ANNEX 1: ACTION FICHE FOR THE REPUBLIC OF MOLDOVA – ENP AAP 2008

1. IDENTIFICATION

Title	Sector Policy Support Programme Health		
Total cost	€ 46.6 million, including € 16.6 million from the Governance facility		
Aid method / management mode	Sector budget support, centralised management **CRIS Ref:** ENPI/2008/019-655		
DAC-code	12110	Sector	Basic health care

2. RATIONALE AND COUNTRY CONTEXT

2.1. Economic and social situation

The macro-economic situation of the Republic of Moldova has improved steadily. Annual GDP growth 2004-2005 was 7% and estimated at 4-5% in 2006-8. The Republic of Moldova remains the poorest country in Europe with GDP/cap of 937 USD in 2006. Life expectancy is low at 68 years (EU 79a).
The IMF concluded recently that 'macroeconomic policies are sound [and] government finances are healthy'. A prudent 2008 budget is in place. Growth has been remarkably resilient in the face of external shocks: a wine-embargo and gas-price rises imposed by Russia in 2006, and a severe drought in 2007 (Article IV Consultation 21/12/2007). Investment is improving.

Foreign Direct Investment in 2007 was 12% of GDP. Remittances are also expected to grow. The central government reported surpluses over the last four years owing to robust revenue from VAT and excises on import. Expenditures were kept in line with budget commitments. The 2008 budget deficit target of 0.5 % of GDP is 'appropriate'. Revenue growth has been squeezed by the reduction of corporate and personal income taxes. External debt, at ca. 2 billion USD in 2007, remains under control. The Republic of Moldova is expected to benefit economically as a new EU neighbour country since 2007 and the new EU Preferential Trade Agreements.

Total health care expenditure is hard to calculate, as it includes direct payments by the population and largely non-budgetised international aid flows. Estimates range from 4.8% (Ministry of Health) to 10% (World Bank Public Expenditure Review 2006) of GDP.

The government approved a Medium-term Expenditure Framework 2008-2010 in May 2007. Slower public expenditure growth rate and a more efficient use of available resources are emphasised. Health, and social protection (supported by 2007 ENPI sector budget support), are emphasised in the budget. Healthcare is projected to rise from 13.9% of the national budget in 2008 to 14.8% in 2010 (from 196 MEUR to 245 MEUR). The public health budget is modest at approximately 50 Euro per person (2008).

IMF and international analyses emphasis that: annual national budgets should be less incremental, more oriented towards capital investments and domestic growth, and better linked to the MTEF and the new National Development Strategy. The Health chapter of the MTEF is comprehensive but as overall, the challenge is to move from historical increments and the Annual Budget towards increased orientation on performance budgeting and MTEF.

With a GDP of 3.35 billion USD in 2006, the Republic of Moldova remains a tiny east European economy, heavily dependent on external energy sources and remittances. Remittances have indirectly contributed to a huge trade-deficit at 50% of GDP. Inflation at 13% in 2007 remains an issue. EBRD transition and World Bank 'Doing Business' indicators still point to: a weak business environment, further need to streamline the regulatory

environment, strengthen the independence of the judiciary, and counter-act reportedly widespread corruption.

Poverty remains wide-spread in the Republic of Moldova. According to the UNDP Human Development Report 2007/2008, 20.8% of Moldovans live on less than 2 USD (PPP)/day. The new National Development Strategy stresses a positive trend and a close relation between poverty reduction and economic growth; this view is not fully shared by all analysts and civil society.
Despite risks, it is considered that the Republic of Moldova fulfils the important eligibility criteria for EC budget support, as the macro-economic situation is challenging but stable. The government is on track concerning conditionality of its IMF Poverty Reduction and Growth Facility 2006-2009. The third PRGF Review was completed successfully in March 2008.

The country meets the general requirements set forth in Article 15 of Regulation (EC) No 1638/2006 of the European Parliament and of the Council. Public procurement practices are on track of alignment with EU practices, though improvements in on-line communication and introduction of e-procurement are essential. Health sector budget support is furthermore consistent with Priority Area 3 (Support for Poverty Reduction and Economic Growth) of the Republic of Moldova Country Strategy Paper 2007-2013 and the National Indicative Programme 2007-2010.

2.2. Cooperation policy of beneficiary country

The National Development Strategy of the Republic of Moldova 2008-2011 was approved by Parliament in December 2007 and promulgated by presidential decree in January 2008. It follows the Economic Growth and Poverty Reduction Strategy 2004-2007. The key objective of the new NDS is to ensure a better quality of people's lives by strengthening the foundation for a robust, sustainable economic growth.

The strategy is based on five medium-term priorities: (i) Strengthen democracy based on the rule of law; (ii) Settlement of the Transnistrian conflict; (iii) Raising competitiveness; (iv) Developing human resources, employment, and promoting social inclusion; (v) Regional development. The Health sector is included under priority 'iv'.

MDG targets, including many for health, are included in the NDS. MDGs are considered "necessary (but not sufficient) conditions to achieve the vision of the NDS". Commitment to and growth in social sector spending, including health care, need now to be matched by improvements in quality and access. As a major public employer and a large component of the state budget, the public health care sector will also be affected by the wider reform agenda particularly: fiscal discipline, PFM, Pubic Administration Reform. The NDS was prepared with public participation, including 25 public discussions. The quality and relevance of the Strategy will be tested on the basis of real achievements over the next years.

2.3. Government Sector Programme

By 1999 the public health care sector in the Republic of Moldova faced 'melt-down' (KPMG 1999). A first phase of reform saw significant and needed restructuring. By 2004 hospitals had decreased from 253 to 65. The number of beds decreased from 45.665 to 20.752. Progress was made in introducing Family ('general') Medicine as the focus of primary care instead of the traditional fragmented primary care model based on 'specialized' medicine.

Future policy and strategy for the health sector are set out in two documents published by the Ministry of Health in 2007. The Health Policy 2007-2021 aims to 1) increase the life expectancy and lengthen the healthy life, 2) ensure life quality and reduce health differences between social groups, 3) strengthen inter-sector partnerships, and 4) increase the individual's responsibility.

The Health Strategy 2008-2017 outlines a large number of actions and indicators to improve four "functions" of the health care system: a) sector "Stewardship"; b) Funding and payment mechanisms; c) Delivery of health care services; d) Resource management. The Strategy emphasises the continued development of primary care. Family Medicine is mentioned in the document.

The MTEF is prepared in parallel to the annual State budget. Health financing as foreseen in the MTEF is predominantly based on government budget allocations (60%) and income from compulsory health insurance premiums (35%) to the Compulsory State Medical Insurance Company (CNAM). CNAM's budget was 2 bln Lei in 2007 (ca. 120 MEUR). Direct budget allocations to CNAM are expected to decrease in relative terms, as premium revenue will grow as a result of increased contributions from 5% (2007) to 7% (2009/2010) on salaries (equally divided between employer and employees); projected premium revenue increasing from approximately 70 (2008) to 100 (2010) MEUR.

Expenditure in the Health MTEF is divided into eight Programmes. The programme for Individual services managed under the CNAM accounts for more than 80% of public expenditure. In the state budget salaries and utilities are estimated to account for approximately 70% of expenditures. The CNAM budget is approved separately by parliament, and is subject to scrutiny by the Court of Accounts.

Approximately 24% of the population, mainly the self-employed and rural low-income groups, are reported as not being covered by the CNAM's Standard Package (Program Unic). A priority of a sector-wide approach will be to better capture data on these private health expenditures as well as from projects funding the sector from outside the Government Budget.

The Policy, Strategy and MTEF fulfil the core eligibility requirements for an EC Sector Budget Support Programme (SPSP). A sometimes unclear link between the three documents as well as a lack of prioritised targets and timelines remain however problematic. Additional capacity building in policy development, strategic planning and development of agreed mechanism of priority setting to integrate budgeting and the longer-term sector policy strategy is considered essential.

In terms of implementation, from January 2008, the administration of Primary Care providers was formally separated from hospitals (formerly all regular health services were integrated under Rayon Chief Doctor administrations). Commitments to strategic priorities, to the extent these are explicit, do not always, however, fit the facts on the ground. There are, for example, 1261 Primary Care facilities but currently all are managed under approximately 70 CNAM contracts to 'autonomous' public non-profit PHC entities: among them 35 run by rayon and municipality level entities, ca. 20 run by larger institutions and only 2 private.

Management authority under these contracts is subject both to: planning and spending norms under the MoH affecting almost all areas of operations and performance, and contractual obligations under the CNAM. Add other program reporting and the administrative burdens on facilities are as great as operational authority is small. SPSP targets are primarily focused on these issues.

After the health crisis of the 1990s and declines in core indicators (life expectancy had fell to 66.6 years by 1999), concrete results have been reached over the period 2001-2006. Maternal deaths per 100.000 live births have dramatically decreased from 43.9 to 16 (however, such a large variation could potentially indicate data problems), and infant mortality has decreased by 26%. Having stabilized the sector, further improvement will require renewed effort.

Another challenge will be to reverse an emerging trend of the exodus of medical personnel form the country and public health care systems. Overall wages are low as are differentials particularly for the skilled. Wage expectations of physician are widely regarded as, and surveys suggest, many multiples of actual salaries. Correcting this would have a strong potential to impact upon performance.
Additional challenges will be to find mechanisms to avoid the risks and distortions of unregulated growth of the private sector (such as licensing, professional associations and ombudsmen) and to protect patient rights in line with European standards.

2.4. Lessons learnt

Over the last years, domestic reforms as well as international support particularly under EU TACIS and World Bank have led to some improvements in the public health care sector, but from a low point of almost total collapse achievements are mixed. Capital investment and Technical Assistance programs in Family Medicine have failed to address the inefficiencies of out-dated functional and performance planning and management, and exaggerated infrastructure norms have lead to high capital (and subsequently maintenance) and upkeep costs.
The same problems exist in the hospital sector, but with greater financial consequences. The relatively low cost and high benefits of particularly Family Medicine hence impact on overall sector performance, plus the relative tractability of the challenge would suggest continued emphasis on Family Medicine. This is adequately reflected in the SPSP benchmarks agreed.

A sufficiently stable macro-economic framework as well as the willingness for further such reforms exists on the Government side. Further systemic improvements in the health sector depend however on increased levels of funding as well as on firm and well-targeted support to the sector strategy. The Health Sector Policy Support Programme can respond to these challenges. Program strategy and targets have been discussed with the Government in order to ensure relevance, feasibility and ownership. Limited technical assistance support as indicated in the sector analysis is foreseen.

2.5. Complementary actions

Under the Health Service and Social Assistance project of the World Bank started in late 2007, 11.5 million USD is reserved for the health component and are to be spent in four sub-areas (capacity development and sector regulation; health-care financing and provider payment; primary health care development; hospital capacity assessment and modernization). A close co-operation between this project and all EC health interventions has been established. Other donors and international organisations active in the sector include Sweden, Netherlands, Switzerland, US, WHO, UNICEF, CoE Development Bank and UNFPA. Under ENPI NAP 2007, the Commission has funded a programme in support to the reform of social assistance.

Finished TACIS projects include Support to the Ministry of Health (2001-2003), Health Promotion and Disease Prevention (2003-2005, 2.3 MEUR) and Public Health Reform (2005-2007, 2 MEUR). TACIS health projects operational in 2008 are a 4.5 MEUR delivery of medical supply the PHC clinics and a 1.5 MEUR technical assistance component focusing on the elaboration of clinical protocols. Funds (up to a reported 20M$US) for capital investment in Family Medicine may be available under the Millennium Challenge Corporation subject to the finalization of feasible proposals. Programs for scaling-up access to HIV/AIDS prevention, treatment and care project (15.9MUSD) and Strengthening TB control project (11.7MUSD) are financed under the GFATM.

2.6. Donor coordination

Regular donor co-ordination meetings have been instituted by MOH since 2007. These meetings are chaired by the Minister and enjoy broad participation amongst staff. There is strong commitment from the Government to further broaden donor coordination; as part of

the conditionality for this budget support, the EC will insist on the regularity, good preparation, and the quality of this donor coordination (TOR, SWAP, donor mapping).

3. DESCRIPTION

3.1. Objectives

The objective of this Sector Policy Support Programme is to support the concrete prioritisation and implementation of the Moldovan Health Sector Strategy towards improving the health of the population, expanding access, and improving the efficiency and quality of essential public health care services.

3.2. Expected results and main activities

The results and activities of the programme are those of the GoM's own Sector Policy and Strategy. For practical reasons discussed, improving overall public health care sector efficiency, quality and performance is to be primarily achieved by focusing on Family Medicine and agreeing more concrete targets. Technical Assistance will consist of technical expertise and capacity building.

One long-term expert in strategic planning and budgeting will be provided to MoH and another to the CNAM and/or Ministry of Finance. Additional expertise will be seeking to support the monitoring system, disseminate information and implement reviews and evaluation of the programme.

Results and targets for monitoring implementation and disbursement are incremental over 4 years and are formulated in a Policy Matrix under the headings of the MoH's own Sector Strategy but also taking into account the broader PFM and public 'stewardship' agenda:

- **Stewardship** (1): harmonized, comprehensive sector reporting and coordination benchmarks (including donor (and donor indicators) mapping); performance benchmarks in key service (output) and disease (outcome) areas;
- **Stewardship** (2): Fiscal discipline and operational performance (inputs/outputs): audits of key entities (including CNAM) and PFM benchmarks, service provider autonomy targets
- Improved **Services**: Access targets, service quality proxies, satisfaction indicators
- Human and Physical Infrastructure **Resources**: Family Medicine training completion and numbers of licensed physicians; Improved efficiency in infrastructure investment
- Stabilization and **Funding** Diversification: Budget variance and legislative acts
- A monitoring system is established, involving relevant Government and, to all possible and feasible extent, non governmental institutions as well as research centres; lessons learnt from the monitoring process are used by the Government to improve over time the effectiveness and efficiency of the strategy.

3.3. Stakeholders

Ministry of Health, Ministry of Finance, Court of Accounts, Compulsory Medical Insurance Company, EC, other donors and international organisations, Rayonal Health Authorities, Healthcare providers, representatives of staff, patients and the private medical sector.

3.4. Risks and assumptions

The main assumption is that the Moldovan government remains committed to efficient reforms in the health sector. This commitment might be distracted by the elections in 2009, by external economic shocks or other unforeseeable factors. A further risk is that Ministry of Health does not succeed in prioritizing its National Health Policy 2007-2021 and Health System Development Strategy 2008-2017 into well-structured shorter-term action plans. These risks have been taken into consideration and minimised by design – namely by allowing for an additional year of duration for the programme implementation.

3.5. Crosscutting Issues

It can be expected that the Programme will have a positive effect upon women and children. Improving access to PHC particularly in rural areas should reduce exclusion. Good governance will indirectly be fostered through support to further reforms in the field of Public Finance Management. Limited environmental impacts are foreseen.

4. IMPLEMENTATION ISSUES

4.1. Implementation method

Following the adoption of the financing decision by the Commission, a Financing Agreement (FA) will be signed with the Government of the Republic of Moldova. Modality of aid delivery will be untargeted sector budget support under centralised management. Funds will be channelled to the State Treasury. Arrival of funds in the Treasury Account will be verified by the Commission. The technical assistance component of the programme will be managed centrally and directly by the Commission.

4.2. Procurement and grant award procedures

All contracts implementing the action must be awarded and implemented in accordance with the procedures and standard documents laid down and published by the Commission for the implementation of external operations, in force at the time of the launch of the procedure in question.

4.3. Budget and calendar

The budget of the programme is allocated to the following two components:

Budget support component:	€ 42.0 million
Technical assistance:	€ 4.6 million

The amount of € 16.6 million awarded to the Republic of Moldova under the Governance Facility have been added to the Budget Support component of this action and will increase disbursements subject to benchmarks/progress indicators on Public Finance Management and Public Administration related reforms being fulfilled throughout the duration of the programme.

The implementation period of the Programme will extend over 48 months. It is anticipated that three annual disbursements of respectively: € 12, 15 and 15 million will be made, in principle in different fiscal years. A number of pre-conditions have been laid down including the initiation of critical improvements to sector statistics, and legislative requirements related to normative planning and PFM. The endorsement of the FA, and satisfaction of pre-conditions, for the Programme by the Government of the Republic of Moldova shall create the condition for disbursement of the first instalment. Disbursement of the following instalments will be contingent on the Republic of Moldova meeting the indicators detailed in the FA and its policy matrix. Partial and negotiated disbursements may occur in case of delays in meeting indicators: a final fourth disbursement would then be made on the successful attainment of all targets. Programme and sector evaluation activities will continue over a post intervention period of up to 1 year after the last disbursement.

4.4. Performance monitoring and criteria for disbursement

The monitoring, evaluation and audit systems and framework for the Programme will reinforce MoH efforts to unify, harmonize, and improve the quality, comprehensiveness and transparency of sector reporting, analysis and management. Whenever feasible and possible, the Commission shall rely on existing monitoring system and review mechanisms implemented by the GoM with other donors involved in relevant sector policy support programme in order to minimise transaction costs.

The criteria for disbursement are the attainment of results as specified in the Financing Agreement (see section 3.2.) Extremely large numbers of performance monitoring indicators

are proposed in health and health care in the Republic of Moldova (the strategy alone includes more than 500!) and a specific and agreed objective is to bring this first under an annual donor coordination report (year 1 and 2) and move toward harmonization across the many GOM departments and donor partners – and various programs and projects of both - under an Annual MoH 'Strategy Review' report (subsequent years).

This will include: MDG, AIDCO standard health, and NDP indicators. These reports should include all indicators needed for the Delegation to monitor performance. Achieving this is itself a benchmark (set). Evaluation, monitoring and audit Technical Assistance is included to support the MoH, Statistical Office and other statistics agencies in this process of indicator data quality, focus, and harmonization. Control against the attainment of targets for disbursement remains the task of the delegation. An indicator on 'satisfaction' is included but will not duplicate similar efforts currently supported under the MCC 'Threshold' program. From the technical assistance component of this project, independent reviewers will be recruited that will assist in gathering evidence concerning the level of fulfilment of indicators/conditionalities and subsequently disbursement.

4.5. Evaluation and audit

Prior to the completion of the sector budget support programme, the Commission will mandate consultants to carry out an independent final evaluation of the programme. The programme will be subject to independent reviews that will assess the level of compliance/ performance with its conditions/indicators set forth in the Financing Agreement. The European Commission might mandate consultants to carry out, in close cooperation with the Chamber of Accounts of the Republic of Moldova, an audit of a sample of expenditures related to the implementation of the GoM health care policy.

4.6. Communication and visibility

In the Financing Agreement, the Government shall commit itself to ensure that the visibility of the EC contribution to the Programme is at least equivalent to that given through media to other donors supporting the implementation of GoM reforms in the area of PFM and health.