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This edition of the Health Systems in Action Insight for the Republic of Moldova was written by Ilaria Mosca and Erica Richardson.

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**The Health Systems in Action series**

The Health Systems in Action Insights series supports Member States in the WHO European Region that are not in the European Union. The Insights for each country are intended to:

- provide core information and data on health systems succinctly and accessibly
- outline the country health system context in which WHO’s European Programme of Work is set
- flag key concerns, progress and challenges health system by health system
- build a baseline for comparisons, so that Member States can see how their health systems develop over time and in relation to other countries.

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<table>
<thead>
<tr>
<th>Contents</th>
<th>page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  ORGANIZING THE HEALTH SYSTEM</td>
<td>8</td>
</tr>
<tr>
<td>2  FINANCING AND ENSURING FINANCIAL PROTECTION</td>
<td>9</td>
</tr>
<tr>
<td>3  GENERATING RESOURCES, PROVIDING SERVICES AND ENSURING ACCESS</td>
<td>11</td>
</tr>
<tr>
<td>4  IMPROVING THE HEALTH OF THE POPULATION</td>
<td>14</td>
</tr>
<tr>
<td>5  SPOTLIGHT ON ANTIMICROBIAL RESISTANCE</td>
<td>18</td>
</tr>
<tr>
<td>6  EUROPEAN PROGRAMME OF WORK (EPW)</td>
<td>20</td>
</tr>
</tbody>
</table>
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This edition of the Health Systems in Action Insight for the Republic of Moldova was written by Ilaria Mosca and Erica Richardson.
HEALTH SYSTEMS IN ACTION: REPUBLIC OF MOLDOVA

Key points

- Entitlement to publicly financed health services is based on a health insurance system. In 2021 the share of the population covered by the National Health Insurance Company (CNAM) was 87.7%.

- The benefits package is relatively broad for insured people, but out-of-pocket (OOP) payments accounted for 36% of health spending in 2019.

- While efforts have been undertaken to address informal payments, they still hinder access to health services, particularly hospital care, and lead to financial hardship.

- Relatively low levels of public spending on health as a share of GDP and per person, and high OOP payments for health services, lead to unmet needs and households becoming impoverished. In 2016, 17% of households experienced catastrophic OOP spending and nearly 7% had impoverishing health spending.

- Primary care has been strengthened through financing reforms that have encouraged gate-keeping for specialist services, while also covering the cost of primary care consultations for the uninsured population.

- Plans to reorganize publicly run hospital services with the aim of improving the efficiency and quality of services have started to be implemented. Meanwhile, the number of private hospitals has increased in the last decade.

- Human resources face large-scale out-migration due to poor working conditions and low salaries. There are geographical imbalances in coverage with health workers, as well as shortages of physicians in certain specialties (e.g. family doctors).

- Coverage for most routine vaccinations has declined steadily since 2008 and dropped further in 2020 and 2021 due to the COVID-19 pandemic. For example, national vaccination coverage for the first dose against measles (MMR) in 2021 was only 83%.

- Life expectancy has improved considerably in the last two decades, but it remains among the lowest in the WHO European Region.

- Alcohol and tobacco consumption are serious public health issues mostly affecting men and contributing to the heavy burden of premature mortality from noncommunicable diseases (NCDs).

- The COVID-19 pandemic has resulted in substantial excess mortality, exceed the WHO European Region average.

- Antimicrobial resistance has been recognized as a challenge, but development of a national action plan was delayed by the COVID-19 pandemic.

This report looks at the action Republic of Moldova is taking to strengthen its health systems; to achieve the Sustainable Development Goals; to address the priorities of the European Programme of Work; and to ensure that no one is left behind.
1 ORGANIZING THE HEALTH SYSTEM

The Moldovan health system is centralized and has a single purchaser of publicly financed health services

Since 2004 the Republic of Moldova has had a publicly financed mandatory health insurance system with a defined benefits package managed by the National Health Insurance Company (Compania Națională de Asigurări În Medicină, CNAM), the single purchasing agency.

All health insurance revenues (including mandatory health insurance contributions (payroll taxes) and transfers from the state budget for the non-working population) are pooled into one autonomous budget managed by CNAM. These funds are used to contract with a mix of public and private health service providers.

The health system has a large range of public and private medical facilities, as well as government agencies and authorities involved in the provision, financing, regulation and administration of health services. The Ministry of Health (MoH) is primarily responsible for health policy and the development of legislation regulating the organization and provision of health services. The National Agency for Public Health is subordinated to the MoH and manages public health services. Other important stakeholders are the Agency for Medicines and Medical Devices that regulates and supervises medicines and medical devices, and the Centre for Centralized Public Procurement in Health that plans and conducts public procurement of medical and protective equipment at the request of public providers.

Local Public Authorities (LPAs) are responsible for the development and maintenance of the medical infrastructure in their territories, which they also own, but they do not finance health services.

Patient satisfaction and patient centredness are increasingly important in the Moldovan health system. Although patient-reported outcome measurements (PROMs) or other such tools are not used nationwide, some rayon hospitals have introduced voluntary questionnaires at discharge to monitor the quality and responsiveness of hospital services.

Population coverage and the benefits package are relatively broad but the share of OOP payments remains high

Paying contributions is the basis for entitlement to publicly financed coverage. In 2020 government contributions covered 11 categories of non-economically active people registered as residents. The share of the population covered by CNAM grew from 85.8% in 2016 to 88.2% in 2018 and then declined slightly to 87.7% in 2021 (CNAM, 2021). In 2016 the people most likely to be uninsured were people in rural areas, people aged 24–54 years, self-employed people, people employed in agriculture and the poorest households (Garam et al., 2020).

Emergency care, primary care visits, medicines for selected diseases and inpatient care for people with specific diseases, including COVID-19, are available to the whole population, regardless of insurance status.

For insured people the benefits package is relatively broad, covering prescribed outpatient medicines on a positive list, outpatient and inpatient care (including inpatient medicines), emergency dental care and a limited range of dental services for pregnant women and children below 18 years.

Insured people co-pay on outpatient prescription medicines (percentage co-payments of 30%, 50% and 70% in 2021, although certain categories of medicines or people are exempt from payments) and pay the full price for dental treatment and materials. Outpatient specialist care and inpatient care are free with GP referral. Uninsured people pay the full cost of elective inpatient care out of pocket. However, the pervasiveness of informal payments, particularly in hospitals, still hinders access to health services and leads to financial hardship (Garam et al., 2020).

The role of primary care is increasing but the system is still hospital-centric

In rural areas primary care services are delivered through family doctor offices and health offices, while in urban areas services are provided through large family health centres. People are obliged to register with a family doctor to access statutory services. In 2021 primary care (excluding reimbursed outpatient medicines) accounted for almost one-fifth of CNAM’s overall expenditure.

Secondary care includes inpatient and specialized outpatient services delivered by municipal and district hospitals that are subordinated to LPAs (except for Chișinău). Tertiary hospitals are located mainly in the capital. They deliver more complex services and are subordinated to the MoH.

Plans to reorganize publicly run hospital services – with the aims of improving the efficiency and quality of services – have started to be implemented. In 2022 there were 17 republican level hospitals subordinate to the MoH, 34 district level hospitals and 9 municipal level hospitals. There were also three hospitals run by authorities other than the MoH, namely the Ministry of Internal Affairs, the Ministry of Defence, and the Security and Intelligence Service. Between 2010 and 2020 the number of private hospitals increased from 11 to 17.

Before the COVID-19 pandemic the policy priority was to contain inpatient spending and increase the share of spending going to primary care. In 2021 hospitals absorbed more than half of CNAM funds (54.1%), while only a quarter went to primary care (25.2%, including 5.5% for the reimbursement of selected outpatient medicines). Some of the remaining funds
went to emergency pre-hospital care (8.8%), prevention measures (0.2%) and the development fund to modernize publicly funded health care providers (0.1%).

2 FINANCING AND ENSURING FINANCIAL PROTECTION

Public spending on health increased rapidly following the introduction of mandatory health insurance in 2004 and then fluctuated in the following years
In 2019 public spending on health as a share of GDP was 3.8%, which was below the average of the EU (6%) and South-Eastern Europe (SEE) (5%) but above the average of lower-middle-income countries (LMIC) in the WHO European Region (2.7%) (Fig.1).

National data for 2020 show that public spending on health as a share of GDP increased to 4.8%. The significant increase in public spending on health as a share of GDP likely reflects two factors: the extra health spending needed to tackle COVID-19, and the contraction in GDP caused by restrictions on economic activity. The annual GDP change for the Republic of Moldova was −7% between 2019 and 2020 (World Bank, 2022).

The share of the government budget allocated to health was around 12% in 2019
The share of the government budget allocated to health has fluctuated over time from a peak of 13.6% in 2010 to 12.1% in 2019 (WHO, 2022a). This is higher than in countries like Armenia (5.7%), Georgia (9.4%) and Ukraine (7.7%), but lower than in countries such as Lithuania (13.2%) and Romania (12.7%) (WHO, 2022a).

Levels of private spending on health are high
In 2019 OOP payments accounted for 36% of health spending, down from 46.2% in 2015 when they were at their highest. This share is much higher than the average of the EU (19%) and SEE (21%), but lower than the average of LMICs in the WHO European Region (49%) (Fig.2). Private spending in the form of voluntary health insurance is not a significant feature of health system financing in the Republic of Moldova.
Financial protection is underdeveloped and catastrophic spending is among the highest in the WHO European Region

The high share of private spending in the form of OOP payments, coupled with a relatively low level of public spending on health, can lead to unmet needs and households becoming impoverished due to health spending. In 2016, 17% of households experienced catastrophic OOP spending and nearly 7% had impoverishing health spending (Garam et al., 2020). The share of people with catastrophic spending is higher than in countries with similar levels of OOP payments as a share of current spending on health (Fig. 3).

Catastrophic health spending is concentrated among the poorest people, people who live in rural areas, people with incomplete secondary education, pensioners, people who live in households of single occupancy and couples without children. Outpatient medicines are the main driver of catastrophic health spending, as coverage of outpatient medicines has been very limited under the mandatory health insurance scheme (Garam et al., 2020). However, between 2017 and 2021 the list of covered medicines was extended. It now includes

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**Box 1**
Enhanced efficiency is one of the priority directions for action in the new National Health Strategy

The new 10-year National Health Strategy that is currently being developed in line with the SDG Agenda 2030 underlines the role of primary care in enhancing the overall efficiency of the health system.

The hope is that the long-awaited reorganization of hospitals by competency level (with a focus on high-performing regional hospitals) will free up resources for primary care and prevention services by improving the efficiency of hospital care. For example, there are currently maternity hospitals with fewer than 500 births a year and surgical departments with low annual numbers of interventions. The main challenge to improving efficiency in inpatient care is the rationalization of hospitals located in district centres and big cities (NBS, 2022a).

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**Fig. 3**
Share of households with catastrophic health spending by risk of impoverishment and OOP payments as a share of current spending on health

**Notes:**
- the data on out-of-pocket payments (OOPs) are for the same year as the data on catastrophic health spending. A household is impoverished if its total spending falls below the poverty line after OOPs; further impoverished if its total spending is below the poverty line before OOPs; and at risk of impoverishment if its total spending after OOPs comes within 120% of the poverty line. The poverty line used here is a relative line reflecting basic needs (food, housing, utilities).
- Source: WHO Barcelona Office for Health Systems Financing.
at least two to three types of medicines without co-payments in each disease group. It is expected that these changes will improve financial protection.

3 GENERATING RESOURCES, PROVIDING SERVICES AND ENSURING ACCESS

Hospital capacity in the public sector has remained constant in the last 10 years, but the number of private hospitals has increased

The number of hospital beds per 100 000 population has decreased in recent years and in 2014 (the latest year for which internationally comparable data are available) was broadly in line with the average of the WHO European Region, but exceeded the EU average (Fig. 4). This reduction of bed numbers in the Republic of Moldova was the result of efforts to rationalize care pathways, but there are marked differences across specialties.

According to national data, the number of beds per 100 000 population decreased between 2014 and 2020 by 5.5% for psychiatric hospitals as capacity for community-based services was increased, and by 71% for dermato-venereology where most conditions can be treated on an outpatient basis. The number of beds for infectious diseases also fell between 2014 and 2019, but increased by 368% in 2020 owing to the rapid scaling-up of surge capacity during the COVID-19 pandemic.

The number of publicly financed primary care facilities has grown from 67 in 2008 to 277 in 2015 and 293 in 2021. The role of primary care has gained importance in the past 25 years with the introduction of the family medicine specialty in 1998 and support from international donors to develop standardized clinical protocols for primary care and criteria for family doctor referrals to specialists, laboratory tests and further investigations. Strengthening primary care has been supported through financing reforms that have encouraged gatekeeping for specialist services, while also covering the cost of primary care consultations for the uninsured population.

Migration of health workers leads to access barriers

The Republic of Moldova is confronted with large-scale out-migration of health workers. Between 2017 and 2018 there was an especially large drop in the number of physicians due to out-migration, as salaries of medical professionals in public institutions in neighbouring Romania increased by 70–170% and the recognition of medical qualifications awarded in the Republic of Moldova was simplified. Over time, a similar drop in the number of nurses also occurred.

The migration process aggravates geographical imbalances in coverage with health workers and shortages of physicians in certain specialties, such as family doctors. Challenging working conditions and comparatively low salaries lead to low morale among health workers and act as ‘push’ factors for out-migration. The National Agency for Public Health estimated that in 2022 an additional 1 142 health workers, including 174 family doctors, were needed to meet national targets for UHC.

Data on the numbers of physicians and nurses per population vary by source. The National Agency for Public Health reports 350 physicians per 100 000 population both in 2005 and 2020. This estimate, however, is based on a population size of 3.5 million. The National Bureau of Statistics has revised these indicators using a population size of 2.6 million (following the findings of the 2014 national census), indicating an increase in the number of physicians from 453 in 2014 to 477 per 100 000 population in 2020, but a decrease in the number of nurses per 100 000 population from 912 to 893 in the same years. This would put the country above the averages of the WHO European Region in 2019 (358 physicians and 516 nurses) (Fig. 5).
Geographical imbalances of health professionals hinder access to health services, especially in rural areas

The distribution of human resources is unequal, resulting in unfilled posts in rural areas. The centre and south of the country have a lower number of physicians per 100,000 population than the north. Geographic inequality in the distribution of nurses is a cause for concern due to their important role in the provision of long-term care for older people. National data show that districts in the north have on average 40% more nurses than those in the centre.

The average age of family doctors – particularly in rural areas – is also concerning, as some are close to or past the retirement age and it is difficult to recruit replacements. In 2018, 28% of doctors and 18% of nurses were at retirement age. Employment of young medical professionals under 30 years halved in absolute numbers from 1080 (25.5%) in 2017 to 516 (9.2%) in 2018 (Trade Union Federation Sanatatea, 2018).

People living in rural areas are less likely to consult specialists, pharmacists and dentists than people living in urban areas. Furthermore, people with higher incomes tend to consult specialists rather than general practitioners, while the reverse is true for those on lower incomes (Garam et al., 2020). Overall, vulnerable groups of people (particularly pensioners, Roma, the unemployed and people with disabilities) are more likely to experience access barriers due to cost, distance to facilities, poor road quality and lack of public transport (Garam et al., 2020).
Between 2010 and 2020 the number of new HIV infections almost halved

In 2021, of the estimated number of people living with HIV approximately 66% were aware of their status, 48% of those diagnosed were receiving antiretroviral therapy, and 42% of those on treatment had achieved viral suppression (UNAIDS, 2022). According to statistics from the National HIV Prevention and Control Programme in 2021, 72% of people diagnosed with HIV were on antiretroviral treatment and 89% of those had achieved viral suppression, thus indicating an improvement of HIV-related indicators during the pandemic. Despite this improvement, these rates are still below the UNAIDS targets of ensuring that 95% of people living with HIV know their status, 95% of these people are receiving antiretroviral therapy and 95% of those on treatment achieve viral suppression (Fig. 6).

The TB case notification rate dropped due to COVID-19

TB services were disrupted by the COVID-19 pandemic. Until the pandemic hit, the case notification rate (the total number of new and relapse cases and cases with unknown previous TB treatment history per 100,000 people) had declined and effective treatment coverage increased (Fig. 7). Between 2019 and 2020, however, there was a major drop (~38.7%) in the
case notification rate due to disruptions in health service delivery caused by the COVID-19 pandemic. In 2021 the incidence of new and relapse TB cases was 51.5 per 100,000 population, which was 17.6% higher than in 2020 (43.8 per 100,000 inhabitants). Between 2020 and 2021 the number of children with TB increased by 61.5%, and the share of non-cavitary forms of TB was high at 41% both in 2020 and 2021.

On the other hand, the BCG vaccination coverage rate of children aged 0–12 months declined from 98.5% in 2019 to 96.4% in 2020 and 94.1% in 2021.

Access to essential health services has improved in recent years

The universal health coverage (UHC) service coverage index measures access to essential services. In the Republic of Moldova it increased from 49 (out of 100) in 2000 to 67 in 2019, although this was still below the average of the WHO European Region (Fig. 8). The increase in this indicator can be partly attributed to better control of infectious diseases: the sub-index on UHC service coverage for infectious diseases increased from 19 in 2000 to 68 in 2019 (WHO, 2022b). It also reflects the extension of coverage for publicly financed services with new benefits over time and free access to primary care visits for uninsured people since 2010.

Self-reported unmet needs have decreased over time, but cost of services is still a major barrier to access

The share of survey respondents reporting unmet needs for health care due to cost declined from over 25% in 2008 to just under 15% in 2016. The share of respondents forgoing care due to the (poor) quality of services declined from 8% in 2010 to 4% in 2016 (Garam et al., 2020). In a survey undertaken during the COVID-19 pandemic in 2021, 19.6% of respondents reported having forgone primary care in the last 12 months, while 2.4% reported having forgone hospital care. Reasons varied and included mainly self-medication for primary care services, and restrictions due to COVID-19 for hospital care (NBS, 2022b).

4 IMPROVING THE HEALTH OF THE POPULATION

The Republic of Moldova has one of the lowest life expectancies at birth in the WHO European Region

Life expectancy at birth, according to internationally reported data, was 73.4 years in 2018, an increase from 67 in 2000 (Fig. 9). Although this indicator is one of the lowest in the WHO European Region, the Republic of Moldova is one of the best performers in terms of years of life gained in the last two decades.

The difference between males and females is quite marked, however: in 2018 life expectancy at birth for females (77.4) was 8.1 years higher than that of males (69.3), a gender gap that was considerably wider than the average of the WHO European Region (6.3 years).

Maternal mortality dropped by 57% between 2000 and 2017

The health of women, children and adolescents is given high priority. This is reflected in the comprehensive coverage of health services for pregnant women, women in delivery and postpartum, and children up to 18 years of age. The Republic of Moldova has made good overall progress in infant and maternal mortality rates: maternal mortality per 100,000 live births is estimated to have declined from 44 in 2010 to 19 in 2017 (WHO, 2022c). Similarly, the infant mortality rate per 1000 live births is estimated to have dropped from 26 in 2010 to 12 in 2019 (WHO, 2022c). Notwithstanding this progress in infant and maternal mortality, the indicators are still well above the averages for the WHO European Region.
A WHO assessment of sexual, reproductive, maternal, newborn, child and adolescent health (WHO, 2020) found that the range of services included in the health packages is appropriate, but that implementation challenges exist. For example, not all covered services were provided for free, and there was variation in the quality of services, geographical access barriers and a suboptimal reach to the most vulnerable groups of people.

Stroke, ischaemic heart disease, cancers, respiratory disease and diabetes are the main drivers of mortality

The leading causes of death are circulatory system diseases and cancer. The age-standardized rates of deaths from ischaemic heart disease and stroke have decreased markedly in the last two decades, while deaths from respiratory diseases have plateaued since 2012 and other main causes of deaths have remained relatively stable (Fig. 10).

The premature mortality rate among people aged between 30 and 69 years for cardiovascular diseases, cancer, diabetes mellitus and chronic respiratory diseases
has fallen over time, but it is still much higher than the average of the WHO European Region (Fig. 11). This points to weaknesses in both the provision of primary care services to support people with NCDs and public health interventions to prevent NCDs (Sécula et al., 2020). Critical shortcomings in the provision of primary care include maintaining adequate staffing levels and equitable access to medicines (Blake et al., 2019).

The COVID-19 pandemic has resulted in substantial excess mortality

As of March 2022 over 11 000 Moldovans were recorded to have died from COVID-19 since the start of the pandemic. Excess mortality, i.e. the number of deaths from all causes above and beyond what is expected under normal conditions (Checchi & Roberts, 2005), was over 15 000 by the end of January 2022. Estimates of excess mortality indicate that rates in the Republic of Moldova exceeded those in the WHO European Region overall (Fig. 12). Excess mortality rates have echoed waves of COVID-19 infection, but the relatively low vaccination rate (by the end of 2021 coverage of the completed primary vaccination programme for COVID-19 was about 30%) has resulted in continuously high mortality rates.

Uncontrolled hypertension is the leading risk factor affecting population health status

In 2019 high systolic blood pressure was estimated to account for 36.6% of all deaths, with poor diet accounting for 24.2%. High body-mass index, tobacco use and high LDL cholesterol were each estimated to contribute to around a sixth of all deaths (Fig. 13).

Smoking is a major public health challenge (WHO, 2019a). In 2000 the smoking prevalence among those aged 15 and over was estimated at 22.1%. By 2020 this rate had increased to 25.4% (WHO, 2022c). However, this masks considerable gender differences in tobacco consumption as smoking rates for women in 2020 were comparatively low (6.2%), with much higher rates among men (44.6%).

Similarly, a high level of alcohol consumption is also a serious public health issue, particularly for men. Total alcohol consumption (including recorded and unrecorded consumption) per person for people aged 15 years and over was estimated at 11.4 litres of pure alcohol in 2018 (18 and 5 litres among men and women, respectively) and the Republic of Moldova has the highest death rate linked to alcohol consumption in the WHO European Region (WHO, 2022b). A well developed primary care system and strong preventive measures are needed to tackle these and other risk factors for NCDs, but this has proved challenging in the Moldovan context (Box 2).
Poverty contributes to ill-health

The Republic of Moldova is one of the poorest countries in the WHO European Region. Between 2014 and 2018 the poverty headcount (measured at the international USD 1.90 2011 PPP/day threshold) fell from almost 30% to 23% of the population, but increased again to 26.8% in 2020. Poverty reduction has slowed down in recent years and has not resulted in an expansion of the middle class, which in 2016 was roughly the same size as in 2007 (Cojocaru & Matytsin, 2018).

Air pollution is a key environmental factor negatively impacting on population health

Two environmental factors – air pollution and non-optimal temperature – are among the top 10 risk factors for deaths in the Republic of Moldova. Between 2009 and 2019 the share of deaths due to air pollution and non-optimal temperature decreased by 44 and 19 percentage points, respectively (IHME, 2022). Air quality is considered moderately unsafe, with an annual mean concentration of PM2.5 of 16 µg/m³, exceeding the recommended maximum of 10 µg/m³ (World Bank, 2022).

Box 2

The Republic of Moldova has a strong legal and policy framework to control NCDs but implementation challenges remain

NCDs account for the majority of premature deaths. Alcohol consumption and tobacco use are among the key health risks for most Moldovans. Both alcohol and tobacco products are easily accessible, even for children and adolescents, leading to high consumption (Tirdea, Ciobanu & Obreja, 2019). The Republic of Moldova has been a party to the WHO Framework Convention on Tobacco Control (FCTC) since 2009, and between 2017 and 2020 the price of a packet of cigarettes increased by 60%. A full ban on tobacco advertising has been in place since 2016. However, there is still scope for strengthening tobacco control, such as through more rigorous enforcement of indoor smoking bans (FCTC DB, 2020).
Mental health reform has become a priority

The reform of mental health services started in 2014 and aimed to redesign the delivery of mental health services to reduce reliance on inpatient care; foster collaboration across the social welfare, health and education sectors; revise the policy framework; and develop and provide capacity building to 40 community mental health centres in the country.

The National Mental Health Programme 2017–2021 has improved access to mental health services, particularly for vulnerable groups of people; introduced pay-for-performance schemes to reward quality; and reduced the number of hospitalizations by 50%. The National Mental Health Programme 2022–2026 and its Action Plan build on the results achieved in the previous phase.

The Republic of Moldova has a relatively low consumption of antibacterials compared with the WHO European Region overall

In 2018 antimicrobial consumption per capita was lower than in many Western European countries (Fig. 14). However, the Republic of Moldova did not meet the WHO national monitoring target of at least 60% of total antimicrobial consumption being from the “Access” category. The country is part of the CAESAR (Central Asian and Eastern European Surveillance of Antimicrobial Resistance) network established by the WHO Regional Office for Europe in 2012. A national AMR surveillance system was set up in 2018 and the national AMR action plan was developed with input from multi-sectoral working groups under government leadership.

Notes: DDD: daily defined dose; EEA: European Economic Area; EU: European Union; Access, Watch and Reserve (AWaRe) traffic light system of antimicrobials (WHO, 2019b) as follows: Access: First- and second-choice antibiotics that should be widely available in all countries; Watch: Antibiotics that should only be used for a specific, limited number of indications; Reserve: Last-resort antibiotics for cases where other antibiotics have failed or for infections of multi-resistant bacteria; Unclassified: Antibiotics which are not yet classified. a Countries for which hospital sector data were not included.

Source: European Centre for Disease Prevention and Control, WHO Regional Office for Europe.
Rates of antimicrobial resistance are higher than the EU/EEA average

In 2020 the rate of bloodstream infections due to Methicillin-resistant *Staphylococcus aureus* (MRSA) was lower in the Republic of Moldova than the EU/EEA average (Fig. 15), although this relative position may be related to the small sample size.

Several activities on AMR have been developed, but more can be done to raise awareness of AMR risks

The Republic of Moldova has developed laws and regulations on the prescription and sale of antimicrobials for human and animal health (the latter with gaps in enforcement) and on the use of antimicrobials for growth promotion. Training on AMR in the human and veterinary health sectors is part of the continuing professional development of health workers and core curricula for graduating veterinarians and veterinary paraprofessionals.

Data from the TrACSS survey (2020/21) show that the Republic of Moldova has adopted guidelines and practices to assure appropriate antimicrobial use in some health care facilities. However, the Government is not conducting any environmental detection or surveillance activities (e.g. in soil or waterways) for antimicrobial residues or AMR organisms. Additionally, to increase awareness of global AMR and to encourage best practices, awareness campaigns should be scaled up to reach all relevant stakeholders and facilitate an integrated “One Health” approach. One step in this direction was the round table “Blue for antimicrobial resistance” on the platform of the Social Protection, Health and Family Commission of the Parliament of the Republic of Moldova that was organized in November 2021 to raise awareness of AMR in the “One Health” approach to attain optimal health for people, animals and the environment.

The development of the AMR National Action Plan was affected by the COVID-19 pandemic

Staff of the National AMR Surveillance team and most surveillance-related microbiologists and staff were deputized in 2020–2021 to work on the COVID-19 response. In the midst of the pandemic, however, 2020 AMR surveillance data were shared with the CAESAR network. The development of the National Programme for Surveillance and Control of Antimicrobial Resistance (2019–2028) was delayed by the COVID-19 pandemic, but a draft is currently being considered by the Government.

Fig. 15

Bloodstream infections due to MRSA (%) are relatively low in the Republic of Moldova

Notes: Percentage of bloodstream infections due to MRSA among patients with symptoms of bloodstream infections who have growth of *Staphylococcus aureus* in tested blood samples. Data refer to 2020.

Source: European Centre for Disease Prevention and Control, WHO Regional Office for Europe.
Moving towards universal health coverage
For the past three years the WHO Country Office has supported the MoH in developing the new National Health Strategy, facilitating the work of working groups and involving key stakeholders in political dialogues. There is a consensus on focusing the new strategy on ensuring universal access to quality care without financial hardship, including increasing public funding and efficiency in the provision of health care.

Protecting against health emergencies
WHO led the development of the COVID-19 Emergency Preparedness and Response Plan, including clinical protocols and training of health professionals; set up the National Laboratory Strategy and action plan for COVID-19 laboratory testing that expanded the laboratories’ test capacity from about 100 to 5000 tests per day; provided technical assistance to CNAM for adjusting the payment methods for COVID-19 case management; and supported health authorities with risk communication and community engagement techniques. Furthermore, in 2022, together with the EU and other partners, WHO delivered humanitarian aid and supported the MoH to assess the health needs of Ukrainian refugees.

Promoting health and well-being
To combat communicable diseases, WHO has supported the implementation of the National Immunization Programme developed by the MoH and the National Agency for Public Health and assisted in drafting the prevention and control programmes for HIV/AIDS and sexually transmitted infections, hepatitis and TB.

WHO has also supported the MoH and the National Agency for Public Health to implement the National Immunization Programme and the associated Communication Strategy. This included the immunization catch-up campaign “Vaccine yourself! Protect your future!” in 10 areas where there was low vaccination coverage.

COUNTRY DATA SUMMARY

<table>
<thead>
<tr>
<th></th>
<th>Republic of Moldova</th>
<th>WHO European Region</th>
<th>EU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (years), both sexes combined* (2017)</td>
<td>73.4</td>
<td>78.3</td>
<td>80.2</td>
</tr>
<tr>
<td>Estimated maternal mortality per 100 000 live births (2017)</td>
<td>16.3</td>
<td>13.0</td>
<td>6.1</td>
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<tr>
<td>Estimated infant mortality per 1 000 live births (2018)</td>
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<tr>
<td>GDP per capita, PPP$ (2020)</td>
<td>12 324</td>
<td>34 581</td>
<td>41 683</td>
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<tr>
<td>Poverty rate at national poverty lines (2018)</td>
<td>23.0</td>
<td>14.9</td>
<td>17.0</td>
</tr>
</tbody>
</table>

*Latest year for which data are available shown in brackets.

Notes: EU: the 28 EU Member States until 2020; GDP: gross domestic product; PPP: purchasing power parity.

Source: WHO, 2022c.
References


WHO Regional Office for Europe

WHO is the authority responsible for public health within the United Nations system. The WHO Regional Office for Europe (WHO/Europe) covers 53 countries, from the Atlantic to the Pacific oceans.

To support countries, WHO/Europe seeks to deliver a new vision for health, building a pan-European culture of health, where health and well-being goals guide public and private decision-making, and everyone can make healthy choices. WHO/Europe aims to inspire and support all its Member States to improve the health of their populations at all ages. WHO/Europe does this by providing a roadmap for the Region’s future to better health; ensuring health security in the face of emergencies and other threats to health; empowering people and increasing health behaviour insights; supporting health transformation at all levels of health systems; and by leveraging strategic partnerships for better health.

European Programme of Work ‘United Action for Better Health in Europe’

The European Programme of Work (EPW) sets out a vision of how the WHO Regional Office for Europe can better support countries in our region in meeting citizens’ expectations about health.

The social, political, economic and health landscape in the WHO European Region is changing. United action for better health is the new vision that aims to support countries in these changing times. “United”, because partnership is an ethical duty and essential for success, and “action” because countries have stressed their wish to see WHO move from the “what” to the “how”, exchanging knowledge to solve real problems. The WHO European Region’s solidarity is a precious asset to be nurtured and preserved and, through the EPW, WHO/Europe supports countries as they work together to serve their citizens, learning from their challenges and successes.

The European Observatory on Health Systems and Policies

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making so that countries can take more informed decisions to improve the health of their populations. It brings together a wide range of policymakers, academics and practitioners, drawing on their knowledge and experience to offer comprehensive and rigorous analysis of health systems in Europe. The Observatory is a partnership hosted by WHO/Europe. Partners include the governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the Veneto Region of Italy (with Agenas); the European Commission; the French National Union of Health Insurance Funds (UNCAM), the Health Foundation; the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM). The Observatory is based in Brussels with hubs in London (at LSE and LSHTM) and at the Berlin University of Technology.