Primary health care financing: policy options for the Republic of Moldova
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The Republic of Moldova has a well-developed family medicine-centred primary health care (PHC) system. PHC system development has being supported by the strategic goals set out in the Strategy for the Development of Primary Health Care for 2010–2013. Although the strategy has not been updated, the Republic of Moldova continues to build on past success in moving towards a strong PHC-centred health system. This policy paper aims to describe the current challenges facing PHC financing in the Republic of Moldova and to present policy options to improve health outcomes and increase value for money in public spending, reflecting relevant international evidence and experience.

Moldovan PHC financing has several strengths, including a relatively high level of public spending and a fairly generous PHC services package, which is available free at the point of use to the entire population. The country also has a relatively long experience of organizing the purchase of PHC services. Nevertheless, several challenges exist. To strengthen PHC financing, the Republic of Moldova could consider improving its PHC budgeting and contracting practices, refining the PHC services package, improving the payment design, and making outpatient prescription medicines more affordable. Beyond health financing, further efforts are needed to invest in the PHC workforce, improve digital data collection, and strengthen PHC governance.

Abstract

The Republic of Moldova has a well-developed family medicine-centred primary health care (PHC) system. PHC system development has being supported by the strategic goals set out in the Strategy for the Development of Primary Health Care for 2010–2013. Although the strategy has not been updated, the Republic of Moldova continues to build on past success in moving towards a strong PHC-centred health system. This policy paper aims to describe the current challenges facing PHC financing in the Republic of Moldova and to present policy options to improve health outcomes and increase value for money in public spending, reflecting relevant international evidence and experience.

Moldovan PHC financing has several strengths, including a relatively high level of public spending and a fairly generous PHC services package, which is available free at the point of use to the entire population. The country also has a relatively long experience of organizing the purchase of PHC services. Nevertheless, several challenges exist. To strengthen PHC financing, the Republic of Moldova could consider improving its PHC budgeting and contracting practices, refining the PHC services package, improving the payment design, and making outpatient prescription medicines more affordable. Beyond health financing, further efforts are needed to invest in the PHC workforce, improve digital data collection, and strengthen PHC governance.

Keywords

CAPITATION
HEALTH FINANCING
PAYMENT METHODS
PERFORMANCE PAYMENT
PRIMARY HEALTH CARE
STRATEGIC PURCHASING
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Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ERDF</td>
<td>European Regional Development Fund</td>
</tr>
<tr>
<td>FD</td>
<td>family doctor</td>
</tr>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
</tr>
<tr>
<td>NHIC</td>
<td>National Health Insurance Company</td>
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<tr>
<td>PHC</td>
<td>primary health care</td>
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</table>
Key messages

1. Prioritize primary health care spending and improve budgeting practices

Primary health care (PHC) spending in the health budget should be prioritized to prevent its further decline. It was an important step to separate outpatient prescription medicines and PHC budget lines as it reduces the risk that one is prioritized over the other, opening up the possibility of addressing the low level of spending on outpatient prescription medicines without reducing spending on PHC. The necessary budgetary space can be created by optimizing spending in other areas, such as hospital care, and by increasing state budget transfers to the health insurance budget.

The current PHC services package is relatively comprehensive, allowing PHC providers to take responsibility for priority preventive care and noncommunicable disease management. However, steps should be taken to ensure that the PHC budget is aligned with the promised services package, the expected role of PHC, and population health needs.

The focus of the National Health Insurance Company (NHIC), in budget planning and execution, on inputs and expenditure based on a defined economic classification incentivizes PHC providers to concentrate on inputs rather than the health needs of the population they serve. The NHIC should therefore move from input-oriented planning and monitoring to focus on population health needs and performance-centred PHC purchasing. The principles employed to monitor contract execution could allow more flexibility at PHC provider level, thereby increasing efficiency of spending and minimizing the risk that spending decisions are made on the basis of rules rather than needs.

Specific steps include:

- Prioritize PHC spending in the NHIC budget to prevent its further decline and to strengthen PHC going forward.
- Take steps to ensure that the PHC budget is aligned with the promised services package, the expected role of PHC, and population health needs.
- Move from input-oriented planning and monitoring to focus on population health needs and performance-centred PHC purchasing.
- Introduce more flexibility at provider level in the principles employed to monitor contract execution.
2. Make the PHC services package more attractive and responsive to population health needs

Although the PHC services package is relatively comprehensive, it could be more explicit on the role of primary and secondary care providers, thereby limiting incentives to bypass PHC, reducing overreliance on specialists, and minimizing the risk of duplication.

The PHC services package revision process could be improved by making it more systematic and transparent and linking it more closely with estimation of budget needs. Steps have been taken to extend the package of services at PHC level. However, uptake of the extended package has been moderate, indicating the need to review requirements and assess providers’ readiness to comply. Additional incentives may be needed to ensure equal access to the extended scope of PHC services.

The universal, relatively comprehensive and free PHC service package is a great achievement for the Republic of Moldova, but a lot more should be done to make outpatient prescription medicines truly affordable. Important steps forward include moving away from heavy reliance on percentage copayments, exempting poor households and regular health-care users from copayments, and making the outpatient prescription medicines programme accessible to the uninsured. Simplifying the prescription procedure, including the requirements for prescribing at PHC level, and increasing providers’ awareness of NHIC-covered medicines would contribute to better adherence to treatment and increase PHC attractiveness.

Specific steps include:

- Make the PHC services package more explicit on the role of primary and secondary care providers.
- Improve the PHC services package revision process by making it more systematic and transparent and linking it more closely with budget planning.
- Improve access to extended PHC services.
- Make outpatient prescription medicines truly affordable to the entire population.
3. Align PHC payment design with policy objectives

The Republic of Moldova could consider a more blended payment design while keeping capitation at its core. The methodology used to calculate the capitation payment rate could be improved to better reflect the cost of delivering evidence-based services to the registered population in an efficient manner. A more blended payment design, with additional targeted and performance-related payments, would help to reinforce the desired incentives.

The Republic of Moldova could benefit from reintroducing performance-related payments with an improved design and partly preserving the pandemic era adjustment of the performance payment that shifted the monitoring responsibility to facility level. Supplementary financial incentives may be used to deliver an extended scope of services. Additional fee-for-service payments could be considered for selected priority diagnostic services in order to reduce the risk that capitation payment incentivizes PHC providers to refer patients to specialists. It would also help to reduce existing incentives that result in patients bouncing between different levels of care or being forced to make out-of-pocket payments. Also, additional financial incentives to rural providers would help to ensure access to PHC services regardless of geographical location.

It is essential to have a transparent process to assess investment needs in PHC facilities and to devise mechanisms to cover the costs related to repair and refurbishment of facilities.

Specific steps include:

• Improve the design of the capitation payment.

• Revise the methodology used to calculate the capitation payment rate to better reflect the cost of delivering evidence-based services to the registered population in an efficient manner.

• Strengthen incentives to deliver extended PHC services.

• Reintroduce a modified motivational performance payment to incentivize quality improvement in PHC.

• Consider partly shifting the performance monitoring responsibility to facility level.

• Consider introducing fee-for-service payments for selected priority diagnostic services.

• Introduce additional financial incentives to rural providers to ensure access to PHC services regardless of geographical location.

• Ensure a transparent process to assess PHC facilities investment needs and explore potential mechanisms to invest in physical and digital infrastructure.
4. Move to multiyear and performance-centred PHC contracting

The Republic of Moldova could consider using a provider contracting mechanism to improve geographical access to PHC services and to incentivize development of multidisciplinary PHC networks providing an extended scope of services. A first step could be to define geographical access criteria such as minimum number of PHC physicians/providers per defined settlement, taking into account sociodemographic characteristics, population density and age distribution.

Multiyear and more automated contracting of PHC providers would bring many benefits. Payment rules for PHC providers are predefined by regulation and can be used, in combination with registration data, to produce the PHC provider contract amount, which can easily be adjusted to reflect annual changes. This process can be automated and replace current bureaucratic contracting, which brings little added value. Multiyear contracts would allow providers to do longer-term planning of necessary investments in physical and digital infrastructure and human resources.

The existing PHC providers’ financial monitoring system should be complemented with a comprehensive PHC performance monitoring system. To achieve this, it is essential that an electronic data collection system is developed and paper-based recording is terminated.

Specific steps include:

- Consider using a contracting mechanism to improve geographical access to PHC services and to incentivize development of multidisciplinary PHC networks providing an extended scope of services.
- Move to multiyear and more automated contracting of PHC providers.
- Complement the existing PHC providers’ financial monitoring system with a comprehensive PHC performance monitoring system based on electronic data.
5. Accelerate efforts beyond health financing

Although refinements in PHC financing are important, other areas need to be addressed as well. The Ministry of Health could strengthen PHC governance mechanisms to ensure greater responsiveness to regional and local needs. Establishing a system for stakeholder involvement would help to increase stakeholder buy-in to planned reforms and win their support when advocating for an increased role for PHC in the health system.

Governance of PHC facilities could be improved, at provider level, by giving a more strategic role to the administrative councils and coordinating efforts at subnational and national level. The members of the councils are well placed to assess community health needs and could use their knowledge to devise a multiyear plan to develop the local PHC network.

Learning from its COVID-19 experience, the Republic of Moldova could benefit from aligning PHC, public health and social services provision to increase efficiency and community focus. This could be achieved by supporting delivery of mental health services in PHC settings, strengthening the PHC role in improving immunization coverage (including COVID-19 vaccination), and enhancing collaboration with social services to reach people with health and social vulnerabilities. Expanding PHC teams with experts based on local population needs would help to better target service delivery and improve population satisfaction. It is also necessary to make PHC attractive to the health professionals who are needed to deliver an increasingly multidisciplinary approach.

The Republic of Moldova needs to accelerate uptake of data collection mechanisms and digital solutions to improve care coordination, quality of care, and access to services. Lessons learned from the COVID-19 pandemic clearly indicate a need for improved mobile, telemedicine and digital platforms, alongside improved digital health literacy in both providers and patients.

Specific steps include:

- Strengthen governance mechanisms for PHC to ensure greater responsiveness to regional and local needs.
- Give a greater strategic role to the administrative councils and coordinate efforts at local and national level.
- Align PHC, public health and social services provision to increase efficiency and community focus.
- Expand PHC teams according to local population health needs.
- Accelerate uptake of digital data collection mechanisms and digital solutions to improve care coordination, quality of care, and access to PHC services.
PHC organization and financing
The Republic of Moldova has a well-developed family medicine-centred PHC. The PHC system underwent a major transformation between 1998 and 2004 in which the former model of feldsher–midwife points, outpatient clinics and polyclinics was replaced. Since 2008, PHC facilities have been autonomous, operating independently from hospitals and contracted by the NHIC. All doctors working at PHC level practise family medicine, and narrow specialists often still work in the same building alongside family doctors (FDs).

There is no updated PHC strategy, but the principles and priorities stated in the Strategy for the Development of Primary Health Care for 2010–2013 are still followed (Box 1). This strategy set a basis for further optimization of the PHC network. The Ministry of Health established a new set of regulations for PHC facilities and providers: requirements for facilities and equipment, PHC functions, organizational modalities, financing principles, the scope of PHC services, and the roles and responsibilities of FDs and family nurses.

Box 1. PHC development priorities in the Strategy for the Development of Primary Health Care for 2010–2013

- Maintain and continuously improve the health of the population through continuous development and strengthening of family medicine
- Ensure equitable access to high-quality and cost-effective PHC, oriented towards the basic health needs of the community
- Support and implement prevention measures, health promotion, and treatment and monitoring of individual and family health conditions

Every person, regardless of their insurance status, has to register with an FD. People have a free choice of PHC provider but are expected to register with the FD in the nearest PHC facility and to register all family members with the same FD. The NHIC is responsible for managing the registration database, and there are options for online registration. A list of facilities with available capacity for registration is published on the NHIC website. People have the right to change their FD every six months. If an FD moves to another PHC provider, registered individuals do not automatically follow the FD but have to submit a new application.

Since 2010 it has been an option for PHC providers to be privately owned, but the option has not been widely taken up. In 2021, 44 of 293 PHC providers (15%) were private. Most of the providers in remote areas are public; private clinics prefer to practise in urban areas. In 2019 the Ministry of Health introduced a new private legal form for PHC providers, called “individual practice of family physician”, to motivate service provision in remote areas (1). Stakeholders interviewed for this report...
indicated that the initial aim of implementing this new legal form was to simplify the accreditation, reporting and management requirements for individual offices. Nevertheless, the legal form has not been widely used, nor has it achieved its initial objective, as new practices have mostly opened in the proximity of urban areas.

There is wide range of PHC organizational models based on geographical location, rurality, ownership, population served, and scope of services provided (Table 1). PHC providers are also classified by levels based on registered population. The variety of organizational models illustrates a willingness to build on the existing historical infrastructure and service delivery models. As a result, in Chisinau the polyclinic type of model is prevalent, FDs take less initiative, and narrow specialists play a more important role. By contrast, outside the capital the family medicine concept has deeper roots because of the strict separation of primary and secondary care facilities.

<table>
<thead>
<tr>
<th>Organizational model</th>
<th>Geographical location</th>
<th>Population served</th>
<th>Legal form and ownership</th>
<th>Scope of services</th>
<th>Number of providers in 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family physician centres</td>
<td>Urban</td>
<td>Includes registered population in the catchment area</td>
<td>Public, owned by Ministry of Health and other ministries, municipalities</td>
<td>PHC, Specialist care, Diagnostic services</td>
<td>12</td>
</tr>
<tr>
<td>Territorial medical associations (in Chisinau)</td>
<td>Rural/urban</td>
<td>Minimum 4500 per facility</td>
<td>Public, owned by municipalities, districts and rural public administrations</td>
<td>Mostly only PHC, In municipal health centres, also specialist care and diagnostic services</td>
<td>237 (15 municipal, 36 district, 186 autonomous)</td>
</tr>
<tr>
<td>Health centres</td>
<td>Rural</td>
<td>In locations with 901–3000 inhabitants</td>
<td>Subdivisions of the health centres</td>
<td>PHC</td>
<td>611</td>
</tr>
<tr>
<td>Offices of family physician</td>
<td>Rural</td>
<td>In locations with up to 900 inhabitants</td>
<td>Subdivisions of the health centres</td>
<td>Family nurse services</td>
<td>390</td>
</tr>
<tr>
<td>Health offices</td>
<td>Rural</td>
<td>Not defined</td>
<td>Private</td>
<td>PHC, Specialist outpatient care, Diagnostic services</td>
<td>44 (including 27 individual practices of family physician, of which 20 are solo practices and seven group practices merging 2-3 physicians under one administration)</td>
</tr>
<tr>
<td>Private health centres and individual practices of family physician</td>
<td>Mostly urban</td>
<td>Not defined</td>
<td>Private</td>
<td>PHC, Specialist outpatient care, Diagnostic services</td>
<td>44 (including 27 individual practices of family physician, of which 20 are solo practices and seven group practices merging 2-3 physicians under one administration)</td>
</tr>
</tbody>
</table>

Table 1. PHC organizational models in the Republic of Moldova

Source: authors
Public PHC facilities are legally owned by the regional administration and steered through administrative councils. Administrative councils include different stakeholder representatives, including facility managers and employees. These councils are responsible for approving PHC facilities’ budgets and investment plans and monitoring budget execution. The Ministry of Health is currently revising the regulation of facility owners to clarify their role and responsibilities, especially with respect to their responsibilities to ensure funding for infrastructure investments. Facilities have financial independence and their own bank account; they also manage their own budget within limits set in their contract with the NHIC. Managers of health facilities have the right to hire and fire staff, assess staff performance and pay salary bonuses. The managements of public PHC providers report to the administrative councils and the NHIC and prepare budget proposals for their approval as part of the contracting process.

The Ministry of Health is responsible for assigning the catchment area for each provider on the basis of administrative/territorial organization, population size and density, rurality, proximity of other health service providers and quality of roads. The Ministry of Health defines territorial catchment areas for PHC providers according to recommended population per FD. Catchment areas are assigned to providers through competition organized by the Ministry of Health. According to the regulation, one FD position is introduced for every 1500 population, which is lower than the average panel size (see below). There should be two nurse positions per FD in urban areas, and 2–3 nurse positions per FD is rural areas. In rural areas with less than 400 inhabitants, one nurse position is compulsory. In addition, in communities with less than 900 inhabitants, only a nursing post is allowed. However, these family nursing posts are not separate legal entities but form part of a network with health centres. The staff regulation defines the numbers of medical and administrative staff to be employed in PHC facilities, but it is unclear whether its implementation is enforced and monitored.

The panel size per FD is regulated, but the regulation is not strictly followed in practice. According to the regulation, the average patient panel per FD is 1700 patients, with a minimum of 1200 and a maximum of 2200. These limits are often not observed in remote areas. A maximum limit of 3500 registered patients has been set if there is no possibility of finding an additional doctor. According to NHIC data, in 2021 the average size of the patient panel per FD was 1877.
**PHC services package**

The PHC service services package is relatively comprehensive and gives PHC an opportunity to take the role of the first care contact (2). The scope of PHC has expanded over the past decade, imposing new tasks and obligations on PHC providers. As of 2022, PHC providers are allowed to conduct more than 300 different diagnostic and investigative procedures, which may be provided at PHC facilities or outsourced to external laboratories. PHC providers interviewed for this report indicated that they tended to feel “overburdened” as new tasks were added, as they were not always matched with adequate training, the option to hire additional staff or increased funding.

PHC providers are allowed to provide additional health services if staff have the necessary qualifications and the required equipment is available. Such additional services include specialist counselling services, family planning, minor surgical procedures, parenteral treatment procedures, rehabilitation services, medical and social services, home care, palliative care, mental health services, youth-friendly health services and treatment of tuberculosis at community level. In practice, the NHIC contracts PHC providers or outpatient clinics to provide these services. Of all PHC providers, 14% are contracted to provide mental health services, 13% youth-friendly services, and 43% home care services.

An ad hoc approach, without any explicit methodology or procedure, is used to revise the PHC services package. The Ministry of Health usually leads the revision process and conducts stakeholder meetings to agree on necessary changes to the services package. Adjustments are generally based on international comparisons or recommendations from international organizations, with less input from the Family Doctors Association and university representatives who are engaged though stakeholder meetings.

Since 2010 the entire population has been entitled to publicly financed PHC services without copayments. In spite of this entitlement, public and private PHC providers can charge for diagnostic services covered by the NHIC if a patient does not have the required referral from an FD or if services are not included in the PHC services package. Any charges for extra billing in public facilities must be approved by the government and made publicly available in the facility (3). Private providers can set their own tariffs. Interviewees for this report indicated that waiting times for diagnostic services are long and patients might prefer to jump the queue by making out-of-pocket payments. Based on the assessment of PHC providers, the share of formal out-of-pocket payments in their revenues remains low, at up to 2%. However, the extent of informal payments in health care is an area of concern. In 2015 almost three quarters of respondents indicated that they had frequently resorted to paying bribes to access health care (4).
Outpatient medicines are the largest single driver of catastrophic health spending. In 2016 outpatient medicines accounted for over 90% of out-of-pocket payments in the poorest quintile, compared to 56% in the richest quintile (Fig. 1). In contrast to PHC services, there are heavy copayments for prescription medicines. Heavy reliance on percentage copayments exposes people to high or fluctuating prices, and there are no copayment exemptions specifically targeting poor people or regular users of health care; only medicines for selected diseases, such as (for example) certain mental health conditions and diabetes mellitus, are covered. The list of covered medicines has expanded over time and most of the medicines included are subject to percentage copayments, depending on disease and population group.

Prescription rules for outpatient medicines limit the role of PHC in chronic care management. PHC providers are allowed to prescribe only a limited number of drugs for a limited period for chronic patients, which is not in line with treatment protocols and forces patients to make frequent visits to providers with the sole purpose of getting the prescription they need. There are also restrictions on specialists that limit their ability to prescribe medicines for chronic conditions. Relaxing prescription rules could help to make PHC more responsive to people’s needs and enhance chronic care management.
Referral requirements allow patients to bypass PHC, including for conditions that could be effectively managed by PHC. Although the PHC gatekeeping function has been in place since implementation of mandatory health insurance, the benefits package contains a list of 77 diseases, including chronic conditions, for which patients are allowed to access specialized outpatient care directly. Interviewees for this report also noted that the guidelines that have been devised often tend to recommend referral for conditions that could be managed by a PHC team. This undermines the role of PHC providers and limits their ability to act as an effective first care contact.

There are no waiting lists for PHC appointments. PHC facilities are usually open on weekdays from 08:00 to 17:00 and at least half a day on Saturdays. An appointment system is compulsory, but an on-call doctor is available during opening hours. Outside the capital, patients are mostly seen on a first come, first served basis.

Poorer people are more likely to turn to their FD and less likely to seek specialist care. People in the richest quintile are twice as likely to seek specialist care as people in the three poorest quintiles (Fig. 2). Higher use of FD services is also common in rural populations. One reason for higher use of PHC services by rural or poor people is that a larger proportion of them are uninsured and so eligible for free PHC.

Fig. 2. Physician contacts over the previous four-week period by quintile, 2022

![Graph showing physician contacts by quintile](source: National Bureau of Statistics of the Republic of Moldova (6))
PHC budget

The Republic of Moldova spends relatively more on PHC than other middle-income countries. In 2019, public spending on PHC was 1.4% of gross domestic product (GDP), higher than other countries in the central and eastern parts of the WHO European Region (Fig. 3).

Fig. 3. Public spending on PHC as a share of GDP in selected countries of the WHO European Region, 2019

The strategic objective has been to maintain PHC spending at about 30% of the total NHIC budget, but this has rarely been achieved (Fig. 4). Until 2022 the PHC budget ceiling included outpatient prescription medicines. Although increasing spending on medicines is a positive trend, it resulted in less budgetary space for PHC because of the shared budget envelope. In 2022, after long debate, the outpatient prescription medicines budget line was separated from the recommended 30% budget allocation threshold for PHC. Currently, the decreasing priority given to PHC spending is alarming.

Note: Estimates are based on the global definition of PHC spending, which includes the following categories (followed by Classification of Health Care Functions (HC) code): general outpatient curative care (HC.1.3.1); dental outpatient curative care (HC.1.3.2); curative outpatient care, not elsewhere classified (HC.1.3.nec); home-based curative care (HC.1.4); outpatient long-term health care (HC.3.3); home-based long-term health care (HC.3.4); preventive care (HC.6); a share (80%) of medical goods provided outside health-care services (HC.5); and a share (80%) of health system administration and governance costs (HC.7). Public spending includes domestic and external funding.

Source: Global Health Expenditure Database (7)
The PHC budgeting process builds on historical expenditure rather than population health needs. The PHC budget estimate is based on expenditure data collected from contracted PHC facilities in alignment with a defined economic classification. In addition, the next year budget estimate takes into account expected salary increases, consumer price index and expansion of the PHC services package. However, no costing for the capitation rate has ever been conducted to assess whether the allocated budget is adequate to deliver the services included in the PHC services package. The decision on PHC budget allocation is made on the basis of the overall budget envelope available, and the budget that is decided serves as the basis for calculating the capitation rate (covered in the next section). The NHIC budget is approved by the government and adopted by parliament. The NHIC is allowed to reallocate approved budget between programmes to a maximum of 2% of total budget (8).

Responsibility for infrastructure development and capital investment lies with the owners of PHC facilities. As a result, PHC infrastructure is weak, and most facilities need refurbishment. The decision on PHC facility infrastructure development is made by administrative councils. The NHIC has a specific development fund for capital investments, including procurement of equipment and facility repair, but it is small relative to the capital investment needs of all providers. The majority of providers interviewed for this report found long-term planning of infrastructure development difficult and getting resources for investments especially challenging.

1. Data provided to the authors in personal communication with the NHIC.
PHC payment system

Since 2004 PHC has been financed by using capitation payment. Initially, a simple unweighted capitation payment was used. In 2009 age adjustment was introduced. The facility-level total contract amount is calculated by taking into account the number of people actually registered; registration information for calculation purposes is updated quarterly. Capitation payments are made monthly – 80% of the contractual capitation amount is paid in advance and 20% in the following month or at the end of the quarter, depending on the availability of the health insurance budgetary funds (the latter payment share used to be performance-related, on which see below).

Capitation rates are revised regularly according to budget availability. As a result, capitation rates have doubled since 2017 (Table 2) and increase in capitation rates usually exceeds the rate of inflation. The 30% budget target for PHC may have played a role in safeguarding sustained annual growth in PHC spending. Still, stakeholders interviewed for the report noted that capitation rate calculation was not transparent as there was no approved methodology or participatory process established.

<table>
<thead>
<tr>
<th>Age group</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 5 years</td>
<td>457.56</td>
<td>471.64</td>
<td>563.76</td>
<td>637.51</td>
<td>913.83</td>
<td>974.67</td>
</tr>
<tr>
<td>5–49 years</td>
<td>269.16</td>
<td>277.44</td>
<td>331.61</td>
<td>375.02</td>
<td>537.54</td>
<td>573.33</td>
</tr>
<tr>
<td>Over 50 years</td>
<td>403.72</td>
<td>416.16</td>
<td>497.44</td>
<td>562.52</td>
<td>806.32</td>
<td>860.00</td>
</tr>
</tbody>
</table>

Capitation age adjustment coefficients are not regularly revised to take into account changes in health needs, clinical practice and the PHC services package. Existing age adjustment coefficients were calculated on the basis of the number of visits made to the FD by different age groups in 2009, when age adjustment was initially introduced. No adjustments in capitation payments to take account of different health needs in different geographical locations (for example, the specific needs of rural populations) are in place.

Additional payments are available to incentivize certain PHC providers to deliver a broader scope of services at PHC level. It is mostly first-level district health centres and territorial medical associations in Chisinau (municipal) that are eligible for additional capitation payments for providing an extended scope of services to a defined catchment area. In 2021 add-on capitation was 10 lei (£0.5) annually. A separate payment for community and home health care, based on number of visits, is also available. Youth-friendly and mental health centres are paid a global budget in addition to regular funding. However, it remains unclear if extended services can only be provided by first-level health centres and family physician centres, and if there is an overlap in coverage of these

Table 2. Annual capitation payment rates (in Moldovan lei), 2017–2022

Note: As of 28 June 2022, 1 Moldovan lei (plural: lei) was equivalent to €0.05.

2. Data provided to the authors in personal communication with the NHIC.
services through capitation for different providers. During the COVID-19 pandemic an additional COVID-19-specific fund aiming to cover increased salary expenses was made available.

**Selected public PHC providers are entitled to additional payment to cover the salary deficit.** For public providers, the NHIC monitors the extent to which the regulation on minimum salaries for health-care providers is fulfilled. In some special geographical areas, providers are eligible for 30% of the salary top-up payment. A separate payment – a lump sum to specifically cover the salary deficit – has been established for this purpose.

**Over the years the share of salary-related expenditure has increased (Fig. 5).** The contracted amount of capitation payment is intended to cover expenditure on salaries, performance payment, medications, investigations, and other costs such as procurement and maintenance of fixed assets, staff training, medical equipment and utilities. In 2021 the base salary formed 69% (80% if the performance component is included) of the PHC budget execution.

![Fig. 5. PHC providers' budget execution by expenditure according to economic categories, 2017–2021](image)

3. Data provided to the authors in personal communication with the NHIC.
Salary levels at PHC facilities are relatively high, but the salary system disadvantages young doctors. Salary levels at PHC facilities are higher than in specialized outpatient clinics, but lower than in inpatient care. The salary levels of public health-care providers are defined by the government and set on the basis of the seniority of medical staff: up to 10 years, 10–20 years and over 30 years. As a result, the existing salary system disadvantages young doctors. There is an ongoing discussion about abolishing the seniority-related adjustments. PHC salaries are also influenced by performance payments described below.

The share of available contract allocation for investigations is small and decreasing, with the result that patients bounce between different levels of care or are pushed to make out-of-pocket payments. The lack of funding for investigations was a concern among the stakeholders interviewed. Investigations accounted for 7% of total reported expenditure in 2020 (Fig. 5). The current level of capitation payment does not allow all investigations to be conducted according to the national protocols and incentivizes PHC providers to refer patients to secondary care. This creates tension with secondary care providers, who also receive capitation payment and are anxious to avoid the cost of investigations that could have been conducted at PHC level. It is an issue especially at the end of the year, when the annual contracted amount is exhausted. About 4% of the overall PHC budget is spent on medicines and medical devices that need to be available at facility level.

In spite of the targeted financial incentives that have been introduced, lack of FDs in rural PHC practices is a growing concern. There are many reasons why working in rural areas is less attractive: outdated infrastructure, low-quality roads, greater responsibilities without a clinical support system. Some remote facilities have only wood-fired heating and no access to running water. In addition, patient panels are smaller in some remote areas, resulting in lower capitation revenues. In rural areas opportunities to increase income by mixing private and public practice are also limited. As a result, salaries of rural FDs are lower. The Ministry of Health has introduced financial incentives for doctors starting work in remote areas in the form of a one-time allowance. This payment is made from the state budget and administered by the Ministry of Health. Providers can receive 120 000 lei (about €5800) over the course of three years. The Ministry sometimes offers free accommodation for FDs. Still, very few doctors decide to take up this opportunity.

Since 2005 different performance payment system designs have been used to incentivize quality improvement in PHC (Box 2). PHC providers receive up to 80% of their contractual amount in advance each month, with the remaining 20% coming at the end of the month. Previously, this 20% was linked to fulfilment of quality indicators – if the indicators were not met, the provider would receive less. Payment for performance was made quarterly (using process indicators) and annually (using output indicators) for each PHC provider. There was a committee within the PHC organization that distributed financial bonuses based on the number of services provided by each participant (FDs and nurses) in the scheme. Other health professionals (such as paediatricians and gynaecologists) did not receive additional performance payment, except in certain health centres and family physician centres that had such personnel in their organizational structure.
Box 2. Evolution of the performance payment in the Republic of Moldova

The first performance payment system, introduced in 2005, focused on three clinical areas: detecting and monitoring tuberculosis patients; monitoring women during the first trimester of pregnancy and providing gynaecological cytology screening; and child checkup during the first year of life. This payment system was put on hold in 2010, partly because of the global financial crisis but also because resources were shifted to other priorities, such as ensuring universal PHC coverage to the entire population (9).

In 2013 a revised performance payment was introduced. The focus areas expanded in alignment with the objectives of the health strategy. The revised indicators focused on health of pregnant women, child checkup during the first year of life, and prevention/early detection and monitoring of treatment of priority diseases (cardiovascular diseases, diabetes, cervical and breast cancer, tuberculosis).

In 2016 output indicators were introduced that focused on certain cardiovascular diseases, cervical cancer, pregnant women and child checkup during the first year of life. For example, eligibility for the performance payment depended on 25% or more of patients with coronary heart disease having blood pressure of 140/90 mmHg or less.

The indicators used in the performance payment were revised annually by a working group consisting of representatives from the Ministry of Health, the NHIC and medical professional associations.

The performance payment was abolished during the COVID-19 pandemic as PHC providers were not able to achieve expected performance targets. Since 2020 all providers have received 100% of the capitation payment (still 80% upfront and 20% in the following month), but providers are obliged to earmark 15% of the salary fund for bonuses. Monitoring of the quality indicators became the responsibility of PHC providers and the NHIC stopped collecting data on performance indicators. Most of the providers interviewed for the report indicated that they continued to monitor performance and facility-level performance assessment committees are still operational, but the list of indicators has been amended and focuses on patient satisfaction and COVID-19-related activities.
Monitoring performance payment-related indicators was a time- and resource-intensive process. Several actors were involved in monitoring performance indicators: FDs, the PHC facility manager and a representative from the NHIC control department. Data on facility-level performance by indicator were reported to the NHIC. No electronic system had been established for automated data collection. Based on the validated results, the NHIC could refuse to make a performance payment if services were not delivered in line with the existing clinical guidelines. Performance payment-related monitoring and reporting required extra data collection and analytical work to be done in parallel by doctors, nurses and managers, as well as by the NHIC, which put a heavy burden on everyone involved in the process. At national level, data on PHC providers’ performance were not made public.
Contracting and monitoring PHC providers

The NHIC has to contract all public and private PHC providers who have been assigned a territory by the Ministry of Health. PHC providers have to comply with minimum contract requirements such as availability of necessary medical personnel and equipment. Existing contract requirements do not cover several aspects – for example, uptake of digital data exchange systems and care coordination across different care settings.

All providers are required to make a contract application annually – an administrative step that currently seems to add little value. The primary purpose of the annual contract application procedure is financial monitoring and information collection for budgeting based on a defined economic classification. Providers need to submit a business plan and financial forecast for the coming year. The NHIC provides draft templates with recommendations to providers on how to prepare their contract proposal. However, calculation of the PHC contract amount for each provider is based on the number of people registered and the payment methods are fixed in the terms of the regulation. The financial forecast is only necessary to prepare for budget execution monitoring according to the economic classification.

PHC providers have a certain degree of managerial autonomy over their budget, but strict oversight by the NHIC undermines the potential benefits. Managers of PHC facilities have an obligation to prepare budgets and distribute funds as they see fit following the salary and other guidelines. However, operational savings can only be redirected to the following financial year with NHIC consent, and they are not allowed to cover anticipated costs related to refurbishment of the facility or any kind of investment. Providers therefore have an incentive to spend the entire budgeted amount rather than making savings or increasing efficiency. Although some contract expenditure ceilings were abolished in 2021, the NHIC continues to use them to monitor PHC providers’ contract execution. Salary expenditure cannot exceed 75% (60% for base salary and 15% for bonuses) of the overall contracted amount. Until 2021, it was permissible to spend up to 4% of the budget on outsourced diagnostic services. All PHC providers have to submit reports on contract execution by expenditure category after six, nine and 12 months. The NHIC uses this information to monitor alignment with salary regulations and to make estimates for the upcoming year budget. Providers interviewed for the report also noted that they informed the NHIC about discrepancies between proposed budget and actual expenditure. The budget execution reports based on the defined economic classification are shared with the Ministry of Health and the Ministry of Finance.
Nonfinancial monitoring is less advanced because of flaws in the digital data collection system. Providers are required to report quarterly on aggregated volume of services, but this is done via email. Often these reports are drafted manually by providers, as paper-based medical records are still allowed and the data recording method is the choice of the FD. Lack of an automated data collection system is a significant burden for health facilities and the NHIC. It results in limited possibilities to validate data quality and to conduct meaningful performance monitoring.

Aggregated reports on clinical indicators were collected prior to the abolishment of the performance payment. In parallel, the Ministry of Health has established a monitoring system for PHC organizations, which focuses on the quality of management of public PHC facilities, including human resources and provision and quality of services.

The NHIC has a well-established system for monitoring PHC providers, which includes checking quality of care and controlling use of financial resources. The NHIC conducts field visits to an annually defined number of PHC providers to monitor if they have followed patient registration procedures, clinical guidelines and prescription rules and made referrals in accordance with the defined care pathways. In the event of noncompliance, providers are required to return part of the received funding. Experience gained during these visits could be useful in strengthening monitoring of provider performance and improving the PHC budgeting and contracting process.
Policy considerations
Prioritize PHC spending and improve budgeting practices

PHC spending in the NHIC budget should be prioritized to prevent its further decline and to strengthen PHC going forward. It was an important step to separate outpatient prescription medicines and PHC budget lines, as it allows them to be considered in the context of the entire NHIC budget and avoids the risk that one is prioritized at the expense of the other. It opens up the possibility of addressing the low level of spending on outpatient prescription medicines without reducing spending on PHC. The necessary budgetary space can be created by optimizing spending in other areas, such as hospital care, and by increasing state budget transfers to the health insurance budget.

Steps should be taken to ensure that the PHC budget is aligned with the promised services package, the expected role of PHC and population health needs. The PHC services package is relatively comprehensive, allowing PHC providers to take responsibility for priority preventive care and noncommunicable disease management. However, no assessment has been conducted to verify if the capitation payment rate is sufficient to cover the cost of delivering the services included in the PHC services package and is in line with population health needs. Transparent decision making is needed to ensure that the PHC budget is aligned with increases in input prices and a widening scope of services.

The NHIC should move from input-oriented planning and monitoring to focus on population health needs and performance-centred PHC purchasing. Focusing on inputs and expenditure based on the defined economic classification in budget planning and execution incentivizes PHC providers to concentrate on inputs rather than the health needs of the population they serve. It also creates a perverse incentive to align data reporting with compulsory requirements such as spending ceilings for salaries. Collecting provider-level cost information is valuable in understanding the actual costs of the services provided and informing development of the PHC payment system. However, this information should not be the primary focus of strategic purchasing, and to have real added value, it must be combined with data on population health needs, PHC service use and performance.

The principles employed to monitor contract execution could allow more flexibility at PHC provider level. Such flexibility would increase efficiency of spending and minimize the risk that spending decisions are made on the basis of rules rather than needs. For example, restrictions on using operational savings made against NHIC funds do not allow providers to act autonomously to plan their longer-term spending needs; instead, they incentivize providers to spend all contracted amounts.
Make the PHC services package more attractive and responsive to population health needs

The PHC services package should be more explicit on the respective roles of primary and secondary care providers. Such clarity would limit incentives to bypass PHC, reduce overreliance on specialists, and minimize risk of duplication. A more explicit PHC services package would also make it easier to proactively inform patients about their entitlements and pathways in the health system, bearing in mind the various PHC organizational modalities (as described in Table 1) and the different service packages available in different PHC facilities.

The PHC services package revision process could be improved by making it more systematic and transparent and linking it more closely with budget planning. This would help to avoid situations in which PHC providers feel that they have to do more without adequate financial resources, staff, training or equipment. Involving PHC providers, the Family Doctors Association and university representatives in discussions early on would increase their ownership of the process and create space to identify in a timely manner where additional support is needed.

The first steps have been taken to extend the scope of PHC services, but patient access to these services needs to be improved. Uptake of the extended package of services has been moderate, indicating the need to review requirements and assess providers’ readiness to comply. Additional incentives may be needed to ensure equal access to the extended scope of PHC services (see below).

The universal, relatively comprehensive and free PHC service package is a great achievement, but more can be done to make outpatient medicines truly affordable to the entire population. If priority medicines are not affordable to the entire population, the impact of PHC strengthening will remain limited. The outpatient prescription programme should be available to all people, not only to those who are insured. The NHIC should start moving away from heavy reliance on percentage copayments and exempt poor households and regular users of health care from copayments. Further attention is needed in addressing inefficiencies in procurement, developing stronger price regulation, and taking steps to encourage rational prescription and use of medicines (5). Moreover, simplifying the prescription procedure for PHC, updating treatment protocols, training doctors, and increasing providers’ awareness of the benefits of available medicines would help to improve adherence to treatment and increase PHC attractiveness. Although promising steps have recently been taken, their overall impact has not yet been assessed.
Align PHC payment design with policy objectives

The Republic of Moldova has long experience of capitation payment – it should continue to be the main PHC payment method, but its design could be strengthened. The capitation rate is adjusted for age to limit the risk of underprovision of services to children and the elderly. However, the age adjustment coefficients and age grouping are not regularly revised on the basis of changes in clinical practice and health needs and may not reflect the actual resources needed. A systematic and regular review of capitation adjustments would help to mitigate this risk. In the future, additional adjustment factors (multimorbidity, socioeconomic status, etc.) could be considered, but transition towards another form of adjustment requires high-quality data on population health and other characteristics, service use and expenditure, as well as a comprehensive system for data collection and monitoring. Therefore, a blended payment model, with additional targeted and performance-related payments, would be a more pragmatic approach in the medium term (Box 3).

Box 3. Benefits of a blended payment model for PHC

A context-specific blended payment model with capitation at its centre is most closely aligned with the principles and objectives of PHC. Capitation is the only payment method that is based on the principle of equity, as its starting point is an equal fixed payment per person, which can then be adjusted to reflect individual health needs. It is also the only method that pays PHC providers to prioritize preservation of good health through health promotion and disease prevention. It offers a predictable and stable revenue stream to PHC providers that can be used to flexibly deliver services in responsive ways that optimally manage care for individuals and population groups.

Blended payment models can combine capitation with elements of other payment methods to maximize beneficial incentives, offsetting the perverse incentives of each payment method and ensuring that other service delivery objectives, such as access, are met. Blended payment models bring the benefits of capitation as the starting point and then use elements of other payment mechanisms to deliberately offset capitation’s disadvantages and to help achieve other specific health system objectives. A model of this kind typically includes:

- a budget payment to cover unavoidable fixed costs, particularly in low-population or hard-to-serve areas;
- some fee-for-service “carve-outs” for health conditions or services that are high-priority or at higher risk of being underprovided in capitation; and
- performance payment to incentivize providers to reach coverage targets for priority services and improve quality of care.

Source: Hanson et al. (2022) (10)
The methodology used to calculate the capitation payment rate could be revised to better reflect the cost of delivering evidence-based services to the registered population in an efficient manner. Currently, the capitation payment rate builds on historic expenditure data subject to annual indexation and budget availability. As a result, the link between the scope of the PHC benefits package and the financial resources needed is missing. In order to be able to deliver the expected scope of PHC services, a costing exercise would help to understand the underlying costs related to salary, premises, medical and other essential equipment, supplies, diagnostics and investigation. Afterwards, this costing model could be used to support revision and budget estimates for the PHC benefits package, as it makes it easier to calculate the budget implications of increased costs of different inputs (such as a minimum salary for health professionals) or an expanded PHC benefits package. A costing exercise is also a useful way to gain a better understanding of the cost drivers and potential efficiency gains. It would also increase transparency in payment rate negotiations between purchaser and providers and enable explicit priority setting if the budget envelope is limited.

Incentives to deliver extended PHC services should be strengthened. Current regulations allow PHC providers to offer extended service packages, but it remains unclear which additional services should be covered through the regular capitation and which through other payment mechanisms. This makes it difficult to assess if the projected funding for extended PHC services is adequate. Adjustments in the extended package requirements are needed, as well as greater transparency in the existing payment mechanism. Moreover, additional financial incentives may be needed if PHC services are extended further – for example, if the scope of available mental health services in PHC is extended.

Reintroduction of a modified motivational performance payment system would help to incentivize quality improvement in PHC. Substantial experience with performance payments in the past has built the necessary capacity in the NHIC as well as at provider level. Nevertheless, the system should be critically revised to eliminate design flaws that have tended to lead repeatedly to abolishment of the system.

To address these challenges, the following steps could be taken:

- Introduce a shorter list of indicators that focus on priority health needs.
- Ensure that data are easily collectable to minimize the administrative burden.
- Bundle similar indicators into aggregated indicators (e.g. diabetes management); this is good practice and helps to keep the focus on patient-centred care.
- Regularly revise the list of indicators and remove those that, for example, offer no prospect (or no further prospect) of improvement in order to create space for new priority indicators.
- Focus on process indicators as a priority, though they should be linked to outcomes and national health strategy priority areas, as these are easier to measure accurately and PHC team performance is directly related to them.
• Start collecting digital data on PHC that are needed for performance monitoring and get rid of additional parallel reporting systems that add an avoidable administrative burden.

• Move to individual doctor-level monitoring of indicators to see trends over time and allow benchmarking.

• Publish performance indicators, which increases transparency and incentivizes providers to improve their performance.

• Introduce a mechanism, preferably automated, to validate provider-level indicators before actual payments are made; this offers a valuable opportunity for the NHIC to establish feedback loops with PHC providers to discuss their current performance and options for improvement.

One way forward could be to partly preserve the pandemic era adjustment of the performance payment that shifted the monitoring responsibility to facility level. For example, the performance payment could be split into parts: national and facility level (Box 4). The national component would have national-level priority indicators in line with the health strategy and central monitoring would be applied. The facility-level component could focus on local and facility-level priorities and be managed at facility level. Such an arrangement would offer more possibilities to address local priorities and to incentivize better coordination between PHC, public health and social services. Part of the facility-level performance payment could be earmarked for quality improvement activities such as continuous medical education.

Box 4. Performance payment in Kazakhstan

In 2010 a performance payment was implemented in Kazakhstan. Its main objective is to encourage quality improvements in PHC. The performance payments are distributed among PHC facilities in each region according to their performance as determined against predefined indicators. The thresholds for each region and facility are defined separately depending on local context.

The list of performance indicators reflects health policy priorities at PHC level, such as reducing maternal and child mortality from preventable causes, timely detection of tuberculosis, early detection of visually localized cancers, reducing hospitalizations for complications of circulatory system diseases, and monitoring patient complaints.

The PHC team comprises an FD, family nurses, a social worker and a psychologist, who all contribute to meeting the criteria set by the indicators. At least 80% of the bonuses received are paid as a monthly salary supplement to increase the motivation of the PHC team. At least 5%, and no more than 20%, of the bonus should be spent on additional training for the care teams in order to stimulate further quality improvement in PHC.

An information system has been introduced for automated monitoring of indicators and calculation of bonuses. This ensures transparency and makes it easier to monitor the extent to which policy priorities have been achieved.
Fee-for-service payment for selected priority diagnostic services could be considered to reduce the risk that capitation payment may incentivize referrals from PHC to specialists. The small and falling share of spending on investigations is not in line with the relatively comprehensive PHC benefits package and the expected role of PHC. Additional fee-for-service payment would incentivize PHC providers to take a more active role in diagnostic activities and to refer fewer patients to specialists. The risk of spending running out of control could be reduced by starting with a small list of priority services, setting an overall ceiling to the fee-for-service fund, and developing a monitoring system.

Additional financial incentives to rural providers are necessary to ensure access to PHC services regardless of geographical location. Financial incentives to take up practice in rural areas are in place, but there is no incentive scheme to retain doctors and nurses and so ensure that PHC services are available in rural settings. Geographical areas could be defined where a minimum level of funding for PHC facilities would be guaranteed, regardless of the number of people registered. Additional adjustments might be needed to make working in remote areas more attractive and to cover transport and other costs increased by remoteness.

A transparent process to assess investment needs in PHC facilities and mechanisms to invest in physical and digital infrastructure are needed. Existing capitation payment is not expected to cover capital costs, and different facility owners have different capacity to cover them and interest in doing so. Part of the solution could be to include capital costs in the capitation payment and to allow PHC providers to retain any surplus, which could be used to cover facility investment needs. The NHIC could also increase the funds available for PHC strategic investments and set up a coordination mechanism with local governments. In view of NHIC and local government budget limitations, external funding options could be explored for PHC strategic investments (Box 5).
Move to multiyear and performance-centred PHC contracting

The NHIC could consider using a contracting mechanism to improve geographical access to PHC services and to incentivize development of multidisciplinary PHC networks providing an extended scope of services. A first step could be to define geographical access criteria such as minimum number of PHC physicians/providers per defined settlement, taking into account sociodemographic characteristics, population density and age distribution. To address the recent trend towards increasing the number of individual practices in urban areas, the NHIC or Ministry of Health could set minimum requirements for PHC practices. For example, in Georgia urban PHC providers are contracted if they serve a population of at least 10 000. In Estonia PHC providers are financially incentivized to establish group practices by allowing additional funding for PHC centres with at least three FDs serving 4500 people. This could also serve as a basis to develop minimum access criteria for extended PHC services. In addition, the contract could include more detailed quality and digital data exchange requirements, as well as incentives for better care coordination with other providers.

Box 5. Using external funding for multidisciplinary PHC centres

Estonia is using funding from the European Regional Development Fund (ERDF) to invest in PHC infrastructure to accelerate implementation of its PHC reform agenda (11).

Eligibility criteria for ERDF grants to construct or refurbish PHC centres were developed by the Ministry of Social Affairs. Geographical location of PHC centres eligible for funding was predefined to ensure that funding went to centres of activity – where people live and use PHC services – and to incentivize mergers of small, fragmented and unsustainable practices. Definition of eligible geographical location was based on a thorough needs assessment conducted to evaluate population age structure and long-term projections.

To be eligible for grants, PHC providers were required to commit to providing an extended scope of services. More specifically, providers had to have at least 3–4 FDs and 3–4 family nurses working in a single facility; they also had to provide a midwife, a physiotherapist and home nursing services for a minimum of 4500 people, or 6000 people in the case of larger urban areas. In locations with a nearby nursing hospital, ambulance or specialist care provider, sharing of infrastructure with PHC centres was recommended.
The NHIC could move to multiyear and more automated contracting of PHC providers. Payment rules for PHC providers are predefined by regulation and can be used, in combination with registration data, to produce the PHC provider contract amount, which can easily be adjusted to reflect annual changes. This process can be automated and replace bureaucratic contracting, which brings little added value. In addition, multiyear contracts would incentivize longer-term planning of necessary investments. Time should be made available for the NHIC and PHC providers to conduct a review and contract planning process that focuses on population health needs and performance.

The existing PHC providers’ financial monitoring system should be complemented with a comprehensive PHC performance monitoring system. To achieve this, it is essential that paper-based recording is terminated and an electronic data collection system developed. Financial incentives could be used to facilitate the transition. Moreover, relevant analytical capacity needs to be established within PHC teams, with the involvement of health authorities.

Accelerate efforts beyond health financing

Although refinements in PHC financing are important, other areas need to be addressed as well.

The Ministry of Health could strengthen PHC governance mechanisms to ensure greater responsiveness to regional and local needs. It is recommended that health authorities are connected at national and local level, with an explicit mandate to develop policy frameworks, facilitate implementation of change, and monitor progress (12). Establishing a system for stakeholder involvement would help to increase stakeholder buy-in to planned reforms and gain their support when advocating for an increased role for PHC in the health-care system. Implementation of any reform requires an accountability framework for all stakeholders involved and regular monitoring to ensure that it delivers what is expected.

Governance of PHC facilities could be improved, at provider level, by giving a greater strategic role to the administrative councils. Administrative councils could participate in long-term planning and assessment of population health needs. Members of the councils are well placed to assess community health needs and could use their knowledge to help devise a multiyear plan to develop the local PHC network. At the same time, national and subnational efforts should be coordinated: national-level engagement in the councils’ work is essential to support necessary investments to realize locally defined development plans.
Aligning PHC, public health and social services provision will increase efficiency and community focus. The COVID-19 pandemic showed how important it is to have joined-up thinking and coordinated effort. PHC in the Republic of Moldova could significantly benefit from building bridges between PHC, public health and social services, which would help to build resilience and crisis preparedness. Such collaboration could be supported by delivering improved mental health services in PHC settings, strengthening the PHC role in improving immunization coverage (including COVID-19 vaccination) and reaching people with health and social vulnerabilities.

Expanding PHC teams to meet local health needs helps to better target service delivery and improve population satisfaction. PHC services should be expanded to ensure that multidisciplinary care teams are available to meet the specific health needs of the local population. Therefore, PHC has to be attractive to the health professionals who are needed to deliver an increasingly multidisciplinary approach. This could be achieved through training and retraining of health-care workers in various disciplines. Redistributing responsibilities, such as allowing nurses to take on an expanded role, is efficient and increases professional contentment among doctors and nurses who are able to rise to the level of their competencies. A motivated PHC workforce contributes to improved service quality and population satisfaction with PHC.

Finally, the Republic of Moldova could consider accelerating uptake of digital data collection mechanisms and digital solutions to improve care coordination, quality of care and access to PHC services. Access to digitalized data and utilizing information and digital solutions is a precondition of the majority of the policy considerations described above and therefore needs to be given high priority. Furthermore, lessons learned from the COVID-19 pandemic clearly indicate a need for improved mobile, telemedicine and digital platforms, alongside improved digital health literacy in both providers and patients (12).
References


The WHO Regional Office for Europe

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.

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