HOME-BASED MEDICAL AND SOCIAL CARE SERVICES ASSESSMENT IN THE REPUBLIC OF MOLDOVA

EXECUTIVE SUMMARY

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CONTENT

ABBREVIATIONS

ATU - Administrative-Territorial Units

CPAs – Central Public Authorities

CSOs - Civil Society Organisations

HBC - Home Based Care

LLC - Limited Liability Company

LPAs - Local Public Authorities

MH - Ministry of Health

MHLSP - Ministry of Health, Labour and Social Protection

NHIC - National Health Insurance Company

PHI - Public Health Institutions

RM - Republic of Moldova

TUSA - Territorial Units of Social Assistance

URONPIC- Union of CSOs "The Network of non-commercial organizations providing community care"

INTRODUCTION

The Republic of Moldova (RM) faces the phenomenon of rapid population aging. At the beginning of 2016 there were registered 592 600 persons aged over 60 years, 13.3% of whom were aged 80 and over.

Social services for the elderly, including Home Based Care (HBC) services, have been developed in Moldova to ensure a decent and independent living for old people, to the possible extent. The social assistance is mainly provided through the social protection system and is under the responsibility of the Ministry of Health, Labour and Social Protection (MHLSP). At the same time, the development and provision of social services at the community/municipality level is the responsibility of Local Public Authorities (LPAs). The main sources of funding for social services are the transfers from the state budget to the LPAs and the local taxes. This funding model is incompatible with the increased need for social services at the local level, resulting from the high level of ageing, poverty and migration.

The legal framework on the organization of medical HBC services was approved in 2008 by the Ministry of Health (MH) and in 2010 by the Ministry of Labour, Social Protection and Family (MLSPF). The first medical HBC service provider was contracted by National Health Insurance Company (NHIC) in 2008. The medical HBC service providers need to be accredited before being contracted by NHIC and access state funding. These funds are limited and cover only the insured people with advanced chronic diseases, people with low mobility and bed-ridden patients, based on doctor' recommendations.

An important role in the development of HBC services is played by the network of Civil Society Organisations (CSOs) providing medico-social home care services. The network was created within the "Development of home care services 2011-2013" project implemented by the CSO "HOMECARE" in collaboration with Caritas Czech Republic. During 2011-2017, 36 CSOs and professional associations providing social, socio-medical, medical and palliative care have joined this network. In January 2017 the existing network has been reorganized.

The founding members:CSO “HOMECARE”, CSO “CASMED”, the Charitable Foundation “Caritas Moldova”, CSO “Bethania”, CSO “Neoumanist”, CSO “Aripile Sperantei”, have established the Union of CSOs ”The Network of non-commercial organizations providing community care” (URONPIC). The observations made during the last few years by the URONPIC show that the demand for social and medical HBC far exceeds the state funding capacity, while comprehensive data on the real needs for such services is not available.

In this context, several donor-driven service providers/projects initiated, in collaboration with the Centre of Investigations and Consultation “SocioPolis”, the Home-Based Medical and Social Care Services Assessment in the Republic of Moldova.

The goal of the initiative was to provide a mapping of social and medical HBC services, including people's demand for HBC services, to help Moldovan authorities develop evidence-based policies and contribute to the sustainable development of HBC service field.

PURPOSE AND SPECIFIC OBJECTIVES OF THE ASSESSMENT

The purpose of the assessment is to assess the existing HBC service provision as well as the need of the population for HBC services.

The specific objectives are:

a. to review existing laws and regulations on HBC services;

b. to assess the existing HBC service providers (public and private, social and medical services providers), including their profile;

c. to analyse the existing HBC models;

d. to assess the real needs of HBC services;

e. to analyse the use of the available funds and potential resources for HBC services;

f. to analyse the cost of HBC services and propose a benchmark costification formula/methodology of the HBC services;

g. to provide evidence based recommendations for development of the HBC services and to increase access to HBC services.

It should be mentioned that this report is the first exercise of this kind in Republic of Moldova in the field of social and medical HBC services provision.

Research data can be used by governmental and local authorities, public and private providers, URONPIC representatives for policy development in the field of HBC provision, advocacy activities planning and development of HBC services.

METHODOLOGY OF THE ASSESSMENT

In order to achieve the purpose and the objectives of the assessment, a complex methodological approach focused on a depth analysis of HBC services delivery in Moldova was proposed. This was formulated based on the opinion of HBC service providers, HBC services beneficiaries and LPAs of I and II levels, enabling data triangulation[1]. The research relied on primary and secondary data sources. Thus, a desk review was conducted on: legal framework, analysis of available funds, analysis of provision models (including international models relevant for the context of the Republic of Moldova) and HBC services cost analysis. Additional to these data, field information/data was collected from HBC service providers, service beneficiaries and LPAs of I and II levels.

The current assessment is mixing quantitative and qualitative research methods (see Figure 1). Quantitative methods (questionnaire completed by providers) revealed the situation of HBC services and the need for this type of services. Qualitative methods (in-depth interviews) with beneficiaries of HBC services enabled an inclusive research of aspects related to HBC services, evaluation of the service, service needs. Those with LPAs representatives revealed the real possibilities of their involvement in financing / co-financing of HBC services.

The survey sample comprised 84 HBC service providers from 23 Administrative-Territorial Units (ATU). The qualitative research involved 2 target groups: 340 beneficiaries of HBC services and 23 LPAs representatives.

Financial data have been collected in order to establish the cost of the HBC provision. The method of cost calculation is based on transformation of resources into products/services. The considered costing method associates the costs of resources with services delivery.

[1] Triangulation facilitates validation of data through cross verification from two or more sources and combination of several research methods. Triangulation ensures the validity and credibility of results.

Figure 1.
Research methods

Qualitative methods

Individual in-depth interviews

- 23 In-depth individual interviews with representatives of the LPA
- 340 Interviews with HBC beneficiaries

Quantitative methods

84 sociological questionnaires with hbc providers

Questionnaire content:

- General information about the organization/institution
- Data about service beneficiaries
- Services provided
- Financing of HBC services
- Specialists employed in providing HBC services

KEY FINDINGS

- ***Types of home based care (HBC) services and their providers***

Data from the Home-Based Medical and Social Care Services Assessment in the Republic of Moldova reveals the presence of three types of HBC services: social services, medical services and integrated services (Figure 2).

Figure 2.
HBC types and sources of funding

Types of the HBC services

Social HBC services

Source of financing:
- local budgets
- grants,
- local & international donations,
- beneficiary contributions

Medical HBC services

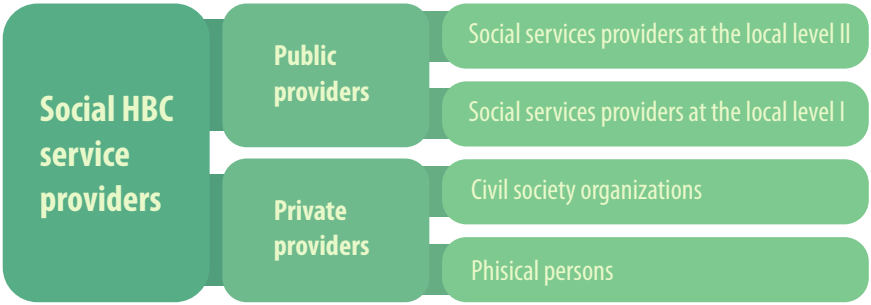
Source of financing:
- Compulsory Health Insurance Funds,
- grants,
- local & international donations,
- beneficiary contributions

Integrated HBC services

Source of financing:
- grants,
- local & international donations,
- beneficiary contributions

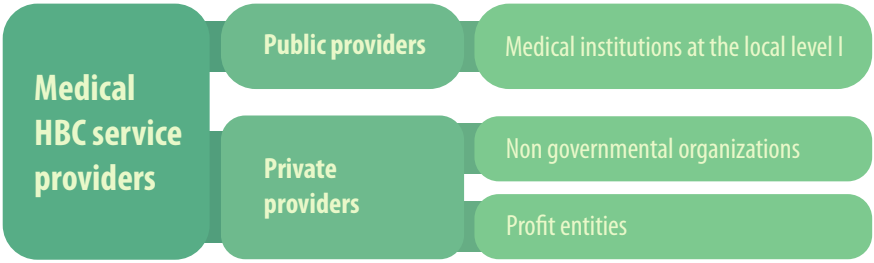
The social HBC services represents a public (established within the territorial structures of social assistance) or private service (created by foundations, private non-profit organizations, registered according to the law, dealing with the social sector (Figure 3). The purpose of the service is to provide qualitative social HBC services as to ensure a better quality of the beneficiaries' life.

Figure 3. **Providers of social HBC services**



Medical HBC services represents any medical care provided directly at the patient's home in his/her familiar environment by a healthcare professional trained in this field, which contributes to the improvement of the patient's health condition. Medical HBC services can be provided by healthcare institutions, no matter of its type of ownership and legal form of organization, usually CSOs, in accordance with the law in force. The purpose of medical HBC services is to provide the patient with qualified, dignified and appropriate care according to his / her individual needs, in order to stimulate the recovery, maintenance and/or rehabilitation of the health condition and reduce the negative effects of the disease (Figure 4).

Figure 4. **Providers of medical HBC services**



Integrated HBC services. There are no legal provisions and standards regarding the integrated HBC services as a concept. However, certain service providers, especially the CSOs, but also some public

institutions, operate within this notion. Integrated services suppose that a person is provided, according to his / her needs, with both social and medical HBC services, in other words, the same beneficiary receives support from a social worker and from a medical assistant, but not always with common coordination of their efforts.

- ***Financing of Home Based Care services***

The registered expenses for social HBC services for 2016 were 103.7 million MDL, which is by 3.9 million more than in year 2015 (Table 1).

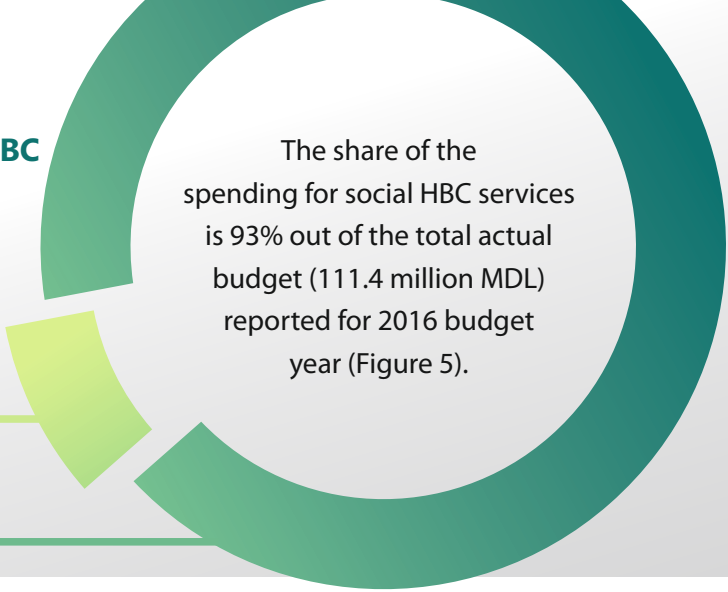
Table 1.

Local budget's expenditures for social HBC services, 2015-2016 years

	Indicators	2015	2016	Changes
1	**Total budget** *thousand MDL*	99 796,0	103 702,2	+3,9%
2	**Number of social workers** *units*	2325	2317	-0,3%
3	**Cost per social worker unit** *MDL*	42 923	44 757	+4,3%
4	**Number of beneficiaries** *persons*	22348	21362	-4,4%
5	**Cost per beneficiary** *MDL*	4 465,5	4 854,5	+8,7%

Figure 5.

Financing of HBC services, 2016 actual budget, *million MDL*



The share of the spending for social HBC services is 93% out of the total actual budget (111.4 million MDL) reported for 2016 budget year (Figure 5).

Medical HBC services are financed from the main fund of the NHIC. Community and medical HBC services have the lowest share in the main fund expenditures. Those represent only 0.2% out of total and count 8.7 million MDL.

Table 2.

Trend of expenditures (part of the basic fund), *million MDL*

Budget subprograms	2014		2015		2016	
	approved	executed	approved	executed	approved	executed
Total main fund	4493,7	**4399,8**	4899,6	**4899,6**	5611,1	**5570,2**
Primary medical assistance, including compensated drugs	1372,1	**1342,8**	1580,0	**1525,2**	1808,9	**1729,2**
Community and medical HB	6,6	**6,4**	8,0	**7,9**	8,8	**8,7**
Medical HBC	X	**X**	X	**7.67**	X	**7.74**

Figure 5 does not include the spending of the CSOs. Those CSOs which do not have a contract signed with NHIC and LPAs are not included in the total budget, because there is no state reporting mechanism. Even if the private healthcare institutions (LLC or CSO) have a contract with NHIC and/or local public authorities, they are not required to report the spending from their own sources. This is the reason why these data was not included in the above figure.

The research data shows that there is donors' money in the HBC sector, but not very much. The problem is with their reporting. The service providers do not report to LPAs and all their spending and achievements are not included in the official reporting documents (except those provided to the donors). There are some donors open to collaborate with the LPAs (CSO "CASMED" and CSOs under "CASMED" umbrella, CSO "HOMECARE", CSO "Neoumanist", Charity Foundation "Caritas Moldova", CSO "Concordia. Proiecte sociale", CSO "Aripele Sperantei"etc.).

- ***Characteristics of Home Based Care providers***

HBC service providers are different - public, private (including profit entities (LLC)). **Most providers offer medical HBC services.** They operate at community level and have the lowest number of beneficiaries (average - 20, minimum - 2, maximum - 107 (municipalities). **The number of public providers of social HBC services** (Territorial Units of Social Assistance - TUSA) **is lower**, but they provide services at the level of ATUs and have the highest number of beneficiaries (average - 636, minimum - 298, maximum - 2171). **Private providers with CSO status are fewer**, some of them provide social HBC services, some integrated HBC services, and some medical HBC services. Some CSOs provide services at the local level, others at the ATU or regional level and there are CSOs that provide services at national level. Also, CSOs have the biggest variation in the number of beneficiaries (average - 472, minimum - 8, maximum - 2100) (Table 3).

Table 3.

The number of beneficiaries per HBC providers,
number

	Medical institutions	TUSA	CSO
Mean	20	636	472
Median	10	522	142
Mode	5	412	44
Minimum	2	298	8
Maximum	107	2171	2100

The vast majority of offered HBC services are free of charge. Some CSOs promote the co-payment model (the client pays a symbolic amount for the services received). Most commonly, this model includes co-payment of HBC services by beneficiaries, providers and LPAs of level I).The analysis underlines that there is currently no normative framework on calculation of the fee for social HBC services; still, the evaluation study reveals that 3 TUSA (Falesti, Cimislia and Glodeni) provide social HBC services for charging a fee.

The models of HBC services are also different. The evaluation allowed differentiation based on 12 criteria of **4 social HBC models, 5 medical HBC models and 4 integrated HBC models**. Integrated models respond to a broader variety of beneficiaries' needs, have the widest team of specialists and are oriented towards developing partnerships at community, ATU, region or national level.

The research outcomes indicate on important voluntary work done by medical assistants that suppose providing social support offered along with the required medical services. Also the social workers in charge with social HBC services, sometimes provide medical HBC services. In such situations, they break the regulatory framework, including professional standards that do not allow the social worker to provide medical services.

Lack of specialists is a major problem for most of HBC providers. This is caused by the fact that young specialists are not attracted by this sector. Most strikingly is the lack of medical assistants. All CSOs that provide medical HBC services or integrated HBC services mentioned difficulties in hiring nurses. Public service providers have mentioned this issue to a much lesser extent. Half of TUSAs who participated in the evaluation have mentioned difficulties in hiring social workers. This situation is a result of the migration of skilled workers but also result of low wages, both in social protection and medical field. The other causes are: (i) high workload, (ii) high responsibilities, (iii) more attractive employment opportunities in other areas, (iv) specific requirements of the provider (medical assistants with a driving license), (v) low professional training of social workers, etc.

- ***Criteria for admission to Home Based Care services***

Territorial Units of Social Assistance provide social HBC services according to the Government Decision no. 1034. Free of charge services are offered to elderly who have reached the standard retirement age and people with disabilities who are without support from children, extended family and other people (friends, relatives, neighbours). However, lack of children/support from children stipulated in the law is actually interpreted mainly as childless status.

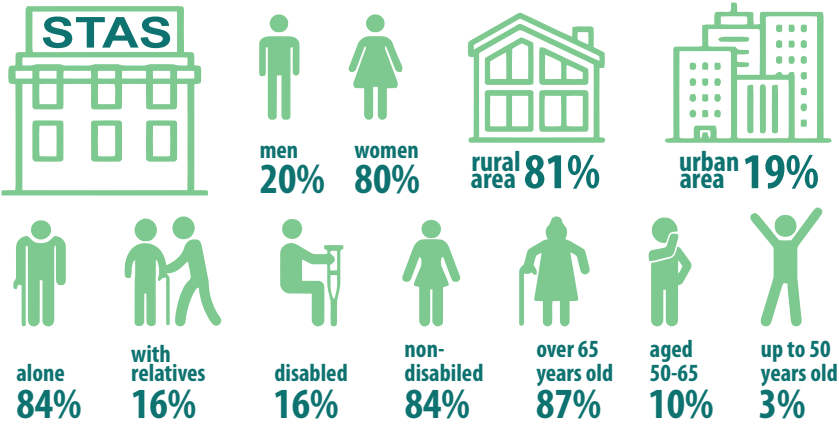
All accredited public and private providers offer medical services to beneficiaries in accordance with the Regulation and Standards related to medical HBC set forth in the Orders of the Ministry of Health no. 855 of 29.07.2013 and no. 851 of 29. 07.2017. The person has to meet a few criteria to benefit from services: (i) to have medical insurance, (ii) to have a recommendation from the family doctor / specialist, (iii) to reside on the territory served by the medical institution.

The CSOs provide HBC services to people who do not benefit from such services from public or private providers, at the same time having to meet specific criteria set by the donors.

The basic request from donors is to include the most vulnerable in HBC service. Usually, individuals are accepted based on certificates from TUSA, LPA (wage/pension, family composition), or medical institution (referral from family doctor/specialized doctor from hospital/health centre).

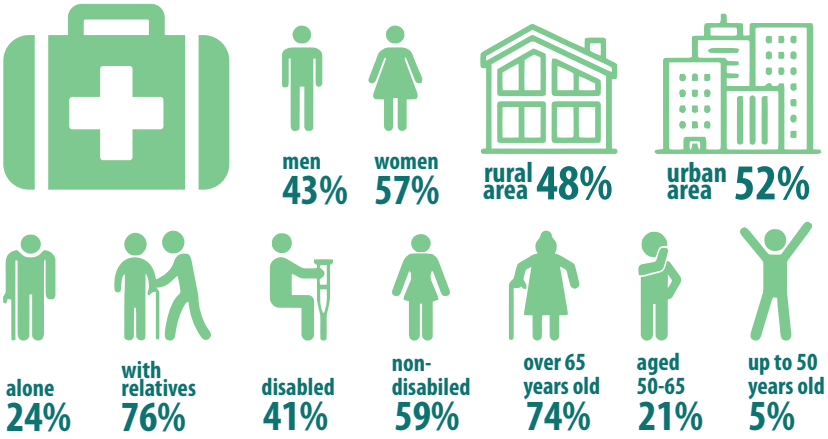
There are differences in the characteristics of the beneficiaries from one type of provider to another, determined by certain particularities of the institutions providing the service and by the normative documents. TUSA beneficiaries are more often women, single persons, mainly from rural areas (Figure 6).

Figure 6. **Socio-demographic profile of TUSA beneficiaries**



The outcomes reveal that medical HBC services are more gender-balanced, targeting the disabled people and being available especially to urban population (see Figure 7).

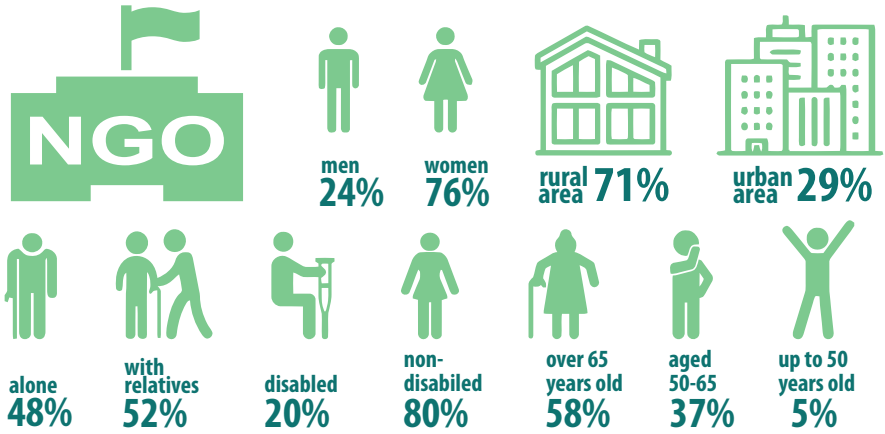
Figure 7.
Socio-demographic profile of beneficiaries of medical institutions



Collected data establish that the CSOs provide services to the categories of beneficiaries that are not covered by public service providers as they do not meet the normative criteria, this leading to the increase in number of men accepted to benefit from services, people aged under 65, with relatives (see Figure 8).

Figure 8.

Socio-demographic profile of CSOs beneficiaries



Currently, in the Republic of Moldova the beneficiaries of medical, social or integrated HBC are not divided into any categories depending on their needs or abilities.

- ***Offer and demand for Home Based Care services***

The analysis of HBC services from a geographic perspective reveals a national coverage with social services for older people, reaching the standard retirement age and people with disabilities, lacking support from children, extended families and other people.

Medical HBC services are distributed not–uniformly. Only half of public health institutions from the local level I were contracted by NHIC for the provision of medical HBC services. When speaking about the geographical coverage with medical HBC services, there are administrative territorial units (ATU) that have more providers and ATUs have only few or even none. The analysis of medical private providers (CSOs and LLC) is also not homogeneous. The distribution is frequently determined by LPA's readiness to collaborate with CSOs in developing HBC services. According to the number of contracted HBC visits these providers can be divided into 4 categories (Table 4).

Table 4.

Number of visits contracted by service providers from NHIC in 2017

Number of contracted visits	Number of providers	Type of providers according the legal form of organization	Type of provider, according the location
From 12 to 299 visits	107	Health Centres	Mostly from rural areas
From 300 to 999 visits	25	20 Health Centres and 5 CSOs	Town or ATU, region
From 1000 to 2230 visits	7	4 medical institutions, 2 CSOs, 1 LLC	Town or ATU, region
14 940 visits	1	1 CSO	Town

Thus, the assessment data show that currently the HBC services are not accessible to all those who need them. One of the main causes is that some people in need of home care do not comply with the normative provisions for admission into such service. Medical HBC is not always available, being provided only to insured people and having no geographical coverage in all the localities of the Republic of Moldova.

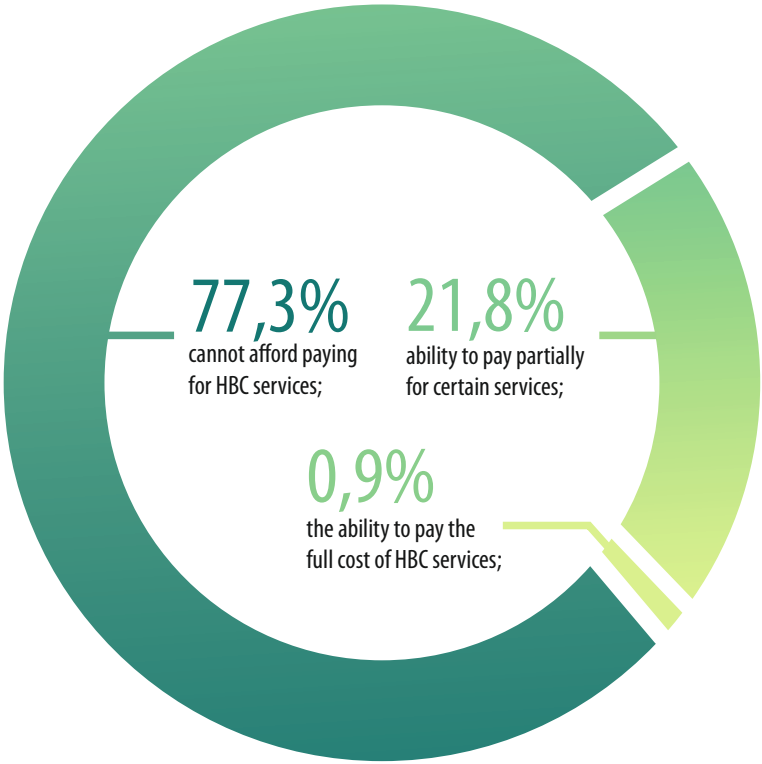
Neither HBC services offered by the CSOs are available in all localities of the country. The paid social HBC services are not available, since there is no legal framework regulating their costs. Old people abandoned by their children are disadvantaged and deprived of HBC services.

Research data has allowed making estimations about people who might potentially need HBC services. The estimated number of people who need social HBC services is 33 915 people. **Currently, social HBC services are offered to about 2/3 of those who need it.** The estimated number of people in need of medical HBC services is 13 972 people, **only 18 percent of the needs are covered at the moment**.

- ***Beneficiaries' possibilities to pay for Home Based Care services***

The large majority of beneficiaries cannot afford HBC services provided for a fee. Representatives of public and private providers, LPAs pointed out that the beneficiaries are not eager to pay for these services because of their poor financial situation (low pension) and insufficient income. In their view, only a very small number of people, with a better financial situation, could accept services offered for a fee.

Figure 9.
Beneficiaries' ability to pay for HBC services, %



The share of beneficiaries who are willing to come up with their own partial contribution to HBC services is still significant - each of the 5th current beneficiary of HBC services (Figure 9).

- ***Local Public Authorities' possibilities to develop HBC services***

In-depth interviews with the mayors reveal that most of them have as priorities in their communities the repairing of roads, water supply, sewage, renovation of a house of culture, street lighting, etc., and less the social protection of the population. The income generated locally is low because of the small number of businesses.

However, LPAs could become one of HBC sources of funding. The assessment data show that some mayors agreed to come up with a contribution to develop HBC services and provide the elderly access to services with the help of the non-governmental sector: CSO "CASMED", CSO "HOMECARE", CSO "Neoumanist", Charity Foundation "Caritas Moldova", CSO "Concordia. Proiecte sociale" etc.

- ***Evaluation of the Home Based Care services by beneficiaries***

Asked on what they like most about HBC services, 47.9% of the beneficiaries said – everything, 29.4% - the fact that someone visits them, 18.0% - help in taking medication, 11.4% - socio-medical services, 11.4% – help in household chores, 10.0% - counselling, 8.1% - workers' responsibility and professionalism, etc.

About 48.3% of beneficiaries believe that the HBC services cover their needs, compared to 51.7% who said – no. Most beneficiaries have very high expectations, especially those serviced by private providers, funded by international donors, noting that the services of public service providers cannot be improved. Among the needs, mentioned by the beneficiaries as sufficiently covered, were the supply with medicines, support in solving financial problems, need for free food, provision of firewood, need for a personal assistant, support in cooking, more services related to household cleaning, but also additional medical devices (wheelchair, tonometer, glucometer, etc.).

- ***Difficulties in providing Home Based Care services***

Private HBC providers mentioned as one of the main difficulties their dependence on external sources of financing given the lack of a functional mechanism for contracting social services by the CPAs and the LPAs. **The possibility of contracting social services from private providers constitutes an opportunity for development of social HBC services.**

Obstacles currently hindering the development of medical HBC services relate to: (i) the limited number of cases contracted by NHIC (ii) the amount of money allocated per a medical visit; (iii) lack of transport for visiting patients, (iv) the list of approved medication is insufficient, etc. So, the representatives of medical HBC providers who participated in the assessment mentioned that they want to provide the same services but within an increased cost and to a larger number of individuals. **Increase of the cost per visit and the possibility to contract more visits are considered as ways to develop the medical HBC services.**

Volunteering is poorly developed in Moldova in general, and particularly in the HBC delivery process. Research data reveals the lack of volunteering activities in public institutions, both medical and social, with a few exceptions. However, the large majority of CSOs (16 from 17) have developed the volunteering component within their organisations, engaging volunteers in providing of HBC services. The number of volunteers varies from at least 1-2 persons to maximum 60 persons. Activities involving the volunteers relate to help with gardening, water supply, provision of firewood, delivery of hot lunches and food packs, organization of cultural activities, psychological counselling, medical assistance and involvement in needs evaluation. Volunteers play an important role in fundraising and activities for promotion of HBC services. Unfortunately, only a few of CSOs include volunteers in socializing activities with the beneficiaries.

- ***Resources used to deliver Home Based Care services***

The resources used for service delivery are relatively homogeneous within each model of providers. At the same time the resources are different if we compare them from one model to another. There are several factors that dictate these differences. Private providers use more diverse resources compared to the public providers. Resources also differ by type of care (medical HBC, social HBC and integrate HBC) and how this service is provided (in-centre or at-home delivery).

The main resource in providing HBC services is the human resource. More than half of expenses across all models go for work remuneration.

Other important expenditures cover maintenance of a work space/premises (office or centre) and transportation means as well as expenditures on medicines.

One of the main differences in resource distribution among models is linked to the availability of existing physical social and medical infrastructure. Public service providers incur lower costs as they do not have to cover costs for work space. Private (including non-profit providers) spend an important amount on rent, utilities and repairs of work premises. Providers as Public Health Institutions (PHI) declared zero costs for such expenditures, as far as the existing healthcare system is taking over some costs for delivery of HBC services. This puts the providers in a different financial position in the context of similar refunding from the state (the cost of a visit covered by NHIC).

The Public Health Institutions have the least diversity of spending for HBC delivery. This is the result of the method of calculating the cost for a visit covered by the NHIC. The biggest part of the resources within this model are used for human resources (including related taxes), expenditures for medicine and materials. Most of medical institutions have only two types of expenditures (on personnel and drugs). Few medical institutions reported expenditures on maintenance of cars, hygiene products, office supplies and bank fees. Very few medical institutions have incurred expenditures for the continuous training of the staff or for work-related trips.

TUSAs have more diversified expenditures related to the delivery of HBC services. Work remuneration remains the most important share of used resources. Another important component are the expenditures for rent / maintenance and utilities for the work premises. Some resources are allocated for rent/ maintenance of cars, office supplies, telecommunication services, trainings and work-related trips. Other particular expenses for this model relate to the rent/ maintenance of equipment and inventory. Very few TUSAs can afford improving the work space, and very few purchase hygiene or pharmaceutical products to be used by the beneficiaries. Professional continuous training for the staff is not also a priority when it comes to expenditures distribution.

The expenditures of non-profit entities do not differ significantly by type of expenditure (compared with TUSA). At the same time the share of certain expenditure in total expenditures and amounts paid for some type of expenditures differ significantly. As mentioned, the major difference is dictated by the fact that private providers deliver services outside an existing physical infrastructure. In this context an important share of expenditures supported by the private providers relate to paying the rent for a work space, utilities and office maintenance. Transportations cost are also bigger for this group, this is linked with the fact that these organizations own cars which require maintenance and repairs. Transportation costs are higher also due to the fact that many villages have no medical assistant in place, and appears the necessity to transport her / him from the neighbouring villages. A specific type of expenditures for the non-profit organizations is linked with formulating and promoting public policies (consultancies for research, outside expertise, training materials etc.). Another exclusive group of expenditures characteristic for the private providers are those for representation (lawyer, notary).

- ***The costs for Home Based Care services delivery***

The cost-analysis shows that the less expensive model is provision of medical HBC by a medical institution, with 2 300 MDL per beneficiary annually. The most expensive is the service provided by TUSAs with 4 425 MDL per year. This is mainly explained by the frequency of delivered support comparing to other models. The non-profit organizations have more balanced costs within the group, the costs for one beneficiary costs reaching 3 270 MDL per year. The pro-profit delivery cost (private entities) is around 2 950 MDL per one beneficiary per year. This could be explaining by the fact that private units receive funds exclusively from the NHIC which constrains them to remain within the visit cost amount paid by the state.

Table 5.
Average cost for delivery of HBC service per model, for one beneficiary, annual, MDL

Provider	Annual cost, per beneficiary, MDL
Medical institutions	2300.00
TUSA	4425.00
CSO*	3270.00
Profit entities	2950.00

*CASMED costs only for mother organization

The most expensive type of HBC service is the integrated one - the average annual cost for a beneficiary is 5 150 MDL (Table 6). This is explained by the use of more resources to provide this service (medical resources and social support), respectively, the total cost is higher. But the cost of the integrated support is less that cumulated costs for social support and medical support. This is predictable and is explained by the fact that the administrative part is cheaper in the integrated service compared to the situation when two distinct HBC services are offered. This is an additional financial incentive to opt for integrated support

offered by the same provider rather that medical support and social support offered by different providers.

Table 6.

The average cost for delivery of HBC services per type of support, per beneficiary, annual, *MDL*

Modelul de prestare	Cost anual, MDL
Social	3570.00
Medical	2285.00
Integrat	5150.00

It is difficult to analyse the cost from the perspective of minimal and optimal costs, because the lack of accreditation and control procedures. A simplified approach to look at the minimal and optimum costs is considering the existing costs and the use or resources. The minimal calculated cost for medical HBC service delivery could be considered 2 300 MDL per year per beneficiary for public entities and 2 950 MDL per year per beneficiary for private provision. The optimal cost can be considered as about 4 500 MDL per year for both sectors, calculated based on optimal resources. The cost for a qualitative service can be considered the one of the integrated service – 5 000 MDL per year per beneficiary.

An additional 5-7% to the costs presented above need to be added on yearly basis for skills improvement of the personnel working in the HBC field.

Assessment results reveal the shortcomings and achievements in the field of HBC services in the Republic of Moldova. These results allow submitting the following recommendations in order to improve the situation in this area:

Recommendations to the representatives of the Ministry of Health, Labor and Social Protection:

- Development of a social services contracting mechanism to ensure the implementation and dissemination of the practice of contracting social services by CPAs and LPAs from private providers.
- Elaborating the normative framework for the development of integrated HBC services. Development of the intersectorial cooperation mechanism for public and private providers of medical and social HBC services (likewise those on child prevention of mortality and child violence, etc.), clearly establishing the duties of each responsible party or developing a Case Management designed for the elderly, according to the National Good Practice Model, currently operating in the Republic of Moldova.
- Development by the MHLSP and NHIC of the public policy of contracting medical HBC providers to cover the needs for services nationwide.
- Development of a cost calculation method that will consider the resources used for HBC service delivery. Both the cost and calculation method should be included in the regulations (for example: the Ministerial Order (MHLSP) No. 253 of 20.06.2008, no. 155-A from 10.07.2008, Chapter II that stipulates the payment modality).
- The MHLSP, together with NHIC may consider the method of setting a unitary price, based on the on "ABC" formula - activity based method. Each activity (for example medical, social, transport, counselling) can be assigned a code, according to the code model assigned to each diagnosis in emergency medicine. This method can be used for residential institutions as well as for HBC services. Codes may include, besides the activity performed, dependency grades, beneficiary' diagnosis, etc.
- A method of increasing the cost (indexation) of these services should be established in order to capture changes of consumer price index in order to ensure the sustainability and a decent quality of service provision.

- Elaboration of the job description models to outline the responsibilities of a medical assistant and of a social worker in providing HBC services for they be offered to the HBC service providers.

- The minimum quality standards should be revised for both social and medical HBC services. The review should focus on the allocation of resources and their costs for each standard / regulation. Standards must provide the opportunity to provide services in a realistic and sustainable way. Standards for integrated HBC service need to be developed. An important step is to correlate the minimum quality standards with the costs calculated in this study.
- Elaboration of a methodology for assessing the needs for social services at community level in partnership with LPAs and CSOs.

Recommendations to the Government Authorities responsible for Policy Development in the Field of Social Protection and Assistance:

- The methodology for setting up HBC services needs to be reviewed by establishing a range of sub-services / activities and the time the social worker has to allocate for each service. This methodology should be published in a regulatory act so that LPAs and providers have access.
- Establish an initial and continuous training system for social workers to improve the quality of the provided HBC services.
- Change the Social HBC Framework Regulation in order to improve the access of vulnerable people to HBC services and to provide services for elderly people who have children but they live far and their family situation is very difficult consequently they are unable to help their parents.
- Accreditation process should start, as well as the gradual inclusion of all HBC providers in this process in order to establish and maintain a minimum quality benchmark.

Recommendations to the Government Authorities responsible for Policy Development in Healthcare Field:

- The methodology for calculation the cost for a medical HBC visit covered by the NHIC should be approved and made accessible. Its publication in the Official Monitor will make it legal and available for LPAs and other potential service providers.
- Introduction of care dependency categories of the beneficiaries in the normative framework and developing of a methodology regarding the cost for a home medical visit based on these categories.
- Training of paramedical assistants who will provide medical HBC services and exclude current situations when social workers offer medical services.
- Development of tools and indicators for evaluation of medical HBC services. Elaboration and introduction of performance indicators for HBC providers, especially indicators related to the aspects of collaboration/partnerships.

Recommendations to Local Public Authorities:

- Introduction of the social services component in the policies and documents elaborated at local level and ensure their implementation, including the allocation of necessary financial resources for HBC services.
- Involvement of civil society in the development of a Local Action Plan for the development of volunteering.
- Developing community-level volunteering for the provision of HBC services in collaboration with CSOs.

- Implementation of good practices of co-financing and financing HBC services at community / ATU level.
- Using the existing medical and social infrastructure per maximum for HBC service delivery. This refers to provide space within the primary medical institutions for private non-profit and proprofit providers (buildings, part of buildings in existing policlinics or hospitals, building of socials sector), offer equipment and other support materials if available.
- Involving the CSOs in assessing the community needs for social services.

Recommendations to the HBC providers, especially the Network of Non-Commercial Organizations providing Community Care:

- Developing partnerships with LPAs for the purpose of providing HBC services, promoting good practice of public - private partnership.
- Providing support to the LPAs in assessing the needs for social services, especially for HBC services.
- Calculate the unit cost of services provided to a beneficiary and keep these calculations updated. The unit cost should be accessible and the expenses cumulated into one budget, even they come from different sources of funding. All costs have to be made public, so beneficiaries will understand what actions/services are being provided and the intensity of their provision. All relevant variables described in this study should be considered for financial planning, such as: beneficiary's profile and especially the dependency degree, type of needed services, form of support and so on.
- Maintaining the financial documents in order and providing an aggregate cost analysis, if necessary, even for multiple sources of funding.
- Promotion of existing HBC services and the ways to access them.
- Involvement in permanent communication with CPAs and LPAs for development of a qualitative and sustainable HBC system in Republic of Moldova.