factors that have led to greater use of health services – a positive outcome – and fewer people reporting unmet need due to cost.

Despite these positive developments, financial protection is weak due to remaining gaps in coverage, notably:

- the linking of entitlement to CNAM benefits to payment of contributions, which means CNAM still only covers 88% of those eligible for coverage; the resulting differences in entitlement between insured and uninsured people exacerbate inequality in access – especially since uninsured people are mainly of low socioeconomic status – and encourage inefficiency in the use of health services;

- limited coverage of outpatient medicines; although the number of medicines (international nonproprietary names) CNAM covers has steadily increased, not all essential medicines are covered;

- heavy user charges for covered outpatient prescriptions and weaknesses in the design of co-payment policy such as the absence of an overall cap on co-payments; heavy reliance on percentage co-payments, which exposes people to high or fluctuating prices; and the lack of co-payment exemptions specifically targeting poor people or regular users of health care; and

- limited dental care coverage, which exposes poorer households to unmet need and richer people to financial hardship.

Financial protection has also deteriorated over time; as access to health services has improved, increasing people’s ability to use health care, it has also increased their exposure to out-of-pocket payments. It may have deteriorated further since 2016 (the end of the study period) because public spending on health has not kept pace with economic growth and fell on a per person basis in 2015 and 2016.
Implications for policy

Financial protection in the Republic of Moldova is weak and has deteriorated over time. In 2016, 17% of households experienced catastrophic out-of-pocket payments, a higher share than in any other year of the study and up from 14% in 2008. Deteriorating financial protection has coincided with two other factors: first, a substantial improvement in unmet need for health care due to cost during the study period; and second, a decline in public spending on health as a share of GDP since 2009. Government efforts to extend coverage appear to have increased access to health care – a positive outcome – but have not been accompanied by adequate public investment or sufficient attention to the design of co-payment policy. As a result, improved access has also increased people’s exposure to out-of-pocket payments when using health services, especially medicines.

Catastrophic spending on health is heavily concentrated among the poorest households. During the study period, nearly half of all households in the poorest quintile experienced financial hardship, compared to only 7% in the richest quintile. Catastrophic spending is also heavily concentrated among people living in rural areas and pensioners.

Outpatient medicines are the largest single driver of catastrophic spending across all quintiles. They account for almost all out-of-pocket payments among poorer households with catastrophic spending and their contribution to financial hardship has increased over time. For poorer quintiles, inpatient care is the second-largest driver of catastrophic spending, perhaps linked to informal payments for hospital care, which have grown substantially over time. For richer households, dental care is the second-largest driver of catastrophic spending. The relatively low spending on dental care in the poorest quintiles is likely to reflect unmet need.

Policy should focus on improving the affordability of outpatient medicines. Coverage policy could be strengthened by: extending the number of essential outpatient medicines covered by CNAM and at the same time introducing exemptions from co-payments for poor households and regular users of health care, including older people; introducing an income-based cap on all co-payments; moving away from the use of percentage co-payments, which expose people to inefficiencies arising from inappropriate prescribing and dispensing and high or fluctuating prices; and addressing inefficiencies in the procurement, pricing, prescribing and dispensing of outpatient medicines, including through an increase in the use of cheaper alternatives (generics).

Limited coverage of dental care is likely to result in high levels of unmet need for dental care, particularly among poorer households, as demonstrated by a marked declined in the use of dental care during the study period.

The increase in informal payments for inpatient care is a further cause for concern. Informal payments impose the heaviest financial burden on the poorest households and may lead people to forego care.
Other aspects of coverage policy also raise concerns about unmet need and financial hardship for vulnerable groups of people. The government has successfully increased the share of the population covered by CNAM, but 12% of those eligible to be covered by CNAM still lack coverage. This is higher than in almost any other country in Europe. International experience suggests it would be wise to consider changing the basis for entitlement to residence, rather than continuing with entitlement linked to payment of contributions, which does not offer any advantages and imposes additional costs on the health system (WHO Regional Office for Europe, 2019).

Public spending in general and public spending on health have not kept pace with economic growth. Efforts to strengthen coverage policy, reduce out-of-pocket payments and improve access and financial protection will require additional public investment, particularly given the decline in investment in recent years. A commitment to allocate a minimum of 12% of the government budget to health is not effective when the government budget is declining. Growth in health spending should aim not only to match economic growth but also for steady year-on-year increases. It remains to be seen if the recent shift to link annual increases in health spending to the consumer price index will achieve these aims. In the future, further expansion of the benefits package should be accompanied by additional public investment to protect people from having to pay out of pocket for goods and services that are covered but subject to co-payments or not available to patients due to budget constraints.

Additional investment should be used in a progressive way to extend entitlement to CNAM benefits and at the same time reduce co-payments – especially for outpatient medicines – first for the people most likely to experience financial hardship: poor people, regular users of health care and pensioners.
References


Glossary of terms

**Ability to pay for health care:** Ability to pay refers to all the financial resources at a household’s disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household’s resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household’s resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on reported levels of consumption expenditure or income over a given time period. The available data rarely capture all of the financial resources available to a household – for example, resources in the form of savings and investments.

**Basic needs:** The minimum resources needed for sustenance, often understood as the consumption of goods such as food, clothing and shelter.

**Basic needs line:** A measure of the level of personal or household income or consumption required to meet basic needs such as food, housing and utilities. Basic needs lines, like poverty lines, can be defined in different ways. They are used to measure impoverishing out-of-pocket payments. In this study the basic needs line is defined as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition. Basic needs line and poverty line are used interchangeably. See poverty line.

**Budget:** See household budget.

**Cap on benefits:** A mechanism to protect third party payers such as the government, a health insurance fund or a private insurance company. A cap on benefits is a maximum amount a third party payer is required to cover per item or service or in a given period of time. It is usually defined as an absolute amount. After the amount is reached, the user must pay all remaining costs. Sometimes referred to as a benefit maximum or ceiling.

**Cap on user charges (co-payments):** A mechanism to protect people from out-of-pocket payments. A cap on user charges is a maximum amount a person or household is required to pay out of pocket through user charges per item or service or in a given period of time. It can be defined as an absolute amount or as a share of a person’s income. Sometimes referred to as an out of pocket maximum or ceiling.

**Capacity to pay for health care:** In this study capacity to pay is measured as a household’s consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. This amount is deducted consistently for all households. It is referred to as a poverty line or basic needs line.
Catastrophic out-of-pocket payments: Also referred to as catastrophic health spending. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household’s capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished and households who are further impoverished.

Consumption: Also referred to as consumption expenditure. Total household consumption is the monetary value of all items consumed by a household during a given period. It includes the imputed value of items that are not purchased but are procured for consumption in other ways (for example, home-grown produce).

Co-payments (user charges or user fees): Money people are required to pay at the point of using health services covered by a third party such as the government, a health insurance fund or a private insurance company. Fixed co-payments are a flat amount per good or service; percentage co-payments (also referred to as co-insurance) require the user to pay a share of the good or service price; deductibles require users to pay up to a fixed amount first, before the third party will cover any costs. Other types of user charges include balance billing (a system in which providers are allowed to charge patients more than the price or tariff determined by the third party payer), extra billing (billing for services that are not included in the benefits package) and reference pricing (a system in which people are required to pay any difference between the price or tariff determined by the third party payer – the reference price – and the retail price).

Equivalent person: To ensure comparisons of household spending account for differences in household size and composition, equivalence scales are used to calculate spending levels per equivalent adult in a household. This review uses the Oxford scale (also known as the Organisation for Economic Co-operation and Development equivalence scale), in which the first adult in a household counts as one equivalent adult, subsequent household members aged 13 years or over count as 0.7 equivalent adults and children under 13 count as 0.5 equivalent adults.

Exemption from user charges (co-payments): A mechanism to protect people from out-of-pocket payments. Exemptions can apply to groups of people, conditions, diseases, goods or services.

Financial hardship: People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care.

Financial protection: The absence of financial hardship when using health services. Where health systems fail to provide adequate financial protection, households may not have enough money to pay for health care or to meet other basic needs. Lack of financial protection can lead to a range of negative health and economic consequences, potentially reducing access to health care, undermining health status, deepening poverty and exacerbating health and socioeconomic inequalities.
**Further impoverished households**: Poor households (those whose equivalent person total consumption is below the poverty line or basic needs line) who incur out-of-pocket payments.

**Health services**: Any good or service delivered in the health system, including medicines, medical products, diagnostic tests, dental care, outpatient care and inpatient care. Used interchangeably with health care.

**Household budget**: Also referred to as total household consumption. The sum of the monetary value of all items consumed by the household during a given period and the imputed value of items that are not purchased but are procured for consumption in other ways.

**Household budget survey**: Usually national sample surveys, often carried out by national statistical offices, to measure household consumption over a given period of time. Sometimes referred to as household consumption expenditure or household expenditure surveys. European Union countries are required to carry out a household budget survey at least once every five years.

**Impoverished households**: Households who were non-poor before out-of-pocket payments, but are pushed below the poverty line or basic needs line after out-of-pocket payments.

**Impoverishing out-of-pocket payments**: Also referred to as impoverishing health spending. An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty. A household is measured as being impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.

**Informal payment**: A direct contribution made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services to which patients are entitled.

**Out-of-pocket payments**: Also referred to as household expenditure (spending) on health. Any payment made by people at the time of using any health good or service provided by any type of provider. Out-of-pocket payments include: formal co-payments (user charges or user fees) for covered goods and services; formal payments for the private purchase of goods and services; and informal payments for covered or privately purchased goods and services. They exclude pre-payment (for example, taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

**Poverty line**: A level of personal or household income or consumption below which a person or household is classified as poor. Poverty lines are defined in different ways. This study uses basic needs line and poverty line interchangeably. See basic needs line.
**Quintile:** One of five equal groups (fifths) of a population. This study commonly divides households into quintiles based on per equivalent person household consumption. The first quintile is the fifth of households with the lowest consumption, referred to in the study as the poorest quintile; the fifth quintile has the highest consumption, referred to in the study as the richest quintile.

**Risk of impoverishment after out-of-pocket payments:** After paying out of pocket for health care, a household may be further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment. A household is at risk of impoverishment (or not at risk of impoverishment) if its total spending after out-of-pocket payments comes close to (or does not come close to) the poverty line or basic needs line.

**Universal health coverage:** Everyone can use the quality health services they need without experiencing financial hardship.

**Unmet need for health care:** An indicator of access to health care. Instances in which people need health care but do not receive it due to access barriers.

**User charges:** Also referred to as user fees. See co-payments.

**Utilities:** Water, electricity and fuels used for cooking and heating.
The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00  Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int

WHO/EURO:2020-1598-41349-56295