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

Prepared by: Centre of Investigations and Consultation "SocioPolis"
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HEKS EPER · Swiss Red Cross · Caritas Czech Republic · Czech Republic Development Cooperation · Asociația Obștească „HomeCare" · CASMED

CONTENT

ACRONYMS

ABC method – Activity Based Costing Method

ATU – Administrative Territorial Unit

ATU Gagauzia – Autonomous Territorial Unit Gagauz Yeri

CHIF – Compulsory Health Insurance Fund

CPA – Central Public Authorities

CSO – Civil Society Organizations

EU – European Union

GDP – Gross Domestic Product

HBC – Home-based care

HC – Health Centers

IHCP – Individual Home Care Plan

LLC – Limited Liability Company

LPA – Local Public Authorities

MDT – Multidisciplinary Teams

MH – Ministry of Health

MHLSP – Ministry of Health, Labour and Social Protection

MLSPF – Ministry of Labour, Social Protection and Family

NBS – National Bureau of Statistics

NHIC – National Health Insurance Company

RM – Republic of Moldova

TMA – Territorial Medical Associations

TUSA – Territorial Units of Social Assistance

UC – Unit Cost

URONPIC – The Network of Non-Commercial Organizations Providing Community Care

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EXECUTIVE SUMMARY

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

Social services for the elderly, including Home Based Care (HBC) services, have been developed in the RM to ensure a decent and independent living for old people, to the possible extent. 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). 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 social services are the transfers from the state budget to the LPA 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 Moldovan 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 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 doctors' recommendation.

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 Association 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, but comprehensive data of the real needs is not available.

In this context, several donor-driven service providers / projects initiated, in collaboration with the Centre of Investigations and Consultation "SocioPolis", the Assessment of social and medical HBC services 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 HBC service development.

The overall objective of the assessment is to assess the existing HBC service provision (private and public) as well as the need of the population in sustainable HBC services. National level data, which serve as reference in the field of social and medical care at home, was collected as part of the initiative.

The current assessment is mixing desk research with quantitative and qualitative research methods. 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, while those with LPA 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 ATU. The qualitative research involved 2 target groups: 340 beneficiaries of HBC services and 23 LPA 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 (inputs) in products/services (outputs). The considered costing method associates the costs of resources with services delivery.

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.

The social HBC service represents a public (established within territorial structures of social assistance (TUSA) or private service (created by foundations, private non-profit organizations, registered according to the law, dealing with social field activities). The overall purpose of the service is to provide quality social HBC services to ensure better quality of the beneficiaries' life. Source of financing for social HBC services are local budgets, grants, local and international donations, beneficiary contributions.

Medical HBC service represents a public (medical institutions at the local level I) or private service, provided in accordance with the law, by a healthcare institution, irrespective of its type of ownership and legal form of organization (usually CSO, but can be also profit entities). The purpose of medical HBC services is to provide the patient with qualified, dignified and appropriate care according to his individual needs, in order to stimulate the rehabilitation, maintenance and/or rehabilitation of the health condition and reduce the negative effects of the disease. Source of financing are Compulsory Health Insurance Funds, grants, local and international donations, beneficiary contributions.

Integrated HBC services. There have no legal provisions regarding the integrated HBC services, neither standards. However, certain service providers (especially the CSOs, but also public institutions) operate with this notion. Integrated services are those services according to which the beneficiary receives, in line with his/her needs, both social and medical HBC support. In other words, the same beneficiary receives the support from social worker and from medical assistant, but not always with common coordination of their efforts. Source of financing for such services are grants, local and international donations, beneficiary contributions.

Spending on HBC services

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

Medical HBC services are financed from the main fund of NHIC and are called medical HBC. Community and medical HBC services have the lowest share of expenditures in the main fund. It is only 0.2% out of total and counted 8.7 million MDL in one year (7.7 million MDL exclusively for medical HBC services).

Official data do not include the CSOs' spending. Those CSOs which do not have the contract with NHIC and local public authorities are not included in the total budget because there is no state reporting mechanism. Even if the private healthcare institutions (LLC or CSO) have the contract with NHIC and/or local public authorities they are not required to report the spending from their own sources.

The research data show that donor money in the sector exist, but not much. The problem lies in their reporting. The service providers do not report to LPAs and all their spending and achievements are not included in the official reporting documents. There are donors open to collaborate with LPAs in this sense (CSO "CASMED" and CSOs under "CASMED" umbrella, CSO "Homecare", CSO "Neoumanist", Charity Foundation "Caritas Moldova", CSO "Concordia. Proiecte sociale", CSO "Aripile Speranței"etc.).

Characteristics of HBC providers

HBC service providers are different - public, private (including the profit entities (LLC)). Most providers are public providers that 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 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 HBC

medical services. Some CSOs provide services at the local level, others at the ATU or regional level and 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).

The vast majority of HBC services offered are free of charge. Some CSOs promote the co-payment model (the beneficiary pays a symbolic sum; the most common is the co-payment model between beneficiaries, provider and LPA from 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 (Fălești, Cimișlia 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 geared towards developing partnerships at community, ATU, region, or national level.

The research outcomes indicate on important voluntary work done by medical assistants which consist of the social support offered along with the required medical support. Also, TUSA social workers in charge with social HBC services, sometimes provide medical HBC services. In such situations, they are forced to overpass 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 a group of HBC providers. This is due the fact that young specialists are not being 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. The lack of medical staff is more felt in municipalities and some towns and less in rural areas. 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 provider (medical assistants with a driving license), (v) low professional training of social workers, etc.

Criteria for admission to HBC services

TUSA provide social HBC services according Government Decision no. 1034. Free of charge services are offered to elderly who have reached the standard retirement age and people with disabilities that 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 MH 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 admission to HBC within the CSOs is based on specific criteria set by 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) and have to be without an infectious or a mental illness. CSOs provide HBC services to people that do not benefit from such kind of services from public or private providers.

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 single women from rural areas. The evaluation data indicates that medical HBC services are more gender balanced, targeted at people with disabilities and are particularly accessible to people from urban area. CSOs are oriented to those categories of beneficiaries that are not covered by public medical institutions and TUSA, thus increasing the number of men, people under the age of 65 and those with relatives as beneficiaries of HBC.

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

Offer and demand for HBC services

The analysis of HBC services from a geographic perspective reveals that single elderly and people with disabilities without support are the ones that are manly covered. 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 of medical HBC services, there are administrative territorial units (ATU) that have more providers and ATUs have only few or even none. The analysis of private provision (CSOs and LLC), is also not homogeneous. The distribution is frequently determined by LPA's readiness to collaborate with CSOs in developing HBC.

Consequently, the HBC services are not available to all those who need them. HBC services are not accessible mainly because some persons who need them do not comply with the normative provisions for admission into such service. Also, HBC services, especially medical services, are not provided in all localities of the RM. Neither HBC services offered by CSOs are also available in all localities of the country. In many cases lonely old people abandoned by their children are disadvantaged and deprived of HBC services.

Home-Based Medical and Social Care Services Assessment in the Republic of Moldova has allowed to made estimations about people who might potentially need HBC services. The estimated number of people who need HBC social services is 33 915 people. Currently, social HBC services are offered for 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 need is covered at the moment.

Beneficiaries' possibilities to pay for HBC services

The large majority of beneficiaries cannot afford and refuse services provided for a fee. Representatives of public and private providers, LPAs pointed out that the beneficiaries are not eager to pay for HBC services

due to their poor financial situation and insufficient income. Only a very small circle of wealthy patients could accept services provided for a fee. 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.

LPA's possibilities to develop HBC services

In-depth interviews with the mayors reveal that most of them have other priorities at the community level (roads, water supply, sewage, concert halls, street lighting, etc.) and the social protection of the population is lesser one. The income generated locally is low due to the small number of businesses. However, LPA 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 HBC by beneficiaries

Asked on what they like most about HBC, 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 service cover their needs, compared to 51.7% who said – no. The majority of beneficiaries have very high expectations from these services, especially those that receive services from private providers that had financial resources from donors, as they know that services provided by the public providers cannot be improved. The uncovered needs specified by the beneficiaries include a wide range: medication, non-involvement 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, blood glucose meter) etc.

Difficulties in providing HBC services

Social HBC providers mentioned as difficulties: their dependence on external sources of financing, the lack of a functional mechanism for contracting social services by Central Public Administration (CPA) and by the LPA. This is especially true for private providers. 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: (i) limited number of cases contracted by NHIC (ii) the amount of money allotted per visit/medical HBC is not enough for the procurement of single-use diapers, (iii) lack of transportation to visit patients, (iv) the list of approved medication is insufficient, etc. So, the representatives of medical HBS that participated in assessment mentioned that they want to provide the same services but within an increased cost and to larger number of individuals. The higher is the cost per visit, more the ability to contract more visits and ensure to development of medical HBC services.

On the collaboration of the medical HBC service providers with NHIC it was mentioned that it currently involves contracting, evaluation, monitoring, reporting and training. But there are also challenges: (i) limited and insufficient funding of medical HBC cases, (ii) small number of cases funded, (iii) lack of contracting requirements, but also lack of fairness, (iv) lack of training on evaluation and accreditation.

Volunteering is poorly developed in the RM in general, and particularly related to HBC delivery. 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 volunteering component, engaging volunteers in providing HBC services. The number of volunteers varies from at least 1-2 persons to maximum 60 persons. Activities performed by HBC volunteers are: gardening, water supply, provision of firewood, delivery of warm lunches and food packs, organization of cultural activities, psychological counselling, medical assistance and needs evaluation. Volunteers play an important role in fundraising and HBC information activities, etc. Unfortunately, only a few of CSOs include volunteers in direct communication with the beneficiaries.

Resources used to deliver HBC services

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

The biggest share of used resources is human resource; more than half of expenses across models cover work remuneration. Other important expenditures cover maintenance of a work space/premises (office or center) and transportation means as well as expenditures on medication.

One of the main differences in resource distribution among models is linked the availability of the existing physical social and medical infrastructure. Public providers have to cover less or no cost for maintaining an office/center. Private (including non-profit providers) spend an important amount on rent, utilities and repairs of work premises. Medical institution providers declared zero costs for such expenditures; therefore it is clear that the existing healthcare system is taking over some costs of delivery of HBC services. This puts the providers in a different financial position in the context of similar refunding mechanism from the state (the visit cost covered by NHIC).

The medical institutions have the least diversified resources used for HBC delivery. This is a result of the method of calculation of per visit cost covered by the NHIC. Biggest parts of the resources used by medical institutions are 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 back fees. Very few medical institutions had expenditures for professional qualifications and work related travel.

TUSA have the most diversified expenditures for HBC service delivery. Work remuneration is the most important share of used resources. Another important component is rent/ maintenance and utilities for the

work premises. Some resources are allocated to rent/ maintenance of cars, office supplies, telecommunication services, trainings and work related travel. Another particular expense for this model is rent/ maintenance of equipment and inventory. Very few TUSA can afford improving the work space, and very few buy hygiene products to be used by the beneficiaries and buy pharmaceutical products. Professional trainings are also not a priority when it comes to expenditures distribution.

The expenditures of non-profit entities don't differ significantly by type of expenditure (compared with TUSA). At the same time, the share of certain expenditure in the total expenditures differ significantly by type. As mentioned, the major difference is dictated by the fact that private providers deliver services outside of an existing physical infrastructure. An important share of expenditures for private providers relate to paying the rent for a work space, utilities and maintenance of an office. Transportations cost are also bigger for this group, this is linked with the fact that these organization 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 the medical assistants have to be transported from neighbouring villages. The non-profit organizations have particular expenditures liked with formulating and promoting public policies (consultancies for research, outside expertise, training materials etc.). Another exclusive group of expenditures are for representation (lawyer, notary).

The cost of HBC 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 TUSA 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 balanced costs within the group, one beneficiary costs about 3 270 MDL per year. The pro profit delivery cost (private entities) is around 2 950 MDL per one beneficiary per year.

The most expensive type of support is integrated HBC service, on average one beneficiary's annual costs of integrated support is 5 150 MDL,

this is due to more intense use of resources for these services (medical resources as well as resources linked with social support). But the cost of the integrated support is less that cumulated costs for social support and medical support. This is explained by the fact that integrated support provided within one entity is cheaper due to lower administrative costs. 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.

The minimal, optimal and high quality HBC services cost scenarious

A simplified approach to look at the minimal and optimum costs is considering the existing costs and their use or resources. The minimal calculated cost for service delivery could be considered 2 300 MDL per year per beneficiary for public entities and 2950 MDL per year per beneficiary for private provision. Optimum provision could be considered 4500 MDL both for public and private provision and high quality could be considered the integrated service which costs around 5 000 per year per beneficiary. An additional 5-7% to the costs presented above should be added on yearly basis for increasing qualifications of the personnel.

Assessment results reveal the shortcomings and achievements in the field of HBC in the RM. These results allow us to present 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 CPA and LPA from private providers.

- Elaboration of the normative framework for the development of integrated HBC services. Development of the intersectoral cooperation mechanism for public and private providers of medical and social HBC services (likewise those on child prevention of mortality and child violence, etc.). The mechanism should clearly established duties of each responsible party or developing a Case Management designed for the elderly, according to the Case

Management addressed to families with children (National Model of Good Practice) currently operating in the RM.

- Development by MHLSP and NHIC of the public policy of contracting medical HBC providers to cover the needs for services nationwide.
- The MHLSP, together with NHIC can develop unit cost/prices method to reimburse for medical HBC services, based on "ABC" formula and/or "codes". Such a method can be used both for residential facilities (hospitals, long-term care houses, hospices etc.) and for HBC services. A working group can be established to elaborate "code" prices for patients in different grades of dependency and health shape (long-term care, short-term post-operational care, patients in terminal stadium of life, etc.). A "code" prices for medical supplies; set special prices of medical workers working over working ours – take overtimes into accounts, etc.
- A method to increase the cost (indexation) of the services should be also established in order to capture changes of consumer price index and ensuring sustainability and decent quality of service provision.
- Elaboration of a methodology for assessing the needs of social services at community level in partnership with LPA and CSOs.
- Elaboration of the job description models to outline the responsibilities of a medical assistant and a social worker in providing HBC services and to offer these models to HBC service providers.
- The minimum quality standards should be revised for both social and medical HBC services from the perspective of realistic and sustainable support. The standards for integrated HBC services should be developed. A most important step is to correlate the minimum quality standards and regulations for HBC provision with the actual costs of resources needed to provide these services as per the requirements.

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

- The methodology for calculation social HBC should be developed and approved, establishing a range of social sub-services, the time that social worker has to dedicate to each service. The publication in Official Monitor will make it legal and available for LPAs and other potential service providers.
- Establish an initial and continuous training system for social workers to improve the quality of provided HBC services.
- Modification of 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 and include all providers of HBC service 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 visit cost for medical HBC service should be developed and approved. The publication in Official Monitor will make it legal and available for LPAs and other potential service providers.
- Introducing in the Medical HBC Regulatory Framework the beneficiaries' dependency categories and developing a methodology for the cost of a medical HBC service visit based on these categories.
- Organising the system training for paramedical assistants who will provide medical HBC services and exclude current situations when social workers provide 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 collaboration/partnerships of HBC providers.

Recommendations to the Local Public Authorities

- Introduction of the social services component in the policies and documents elaborated at local level and ensure their implementation, including by allocating the necessary financial resources.
- 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: support form primary healthcare facilities to private providers as well as public providers of social HBC, offer when possible work premised (buildings, part of buildings in existing policlinics or hospitals, building of socials sector) to private providers (non-profit), offer equipment and other support materials if available.
- Involvement of CSOs in assessing 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 LPA support in assessing the needs of social services, especially HBC services.
- Calculate the unit cost of services they provide and keep these calculations updated. The unit cost should be accessible and cumulated into one source. All costs should be made public, so

beneficiaries will understand what actions/services are being provided and the intensity of 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 etc.

- Keep accurate financial documentation and provide an aggregated analysis regardless of source of financing.
- Promotion of existing HBC services and how to access them.
- Involvement in permanent communication with CPA and LPA for development of qualitative and sustainable HBC system in the RM.

INTRODUCTION

Republic of Moldova (RM) is the poorest country in Europe, with a Gross Domestic Product of 1900 USD per capita in 2016. Moldova's livingstandards and human development indicators still rank amongst the lowest in Europe, even in comparison with other transition economies. The UN's Human Development Report 2016 ranks Moldova 107 out of 188 countries. The Moldova Government Social Report 2015 rates poverty level at 11.4%, with poverty mostly concentrated among vulnerable groups such as elderly people and children. Uncontrolled urbanization and out-migration produce a widening gap between the urban and rural population, dependent on subsistence farming and remittances. Social exclusion, therefore, is largely driven by poverty and sharp increase in economic inequality.[1]

RM faces the phenomenon of rapid population aging. At the beginning of 2016 there were 592 600 persons aged over 60 year old in the RM, 13.3% of whom were over 80 years old. Social services for the elderly, including HBC services, have been developed in the RM to ensure the old people a decent living and, as far as possible, independently in their own homes.

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). The development and provision of social services at the community/municipality level is the responsibility of Local Public Authorities (LPAs). The current mechanism, for financing the social services at local level, doesn't create motivation that would ensure their efficiency and sustainability. The main sources of funding for social services are the transfers from the state budget to the LPA and the local taxes. This funding model is incompatible with the increased need for social services at the local level, need resulting from the high level of poverty, migration and ageing. Currently is difficult to cover the need from the available state funds as well as small local tax revenue of the LPAs.

The Regulation on Procedures of Accreditation of social services providers was approved by the Government in December 2013. During 2014-2015 the accreditation process of the social services started for

[1] Vremes M., Cheianu-Andrei D., etc. Approaches to Social Exclusion in the Republic of Moldova. Methodological and Analytical Aspects. – UNDP, Chisinau, 2010.

services that already have an established mechanism (evaluation and self-evaluation forms), such as: Mobile Team Service, Personal Assistant, Professional Parental Assistance Service and Temporary Placement Centres for Children at Risk etc. Assessment and self-evaluation tools for the social HBC service have been developed by the National Council for the Accreditation of Social Services Providers and approved by the MHLSP in 2017. For the year 2018 the accreditation procedure for the providers was planned.[2]

The Moldovan legal framework regarding 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 in order to be contracted by NHIC and have access to 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 doctors' reco-mmendation. The funds from the NHIC, allocated for medical HBC, have increased from about 4.7 million MDL in 2013 to 7.7 million MDL in 2016. When compared with the total budget for health sector, it still remains a negligible amount of about 0.2%.[3]

The LPAs undertake measures to develop HBC services and cover a larger number of inhabitants. Thus, in some ATU of the country, the local public authorities have initiated partnerships with civil society organizations and donors for developing such services.

The CPAs also issued a series of regulations in the sector, to be able to monitor and standardize the services provided by public and private institutions. The government shows its willingness to continue the development of the regulatory frame, meant to facilitate the situation in the field, giving more freedom to the CSOs and improving the quality and accessibility of the service for population.

[2] http://cnapss.gov.md/sites/default/files/document/attachments/grafic%20acreditare%202018.pdf
[3] http://cnam.md/httpdocs/editorDir/file/RapoarteActivitate_anuale/executare%20faoam/Raport-executare-FAOAM.pdf

An important role in the development of HBC services is played by the network of CSOs providing medico-social home care. 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, through the International Cooperation and Development Program, with the financial assistance of the Czech Development Agency. 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 Association 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, although comprehensive data on the real demand is still not available.

In this context, several donor-driven services / 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 as to provide a mapping of social and medical HBC services, including people's demand for HBC services. The results of the assessment will help Moldovan authorities develop evidence-based policies and will contribute to the sustainable HBC service development.

THE ASSESSMENT FRAMEWORK

1.1. Overall and specific objectives

The overall objective is to assess the existing HBC service providers (private and public) and the needs of the population in HBC for sustainable HBC services development.

The specific objectives are:

- to review existing laws and regulations on HBC services;
- to assess the existing HBC service providers (public and private, social and medical services providers), including their profile;
- to analyze the existing HBC models;
- to assess the real needs of HBC services;
- to analyze the use of the available funds and potential resources for HBC services;
- to analyze the cost of HBC services and propose a benchmark costification formula/methodology of the HBC services;
- to provide evidence based recommendations for development of the HBC services and to increase access to HBC services.

1.2. Methodology of the assessment

In order to achieve the purpose and the objectives of the assessment, a complex methodological approach focused on in depth analysis of HBC services delivery in the RM was proposed. This was formulated based on the opinion of HBC service providers, HBC services bene-ficiaries and LPAs of the I and II levels, enabling data triangulation.[4]

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 RM) and HBC services cost analysis. Additional to these data field information/data was collected from HBC service providers, service beneficiaries and LPAs at I and II levels.

[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.

The current assessment is mixing quantitative and qualitative research methods (see Figure 1. Research methods). 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 LPA representatives revealed the real possibilities of their involvement in financing / co-financing of HBC services.

☆ Figure 1. **Research methods**

Qualitative methods

Individual in-depth interviews

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

Quantitative methods

84 sociological ques- tionnaires with hbc providers

Questionnaire content:

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

The survey sample comprised 84 HBC service providers from 23 ATUs (see Annex 1). The questionnaire completed by organizations providing services included 5 sections: 1. General information about the organization/institution; 2. Data about service beneficiaries; 3. Services provided; 4. Financing of HBC services; 5. Specialists employed in providing HBC services.

The qualitative research involved 2 target groups: 340 beneficiaries of HBC services and 23 LPA representatives. The interview guide for beneficiaries of HBC services was focused on the next aspects: 1. HBC services received and needs for services; 2. Home visits; 3. Possibility of partial or full payment for HBC services; 4. Recommendations on the improvement of HBC services. The interview guide for LPA representatives approached the following subjects: 1. LPA's overall priorities and namely in the social field; 2. Views about HBC services; 3. Collaboration between LPA and HBC service providers; 4. Financing of HBC services; 5. LPA's recommendations on the improvement of the accessibility and quality of HBC services.

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 (inputs) in products/services (outputs). The considered costing method associates the costs of resources with services delivery.

The assessment presents the situation of HBC services till 31.12.2017 and the data on the number of beneficiaries refers to 2016.

The analysis on transformation of international experience was conducted by Radka Rubilina, PhD. International expert focused on European models of HCB services and she was looking at countries, which experience could be used for development of further steps in the health and social sector related to HBC services in RM.

The international expert based her methodological approach on qualitative research. Such a research run in three phases: research on Moldovan legislative framework related to HCB services and the level of

development of HBC services in RM; the second phase was analytical comparison among the European systems of HBC services applicable in RM; the third stage was development of some recommendations to chapters 2, 4, and 5 adjusted to the current needs of HBC services development in RM, mostly on systematic level. Such a study offers different approaches which can be picked up by the Moldovan authorities.

This assessment combined desk research and interviews (with open questions): The international expert conducted 15 interviews with HBC services providers, 6 interviews with officials and 4 interviews with academicians/experts in all analyzed countries: Republic of Moldova, Romania, Czech Republic and Slovak Republic.

During interviews with local stakeholders from the working group emphasized relevance of **Romanian model of HBC services** for RM with the successful example of CASMED CSO which has set partnerships with 16 local CSOs and 35 mayoralties in 11 northern districts of Moldova.[5] Using local budget was one of strong argument from the point of view of sustainability, so the Romanian experience became a starting point for the analysis of the European models of HBC services for the international expert.

As a second step, the international expert was looking for European countries, which evinced similar priorities or problems as RM in the past but and were able to create more or less sustainable model of HBC. Among European countries with underdeveloped social/health system and strong role of local government was chosen – **Slovak Republic**.

During the research and interviews with Slovak HBC services providers, the expert understood that this study could offer an inspiration for Moldovan stakeholders through shifting the focus from the local government perspective to different model of financing HBC services. A **model in the Czech Republic** shows a reform that still leaves decision making powers to the local government, but the funds are distributed to clients directly. Emphasis on individual needs of clients led in the Czech Republic to the quick development of a market with social and medical services and contributed to better sustainability of the HBC services.

[5] http://casmed.md/en/evenimente/english-casmed-socio-medical-homecare/

In the whole research, the expert kept in mind two criteria: Keep in focus countries which:

1. were in similar transition of health and social sector from socialistic, state-driven system to liberal democratic, partly privatized and capitalized system; had to pass similar problems with underdeveloped market of social and medical services

2. the state organization is not a federation, so that local governments of European countries have more or less similar responsibilities/ possibilities as local governments in RM.

1.3. Limitation of the assessment

The assessment was influenced by some limitations:

Geographic area

The assessment was conducted in 23 of the 35 ATUs of the RM, except Transnistria. The ATUs were randomly selected to enable through generalization and extrapolation, the countrywide description of HBC services.

The selection of public and private HBC service providers and the level of openness

It was attempted to collect data from all HBC service providers from the 23 ATUs. Although there was a cooperation agreement with the MHLSP, participation in the evaluation was voluntary, consequently, certain providers refused to participate for various reasons. Not less important is the fact that the level of openness of authorities and providers was different, from those who provided comprehensive information to all our questions, to those who provided partial (incomplete) data (without financial data).

The need for HBC services

The large majority of providers, both public and private, do not keep track of beneficiaries requiring HBC services in the geographical area they provide services, which makes it difficult to estimate the number of beneficiaries in need of such services.

The selection of LPA representatives

In selecting the LPA representatives special attention was paid to LPAs involved in the development of HBC services at the community level or in the process of discussion to develop such services. As to find out their opinion about: the need for HBC services, collaboration with HBC service providers, their potential for financing/co-financing HBC services and recommendations for the development of sustainable HBC services focused on the needs of the beneficiaries. Still, these views might not correspond to the opinion of the large majority of the LPA of the first and second level from the RM.

Recommendation which do not necessarily come up from the current assessment

While the conclusions and recommendations formulated by the international expert enrich the paper bringing good practices, some of the formulated recommendations are not being necessarily supported by the data collected through the current assessment.

DESK REVIEW OF THE EXISTING LEGAL FRAMEWORK ON HBC SERVICES

2.1. Evolution of HBC services

The social HBC is one of the oldest social services in the RM. Social workers were the first specialists to be employed in the social assistance sphere to provide social HBC services. Within the first years of Moldova's independence, social workers providing social HBC services were employed by the National Social Insurance House (NSIH) and with the creation of TUSA in 1998, they were subordinated to the last. Gradually, social HBC service has been developed and private providers have emerged alongside with public providers.

The bedrock of HBC services, in a more comprehensive variant, in the RM was put in December 1999 by the Catholic Religious Mission "Caritas-Moldova", Interconfessional Society of Christian Doctors "Emanuil" and the CSO "Nursing Association from RM", with the support of "CORDAID" organization, Holland. They implemented the first pilot project on HBC. The first lobby and advocacy actions were initiated at that time to create a regulatory framework for the development of medical and social HBC services.

The national health assessment and accreditation system in the Republic of Moldova was established in 2001. The first health assessment and accreditation took place in 2002, and the procedure for assessment and accreditation of HBC medical institutions started in 2003. The first institution providing medical HBC services, to be accredited, was the Interconfessional Society of Christian Doctors "Emanuil" (created in 1992), in 2003. Later, accredited status was granted to medical HBC services provided by the Charitable Foundation ,,Caritas Moldova" (created in 1995), CSO "Speranțele bătrânilor din Nordul Moldovei" (created in 1997), CSO "Prosperare Zubrești" (created in 1999), CSO "Neoumanist" (created 2000), CSO "Homecare" (created in 2005), CSO ,,Medlife" (created in 2009), CSO ,,Medasist", (created 2010), CSO ,,CASMED" (created in 2010), CSO "Aripile Speranței" (created in 2013) etc.

An essential step in the development of the medical of HBC services was the approval in 2007 of the Unique Compulsory Health Insurance Program and the inclusion of medical HBC services as a form of medical assistance, alongside with pre-hospital emergency, primary, ambulatory

and hospital care.[6] The section 6 of this Program stipulates that insured bedridden patients are entitled to medical HBC services. These services are provided individually by service providers contracted by the NHIC according to the law. The first service providers were contracted in 2008.

Starting with 2011, with the establishment of the Association of CSOs providing medico-social home-based care, CSO "Homecare", CSO "CASMED", Charitable Foundation "Caritas Moldova", CSO "Neoumanist" and CSO "Nursing Association from the RM", intensive, well-prepared and coordinated lobby and advocacy actions have been undertaken to create the regulatory framework and to organize and develop HBC services at the national level. The Association of CSOs pursues ensuring the appropriate provision, promotion, performance of services as well as the creation of the methodology for calculating the cost of medical and social HBC services, elaboration and approval of the forms of primary medical records, assessment and accreditation standards for HBC service providers etc.

The cooperation of the non-governmental sector with the MH (currently MHLSP) led to the development/adjustment of the regulatory framework on medical and social HBC services, national standards on medical HBC services (minimum requirements for providers of medical HBC services, list of medicines for rendering HBC services, list of basic medical interventions for HBC services), assessment and accreditation standards for medical HBC service providers. It also led to increase if assigned financial resources[7] per one home care visit from 32.63 (2.21 Euro[8]) MDL in 2008 to 137.25 MDL in 2017 (6.72 Euro).

Another important result of the aforementioned collaboration is the elaboration and approval of the Law on accreditation of social service providers, the Strategic Plan for the creation and development of social HBC services in the RM for 2015-2017, the Regulatory framework on social HBC services and the Minimum Quality Standards.

[6] http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=326302
[7] According to National Bank of RM exchange rate at 31.12.2008
[8] According to National Bank of RM exchange rate at 31.12.2017

2.2. Short review of the legal framework for HBC services

Under this study we will analyze 3 types of HBC services: social HBC services, medical HBC services and integrated HBC services[9] (see Figure 2).

The main normative acts regulating the functioning of these 3 types of HBC services are:

I. **Law no. 123 of 18 June, 2010 on social services**[10], with subsequent amendments and completions, stipulates the general framework regarding the establishment and functioning of the integrated system of social services. The law makes provisions for the next types of services: a) primary social services; b) specialized social services; c) very high specialized social services (art.6). The law specifies that central and local public adminis-tration authorities can procure and contract social services (art. 26, line 4) which may be jointly financed in partnership from the state budget, the budget of territorial unit of the 1st and 2nd level (art.27-28). Social services providers can use the own income of social service providers, donations, sponsorship or other contributions of citizens form the RM and foreign indi-viduals or legal entities as well as other sources, under the law. Depending on the income, the beneficiary can contribute to social service financing and social service providers can develop economic activities for self-financing of the social services rendered.[11]

II. **Nomenclature of social services endorsed through the Order of MLSPF no. 353 of 15 December, 2011**[12] indicates that primary social services are community-based services for all beneficiaries and aim to prevent and/or reduce situations of difficulty that may lead to the marginalization or social exclusion. The development and provision of these services is the responsibility of the LPAs of the 1st level. They have to ensure the needs assessment, to plan the development of these services in accordance with the revealed needs, including the financial resources required and

[9] Are not regulated by normative acts
[10] http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=335808
[11] http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=335808
[12] http://msmps.gov.md/sites/default/files/document/attachments/nomenclatorul_serviciilor_sociale.pdf

to provide the services. At the same time, the Nomenclature specifies that primary social services are classified into: a) community social assistance service; b) social HBC service; c) social canteen service; d) community social assistance centre.

III. **Law on social assistance no.547 of 25.12.2003**[13], with subsequent amendments and completions, regulates social assistance financing. Art.22 provides that social assistance activities are financed by the state budget, the budgets of territorial units and local budget, donations, sponsorship as well as contributions of the beneficiaries of the social assistance. At the same time, institutions providing social assistance can organize social entrepreneurship to obtain certain income they can manage as special resources. The funds received as contributions of the beneficiaries who have their own income are also used to finance the social services. The contributions of social assistance beneficiaries are determined by the beneficiaries' own income, as follows: a) by LPAs – for social services financed of their own budgets; b) by legal entities (with LPAs' approval) – for social services created and provided by them; c) by CPA – for social services financed of the state budget; d) by joint agreement – in case of social an assistance programs funded in partnership.

IV. **Government Decision no. 1034 of 31 December, 2014**[14] regarding the Framework Regulation for social HBC services and Minimum Quality Standards.

V. **Law no. 129 of 08.06.2012**[15] regarding the accreditation of social service providers sets down the general framework on the creation and functioning of the national system for the accreditation of social service providers but also the basic principles, general criteria, accreditation requirements for social service providers.

VI. **Government Decision no. 95 of 07.02.2014**[16] on the approval of "Regulations regarding the procedure of accreditation of social service

[13] http://lex.justice.md/index.php?action=view&view=doc&id=312847
[14] http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=356264
[15] http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=344610
[16] http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=351555

providers" sets down the procedure of organizing the accreditation of social service providers. According to this procedure, all social service providers are subject to accreditation, irrespective of their type of ownership and legal form of organization.

VII. **Law no. 411 of 28.03.1995**[17] on health care, stipulates the structure and basic principles of the healthcare system, the types of healthcare and the way it is provided.

VIII. **Law no. 552 of 18.10.2001 on health assessment and accreditation**[18] sets down the basic principles of the assessment and accreditation of the healthcare and the pharmaceutical units. The state and private healthcare and pharmaceutical units are subject to accreditation once in 5 years.

IX. **MH Order no. 855 of 29 July 2013**[19] Framework Regulation on medical HBC services.

X. **MH Order no.851 of 29 July 2013**[20] regarding the National Standards for medical HBC services.

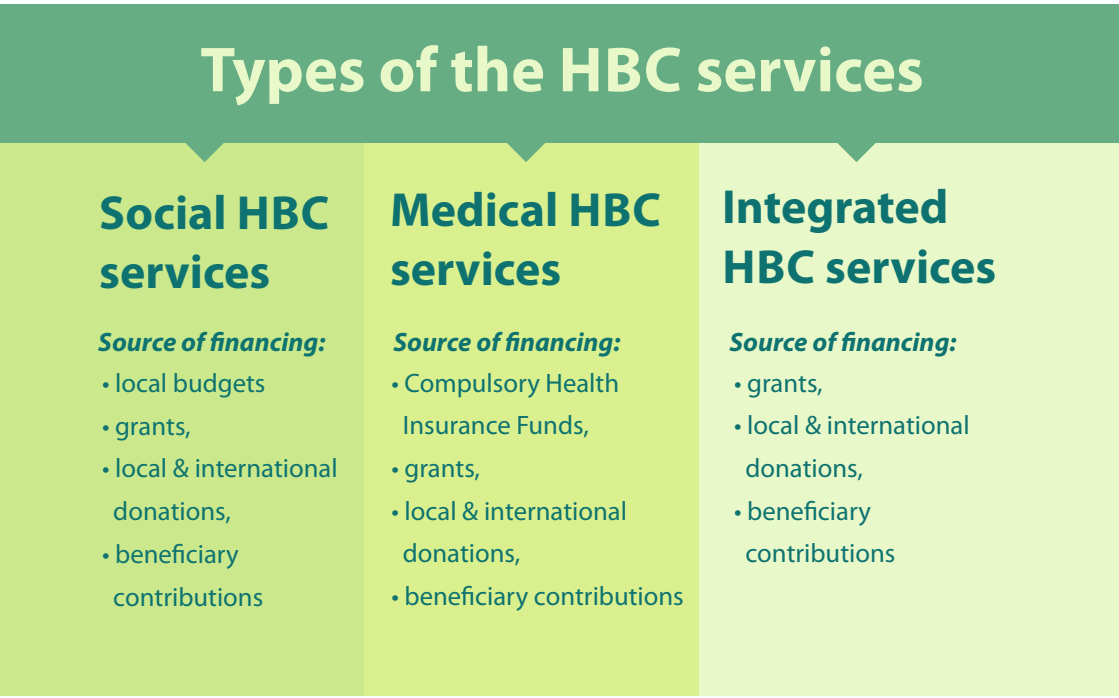
XI. **MH Order no.66 of 31 January 2017** regarding to cost approval for 2017.

XII. **NHIC Order no. 430A of 17 September 2015**[21] regarding medical institutions contracted for 2016.

XIII. **Order no 596/404 of 21.07.2016** on the approval of Methodological Norms for applying the Unique Program of Compulsory Medical Insurance. It defines the basic principles of organization of medical services provided within the system of compulsory medical insurance by healthcare institutions contracted by NHIC.

[17] http://lex.justice.md/viewdoc.php?action=view&view=doc&id=312823&lang=1
[18] http://lex.justice.md/viewdoc.php?action=view&view=doc&id=312848&lang=1
[19] http://old2.ms.gov.md/sites/default/files/legislatie/ord_nr._855_din_29.07.2013-_cu_privire_la_organizarea_ingrijirilor_medicale_la_domiciliu.pdf
[20] http://old.ms.gov.md/_files/14371-ordinul_ms_nr._851_din_29.071.2013-_cu_privire_la_aprobarea_standardului_national_de_ingrijiri_medicale_la_domiciliu.pdf
[21] http://www.cnam.md/editorDir/file/Ordine_ale_CNAM/Ordin_contractare_430A.PDF

Figure 2.
HBC types and sources of funding



Source: Author's analysis

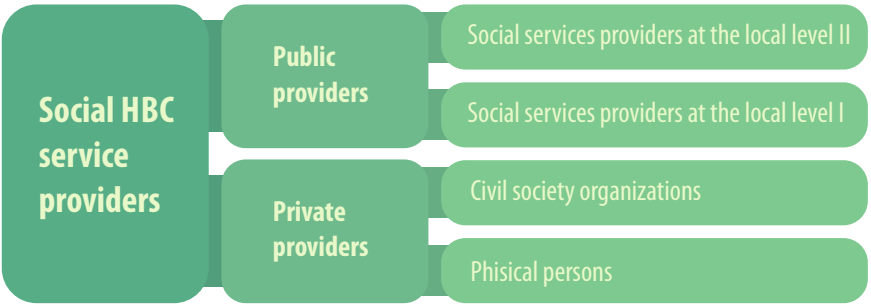
2.3. Social HBC service

Providers of social HBC services

The social HBC service[22] represents a public (established within territorial structures of social assistance) or private service (created by foundations, private non-profit organizations, registered according to the law, dealing with social sector). The purpose of the service is to provide quality social HBC services as to ensure better quality of the beneficiaries' life. The providers of social HBC services are presented in the Figure 3.

[22] Government Decision no.1034.

Figure 3. **HBC social service providers**



Source: Author's analysis

Service organization and existing requirements

The public social HBC services are provided by territorial units of social assistance (TUSA)[23], except the ATU Găgăuzia, where these services are provided by the LPA of the I level. The TUSA provide social HBC services and the number of employed social workers depend on: the number of beneficiaries, the number and size of localities under the administration of the territorial unit of social assistance (the highest number - 208 social workers are in the municipality of Chișinău, the lowest - 17 in the Dubăsari rayon[24]). A manager of the social HBC services coordinates the work of social workers, checks and supervises their work that has to comply with the Regulations and the Minimum Quality Standards.[25] The manager reviews and completes the beneficiaries' records for their admission or exclusion from a service. The service manager is also in charge with accepting the beneficiaries for a fee and signing the contract between parties. The manager/managers is/are employed depending on number of social workers. For example, in the municipality of Chișinău there are 8 social HBC service managers, in the municipality of Bălți, districts of Râșcani, Fălești, Florești there are 3 managers, in other districts - 2 or 1

[23] The Department of Social Assistance and Family Protection from the districts and the municipality of Balti, the General Department of Social Assistance in the case of the municipality of Chisinau (The General Department of Social Assistance, based on the Chisinau Council Decision of 07.02.2018, has merged with the Department of Health and will be further called the Department of Health and Social Protection) and the Department of Health and Social Protection in the case of ATU Gagauzia.

[24] The mapping of employees and employers in the social assistance field from the Republic of Moldova and their needs. Diana Cheianu-Andrei at the request of Ministry of Labour and Social Affairs of the Czech Republic and Ministry of Labour, Social Protection and Family of the Republic of Moldova, 2016.

[25] Government Decision nr.1034, Annex 1 and Annex 2.

service managers. *Home-Based Medical and Social Care Services Assessment in the Republic of Moldova* revealed the current lack of indicators to show the distribution of service managers and their workload. Thus, in some districts, the number of localities is divided into 3 or 2 in equal parts. In other units there is a service manager for rural localities and a service manager for urban localities. The manager of social HBC services has his office in the building of the TUSA, while the social workers is placed in the mayor's offices (except the municipality of Chișinău where social workers also have their offices in the building of the TUSA). According to the Nomenclature of social services the following categories of speci-alists can be employed in the provision of social HBC services[26] : service manager, social assistant, social workers and other specialists. Only 2 categories of the mentioned above specialists are employed in all ATU: service managers and social workers. None of the ATU has the position of social assistant as part of the social HBC service.

In the case of ATU Găgăuzia, public social workers are not part of the territorial social assistance structure but are employees of the local communities/municipalities. The mayor or vice-mayor is in charge of the mayoralty. The social workers in this region are not subordinated, at least not de jure, to the TUSA. This way of working is inherited from the soviet period. The same way of providing HBC services is used in the Transnistria region (not covered by the assessment).

The state social workers could provide the following types of services within the social HBC service: counseling; procurement, from the financial means of the beneficiary, of food products, household goods and medicines; preparation of food, delivery of warm meals (if needed); bills for communal services payment from the financial means of the beneficiaries; house cleaning; organizing the process of adapting the dwelling to the needs of the person; involvement of the beneficiary in social and cultural activities; handing over and lifting household items and clothes to / from laundry, dry cleaning, repair; other activities.

Public social HBC services can be for free of charge or paid, but in both cases only some categories of persons can benefit.

[26] Endorsed through the Order of the Ministry of Labour, Social Protection and Family no. 353 of 15.12.2011.

The beneficiaries for **free services** are:

- The elderly who have reached the standard retirement age and people with disabilities, lacking support from children, extended family and other people (friends, relatives, neighbors);
- The elderly who have reached the standard retirement age and fall under Art. 2 par. (1) of the Law no. 274 of 27 December 2011 on the integration of foreigners in the RM, lacking support from children and the extended family.

Free services are usually provided to the beneficiary until his passing or is excluded from the service due to change of residence, at the beneficiary's own request or due to circumstances that do not comply with requirements set forth by Framework Regulation of the social HBC Service (for example children of beneficiaries can take care of them).

The following category of people benefit from the paid services:

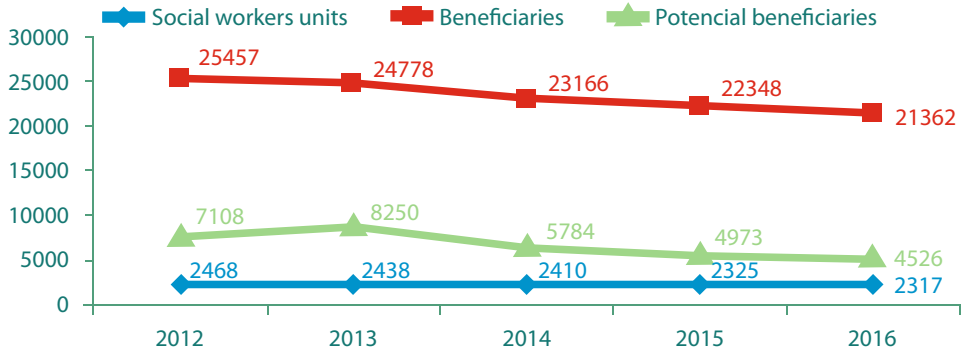
- elderly people who have reached the standard retirement age and persons with disabilities, whose children are obliged, according to the legislation, to support them, but for good reasons they cannot fulfill their obligations;
- elderly who have reached the standard retirement age and fall under Art. 2 par. (1) of the Law no. 274 of 27 December 2011 on the integration of aliens in the RM, whose children are obliged, according to the law, to support them, but for justified reasons they cannot fulfill their obligations;
- persons over the age of 18 who, after hospitalization, require temporary health care and do not have support for home care: persons who leave the hospital after surgery; convalescence following strokes, femoral, neck fractures, paralysis;
- end-stage patients (cancer and cirrhosis);
- people requiring long-term care: chronic patients (except for infectious diseases) who are unable to perform their everyday activities (food, personal hygiene, etc.) due to illness, being immobilized in bed and requiring permanent help.

The private social HBC providers render services in compliance with the existing laws. They provide services to vulnerable people that do not benefit from this kind of services from public providers. Selecting the beneficiaries, the private social HBC services providers rely on specific criteria set by donors (further details are available Chapter III, 3.4.).

Trends in service providing

According to the information submitted by the TUSA at the end of 2016, about 2317 units of state social workers were active, with 35 units less than in 2015.[27] Unfortunately this negative trend could not be stopped starting with 2014 (see Figure 4). At the same time, the number of beneficiaries and potential beneficiaries[28] of the social HBC service delivered by the state decreased. The decrease in number of beneficiaries and potential beneficiaries of social HBC was determined, on the one hand, by the development of the personal assistance service for people with severe disabilities[29] and on the other hand, by the endorsement in 2015 of the Framework Regulation on social HBC service that changed the conditions for admission of the beneficiaries to the service.

Figure 4. **Trends in number of beneficiaries of the public social HBC service providers, number**



Source: Social Report, 2016 year

Data collecting within the *Assessment of social and medical HBC services in the Republic of Moldova* also reveal decrease in number of beneficiaries of the private social HBC service providers (see Chapter III, 3.6).

[27] Annual Social Report for 2016 prepared by MLSPF
[28] Potential beneficiaries are people that meet the legal requirements (currently - pt.11, line 1 and 2 of the Framework Regulation on social HBC service.
[29] 43 658 297 Euro (According to National Bank of RM exchange rate at 31.12.2016)

Accreditation

There is not yet any public or private provider of social HBC accredited by the National Council for the Accreditation of the Social Service Providers. Assessment and self-evaluation tools for social HBC service accreditation have been developed by the National Council for Accreditation of Social Services and approved by the MHLSP at the end of December 2017. The accreditation procedure for the social HBC providers was planned for 2018. According to this plan, 14 providers have to undergo accreditation, including 11 public (TUSA) and 3 private (CSOs).

Financing

The HBC social services are supported financially from the local budgets, grants, local and international donors and beneficiary's contribution. The total consolidated local budget in 2016 was approved in amount of 912.0 million MDL[29] of which 256.5 million MDL[30] (28.1%)[31] are transfers from the state budget for the delegated functions. The social HBC services are own services and need to be finances from the own resources (more details see in Chapter V).

With the approval of the Framework Regulation of the social HBC Service and the Minimum Quality Standards, there was a need to consolidate and promote the social HBC Service for all public and private providers, especially for partnerships in service delivery. Thus, the MLSPF through Order no. 20 of February 18, 2015 approved the Strategic Plan for the Development and Consolidation of the social HBC Service in the RM for the years 2015-2017. It is implemented in partnership with the TUSA and the CSO network of HBC services.

Unfortunately, till now there is no action or measure that will improve and/or increase the funding of social HBC. Currently, the expenditures that are included in the forecast calculation and then subsequently approved in the budget are reimbursed based on the cost per social worker and their number employed in the service. The cost of a social worker is calculated based on historical data (spending registered in the previous years).

[30] 12 278 896 (According to National Bank of RM exchange rate at 31.12.2016)
[31] 2016 Budget for citizens, http://mf.gov.md/sites/default/files/bugetul_pentru_cetateni_2016_0.pdf

Although the questionnaires data indicates a large diversification of the types of expenditures, in the end all of them are for the maintenance of the administrative apparatus and the personnel expenses such as salary and all compulsory payments related to it, the training costs, the necessary equipment for social workers workplace in the offices (Standard 9), the equipment to the social worker (Standard 8).

The funds for the social HBC service, which are covered from the local budget, do not include direct expenses, such as paramedical equipment, cash support etc. for the beneficiaries. These costs, in accordance with point 7 of the named Regulation, are covered by the beneficiary's means. Only some CSOs are covering such costs (especially CSOs that provide integrated HBC services).

It should be noted that the legislation obliges the local authorities to include the received donations and grants in the local budget and to spend the funds as foreseen in the Framework Regulation. In this sense, diversification of expenditure's types is limited to the list approved by the Regulation.

2.4. Medical HBC services

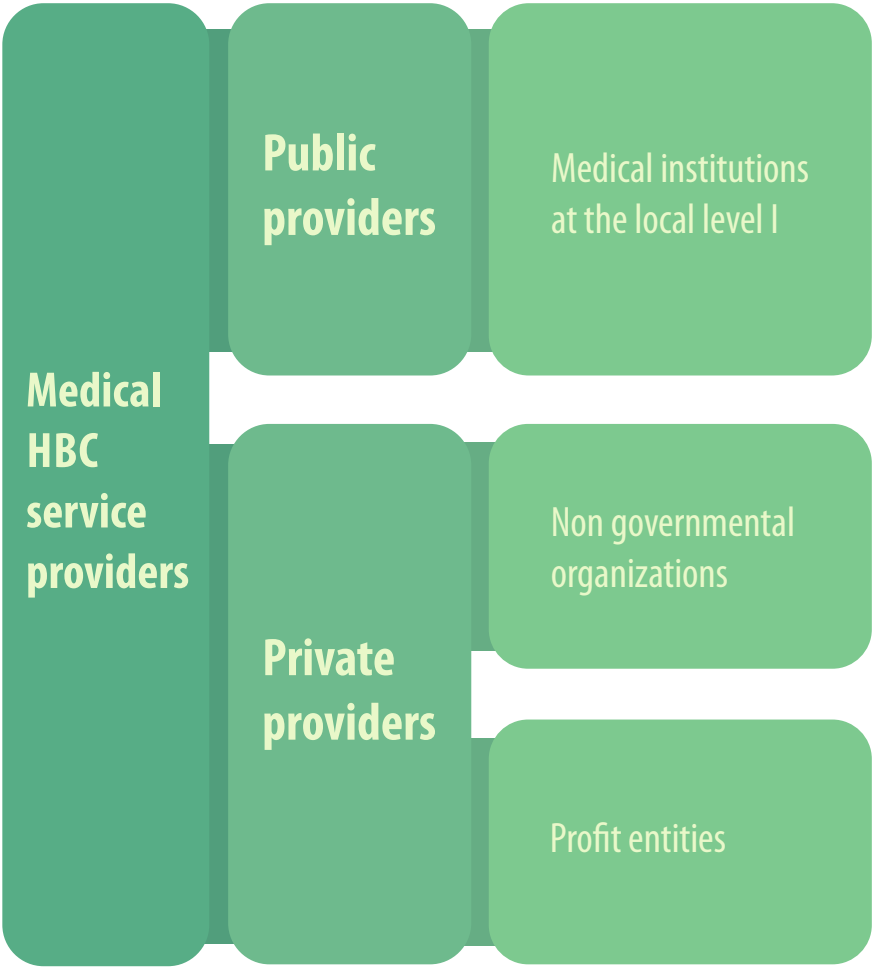
Providers of medical HBC services

Medical HBC service represents a public or private service provided, in accordance with the law in force, by a healthcare institution, irrespective of its type of ownership and legal form of organization, usually CSOs. The providers of medical HBC service are presented in Figure 5. The[32] purpose of medical HBC services is to provide the patient with qualified, dignified and appropriate care according to his individual needs, in order to stimulate the rehabilitation, maintenance and/or rehabilitation of the health condition and reduce the negative effects of the disease.

The public medical HBC service providers are mainly medical public institutions and a few private institutions. In 2017 NHIC contracted, for the provision of medical HBC services, 131 state medical[32] institutions and other 9 private institutions.

[32] For 2016 there is no data available about contracted providers, but only general one that constituted 7.74 mln MDL (370 521 Euro According to National Bank of RM exchange rate at 31.12.2016) contracted by providers.

Figure 5. **Medical HBC service**



Source: Author's analysis

Service organization and requirements

The medical HBC services are provided in case of an advanced chronic diseases (consequences of cerebral stroke, fractures of the femoral neck, etc.) and/or following major surgery, as recommended by the family doctor and profile specialist doctor from hospital and outpatient departments.

The health HBC services include the following medical procedures:

- monitoring temperature, blood pressure, respiration, pulse, urine and fasces output – in patients with cerebrovascular accidents, chronic cardio-circulatory failure and digestive tract, liver and pancreas pathology in the uncompensated period;
- care of wounds, bedsores, trophic ulcers, etc. (Further details about services provided will be given in the Chapter III).

The provision of medical HBC services is regulated by the Law on organization of medical HBC services of insured people, endorsed through the Order of the MH no.333 of 19.08.2008. Consequently, public and private providers contracting funds from NHIC render medical HBC services only for the insured people.

The staff involved in the provision of medical HBC services in public institutions (TMA and HC) include medical assistants employed by the medical institution only for the provision of these services or medical assistants already working in the institution who receive a salary supplement.

Private institutions (CSOs and LLC) that signed contracts with the NHIC on medical HBC services, work in 2 ways:

1. employ part-time medical assistant already working in public medical institutions (TMA and HC) from the localities they serve or

2. employ a full time medical assistant from their institution. In addition to this, private medical institutions hire doctors, social workers, drivers or other specialists to increase the quality of medical HBC service provided. In the case of public medical institutions, family doctor that provide consultations for medical HBC beneficiaries are not part of the service. Moreover, the CSOs, in order to increase the quality of services, with donor or client support, offer a wider range of drugs, para-medical products, limited not only to those provided by the Standards for Medical HBC Service.[33]

[33] Order no.851 of 29.07.2013 "On the approval of Medical Standards for HBC service".

Accreditation

All providers of medical HBC services contracted by the NHIC are accredited in compliance with the Law no.552 of 18.10.2001 on Health Assessment and Accreditation and the Standards for Assessment and Accreditation of medical HBC Service Providers. The providers are subject to evaluation and accreditation once in 5 years by the National Council for Health Assessment and Accreditation.

Financing

Medical HBC services are provided to insured persons by accredited institutions based on a contract with NHIC. Contracting medical HBC service follows the "per visit" principle. The evolution of costs "per visit" is presented in Table 1. Devices, one-use medical supplies and medicines are provided by the medical institution.

Table 1. **Changes in cost of medical HBC service per visit within the Unique Program of Compulsory Health Insurance,** *for 2008-2018*

Year of contracting providers of medical HBC by NHIC	Cost per Visit	No. of the normative act
2008	32.63 [34]	• Order no.180 of 30.04.2008 "Regarding the approval of the cost for an assisted case of medical home care for 2008" • Order no.342 of 22.08.2008 "Regarding the clarrification of the economic cost of an "assisted case" of medical home care for 2008" • Order no.1239/253 of 10.12.2012 "Regarding the approval of the Methodological Regulation of application of the Single Program of Compulsory Health Insurance"
2009	32.63 [35]	
2010	32.63 [36]	
2011	32.63 [37]	
2012	35.00 [38]	
2013	35.00 [39]	
2014	91.44 [40]	• Order no.1522 of 23.12.2013 " Regarding the endorsement of the cost of the medical home care visit"
2015	91.44 [41]	
2016	91.44 [42]	
2017	131.59 [43]	• Order 66 of 31.01.2017 "Regarding the endorsement of the cost of the medical home care visit
2018	137.25 [44]	• Order no.1035 of 20.12.2017 "Regarding the endorsement of the medical home care visit"

[34] 2.21 Euro According to National Bank of RM exchange rate at 31.12.2008
[35] 1.85 Euro According to National Bank of RM exchange rate at 31.12.2009
[36] 2.03 Euro According to National Bank of RM exchange rate at 31.12.2010
[37] 2.16 Euro According to National Bank of RM exchange rate at 31.12.2011
[38] 2.19 Euro According to National Bank of RM exchange rate at 31.12.2012
[39] 1.95 Euro According to National Bank of RM exchange rate at 31.12.2013
[40] 4.81 Euro According to National Bank of RM exchange rate at 31.12.2014
[41] 4.26 Euro According to National Bank of RM exchange rate at 31.12.2015
[42] 4.38 Euro According to National Bank of RM exchange rate at 31.12.2016
[43] 6.45 Euro According to National Bank of RM exchange rate at 31.12.2017
[44] 6.72 Euro According to National Bank of RM exchange rate at 01.01.2018

The provision of medical HBC services contracted to NHIC is limited in time and includes 36 visits (or 72 visits in special cases). Most often, according to the data provided by medical HBC providers, the visits per beneficiary are consummated in 3 months (36 visits) or 6 months (72 visits), after which the services are ceased. This causes problems for both, the beneficiary and the provider in the case of people requiring permanent or long-term care. Certain medical institutions, in order to avoid the suspension of services, choose to visit beneficiaries less frequently, so that they can benefit from services for a longer period of time.

After implementation of the Compulsory Health Insurance Fund (CHIF), the public health expenditures increased about 5 times, from 1 105.2 million MDL in 2003, up to 5 764.2 million MDL in 2016, and make up 13.2% of the total national public budget of the RM. In the[45] recent years,[46] public health expenditures referred to the GDP decrease slightly exceeding 4.2%. The CHIF funds make up 80.9% of public expenditures for the health system. More than 56.4% (3 251.4 million MDL) from the funds collected are own revenues and 43.6% (2 512.7 million MDL) are transfers from the state budget.

The budget for medical HBC services represents only 0.2% from the total expenditures of the Main Fund which is a very small amount in comparison with spending from other[47] type of healthcare. More details are presented in the Chapter V.

The medical HBC services provided by CSOs are using two modalities:

1. The contracting of the NHIC visits and following the same rules that the public providers. CSOs contracting medical HBC services from NHIC, as well as public service providers are obliged to be accredited for medical HBC services.

2. Offering medical HBC services from the funds they receive from international donors, from individuals and businesses, or from different different fundraising campaigns.

[45] 66 878 055 Euro According to National Bank of RM exchange rate at 31.12.2003
[46] 275 937 672 Euro According to National Bank of RM exchange rate at 31.12.2016
[47] Main Fund is one out of 5 funds in the Compulsory Health Insurance Funds (CHIF).

Beneficiaries may be: (i) persons who are not eligible to NHIC funds (do not have medical insurance, etc.), (ii) persons who need long-term care, and initially received medical HBC services from NHIC fund, and on expiry of visits they receive HBC from other funds, (iii) people who receive medical HBC from NHIC fund, but they need more support that cannot be provided from NHIC fund (single-use diapers, expensive medicine and complex procedures). Donor funds sometimes come to support the purchase of equipment that can increase the quality of medical HBC service that the CSO is contracting from NHIC. In this case the CSOs have more flexibility in spending funds. Anyway the procedures are established in the mutual contracts with donors and in internal regulations of activities.

2.5. Integrated HBC services

There are no legal provisions regarding the integrated HBC services, neither standards. However, certain service providers, especially the CSOs, but also some public institutions, operate within this notion. Integrated services provide, as per particular needs, both social and medical HBC services or 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 (further details on integrated services see in Chapter III).

2.6. Suggestions and recommendations to Chapter II

At present, there is no normative framework on integrated social and medical HBC services in the RM, standards of quality and criteria for accrediting providers of such services.

Although the Law on social services has important provisions on contracting social services, the practice of contracting social services from private service providers is very poorly developed. The provision of services by the private sector is discouraged. This is explained by the lack of a regulatory framework to ensure putting in place the contracting mechanism, as well as the methodology on the calculation of the cost of the social services.

There are certain obstacles and gaps in the clear separation of the competencies of the LPA of the 1st and 2nd level regarding the provision of social services, as well as their funding. The share of the local own revenues in the local budget is quite small, hindering LPA of the 1st level to develop/contract social services for those in need for such services in the locality.

Although there is a law on the accreditation of social service providers, until 01.01.2018 no provider of social HBC services has been subject to the accreditation.

The mechanism on contracting medical HBC is functional, as the NHIC contracts public and private service providers. There are no provisions on the distribution of the contract sums per providers. When contracting services, the number of the population, registered in the locality or living in the area covered by the provider, is not taken into account.

Recommendations based on the international experience:

RM should define the position of HBC services in the whole health and social system and the level of integration that should medical and social services achieve. HBC services should be placed as an intersection between the health care system and the social system or fully integrated. At this stage, it is necessary for the MHLSP to decide what organizational model would be chosen for the RM in the next decades as each of the models requires deeper reforms in other sphere of governance:

- **a model in which the "medical" component stays a part of the health care system and the "social" component of the social system (f. e. Czech Republic, Slovak Republic, Romania).** Under this model, two or more different state bodies create policies related to HBC. This generates sort of artificial administrative division between the social and medical HBC. Based on experience in Czech and Slovak Republics, in most cases integrated HBC services are delivered to beneficiaries anyway and mostly by the same provider organization (not by the same person). The administrative clearance runs afterwards on two separated lines, one for medical services (reimbursed by an insurance company) and one for social services (paid by the beneficiaries, municipalities or regions, state funds). Private providers of integrated HBC services who fully rely on beneficiaries' payments don't divide the accountancy of both services and provide the beneficiaries with one receipt for integrated social and medical services. Most of European countries follow a model of divided medical and social services with responsibility lying between ministries. The funds are gained through taxation, social insurance and health insurance funds.

- **a model in which social and medical services are almost fully integrated and provided within a single organization under responsibility of one institution, mostly municipalities (a "Scandinavian model" – f. e. Sweden, Finland, Norway)**. It is practically only Sweden, where there is only one integrated HBC scheme and one governmental unit responsible for policy making, as in Finland and Norway some regulations differ among state, regional and municipal responsibility. Scandinavian model of HBC services is dependent on system of taxes gained through municipalities – beside a national income tax (20-25% of income), tax payers contribute to local budget with another amount of 29 – 35% of their income to cover these expenses.

- In case of following any of this models, accreditation criteria for integrated social and medical services must be elaborated.

MAPPING OF THE EXISTING HOME CARE SOCIAL AND MEDICAL SERVICE PROVIDERS AND THE REAL NEEDS OF HBC SERVICES[49]

[49] Further on, the Mapping analysis will refer to the 84 providers of 23 ATUs that participated in the mapping assessment.

3.1. Characteristics of HBC service providers[50]

Legal status of providers

The mapping study reveals a wide range of HBC service providers according the organization and legal status: medical institutions, TUSA, CSOs, providers appointed by LPA (see Box 1), including profit entities (LLC). Most of the service providers are public institutions (medical institution, TUSA), followed by CSOs.

Box 1. HBC service provider appointed by LPA of the II level

"We have about 120 beneficiaries from different villages of the district. A beneficiary is accepted based on mayor's request, even if he/she has children. The record is being completed and the beneficiary is accepted into service. We have a mobile team that provides home cleaning, water supply, washing bed linen, cutting firewood and making the fire, including a warm lunch". (IIA_15_STAS)

Geographical coverage

From the perspective of the geographical coverage, most of the HBC service are provided at the community/first level (50), followed by those operating at the district (ATU)/second level (29), regional (2) and national providers (3). Thus, public medical institutions usually provide HBC at community level, TUSA - at the ATU level (except ATU Găgăuzia, where TUSA does not provide social HBC services, but the mayoralties), providers appointed by LPA at both, community level and ATU, profit entity at the district level.

The CSOs are diverse and operate in different geographical areas - starting with the community, ATU, regional and finishing with national coverage (Table 2).

Table 2. **HBC providers according to the geographical coverage, number**

Geographical area	Medical institutions	TUSA	CSO	Provider appointed by LPA	Profit entity
National	–	–	3	–	–
Regional	–	–	2	–	–
District / ATU	3	22[52]	4	1	1
Local	39	–	8	1	–
	42	**22**	**17**	**2**	**1**

[50] For some details see also Annex 2. Data about social and medical HBC services providers that participated in the assessment.

[51] There are 2 situations in this case: HBC service provider appointed by the LPA of the II level and the provider appointed by the LPA of the I level. Social workers from ATU Gagauzia are employed within the municipality, not the TUSA. The representative of LPA of the II level believes it is more correct that social HBC services is within TUSA ensuring in this way a methodological control and increasing social HBC quality.

Type of HBC providers

According the types of provided HBC, it was established that most of providers offer medical services, followed by those providing social services and only a few provide integrated services (Table 3). The CSOs, most often, provide integrated HBC services. However, some medical institutions and TUSA follow their example. The HBC services depend on the beneficiaries need and possibility of provider to respond to these needs.

Table 3. **Types of HBC providers, number**

Type of HBC services	Medical institutions	TUSA	CSO	Provider appointed by LPA	Profit entity
Social	–	20	9	1	–
Medical	38	–	1	–	1
Integrated	3	2	7	1	–
Total	**42**	**22**	**17**	**2**	**1**

HBC services for free or for a fee

According to HBC service for free or for a fee, out of the 84 service providers, 74 render free HBC services, 3 from 74 providers render HBC services for free and for a fee (see Box 2), while 10 providers offer only co-paid services (Table 4).

Box 2. Social HBC services provided for a fee by the public institution

"We took into account people's needs. Individuals or their children were addressing. We have established social HBC cost according to budget approved for the current financial year. The budget of the service was divided to the number of beneficiaries. Respectively, the resulted price is the one we perceive". (IIA_16_STAS)

Table 4. **HBC service providers ensuring services for free or for a fee, number**

Type of HBC services	Free services	Co-paid services	Paid services
Medical institutions	42	-	-
TUSA	22	-	3
CSO	7	10	-
Provider appointed by LPA	2	-	-
Profit entities	1	-	-
Total	**74**	**10**	**3**

[52] 20 at the ATU level + 1 in the municipality of Chisinau + 1 in the municipality of Balti.
[53] An amount is paid by the beneficiary, a part by – LPA and the rest by – CSO "CASMED" or an amount is paid by the beneficiary and the rest by different CSOs.

Number of beneficiaries per provider

The number of service beneficiaries differs from one provider to another, including from one type of service to another. Thus, the research data reveal that medical institutions provide services to a minimum of 2 persons (HC from rural areas) to maximum - 107[1] persons (20 beneficiaries on average). The number of CSOs' beneficiaries is much higher, from at least 8 persons to maximum 2100 (472 beneficiaries on average). TUSA registered the highest number of beneficiaries, from a minimum of 298 persons to 2171 persons (636 beneficiaries on average) (see Table 5).

Table 5.

The number of beneficiaries per HBC providers, *number*[54]

	Medical institutions	TUSA	CSO
Mean	**20**	**636**	**472**
Median[55]	**10**	**522**	**142**
Mode[56]	**5**	**412**	**44**
Minimum	**2**	**298**	**8**
Maximum	**107**	**2171**	**2100**

The period of HBC services delivery

Almost every 4th institution[57] of those 84 participating in assessment, asserted that they have restrictions in providing HBC services.[58] Most restrictions were mentioned by medical institutions, followed by TUSA and CSOs. Medical institutions have contracted an exact number of

[55] Service providers appointed by LPAs and businesses will not be assessed, due to their small number. The LLC provided services in 2016 to 101 persons. The service provider appointed by LPA that operates in the district, provided services to 110 in 2016, while that working in the community – to 58 persons.

[56] The **median** is the value separating the higher half of a data simple, from the lower half. For a data set, it may be thought of as the "middle" value.

[57] The **mode** of a set of data values is the value that appears most often.

22 institutions.

[58] There are restrictions regarding free services.

visits – 36 visits per beneficiary (72 visits in special cases), visits exceeding this number are not paid. Some CSOs also have to provide services to beneficiaries in rotation (once every 3 or 6 months) at the donor's request or according to their own regulations. Maintaining a fixed period for HBC service provision is targeted to serve much more beneficiaries requiring HBC services. The number of those in need is high and still growing, triggered by the ageing of the population (the national ageing index in 1980 was 10.7%, while in 2017 it reached 17.2%).[59]

Service providers revealed both, **advantages and disadvantages of a fixed period for service** provision to both, providers and beneficiaries (see Table 6). Based on some arguments, certain CSOs manage to get the opportunity to extend the provision of HBC services. As arguments serve: (i) lack of a positive evolution or worsening of the beneficiary's health, (ii) beneficiary's impossibility to take care of himself, (iii) people of the waiting list are less disadvantaged. The possibility of extending the period of HBC provision may be negotiated for private providers or in the case of partially paid services.

Table 6.

Advantages and disadvantages of a fixed period for service provision

Advantages for institution	Advantages for beneficiaries
• Big number of beneficiaries, • Rigorous planning and well-established individual plan, • High level of specialist's responsibility to provide quality services for a period, • Development of intersectoral collaboration, • Do not develop dependence.	• Improvement of health condition in a short time, • Motivation of the beneficiary, including the family, • Social inclusion, • Prevention of institutionalization.
Disadvantages for institution	**Disadvantages for beneficiaries**
• In 36 visits / 6 months, the complete improvement of the situation is not achieved, • Increased workloads for specialists, • Job burnout, • Conflicts with the beneficiaries.	• Worsening of the health condition, • Isolation, marginalization, loss of hope in a bright tomorrow.

[59] Official data of NBS.

3.2. HBC service models

The assessment revealed various models of HBC service provision. Within each type of HBC service (medical, social, integrated), several models were identified based on 12 main criteria: (i) type of provided service, (ii) legal form of organization of the provider, (iii) human resources involved in the provision of services, (iv) working mode of the provision of HBC services, (v) type of beneficiaries, (vi) criteria for admission to service, (vii) duration of service provision, (viii) area of service delivery (ix) cost of the service paid by the beneficiary, (x) financing the service, (xi) conditions of accreditation, (xii) partnerships established with other authorities/institutions/organizations.

Social HBC models

The models of social HBC services have in common only the development of partnerships and, with few exceptions, the working hours. Social models are designed to complement each other (see Table 7) which is a major advantage. Thus, local private providers, or even the public ones, target vulnerable beneficiaries that do not meet the criteria of the Government Decision no.1034 of 31.12.2014.

The strong points of the **model A-social** consist provision of funding from the LPA budget and the presence of social workers in almost all localities from the RM. The weak points of the model lie in the fact that vulnerable people requiring HBC are not admitted to services if they do not meet the provisions of the Government Decision no. 1034. The opportunity of this model is the development of services provided for a fee that could be delivered to beneficiaries with a better financial situation but still requiring such services.

Model B-social and C-social are designed to complement the gaps of the model A, through undertaking certain responsibilities by LPA (model C) or by assigning responsibilities to both, LPA and beneficiaries (model B).

Model D-social exists only in the ATU Gagauzia and is the archaic model from the Soviet Union period. The gaps of this model lie in the fact that social workers employed by LPA of the 1st level are not part of a service evaluation and monitoring system.

Table 7.

Models of social HBC services delivery

Criteria for differentiation	Model A of social HBC services	Model B of social HBC services	Model C of social HBC services	Model D of social HBC services
Type of provided service	**Social HBC services**			
Form of organization	Public	Private (CSOs)	Public	Public
Human resources	Head of the service, Social workers	Head of the service, Social assistant, Social workers	Social workers	Head of the service, social workers
Working mode	8 hours per day, on Saturdays and Sundays at request	8 hours per day 5 days a week	8 hours per day 5 days a week	8 hours per day 5 days a week
Type of beneficiaries	Categories enlisted in the pt. 11 and 12 of the Regulatory Framework on Home based Social Care Services, Government Decision no.1034	Categories enlisted in the pt. 11 and 12 of the Regulatory Framework on Home based Social Care Services, Government Decision no.1034, vulnerable people that have not reached the retirement age	Vulnerable people that have reached the retirement age	Categories enlisted in the pt. 11 of the Regulatory Framework on Home based Social Care Services, Government Decision no.1034
Criteria for admission to service	Based on the eligibility criteria for care services and the results of the assessment of applicant's care needs	Based on the eligibility criteria for care services and the results of the assessment of applicant's care needs. Referral mechanism applied by TUSA, LPA, other relevant institutions. Beneficiary's own request or request from his/her representative	Request from LPA	Request from LPA
The duration of service provision	Till the decease, improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	3-6 months, till the improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	Till the decease, improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	Till the decease, improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible
Area of service delivery	ATU	Local	ATU	Local
Cost of the service paid by the beneficiary	Free of charge For a fee	Free of charge. Symbolic co-payment of the cost of the service	Free of charge	Free of charge
Financing the service	Entirely from the 2nd level local budget for services provider free of charge or from own sources (Full payment of services by the beneficiary/relatives)	Multiple funding: non-reimbursable external funds, donation and sponsorship, of the 1st level local budget, co-payment from beneficiaries	Entirely from the 2nd level local budget	Entirely from the 1st level local budget
Manner and conditions of accreditation	The service is not accredited	The service is not accredited	The service is not accredited	The service is not accredited
Partnerships established with other authorities/institutions/organizations	LPA, sometimes with CSOs	LPA, CSOs, TUSA, donors	LPA, TUSA, CSOs	-

Medical HBC models

Medical HBC models have much in common (see Table 8).

Model A-medical addresses the insured people, but does not allow all insured people to benefit from such services (the evaluation study outcomes show that not all medical institutions contract medical HBC services from NHIC). It can be explained by the small number of visits offered to medical institutions from rural areas and the low cost of a visit reimbursed by the NHIC (further details on the cost and reimbursement are provided in the Chapter VI).

Model B-medical is a successful one, both, from the perspective of the working schedule – 7 hours per day but also from the perspective it meets the beneficiaries' needs. This model aims to provide services to the large majority of insured beneficiaries from the TAU.

Model C-medical has as advantage the opportunity to access the service – 7 hours per day, admission to services of uninsured people, people without identity documents, multiple funding (NHIC, donors, LPA), including the empowerment of beneficiaries to come up with a symbolic co-payment, possibility to provide services for a period of time up to one year.

Model D-medical differs from model **C-medical** in the absence of the symbolic co-payment from the beneficiaries' side.

Model E-medical differs from **models C-medical** and **D-medical** in the existence of funding exclusively from the NHIC, provision of services for 36/72 visits, limited collaboration with authorities.

Table 8.

Models of medical HBC services delivery

Criteria for differentiation	Model A of social HBC services	Model B of social HBC services	Model C of social HBC services	Model D of social HBC services	Model E of social HBC services
Type of provided service	**Medical HBC services**				
Form of organization	Public	Private (business entity)	Private (CSO)	Private (CSO)	Private (CSO)
Human resources	Doctors, medical assistants	Doctor, medical assistants	Doctor, medical assistants	Doctor, medical assistants	Doctor, medical assistants
Working mode	Differ from 2/4 hours to 7 hours per day or a few hours 2-3 days a week	7 hours per day, on Saturdays and Sundays at request	7 hours per day, at request	7 hours per day, at request	7 hours per day, at request
Type of beneficiaries	Insured people	Insured people	Insured people, uninsured people, without identity documents inclusively	Insured people, uninsured people, without identity documents inclusively	Insured people
Criteria for admission to service	Family doctor's recommenda-tion written in the patient's medical record	Referral form (form no. 027/e) from the family doctor or specialist	Referral form (form no. 027/e) from the family doctor, specialist, doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request	Referral form (form no. 027/e) from the family doctor, specialist, doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request	Referral form (form no. 027/e) from the family doctor, specialist, LPA
The duration of service provision	36 visits, sometimes 72 visits	36 visits, sometimes 72 visits	36 visits, sometimes 72 visits contracted from the NHIC. Up to 365 visits per year, depending on the current financial resources of the provider (donations, sponsorship, co-financing)	36 visits, sometimes 72 visits contracted from the NHIC. Up to 365 visits per year, depending on the current financial resources of the provider (donations, sponsorship)	36 visits, sometimes 72 visits Local Free of charge Contract with NHIC
Area of service delivery	Local	ATU	Regional (more ATUs)	Regional (more ATUs)	Accreditation certificate valid for 5 years, issued by the National Council for Health Assessment and Accreditation
Cost of the service paid by the beneficiary	Free of charge	Free of charge	Free of charge, a symbolic co-payment of the cost of the service	Free of charge	Medical institutions, LPAs, CSOs
Financing the service	Contract with NHIC	Contract with NHIC	Multiple funding: contract with NHIC, non-reimbursable external funds, donation and sponsorship, symbolic co-payment from the beneficiary's side	Multiple funding: contract with NHIC, non-reimbursable external funds, donation and sponsorship	
Manner and conditions of accreditation	Accreditation certificate valid for 5 years, issued by the National Council for Health Assessment and Accreditation	Accreditation certificate valid for 5 years, issued by the National Council for Health Assessment and Accreditation	Accreditation certificate valid for 5 years, issued by the National Council for Health Assessment and Accreditation	Accreditation certificate valid for 5 years, issued by the National Council for Health Assessment and Accreditation	
Partnerships established with other authorities/institutions/organizations	No	Medical institutions	Medical institutions, LPAs, CSOs, religious missions, churches	Medical institutions, LPAs, CSOs, religious missions, churches	

Integrated HBC models

The integrated models meet a wider variety of needs (social, medical) through the presence of a diverse team of professionals. They provide services 8/24 hours per day, 5/7 days a weeks and focus on the establishment of partnerships in the community, ATU, region or national (see Table 9). The development of these models has been possible due to funding from international donor agencies. All models address the vulnerable categories of beneficiaries, besides the referral from the family doctor and/or the specialist, they also have referral from the LPA, churches, religious missions. It is important that 3 of the 4 models of the integrated HBC services are accredited to provide medical services and contract medical visits from NHIC. Not less important is the fact that the 3 models render services for a period of 3 months (with the possibility to extend it up to 6 or 1 year), which enables a rotation of the beneficiaries and delivery of services to a larger number of people requiring these services.

In the favor of the integrated models are also the ways of fund allocation as well as the cost of the provision of services, which is lower, compared to the delivery of two separate components (see details in Chapter VI).

Peculiarities of the **model A-integrated** – consists in the team of medical experts providing a limited range of social services. The services are delivered most often at the community level, sometimes in several villages from the ATU.

Model B-integrated implies a team of social workers and medical assistants, providing services in ATU, but has no accreditation for the medical services rendered, respectively has no financing from NHIC, relying exclusively on the non-reimbursable external funds. This model stands out by offering the widest range of social services. We also point out that services are provided for an unlimited period of time.

Model C-integrated implies a larger team of experts if compared to **models A and B-integrated**, based on the financial participation of LPA for the provision of services, including on a contribution from the beneficiary and renders regionally-based services (in more ATUs).

Model D-integrated implies the largest team of specialists (medical assistant, jurist, psychologist) providing services regionally (in more ATUs).

Table 9.

Models of integrated HBC service delivery

Criteria for differentiation	Model A of social HBC services	Model B of social HBC services	Model C of social HBC services	Model D of social HBC services
Type of provided service	**Integrated HBC services**			
Form of organization	Private (CSOs)	Private (CSOs)	Private (CSOs)	Private (CSOs)
Human resources	Doctor, medical assistants	Social workers, medical assistants	Doctor, medical assistants, social workers	Medical assistants, social workers, psychologist, jurist
Working mode	7 hours per day 5 days a week	7-8 hours per day 5 days a week	7-8 hours per day 5 days a week	7-8 hours per day 5 days a week
Type of beneficiaries	Insured people, uninsured people	Uninsured people, including without identity documents, vulnerable people that have not reached the retirement age	Insured people, uninsured people, including without identity documents, vulnerable people that have not reached the retirement age	Insured people, uninsured people, including without identity documents, vulnerable people that have reached the retirement age
Criteria for admission to service	Referral form (form no. 027/e) from the family doctor, specialist, doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request	Based on the eligibility criteria for care services and the results of the assessment of applicant's care needs. Referral mechanism applied by TUSA, LPA, other relevant institutions. Beneficiary's own request or request from his/her representative	Referral form (form no. 027/e) from the family doctor, specialist, doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request. Based on the eligibility criteria for care services and the results of the assessment of applicant's care needs. Referral mechanism applied by TUSA, LPA, other relevant institutions. Beneficiary's own request or request from his/her representative	Referral form (form no. 027/e) from the family doctor, specialist, doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request. Based on the eligibility criteria for care services and the results of the assessment of applicant's care needs. Referral mechanism applied by TUSA, LPA, other relevant institutions. Beneficiary's own request or request from his/her representative
The duration of service provision	3-12 months till the improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	Unlimited	3-6 months till the improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	3-6 months, till the improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible
Area of service delivery	Local / ATU	ATU	Regional (more ATUs)	Regional (more ATUs)
Cost of the service paid by the beneficiary	Free of charge	Free of charge	Free of charge, symbolic co-payment of the cost of the service	Free of charge
Financing the service	NHIC, non-reimbursable external funds	Non-reimbursable external funds, donation and sponsorship	Multiple funding: NHIC non-reimbursable external funds, donation and sponsorship, 1st level local budget, co-payment from the beneficiary	NHIC, non-reimbursable external funds, donation and sponsorship
Manner and conditions of accreditation	Accreditation certificate valid for 5 years, issued by the National Council for Health Assessment and Accreditation	Is not accredited	Accreditation certificate valid for 5 years, issued by the National Council for Health Assessment and Accreditation	Accreditation certificate valid for 5 years, issued by the National Council for Health Assessment and Accreditation
Partnerships established with other authorities/institutions/organizations	NHIC, LPA, medical institutions, TUSA, donors	TUSA, LPA, CSOs, medical institutions	LPA, TUSA, CSOs, NHIC, medical institutions, donors, etc.	LPA, TUSA, CSOs, NHIC, medical institutions, donors, etc.

3.3. Geographical coverage of HBC services

Geographical coverage of social HBC services

From the geographic perspective the analysis reveals national coverage with social HBC of elderly people officially registered single and people with disabilities without support from children, extended family and other people (friends, relatives, neighbors), with the exception of very small villages. TUSA from all ATUs try to provide social HBC services in every village according to the normative documents in force.

Authorities from one ATU have developed social HBC for people requiring this type of services but people cannot receive it as they do not meet the requirements of the Government Decision no. 1034.

Geographical coverage of medical HBC services

Medical HBC are distributed non-uniformly. For example, in 2017[60] NHIC contracted 131 state medical institutions (Territorial Medical Associations (TMA) (5), Health Centers (HC) (126) of 258 public health institutions and other 9 private institutions (6 CSOs, including 2 religious organizations and 1 LLC).

In general, just half (51%) of public health institutions were contracted for the provision of medical HBC services, when speaking about the geographical coverage, there are ATU covered by more providers and ATU served only by one or no one.

The number of contracted visits groups the medical HBC service providers into 4 categories (see Table 10).

Table 10.

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 Centers	Mostly from rural areas
From 300 to 999 visits	25	20 Health Centers 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

[60] For 2016 there is no data available about contracted providers, but only general one that constituted 7.74 mln. MDL (≈380 000 EURO).

These data reveal that there are no well-defined criteria for contracting a certain number of visits for medical HBC services. The number of people is not taken into account when contracting service providers thus leading to discrepancies. For example, of the total amount of funds allotted for medical HBC in 2017, about 35% are given to the municipality of Balti, and only 10% to the municipality of Chisinau which is 5 times bigger when speaking about the population than Balti[61] and other 55% to the rest of localities of the RM. The fact that the municipality of Balti representing 5% of the total population of the RM absorbs about 35% of the funds denotes that (i) there are people requiring medical HBC services, (ii) the lack of a mechanism to ensure the coverage with medical HBC services, (iii) medical institutions are not encouraged to sign contracts with the NHIC on medical HBC services or (iv) the current cost covered by the NHIC discourages potential medical HBC providers.

The geographic distribution of private HBC service providers (CSOs and LLC), is also not homogeneous. The distribution is frequently determined by LPA's readiness to collaborate with CSOs in developing HBC.

[61] Data provided by the National Bureau of Statistics (NBS). Number of population on January 01, 2017.

3.4. Admittance of beneficiaries to HBC service

Admission to social services provided by TUSA

TUSA provide social HBC services according to the Government Decision no.1034. The mapping reveals that admission to social HBC services is done based on referral from LPA or beneficiary's own request, referral from CSOs, medical institutions or CPA. The social worker is in charge with completing the needs assessment form, calls the doctor if necessary, who based on beneficiary's health condition, writes the recommendations in the record but also municipality's representative who provides information about the family of the beneficiary. The beneficiary's record is submitted for approval to the Multidisciplinary Commission on the Protection of Rights of People in Difficulty or with Disabilities aged over 18. Based on the assessment results, the Commission issues a decision on admission or refusal to benefit from HBC services, establishing if the applicant will benefit from free services. The applicant receives a written notification about the decision, within 5 working days from the date of issue. Service providers mentioned the following criteria to benefit from free services: (i) lack of children/support from children, (ii) disabled people, (iii) retirees, (iv) recommendation from the multidisciplinary team. However, the syntagma "lack of children/support from children" stipulated in the law is actually interpreted mainly as childless. Certain public institutions require certificates proving the person does not have caregivers or any inheritance.

Admission to medical services provided by medical institutions (public and private)

All accredited public and private providers offer medical HBC services to beneficiaries in accordance with the Regulation and Standards related to medical HBC. The research data reveal that the admission to medical HBC beneficiaries most often is done based on the referral from the medical institution (family doctor, specialized doctor from hospital/health center), and rarely based on people's own request. The person has to meet a certain 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 public or private providers.

In the case of LLC, the referral to benefit from medical HBC is strictly from medical institutions (family doctor, specialized doctor from hospital/health center). The admission to CSO provider is done by referral from the medical institution (family doctor, specialized doctor from hospital/health center), but they also ask a referral from LPAs.

Admission to services provided by CSOs

The admission to HBC within the CSO is based on specific criteria of donors. The basic request from donors is to include the most vulnerable in HBC service. The admission is done: at the beneficiary's own request, referral from LPA, TUSA, medical institutions, other CSOs, churches, religious missions. Usually, individuals are accepted based on certificates from TUSA, LPA (wage/pension, family composition), medical institution (referral from family doctor/specialized doctor from hospital/health center), without infectious or mental illness. CSOs offer services for a broader range of beneficiaries: retirees with or without disabilities, single elderly with health issues, people requiring long-term medical care, people with a poor social and economic situation unable to meet their needs, people experiencing inability for self-care, people without ID documents etc.

3.5. Characteristics of HBC beneficiaries

Categories of beneficiaries' dependency

Currently, in the RM, the beneficiaries of medical, social or integrated HBC are not divided into any categories depending on their needs and beneficiary's movement ability. Within the mapping assessment, it was proposed to divide beneficiaries into 4 categories. The method of distribution of beneficiaries into these categories is based on the perception[62] of the providers that participated in the assessment.

Table 11. **Categories of beneficiary dependency**

Group "I"	Relatively healthy people who most often do not have social problems but require short-term home care (patients recovering after fractures, trauma, or surgery).
Group "II"	Relatively healthy people who have slight deviations and / or limited social opportunities. Members of this group are mentally (psychologically) healthy and physically healthy and / or disabled people who have difficult living conditions and have social needs due to social factors. Their self-care skills, social capabilities are almost completely preserved. The need for care is due to age and occurs as needed. People in this group do not have serious physical or mental disorders. In principle, they need psychosocial support, support in everyday life to improve their quality of life.
Group "III"	People with health problems and requiring partial / non-attendant care. They have partially preserved their locomotor autonomy, but require daily help for some daily basic activities. People of this group cannot stand up by themselves, or they do that with great difficulty, but once raised they can move around in the house or into the yard, requiring partial help for some certain daily basic activities. They move especially with the stick or other equipment.
Group "IV"	Elderly people with health problems and disabled, largely bedridden. Due to age and disease, these people are mostly limited to all forms of life and need permanent care. It is difficult for them to use objects from daily life, they need customized equipment and require help from a third party. Their social skills, communication, self-care skills and ability to control their own behavior are practically limited. People in this group need care and supervision, development and rehabilitation of social, life and communication skills

[62] In accordance with the description provided but it should be taken into account when drafting regulatory framework related to HBC services as the needs of these beneficiaries are quite different.

Number of medical HBC beneficiaries

Collected data reveals differences in each type of HBC service depending on providers. Public medical institutions operate locally and cover from 1 to 4-5 villages in the case of rural areas and 1 town in the case of those operating in urban areas. Consequently, one medical institution provides services (36 visits/72 visits rarely), on average to 12 beneficiaries of the category III, 11 of the category IV, 4 category I and 4 category II during a year (see Table 12).

The LLC provided services in 2016 to 101 beneficiaries (81 beneficiaries of the category III and 20 beneficiaries of the category IV).

Table 12. **Number of beneficiaries of medical HBC services registered with public medical institution according to their category, number**

	Category I	Category II	Category III	Category IV
Mean	4	4	12	11
Median	2	3	7	5
Mode	2	1	2	2
Minimum	1	1	1	2
Maximum	18	8	56	51

Number of TUSA HBC beneficiaries

On average, **one TUSA provides services to 452 beneficiary of the category II, 215 of the category III, 36 of the category IV and 30 of the category I** (see Table 13).

Table 13. **Number of beneficiaries of social HBC registered with TUSA according to the their category, number**

	Category I	Category II	Category III	Category IV
Mean	30	452	215	36
Median	16	404	205	28
Mode	11	44	24	18
Minimum	11	44	24	4
Maximum	59	1539	500	87

Number of CSOs HBC beneficiaries

CSOs provide HBC services to people that do not benefit from such kind of services from public providers (medical institutions or TUSA). Some CSOs operate at the national level, some at regional, the biggest part at the community level.

On average, **one CSO provides services to 266 beneficiaries of the category III, 171 beneficiaries of the category IV, 61 beneficiaries of the category II and 38 beneficiaries of the category I** (see Table 14).

Table 14.
Number of HBC beneficiaries of CSOs according to their category, number

	Category I	Category II	Category III	Category IV
Mean	38	61	266	171
Median	45	24	45	30
Mode	7	20	8	8
Minimum	7	17	8	8
Maximum	68	257	1259	936

Socio-demographic characteristics of the beneficiaries

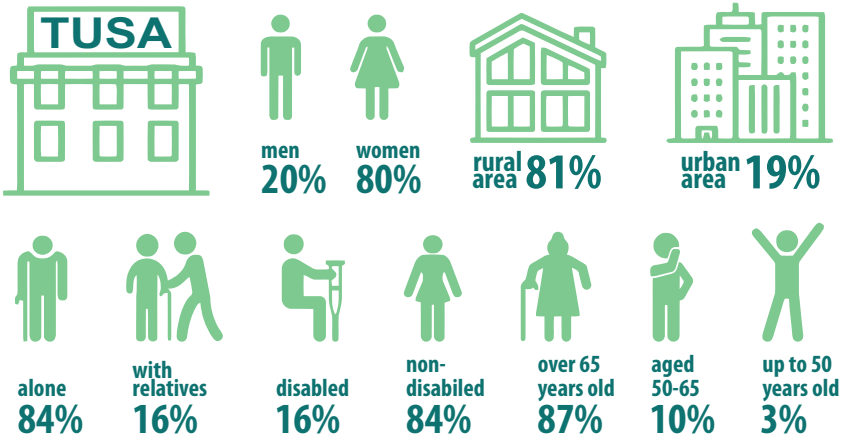
Information given by HBC service providers participating in the research, allows us to highlight the **general socio-demographic characteristics of the beneficiaries**. Thus, there is a prevalence of **female beneficiaries**[63] (78% women compared to 22% men), **from rural areas**[64] (78% from rural areas compared to 22% from urban areas), **living alone** (74% live alone, compared to 24% that live with the partner, children or other relatives), **without disability** (83% without disability compared to 17% that have a degree of disability), **aged over 65** (79% are over 65 years old, 18% - aged 50-65 and 3% - up to 50 years old).

Still, there are differences in the **characteristics of the beneficiaries** from one type of provider to another, determined by the **peculiarities of institutions providing services and the normative documents**.

Most of TUSA's beneficiaries are women, lonely people and those living in the rural areas (see Figure 6).

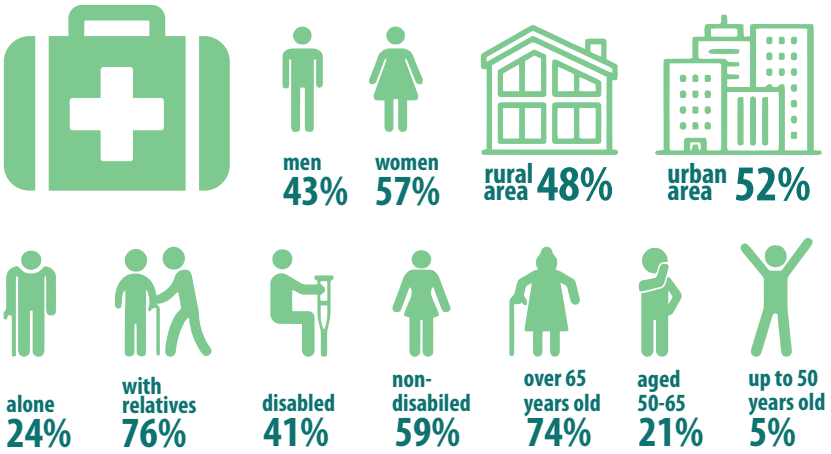
[63] The prevalence of women is determined by a longer life expectancy. In 2016 in the RM, female life expectancy was of 76.2 years and male – 68.1 years.
[64] In 2016 in the RM, 42.7 of population lived in urban areas and 57.3 in rural areas.

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



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

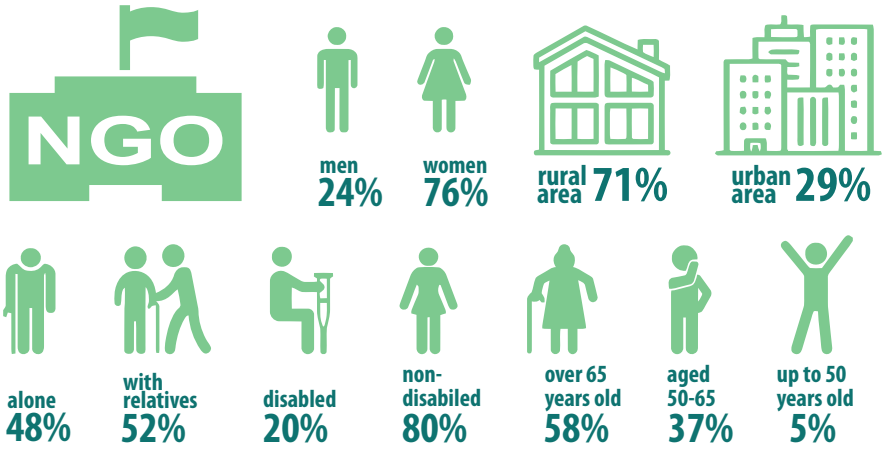
Figure 7.
Socio-demographic profile of beneficiaries of medical institutions



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

Figure 8.

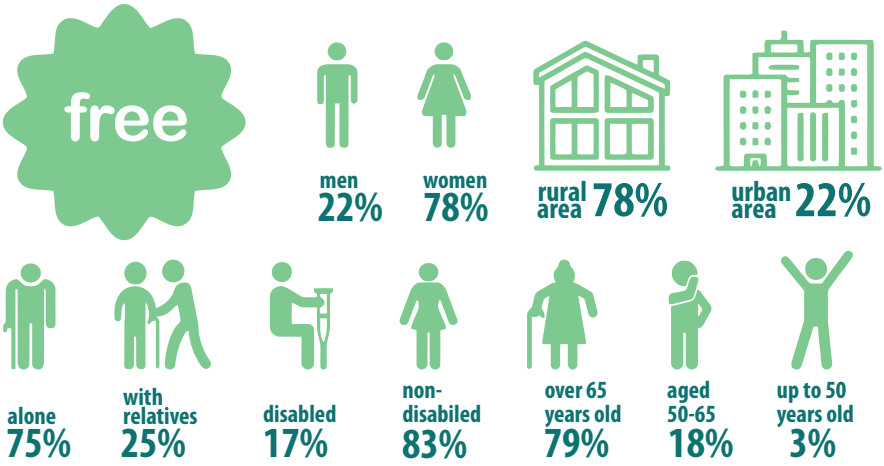
Socio-demographic profile of CSOs beneficiaries



The analysis of beneficiaries regarding the payment of HBC services reveals:

The beneficiaries of free HBC services are mostly the elderly, single women from rural areas (see Figure 9).

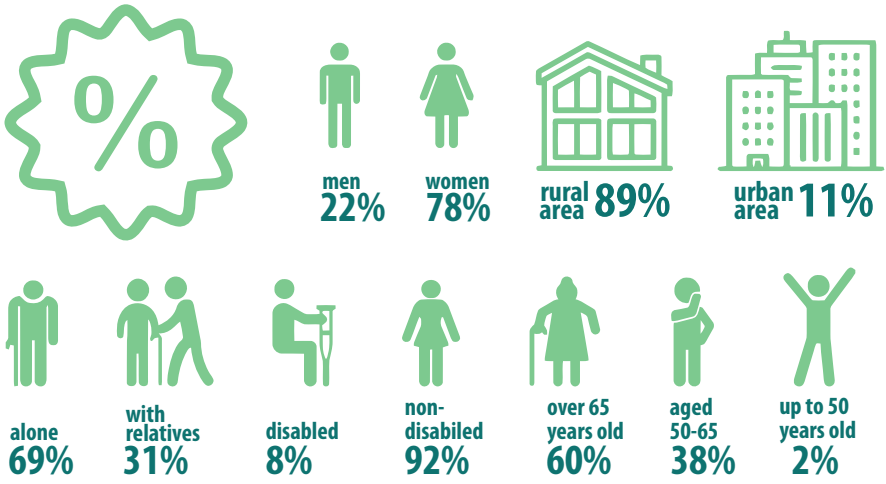
Figure 9. **Socio-demographic profile of beneficiaries who receive for free HBC services**



Co-paid HBC services are also available to vulnerable people aged up to 65 years old, living with others and without disability degree (see Figure 10).

Figure 10.

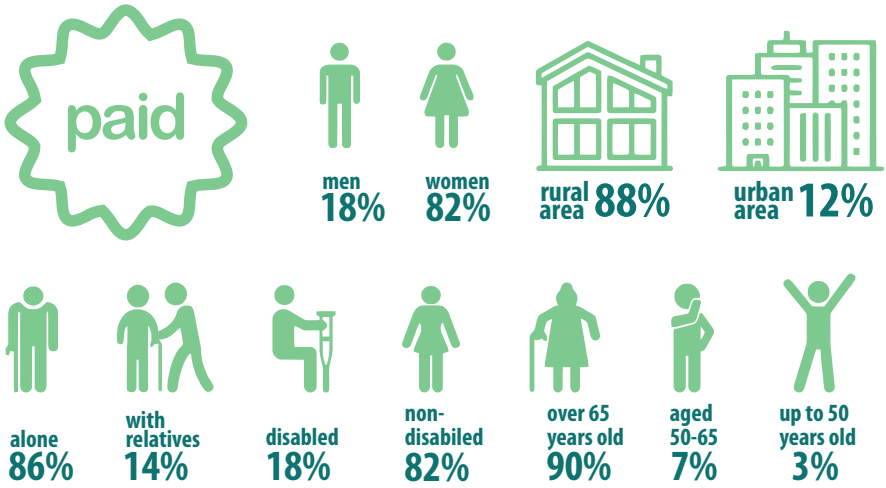
Socio-demographic profile of beneficiaries who receive for partially paid HBC services



The beneficiaries of paid HBC services are mostly women aged over 65, from rural areas, living alone, do not experience vulnerability but requiring help for certain activities (see Figure 11).

Figure 11.

Socio-demographic profile of beneficiaries who pay for HBC services



3.6. Evolution of HBC beneficiaries for 2014-2016

The analysis of the average number of HBC beneficiaries during 2014-2016 shows a slight decrease in the average number of beneficiaries per institution – from 298 beneficiaries in 2014 to 275 beneficiaries in 2015 and 273 in 2016 (see Table 10).

TUSA has the largest decrease in the number of beneficiaries (see explanation in Chapter II, 2.3). CSOs have a certain stability (except in 2015), and medical institutions, including LLC that participated at the assessment register an insignificant increase (see Table 15).

Table 15.

The average number of HBC beneficiaries per institutions participating in the research during 2014-2016

	2014	2015	2016
Total	**298**	**275**	**273**
Medical institutions	17	20	20
TUSA	708	690	652
CSOs	435	324	433
LLC	-	90	101

Taking into account the types of provided HBC services (medical, social, integrated), it was noticed a significant decrease in the average number of social services but also integrated services, and a slight increase in medical services in 2016 (see Table 16).

The data collected from medical HBC service providers reveal a slight increase in the number of beneficiaries of medical HBC – from 47 in 2014 to 65 in 2015 and 81 in 2016. On the other hand, as indicated in Chapter II, by increasing the amount of the medical HBC visit and maintaining the same budget in 2017, the number of medical HBC beneficiaries has significantly decreased.

The decrease in number of beneficiaries of integrated HBC services is explained by the reduction of the number of donors and their funds received by CSOs providing HBC services.

Table 16.

The average number of beneficiaries according to the type of HBC services (medical, social, integrated), during 2014-2016

	2014	2015	2016
Medical services	47	65	81
Social services	625	511	477
Integrated services	338	244	275

HBC service advertisement

TUSA promotes social HBC services, by informing the population with the help of community social worker, distributing leaflets, displaying HBC information on TUSA, municipality's information board, periodicals.

Medical institutions promote medical HBC by displaying the joint Order of the MH and NHIC in the medical institution and on the institution's web page, informing patients and their relatives about the provision of medical HBC services. However, some representatives of the medical institutions have pointed out that they do not advertise the services due to their improbability to provide services to all those who need it.

The CSOs promote their services on the web page as well as by orga-nizing information campaigns in the community, door-to-door cam-paigns, including various events organized. They are also distributing information booklets, writing newspaper articles.

3.7. Types of HBC and their subservices

Social HBC services

The current Framework Regulations of the social HBC Service include the next types of services: 1) counseling, 2) support under a very wide range of activities (cooking, delivery of warm lunches, buying food, household goods or medication etc.).[65] Or, there is currently no sub-service package and a costification formula.

The research analyzed the range of social HBC sub-services provided by various institutions. It was established that there are more than 44

[65] Government Decision no. 1034 of 31.12.2014, Annex 1, art.7.

social HBC sub-services. It was important to identify all the sub-services provided and the most requested ones according to the providers (see Table 17). The research outcomes ravel the voluntary work involvement of medical assistants from public institutions in charge with medical HBC in providing social HBC. The Table 17 shows the types of social sub-services provided by medical assistants. This situation indicates on the need for the development of the integrated services.

Table 17.

Types of provided social HBC, % of the total number of service providers[66]

Sub-Services of social HBC	TUSA (social worker)	CSO (medical assistant, social assistant, social worker or volunteer)	Medical institutions (medical assistant)
Ordinary house cleaning	**100**	**76.5**	-
Room heating	**100**	**58.8**	-
Taking water from the well	**100**	**70.6**	-
Accompanying on doctor visit/for a walk	**100**	**70.6**	7.1
Buying food, hygiene products, etc. from beneficiaries' financial means	**100**	**76.5**	2.4
Utility billing	**100**	**70.6**	4.8
Support in communication with public institutions	**95.5**	**82.4**	7.1
Support in preparing food	**95.5**	**76.5**	-
Help with household chores	**95.5**	64.7	-
Nail care	**95.5**	**70.6**	14.3
Partial bath	**90.9**	64.7	9.5
Changing bed linen	**90.9**	**76.5**	21.4
Communication with relatives and friends	**90.9**	58.8	14.3
Food delivery	86.4	35.3	-
General house cleaning	86.4	**70.6**	-
Help in gardening activities	86.4	58.8	-
Window cleaning	86.4	**76.5**	-
Dressing/ undressing	86.4	**70.6**	19.0
Canning	81.8	47.1	-
Brushing hair	81.8	**76.5**	7.1
Haircut	72.7	58.8	2.4
Help with setting the table	72.7	64.7	2.4
Counseling (social, psychological)	72.7	58.8	9.5
Washing bed linen in the washing machine	68.2	**76.5**	4.8
General bath	68.2	64.7	9.5
Involving the beneficiary in social and cultural activities	63.6	64.7	-
Shaving	59.1	58.8	4.8
Supervising the elderly/sick people	54.5	58.8	14.3
Hand washing of linen	50.0	58.8	4.8
Eye care	50.0	35.3	16.6
Changing single-use diapers (diapering)	45.5	41.7	21.4
Skin care	36.4	41.2	19.0
Oral cavity hygiene	31.8	35.3	16.7
Transportation	45.5	29.4	2.4
Delivery of bed sheets	40.9	**76.5**	2.4
Seating the elderly down, on a toilet seat	40.9	41.2	11.9
Ear care and cleaning	40.9	29.4	14.3
Ironing the linen	31.8	47.1	2.4
Putting the bedpan	27.3	47.1	21.4
Nose care	27.3	23.5	14.3

[66] The LLC does not provide social services, but exclusively medical HBC services.

Medical HBC services

The range of medical HBC services is described in the Annex 3 of the National Regulation on Medical HBC Services[67]and is more limited compared to social HBC (see Table 18). The assessment reveals that some of the TUSA social workers in charge with social services sometimes provide medical HBC. The Table 18 shows the types of medical sub-services provided by social workers. Some of the social workers providing medical services to the beneficiaries have medical education. Still, we underline, that according to the regulatory framework and professional standards, the social worker is not entitled to provide such services.

Table 18.
Types of medical HBC services provided, %

Sub-Services of medical HBC	Medical institutions (medical assistant)	CSO (medical assistant, social assistant, social worker or volunteer)	TUSA (social worker)
Measurement of basic physiological parameters	97.6	41.2	22.7
Healing of simple bedsores	97.6	41.2	13.6
Healing of multiple superinfected bedsores	97.6	41.2	-
The dosing of medication	95.2	41.2	9.1
Administration of medicines to mucous membranes	95.2	41.2	9.1
Nursing of infected wound	95.2	41.2	-
Nursing of simple wound	92.9	41.2	13.6
Checking blood glucose level	90.5	41.2	9.1
Oral medication administration	90.5	41.2	31.8
Caring for stoma	88.1	41.2	-
Subcutaneous medication administration	85.7	29.4	9.1
Help to change position	83.3	41.2	27.3
Making compresses	81.0	41.2	27.3
Training the patient on self-care techniques	81.0	41.2	9.1
Instilling eye, ear, nose drops	78.6	41.2	31.8
Therapeutic enema	78.6	35.3	4.5
Medical massage	78.6	41.2	22.7
Mobilizing totally dependent patient	73.8	41.2	4.5
Mobility exercises	71.4	41.2	9.1
Teaching relatives in nursing	66.7	35.3	4.5
Back massage	61.9	41.2	13.6
Leg massage	61.9	41.2	13.6
Hand and arm massage	61.9	41.2	13.6
Facilitation of movement, indoor/outdoor	59.6	41.2	13.6
Electro massage therapy	28.6	23.5	4.5
Physiotherapy	21.4	11.8	-

[67] 2013

3.8. Drafting the Individual Home Care Plan (IHCP)

Elaboration of the IHCP

In order to determine the needs of HBC services, the community social assistant convenes the members of the multidisciplinary local team (community social assistant, family doctor, social worker, LPA representative). The beneficiary participates to the need assessment exercise and development of IHCP, including the re-evaluation of needs and revision of IHCP. Certain services are performed together with the beneficiary (cooking, personal hygiene).

The type of medical HBC services for each beneficiary is established according to the Medical record filled in by the family doctor and the specialist according to the National Regulation for medical HBC Service. Based on this, the IHCP is being developed.

Within CSOs, needs are assessed by the multidisciplinary team by organizing a home visit, a doctor is being employed by the provider. All actions are undertaken with beneficiary's consent, including his participation in the evaluation process and the development of IHCP. The specialists from medical institutions and CSOs provide training to the patient / his relatives on self-care (medical care, self-control on disease, prevention of complications).

Challenges in the IHCP development and implementation

Challenges faced in ensuring beneficiaries participation in the development/implementation of IHCP: (i) poor personal hygiene habits, (ii) inadequate living conditions and poor financial condition, (iii) poor motivation, (iv) limited possibilities of acquiring self-care techniques etc.

Another big challenge - the beneficiary requires services that are not included in the IHCP (working the land, collecting the pension from the Post Office, cutting wood, gardening activities, making provisions for winter, etc.).

Other challenges in providing HBC refer to lack of transportation, shortage of medicines and pharmaceutical products, unfair attitude towards social workers (sometimes they are seen as "personal servants that have to do that").

This highlights the need to improve actions related to the participation of beneficiaries in the development / implementation of IHCP through a more efficient cooperation with the patient, including MDT, listening to the opinion of the beneficiary and his/her relatives in drafting the IHCP, but also the clear establishment of the range of HBC sub-services.

3.9. Human resources and continuous training

Hiring specialists

Lack of specialists is a problem for majority of HBC providers, according to the mapping. The sector is not attractive to the young specialists. Most striking is the shortage of medical assistants, social workers and community social assistants.

All CSOs that provide medical HBC services or integrated services have encountered difficulties in hiring medical assistants. Public providers of medical services have mentioned this issue less frequently (12 providers of 42). The lack of medical staff is more felt in municipalities, certain cities and less in rural areas. We also stress that half of the TUSAs participating in the research said they face difficulties in hiring social workers.

This situation is a result of the migration of skilled workers but also is due to low wages both, in social protection and medical field. Other causes are: (i) high workload, (ii) high responsibilities, (iii) more attractive employment opportunities in other fields, (iv) specific provider's requirements (medical assistants with driving license), (v) social workers' poor professional knowledge etc.[68]

There are multiple challenges in identifying and employing HBC specialists: (i) lack of financial motivation of the staff (low salary, high workload, high responsibilities), (ii) lack of prestige, (iii) job burnout due to difficult work etc.

Continuous training of specialists

Continuous training represents a problem for 27 of the 84 service providers (see Table 19). Or, in 2016 no employee of 27 providers benefited of continuous training related to HBC. Most providers requiring trainings are from medical institutions (22 of 42 institutions).

[68] Government Decision no. 1034 of 31.12.2014, Annex 1, art.7.

Table 19.

HBC service providers from the perspective of the continuous training of employees during 2016, number

	Yes, all employees	Yes, the majority of employees	Yes, some employees	No, no one
Medical institutions	3	9	8	22
TUSA	10	7	3	2
CSO	10	3	2	2
Provider appointed by LPA	1	-	-	1
Profit entities	-	-	1	-
Total	**24**	**19**	**14**	**27**

Subjects tackled during home based care training provided to specialists are quite diverse, depending on peculiarities of HBC service providers (see Annex 3. Subjects tackled during HBC training, according to categories of providers).

3.10. HBC services and specialists' assessment

Service evaluation system

Of the 84 home based care service providers, 36 do not have a service evaluation system for HBC service (see Table 20).

Table 20.

The existence of an evaluation system for HBC, number

	Yes, all employees	Yes, the majority of employees
Medical institutions	21	21
TUSA	15	7
CSO	12	5
Provider appointed by LPA	-	2
Profit entities	-	1
Total	**48**	**36**

Within TUSA, service evaluation is carried out differently. Most often the assessment is done by head of the HBC service Department or head of the TUSA, MDT, and rarely by specialists employed within TUSA, District Council or by the social-medical commission of the District Council. With a few exceptions, within TUSA, it was revealed that the assessment and supervision of social HBC services was done in accordance with the *Minimum Quality Standards regarding the organization and operation of the social home-based care services*.[69]

Challenges faced by pubic social HBC service providers (TUSA) are related to the lack of transportation (certain villages are located more than 50 km far away from the district center and there are no direct connections to the locality). Another challenge is lack of field-related training for social workers. Much difficult is to asses HBC services from ATU Gagauzia, where social workers are subordinated exclusively to the mayor of the locality.

Only half of the **medical institutions** participating in the research mentioned the existence of an assessment system of HBC service. However, being asked who performs the evaluation and the way it is done, there were found some gaps which need to be remedied.

The *National Homecare Standards*[70] set down in the chapter XII, standard no. 23 on the medical HBC performance evaluation is carried out in accordance with the normative acts in force. Consequently, each institution develops its performance indicators to assess the performance of the employee taking into account beneficiary's satisfaction. The representatives of certain medical institutions pointed out that medical HBC evaluation sessions are carried out by the NHIC experts and a group of evaluators from the medical institution or by NHIC experts within a planned, thematic inspection.

Challenges faced by medical institutions in the evaluation of medical HBC services are related to the non-compliance (full compliance) with the standards, consequently the case is not paid. The respondents also mentioned that medical HBC services are provided according to family doctor's prescriptions, while the beneficiary or his/her relatives ask for more HBC services (requiring time, frequency, and complexity), including services requiring medical equipment or medication that are not included in the list of home care based services.

[69] Government Decision nr.1034 from 31.12.2014, Annex 2, section 6.
[70] Endorsed through Order of the MH of the RM no.851 of 29.07.2013

It was revealed cases which are not paid by the NHIC, as well as the thematic inspections of the NHIC, are perceived by the representatives of some medical institutions as ways to assess and improve the performance of the services.

Within CSOs, service evaluation is done by the head of the organization or the manager, MDT, coordinating doctor/ doctor/ project assistant. But also, some CSOs perceive the participation of NHIC experts (if the CSO is accredited to provide medical HBC) during a planned, thematic inspection as service evaluation.

Challenges faced in assessing HBC services provided by civil society organizations refer to the lack of evaluation criteria, objectivity from certain beneficiaries.

The frequency of HBC service evaluation differs from one HBC service provider to another. Certain institutions conduct the evaluation weekly, quarterly by using questionnaires, tests or self-assessment practices, while the other do it once in 6 months or even rarely.

Supervision system

Mapping data prove the existence of supervision system in all **TUSA**, and less in CSOs (see Table 21). The supervision is conducted in different ways. For example, within TUSA, the supervision most often is ensured by social HBC manager/specialist dealing with issues faced by the elderly, head of ,TUSA or the team appointed for that purpose.

Table 21.

The existence of HBC supervision system, *number*

	Yes, all employees	Yes, the majority of employees
Medical institutions	12	30
TUSA	22	0
CSO	11	6
Provider appointed by LPA	1	1
Profit entities	1	-
Total	**47**	**37**

Among identified challenges: difficulties in collecting all documents, the shortage of social workers, the high number of social workers to be assessed and supervised, the fact that field visits take more than 8 hours per day. Another problem concerns the way the supervision sessions are organized in the TUSA ATU center. According to the work schedule, the social worker has a certain number of beneficiaries that he/she needs to visit during the day and consequently he/she cannot be present at the supervision sessions.

Medical institutions do not have any supervision system.

Within the **CSOs** that had a supervision system, the supervision is usually conducted by the manager or the organization or the head of the service. At the same time, the specialists are not acquainted with the term of supervisions, as some have pointed out that this is done by donors. Challenges in the supervision refer to staff turnover and the lack of a specialist who would be in charge with staff evaluation and supervision.

Evaluation of HBC services by beneficiaries

The *mapping* research also included HBC evaluation by the beneficiaries. Consequently, 340 beneficiaries have been interviewed. Asked on what they like most about HBC,[71] 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% - *counseling*, 8.1% - *workers' responsibility and professionalism*, etc.

Amongst things they do not like HBC[72] *rare visits* (17.5%), *lack government authorities' involvement* (5.7%), *the fact that the person does not have money and the service does not have a financial component* (3.8%), *shortage of medication* (3.8%), *short period of HBC service provision* (3.8%).

According to certain interviewed mayors, HBC services provided by CSOs are better due to the strict evaluation but also the fact that beneficiaries pay 10%[73] or 20%[74] of the cost (partially paid services) and higher requirements towards the social worker/medical assistant – "in the case of state services, the elderly do not even know when the social worker/medical assistant shall come" (IIA_2_P_R). Still, there were mayors asserting there are no differences in public or private service provision.

[71] Open question.
[72] Open question.
[73] For social HBC services.
[74] For medical HBC services.

Table 22.

Beneficiaries' views regarding the extent their needs are covered by provided HBC services, %

Socio-demographic characteristics		Yes, covered	No, not covered
Types of services	Medical	43.5	56.5
	Social	63.4	36.6
	Integrated	33.7	66.3
Payment of the service by the beneficiary	Free	45.9	54.1
	Partially paid	47.5	52.5
	For a fee	100	0
Form of ownership	Public medical institution	48.0	52.0
	Public social institution	65.8	34.2
	CSO	33.6	66.4
Degree of dependency	A	0	100
	B	39.3	60.7
	C	68.2	31.8
	D	40.0	60.0

Asked if received HBC services cover their needs, 48.3% said yes, compared to 51.7% who said – no. However, these views depend on beneficiary's age, degree of dependency, type of services received and beneficiary's involvement in co-paying for the service, including the institution providing the services (see Table 22).

The great majority of beneficiaries have very high expectations from HBC services, especially those that receive services from private providers that had financial resources from donors, as they know that services provided by the public providers cannot be improved. The interviewed LPA representatives said that "some people are content with what they are given while the others expect social workers to do all household chores" (IIA_11_P_U).

The high number of CSO beneficiaries, whose HBC needs are not covered, is explained by the prevalence of elderly with multiple needs - from home repairs to complex medical interventions, but also their dependence on social HBC services (see Box 3).

Box 3. Case studies on beneficiaries expectations from services

Case Study 1 shared by a private provider (CSO)

"We have a beneficiary that has been long in the service. His situation is really difficult and he faces many problems. Although the services should not be provided more than 3 months, we discussed with the donor to allow us continue the provision of the services. He was visited daily, receiving social and medical services, requiring much attention from our workers. Visiting Moldova, the donor wanted to see this beneficiary. When asked if he is satisfied with the services he receives, the beneficiary replied that he is not, because he needs a dental implant and we do not give him any funds for it".

Case Study 2 shared by a private provider (CSO)

"We provide services in several districts, and when we go to monitoring visits we do it by car. When I visited a beneficiary I inquired about his satisfaction with the services. He replied that no, because we have a car, and we never proposed to take him to his wife's grave, which is in another district than the one he lives in".

This fact was confirmed by LPA representatives - *"socially vulnerable persons, no matter the effort you take to help them, are always discontent and do not care about what is being done"* (IIA_7_P_R). Some mayors have also reported unusual expectations of HBC beneficiaries' - *"people require more gardening activities and ask for other things that are not covered by the regulations. For example, we have an old lady with 5 goats who asks the social worker to take care of these goats too"* (IIA_3_P_R).

The uncovered needs specified by the beneficiaries include a wide range: medication (49.1%), non-involvement in solving financial problems (23.6%), need for free food (14.5%), provision of firewood (14.5%), need for a personal assistant (12.7%), support in cooking (8.2%), more services related to household cleaning (5.5%), but also additional medical devices (wheelchair, tonometer, blood glucose meter) (4.7%) etc.

3.11. Development of partially paid and paid HBC services

Beneficiaries' ability to pay for HBC services

The large majority of beneficiaries cannot afford and refuse services provided for a fee. They expect state or non-governmental organizations to provide these services free of charge. Public providers pointed out situations when children pay social HBC services for their parents, but they do not want them to know this – *"their children ask us not to say them that they pay for these services. In case they find out, parents may refuse the services"* (IIA_17_STAS). Thus, the situation is complicated - *"there is a small number that can afford the services while the majority cannot pay"* (IIA_11_P_U).

As it was mentioned, TUSA from Fălești, Cimișlia and Glodeni have developed services provided for a fee. The contract is signed between TUSA and the individual (usually the beneficiary, in certain circumstances with his/her relatives). The cost of the services was calculated by the TUSA and approved by the District Council (LPA of the II level). There is no cost calculation method approved at the central level. Each of the mentioned ATU has approved the cost based on its own calculations. This practice is acceptable from local public administration regulatory framework.

Box 4. Exclusion from public social HBC

"A lady from the village gave her house, goods and land to a relative to take care of her. She did not have children but was benefiting from social HBC. When visiting her, the social worker was obliged to clean the house, the yard. The social worker was complaining every time. I called her to the village hall, I talked to her and said, "Because you were brutal and you have a person to take care of you, you will not receive these services anymore"".… I hope this will be a lesson for others too". (IIA_6_P_R)

There are also elderly who are ashamed to ask for help from children, but children's responsibility to take care of their older parents is limited. Thereat, some mayors were categorical in identifying solutions to the problem – *"to oblige children to take care of their parents and fine them if they fail to fulfill their duties"* (IIA_19_P_R) or suggested to refuse social HBC services to people that donated their house or land to certain relatives but expect to receive free services from the state (see Box 4). Respectively, LPA, CSOs and other state institutions shall pay more attention to people who have no one to help them.

Medical institutions pointed out that the beneficiaries are not eager to pay for medical HBC services due to their poor financial situation, insufficient income. The same was asserted by TUSA representatives.

Only a very small circle of wealthy patients could accept services provided for a fee. But the development of paid HBC services requires well-trained specialists – *"requirements are quite different in the case of paid services… we need quality"* (IIA_15_STAS).

Data collected from beneficiaries confirms providers' statements. Thus, 77.3% mentioned they have not possibility to pay for HBC services, in comparison with 21.8% who admitted the possibility to pay certain services and only 0.9% said they can afford paying the full cost of HBC services (see Figure 12). The share of those who are willing to come up

with their own contribution to benefit from HBC services is still significant - every 5th person currently receiving HBC services.

Of the large variety of HBC services, CSOs mentioned that some beneficiaries would most likely pay for house cleaning, laundry services, personal bath/care, gardening, cooking. Meantime, they emphasized that HBC beneficiaries would never agree to pay for: purchasing of products, water supply, social counseling, equipment, office supplies, salary of staff providing services, training, including operational costs of the service.

Figure 12.

Beneficiaries' ability to pay for HBC services, %

Currently, paid HBC services are not affordable to the elderly because their small pensions. Consequently, **lonely old people abandoned by their children are disadvantaged and deprived of HBC services** - *"their children went abroad and completely abandoned their parents"* (IIA_15_STAS), as well as the **elderly which lack support from their children** - *"some of them have poor children who cannot take care of their parents"* (IIA_1_P_R). Thus, TUSA representatives mentioned the need for changes in the social HBC Regulations and the acceptance of other categories of beneficiaries.

Possibilities of LPA to contribute to HBC service development

In these circumstances, LPA could become one of HBC sources of funding. However, in-depth interviews with the mayors reveal that most of them have other priorities in their communities (roads, water supply, sewage, concert halls, street lighting, etc.) and less the social protection of the population. Income in the local budget is low due to the small number of businesses. Thus, the assessment data show that only some mayors agreed to come up with a contribution to develop HBC services and provide the elderly access to services with the help of non-governmental sector: CSO "CASMED", CSO "Homecare", CSO "Neo-umanist", Charitable Organization "Caritas Moldova", CSO "Concordia. Proiecte sociale"etc.

In the case of "CASMED" CSO, the LPAs contribute with 30% of the amount required for the development of HBC, the beneficiary with 10% or 20% and CASMED with 50% or 60%.

Table 23.

Share of financing HBC services provided by CSO "CASMED" or CASMED umbrella CSOs

Type of HBC services	CASMED	LPA	Beneficiaries
Social HBC	60%	30%	10%
Medical HBC	50%	30%	20%

The large majority of Moldovan mayors do not get involved in the development of HBC services, referring to other priorities for community or impossibility to come with financial contribution. For example, the administration of a district center told us that they cannot pay 200 000 MDL[75] annually to help vulnerable elderly - *"they (CSO) subsidized the services so far. This year they paid 70% and we contributed with 30%. Beginning with 2018, we have to pay the entire amount, but we are not able"* (IIA_9_P_U).

Mayors, who allocated funds to the development of HBC services, highlighted that the elderly from the locality, at the beginning, had certain concerns regarding the contribution – *"the beneficiaries were afraid. 10% or about 50 lei of their pension of 500-700 lei is a lot for them. 10 % means for*

[75] App. 9800 Euro according to National Bank of RM exchange rate at 31.12.2017

him/her bread every two days during a month…" (IIA_2_P_R). Still, according to the mayors, 10-20% is not much, it is more a symbolic price, but it makes both, the social worker and the beneficiary, more responsible – *"when he/she gets it for free, he/she does not really appreciate it "* (IIA_5_P_R). Certain mayors reported many cases when children pay 10-20% for their parents for HBC services. There were situations when children refuse, which indicates the need to discuss and explain the situation. Or, *"it is children's duty to take proper care of their ageing parents"* mentioned a part of mayors (IIA_3_P_R).

3.12. Collaboration between institutions in providing HBC services

Collaboration with institutions at local and ATU levels

The collaboration between institutions in providing HBC services requires mediation. Most often, the collaboration depends on the personality of the individual running the institution.

CSOs are more eager to establish partnerships with all kind of institutions of LPA, both, of I and II levels. Their collaboration is formalized on the basis of certain Agreements/Memoranda/Service provision contract. The CSOs collaborate with municipalities to initiate, develop HBC services in the community, requiring LPA's participation but also to establish HBC future beneficiaries. Frequently, their collaboration is broader, especially with the LPA of the II level - "we have a close collaboration with CSOs providing HBC services in organizing social activities, conferences. We also conduct joint training to social workers" (IIA_17_TUSA). There are also collaborations between TUSA and municipalities for organizing various activities - the day of older persons, the day of disabled persons, etc., but these are more sporadic. However, in some ATU there is also a perception of public institutions that CSOs are competing with them in the provision of HBC services.

At the community level, the MDT consisting of the community social assistant, family doctor/medical assistant, policeman, etc., it must be functional, but its presence is often not felt by specialists or beneficiaries. Taking into account its community-related obligations, the community social assistant cooperates most often with all the public and private institutions providing HBC services. Therefore, certain community social

assistants identify and provide referral to people requiring HBC services. Most often the collaboration is established to solve a concrete case. For example when the person needs a medical certificate, recipes for compensated medicines, to benefit from allowances, to improve living conditions, etc. The training of MDT members at local or ATU level on HBC services is not currently provided.

Collaboration at local levels frequently is affected by several causes: (i) shortage of specialists (medical assistants, family doctors, community social assistants) mainly in rural localities and their high turnover rate, (ii) lack of some collaboration methods, (iii) ignorance of the HBC regulatory framework – *"mayors require to accept applicants, but the latter do not meet the eligibility criteria stipulated by the social HBC Regulations and the Minimum Quality Standards"* (IIA_24_TUSA).

Among the ways to improve cooperation, respondents pointed out: (i) MDT training in the community, (ii) organization of joint meetings with HBC service providers and LPAs of the I and II level twice a year, (iii) drafting a Government Decision or instructions regarding the inter-sectoral collaboration for adults (as those on child mortality, prevention of violence, etc.), clearly establishing the duties of each responsible party, (iv) introduction of state institution's performance indicators related to the collaboration with CSO providing HBC services. Measures related to the improvement of the quality of services as well as the cooperation could be achieved by developing a Case Management designed to the elderly, according to the Case Management addressed to families with children (National Model of Good Practice) currently functioning in the RM. Thus, the Case Management reflects on person's needs, problems they face (especially medical or social, or both), will determine the case manager, cooperation way, referral and monitoring mechanisms, etc.

Box 5. Positive practices of partnerships

"Adopting an old man is a program supported by Moldovan migrants working in Germany. Every month, they give 6 euro to one old person. But this money is very important to them. We give them bread twice a week and at the end of the month they receive a food pack. Moreover, 4 of the most vulnerable persons get firewood for the cold season of the year";

"We also provide 50 warm lunches daily, to vulnerable people and families with many children".

Several positive practices have been revealed when mayors take an

active participation and develop partnerships with different institutions to improve the life of the community, especially of the elderly (see Box 5).

The CSOs also mentioned the inability of certain LPAs to pay their contribution to the development of HBC services due to the lack of money in the local budget, the lack of information regarding the situation of the elderly from the locality but also the lack of responsibility of some mayors. Respectively, is important to provide information about HBC services and training to mayors to increase their responsibility in the development of community social services. The TUSA representatives highlighted - "Mayors have to take the responsibility. Analyze priorities and understand the importance of their contribution to the development of social HBC services in their locality" (IIA_17_STAS).

Collaboration with institutions at central level

The collaboration of the medical HBC service providers with NHIC it limited to contracting, evaluation, monitoring, reporting and training. The biggest challenges are: (i) limited and insufficient funding of medical HBC cases, (ii) small number of cases funded, (iii) lack of contracting requirements, but also lack of fairness, (iv) lack of training on evaluation and accreditation. Consequently, changes that should be made include: (i) increase the level of transparency of NHIC at the stage of negotiating contracts for the provision of HBC services; (ii) transparent negotiation of the cost of medical services, (iii) appropriate funding to meet patients' needs. Some of these aspects are also tackled in the *"Healthcare system from the Republic of Moldova: real needs of consolidation and optimization"* research, conducted by the Independent Analytical Centre Expert-Grup.[76]

Last but not least, it was noted that there is also collaboration between CSOs providing services that have established the Association of CSOs "The Network of Non-Commercial Organizations providing Community Care" (URONPIC) and the MHLSP, which supports the establishment and development of community integrated services all over the country (Memorandum signed in June 16, 2017). MHLSP and URONPIC, as a result of multiple negotiations, have proposed to take all possible measures to increase citizens' access to HBC services, improve their quality, develop quality standards for nationally integrated medico-social care, adjust the cost of a home care visit to the real needs of the beneficiaries and provide training for service providers that want to

[76] https://www.expert-grup.org/media/k2/attachments/Eficienya_ui_transparenya_sistemului_de_sInItate_din_Republica_Moldova.pdf

services. The CSOs providing HBC services still believe the communication with the MHLSP could be improved. Improved collaboration will: enable the development of the nationwide HBC services, improve people's access to HBC services, supervise the quality of these services and solve issues that threaten their development.

3.13. HBC volunteering

Volunteering is poorly developed in the RM. Only 0.2% of the Moldovan population aged over 10 years old does voluntary work through the medium of certain organizations/institutions.[77] The reasons are determined by the legal framework in force that **makes no difference between employees and volunteers regarding the way they are treated and involved** (they are treated the same way, they are asked to delivers the same quality of job performed, are assigned by the order / decision of the head of the organization, a similar tool for management of the activity is used - personal file, contract, job description, volunteer badge, etc.).

Research data reveal lack of volunteering activities in public institutions, both, medical and social with a few exceptions (1 medical institution from 42 and 2 TUSA from 22 had volunteers). However, the large majority of CSOs (16 from 17) have developed volunteer component, engaging volunteers in providing HBC services. The number of volunteers varies from at least 1-2 persons to maximum 60 persons. Volunteers perform the following: gardening, water supply, provision of firewood, delivery of warm lunches and food packs, organization of cultural activities, psychological counseling, medical assistance, needs evaluation. Also, volunteers play an important role in fundraising and HBC information activities, etc. We underline that only a few of CSOs involve volunteers in the communication with the beneficiaries.

Considering the fact that 29.4% of HBC services beneficiaries that participated in the research, mentioned they are content with the fact that *someone visits them* and that the representatives of the LPA have pointed out that many elderly also need socialization (*"the people wants you to talk to them, especially the old one"*), we emphasize that this aspect has to be developed by HBC service providers by involving volunteers.

[77] NBS. Analytical note. How popular is volunteering and meeting among Moldovans.

3.14. Switching from medical HBC to palliative care

Medical institutions cease provision of medical HBC services by transferring the beneficiary to palliative care ward when his/her health condition is getting worse or when the prescribed treatment is not efficient, based on family doctor's decision. But medical institutions that contracted a small number of home visits reported– *"being contracted only for 5 cases of medical care, we could not make the switch"*. Medical institutions highlighted the following issues in switching the beneficiary from medical HBC services to palliative: (i) long waiting list for hospitalization (ii) short inpatient treatment period, (iii) only hospitalization of oncology patients.

The CSOs mentioned that they do this switch after 3 months or depending on patient's diagnosis. Most frequently, CSOs that do not have contracted visits from NHIC, refer the beneficiary to the medical institution. The respondents pointed out that the number of such beneficiaries is increasing. Moreover, these people require different approach, from, both, medical and psychological perspective, including higher costs.

The referral process should be improved for patients to specialized organizations by consulting the specialist who would confirm palliative care.

3.15. Access to HBC

Availability of HBC services

Out of 84 institutions providing HBC services, 59 agree that services provided are not available to all those who needs them. This was asserted by 21 of the 22 TUSA, 15 of the 17 CSOs, 21 of the 42 medical institutions as well as by the LLC, including one of the 2 service providers appointed by LPA. It was highlighted that free, partially paid services as well as services provided for a fee are not available. Currently, the HBC services are not available as:

1. Certain people in need for such services do not meet the eligibility criteria: for medical HBC services – the most important is the person should be insured and have identity documents, for public social HBC services – the most important is the person should have reached the retirement age, should be disabled lacking support from children,

relatives, neighbors. Other constraint factors in HBC provision (in the order they were mentioned by the respondents) are: mental health issues, lack of identity documents, age, HIV infection/AIDS etc. The last mentioned constrain factors are determined by internal regulations of service providers, donors' requirements, including the need for specific training.

2. HBC services, especially the medical ones, are not provided in all Moldovan localities. HBC services provided by CSOs are also not available in all localities from the RM.

3. Paid social HBC services are not available as there is no regulatory framework regarding the cost of this service.

Profile of people included in the waiting lists for HBC services

26 of the 84 HBC service providers have waiting lists. 19 of them are public institutions (13 TUSA and 6 medical institutions) and 7 CSOs. The obligation to register a person, who addresses for services, in a waiting list is not regulated by any normative document, waiting list are established at provider's request.

Waiting lists are more common for free HBC services, but these also exist for services partially paid and for fee HBC services. Speaking about services, most people are waiting for social HBC services, followed by integrated services and on the last – medical services.

Characteristics of people included in the waiting lists: (i) both, women and men, (ii) mostly from rural areas but also urban areas, (iii) lonely but also people that have relatives, (iv) people without disability but also with disabilities, (v) aged over 65 years old although there are younger.

The profile of people on waiting lists of medical institutions: 2/3 women, 2/3 from urban areas, the large majority has relatives, half disabled and half without disabilities, 2/3 aged over 65.

The profile of people on waiting lists of TUSA: 2/3 women, 2/3 from rural areas, 2/4 lonely, the large majority without a degree of disability, 2/3 aged over 65.

The profile of people on waiting lists of CSOs: 2/3 women, 2/3 from rural areas, almost half of them have relatives while the others are alone, about half of them are disabled and half without disabilities, half aged 50-65 years old.

Possibilities to improve people's access to HBC services

According to participants, the most important things to be done as **to ensure people's access to social HBC services** relate to:

I increase the number of service providers by supporting CSOs rendering HBC services, including to provide tax incentives to social HBC providers,

II amend Framework Regulations on social HBC, to provide services also to the retirees whose children live in other villages and are not able to take care of the parents due to their poor financial condition,

III assess the cost of social HBC and develop the legal framework on services provided for a fee (see Box 6.)

Box 6. Need for social HBC cost assessment

"If we had the costs of each sub-service, the beneficiary would choose the services he/she needs. Thus, not everyone would need the social worker 3 times a week for 2-3 hours. Moreover, services would be focused on beneficiary's needs". (IIA_16_STAS)

It is also necessary for LPAs to be involved in the provision of social HBC services, through the development of public-private partnerships and HBC volunteering.

The following is needed done to **ensure the access to medical HBC services:**

I improve funding mechanisms (amount, number of visits) by NHIC,

II insure all people requiring medical HBC, including to give up the requirement on the status of insured person mandatory to benefit from home based care,

III introduce the position of the medical assistant in charge only with medical HBC in the organization chart of medical institutions,

IV provide medical staff with transportation.

3.16. The estimated number of people requiring HBC

Provider's estimation

43 of the 84 service providers made an estimation of the number of people requiring HBC, but who not benefit actually by any services: 21 medical institutions, 13 TUSA, 8 CSO and 1 LLC. Estimation is based on different data sources held by service providers.

When making the estimation, accounted peculiarities of services provided and beneficiaries' profile. TUSA relied on data presented by institutions and solicitations from beneficiaries/their relatives.

The estimated average number of TUSA – 333 persons, more than currently served by one territorial unit. Most of them are from rural areas, without disabilities, aged over 65 years old.

Estimation made by medical institutions relied on medical statistics, beneficiaries/their relatives' requests. **The estimated average number per medical institution was of 44 persons.** Most of them coming from rural areas, with relatives, aged over 65 years old.

Making the estimation, the CSOs relied on: data provided by TUSA, solicitations from beneficiaries/their relatives, medical statistics, information from religious organizations (churches), requests from LPAs. The average number of people requiring HBC, per CSO operating at regional or national level – 2318 persons. Most of them are from rural areas, have relatives, with or without a confirm disability, aged 50-65 years old. Not all elderly are lonely. Thus, HBC services provided by CSOs target to meet the needs of people that are not entitled to public services (see Box 7). A part of interviewed mayors pointed out that "about 30-40% are not covered by social HBC services" (IIA_11_P_U). For them was impossible to make an estimation of the number of people that cannot be provided with medical HBC.

Box 7. Examples how CSOs supplement public HBC services

In an average size village - "besides the 2 state social workers that provide services to 20 people, we have 2 more social workers from CASMED providing services to 40 people" (IIA_2_P_R).

A village with 2600 inhabitants – "2 social workers from CASMED providing services to 39 beneficiaries, 4 state social workers providing services to other 40 inhabitants, other social services – 50 warm lunches for vulnerable people and families with many children and 20 more old people included in the "Adopt an old man" program and there are 20 more people that need such services … but the LPA does not have money to pay the 30% required contribution" (IIA_3_P_R).

Estimation of HBC services at the national level

Estimating the approximate number of people requiring HBC services was based on data estimated by public service: TUSA as they provide services in TAU and medical institutions as they have a local coverage. Data provided by CSOs on the estimation of the number of beneficiaries were not used because CSOs are diverse with local, regional or national provision making it impossible to establish a calculation formula. However, the estimation made by TUSA and medical institutions took into account the potential beneficiaries of CSOs.

To estimate TUSA beneficiaries, the next formula was used: *calculating the average number of beneficiaries of the **existing** beneficiaries per provider + calculating the **estimated** average number of beneficiaries per provider x 35 TAU*. Consequently, the average number of beneficiaries per **TUSA** is of 636 persons + 333 persons that requiring support x 35 TAU = **33915 persons. Thus, the number of people estimated to need HBC social services is of 33915 persons.**

In estimating the number beneficiaries of the medical institutions the formula has changed a little, taking into account the fact that there are medical institutions providing HBC services and medical institutions that do not provide such services. For those providing this kind of services, the estimation was based on: *calculating the average number of the **existing** beneficiaries per provider + calculating the average number of the **estimated** beneficiaries x number of medical institutions that provided HBC services*. Thus, the average number of beneficiaries per medical institution that provided HBC services is of 20 persons + 44 persons requiring support x 131 medical institutions = 8384 persons.

In the case of medical institutions not providing such services, the number of beneficiaries accessing from services was excluded from the formula, assuming the idea that these medical institutions did not contract HBC medical services because they did not need it. Thus, we took into account only the estimated number of 44 persons that would require services: 127 medical institutions that did not contract medical HBC services x 44 persons = 5588 persons. **Overall, for medical institutions, the estimated number of people requiring HBC services is of 13972 persons** (8384 + 5588 persons).

As a result, it was established that social HBC services are currently available for about 2/3 of people requiring such services and medical HBC services to about 18 percent of those who need.

We underline that **the minimum number of beneficiaries of social and medical HBC services was estimated**. At the same time, we stress that the profile of the potential beneficiaries by gender, residence, disability, etc. is impossible to calculate (in order to understand the peculiarities of people requiring HBC services, see Chapter III, 3.15).

3.17. Providers' opinion regarding the improvement of HBC quality

In order to improve the quality of HBC, **providers mentioned that actions are required in several directions:**

a. Improving the operating mechanism by:

- revising the regulatory and institutional basis. Public social HBC service should be subordinated to TUSA, not LPA of the I level (as it is now in ATU Găgăuzia),
- creating a specialized multidisciplinary field-related service, integrating medical-social services. To establish a collaboration mechanism between medical and social institutions and CSOs in order to provide integrated services (Box 8),
- developing a costification methodology for social HBC,
- ensuring the accreditation of social HBC providers,
- reducing the number of beneficiaries per employee, in the case of social HBC - "More time for the beneficiary and fewer beneficiaries per social worker" (IIA_11_P_U),
- developing service operating guidelines,
- establishing a social worker training system. Currently, they are required a bachelor's degree, there are no requirement regarding

Box 8. Need for integrated services

"The individual must be assessed as a whole. Medical and social issues are interdependent and cannot be separated. It is necessary to establish a mechanism for intersectoral cooperation in the case of adults and the elderly, following the one addressing children. Job duties have to be clearly defined in the job description". (IIA_17_STAS)

their qualification – "social workers should graduate from a secondary school, college or vocational school" (IIA_15_STAS),

- instructing paramedical staff that will perform this work (due to the lack of medical assistants),
- ensuring initial and continuous training of HBC specialists,
- increasing the efficiency of HBC management by medical institutions,
- providing the necessary equipment, medical devices, medication and consumables.

b. Improving the financial mechanism by:

- improving funding of social HBC, NHIC's funding for medical HBC inclusively,
- raising the salary of social workers and medical assistants,
- extending the list of medication for HBC services,
- involving LPA in developing HBC services,
- assessing the cost of one visit according to patient's degree of dependence.

c. Other actions demanded to improve the quality of HBC services by:

- setting up a communication club between generations to raise awareness among younger generations and the elderly for a more effective communication and collaboration,
- ensuring HBC services coverage,
- educating people to come up with contributions – "people have to understand and come up with a contribution, but not wait to receive everything for free from the state" (IIA_18_STAS).

3.18. Suggestions and recommendations to Chapter III

The assessment data allow as to come with the following recommendations:

1. To develop integrated HBC services and a regulatory basis for this purpose, including a mechanism for cooperation between healthcare institutions, social services and CSOs to provide integrated services. To draft a Government Decision or instructions regarding the intersectoral collaboration (as those on child mortality, prevention of violence, etc.). The instruction should clearly establishing the duties of each responsible party or developing a Case Management designed to the elderly in need of HBC services. Analogically to the Case Management addressed to families with children (National Model of Good Practice) currently functioning in the RM. The Case Management, depending on person's needs, problems they face (especially medical or social, or both), will determine the case manager, cooperation way, referral and monitoring mechanisms, etc.
2. To include the categories of beneficiaries' dependency in the regulatory framework on HBC services and determine the cost of a medical HBC service visit based on dependency categories.
3. To provide trainings to paramedical staff that will provide medical HBC services excluding current situations when social workers provide medical services.
4. To establish a social worker vocational training system to increase service quality.
5. To establish a range of social sub-services, the time that social worker has to dedicate to each service, including the costification for HBC services (see chapter VI).
6. To develop tools and indicators for the assessment of medical HBC services. To develop and introduce performance indicators for HBC providers, especially indicators related to collaboration of public and private HBC providers.
7. To develop standard job descriptions that would outline the responsibilities of medical assistant and social worker in providing HBC services.

8. To develop policies for providers contracting visits for medical HBC to meet the needs for these services at the national level.

9. To continue partnerships with LPA and HBC service providers.

10. To promote volunteering among HBC service providers by: (i) initiating collaboration with educational institutions, private companies and involving their representatives in social activities delivering HBC services; (ii) asking LPA's support to develop volunteering in the provision of HBC services in the community; (iii) involving the elderly in voluntary activities as a step to their social inclusion; (iv) creating communication clubs between generations at the community level.

11. To improve the access of vulnerable people to HBC services by changing the Regulations on social HBC services, to provide services to the elderly whose children live in other localities but have a poor family situation and are unable to help their parents.

INTERNATIONAL HBC MODELS[78]

4.1. Model of HBC services in Romania and the role of the local government

Romanian society shows a big amount of similarities to RM social system based on soviet type of institutions. Romania has one of the lowest GDP per capita in the EU and the health status of citizens in Romania[79] is also closer to RM[80] than to other EU countries. These two countries also share one of the biggest problems affecting demographic ageing: continuous population decline due to migration/ work emigration. Health and social care sector related to HBC services are regulated by six legal acts.[81] Romanian language is spoken across both countries, which makes the transfer of knowledge much easier.

As there were some steps taken in RM to transfer the system of HBC services application through the local government, let me explain their role in Romania: Municipalities and local councils play an important role in

- needs assessment of home care to those in need and
- providing and financing services.

Municipalities receive funding from the central fund. Social HBC workers are employed and paid by local authorities/councils. These home care providers are reimbursed on a fee-for-service basis. Local municipalities hire personnel and employ them by the hour. There are many legal and institutional obstacles for local authorities to hire enough CSO workers for specific period of time and specific amount of people in a situation of

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[78] This part of the report was developed only by the international expert **Radka Rubilina, PhD**.

[79] WHO data related to health status of Romania: http://www.who.int/countries/rou/en/

[80] WHO data related to health status of RM: http://www.who.int/countries/mda/en/

[81] **1. Law 17/2000 on the Social Assistance for the Elderly** (Legea privind asistenta sociala a persoanelor varstnice) with the additional modifications (Law 281/2006, Law 270/2008 and GO 118/2008)

2. Law 47/2006 establishing the National System of Social Assistance (Sistemul National de Asistenta Sociala).

3. **Law 95/2006 on Health Reform** (Legea priving reforma in domeniul sanatatii) which set the grounds for national reform in the health care system and established the national social health insurance system (The medical services for all categories of people, including the disabled and the non-disabled elderly, are supported by the social medical insurance and are regulated by this law)

4. **Decree (Ordin) 318/2003** refers to the norms regarding the organisation and functioning of home care services as well as the authorisation of people who provide these services.

5. **Decree (Ordin) 246/2006** which established the minimum specific quality standards for home care services and residential centres for the elderly in terms of organisation and administration, human resources, access to services, service provision, rights and ethics.

6. **Law 435-XVI/2006** (Legea privind descentralizarea administrativa nr. 435-XVI/2006 - The decentralisation of the administrative bodies

a need of HBC services,[82] but the responsibility to assess the needs of people for HBC services is a good way how to react flexible to the situations in concrete regions. The medical home care providers are contracted with the National Health Insurance Company. Eligibility criteria may differ across the country, delivery of home care is separated between that for elderly and that for persons with an illness.

Medical HBC services are funded through the central public administration's social health insurance fund and through contributions of private payments. Social HBC services have different funding: insurance fund, services' beneficiary's co-payment, salaries are covered by relevant municipalities' budget. The amount of services' beneficiaries' co-payments differ according to rules of provider (CSOs) and according to municipal taxation. The home care workers are usually employed by local government and paid from through the municipalities from the central fund. They are hired for a given period by municipalities or by CSOs. People providing HBC services can also be self-employed, but need an authorization from the state. Family members taking care of a dependent elderly person may receive either an additional sum to their salary when they are still part-time employed somewhere or a payment that is similar to a minimal salary of a social assistant with medium level training. They work as personal assistants but not officially in that function.

Even if there are so many similarities between these two countries, I don't consider the Romanian model of HBC services as the most inspiring for RM. The reason for such a statement is disfunction of the home care system in a long run.

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[82] "The organization of social and socio-medical services is the responsibility of local councils, directly or under arrangement with CSOs, religious units recognized in Romania or other natural or legal persons. CSOs provide home care services, but most do not operate under a contract with the Country social assistance directorate, which means that public-private partnership is not sufficiently developed at national level. This translates into the perpetuation of the dysfunctions in terms of care needs coverage and disparities between cities/regions within the country. The system of outsourcing/contracting services in Romania is over-regulated, making difficult the relationship between the entities involved in providing social and socio-medical services in the process of concluding public-private partnerships. To avoid bureaucratic procedures, some local public authorities prefer to fund CSOs providing social services on the basis of partnership protocols. This prevents auctions that may cause a malfunction such as those related to the discontinuity of services provided to beneficiaries. The legislation in financial field from Romania does not encourage financial transfers to the non-profit and private sectors, requiring a better correlation of normative acts from the social and health care sector for a common coordination and financing." Bertha SANDULEASA: The Romanian Health and Social Care System - Funding Arrangements and Approach to Social and Medical Care Delivery:
ftp://ftp.repec.org/opt/ReDIF/RePEc/icb/wpaper/ICESBA2016_17SANDULEASA_p138-145.pdf

According to specialists and providers, the biggest gaps in the HBC system in Romania are:[83]

- **The system couldn't generate enough qualified staff** and there is an evidence of a low number of social workers and nurses.
- **Low accessibility** of the HBC services in rural areas is another painful issue of the system, even if tele-care services have been introduced on some of the places.
- Relatively **high private payments** for health services which are requested f**rom services' beneficiaries**. Services' beneficiary co-payment system has been introduced since 1st January 2010, both for social and health care system.[84]

4.2. Model of HBC services in Slovak Republic and the role of the local government in social HCB services

Decentralization of social services in Slovakia started in 2002-04 as part of a wider effort to delegate responsibilities from national to sub-national tiers of government. This administrative and territorial structure has influenced Slovakia's fiscal decentralisation model based on a personal income tax (PIT) transfer formula.[85] The formula was determined through objective criteria supposed to reflect the financial needs of municipalities and regions, as they are linked to the specific competencies and responsibilities of municipalities and regions.

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[83] "Home care services are underdeveloped and limited to housekeeping and food supply and less to medical assistance [National Council for the Elderly, 2014]. The National Health Strategy 2014-2020 indicates that community services, including home care services for dependent patients, are offered in a volume far below necessary, they are insufficiently organized, coordinated, controlled and funded [Romanian Government, 2014]." Bertha SANDULEASA: The Romanian Health and Social Care System - Funding Arrangements and Approach to Social and Medical Care Delivery: ftp://ftp.repec.org/opt/ReDIF/RePEc/icb/wpaper/ICESBA2016_17SANDULEASA_p138-145.pdf

[84] So called "coplata system" in Romania: Contributions are between RON 5 and 10 per patient. Emergency care, family doctors and medical laboratories do not charge the co-payment. Children up to 18 years, youth aged 18-26 without income, pregnant women, war veterans, persons with chronic diseases, and pensioners receiving a pension benefits inferior to RON 740 per month are exempted from these co-payments. There are reports of significant informal (nonofficial) payments. https://ec.europa.eu/info/sites/info/files/file_import/joint-report_ro_en_2.pdf Out-of-pocket payments in Romania include: direct payments for goods or services that are not included in the statutory health insurance benefits package or covered by the national health programmes; direct payments by uninsured patients; direct payments for (uncontracted) private providers; user charges for some health care services and pharmaceuticals; and informal payments. The exact share of private expenditure on health has always been difficult to estimate because of informal payments and the underreporting of incomes by private providers: http://www.snspms.ro/images/download/banner/HST/hit-romania.pdf

[85] Since 2002, there was a general trend in Central Europe to move away from origin based sharing towards formula driven sharing mechanisms for local governments. Between 2000 – 2002 only 5 percent of PIT was allocated to the place of origin, but in 2007, from 10 to 40 percent are returned to the municipalities where they were generated. In Slovakia, the sharing is confined to Personal Income Tax, but local governments get 93.8 percent of its yield (70.3 per cent for municipalities and 23.5 per cent for regions). The complex formula in Slovakia is combining population with numbers of children in schools and elderly people. In: Coulson, A; Campbell, A: Local Government in Central and Eastern Europe: The Rebirth of Local Democracy. Routledge, NY, 2008. P.53

Eligibility criteria for all home care have been set at the national level. General eligibility criteria and conditions for social services can be further elaborated at municipal level (e.g. exemptions to co-payments).

Governance on home care is split between **home nursing** (which belongs to health care) and formal home care i.e. personal hygiene and household chores (which is part of social services, provided by professional caretakers from municipalities). Since 2003, regarding health care the accent was shifted from hospitals to out-patient services, including home care nursing. In contrast to personal care provided at home, home nursing is poorly developed. In addition to services cash-benefits are possible under certain conditions (for example, personal assistance benefits for people whose disability started before the age of 65). The Ministry of Health developed national legislation and defines the package of benefits, safeguards access to home nursing and supervises the private insurers (via the Office for Supervision in Health Care).

Compulsory health insurance covers most of the services. Care outside the insured package needs to be privately paid (unless covered by voluntary insurance). For privately purchased care services' beneficiary and purchaser can negotiate prices. Insurance companies agree on prices of home nursing with providers in a contract. In general, prices are related to the case-weight (the level of disability and the hours needed). There are variety of benefits for temporal and long-term disability in the Slovak republic, depending on the services' beneficiary's health, social and economic status.[86] For disabled people, three main categories are applied: I. degree: 10 EUR; II. Degree: 16.6 EUR; III. Degree 23.2: EUR. There are other possible allowances for the highest levels of dependency and five categories of dependency for long-care.[87]

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[86] https://www.ssa.gov/policy/docs/progdesc/ssptw/2016-2017/europe/slovak-republic.pdf

[87] Different cash payments are provided to eligible disabled people of high severity, as part of the 2009 "Act on Direct Payments for Compensation of Severe Disability". Severely disabled individuals are those whose level of functional impairement is at least 50 %. One of these payments is an income-related cash allowance for personal assistance. The cash benefit is paid to the care recipient and it can be used only for hiring a personal assistant. The amount of benefit depends on the number of hours of personal assistance (maximum 20 hours daily), and corresponds to EUR 2.5 per hour. This is higher than the minimum hourly wage (EUR 1.85), but lower than the average hourly wage (EUR 4.79). This cash Slovak Republic Long-term Care allowance can be combined with other payments, such as compensation for mobility and invalidity pension. Counselling is also provided free of charge. Under the same Act, other direct payments can be granted to disabled people, including payments for the purchase of assistive devices, transport, dwelling adaptation, dietary meals, clothes and household equipment. In order to receive these LTC services, the degree of dependency in terms of ADL acts as an eligibility criterion, and has to be equal to at least degree level II. This needs' assessment is conducted by doctors and social workers in municipalities' and regional offices. In: OECD report 2017, http://www.oecd.org/slovakia/47878036.pdf

For **home social services** maximum prices are set by municipalities and self-governing regions. Municipalities choose their own mode of price setting (e.g. an amount per hour or per ADL activity). The amount of services' beneficiary co-payment is usually established per service. If private providers are hired, maximum prices are specified in the contract. Limits of co-payments by services' beneficiarys are set by the Law on Social Services. Most caretakers employed by municipality are employed with a salary, but some are employed through a work performance agreement (paid for a certain number of services to be provided instead of hours). Salaries of municipal employees are set according to national regulation. Salaries in the private sector are free. Home caretakers earn € 300 – € 500 per month, which is just about or just above the minimum wage. The nurse's monthly salary in social services is € 652 (2009), which is below average (€ 766).

One can apply to the municipality for social services, while for personal assistance and paid informal home care one needs to apply to a Local Office of Labour, Social affairs and Family, a public organization. In the municipality a **municipal assessment teams** performs the needs assessment. A social worker will assess the social situation, while a physician will examine the services' beneficiary's health status. Medical devices and technical aids are prescribed by general practitioners and paid by the public health insurance agency. Other devices and technical aids are paid from state budget via financial allowance for severe disability compensation. Home care social services are provided by municipalities and self-governing regions or, on their behalf, by private providers (either for profit or non-profit). However, most providers are public, although the revised Act on Social Services is said to have complicated financing of private providers and thus to make private provision less attractive.

Responsibilities for HCB services in Slovak Republic are divided between the two sub-national tiers of government; **regional governments are in charge of providing social services for the severely disabled. Offices of state administration** (Offices of Labour, Social Affairs and Family) are responsible for the provision of personal care (e.g. care allowance, personal assistance), technical aids. **Local government is in charge of providing services for the elderly** (except those with disability degrees 5 or 6). **Local governments are legally obliged to provide home care** so anyone in need who does not receive it can theoretically take the local

authorities to court. However, in reality this does not happen as there is a weak rule of law in Slovakia and those in need of services are mostly marginalized and disempowered members of society. Municipalities should also establish (public) health care agencies (providing home nursing); secondary nursing schools and license private health care providers. Most municipalities struggle to introduce home-based services as they pay larger municipalities to accommodate their elderly citizens in need. In practice, if there is substantial pressure from the user and his/her family, a municipality pays another municipality to accept him/her into a seniors' home. The Association of Towns and Municipalities lobbies to make municipalities responsible only for home care and day care centers, and in cases where these cannot be provided force them to pay regions for institutional care. **There has been a push by the CSO sector to establish a system of financing social services in which money follows the services' beneficiary**, i.e. the services' beneficiary gets to choose which provider he wants and then has the state pay for it. A new Law on Social Services from 2011 allows equal access to public finance for all providers. **The CSO sector is also concerned local governments think less about the quality of services for end users than protecting state institutions and their interests.**

4.3. Care provisions distributed directly to services' beneficiaries: Czech Republic

Similar to the Slovak Republic, a sharp dividing line exists between home nursing and home social services in the Czech Republic: **Home nursing** is a medically oriented care out of hospitals, including, for instance, injections, care of persons with severe pressure ulcers or diabetes mellitus, or the post-acute care for individuals who do not need or do not want to be in hospitals. Home nursing is understood as health care: **It is covered by the health care insurance**, if a general practitioner has confirmed the necessity. Home nursing is intended to care for persons after a hospital stay or for chronically ill services' beneficiaries who do not need a hospitalization, but qualified care and treatment by a professional nurse. **Prices for home nursing** (for procedures and time spent by a services' beneficiary) **are set by the health care insurance institutions**. The salaries in home nursing are lower than salaries of nurses working in hospitals, home nurses receive monthly payment in amount of 600-800 EUR. In private companies providing home nursing, nurses are paid by

factual hours spent by services' beneficiaries, so their salaries differ from month to month. Such difference in salaries between the recent medical staff in hospitals and HBC services creates disadvantage for the home care services providers on one side, because they usually receive lower salaries. Anyway, there is also an advantage of home care services providers comparing to nurses in hospital: they usually don't work on shifts, change the environment during the day and fulfill more heterogenous tasks.

Social home care service is a field-based or out-services' beneficiary service provided to persons with reduced self-sufficiency due to their age, chronic illness or disability, and to families with children, where their situation requires that they be assisted by another person. This service is provided at a specified time (with the time specification being the main factor differentiating this service from the personal assistance service) in their households or in out-patient facilities. This service is provided to the user **for a fee**. Their providers need to be registered as social care providers. The majority of social home care providers are founded and run by municipalities followed by the CSO sector. A monthly salary of a social caretaker differs from 500 till 720 EUR.

According to the Act about social services, social home care is based on 15 quality standards determining the conditions for staff, organization and administration. It contains the following activities:

- help with the activities of daily life,
- help with daily hygiene,
- providing food or help with meal preparing,
- household services,
- enabling contact with social surroundings.

The user's or services' beneficiary's maximum payments are limited by a ministry notice for all providers: For a care hour 5 EUR; for whole day meals 6.5 EUR; for a lunch 3 Euros; for one kilometer (meals on wheels) 1 EUR; for one kg laundry 2.5 Euros.

Care allowances: The social services system in the Czech Republic is regulated by Act No. 108/2006 Coll., on Social Services, and by the Ministry of Labour and Social Affairs Decree No. 505/2006 Coll. Social

services provide support and assistance to persons in adverse social situations in a form that preserves their human **dignity**, respects **individual human needs**, while at the same time bolstering the ability for the **social inclusion** of every individual in his or her natural social environment. The Social Services Act offers the following fundamental instruments:

- It guarantees free social counselling for every person
- It offers a very **diverse range of social service type, from which a person can freely choose at his/her volition, financial possibilities or other individual preferences**
- People dependent on the assistance of another person due to their age or state of health, are provided a social security benefit – a social allowance
- The Act guarantees that the services provided will be safe for the user, professional and adapted to people's needs
- The Act also gives people room to participate in the decision-making processes pertaining to the scope, types and accessibility of social services in their municipality or region. An application for this allowance may be submitted to a labour office in whose catchment area the applicant has his/her permanent or reported residence.
- The allowance provided to persons up to 18 years of age in a calendar month shall amount to a) 132 EUR in the case of grade I (light dependence), b) 264 EUR in the case of grade II (medium-heavy dependence), c) 396 EUR in the case of grade III (heavy dependence), d) 528 EUR in the case of grade IV (total dependence).
- The **allowance provided to persons over 18 years** of age in a calendar month shall amount to a) **36 EUR**, in the case of grade I (**light dependence**), b) **176 EUR** in the case of grade II (**medium-heavy dependence**), c) **352 EUR**, in the case of grade III (**heavy dependence**), d) **528 EUR** in the case of grade IV (**total dependence**).

The financing of social home care services: is regulated by the law on social services (§ 101 and 102). Only registered services get a subsidy. **Three different channels are used to distribute the subsidy: Firstly, the care providers are subsidized directly by the state, secondly by the region that gets money from the state. Thirdly, they are**

subsidized by the municipality that gets money from the region. The payment covers the running expenditures related to social care provision/ providers that are registered. The aims are:

- support of services that are operating in the whole republic or in more than one region
- to develop infrastructures but above all to invest into education and training of staff
- to develop regional plans
- to develop quality etc.
- to build reserves for the case of catastrophe or emergency

Regional administrations and local municipalities started to use the method of **community planning**, also for the development of social services. The total amount of state subsidies for the social home care is slightly raising but the total amount of the state subsidies has been decreasing since 2009.

The role of municipalities: Persons can apply for care allowance that enables them to maintain an independent life style (by state, paid through regions from the state budget money). **Municipalities appoint the commission responsible for making decisions.** Its members are: the assessment physician who is a medical specialist employed by the Czech Social Insurance Institution and the representatives of the social services of that municipality. **For the purpose of quality control, the employees of the municipalities are authorized to enter the home of the services' beneficiarys in accordance with their agreement.** If major quality problems are identified, the municipalities have to inform the institution that was responsible for the registration of the agency. The municipalities have to monitor whether the money was spent on social services. **However, the services' beneficiary is free in his/her decision how he/she will distribute the money and which of the social services he/ she will use.** The municipalities provide information on the prices as well as forms for the contracts.

Quality control of the social services: In social home care, the quality is ensured by the Standards of quality of social services that are defined and inspected by the state. Social services may only be provided on the basis

of the registration of the provider of the social services. Registration is understood to mean the issue of licenses to provide concrete types of services. These licenses are issued by regional authorities in administrative proceedings based on an assessment of whether the provider is capable of meeting all the conditions prescribed by the Act. The meeting of all the conditions prescribed by the Act, including the quality standards of social services, is controlled in the form of an inspection made of the social services. If the provider does not meet these conditions, the license to provide these social services may be withdrawn. The fundamental measure of the quality of social services is the compliance with human rights when providing social services. The quality standards are divided into three groups:

- **PROCEDURAL** (goal, principles, human rights, conflict of interests, contract, documentation, complaint management, user centred attitude, etc.);
- **PERSONAL** (staff – structure, education, personal goals and developments, volunteers, rewards, communication channels and ways, etc.);
- **TECHNICAL** (equipment, information, critical situation, quality raising, etc.). The municipalities monitor the quality of the provision of social services and therefore also of home care.

4.4. Matrix on dependency rate systems in Romania, Slovakia and Czech Republic

Table 24. **Matrix on dependency rate systems in Romania, Slovakia and Czech Republic**

Czech Republic	Slovak Republic	Romania no exact or regulated amount of contributions detected	RM
I cat 36 EUR	I no contributions for HC	I (most sever cat) divided into categories A, B, C	no official categories of dependency rates developed so far
II 176 EUR	II 89.82 EUR	II divided into categories A, B, C	
III 352 EUR	III 179. 68 EUR	III divided into categories A, B	
IV 528 EUR	IV 269.47 EUR		
	V 359.29 EUR		
	VI 449.18 EUR		

ROMANIA:

The National Grid for Evaluating the Needs of the Elderly/National Grid for Dependent Elderly Assessment (Grila Nationala de Evaluare a Nevoilor Persoanelor Varstnice) (GO, Ordonanta de Guvern, 886/2000) evaluates degrees of dependency and is based on his or her functional status (for basic daily living activities and functional activities) and his or her sensorial and emotional and psychological well-being. Compare to RM, this is a big step forward, as in RM no official system of dependency rates was introduced so far. Based on this evaluation, there are three levels of dependency in Romania, each of which is further sub-divided into **three categories, A, B, C,** with the first degree being the most severe: **I. A** - the person has lost autonomy and needs continuous care; **B** - the person cannot perform daily activities and needs help and medical care for most activities throughout the day and night; **C** - the person needs permanent surveillance and help due to behavioural disorders and regular care for activities related to personal hygiene. **II. A** - the person has perfect mental abilities but partial motor ability and needs daily care for basic activities; **B** - the person needs help getting up and partial help with daily activities; **C** - the person has no motor problems, but needs help with daily activities related to personal hygiene. **III. A** - the person needs regular help with daily life activities, but when placed in an elderly institution can be considered independent; **B** - the person has complete autonomy and can perform daily activities without help.

The assessment is carried out by a team of two social workers from the local council and the General Directorate of Social Assistance and Child Protection from the County Council, together with the medical specialist who has supervised the progress of the individual. This team may be completed by a representative of the Pensioners Organisation or other Nongovernmental Organizations (CSOs) which provide social assistance to the elderly. (Law 17/2000, Art. 28).[88]

CZECH REPUBLIC[89]

The allowance provided to persons up to 18 years of age in a calendar month shall amount to a) 132 EUR in the case of grade I (light depen-

[88] in Romanian: http://legislatie.just.ro/Public/DetaliiDocument/133913
and in English: http://sar.org.ro/wp-content/uploads/2013/01/The-Long-Term-Care-System-for-the-Elderly-in-Romania.pdf

[89] Act No. 108/2006 on social services
in English: https://www.mpsv.cz/files/clanky/4088/Annex_3_social_services_act.pdf
In Czech:http://ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=74443&p_country=CZE&p_count=261

dence), b) 264 EUR in the case of grade II (medium-heavy dependence), c) 396 EUR in the case of grade III (heavy dependence), d) 528 EUR in the case of grade IV (total dependence).

The **allowance provided to persons over 18 years** of age in a calendar month shall amount to a) **36 EUR**, in the case of grade I (**light dependence**), b) **176 EUR** in the case of grade II (**medium-heavy dependence**), c) **352 EUR**, in the case of grade III (**heavy dependence**), d) **528 EUR** in the case of grade IV (**total dependence**).

SLOVAK REPUBLIC [90]

The level of dependence of a services' beneficiary is considered according to a six-grade scale. Act No. 448/2008 on social care defines 12 criteria (e.g. eating, drinking, sitting, walking, hygiene, washing, orientation, etc.) for which individual score (of 0-10 points) is assessed on the performance of a particular personal activity.

The total sum gives six degrees of dependence:

I. total points 105-120, average time of dependence (hours/day) 0;
II. total points 85-104, average time of dependence (hours/day) 2-4;
III. total points 65-84, average time of dependence (hours/day) 4-6;
IV. total points 45-64, average time of dependence (hours/day) 6-8;
V. total points 25-44, average time of dependence (hours/day) 8-12;
VI. total points 0-24, average time of dependence (hours/day) – more than 12.

Maximum contributions for home care per month: I. degree – 0 EUR; II. degree – 89,92 EUR; III. degree – 179,68EUR; IV. degree – 269,47EUR; V. degree – 359,29EUR; VI. degree – 449,18.

4.5. Lessons learned

According the Eurostat,[91] there are significant differences in HCB services delivery across the three European countries chosen for comparison.

[90] Act No. 551/2010 amending the Act No. 448/2008 on social services and modifications of other relevant Acts and amending the Act No. 447/2008 on financial compensation of serious physical disablement and modification of other relevant Acts (in Slovak language): http://www.nrozp.sk/files/2010-551.pdf

[91] Eurostat: Persons using professional homecare services if needed by household type, income group and degree of urbanisation. Last update in December 2017: http://appsso.eurostat.ec.europa.eu/nui/show.do?query=BOOKMARK_DS-900565_QID_-52D2535F_UID_-3F171EB0&layout=TIME,C,X,0;GEO,L,Y,0;DEG_URB,L,Z,0;INCGRP,L,Z,1;CARESTAT,L,Z,2;HHTYP,L,Z,3;UNIT,L,Z,4;INDICATORS,C,Z,5;&zSelection=DS-900565INDICATORS,OBS_FLAG;DS-900565DEG_URB,TOTAL;DS-900565CARESTAT,PROF;DS-900565INCGRP,TOTAL;DS-900565UNIT,PC;DS-900565HHTYP,TOTAL;&rankName1=HHTYP_1_2_-1_2&rankName2=CARESTAT_1_2_-1_2&rankName3=UNIT_1_2_-1_2&rankName4=INDICATORS_1_2_-1_2&rankName5=INCGRP_1_2_-1_2&rankName6=DEG-URB_1_2_-1_2&rankName7=TIME_1_0_0_0&rankName8=GEO_1_2_0_1&sortC=ASC_-1_FIRST&rStp=&cStp=&rDCh=&cDCh=&rDM=true&cDM=true&footnes=false&empty=false&wai=false&time_mode=ROLLING&time_most_recent=true&lang=EN&cfo=%23%23%23%2C%23%23%23.%23%23%23

Available data from 2016 show clearly that a **deep reform conducted in the Czech Republic brought substantial changes in total number of beneficiaries and also in the accessibility of these services** from the socio-economic perspective. In the Czech Republic, 58% of households use[92] professional HBC services which is the second highest rate in the EU. Most of the Czech population use HBC services in towns (72,3%), more than half of the population in towns and suburbs (50,4%) and more than half of the population takes advantage of HBC services in rural areas (55,7%).

Table 25.

Use of HBC services in the Czech, Slovak Republics and Romania – urbanization

Degree of urbanization: (% of the population using HBC in each area)	cities	towns and suburbs	rural areas
Czech Republic	72.3	50.4	55.7
Slovak Republic	13.0	14.2	17.7
Romania	9.2	4.0	5.4

Regarding the income situation of beneficiaries, data show that accessibility of HBC services in post-soviet countries is extremely difficult for people with lower income. Without a serious reform of the post-soviet system of social and medical care it is almost impossible to address HBC services to families/households about or below the poverty threshold. Based on the system of personalized allowances in the Czech Republic, the system covers more than half of the households with risk of poverty threshold:

Table 26.

Use of HBC services in the Czech, Slovak Republics and Romania – income related

Income situation of the beneficiaries was below of median equivalized income (% of total number of responders)	
Czech Republic	53.6
Slovak Republic	20.7
Romania	0.8

[92] Ghttp://ec.europa.eu/eurostat/web/products-eurostat-news/-/DDN-20180228-1?inheritRedirect=true

The very low percentage of HBC users in Romania around the poverty threshold shows, that the HBC services provided by CSOs are not sufficient for the needs of the country and are affordable mostly for services' beneficiaries who can pay for the services from their own pocket. The final comparison based on Eurostat data from 2016 is related to the most significant demographic trend of whole Europe – ageing of society. From this perspective, it's important to understand, how different models address this issue and how accessible are HBC services especially for lonely elders.

Table 27.

Use of HBC services in the Czech, Slovak Republics and Romania – access of elders

Type of households: (% of total number of responders)	One adult older than 65 years	Two adults older /about 65 years
Czech Republic	72.3	52.3
Slovak Republic	20.7	6.6
Romania	0.8	4.1

The table shows how are lonely elder people in Romania vulnerable, as the system doesn't include them into the net of free and accessible HBC services, both due to lack of funds and minimal reform in social and health spheres.

Broader responsibilities of local government don't ensure better addressing of the HBC services and their functioning system. In the Slovak republic, where municipalities have legal obligation to ensure social HBC services to inhabitants, great problems remain in under-developed regions with accessibility of these services. Bureaucratic procedures obliged for the local government to be able to hire CSOs or private providers of HBC services remain to be limitation the process of development of a sustainable and living market with social and medical services the country.

Outcome of the reform in the Czech Republic - sustainability: the most important outcome of this reform is creation of a **growing market with social and medical services** provided to services' beneficiaries at home. Except of one house for elderly run by the state, all day-care, hospices or senior houses are run by CSOs/firms, getting subsidies from the state and from the services' beneficiaries. As there are different care providers, they compete in the quality of services and prices. Services' beneficiaries decide by whom to buy needed service and they are also looking for the most reasonable costs. As a services' beneficiary is free to choose a caretaker, the relationship between them can change every month or when needed according the current needs of a services' beneficiary – the contract can get modified any time. In such a way, a services' beneficiary can get a quick reaction to his/her needs, providers are more flexible to provide the care that is needed and the whole market is liquid and changing according the needs without serious bureaucratic or systematic problems. Nonetheless, i**t's important, that the market is still partly regulated by the state** – the maximum price for service and working hours of caretakers are set by the law for every care provider. Such a measure was taken to ensure financial accessibility of services' beneficiaries. The reform started in 2006 and it took from 7 to 10 years to develop and stabilize the market. One of the most requested services in 2017 were home hospice/palliative services.

As an inspiration, approximate percentage representation of financing social services is summarized in the following Table 28:

Table 28. **Financing of HBC services**

Financing of HBC social services in the Czech Republic in one calendar year (2017)	
Ministry of Labour and Social Affairs (through regional administration)	42%
Municipalities (taxes)	22%
Regional administration	9%
Services' beneficiaries	23%
Donors/sponsors	4%

The role of the state: State remains in all developed European countries **the main investor in HBC services**, but each state is looking for ways how to create a less bureaucratic, less costly system. As the number of services' beneficiaries is rising in Europe, each state is looking for a system how to provide the care, but decrease the costs. Only reforms of the social and medical systems can bring improvements. A **deep reform** in the health and social sector **must start with setting a political vision of the reform on the level of the government.** Such a reform can be realized from the very first point to the situation of a functioning market in one decade (10 years), on condition that **sufficient funds for such a reform are allocated by the government**. Without investment in services' beneficiaries won't be created a market with services.

Overview of Prices setting mechanisms EU countries: Similar to RM, where the process of setting prices by the state (NHIC, Ministry of Health, Labour and Social Protection) has slowly started, in Europe, prices for home nursing are set by state in Estonia, Hungary and Slovenia and for most home-care services in Iceland. In France, prices are set through both a technical evaluation (e.g. in terms of a standard time and the tariffs for personnel) and a negotiation between providers and the funding institution at national level. Luxembourg uses a similar process, involving the umbrella organization of care providers. In the Netherlands, the Dutch Healthcare Authority sets maximum prices by considering labour costs, level of expertise required, productivity and overheads – these prices are index-linked. In Germany, prices are negotiated between representatives of care providers and long-term care institutions. In some countries, the municipal level has a high degree of autonomy in negotiating the price of social home care directly with providers – as in the Scandinavian countries (e.g. Denmark, Finland and Sweden), Slovakia and Switzerland. But even where there is freedom to decide the prices of (some) home-care services, some central governments have set national guidelines for price setting (e.g. social home care in Slovenia). In Spain, prices vary among the autonomous communities and the lack of recognition of home-care prices is now considered to be a demanding governance problem.

In most EU countries (24) services' beneficiaries must contribute out-of-pocket for publicly provided home care. This may be either because they

are not eligible for free care – for instance due to income limits, as in Greece, Italy, Latvia, Slovenia and for social home care in Poland – or because all services' beneficiaries are required to make a co-payment, which can be means tested. In Portugal, for example, the co-payment for social home care is 50–60% of the income per capita of the household. Free-of-charge services are provided in Bulgaria and, for social home care, in Poland but only for those on very low incomes. In Denmark and Sweden most services are also free of charge and long-term home care is a universal right that is not means tested. Health services are more often free of charge than social care services. Free home-health services are provided in, for instance, Ireland, Norway, Poland, Slovenia and Spain. The opposite is true for Luxembourg where domestic care and personal care are free of charge and home health care is subject to co-payments.

Table 29.

Types of medical HBC services delivered in the Czech Republic, Slovak Republic and Romania

Distinguishing criteria	CZECH REPUBLIC	ROMANIA	SLOVAK REPUBLIC
Types of services offered	Medical HBC services	Medical HBC services	Medical HBC services
Form of organization	Private companies, CSOs, state entities	Private companies, CSOs, state entities	Private companies, CSOs, state entities
Working mode	Usually 8 hours per day, 24 hours per day with payment for overtimes	Usually 8 hours per day	Usually 8 hours per day, 24 hours per day if needed (no special payment for overtimes)
type of service recipients	Insured persons	Insured/uninsured persons	Insured persons
Criteria for admission to service	Official general practitioner's recommendation Specialist doctor's – usually hospital physicians recommendation (after a surgery etc.)	Official general practitioner's re-commendation Specialist doctor's recommen-dation	Official general practitioner's recommendation Specialist doctor's – usually hospital physicians recommen-dation (after a surgery etc.)
The duration of service provision	Long-term period (for elders and other long-term services' beneficiaries) Short-term period (just for a convalescence after a surgery)	Long-term period (for elders and other long-term services' beneficiaries) Short-term period (just for a convalescence after a surgery)	Long-term period (for elders and other long-term services' beneficiaries) Short-term period (just for a convalescence after a surgery)
Area of service delivery	Without restriction, usually maximum of 25 km away from the office or within the concrete region	Within the municipality area or region	Within the municipality area
Customer service cost (for a services' beneficiary)	Paid from insurance (an insurance company reimburses the costs to the provider) or services' beneficiary's payments to the provider services' beneficiary's payment for overtimes (usually weekend between 10 am and 6 pm)	Paid from insurance (an insurance company reimburses the costs to the provider) or services' beneficiary's payments to the provider	Paid from insurance (an insurance company reimburses the costs to the provider) or services' beneficiary's payments to the provider
Financing the services	Insurance company (services offered, medical equipment for services' beneficiaries), donors (equipment of providers), services' beneficiaries (in case of full private payments)	Insurance company, donors, services' beneficiaries	Insurance company, donors, services' beneficiaries
Manner and conditions of accreditation	Full accreditation with fulfillment of all standards required by the Ministry of Health	Full accreditation with fulfillment of all standards required by the Ministry of Health	Full accreditation with fulfillment of all standards required by the Ministry of Health
Partnerships to ensure service quality	Insurance companies, donors, municipalities, regions	Insurance companies, donors, municipalities, regions	Insurance companies, donors, municipalities, regions

Table 30.

Types of social HBC services delivered in the Czech Republic, Slovak Republic and Romania

Distinguishing criteria	CZECH REPUBLIC	ROMANIA	SLOVAK REPUBLIC
Types of services offered	Social HBC services	Social HBC services	Social HBC services
Form of organization	Private companies, CSOs, state entities, churches, family members	Private companies, CSOs, state entities, churches	Private companies, CSOs, state entities, churches
Working mode	Based on individual contracts	in usual working hours from	In usual working hours
type of service recipients	Anyone who is in need – for private payments Anyone who wishes and was eligible for allowances related to the degree of independence	Anyone eligible for home care services (approved by municipalities)	Anyone who is in need – for private payments Anyone eligible for home care services (approved by municipalities)
Criteria for admission to service	Anyone who is in need – for private payments Anyone who wish and was eligible for allowances related to the degree of independence	Anyone eligible for home care services (approved by municipalities)	Anyone eligible for home care services (approved by municipalities)
The duration of service provision	As long as needed	As long as there is financing (from donors) As long as approved by the municipality	As long as approved by the municipality
Area of service delivery	Within the municipality area or region	Within the municipality area or region	Within the municipality area or region
Customer service cost (for a services' beneficiary)	Full services' beneficiary's payment through allowances related to the individual's degree of dependency offered by state	No payment (in case of HBC services approved by municipality) Full services' beneficiary's payment (in case of private initiative of a services' beneficiary or his/her relatives)	No payment (in case of HBC services approved by municipality) Full services' beneficiary's payment (in case of private initiative of a services' beneficiary or his/her relatives)
Financing the services	European funds, state, regions, municipalities, services' beneficiaries (through allowances offered by Ministry of Social Affairs)	European funds, state, regions, municipalities, services' beneficiaries	European funds, state, regions, municipalities, services' beneficiaries
Manner and conditions of accreditation	Accredited registrations and accredited social workers	Accredited registrations and accredited social workers	Accredited registrations and accredited social workers
Partnerships to ensure service quality	Regions, municipalities, Ministry of Social Affairs, services' beneficiaries, CSOs, churches, private companies, charity, international donors	Regions, municipalities, Ministry of Social Affairs, services' beneficiaries, CSOs, churches, private companies, charity, international donors	Regions, municipalities, Ministry of Social Affairs, services' beneficiaries, CSOs, churches, private companies, charity, international donors

Table 31. **Types of integrated HBC services delivered in the Czech Republic, Slovak Republic and Romania**

Distinguishing criteria	CZECH REPUBLIC	ROMANIA	SLOVAK REPUBLIC
Types of services offered	Integrated HBC services: Widely used services with one provider of medical and social HBC services, but divided accountancy	Integrated HBC services: Very limited use	Integrated HBC services: Limited use, focuses mostly on integration of people in social excluded localities
Form of organization	Private providers, CSOs	CSOs	Mostly CSOs
Working mode	In usual working hours with special payments for overtimes	In usual working hours	In usual working hours
type of service recipients	Insured persons services' beneficiaries eligible to allowances related to their degree of independence	Insured persons Uninsured persons (in case of some providers) Anyone eligible for home care services (approved by municipalities)	Insured persons Anyone eligible for home care services (approved by municipalities)
Criteria for admission to service	Recommendation of a generally practitioner/ a doctor specialist Eligibility for allowances related to degree of independence	Official general practitioner's recommendation Specialist doctor's recommendation Anyone eligible for home care services (approved by municipalities)	Recommendation of a generally practitioner/ a doctor specialist Anyone eligible for home care services (approved by municipalities) – focused mostly on inclusions of people living in social excluded areas and disabled people
The duration of service provision	Long term Short term	Long term Short term	Long term Short term
Area of service delivery	Usually Within the municipality or region	Within municipality	Within municipality
Customer service cost (for a services' beneficiary)	No payment for medical HBC, full payment for social HBC through allowances Full payment	Partly paid (in case of some pilot projects funded by donors) Full services' beneficiary's payment (in case of private initiative of a services' beneficiary or his/her relatives)	No payment for medical or social HBC services
Financing the services	Insurance company, services' beneficiary (through allowances from the state)	Insurance company, donors, municipalities	Insurance company, municipality, region
Manner and conditions of accreditation	Accreditation of nurses, accredited registration of a company Accreditation of social workers	Full accreditation with fulfillment of all standards required by the Ministry of Health Accredited registrations and accredited social workers	Accreditation of nurses, accredited registration of a company Accreditation of social workers
Partnerships to ensure service quality	Hospitals, insurance companies, regions, municipalities, Ministry of Social Affairs, services' beneficiaries, CSOs, churches, private companies, charity, international donors	Insurance companies, municipalities, regions Ministry of Social Affairs, services' beneficiaries, CSOs, churches, private companies, charity, international donors	Hospitals, insurance companies, regions, municipalities, Ministry of Social Affairs, services' beneficiaries, CSOs, churches, private companies, charity, international donors

4.6. Suggestions and recommendations to Chapter IV

General recommendations:

- The state policy should be clear in the direction of two main approaches towards to HCB services: 1. providing integrated care and for all (Scandinavian model,)[93] or 2. providing intensive care for individuals with highest levels of need (as in Czech Republic, Germany). Each model is connected to different sources of finances: Scandinavian model requires more fiscal powers for municipalities and relatively high local taxes (at least 20% of an income). The second model is related more to national social insurance funds and health insurance funds. In line with one of the chosen directions, the HBC services should be provided in combination with hospital care, primary care and long-term institutional care. **The state should ensure elaboration of laws and policies which can coordinate a cooperation of all institutions named above.**
- The main source of financing of HCB services should not come from donors through some CSOs, as such a model is not sustainable. Different donors have different expectations, approaches, priorities, so it's impossible to create and maintain a sustainable system of HBC services in the country. Anyway, the already realized projects can be used as great example of the work used for – finding the standards, quality standards, identification of needs, identification of real costs and lessons learned. From the whole scale of possible financing (private insurance, compulsory insurance, taxation, user contribution) the contribution from the state budget (provided through different state stakeholders in the case of medical and social care) should be the most significant one in RM.

Social HBC services:

A legal act should be further developed to ensure quality control of social and medical services. In the social and health standards used in RM, there

[93] Disability allowances: they are granted in the framework of social assistance, are noncontributory and impose a means test. They often cover people with congenital impairments and/or people in institutions. In certain countries, there are no specific non-contributory invalidity allowances (e.g. Sweden, Luxembourg). In these countries, the general scheme for guaranteed minimum income covers people excluded from the contributory scheme. In: STUDY OF COMPILATION OF DISABILITY STATISTICAL DATA FROM THE ADMINISTRATIVE REGISTERS OF THE MEMBER STATES STUDY FINANCED BY DG EMPLOYMENT, SOCIAL AFFAIRS AND EQUAL OPPORTUNITIES. https://www.researchgate.net/publication/319881577_STUDY_OF_COMPILATION_OF_DISABILITY_STATISTICAL_DATA_FROM_THE_ADMINISTRATIVE_REGISTERS_OF_THE_MEMBER_STATES_STUDY_FINANCED_BY_DG_EMPLOYMENT_SOCIAL_AFFAIRS_AND_EQUAL_OPPORTUNITIES

is missing **information about the body with authority to check quality of services** (in Slovak Republic - it's mainly the Ministry of Health and Ombudsman for health care services and municipalities, Ministry of Labour, Social Affairs and Family plus Ombudsman for social services), **fees and further steps taken in case of low quality performance**, definition of insufficient fulfillment of ethic and other quality standards etc. In Slovakia, 21 legally binding quality requirements; in the Czech Republic,23 criteria divided in four sections, in Romania quality standards are set the license/accreditation, but can vary depending on concrete region.

- **A deeper approach towards integrated social and medical services** is needed in RM: As the budget for HCB services in RM is currently allocated mostly under the local and regional adminis-tration, RM should develop policy priorities based on decentralization of state budget distribution, deinstitutionalization of different medical/social facilities and development of community living. If the budget for HCB social services remains under municipalities/regions, it gives an opportunity to address the needs of services' beneficiaries and to plan in accordance of the real situation in the region. To achieve this, there is a need to formulate policies and laws on:
    - the legislative framework should be revised to allow simple contracting between municipalities and HBC services providers, especially from a non-profit sector (out of TUSA system) – to avoid the situation in Romania, where bureaucracy makes such a sub-contractors-system protracted with limited possibility to react to actual increase/decrease of beneficiaries.

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[95] Slovakia: In January 2009 the Act No. 448/2008 Coll. on social services came into legal force (In Slovak language with English summary available here: http://ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=84794&p_country=SVK&p_count=379). The Act incorporated a preliminary legal framework for quality issues in social services which was worked-out into details since January 2014. Providers of social services of each legal status and all types of services became responsible to adhere to 21 legally binding quality requirements and conditions which are divided into following four domains: a) human rights and freedoms of service recipients; b) procedural quality conditions; c) personal quality conditions; d) operational quality conditions.

[95] All criteria available in English: https://www.mpsv.cz/files/clanky/2057/standards.pdf

[96] The law act nr. 292 available in Romanian here: http://legislatie.just.ro/Public/DetaliiDocument/133913

[97] Quality assurance for the social and health services is provided via the certification based on quality standards and the inspection of the social inspection. The social inspection works within the National Agency for Payment and Social Inspection (NAPSI) conducting inspections based on an annual plan and unannounced controls. In: https://eacea.ec.europa.eu/national-policies/en/content/youthwiki/46-access-quality-services-romania

- it would be worthy to divide responsibilities of social workers: TUSA workers can be active more in case management, identification of services' beneficiaries' needs, contacting different state agencies etc. The HBC social services providers would provide every day social care to services' beneficiaries or elderly based on a contract with municipality.
- After some transformation of the system, the budget of HBC services paid by municipality to HBC social services providers should be based on estimation of needs (it must calculate the number of elders living in the town/region, number of people with disabilities, etc.). As there are no sufficient funds at the moment to cover all these cases, the municipalities should start with pilot projects focused on a part of town or a few villages and conclude a contract for HBC social services through public-private partnership. In pilot projects, the real costs in two-three years can be calculated and the legal provision can be further developed.

Health HBC services:

- The NHIC as a most important source of funding of medical services in RM should be reformed: Ministry of Health, Labour and Social Protection together with NHIC should improve quality standards through introduction of dependency grades and apply different reimbursement of costs by different categories of services' beneficiaries.
- The administrative burdens for HCB accreditation and for reimbursement of costs should take place as soon as possible

New approaches / trends in HCB services:

- **Telecare and telemedicine can be piloted in RM.** Telemedicine is used by health care professionals to consult colleagues or to outsource diagnostics. Other examples of telemedicine are teleconsultations, teleradiology, telemonitoring and diagnosis, treatment and prescription of pharmaceuticals through the internet. eHealth contains the supply of medical information through websites and the development of the medical health record. Telemedicine is more efficient as travelling time is reduced and it creates access to high specialized health care (in remote areas). There were already piloting

projects (mostly with "panic button") on telecare conducted in Romania with first lessons learned.[98] In the Slovak and Czech Republic, mostly e-consultations are offered, with some of these services paid and some of them for free.[99] The Ministry of Health, Labor and Social Protection should develop together with doctors and providers of this services an e-Health Strategy for the further steps to be taken. E-health is one of the latest trends financed by the financial instruments of European Union.

- Another inspiration from Europe could be **home based palliative care**. The biggest insurance company in the Czech Republic piloted in the last two years new financing schemes for "home hospices" as such a service is rapidly extremely requested by services' beneficiaries. In piloting projects, the effectivity of palliative care at homes together with its efficiency (related expenses) has been examined. The data of Czech Statistical authority clearly showed, that mobile hospices are able to soften pain by services' beneficiaries and maintain the quality of life. The costs for such were declared to be lower than such a service in residential homes. Home based hospice takes care of a services' beneficiary 24 hours a day, a doctor is reachable 24 hours/day per phone and is ready to come to the patient any time. A doctor is special trained to soften pain by a patient and by his/her family members too. Ministry of Health included home hospices into the services paid by insurance companies starting from February 2018.

[98] Projects conducted in Romania: E-care project -
[99] http://ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=84794&p_country=SVK&p_count=379; Teleasis - http://www.cnscc.ro/en/index.php?page=obiective; or Siveco - http://www.siveco.ro/en/about-siveco-romania/press/press-reviews/leverage-of-ict-solutions-in-elderly-care-cooperatives

For example: Czech Republic: 24doctor.cz - http://muj-lekar.cz/lekar-na-telefonu/#Lekarska_poradna_po_telefonu; or Agel laboratories - https://laboratore.agel.cz/index.html. In Slovak Republic: Poisťovňa Dôvera http://www.teraz.sk/magazin/video-telemedicinu-mozete-vyuzit-a/216367-clanok.html.

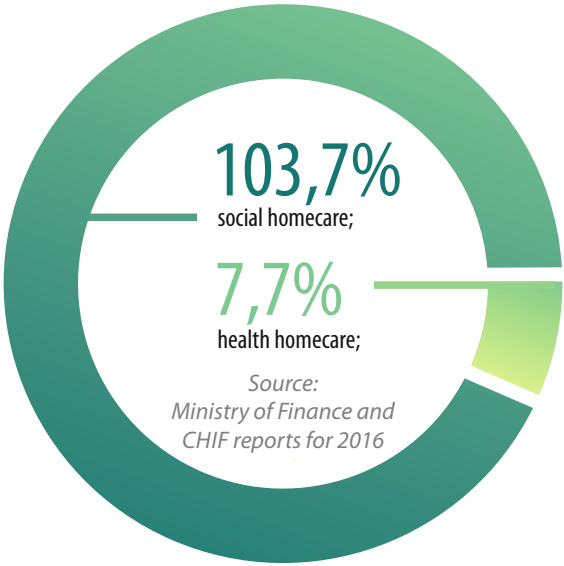
V.
ASSESSMENT OF THE USE OF THE AVAILABLE FUNDS AND POTENTIAL RESOURCES FOR HBC SERVICES

5.1. Available HBC service funds

The HBC services are financed in the RM from the local budget, health insurance main fund, beneficiaries' contribution and private funds (local and international grants and donations).

Unfortunately, the available data and current published reports do not allow us to see the share of each of these resources in the total spent budget. The health insurance reports does not required spending from other sources than those received from the insurance fund. As well the social HBC services reports only the spending from the budget money. The CSOs are not required to presend financial reports to local authorities.

☆ Figure 13.
HBC services funds, 2016 actual budget, *million MDL*



The share of the spending for social HBC services (103.7 million MDL) is 93% out of the total actual budget (111.4 million MDL) reported for 2016 budget year (see Figure 13). Respectively, the share of the spending for medical HBC services is 7% out of the total reported actual budget. The main burden in HBC service delivery stays with the local authorities' budget (social HBC services) in comparison with the inputs from the healthcare budget.

The data used in the Figure 6 does not include CSOs spending. The CSOs that do not have the contract with NHIC and with local public authorities are not included in the total budget because they do not report to the

[100] The budget year in the RM corresponds to the calendar one – starts on January 1 and ends on December

spending from their own sources. This is the main reason why this money is not included in the figure above.

5.2. Potential resources for HBC services

The RM unfortunatelly has no access to neither European Structural and Investment Funds, nor Operational Programme Human Resources, which cover sufficient part of the social and health reforms in Romania, Czech and Slovak Republics. RM can gain funds for reforms from European Neighbourhoud Instrument (ENI), which is a financial instrument dedicated to the Neighbourhood for the period 2014 – 2020. Taking into account the priorities of ENI and Eastern Partnership, RM could use EU funding for development of e-helth, e-administration in health/social sector and development of community planning with HBC services element under the programmatic area "Support to citizens' empowerment to engage in local decision making and participatory budgeting".[101] The same component might be applicable for the programmatic area "social inclusion" and "e-health legislation" in another financial instrument EU – the Single Support Framework for EU Support to RM (2017-2020).[102] Support to innovations in health care sector can be also financed through instruments defined in the Association Agreement of the RM with European Union signed in 2016, especially though a programme "Horizont 2020"[103] under sections "Inclusive, innovative and reflective societies". But unfortunately under the current partneship of RM with EU the only instrument that feed the budget is the budget support program under which there are no conditionalities connected with heathcare and social services development.

5.3. LPA budget potential and forecast

Administrative decentralization

Functions related to the delivery of social services are considered own areas of activity of the local public authorities of the second level (art. 4, par. 2, letters j) and k) of the Law no. 435 on Administrative Decentralization) namely:

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[101] European Neighbourhood Policy And Enlargement Negotiations - Moldova: https://ec.europa.eu/neighbourhood-enlargement/neighbourhood/countries/moldova_en

[102] https://www.gtai.de/GTAI/Content/DE/Trade/Fachdaten/PRO/2017/08/Anlagen/PRO201708115013.pdf?v=1; https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/single_support_framework_2017-2020.pdf

[103] http://www.h2020.md/

- **letter j)** administration of district-based social assistance units;
- **letter k)** development and management of community social services for socially vulnerable categories, monitoring of the quality of social services.

Although the services are provided in the community, they are included in the expenses of the ATU budget, because they are the responsibility of the LPAs of the 2nd level.

Law on Administrative Decentralization no. 435 of December 28, 2006, defines: functions of the LPA, the rules of the administrative decentralization process, the financial and material resources of the local authorities and the institutional framework of the administrative decentralization process. The articles that indirectly or directly refer to the funding of services are 3, 4, 6, 6 (prim), 9, and 10. The last two articles refer to the correlation between the transfers of competencies and budget resources. The **Law on Social Services no. 123 of June 18, 2010**, stipulates the types of social services, providers, rights and obligations of the beneficiaries and the source of funding. In the context of this analysis, we will refer to articles 6, 8, 11, 26, 27 and 28.

For all LPAs, the relations between the state and local budgets are set out in the **Law no. 397-XV of October 16, 2003 on Local Public Finance**. With the approval of the Law no. 267 of November 1, 2013, amendments were made to the method of calculation of transfers from the state budget to the local budgets.

Until January 1, 2015, the transfer amount for a specific public authority used to be established in compliance with the needs of the LPA according to the functions stipulated by the Law on Administrative Decentralization and the own revenues, plus the transfers from the state general revenues. The needs and revenues were estimated at central level on the basis of pre-established normative costs. After the approval of the last amendments to the Law no. 397 on Local Public Finance (came into force on January 1, 2014), for the budgets of the ATU of the districts Basarabeasca, Ocnița, Râșcani and Chișinău, and then, in the budget year 2015, for all the ATUs of the country, the system of transfers to local authorities is oriented towards revenues, not expenses. The calculation of average budget expenses per capita was dropped. This means that the social services, including **social HBC service are financed completely from the collected revenues in the local budget**.

Local budget expenditures for HBC services: availability and potentials

Because the local authorities always lack funds, the HBC services are provided mainly to the elderly persons. Some of the children (special with disabilities) and the people under the retire age benefit by medical HBC services from medical institutions.

Social HBC service is in a better position than other social services financed from the local budget. The reasons: (i) targeted beneficiaries, potential voters in local elections, (ii) historically used service that employs social workers, a big number of people working and paying taxes in the local budget. The registered expenses for social HBC services in year 2016 were 103.7 million MDL which is by 3.9 million more than in year 2015 (see the data in the Table 32).

Table 32.

HBC medical services, home visits

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	42923	44757	+4.3%
4.**Number of beneficiaries**, persons	22348	21362	-4.4%
5.**Cost per beneficiary**, MDL	4465.5	4854.5	+8.7%

Source: Ministry of Finance data and author's calculations

The cost per beneficiary increased as well as a cost per social worker. Unfortunately, we cannot judge what variables influenced these changes because the methodology of calculation the costs for social HBC services is not available yet. We can only assume that the increase was due to the salary increase of the social workers and some price changes for the utilities costs.

The reform initiated for reorganizing the **Population Social Protection Funds**[104] can provide additional means to support the social HBC service. However, the issue may be difficult to implement. The current sources of revenues of these funds are the so called additional state fees paid by legal entities and population: (i) fee for car registration, (ii) fee for

[104] http://particip.gov.md/proiectview.php?l=ro&idd=4893

providing mobile and GSM services, and (iii) fee for buying foreign currency.

The fee that brings the biggest part of the funds is paid by mobile and GSM providers. This fee is collected at the central level. It could arrive in the local funds only via transfers from the republican fund. This fee is planned to be cancelled. The Directive 2022/22/CE approved by European Parliament on March 07th, 2002 foresee that all state fees collected from mobile sector need to be used for improving this sector not others. This measure is included in the National Plan of implementing the Association Agreement of the RM with EU. Other named fees could be perfectly fitted in the local budgets and used for support homecare services.

5.4. Share of the NHIC funds in the health system for HBC, potential and needs

NHIC funds

For the purpose of fulfilling the compulsory health insurance objectives, the NHIC complies and manages the following funds:

- the fund for the payment of current medical services (here and after - the main fund) – 94% of total;
- the reserve fund for compulsory health insurance – 1% of total;
- the fund for prevention (insurance risk prevention) – 1% of total;
- the fund for the development and modernization of public health service providers – 2% of total;
- the fund for administration of the compulsory health insurance – 2% of total.

All together they are called **Compulsory Health Insurance Funds (CHIF).** The revenue part of these funds **is established from**:

- the amount of compulsory health insurance premiums paid by employers, calculated on the basis of remuneration fund;
- the amount of compulsory health insurance premiums deducted from the salary (income) of employees;
- transfers (subsidies) from the state and local budgets calculated as

contributions (insurance premiums) for persons insured by the Government of the RM according to the legislation in force;

- income earned from the categories of population to which the cash insurance policy applies in a fixed amount;
- other income allowed by legislation, including the amount of compulsory health insurance premiums paid by foreign citizens and stateless persons residing on the territory of the RM;
- means disbursed from the single tax paid by the residents of the information technology parks according to the provisions of art. 14 of the Law no.77 of April 21, 2016 regarding the information technology parks;
- the penalties collected from the payers of the mandatory health insurance contributions;
- special purpose grants - grants, credits or other financial means legally obtained, which are intended to complete certain mandatory health insurance funds or to cover administrative expenses.

In accordance with point 9 of the Government Decision no.594 of 14.05.2002, the fund for covering current medical services (the main fund) are distributed no less than 94% of CHIF funds' revenue. Financial means accumulated in the fund are used to cover the expenses required to implement the Unified Health Program of CHIF, provided at all levels of health care: urgent pre-hospital, primary, specialized outpatient, hospital, high medical services.

Expenditures for medical HBC services

Medical HBC services are financed from the main fund and are considered current medical HBC. **Community and medical HBC services** have the lowest share in the main fund expenditures. It is only 0.2% out of total and counted 8.7 million MDL (see Table 33).

Table 33.

Expenditure trend of the expenditures (part of the main fund), *million MDL*

Budget subprograms	2016[105]		2015[106]		2014[107]	
	approved	executed	approved	executed	approved	executed
Total main fund	5611.1	5570.2	4899.6	4899.6	4493.7	4399.8
Primary medical assistance, including compensated drugs	1808.9	1729.2	1580.0	1525.2	1372.1	1342.8
Community and medical HBC, **of which**	8.8	8.7	8.0	7.9	6.6	6.4
Medical HBC	X	7.74	X	7.67	X	X

Source: CHIF report for 2016 and author's calculation

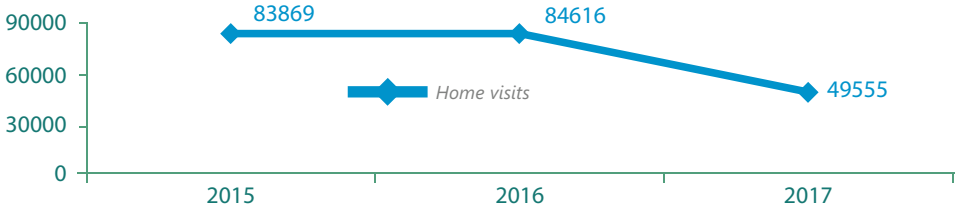
[105] Exchange rate at 31.12.2016 for 1 Euro – 20.8895 MDL
[106] Exchange rate at 31.12.2015 for 1 Euro – 21.4779 MDL
[107] Exchange rate at 31.12.2014 for 1 Euro – 18.9966 MDL

Even so, it is difficult to say how much is spent for medical HBC only. The available data include the community, palliative and medical HBC services all together. If we will consider the number of visits, in 2016 were paid 84 616 visits at home, or by 747 more compared to 83 869 visits in 2015. These data allow us to deduct the costs for medical HBC services from the total amount included in all reports. We used the cost visit in amount of 91.44 MDL per visit for these propose (see data in the table above). The funds for medical HBC services increased by 1% only.

In 2017, the cost of a visit amounted to 131.59 MDL, but without an increasing the budget allocated to medical HBC, thus ensuring payment for 49 555 visits (35 061 visits less in comparison to 2016).

Unfortunately, data in the Figure 14 shows a big drop in the number of visits for medical HBC in 2017. We can assume that this pint to: (i) demography problem in the country and (ii) the problem in covering this type of healthcare in the budget. The second reason could be explained by luck of funds or by no interest from the healthcare service providers in delivering such a service.

Figure 14. **HBC medical services, home visits**



Source: CHIF report for 2016 and author's calculation

Suggestions for methodology for calculation of the cost per one visit of medical HBC services

The methodology for calculation of the cost per one visit of medical HBC is not public as well. We cannot say if it exists. Coming out of it we cannot say if the approved cost per visit is enough or not. But taking into consideration the beneficiaries complains it is possible to say that it needs to be revised.

[108] Exchange rate at 31.12.2015 for 1 Euro – 21.4779 MDL
[109] Exchange rate at 31.12.2017 for 1 Euro – 20.4099 MDL

The cost establishing methodology should show all variables with need to be taken into account such as[110] :

- Type of illnesses,
- Type of beneficiary (independent, partially dependent, totally depended),
- Time spent for one visit,
- Number of visits for one treatment,
- Number of treatments per year,
- Type of medicines used,
- Nurses/medical assistants payment,
- Transport costs,
- Other relevant cost.

Having all this together we may do same average calculations and to have more or less real cost per visit.

5.5. Social Insurance Fund, potential use for social HBC services

Social Insurance Fund could be a potential source of financing for social HBC services.

The public system of state social insurance is an integral part of the social protection system. The main objective of the system is to provide monetary (in cash) allowances to insured persons currently incapable of obtaining a wage income due to certain risk situations (temporary or permanent loss of work capacity, maternity leave, old age, unemployment, etc.). The public system of social insurance covers all RM residents of which a part (the employed people) pay insurance contributions, while the other part benefits from system allocations (pensions, allowances etc.). The main purpose of the insurance system is to guarantee an income to the insured people in case of income loss due to sickness, unemployment, old age etc. The amount of the financial support depends on length of service (employment), amount of salary,

[110] Government Decision nr.1034 from 31.12.2014, Annex 2, section 6.

severity of labor capacity loss, as well as other factors set forth in the respective legal framework.

The public system of social insurance in the RM functions based on Law no.489-XIV of 08.07.1999 on public system of social insurance, Law no.156-XIV of 14.10.1998 on pensions of state social insurance, Law on State Social Insurance Budget for the respective year, as well as other legal and normative acts that regulate social insurance activities.

The biggest share of the all social insurance fund in 2016 belongs to social insurance pensions 86.6% from the total (in 2015 the share was 84,8%), while the social insurance allowances only 13,1 % out of total (in 2015 the share was 12,6%), other social insurance benefits are 0,3% out of total.

The resources collected in this fund could be used for proving cash support (allowance) only if such type of insurance will be included as assured risks. The approval of such changes will need political support and financial support. At the same time, the Social Insurance Fund is registering a big deficit during the last years covered from the state budget. Under such conditions use of Social Insurance Fund for HBC services is very problematic.

5.6. Contribution from the clients

Co-financing as an alternative modality for HBC service development

This source of financing has the biggest potential for implementation. In the RM many people need qualified support from specialist and some of them are available to pay for this support. The changes in the Regulation that allow the partnership with private and CSOs (Standard 4) will open the window for largest access to social and medical HBC services. The main problem here is the lack of qualified specialists. Such type of service is very risky for LPAs because this staffs needs to be employed and kept qualified. People employed at the local level are used to be paid monthly which might not the case for this service. Such habits should be cultivated. A lot of Moldovan women are working in such conditions abroad.

A practical and good way of funds rising could be the co-financing by the beneficiary and /or beneficiaries' relatives. This experience already exists in the RM and it is applied by some local public administration in about 1/3 of the ATU. The cost of service could be different. The important

issue is that the unit cost/ or service cost needs to be approved by ATU council. Each local authority could approve its own regulation on costing HBC services, since an approved methodology at the level of the country will be available. This decision could serve as a ground for approval such spending in the local budget.

The main issue to ensure correctives from perspective of tax authorities and other LPAs to avoid the phenomena of "salaries in the envelope". The system should be well developed and transparent in the regulatory framework.

Czech Republic case as model for RM

In the opinion of international expert Czech Republic oriented its whole social reform starting in 2006 towards to more direct support of individuals in need. The reform started with abolishment of most of subsidies, followed by cut in social administration units both on ministerial and regional levels. A new system of personal allowances (related to dependency rates) was introduced and administration transferred to local departments of labour and unemployment (formally under the Ministry of Social Affairs). The system of dependency rates related allowances was introduced as a main source of financing social services for citizens. Social allowances are paid directly to clients and clients are free to decide and use any provider / services offered on the market. No socio-economic parameters of clients are taken into account – the only criterium for granting of social allowances is his/her grade of dependency.

Starting from 2006, some clients had a tendency to keep these allowances for their family or for themselves, but during the last ten years, population started using social services in great amount. Czech Republic is the second country in the EU in using professional home care, 58% households took advantage in home care services in 2016. As the request from clients grows, providers of HBC services are able to keep their staff on monthly remuneration basis.

5.7. Contribution from the donors

The research data shows that exist the donors money in the sector, but not much.[111] The problem is with their reporting. The service providers do not report to LPAs and all their spending and achievements are not

[111] The main donors in HBC sector are: Swiss Red Cross, HEKS, Czech Development Agency through Caritas Czech Republic, ADA, Caritas Vienna, "R. Bosch" Foundation etc.

included in the official reporting documents. There are some donors open to collaborate with LPAs (CSO "CASMED" and CSOs under "CASMED" umbrella, CSO "Homecare", CSO "Neoumanist", Charity Foundation "Caritas Moldova", CSO "Concordia. Proiecte sociale", CSO "Aripele Sperantei" etc.). There are others that for tax propose are not interested in opening their financial documents. It is result of (i) RM fiscal legislation that is not perfect and (ii) the unwillingness to pay taxes, mainly from the paid salaries. The issue with 2% support for CSOs is one step forward to open the collaboration between private and state structures.

Another very important step should be the reporting issue. It should be compulsory included under the conditionality for service delivery accreditation. The LPAs should know the number of beneficiaries supported by the private HBC service providers, the unit cost for this as well the territory where this service is provided. In this case the issue on private public partnership could be easier implemented.

International expert proposes to be introduced the issue in the kind contribution. In Slovak and Czech Republics, the donor's money has been used mostly for obtaining material assets, like cars, buildings, medical supplies (wheelchairs, crutches, adjustable beds etc). Medical supplies are in the ownership of the HBC services providers, but they are offered to clients for rent if needed. In this way many clients bridge a period till they receive medical supplies requested through the insurance company, as it usually takes several months.

5.8. Suggestions and recommendations to Chapter V

The analysis of the organization of the HBC services made by Moldovan team of experts gives some windows for improvements for increasing the access to HBC services:

1. The methodology for calculation the visit cost for medical HBC service and beneficiary cost for social HBC should be developed and approved. The publication in Official Monitor will make it legal and available for LPAs and other potential service providers. It will allow local authorities to have more arguments in front of local councils and potential donors in defending for additional funds.

Recommendation: *In case if Methodologies are prepared, to publish them in Official Monitor and make them legal. If the methodology does not exist then it needs to be developed with expert's support and approved by the NHIC and MHLSP.*

2. Delivery of the medical HBC services is limited due to limited funds. This is even mentioned in the **Standard 1 of the National Standards for Medical HBC**. Having such statement in the legal framework the health institutions are covered legally not to perform this service to all persons requiring it.

Recommendation: *To change this statement in the Standard 1.*

3. The existing regulations allow medical institutions to perform social HBC too. This is stated in the **Standard 5 of the National Standards for Medical HBC**. This is good, from one point of view, since the team could have multifunctional activities. But, we consider this is hard to enforce due to low level of price for one visit. This situation does not allow delivery of quality service. How you may offer all spectrums of services described in the Standard, if you have no available funds for purchasing diapers even.

Recommendation: *To create a good communication between TUSA and medical institutions at the local level. They need to change the information about the beneficiaries and potential beneficiaries. In this case they will be able to plan better the limited available funds. This is important because we can see that the budget for medical HBC services is not always executed as planned. The health care sector is more flexible and TUSA should cooperate with them more closely.*

4. Another way on how to achieve better coordination among state agencies, medical institutions and HBC services providers is a possibility to establish **case management**. Although HBC service has long been present in social care, its delivery is better described in the **National Standards for Medical HBC**. This, including the availability of funds, allows the implementation of this service with support from medical institutions. Here will be necessary to mention the possibilities to use the voluntary services.

Recommendation: *To increase this service by using also a voluntary work in performing medical HBC services. It could be supported from the healthcare main fund (Standard 5).*

5. It should be noted that the legislation in force obliges LPAs to include the received donations and grants in the local budget and to spend the funds as foreseen in the Framework Regulation. In this

sense, there is also the clause and the possibility of concluding partnership agreements (Standard 4), allowing diversification of types of expenditure.

Recommendation: *In the context of the Strategic Plan for the Development and Consolidation of the social HBC Service in the RM for the years 2015-2017, Order no. 20 of February 18, is necessary to have training and series of discussions on applying the new provisions included in the Regulation (Government decision no. 1034 dated December 31, 2014). It is also possible to use the process of community planning in Moldova, at least in some municipalities, to raise by citizens the issue of higher HBC services financing from local budgets.*

6. Co-financing and financing of the HBC services (social or medical) by individuals are a good opportunity for increasing the quality of provided services or even to include more beneficiaries in the service. Legal framework does not forbid the individuals to participate as financer or co-financier. Meantime, there are no clear provisions in the regulatory framework on how co-financing and financing could be applied in the practice. The experience of the ATUs shows that it is possible in the context of the existing legal framework by applying in practice the local authority's autonomy principles that are recognized by the Law on local public administration and Law on local public decentralization.

Recommendation: *Local public administration should have more initiatives in applying good practices during its mandate.*

Suggestions on different financial sources of HBC services from the international comparative perspective **submitted by international expert:**

The European experience shows, that social and health insurance funds together with taxes constitute the main resource of financing HBC services. The OECD statistics also proved that expenditures in health and social sector depend fully on the GDP of each country – in time of an economic crisis, the expenses on health and social sector in all countries decrease significantly. From this point of view, it is necessary to use funds available now and make realistic estimation of the situation in Moldova.

Based on the expert's interview with state officials and research in mass media, political establishment doesn't express will to start with big fiscal

reform with the aim of stronger and more independent local government. Based on this, local government most probably won't receive more money for possible HBC services in the next decade. Anyway, a restructuralization of their funds can bring some achievements in social HBC:

- based on community planning, municipalities can express their will to allocate funding for HBC services in their budget for social-related activities. Municipalities should become a part of drafting group for new period of "Strategic Plan for Development and Consolidation of social HBC services in Moldova"
- when any (even small) budget allocated (as it happened for example in Balti or Chisinau already), pilot projects with contracting of CSOs for HBC services provision can take place (as it is happening in the same cities), following the model of Romania and Slovak republic
- the municipal social workers can move their responsibilities more toward case management and contribute to more integrated social and medical services application; a network of home carers can be established on local levels through contracting pilot projects

Such an approach seems to be one of the most affordable in Moldova at the moment. If such a model is chosen, it is necessary to:

- develop and ratify accreditation criteria for HBC providers (recommendation for: Ministry of Health, Labour and Social Protection of Moldova)
- simplify legislation of hiring private providers and CSOs by municipalities (Ministry of Finance, Ministry of Health, Labour and Social Protection)
- calculate costs of social services based on pilot projects in a few municipalities (municipalities + providers) and fix them in an act or law (Ministry of Health, Labour and Social Protection of Moldova)

Health HBC services can be improved through reform on financing structure from NHIC:

- rates of dependency must be created and accredited
- NHIC should reflect rates of dependency for reimbursement of HBC providers services

- effective system of prices must be developed (see a model of "codes" used in the Czech Republic see Chapter VI.)
- a system of quality control must be introduced with developed sanctions and recommendations for improvement by the Ministry of Health, Labour and Social Affairs.

In the current situation of Moldova, the international expert doesn't see the possibility of unification of Social Insurance Fund with the NHIC. In this case, the decision-making powers should be transferred to local administration (Scandinavian model) which again needs a strong political will for decentralization on both geographical and financial levels.

VI.
THE COSTS OF DELIVERY OF HBC SERVICES

6.1. Methodological approach

The method used for cost calculation with this document is called ***activity-based costing methodology***, the **ABC method**. ABC method is considering the activity a process, a task or a function which transforms the resources (inputs) in products/services (outputs). The ABC costing method associates the costs of resources with services delivery.

This method implies:

1. Defining and evaluating all resources used (administrative, personnel etc.);

2. Identifying activities linked to each social service and distributing the resources used for each activity;

3. Combining activities related to the service and allocation of the resources used for each of the activities in order to obtain the cost of the activity;

4. Combining the activities related to the service to obtain the cost of the service, which will be divided by number of beneficiaries.

The result of the ABC method is presenting the Unit Cost (UC) of a service by dividing the costs of resources (inputs) to the level of the activity (outputs).

UC = Cost of Resources/Cost of Activity per each beneficiary

Basic assumptions for cost calculations:

1) UC should include the **total running cost** of the delivered service;

2) UC should comply with the **minimum quality standards** for each service;

3) Resources used for service delivery are efficiently used and distributed according minimum quality standards;

4) The costs are different for each delivery model;

5) UC reflects the overtime changes in costs (adjustments could be done by considering the changes in consumer price index).

Definition of COST – a cost represents the **monetary value** of **all resources** used to achieve **a specific result**. In the process of defining the

cost two basic rules are to be considered:

1) quantification of all running costs that makes possible the delivery of a defined service (the costs of putting in place a services will not be considered (**example: buying a building, capital investments etc.**);

2) quantification of resources at a given period of time, without considering the time when financing was assigned (**all costs of resources for the 2016**[112]).

Steps to cost calculation:

1. Define the services that will be assigned a cost (2.1 to 3.2 of the current assignment). It is very important to have a clear definition of each service and a clear understanding of what activities are being performed under each service.

2. Identification of resources associated with each service/activity (as per the executed budgets for each service provider). Example of activities under HBC (medical assistance, social assistance, hygiene, transportation, legal support, etc.).

3. Calculation of UC or each activity and service (the unit cost of each activity is calculated by dividing the total cost of the activity to the number of units (volume) of activity. The UC of the service is established by dividing the total cost of resources by the number of beneficiaries in a given period of time (2016).

Data, used for cost calculation is based on the information provided by HBC service providers within the questionnaire. Provided data come from financial and accountant documentation: 1) executed annual budgets; 2) accountant documents and reports; 3) particular invoices and payment documents). Other information considered for cost calculation: 1) functioning regulations and quality standards; 2) number and profile of the beneficiaries.

The models/groups of providers considered: 1) medical institutions; 2) TUSA; 3) CSO "Homecare"; 4) CSO "CASMED" (for cost resources analysis and calculation only the mother unit was considered); 5) CSO "Neoumanist".

The models have been defined based on particularities of service delivery described in Chapter III of the report, part 3.2. Main considered

[112] Exchange rate at 31.12.2016 for 1 Euro – 20.8895 MDL

particularities are: main activities/services offered by providers (Tables 17 and 18), profile of the beneficiaries assisted by various providers, sources of funding, public-private delivery, number of beneficiaries served with a set period of time. These particularities dictate what resources are being used and the intensity of used these resources. Costs could not be provided as per the sub-models presented in the Tables 7, 8 and 9 since due to impossibility to desegregate the current spending within a group.

6.2. Resources used to deliver HBC services

The resources used for delivery of HBC services are dictating the cost of these services. The resources are quantified and the amount of money to buy these resources is established (in this context resources and expenditure are synonyms).

The resources used for service delivery are relatively homogeneous within each model of providers. At the same time resources are different if we compare them from one model to another. There are several factors that dictate these differences. Private providers use more divers resources compared with public providers. Resources also differ by type of care (medical HBC, social HBC and integrate HBC) and how this service is provided (in-center or at-home delivery). Annex 4 presents a list of resources used for HBC delivery.

The biggest share of used resources is human resource; more than half of expenses across models cover work remuneration. Other important expenditures cover maintenance of a work space/premises (office or center) and transportation means as well as expenditures on medication.

One of the main differences in resource distribution among models is linked to the availability of existing the physical social and medical infrastructure. Public providers have to cover less or no cost for maintaining an office/center. Private (including non-profit providers) spend an important amount on rent, utilities and repairs of work premises. Providers as medical institutions declared zero costs for such expenditures; therefore it is clear that the existing healthcare system is taking over some costs of delivery of HBC services. This puts the providers in a different financial position in the context of similar refunding mechanism from the state (the visit cost covered by NHIC).

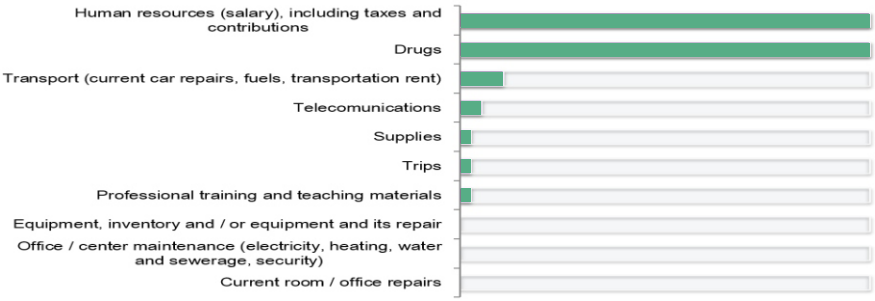
It is important (when refunding the visit cost for HBC services that the NHIC should be aware that the cost for the same service is different depending on the status of the provider. The cost for non-profit and profit providers for one visit is higher considering the fact that they function outside of the healthcare system which is taking over some of delivery costs.

Resources / expenditures particular for public medical institutions

The medical institutions have the least diversified resources used for HBC delivery. This is a result of the method of calculation of per visit cost covered by the NHIC. Biggest part of the resources used by medical institutions are human resources (including related taxes), expenditures for medicine and materials.

The Figure 15 shows how many providers have one or another type of resource. How to read the figure - the first bar is fully colored which indicates that all providers have such a type of expenditure (ex: salaries). If a bar is entirely colorless this shows that none of considered providers have this type of expenditure. The intensity of used resource is not reflected in the figure. The Figure 15 refers only to medical institutions. 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 back fees. Very few medical institutions had expenditures for professional qualifications and work related travel.[113]

Figure 15. **Expenditures on different type of resources by incidence of each type of resources, medical institutions (share of total providers)**



Source: Author's calculations based on data provided by medical institutions

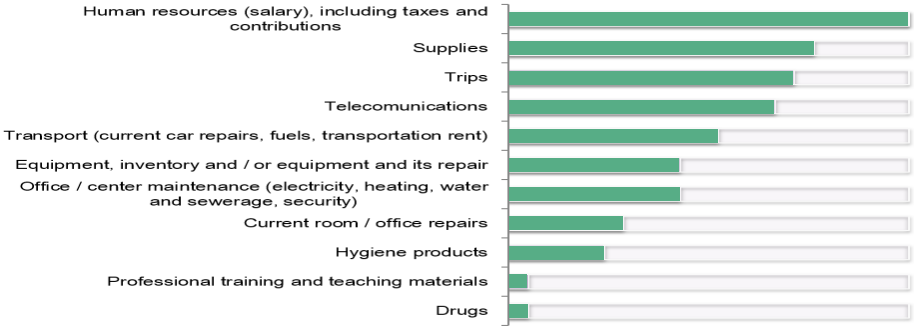
[113] Trips costs refer to costs for the personnel to travel to district centre or Chisinau for trainings and other activities; transportation costs refer to the costs of visiting or moving beneficiaries, usually with transportation means owned by the providers, these costs include repairs of the cars, gasoline and other car related costs.

Total money distribution per model is not possible to show considering the different incidence by type of expenditures. For instance, just one medical institution had expenditures on trainings and professional rehabilitation with a significant amount. Nonetheless this is not representative in terms of general spending and will not provide a clear image on how funds are spent.

Resources / expenditures particular for TUSA

TUSA have the most diversified expenditures for HBC service delivery. Work remuneration remains the most important share of used resources. Another important component is rent/ maintenance and utilities for the work premises. Some resources are allocated to rent/ maintenance of cars, office supplies, telecommunication services, trainings and work related travel. Another particular expense for this model is rent/ maintenance of equipment and inventory. While medical institutions have more or less same expenditure inside the model, the expenditures of various TUSA differ from one to another. Figure 16 presents the distribution and incidence by type of expenditure with TUSA group. The first bar fully colored shows that all providers have such a type of expenditure (salaries). If a bar is entirely colorless this shows that none of considered providers have this type of expenditure. Expenditure distribution shows that TUSA have more direct costs. Very few can afford improving the work space, and very few buy hygiene products to be used by the beneficiaries and buy pharmaceutical products. Professional trainings is also not a priority when it comes to expenditures distribution.

Figure 16. **Expenditures on different type of resources by incidence of each type of resources, TUSA (share of total providers)**



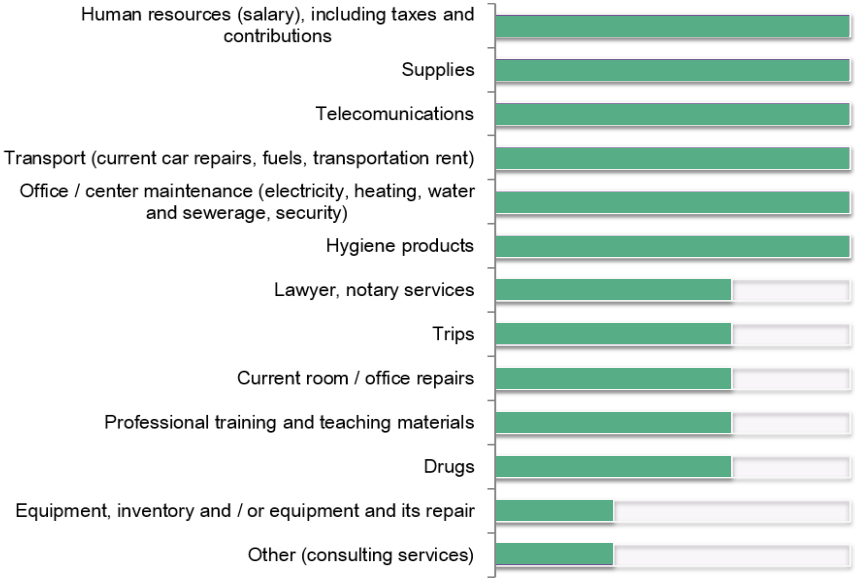
Source: Author's calculations based on data provided by TUSA

Resources / expenditures particular for non-profit providers

The expenditures of non-profit entities don't differ significantly by type of expenditure (Figure 17) (compared with TUSA). At the same time the share of certain expenditure in total expenditure and amounts for some type expenditures differ significantly. As mentioned, the major difference is dictated by the fact that private providers deliver services outside of an existing physical infrastructure. An important share of expenditures for private providers relate to paying the rent for a work space, utilities and maintenance of an office. Transportations cost are also bigger for this group, this is linked with the fact that these organization 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 the medical assistants have to be transported from neighboring villages.

The non-profit organizations have particular expenditures linked with formulating and promoting public policies (consultancies for research, outside expertise, training materials etc.). Another exclusive group of expenditures are for representation (lawyer, notary).

Figure 17. **Expenditures on different type of resources by incidence of each type of resources, non-profit providers (share of total providers)**



Source: Author's calculations based on data provided by HBC non-profit providers

Almost all models (medical institutions are the exception), on yearly basis spend an important amount of funds on inventory, special equipment tools and goods such as: portable toilets, wheelchairs, walking stick, walk carrier, tonometer etc. These might be one off expenditure, with quarter or annual regularity or at need expenditure. These costs will not be a part of the general UC but will be presented as an additional share of cost for each considered model.

6.3. The cost of delivery of HBC services

Before discussing the actual cost of delivery of HBC services, one should understand the variables that define the various costs. The following main variables should be considered when defining and comparing the provided costs: a) frequency of delivery (Table 34); b) share of resources used for a certain beneficiary depending on the need (cost per dependency grade I, II, III, IV, see Chapter III, 3.5); c) place of delivery (in-center or at-home); d) main component (medical HBC, social HBC or integrated HBC services); e) geographic area of service delivery (urban, rural, municipalities).

Table 34. **Frequency of HBC delivery**

Model/provider	From 1 to 12 moths per year	36/72 visits usually during 3 months	From 1 to 3 months per year
Medical institutions			✓
TUSA	✓		
CSO "CASMED"	✓		✓
CSO "Caritas"		✓	✓
CSO "Neoumanist"	✓		
CSO "Homecare"		✓	
Profit entities (LLC)			✓

Source: Mapping of existing home care social and medical service providers and the real needs of HBC services

The costs were calculated for each provider group/profile, an average cost based on used resources are presented within each provider group. Due to significant differences in the nature of provided services between provider groups is not possible to present an overall average cost.

Cost per one beneficiary = Cost of all resources used for service delivery in one year/number of beneficiaries which have been offered the support during one year

Cost per one beneficiary is presented:

a. **Per particular model;**

b. **Per a given period of time (yearly);**

c. **Per dependency degree;**

d. **Per type of service (social HBC, medical HBC, and integrated HBC).**

In order to ensure accuracy, all used resources have been analyzed. The one time use of resources and high costs (example – an important amount for taking repairs of the premises) have not been considered when calculating the average costs. Only running costs have been considered.

Two types of costs (based on used resources/expenditures) have been considered for cost calculation: 1) direct costs (which are easily attached to the activity/service) and 2) indirect costs, attached to more than one activity/service. For all providers direct costs are exceeding the indirect costs.

The monthly amount is difficult to present considering different frequency of delivery, some models provide monthly services to the same beneficiary, others have quarterly support; some have at-need or one-off support. Therefore, the most accurate presentation is the annual cost per one beneficiary.

Table 35 presents the average annual cost in MDL for one beneficiary for each model/provider.

Table 35. **Average cost of 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

Source: Mapping of existing home care social and medical service providers and the real needs of HBC services

The less expensive model is provision of medical HBC by medical institution, with 2300.00 MDL per beneficiary annually. While this model is providing services to most difficult beneficiaries and medical component proved to be the most expensive, ***why the costs remain small***? This is due to two main reasons:

1) the low cost is mainly dictated by insufficient funding coming from the NHIC. Therefore, unlike other providers medical institutions have to fit within the one-visit-cost which is reimbursed by the state. This proves, as explained above why medical institutions are not active and provide services to such a small number of beneficiaries (on average 20 beneficiaries per on medical institution).

- **2)** Another reason for low provision costs is existence of hidden costs for this model. As explained above, an important part (the physical infrastructure) is ensured by the healthcare system and is not reflected in the final amount. The non-profit entities have to spend an important part of funds on ensuring an office, transportation, management and monitoring of service delivery.

The most expensive is the service provided by TUSA with 4425.00 MDL per year. This is mainly explained by the frequency of delivered support comparing to other models. But it could be also partially explained by inefficient use of public funds, for instance many necessary resources are being rented (office rent, car rent, equipment rent) instead of investing one-off funds for buying some of these goods. Also the TUSA have significant expenditures in ensuring work premises and paying utilities.

The non-profit organizations have balanced costs within the group, one beneficiary costs about 3270.00 MDL per year.

The pro profit delivery cost (private entities) is around 2950.00 MDL per one beneficiary per year. This could be explained 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.

When discussing the cost by type of support, again, medical HBC services cost less comparing with other types (Table 35). Still, if by proxy

[112] The cost is higher in comparison with medical institution because they had cost for work space, utilities and maintenance of an office etc.

distribution of resources, we add to the medical HBC cost the same share of administrative and physical infrastructure costs that we could see in TUSA model, then medical HBC and social HBC care costs will equal.

Naturally, the most expensive type of support is integrated HBC service, on average one beneficiary's annual costs of integrated support is 5150.00 MDL, this is due to more intense use of resources for these services (medical resources as well as resources linked with social support). As per Table 36, **the cost of the integrated support is less than cumulated costs for social support and medical support**. This is explained by the fact that integrated support provided within one entity is cheaper due to lower administrative costs. 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 36. **The average cost of delivery of HBC services per type of support, per beneficiary,** *annual, MDL*

Model of delivery	Annual cost, MDL
Social	3570.00
Medical	2285.00
Integrated	5150.00

Source: Mapping of existing home care social and medical service providers and the real needs of HBC services

Within the current analysis, beneficiaries have been divided into four dependency categories with less dependency in group (I) and maximum dependency in group (IV). The providers have been asked how many beneficiaries by each type they support with the analysis period. Than resources used for this support have been allocated to each dependency group and the costs of these resources estimated (Table 37). Providers reported less beneficiaries of group (I) since they are not so often considered for HBC services. The cost for this dependency group could not be provided due to insufficient number of such beneficiaries.

The cost of beneficiaries for the group (II) is 2150.00 MDL per year, but this information should also be considered with reservation considering the small number of this type of beneficiaries.

The cost for beneficiaries of category (III) is about 2500.00 MDL per year; and the cost for beneficiaries of category (IV) is about 2300.00 MDL per

year. The possible explanation of lower cost for category (IV) is the underestimation of medical component overall, which is the dominating component for (IV) dependency category. These people are in many cases bedridden people with lesser needs other than basic medical support.

Table 37. **The average cost of delivery of HBC service per dependency grade,** *annual, MDL*

Dependency rate	Annual cost, MDL
Category I	No enough entries
Category II	2150 (few entries)
Category III	2500
Category IV	2300

Source: Mapping of existing home care social and medical service providers and the real needs of HBC services

As mentioned above, an important share of costs is linked with ensuring equipment and support inventory for beneficiaries. All equipment/inventory related expenditures have not been considered in average costs calculations presented above. Still, none of these services can be provided without considering expenditures for equipment and other support items. The resources allocated (by all models) to buy these goods have been considered in a separate analysis. Money has been allocated to these resources and an average cost per beneficiary was calculated. This cost reflects only the cost of additional equipment and materials acquired during the analysis period and should come as an addition to the general costs presented above. In order to have a total cost for good quality delivery, a provider should add this component to the general costs. The cost of ensuring relevant equipment and support material is 90625.00 MDL per year. It is clear that not all potential beneficiaries will need such support, but the provider could identify the beneficiaries that do need additional goods and services and plan respective funds to cover these needs.

When it comes to public providers, a more sustainable solution should be discussed related to support goods and materials. One solution is to put in place a special fund[115] (joint for social and medical HBC services) and compensate these big expenditures from this fund based on individual needs.

[115] This is according to US and UK good practice.

The minimal, optimum and high-quality HBC services costs scenarios

It is very difficult to quantify the quality component within the current exercise. This is mainly due to different models of service provision, lack of accreditation for these services, lack of report of social inspection on quality of provided services. It is very important that the social infrastructure will continue to develop and these services will be included into accreditation and inspection procedures.

The chapter presents an overview on the beneficiaries' evaluation and needs which could be connected to quality of HBC delivery. The evidence is not showing direct link between beneficiary's satisfaction and the cost of provided service. This is mainly explained by the fact that beneficiaries are generally grateful for any form of support.

Minimum cost = Cost of human resources + cost of other resources for basic delivery (see Annex 4) /number of beneficiaries

A simplified approach to look at the minimal and optimum costs is considering the existing costs and their use or resources. The minimal calculated cost for service delivery could be considered 2300.00 MDL per year per beneficiary for public entities and 2950.00 MDL per year per beneficiary for private provision. Optimum provision could be considered 4500.00 MDL both for public and private provision and high quality could be considered the integrated service which costs around 5000.00 MDL per year per beneficiary. This was formulated based on resource distribution presented above.

Considering the nature of the service one could assume that quality of provision is directly linked with human factor. The share of human resources within the analyzed models is more significant as share of total used resources, which could be considered an indicator of services' good quality. At the same time, investments in increasing qualification of personnel are small for all models. An additional 5-7% to the costs presented above should be added on yearly basis for increasing qualifications of the personnel.

Regional approaches on costing different dimensions of HBC services

In the Czech Republic, a system of "codes" has been implemented since 2006. Codes were developed by the biggest and partly state insurance company Všeobecná zdravotní pojišťovna (VZP) together with experts

from the Ministry of Health. They developed a list of codes according the ABC method mentioned at the beginning of current chapter.

A final code can determine the real costs of a service delivered is calculated by: price of the code from the list of VZP + actual direct costs (increased personal costs during overtimes + transportation) + price of indirect costs (time of service delivered in minutes-price of each minute of service). VZP codes are revised every year to reflect the real costs of services provided. In Slovak Republic, the list of codes set by insurance companies/Ministry is similar to the Czech Republic. As the home care sector was extremely underfinanced during the last decade, the insurance companies revised the codes in 2017 and increased them for 25%.

The RM has also experience in code system, the healthcare system uses the diagnosis-related groups (DRGs) as a hospital reimbursement mechanisms applied to the acute inpatient care. This is in line with the activity based costing described above, to each activity a particular code could be assigned and the systems (both medical and social) could reimburse the service providers based on these codes.

6.4. Cost of HBC versus cost of services provided in public facilities

The costs of HBC provision are, in relative terms, lower that costs of provision of various services to people with need in social and medical care. It makes economic sense to invest more in services that will prevent the need to institutionalize the beneficiaries which results in greater costs for the state and/or beneficiaries and their families.

On all accounts the cost of HBC services is cheaper that all other forms of support. Table 38 presents different types of costs for different types of support provided to needy elderly.[116] While it is expected that HBC should be cheaper than other forms of support the differences between HBC costs and other costs are quite significant.

Table 38. **Cost of various services provided to elderly,** *annually, MDL*

	Per visit cost, MDL	Monthly cost, MDL	Annual cost, MDL
HBC	-	-	4500.00
Palliative care	181.40	9930.00	
Geriatric care	-	-	3913.00
Day care (public) Republican retirement homes	-	-	7429.00
Day care centers (public) at ATU level	-	-	4532.00
Retirement homes public 24/24	-	-	99500.00
Private Center ACASA for geriatric and social care Ulmu/Rusesti 24/24	-	11000.00	132 000.00

Source: Palliative care (Order MS no. 66 of 31.01.2017 on approval of costs for 2017); Retirement homes – Annual Social Report 2016

As presented in the Table 38, the cost for 24/24 care is much more expensive comparing with costs for the HBC service. This is normal considering the nature and intensity of provided service. While it is not possible to compare these services, it is important to understand that HBC service could prevent situations when the 24/24 support is needed. The retirement homes are no numerous and most likely will not be able to accommodate all the existing needs in an aging society.

[116] Elderly represent the main beneficiaries of HBC services.

[117] The cost of one day of palliative care as per NHIC regulations was 331 MDL in 2017 (app. 16.22 Euro, National Bank of Moldova exchange rate at 31.12.2017)

[118] The geriatric and gerontologic care is the medical assistance in care, prevention of acute and chronic diseases, of rehabilitation and support for terminal illnesses for elderly population.

[119] Annual Social Report, MLSPF. Institutions specialized in the care of elderly persons and with physical disabilities.

As presented in the Table 38, the cost for 24/24 care is much more expensive comparing with costs for the HBC service. This is normal considering the nature and intensity of provided service. While it is not possible to compare these services, it is important to understand that HBC service could prevent situations when the 24/24 support is needed. The retirement homes are no numerous and most likely will not be able to accommodate all the existing needs in an aging society.

6.5. Suggestions and recommendations to Chapter 6

1. The service delivery support systems should be revised considering the comparative analysis of the HBC delivery costs. The minimum quality standards should be reviewed for both social HBC and medical HBC services from the perspective of realistic and sustainable support.

2. The *per-visit cost formula* should be transparent, clear and should reflect all needed resources for good quality service delivery. The formula could be presented as part of the Government Decision No. 1020 from 19.12.2011 on the medico-sanitary rates. The annual Ministerial Decision (MHLSP) (for 2017 this was the Order no. 66 from 31.01.2017) apart from stating the per-visit amount should present a breakdown of main components of these costs (ex: how much of this amount is paid for work, how much for medicine, how much for transport, the share could be specified based on the example of resource allocation for non-profit providers presented above).

3. More clarity in cost calculation and resource attribution could be achieved by adding the concrete share of each resources used into total per-visit cost presented in the Ministerial order (MHLSP) number 253 from 20.06.2008, no. 155-A from 10.07.2008. The Chapter II [120] of the order stipulates the payment modality, it is advisable to also mention (a separate Annex to the Order) the share of each used resource.

4. A most important step is to correlate the minimum quality standards and regulations for HBC provision to the actual costs of resources needed as per the requirements. An analysis of the national standards and regulations prove that they are not realistic when compared to the funds allocated to service delivery. A thorough revision of all standards should be done keeping in mind that each

[120] Payment model and contracting criteria of the HBC service providers as part of the mandatory medical stat assistance.

provision will bear a cost. Setting these costs within these documents might help better understand what could be provide and how.

5. In this context, the Governmental Decision no. 1034 from 31.12.2014 on Approval of the regulation frame of the social HBC service and its minimum quality standards should be revised. The Order number 851 from 29.07.2013 issued by the MH on National Standard on Medical HBC should be revised.

6. A method of increasing the cost (indexation) of these services should be also established in order to capture changes of consumer price index and ensuring sustainability and decent quality of service provision.

7. From a cost-benefit perspective the integrated support should be considered since this approach offers the best outputs in terms of beneficiary satisfaction. At the same time being not much more expensive than the combined medical and social support provided in isolation.

8. HBC services costs are much lower that costs for other services offered to elderly and other people with need in constant care. This should be considered by authorities and the services should be expanded as a prevention measure to most costly support.

9. Accreditation process should start and include all providers of HBC service in order to establish and maintain a minimum quality benchmark.

10. The existing general medical and social infrastructure should be used per maximum for HBC service delivery. This refers to: support from primary healthcare facilities to private providers as well as public providers of social HBC, offer when possible work premised (buildings, part of buildings in existing policlinics or hospitals, building of socials sector) to private providers (non-profit), offer equipment and other support materials if available.

11. All providers should calculate the unit cost of services they provide and keep these calculations updated. The unit cost should be accessible and cumulated into one source. All costs should be made public, so beneficiaries will understand what actions/services are being provided and the intensity of provision.

12. All providers should do the "used resources" analysis, keep accurate financial documentation and provide an aggregated analysis regardless of source of financing.

13. 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 etc.

14. A comparative advantage of using the ABC costing methodology is the fact that it provides a cost unit for each activity, which can be further combine to create different costing sub-models as well as tailored support within each model/sub-model. The activities done within a service should be defined through regulations and each provider should calculate how much a certain activity costs on annual basis per one beneficiary.

Recommendations to chapter VI from international perspective.

15. The MHLSP together with NHIC can develop prices for units' reimbursement for medical HBC services, based on "ABC" formula and "codes". Such a method can be used both for residential facilities (hospitals, long-term care houses, hospices etc.) and for HBC services: a working group can be established to elaborate "code" prices for patients in different grades of dependency and health shape (long-term care, short-term post-operational care, patients in terminal stadium of life, etc.); "code" prices for medical supplies; set special prices of medical workers working over working hours – take overtimes into accounts, etc.

ANNEXES

Annex 1.

List of territorial administrative units where the assessment was done

Nr	Teritorial administrative unit	Geographic area
1	**Chisinau**	Municipalities
2	**Balti**	
3	**Soroca**	North
4	**Falesti**	
5	**Ocnita**	
6	**Riscani**	
7	**Donduseni**	
8	**Singerei**	
9	**Anenii Noi**	Center
10	**Hincesti**	
11	**Ungheni**	
12	**Soldanesti**	
13	**Straseni**	
14	**Criuleni**	
15	**Ialoveni**	
16	**Orhei**	
17	**Telenesti**	
18	**ATU Gagauzia**	South
19	**Cahul**	
20	**Stefan Voda**	
21	**Leova**	
22	**Basarabeasca**	
23	**Cimislia**	

Annex 2. **The sample**
Data about social and medical HBC service providers that participated in the assessment

Type of HBC provider	Provider	Location	Legal status	Geographical area	Number of Beneficiaries	For free, For fee or Co-paid	TOTAL budget for HBC, 2016	Sources of funding
Profit entity	Mediclas LLC	Ungheni	Profit entity, LLC	ATU	101	Free services	297790,00	NHIC
Health Centre	HC Anenii Noi	Anenii Noi	Public institution	ATU	11	Free services	18471,00	NHIC
Health Centre	HC Chirsova, ATU Gagauzia	Chirsovo	Public institution	Local	10	Free services	7315,20	NHIC
Health Centre	HC Taul, Donduseni	Taul	Public institution	Local	6	Free services	17739,36	NHIC
Health Centre	HC Olanesti, Stefan Voda	Olanesti	Public institution	Local	7	Free services	11064,24	NHIC
Health Centre	HC Sarateni, Leova	Sarateni	Public institution	Local	6	Free services	19568,16	NHIC
Health Centre	HC Leova	Leova	Public institution	Local	12	Free services	4206,00	NHIC
Health Centre	HC Ivancea, Orhei	Orhei	Public institution	Local	5	Free services	8889,61	NHIC
Health Centre	HC Hijdeni, Glodeni	Hijdeni	Public institution	Local	2	Free services	5212,08	NHIC
Health Centre	HC Ialoveni	Ialoveni	Public institution	Local	5	Free services	14264,64	NHIC
Health Centre	HC Basarabeasca	Basarabeasca	Public institution	Local	9	Free services	35478,72	NHIC
Health Centre	HC Radoaia, Singerei	Radoaia	Public institution	Local	5	Free services	7590,00	NHIC
Health Centre	HC Orhei, nr 1	Orhei	Public institution	Local	44	Free services	90385,45	NHIC
Health Centre	HC Lozova, Straseni	Lozova	Public institution	Local	4	Free services	8686,80	NHIC
Health Centre	HC Mindresti, Telenesti	Mindresti	Public institution	Local	10	Free services	13716,00	NHIC
Health Centre	HC Straseni	Straseni	Public institution	ATU	18	Free services	50840,00	NHIC
Health Centre	HC Singereii Noi, Singerei	Singerei	Public institution	Local	6	Free services	8046,72	NHIC
Health Centre	HC Cioc-Maidan, ATU Gagauzia	Cioc-Maidan	Public institution	Local	5	Free services	4572,00	NHIC
Health Centre	HC Cahul	Cahul	Public institution	Local	31	Free services	82844,64	NHIC
Health Centre	HC Orhei, no. 2	Orhei	Public institution	Local	14	Free services	36576,00	NHIC
Health Centre	HC Durlesti, Chisinau	Durlesti	Public institution	Local	5	Free services	26517,60	NHIC
Health Centre	MPHI Buiucani, Chisinau	Chisinau	Public institution	Local	73	Free services	149689,00	NHIC
Health Centre	HC Criuleni	Criuleni	Public institution	Local	16	Free services	26426,16	NHIC
Health Centre	HC Telenesti	Telenesti	Public institution	Local	10	Free services	32370,00	NHIC
Health Centre	HC Stefan Voda	Stefan Voda	Public institution	Local	18	Free services	74157,84	NHIC
Health Centre	HC Biruinta, Singerei	Biruinta	Public institution	Local	6	Free services	15087,60	NHIC
Health Centre	HC Vulcanesti, ATU Gagauzia	Vulcanesti	Public institution	Local	9	Free services	20116,80	NHIC
Health Centre	HC Soldanesti	Soldanesti	Public institution	Local	8	Free services	19842,00	NHIC
Health Centre	FDC Balti	Balti	Public institution	Local	75	Free services	241858,80	NHIC
Health Centre	MPHI Ciocana, Chisinau	Chisinau	Public institution	Local	107	Free services	285658,00	NHIC
Health Centre	HC Balatina, Glodeni	Balatina	Public institution	Local	3	Free services	12891,00	NHIC

Type of HBC provider	Provider	Location	Legal status	Geographical area	Number of Beneficiaries	For free, For fee or Co-paid	TOTAL budget for HBC, 2016	Sources of funding
Health Centre	HC Edinet	Edinet	Public institution	Local	34	Free services	106344,72	NHIC
Health Centre	HC Cimislia	Cimislia	Public institution	Local	18	Free services	60899,04	NHIC
Health Centre	HC Singerei	Singerei	Public institution	Local	38	Free services	55951,28	NHIC
Health Centre	HC Donduseni	Donduseni	Public institution	Local	13	Free services	37581,84	NHIC
Health Centre	HC Frunze, Ocnita	Frunze	Public institution	Local	8	Free services	6964,22	NHIC
Health Centre	HC Otaci, Ocnita	Otaci	Public institution	Local	6	Free services	12435,84	NHIC
Health Centre	HC Comrat, ATU Gagauzia	Comrat	Public institution	Local	37	Free services	54132,00	NHIC
Health Centre	HC Ocnita	Ocnita	Public institution	Local	17	Free services	53035,20	NHIC
Health Centre	HC Iabloana, Glodeni	Iabloana	Public institution	Local	4	Free services	3967,20	NHIC
Health Centre	HC Falesti	Falesti	Public institution	Local	36	Free services	87508,00	NHIC
Health Centre	HC Vasieni, Ialoveni	Vasieni	Public institution	Local	4	Free services	9144,00	NHIC
Health Centre	HC Dubasari - Hipocrates	HC Dorotcaia	Public institution	ATU	26	Free services	91257,12	NHIC
Provider established by LPA II	Social Centre, Hincesti	Hincesti	Public institution	ATU	110	Free services	481712,00	LPA II
Provider established by LPA I	Mayoralty Chirsova village, ATU Gagauzia	Chirsova	Public institution	Local	58	Free services	Does not know	LPA I
TUSA	TUSA Singerei	Singerei	Public institution	ATU	538	Free services	2815696,00	LPA II
TUSA	TUSA Stefan Voda	Stefan Voda	Public institution	ATU	497	Free services	1925100,00	LPA II
TUSA	TUSA Straseni	Straseni	Public institution	ATU	412	Free services	2157773,84	LPA II, Profit entities
TUSA	TUSA Anenii Noi	Anenii Noi	Public institution	ATU	453	Free services	2500951,00	LPA II
TUSA	TUSA Cimislia	Cimislia	Public institution	ATU	319	Free services, Services for fee (5 beneficiaries)	1616700,00	LPA II, Beneficiaries
TUSA	TUSA Soroca	Soroca	Public institution	ATU	905	Free services	4414800,00	LPA II
TUSA	TUSA Falesti	Falesti	Public institution	ATU	635	Free services, Services for fee (8 beneficiaries)	2955700,00	LPA II, Beneficiaries
TUSA	TUSA Ocnita	Ocnita	Public institution	ATU	658	Free services	3037000,00	LPA II
TUSA	TUSA Donduseni	Donduseni	Public institution	ATU	726	Free services	2725817,00	LPA II
TUSA	TUSA Chisinau	Chisinau	Public institution	Local (municipal)	2171	Free services	11590500,00	LPA II
TUSA	TUSA Criuleni	Criuleni	Public institution	ATU	310	Free services	-	LPA II
TUSA	TUSA Ialoveni	Ialoveni	Public institution	ATU	364	Free services	2606000,00	LPA II
TUSA	TUSA Orhei	Orhei	Public institution	ATU	686	Free services	2876438,00	LPA II
TUSA	TUSA Telenesti	Telenesti	Public institution	ATU	412	Free services	1792326,00	LPA II
TUSA	TUSA Basarabeasca	Basarabeasca	Public institution	ATU	380	Free services	1641639,00	LPA II
TUSA	TUSA Leova	Leova	Public institution	ATU	298	Free services	1282900,00	LPA II
TUSA	TUSA Ungheni	Ungheni	Public institution	ATU	754	Free services	3325133,00	LPA II

Type of HBC provider	Provider	Location	Legal status	Geographical area	Number of Beneficiaries	For free, For fee or Co-paid	TOTAL budget for HBC, 2016	Sources of funding
TUSA	TUSA Soldanesti	Soldanesti	Public institution	ATU	464	Free services	2264989,00	LPA II
TUSA	TUSA Glodeni	Glodeni	Public institution	ATU	506	Free services, Services for fee (3 beneficiaries)	2390300,00	LPA II
TUSA	TUSA Cahul	Cahul	Public institution	ATU	864	Free services	3883900,00	LPA II
TUSA	TUSA Balti	Balti	Public institution	Local (municipal)	900	Free services	3055729,52	LPA II
TUSA	TUSA Hincesti	Hincesti	Public institution	ATU	750	Free services	3523040,00	LPA II
NGO	Sat Modern	Glinjeni, Falesti	NGO	Local	116	Co-paid services	57018,00	LPA I, Profit entities, Beneficiaries, Private (donors)
NGO	Home Care	Chisinau	NGO	Regional (8 Medico-social centers in different districts. 2 of the 8 now are in the exclusive management of LPA)	1800	Free services	8362964,20	NHIC, Private (donors)
NGO	Aripile Sperantei	Seliste, Orhei	NGO	ATU	44	Free services	386403,52	NHIC, Private (donors), Donations from individuals
NGO	Concordia	Chisinau	NGO	National	2690	Free services	8003818,00	LPA I, LPA II, Private (donors), Donations from individuals, donations from Profit entities
NGO	Betania	Tintareni	NGO	Local	8	Free services	It is under the service of a wider service. Could not calculate	Private (donors)
NGO	Angelus Soroca	Soroca	NGO	ATU	142	Free services	309056,33	NHIC, Private (donors), Donations Profit entities
NGO	Neoumanist	Straseni	NGO	ATU	58	Free services	1073932,00	Private (donors)
NGO	Gutta	Cusmirca, Soldanesti	NGO	Local	136	Co-paid services	151699,00	LPA I, Beneficiaries, Private (donors)
NGO	Viitorul	Sarata Veche, Falesti	NGO	Local	170	Co-paid services	156539,00	LPA I, Beneficiaries, Private (donors)
NGO	Cuget	Izvoare, Falesti	NGO	Local	322	Co-paid services	223369,00	LPA I, Beneficiaries, Private (donors)

Type of HBC provider	Provider	Location	Legal status	Geographical area	Number of Beneficiaries	For free, For fee or Co-paid	TOTAL budget for HBC, 2016	Sources of funding
NGO	Vatra Strabuna	Prepelita, Singerei	NGO	Local	110	Co-paid services	95664,00	LPA I, Beneficiaries, Private (donors)
NGO	Pro Asistenta	Ciolacu Nou, Falesti	NGO	ATU	240	Co-paid services	312263,00	LPA I, Beneficiaries, Private (donors)
NGO	Renastere	Soldanesti	NGO	Local	170	Co-paid services	142168,00	LPA I, Beneficiaries, Private (donors)
NGO	Bella Getica	Cobilea, Soldanesti	NGO	Local	66	Co-paid services	0,00	It did not provide services in 2016. It started in 2017
NGO	Casmed	Balti	NGO	National. CASMED with local NGOs covers 47 communities with HBC services (integrated HBC Services to more than 30 communities and only medical HBC services in 16 communities)	2100	Co-paid services	7040581,91	NHIC, LPA I, Private (donors), Donations Profit entities, Beneficiaries
NGO	Caritas Moldova	Chisinau	NGO	Regional	150	Co-paid services	1207768,22	NHIC, Beneficiaries, Private (donors)
NGO	Medlife	Chisinau	NGO	National	-	Free services	2400000,00	NHIC

Annex 3.

Subjects tackled during HBC training,according to categories of providers

Medical institutions	TUSA	NGO
• Neurological rehabilitation at home (training for nurses, 72 hours). • Organizing and providing home based care to the elderly and disabled. • Widespread use of oral opiates. • Nursing patients with stoma. • Advanced heart disease. • Stroke. • Bedsores. • Trophic ulcers. • Cancer pain. • Constipation. • Basics of home based care. • Nursing the patient with pain. • Nursing the patient and the bedsores. • Nursing patients with gastrostomy tubes. • Nursing patients with tracheostomy tubes. • Elderly care. • Family medicine (Infectious and noninfectious diseases. Family Care practices. Palliative care). • Healing infected wounds. • Nursing bedridden people. • Massage. • Medico-social home care services. • Home care provided to end-stage patients and the elderly. • Nursing practices to prevent bedsores. • Therapy to prevent pulmonary complications. • Physical therapy and kinetotherapy. • Training and informing relatives. • Promoting health living etc.	• Initial training of social workers in providing social home based care. • Adjustment of the framework regulation on social home based care. • Firs aid in emergency situations. • Correct completion of the beneficiary's record. Beneficiary's admission to SHBC. • Interpersonal communication. • Minimum quality standards of the service. • Help provided to lonely old people. • Individual plan, assessment of beneficiary's needs. • Code of conduct of social worker. • Measures to protect vulnerable people during the cold period of the year. • The principle of non-discrimination and protection against abuse, violence. • Importance of intersectoral collaboration in helping people with mental health issues. • Changing the bed sheets for bedridden beneficiaries. Ensuring the body and personal hygiene, dressing the beneficiary. • Ensuring the observance of beneficiary's rights. • Communication between the social worker and the beneficiary. • Occupational hazards, injuries and illness in social workers. • Communication skills in creating community-based collaboration relationships with community social assistants. • Training social workers to care patients with diabetes. • Organizing socio-medical home care.	• Accreditation of home based care service providers. • Communication with the beneficiaries. • Completing the beneficiaries' record and compilation of documents. • Palliative care. • HBC • Palliative care provided in the Eurasian region (Ivano- Frankovsk). • All about stomas • Support in service development. • Basics of palliative and home based care. • Changing underwear. • First aid. • Home based care practices. • Palliative care for end-stage patients. • National clinical guidelines for palliative care in children. • Kinaesthetics. • Legal framework on HBC. • Nursing patients with wounds. • Caring patients with complications of diabetes. • Caring patients with locomotor disorders. • Disinfection and waste disposal. • Nursing patients with diabetes.

Annex 4.

Summary of resources used for HBC service delivery

NAME/DENOMINATION OF RESOURCES	COMMENTS
Non-human resources	**Human resources**
Direct Costs • Drugs and other needed medical supply • Teaching materials, self-care manual • Detergents and household goods • Diesel, fuel • Current repairs, the car(s) • Rent of means of transportation and maintenance of the cars • Equipment and special inventory (portable toilet, wheelchair, canes, walking frame support)	*Direct Costs* • Nurse • Medical assistant • Doctor • Social assistant • Social worker • Psychologist • Driver
Indirect costs /Administration costs • Electric and thermic energy, water, sewage and sanitation • Security service • Office supplies • Telecommunication service, post • Inventory and equipment (in-center) • Current repair buildings, rooms • Current repair equipment, inventory • Rent of goods and services • Mobile communication, GSM	*Indirect costs /Administration costs* • Director • Accountant • Legal specialist • Office manager • Project assistant