Study on Social Protection and Social Inclusion in Moldova

Chisinau - 2009

This report was financed by and prepared for the use of the European Commission, Directorate General for Employment, Social Affairs and Equal Opportunities. It does not necessarily represent the Commission's official position.

http://ec.europa.eu/social/main.jsp?langId=en&catId=750.

Contractor: Institute for Development and Social Initiatives "Viitorul", Chisinau, Moldova

MD-2005 Iacob Hincu 10/1 str., Chisinau, Republic of Moldova

Tel: 373 / 22 221844
Fax: 373 / 22 245714
E-mail: office@viitorul.org

Web-site: www.viitorul.org

Authors:

Olesea Cruc
Onorica Banciu
Iurie Brinişter
Maria Vremiş
Viorica Craievschi-Toartă
Alexandru Sinchetru

TABLE OF CONTENTS

TABLE OF CONTENTS 2
ACRONYMS 5
EXECUTIVE SUMMARY 7
CHAPTER I. GENERAL OVERVIEW 15
Introduction 15
1.1. Macroeconomic situation 15
1.1.1. Historical background 15
1.1.2. The first stage of transition (1991–1999) 16
1.1.3. The second stage of transition (2000–present) 17
1.2. Budgetary and fiscal policy 19
1.2.1. Latest reforms 20
1.2.2. Structure of revenues and expenditures 20
1.2.3. External debt 21
1.2.4. Response to the economic crisis 22
1.3. Demographic trends 22
1.3.1. Depopulation 22
1.3.2. Demographic ageing 23
1.3.3. Population ethnic structure 24
1.3.4. Population growth projections 24
1.4. Situation on the labour market 25
1.4.1. Employment and activity 25
1.4.2. Unemployment 27
1.4.3. Wages 28
1.4.4. Discrimination within the labour market 29
1.4.5. Labour market policies 29
1.5. Migration and remittances 30
1.5.1. External migration 30
1.5.2. Migrant remittances and impacts of out-migration 32
1.5.3. Internal migration 34
1.6. Informal economy 34
1.6.1. Main features of the informal economy 34
1.6.2. Components of the informal economy 35
1.6.3. Underreporting and tax evasion 36
1.7. Educational system 36
1.7.1. Preschool education 37
1.7.2. Primary and secondary education 37
1.7.3. Vocational education 38
1.7.4. Higher education 38
1.7.5. Special education 39
1.7.6. Lifelong learning 39
1.7.7. Minority languages 39
1.7.8. Education-related indicators 39
1.7.9. Corruption in education 40
1.7.10. Vulnerable groups 40
1.7.11. Impacts of the economic crisis 41
1.8. Territorial disparities 41
1.8.1. Urban-rural disparities 41
1.8.2. Regional disparities 42
Conclusion and key challenges 43
References 46

CHAPTER II. SOCIAL PROTECTION AND SOCIAL WELFARE SYSTEM.....53
2.1. Overview of the Social Protection System.....53
2.1.1. Institutional framework of the social protection system.....54
2.1.2. Centralization/decentralization of the social protection system.....55
2.2. Financing of the social protection system.....56
2.2.1. Financing and sustainability.....56
2.2.2. Role of donor financing.....57
2.3. Types of benefits and services:.....59
2.3.1. Social insurance benefits.....59
2.3.2. Social assistance benefits.....60
2.3.3. Means tested benefits.....63
2.3.4. Social services.....64
2.4. Social protection of vulnerable groups.....67
2.4.1. Children and families with children at risk.....67
2.4.3. Roma population.....70
2.4.4. Elderly persons.....70
2.5. Conclusions and key challenges.....70
References.....72
Annex. Statistical data.....74
CHAPTER III. POVERTY AND SOCIAL EXCLUSION.....80
3.1. Introduction and objectives.....80
3.2. Trends in poverty and social inclusion since the beginning of transition.....81
3.3. Government policies and strategies aimed at reducing poverty and social exclusion.....83
3.4. Profiles of poverty and social exclusion.....83
3.4.1. Absolute poverty versus relative poverty approach.....83
3.4.2. Poverty profile by area of residence.....84
3.5. Vulnerability and social inclusion.....87
3.5.1. Vulnerable population groups.....87
3.5.2. National social inclusion policies.....91
3.5.3. Available indicators of social inclusion.....95
3.6. Conclusions and key challenges.....96
3.7. References and tables.....98
References.....98
Annex I. Statistical data.....99
Annex II. Methodological issues.....107
Annex III. Overview of research on poverty and social inclusion in the country.....108
CHAPTER IV. PENSION SYSTEM.....109
4.1. Introduction and objectives.....109
4.2. Historical perspective.....110
4.3. Existing pension system.....111
4.3.1. Types of pensions and assignment criteria.....111
4.3.2. The minimum pension.....114
4.3.3. Indexation of pensions.....114
4.3.4. Insurance contributions and taxable base.....114
4.3.5.1. Number of pensioners.....115
4.3.5.2. Pensioner living standards.....118
4.4. Main reforms and drivers of change.....123
4.5. Pensions, exclusion and vulnerable groups.....124
4.6. Sustainability of pension systems.....125
4.6.1. System losers.....126
4.6.2. Effect of the economic crisis.....126
4.6.3. Public awareness and acceptance.....127

4.7. Conclusions and key challenges 128
References 129
Annex. Statistical data 130
CHAPTER V. HEALTH CARE AND LONG-TERM CARE 140
5.1. Historical Perspective 140
5.2. Health Outcomes 141
5.2.1. Demographic changes 141
5.2.2. Infant and Maternal Mortality 143
5.2.3. Morbidity 145
5.2.4. Health determinants 147
5.3. Governance and Financing 149
5.3.1. Regulations and administrative bodies 149
5.3.2. Institutional structure and ownership 151
5.3.2.1. Public Health Service 151
5.3.2.2. Emergency Service 151
5.3.2.3. Primary Care 152
5.3.2.4. Secondary (district) and tertiary (republican) hospital care 153
5.3.2.5. Private health care institutions 154
5.3.3. National Programmes 154
5.3.4. Wages and incentives in health care sector 155
5.3.5. Health care education 155
5.3.6. Breakdown of funding sources 156
5.3.7. Provider network reimbursement 156
5.3.7.1. Health Insurance 157
5.3.7.2. Out-of-pocket 159
5.3.8. State and local budget non-insurance contributions: Health and Social Investment Fund 159
5.3.9. Donors 160
5.4. Access and equity 162
5.5. Quality of services 166
5.6. Health coverage of vulnerable groups 168
5.7. Long-term care 170
5.8. Issues of sustainability 172
5.9. Drivers of reform 174
5.10. Conclusions and key challenges 176
References 180
Annex. Statistical data 183
VI. CONCLUSION AND KEY CHALLENGES 198
6.1. Main findings of the report 198
6.2. Insufficient and poor use of financial resources 199
6.3. Political and economic crisis 200
6.4. Need for better policies 201
6.5. Methodological and analitical problems 202

ACRONYMS

ASR	Annual Social Report of the MSPFC
BATU	Budgets of Administrative Territorial Units
CMEVF	Commission for Medical Examination of Vital Functions
DFID	UK Department for International Development
DSAFP	Divisions of Social Assistance and Family Protection
EC	European Commission
EGPRSP	Economic Growth and Poverty Reduction Strategy Paper
ENP	European Neighbourhood Policy
ENPI	European Neighbourhood and Partnership Instrument
ERCPOR	Experimental Republican Centre for Prosthetics, Orthopaedics and Rehabilitation
EU	European Union
EURMAP	European Union – Moldova Action Plan
HBS	Household Budget Survey
GoM	Government of Republic of Moldova
GDP	Gross Domestic Product
IMF	International Monetary Fund
ILO	International Labour Organization
LPA	Local Public Administration
LFS	Labour Force Survey
MDGs	Millennium Development Goals
MET	Ministry of Economy and Trade
MEY	Ministry of Education and Youth
MF	Ministry of Finance
MH	Ministry of Health
MSIF	Moldova Social Investment Fund
MSPFC	Ministry of Social Protection, Family and Child
MTEF	Medium Term Expenditure Framework

NBM	National Bank of Moldova
NBS	National Bureau of Statistics
NCU	National Coordination Unit
NDS	National Development Strategy
NEA	National Employment Agency
NES	National Employment Strategy
NIP	EU National Indicative Programme
NGOs	Non-governmental organisations
NHIC	National Health Insurance Company
NPB	National Public Budget
NSIH	National Social Insurance House
PPP	Purchasing Power Parity
RFSSP	Republican Fund for Social Support of the Population
SADI	Small Area Deprivation Index
SB	State Budget
SSIB	State Social Insurance Budget
SIDA	Swedish International Development Cooperation Agency
TA	Technical Assistance
TAU Gagauzia	Autonomous Territorial Unit Gagauzia
TB	Tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
USAID	United States Agency for International Development
WB	The World Bank
WHO	World Health Organization
UN	United Nations

EXECUTIVE SUMMARY

Introduction

This report aims to highlight the most important developments and features of the social protection and healthcare systems in Moldova, particularly analysing the impact of public policies on vulnerable and marginalised groups of the population. It briefly describes the development of macroeconomic, fiscal, demographic, labour market and education sectors and provides a thorough analysis of the social protection and social welfare system, poverty, and pension and healthcare systems. The analysis is built on the EU Open Method of Coordination and represents a basis for a comprehensive strategy designed to achieve sustainable economic growth, labour market inclusion and social cohesion. This report represents the first attempt to address the degree of harmonisation of the policies and statistical data between Moldova and the EU as well as countries in the region.

After being a part of the Soviet Union for a half century—benefiting from significant subsidies and the development of both the industrial and agricultural sectors that ensured an adequate income for the entire population—Moldova found itself at a crossroads when dissolution of the Soviet Union occurred. Moldova's transition to a market economy has been slow and extremely challenging, accompanied by a series of failures including: land reform, privatisation of state owned enterprises, and total collapse of the industrial sector. Its complete lack of energy resources together with the territorial dismantling of the country with the self proclamation of Transnistria (which once generated a third of Moldova's industrial output and almost entire energy production) has hit hard. Lack of sound economic and social reforms, coupled with political instability in the first phase of transition, has led to economic recession and increased poverty, thus qualifying Moldova as the poorest country in Europe.

Despite these setbacks, since 2000, Moldova's economy has been recovering, mainly due to migrant remittances, which currently represent about a third of GDP. Thus, over 2000–2008 the Moldovan economy recorded a cumulative growth of 62.9%, although this still represents only 56.6% of 1990 output. Remittances increased population incomes, raising aggregate demand and consumption. Consumption is satisfied largely by imported goods, with their more competitive prices and quality, dramatically increasing the trade and current account deficits. While over 2000-2008 salaries and pensions increased by more than 10% in real terms, they did not play a significant role in increasing population living standards. The current average net salary of €165 is well below the EU average salary.

Remittance-based economic growth was accompanied by poverty reduction, but the related population exodus created disruption within the domestic labour market. The population declined by more than a fifth during transition and emigration of almost a quarter of the active population has threatened the labour market, leading to a decrease in the economically active population and the population employed within the economy (also by almost one-fifth), whereas the inactive population has dramatically increased. At the same time, the unemployment rate is gradually decreasing, mainly due to emigration and, to some extent, as a result of legalisation incentives launched by the Government in 2007.

The informal economy, widespread in the first decade of transition, began to retract in the second phase. According to the National Bureau of Statistics (NBS), in 2008, the informal economy's contribution to GDP was 20.8%, compared to 34.6% in 2000. In the last eight years, the share of household production for own consumption, which constitutes a component of the hidden economy, dropped from 18.5% to 6.7% as a share of GDP—the biggest drop caused by threefold shrinkage of production in subsistence farming.

Inefficient structural reforms during transition have not only damaged the economy but have also led to a shift in the labour force between sectors. The number of employed within the agricultural sector decreased considerably—from 50.6% of total employed in 2000 to 29.8% in 2008. Structural adjustments, migration, and shift of workers between sectors led to a doubling of revenues in non-agricultural activities in the last three years, amid a decrease in the incomes generated by agricultural activities—in total of about one-fifth. While some workers became engaged in other sectors of the economy, particularly in construction, most of them emigrated. Unlike the agricultural sector, the industrial sector, which was also unable to revive during transition, has nevertheless absorbed the labour force released from the agricultural sector (particularly in the construction sub-sector).

Moldova's transition to a market economy caused a number of disruptions to the educational system, affecting both the quality of the educational process and the accessibility of educational services. Though spending on education has been steadily growing, reaching 8.7% of GDP in 2008 compared to 5.7% in 2000 inter and intra-sector distribution of expenditures is inadequate. There is a huge gap in financing between the different levels of education—general compulsory education benefiting from almost one-half of the funds, and these are inefficiently used. Less than one-tenth of financing goes to secondary vocational education. This level of resourcing is insufficient for modernization of the system and training of specialists for the labour market. The lifelong learning concept in general, together with distance learning in particular, are poorly developed in Moldova. These problems in the education system, coupled with economic and social challenges among the population, have stunted education indicators. Over the last few years, gross enrolment rates in primary and lower secondary education have decreased. In contrast, the enrolment rate in preschool education is increasing, although there is a shortage of child care facilities, particularly in urban areas.

Moldova has been affected by demographic aging, generated mainly by a decrease in birth rates. This has resulted in an absolute and relative decrease among the young population and an increase in the share of elderly. The birth rate is falling alongside a decreasing mortality rate and life expectancy is increasing. The demographic projections are not positive. According to UN forecasts, the population of Moldova could drop by some 20% by 2050. The demographic crisis will have an adverse impact in the medium to long term, particularly on the labour market and pension system.

Transition to a market economy has caused significant disparities between the capital city and the rest of the country, between urban and rural areas and, more recently, between development regions. The biggest socio-economic gap is between Chisinau municipality and other administrative-territorial units. The capital is the key point of not only consumption and revenues, but also public spending and well-being. Unlike Chisinau, which suffered less from the industrial collapse, other towns that depended on one or more industrial enterprises were affected considerably more. Since 2006, the country has been split into six development regions, three of which in particular (North, Centre and South) will be considered by authorities in the medium term in order to reduce the gap both among these three regions and between these regions and Chisinau. Among the North, Central and South regions, the most developed is the North, while the least developed is the South, with the smallest industrial output per capita, the lowest level of investment in fixed capital, and the smallest number of reporting enterprises.

Despite gradual recovery in the second phase of transition, the current world financial and economic crisis has set back Moldova's economy and eroded population living standards. At the beginning of 2009, the evolution of the Moldovan economy slowed, foreshadowing the impending problems that Moldova is likely to face in the short to medium terms. In the first

quarter of 2009, exports, imports, industrial output and the transport sector all contracted, while the number of unemployed and wage arrears have increased dramatically. At the same time, budget revenues and National Bank of Moldova (NBM) official reserves continually dropped, while budget expenditures increased. A reduction in budget revenues due to aggregate demand contraction, coupled with a reduction in migrant remittances by one-third, will put not only vulnerable population groups at further risk but also active businesses. The economy will most probably not be able to absorb the domestic workforce, or emigrants returning to Moldova.

The political crisis in the country, which emerged after Parliament elections held in April 2009 and associated budget expenditures, represents a threat to the sharply declining economy, obstructing the proper implementation of anti-crisis policies to support the private sector and vulnerable groups. Response to the economic crisis was late and incomplete, mainly due to the political situation. Without a fully functioning Parliament, the most effective proposed fiscal measures cannot be adopted. Notwithstanding these measures, in 2009, the Moldovan economy is predicted to contract at least 5% and the unemployment rate to reach 10% with little prospect of recovery in the medium term.

ACCESS TO SOCIAL PROTECTION

With regard to the social protection system, there have been several transformations since 1998. The present system of social protection in Moldova is divided into state social insurance and social assistance—the latter non-existent prior to independence. Despite numerous institutional reforms, the current social protection system is centralized from both a political and administrative point of view, while the analytical and strategic planning capacities, including the capacity to assimilate external assistance, need to be strengthened. Implementation of administrative decentralization without fiscal decentralization undermines the capacity of local public authorities (LPAs) to support the sustainability of community-based social services. Lack of financial resources within territorial-administrative unit budgets does not allow LPAs to meet the demand for social services, resulting in heavily institutionalised and costly care.

The cost of social protection is on an upward trend, and in 2008 had reached 30% of the total expenditures of the national public budget and represented 12% of GDP. Donor assistance to the social protection sector was considerable, particularly in the second decade of transition. A total of €83 million in external assistance was directed into the social protection sector over an 8–9-year period. European Commission assistance in the field of social protection is significant, amounting to €27 million over 2008–2010, followed by technical assistance provided by the International Organisation for Migration (IOM), United Nations Children's Fund (UNICEF), Swedish International Development Cooperation Agency (SIDA) and other country development partners. The effectiveness of donor support varies, depending on the political will to implement a number of sensitive policies and quality of advice provided. It is also dependent on donor coordination which initially was somewhat weak but which has significantly improved after strengthening of the partnership among donors.

Unlike the national public budget, the state social insurance budget (SSIB) performed as well in 2008 as in 2004, resulting in a budget surplus. Despite this performance, as a result of the contraction of national public budget revenues, the return of some 40 thousand emigrants, and increase in unemployment and the number of vulnerable people, the deficit of the state social insurance budget could further increase to unprecedented levels. The economic crisis, the effects of which are already visible, coupled with demographic and labour market disturbances, will undermine the sustainability of the SSIB. The impact of this would be reflected in slower increases in the size of social benefits as well as the occurrence of arrears.

Of note in relation to the role played by social protection benefits among the vulnerable population, is that they represent an important source of income for households after salary revenues. However, the impact of social assistance benefits on poverty reduction is highly insignificant, representing a difference of 1% compared to 11.9% for social insurance benefits. Moreover, those from households whose main source of income is from social benefits register a high poverty risk (33.6%). The marginal impact of social assistance benefits on living standards can be explained in part by the categorical approach to access. The fact that households obtaining social benefits are considered among the poorest, however, indicates that the problem does not reside only in targeting but also in the small size of benefits.

The most important and costly social insurance benefits are pensions, unemployment benefits, maternity benefits and child care allowances. The size of social insurance benefits are on an upward trend and, to some extent, contribute to avoiding social exclusion. However, the average size of social insurance benefits is small compared to that of the EU member states.

Social assistance schemes include 18 types of cash benefits and social services. Eligibility for cash benefits is based on the categorical approach and the payment is intended to be compensatory. Only in the case of three benefits is the income test applied to determine the eligibility of applicants (allowances for child care from the age of one and a half up to 16 years, material and humanitarian, and the newly introduced poverty benefit, named"social aid").

The largest social assistance benefits in both monetary and coverage terms are the targeted compensations for utilities payment that are provided to 11 categories of the population. In 2004, this was identified as the most expensive social programme, holding a share of total social assistance transfers of about 47%. Although targeted compensations do help certain vulnerable categories to cope with poverty and social exclusion, the fact that the system of targeting is based on categories of the population and does not take into account the living standards of beneficiaries and their need for social assistance leads to certain failures of the system—targeted compensations benefiting both poor and non-poor households. For instance, in 2007, the richest two quintiles received one-third of the targeted compensations.

These inclusion errors in the compensatory system have forced the Government to replace targeted compensations with social aid that is based on means testing rather than the categorical approach, in an attempt to better target the poor. Social aid for poor families was introduced on 1 October 2008 , and is estimated on the basis of the average global income of the family tested by applying a proxy means testing mechanism where income is tested using a number of measures to ensure proper targeting. The first stage of reform envisages the coexistence of social aid with targeted compensations, the size of the latter being frozen and no new beneficiaries allowed. Targeted compensations will subsequently be eliminated. This could happen by the end of 2009, depending on the evolution of both the political and economic crises in Moldova.

In relation to social services, the most important types of services provided by the state are residential care, home care and social canteens. Apart from these services the Government provides rehabilitation services and sanatorium and spa treatment to persons with disabilities, as well as prosthetic and orthopaedic services, and other locomotive aids, to war invalids and participants. There are also community-based services that have emerged mostly since 2003, when local public authorities established partnerships with civil society and donors. These partnerships are generally focused on providing social services, or opportunities to use free of charge fixed assets, and less on economic and community social development strategies.

The quality of services offered varies among providers. In the absence of a regulatory framework of social services, providers are confronted with outdated regulations constraining the delivery of

services, and in most cases, the need to comply with the requirements of donors. The monitoring of social services is conducted by public authorities only on an outputs basis (counting the number of services and beneficiaries), without assessing outcomes (the costs and social effects on the groups at risk). This lack of proper evaluation hinders the development of an accreditation mechanism focused on meeting quality and efficiency conditions.

According to the Law on Social Assistance, children, families with multiple children or disabled children, disabled persons and elderly, especially singles, are considered the most vulnerable categories of the population. Roma can also be added to this group, as given lifestyle factors they are more excluded from the labour market, education and healthcare systems than other ethnicities. These categories, to a certain extent, overlap with the vulnerable categories identified by the Household Budget Survey (HBS).

There are, however, certain groups of the population who are not given sufficient attention by the Government. Therefore, although social protection programs include a significant number of beneficiaries and benefits, they do not contain measures of adult protection in situations of risk. Young people who have left a residential institution enter these excluded groups. With a low level of education, poor skills for independent living and lack of qualifications, they cannot integrate into the labour market. Without adequate housing and resources to survive, coupled with a passive degree of involvement of local authorities, they are also forced to seek means of survival that are not always legal. A further group considered to be excluded are those released from places of detention. On release from prison, institutions only grant them a one-time allowance for employment, and as with youth released from residential institutions they are not provided further support. Addressing these vulnerable groups and preventing the economic downturn from detriorating into a social crisis is crucial in the short to medium terms.

POVERTY AND SOCIAL EXCLUSION

Economic growth during the second decade of transition was accompanied by some poverty reduction. The absolute poverty rate, assessed on the basis of HBS data has registered a decreasing trend, with poverty incidence in 2006 representing about 30% of the total population, compared to 25.8% in 2007. The incidence of poverty in the context of achieving the Millennium Development Goals (MDGs) in Moldova is also recording a similar picture. The share of the population with consumption below MDG thresholds decreased in 2006 and 2007, accounting for 34.5% and 29.8%, respectively, of the total population.

Poverty reduction was accompanied by a reduction in inequalities. In 2007, the Gini coefficient decreased compared to 2006, reaching the lowest value for the entire period under survey (0.298)—this measure indicating a decrease in the consumption expenditure gap between the rich and the poor. The decrease in inequality is also confirmed by the 90/10 distribution of the average expenditure per adult equivalent, which recorded values equal to 7.0 and 6.1 in 2006 and 2007 respectively,.

In regards to the territorial distribution of poverty, according to 2006 and 2007 HBS data, the highest poverty rates of 34.1% and 31.3%, accordingly, were registered in rural areas. These high rates are due to the large share of the population employed in the agricultural sector despite its considerable reduction in the second decade of transition. The absolute poverty risk is also relatively high in small towns representing 30.1% in 2006, and 23.8% in 2007. Insufficient development of services and infrastructure hindered the attraction of investments and economic rehabilitation of many small towns, leading to a high level of poverty. A lack of land plots, which would have ensured at least the minimum necessary food consumption, further aggravated the quality of life of the population in the small towns.

According to the HBS, the most vulnerable groups of the population in Moldova are households with children, headed by persons other than parents, families with many children, persons from households employed in agriculture, the elderly, disabled, unemployed, and persons without education or professional skills. Education remains one of the main factors that determines the level of household vulnerability. More specifically, poverty risk is dependent on the education level of the household head, decreasing substantially as the education level of the household head increases.

Income from remittances has a significant impact on the population's living standards. Households whose main source of income is remittances have the lowest degree of poverty risk (16.7%), in contrast to households receiving income from agricultural activities and social benefits. Migration is identified as one of the options among the poor to escape poverty, and members of households who consider themselves poor are more likely to go abroad to work than those in non-poor households. Emigration appears to contribute significantly to improving the standard of living among the poor.

The last few years have seen the majority of national policies concentrate on economic development and on poverty reduction. Poverty reduction objectives have focussed on increasing access of poor groups of the population to education, health, social protection and the labour market, all of which represent the key sectors in which the level of social inclusion and inequality can be measured.

PENSION SYSTEM

The pension system has gone through several transformations since 1998, when pension reform was launched. Reforms, among other measures, included expanded coverage, changes in benefit levels, increases in retirement contributions, alterations in retirement ages and contribution period, and application of highly sophisticated retirement formulas. The result is, perhaps inevitably, a very complex and poorly understood system that is far from transparent, making it inherently difficult to explain to new generations of workers and retirees exactly how "their" system works. The present pension system under-performs on the adequacy of pension benefits, struggles with compliance and collection, and does not provide sufficient incentives to participate and contribute to the system.

In more detail, a number of factors continue to compromise the pension system in the country. First, while fiscal sustainability has improved, the pension system is not fully prepared for the inevitability of population ageing and mass migration. Second, the linkage between contributions and benefits has been strengthened, and the pension system is better suited to market conditions. However, the provision of preferential pensions and a large redistribution to farmers create discrepancies. Third, the level of income replacement is generally inadequate for common categories of pensioners and represents less than one-third of the current average net salary, while the minimum pension stands at an exceptionally high 70% of the average pension, reflecting efforts to protect the living standards of low-income individuals (including those with intermittent formal sector employment or low lifetime wages). Fourth, pension equity is compromised as different categories of retirees are treated unequally with regard to their retirement.

In order to strengthen the pension system, structural problems first need to be addressed. Re-establishing valorisation of past earnings in the pension formula accompanied by a lower accrual rate—the accrual rate is 1.4% of gross wage for up to 30 years of service, and 2% for over 30 years of service—would yield more sustainable long-run replacement rates and reduce differences among cohorts of pensioners. Strengthening incentives in the current pension system

through a tighter link between contributions and benefits, avoiding contribution forgiveness, and adjusting minimum pension and contribution levels for the self-employed and farmers, would improve system finances and provide additional fiscal space for improvements in benefits, contribution rate reduction, and/or second pillar introduction when the time is right. Further reforms to cope with population ageing should focus on extending labour force participation by the elderly to avoid benefit cuts that may undermine adequacy and very high contribution rates, and discourage formal sector employment.

Measures to improve the pension system were recently addressed by the Government. It has contemplated continuing the 1998 reforms within a broader set of pension reform options, and is attempting to study the possible effects of the introduction of a second fully-funded pension pillar. However, a mandatory-funded pillar requires a sustainable first pillar, functioning capital markets and framework, and adequate administrative capacity. It also requires a sound and stable macroeconomic base, diametrically opposed to the one resulting from the current rumbling global recession. All these conditions have still not been met in Moldova and are unlikely to be met in the short to medium terms as a result of the economic crises that erode budget and population revenues and lead to the temporary disturbance of reforms.

HEALTH CARE AND LONG-TERM CARE

Turning to the health care system, the Semashko model of health care failed shortly after the independence of Moldova due to its incapacity to effectively utilize available resources. This incapacity was expressed in financing shortages, degradation of the quality of health services, and rapidly growing access barriers to health care for the citizens of the country. As a result, rent-seeking behaviours flourished. By the year 2000, almost half of health expenditure was paid through out-of-pocket means, although slightly improving over the following period. Reported by various sources, informal payments that bridged the gap after the state financing collapse still remain a strong impediment for the population in accessing health care services.

As a consequence of the social and economic disturbances during transition and the incapacity of the health care system to tackle old and newly appearing health threats, the health status of the population deteriorated considerably. Although tuberculosis (TB) management in the country has improved over the last five years, tuberculosis still represents a threat to society. The growing incidence of HIV/AIDS cases through heterosexual contacts (previously mostly among injection drug users), along with a high incidence of sexually-transmitted infections (STIs), is cause for immediate attention.

Health determinants such as lifestyle and living conditions are strongly influencing morbidity and mortality in the country. The alarming trends in alcohol consumption and increased smoking incidence have not been reversed and, along with pollution of water sources and conditional accessibility of water and sanitation, stand behind a large share of morbidity and mortality in the country. Moreover, Moldova remains an endemic zone for hepatitis. Although reforms of the last decade arrested the degradation of life expectancy in the country, Moldova is strongly lagging behind its neighbours and the EU.

A package of reforms, considered to have changed the face of health care in the country, was launched in 1996. It included introduction of a basic package of freely available health services along with a list of fees for health care services—virtually free before 1998—considerable reduction of secondary hospital capacity (1996–2006), re-enforcement of primary care and the country's emergency service, and introduction of compulsory health care insurance (2004). Although these reforms improved financing and administration of the health care sector, to date, universal access to health care services is still compromised by strong regional differences and

inequalities in access between urban and rural areas. Moreover, hospitalization rates and ambulatory care favour the urban population.

Compulsory health care insurance provides access to health services within the limits of the annually approved packages of services to only three-quarters of the population, leaving some vulnerable groups out of the system. Upon the introduction of health insurance, universal access to primary and emergency care was declared; however, the universally accessible volume of services available to the non-insured is much smaller compared to the insured. Rural areas remain the most deprived of access to compulsory health care insurance. Although children have been included as a vulnerable category in the list of categories benefiting from free access to health insurance, the volume of services included and drugs reimbursed still triggers high out-of-pocket expenditure for families. Moreover, the cost of pharmaceuticals to the population represents a strong barrier to accessing all types of care. Both the insured and non-insured in many cases have to pay for most medicines at the primary and ambulatory level, and sometimes in hospital settings.

The health care services provided to the population are not supported by strong quality control mechanisms. The implementation mechanisms for the stipulations of laws regulating the obligations of medical personnel and patient rights are still under development. Proactive measures are being undertaken to develop modern clinical guides and protocols. However, clinical implementation of newly developed protocols in clinical practice is slow.

The technological side of the health care sector has been reported to be outdated by a number of sources. In addition to evidence of obsolete, faulty and, in many cases, lack of equipment at all levels of care, slow the pace of implementation of eHealth technologies in clinical practice, increasing the gap between quality of health care in Moldova and other European countries. The low level of training and motivation of health care personnel raises questions about the capacity of the health care sector to provide an adequate number of well-trained and dedicated medical professionals. The challenge of the exodus of health professionals is obvious, and requires rectification.

Long-term care in Moldova has not been officially defined and represents a range of social and health services provided by different government bodies and non-government organizations. Most long-term care still comes from family networks. Existing state institutional capacity does not satisfy either the demand or quality standards for adequate care. A limited number of standards have been developed to date with the assistance of strong lobbying from the non-government sector and donor community.

Evaluation of the impact of the financial crisis on the health care sector is difficult under the present conditions, as it will depend to a large extent on the government response to be developed and introduced to address the situation, and the timing of implementation. The present lack of such a strategy points to the under-preparedness of health sector administration to deal with the present and future impact of the financial crisis. A possible decrease in financing of the health care sector due to a reduction in compulsory health care insurance collections, and drop in national public budget revenues, may lead to deterioration of the financial situation in health care institutions and compromise the sustainability of the sector. Possible financial shortages are likely to compromise the supply of pharmaceuticals in hospital settings and the availability of reimbursed medicines in primary care settings. The persistence of rent-seeking behaviour among health personnel and the incapacity to continue with the modernization of the health care sector are likely to reduce the accessibility and quality of health services.

CHAPTER I. GENERAL OVERVIEW

Introduction

Moldova is a young European state bordering Romania and Ukraine, which declared its independence on 27 August 1991 following the dissolution of the Soviet Union. The development of Moldova since gaining independence has been subject to both successes and failures, the latter resulting from the promotion of a number of counterproductive reforms, as well as unfavourable conditions at commencement, for sustainable development.

Unlike other countries of the former Soviet bloc, Moldova is a small country with very limited natural resources. Its fertile soils were not properly and fully utilised during transition. The geographical position of Moldova, between Eastern and Western Europe, and in close proximity to the European Union, has also not been fully exploited and the authorities have so far been unable to transform the country into a regional hub.

Although Moldova's economy is slowly recovering, the fact that for a number of consecutive years it was hit by various external shocks has hindered a full recovery and a sustained increase in living standards. These shocks included Russian restrictions on some Moldovan exports (2006), severe drought (2007), and devastating floods (2008). Moreover, the world financial crisis, while not having seriously affected the Moldovan financial sector to date, has had an adverse impact on the Moldovan economy, which is largely dependent on migrant remittances predicted to decrease in the medium term. The current development pattern indicates that Moldova is still at a crossroads, with stalled agricultural and industrial sectors that generated considerable incomes during soviet times, and a still underdeveloped tertiary sector. In the absence of a reform strategy that is generally accepted by the population, and with a lack of continuity in the activities of succeeding governments, the transition to a market economy continues.

This report provides a retrospective of the major economic, political, social, and demographic events faced by Moldova throughout the transition to a market economy. Particular emphasis is placed on social protection and healthcare systems, and policies implemented for the support of marginalized groups and the reduction of poverty. Extensive use is made of national reports and statistics. However, while the national statistical authorities have undertaken efforts to improve methods of statistical data collection, compilation and analysis, through the introduction of the System of National Accounts in 1993, not all indicators are comparable to those of the EU member countries. In these instances, the report highlights observed weaknesses, providing instead national data or the necessary qualitative analysis.

1.1. Macroeconomic situation

1.1.1. Historical background

For a half century Moldova was one of 15 socialist republics of the former Soviet Union. Although Moldova was the most densely populated republic, under the planned soviet economy

it was considered to be essentially rural, specializing in agriculture[1]. Moldova's narrow agricultural economy is partly a function of geography, which endowed it with a favourable climate and fertile "black soil" that covers more than three-quarters of its agricultural land. In the 1970's and 80's, Moldova received substantial investment from the budget of the Soviet Union to develop industrial and scientific facilities, as well as housing. However, this did not change the overall perception of Moldova as an agriculture-led economy.

In 1991, at the initiative of a liberal Russian State Secretary to confer independence to Soviet republics, Moldova seceded from the Soviet Union and became a sovereign and independent country. In the process of transition to a market economy, Moldova has undergone several development stages. The first stage, which started in 1991, consisted of price and trade liberalization. In 1993, with the support of the International Monetary Fund (IMF) and the World Bank (WB), mass privatization of state enterprises was carried out and the national currency, the Moldovan Leu, was introduced. By 1995, the country had fallen into recession—culminating in 1998—as a result of the regional financial crisis. Land privatization, which commenced during this period, slowed and the Government began accumulating external debt. Only since 2000, when the second phase of transition had begun, did Moldova's economy start to recover. The recent global financial and economic slowdown did not significantly affect Moldova until 2009, when it began to have an adverse effect on almost all sectors of the economy.

1.1.2. The first stage of transition (1991–1999)

The difficulties of the first years of transition were exacerbated by political events in Moldova. The most dramatic blow was the territorial dismantling of the country with the self-proclamation of the region on the left bank of the Nistru River—located *de jure* within Moldova—as the Transnistrian Moldovan Republic. This separation has not only created political pressures between these two regions and the countries involved in the settlement of the Transnistrian conflict, but has also caused significant economic losses to Moldova and generated considerable opportunity costs. Despite the small size of Transnistria (comprising 10% of the territory and 14% of the population), most of the country's industry was located in this separatist region. Any analysis of the socio-economic situation cannot ignore the role of Transnistria, although the economy of this region is not captured in the official statistics of Moldova. In 1990, Transnistria generated 40% of the economy's output, including 33% of industrial output, and 90% of total energy production.

> The national accounts statistics are compiled using methodology developed in 1993. The estimates do not include the Transnistrian region, for which data has not been collected since 1991.

The separation of Transnistria was accompanied by an armed conflict in 1992, after which several attempts to regulate relations between Moldova and Transnistria have been made. Despite these efforts, all attempts have failed, due largely to the presence of Russian troops within Transnistrian territory.

A further setback to the Moldovan economy since independence was the cessation of direct and indirect subsidies from the Soviet Union (which accounted for 25% of GDP in 1990), together with increasing prices for imported energy resources. With loss of control over the most profitable enterprises in the industrial sector, the only way out for Moldova was the agricultural sector, which employed about half of the labour force of the economy at that time. Moreover, with the dissolution of the Soviet Union, Moldova was forced to accept the new realities, namely: a shortage of financial resources (previously provided through subsidies to the former Soviet republics), absence of advanced technologies, and closure of traditional markets due to

[1] Kyrgyzstan was the only Soviet Republic to hold a larger percentage of rural population.

the low competitiveness of Moldovan products. A lack of domestic energy supply[2], and consequent dependence on importing energy resources from countries whose prices have increased considerably (especially Russia and Ukraine), has further undermined the efforts of the transition governments to revive the economy.

These setbacks led to the economic collapse of Moldova, and an increase in poverty in the early years of transition. The economy was not generating sufficient resources to develop and support vulnerable population groups; moreover, both internal and external debt was increasing rapidly. Thus, over 1992–1998, state external debt increased from €14.2 million to €1.24 billion. The failure of privatization on the basis of patrimonial bonds, state control over the country's key industrial sectors (tobacco, wine and energy)—leading to modest performance and even bankruptcy of many enterprises—as well as shortcomings in the land privatization programme, have further undermined the transition to a market economy.

These events, combined with the receipt of credits under non-preferential conditions from international financial institutions, led to both adverse and possibly irreversible consequences. Output in 1992 dropped by almost 40% compared to 1990. The inflation rate at the end of 1992 and 1993 reached levels of 1670% and 2777% respectively (following the switch to the national currency, Moldovan Leu), falling to 11.2% by 1997. In 1999, the volume of industrial production dropped by 68.4% from 1990, and agricultural output, generated by the sector considered the main saviour of the crisis, halved.

Finally, after six years of attempted reform, economic improvement was seen in 1997 as the result of modest growth in the industrial output of the country. This appeared to have marked the beginning of a period of general economic recovery. At that time, the national currency was introduced and the banking sector was restructured and strengthened, property reform was completed, and the foundations to promote agricultural reform were laid. Despite this positive growth, in 1998, the financial crisis in Russia—Moldova's main trading partner—delivered a major blow to the Moldovan economy. It resulted in a significant reduction in the demand for Moldova's industrial and agricultural exports. As Moldova's economy is small and relatively open, it is extremely vulnerable to external shocks (as demonstrated by the impact of this crisis). Lack of political stability and consensus on economic policies has further undermined efforts undertaken by the authorities to promote consistent structural reforms.

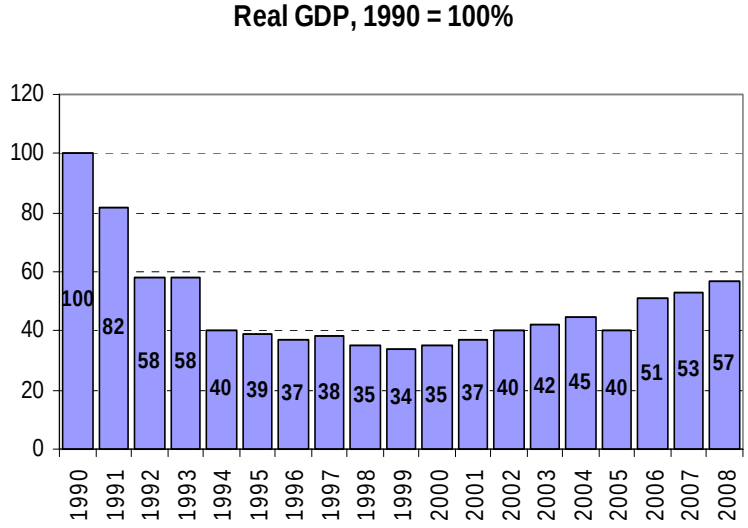
1.1.3. The second stage of transition (2000–present)

After almost a decade of recession and sporadic progress, commencing in 2000, the country's economy achieved an upward trend, recording a cumulative growth in real GDP of 62.9% over 2000–2008. In 2008, real GDP grew by 7.2%, in contrast to countries such as Latvia and Estonia that experienced a negative growth of 4.6% and 3.6% respectively. The GDP per capita tripled during this period, reaching a level of €1,113 in 2008, compared to €232 in 1993. This performance, however, was not sufficient to achieve the levels of output that occurred prior to transition—real GDP in 2008 represented only 56.6% of the output recorded in 1990[3] (Figure 1.1.). Economic growth during this period was generated, among other factors, by a number of reforms initiated by the government including judicial, public administrative, fiscal and regulatory. This led to an increase in foreign direct investment, which quadrupled during this period, and an increase in incomes due to wage rises and worker remittances from abroad. Also over this time, in nominal terms, the average monthly wage in Moldova increased by approximately five times the amount and the average monthly pension over six times. However,

[2] Imported energy resources comprise approximately 80% of the volume consumed in Moldova.

[3] [3] In order to have an idea of the discrepancy between current GDP and the output in 1990 the National Bureau of Statistics makes the assumption that the output in 2008, excluding Transnistria, is comparable with the 1990's output that includes Transnistria

the average salary and pension levels in 2008 decreased in real terms compared with 1990 by 28% and 63% respectively.



Source: National Bureau of Statistics

Economic growth over the last eight years has been accompanied by changes in the composition of GDP, with service sector output increasing faster than that of agriculture and industry. The agricultural sector, which was characterized by low productivity and income, was no longer as attractive to rural residents, who chose either to emigrate or switch to better paid sectors. Within the industrial sector, the most developed branches are textiles and food processing. The dependence of the country on industries that are extremely vulnerable to external factors, such as the food industry, does not represent a solid foundation for sustainable economic growth. Slow development of the agricultural and industrial sectors, especially in the last two years, was caused by unfavourable climatic conditions and tensioned trade relations with some partner countries, particularly the Russian Federation, which imposed an embargo on wine imports from Moldova in 2007. This situation was also accompanied by an increase in the trade deficit, reaching €2.2 billion in 2008 compared with €0.33 billion in 2000, and €0.1 million in 1990. Given Moldova's high dependence on imported energy resources, accompanied by demand and purchasing price increases, expansion of the trade balance deficit was inevitable.

Economic growth was backed by emigrant remittances. These stimulated high consumption (an increase in final consumption was largely associated with the final consumption of households, which increased over 2000–2008 by more than three times the amount) and increased imports—local production being unable to meet the increased domestic demand—which consequently led to the deterioration of the trade balance. Moreover, economic growth, the influx of foreign currency into Moldova and, in particular, the increasing price of natural gas imported from Russia, contributed to the intensification of inflationary pressures. These were, however, successfully controlled by the NBM and, in 2008, inflation with its largely "imported" nature, was 7.3% compared to 18.4% in 2000 (end of year). This was the lowest inflation rate in Eastern Europe, with the exception of Romania (6.2% in 2008).

Economic growth was accompanied by high but decreasing rates of poverty, and a massive exodus of the labour force. About a quarter of the active population[4] left Moldova to find better-paid jobs. At the same time, remittances, and wage and pension rises, led to a reduction in absolute poverty. Although migration and remittances have led to an improved standard of living, they have also created a series of adverse effects, both economic (due to the negative impact of the increase in aggregate demand brought about by remittances on prices and the economy's external balance) and social (separation of families).

[4] National Bureau of Statistics, Labour Force Survey 2008. Other sources give a significantly higher figure, see Section 5: Migration and remittances.

Unlike other countries in the region, the global financial and economic crisis did not dramatically affect Moldova in 2008—the economy eventually experiencing a slowdown in 2009. Due to the efforts of Government and the NBM to maintain the economy and ensure a strong currency prior to Parliamentary elections, Moldova's economy did not show signs of recession until the end of 2008. Up to that time, GDP had increased by 7.2%, both exports and imports had risen by 18.6% and 32.8% respectively, net foreign direct investments had increased by 1.4 times and the national currency, due to NBM efforts, remained strong.

From the commencement of 2009, however, Moldova's economic growth slowed, signalling that Moldova is likely to face problems in the short to medium terms. In the first quarter of 2009, the GDP dropped by 6.9%, exports decreased by 20%[5], imports by 23%, industrial output by 25%, and the transport sector contracted by nearly 65%. At the same time, budget revenues dropped by 9%, expenditures increased by circa 17%, and the NBM official reserves dropped by 35%. Despite these impacts, the population had accumulated sufficient savings (particularly from remittances) to afford almost the same consumption pattern in the first quarter of 2009 as in previous years—consumption dropping by only 10.2%. However, consumption is likely to decrease more sharply with a predicted increase in returning emigrants and an associated decline in remittances and population savings. A projected reduction in budget revenues this year by at least one-third is a reflection of the decline in consumption.

The world economic crisis, closely tied to the collapse of the banking sector in advanced economies, has led to a loss of confidence among the population in the Moldovan banking sector, demonstrated by the rapid withdrawal of banking deposits from early 2009. One commercial bank has already gone bankrupt (July 2009) due to loss of depositor confidence. Reduction of liquidities in the banking sector has, in turn, led to an increase in credit interest rates by 5 p.p., reaching an average of 23% in early 2009. High interest rates have impeded businesses' access to credits. In May 2009, credits provided to the economy dropped by three times compared to the same month in the previous year—this despite reduction in the second quarter of 2009 of the NBM interest rate from 11% to 9%, and in commercial bank compulsory reserves from 17.5% to 16%.

Without the necessary financial resources, businesses have decreased outputs, reduced salaries, encouraged unpaid vacations or dismissal of staff, and gone into bankruptcy. The number of unemployed in the first quarter of 2009 increased by 1.9 times, wage arrears by 1.5 times, and the number of liquidated enterprises by 1.6 times compared to the first quarter of 2008. These first signs of economic downturn, coupled with a reduction in migrant remittances by one-third, will put not only the existing vulnerable population groups at further risk, but will likely generate new victims among both individuals and businesses. In addition, as the most recent economic growth seen in the country was fuelled by consumption and remittances rather than industrial and technological advances, the economy has not built the technological and production capacities that are crucial during a crisis. This makes Moldova one of the most vulnerable countries in the region to the deepest crisis.

1.2. Budgetary and fiscal policy

Moldova's centrally-planned economic system, prior to transition, derived government revenues by taking a share of the operating surplus of state enterprises, which accounted for virtually all

[5] One reason for the reduction in exports is the contraction of aggregate demand among Moldova's main trade partners. An important role, however, was also played by the strong national currency that has appreciated against the USD (the reference currency) by 8.8%.

production and distribution. When transition policies removed the surpluses of most enterprises, massive government deficits resulted. Commencing in 1997, in order to ensure macroeconomic stability, government budgetary policy aimed at reducing public expenditures, direct and indirect subsidies granted to certain sectors and enterprises (especially state-owned), and expenses for health, education and social protection. Although debt servicing has improved, it has occurred at the expense of the population's access to certain public services. While narrowing the fiscal gap represented a necessary step towards macroeconomic stability during the first years of transition, the result was a more serious gap in social provisions.

1.2.1. Latest reforms

Later in the second decade of transition (2003), in order to increase the efficiency of the budgetary process, the Medium Term Expenditure Framework (MTEF) was introduced as a tool to forecast revenues and expenditure over a three-year period. The practice of MTEF forecasting was extended to local authorities and the development of programme-based budgets was initiated. Strategic plans covering 12 sectors have been developed for the 2009–2011 MTEF, doubling over the 2008–2010 MTEF. These strategic plans will cover about 82% of public expenditure in 2011 compared with 72% in 2008 (WB, 2008).

Fiscal policy, at the initiative of the President, underwent major reforms in 2007 in three interrelated areas: (i) introduction of a "zero" tax on reinvested income for economic agents; (ii) cessation of capital legalisation (subject to a 5% tax) until 1 January 2009; and (iii) a general amnesty on tax arrears. As a result of the amnesty on tax arrears, debts amounting to MDL 4.3 billion (€260 million) were cancelled**.** Overall, this initiative was not as successful as the Government had anticipated—entrepreneurs were reluctant to declare hidden incomes, fearing that they would subsequently be harassed by the authorities.

1.2.2. Structure of revenues and expenditures

The structure of national public budgets in recent years has become more consistent, with a strong social orientation and comprising largely of indirect taxes (particularly VAT). In 2007, national public budget revenues reached the highest level of GDP in the last eight years—41.8% compared with 33.9% of GDP in 2000. In 2008, these represented 40.6% of GDP. As in previous years, the main source of income has been the VAT (35.6% of total expenditures), with a tendency for non-fiscal revenues to decrease. Of direct revenues in 2008, the largest shares were represented by contributions to the state social insurance budget (21.3% of total revenues), income tax, including corporate income tax (8.6% of total revenues), and insurance premiums for the mandatory medical insurance fund (4.5% of total revenues).

Expenditures of the national public budget also increased, reaching 41.6% of GDP in 2008 compared with 36.4% in 2000. Around two-thirds of expenditures of the national public budget were directed towards the social sector[6], consisting of 68.5% of total expenditures in 2008 compared to 44.2% in 2000. Budgetary allocations for this sector are continually increasing although, in the medium term, expenditures on education and social protection (both as a share of GDP and total expenditures) will decrease as opposed to health expenditures, which will continue to grow. One of the main objectives of the Government is to support individuals with low incomes and those at risk. Budgetary expenditures for this purpose revealed a continuous growth trend, registering a major share of 31.8% of discretionary expenditures and about 13% of GDP. Staff expenditures are on an upward trend, reaching 9.7% of GDP in 2008[7].

[6] Social sector includes social insurance and social assistance expenditures.

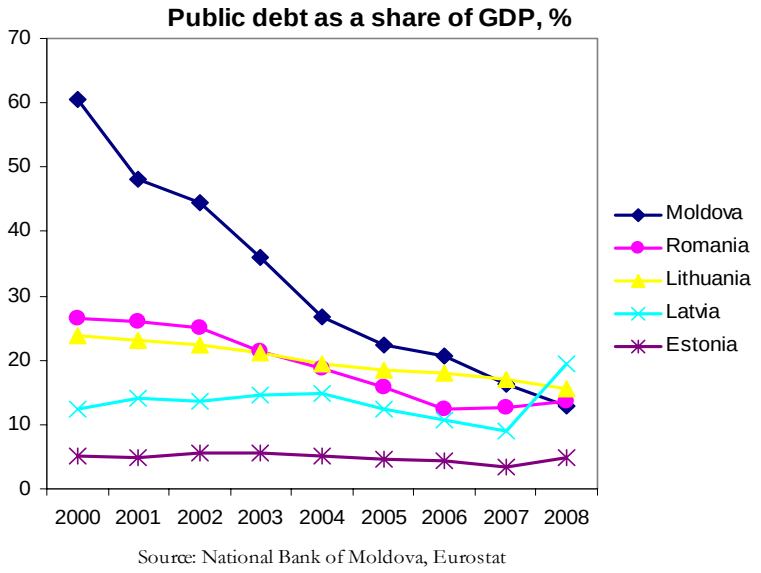
[7] The Government has set the goal to maintain expenditures on staff at 10% of GDP (according to the commitments undertaken with the IMF).

During the period 2006–2008, the Government undertook a series of commitments to the IMF under the framework of the Poverty Reduction and Growth Facility (PRGF), as stipulated by the Memorandum of Economic and Financial Policies. The primary objective of this programme was to maintain macroeconomic stability against inflation, achieved by the Government through adherence to a strict fiscal policy. Another objective of this programme was to maintain the budget deficit at 0.5% of GDP, by channelling income overflows into investments, with a minimum impact on inflation. Through the implementation of this programme, the Government maintained the budget deficit for the period 2006–2007 at 0.2–0.3% of GDP, reaching 1% of GDP in 2008. With increasing population needs and economic breakdown associated with the global crisis, the budget deficit is likely to increase.

1.2.3. External debt

External debt is a dire legacy of the early transition period, when average income dropped precipitously to the level of a low-income country, and international financial institutions did not offer concessional terms for lending. In order to finance its budget deficit in the 1990's, generated primarily by the servicing of external debt, the Government had little alternative but to increase domestic debt.

Although total external debt and debt administered by the Government are increasing in nominal terms, their balance in relation to the GDP is constantly decreasing. Thus, over 2000–2008 the ratios of total external debt and debt administered by the Government to GDP were reduced from 133.1% to 67.5%, and from 60.4% to 12.9% respectively. This level of public debt is lower than in Romania, Latvia and Lithuania, but higher than in Estonia, which seems to perform better than the other two Baltic states (Figure 1.2). Moldova's major creditors are international financial institutions, although Russia and the Paris Club members are equally important. While through this performance Moldova has managed to reduce its fiscal pressures, its large outstanding external debt still burdens the development of the national economy. The debt burden continues to constrain the government's ability to allocate public revenue for growth and poverty reduction.



Source: National Bank of Moldova, Eurostat

It is possible that public debt will increase further if the Government negotiates a credit for budget support to help Moldova ride out the crisis. In June 2009, the IMF postponed negotiations on the new credit until the end of the year, due to the political crisis that emerged in Moldova after the Parliamentary elections held in April 2009, when it anticipates that there will be a stable government in place. In response, the Government has initiated bilateral negotiations with Russia and China. A higher interest rate might not be an obstacle for the Government, since unlike the IMF, these countries will not set policy conditions with which the ruling party does not agree, particularly on the eve of anticipated Parliamentary elections.

1.2.4. Response to the economic crisis

Although the Government has not yet approved a recession strategy, the President has made public certain measures for stimulating the Moldovan economy over 2009–2010. Hence, it is expected that contributions to the social fund will be reduced by 5 p.p. (4 p.p. cut for employers and 1 p.p. for employees). Individual income tax will flatten out, reaching a rate of 15% and substituting the progressive tax rates of 7% and 18%. Finally, the VAT will be increased by 2 p.p., reaching 22%. On one hand, reduction of the social tax is welcomed, as it will create incentives for the private sector to develop and reduce unofficial payments. On the other hand, the introduction of a flat income tax on individuals, although potentially increasing budget revenues, may hurt low income groups whose incomes were subject to a lower (7%) income tax in the past. An increase in the VAT rate, while raising budget revenues, could also have adverse effects on final consumers, most of whom have become vulnerable since the crisis.

Given high credit interest rates that limit the access of businesses to financial resources, the Government has come to an agreement with the NBM to provide preferential credit to the commercial banks with an interest rate of 10%. The credits will subsequently be provided to the economy at a 16% interest rate. While this is a somewhat late measure, it may help some businesses within the affected industries if not to invest in production, to at least pay back old credits.

At the same time, the Government is likely to resort to cutting back and redistributing budget expenditures. It has already cut local budgets by 20%. Sectors such as agriculture where, for instance, certain subsidies are not justified, might be the first to suffer from expenditure cuts and redistribution. The released funds could be used to supplement the construction, transport and trade sectors that were hard hit by the crisis. These measures, together with an increase in the size and amount of unemployment benefits, will further increase the budget deficit. Moreover, the fact that the Government has taken a reactive rather than proactive approach to managing the crisis will likely increase the time lag between actions and results.

1.3. Demographic trends

1.3.1. Depopulation

Over the last decade, Moldova has been subjected to a population decrease, caused by low birth rates amid increased mortality and mass emigration. While over 1950–1990 the population rose by 90.4%, over 1990–2008 it fell by one-fifth. After a 15-year break, a population census was conducted in 2004 updating the existing demographic data[8] (Table 1.1).

Table 1.1. ***Population size as per the census from 1959, 1970, 1979, 1989, 2004***

	Population at census conducted in:				
	1959	**1970**	**1979**	**1989**	**2004**
Size of population	**2513483**	**3085080**	**3372051**	**3657665**	**3383332**

Source: NBS

Moldova's population according to the 2004 census was approximately 3.38 million (excluding Transnistria)[9]. A census undertaken simultaneously in Transnistrian indicated a population in this region of 555,300. On 1 January 2009, the population of Moldova was 3.6 million, of which

[8] This is the fifth census in almost the last 50 years, delayed due to lack of financial resources.

[9] If it is assumed that the number of emigrated people is higher than recorded, then the actual population of Moldova will be, accordingly, much lower than official estimates.

41.4% were from urban areas and 58.6% from rural areas. Although the evolution of the urban and rural populations over the last decade has not been subject to major disturbances, the share of rural population declined by 1.9% between 2000 and 2008, while the urban population reduced by some 2.6% (excluding Transnistria). Despite the recent migration trends of the population from rural to urban areas, the level of urbanization in Moldova is one of the lowest in Europe.

The urban population is concentrated in big cities (50% live in Chisinau), while small towns have been depopulated through internal and external migration. Over the last two decades, massive depopulation has been recorded in most cities, including the largest and most prosperous. Between 1989 and 2004, the city of Balti lost over one-fifth of its population, Cahul and Ungheni over one-quarter, while Soroca and Orhei lost nearly one-third. This was the result, among other factors, of a decrease in birth rates in cities, which unlike rural areas have recorded a negative growth in recent years, as well as labour migration due to the absence of internal employment opportunities.

1.3.2. Demographic ageing

Moldova has been affected by demographic aging, generated mainly by a decrease in birth rates, which has resulted in an absolute and relative decrease among the young population. A reduction in the population share of this age group from 23.8% to 17.6% was seen between 2000 and 2008, and an increase in the share of elderly (65 years and older) from 9.4% to 10.2%. A gender imbalance is growing within the elderly group. For example, while in 1989 the population share of elderly females over 60 years was 14.7%, this index reached 16% in 2008 compared with 11.2% for males. The population ageing coefficient increased from 12.8 in 1990 to 13.7 in 2008, with most of the elderly residing in rural areas. This increase in the ageing coefficient reflects an increase in demographic pressure brought about by the reliance of a larger population on a smaller amount of resources and subsistence means.

The birth rate dropped by nearly four times between 1950 and 2008, and decreased by a half compared to 1990. Unlike other countries in the region that have registered positive natural population growth throughout transition, Moldova has experienced an adverse phenomenon — since 1999, rural areas, which typically had higher birth rates, have been characterized by negative natural growth. Labour migration, which intensified in the last decade with the settlement of emigrants in their countries of destination, is one of the causes of the drop in natural growth.

With women becoming more employment-oriented, small child allowances and limited access to childcare facilities, particularly in urban areas, young families with two or more children are now a rare phenomenon. The demographic trends in Moldova indicate a continuous reduction in the total fertility rate of the population[10]. While between 1950 and 1960 the total fertility rate was 3.5–4.0 children per woman, today it is only 1.2–1.3. These negative trends indicate that the demographic evolution of Moldova over the last 17 years has taken place under conditions that are inadequate for even the replacement of the population.

At the same time, the mortality rate in recent years recorded a decline from 12.4 deaths per 1,000 inhabitants in 2005 to 11.8 in 2008—the mortality rate in rural area being higher than in urban areas by 60–65%. The introduction of compulsory medical insurance in 2004, which provides a minimum package of health services and free medicines to vulnerable population groups, could be one of the reasons for a drop in the mortality rate. The male mortality rate is higher than that of women by 1–2%. Along with the decrease in the mortality rate, in the same period, life

[10] The average number of children that a woman would give birth to within her reproductive period.

expectancy was increasing. Thus, in 2008, life expectancy at birth was 69.4 years, compared to 67.9 in 2005 and 65.8 in 1996. This indicator, however, is below the average of EU-27 countries (79 years in 2006), and much lower than that of EU countries with the shortest life expectancy—Latvia (70.9 years), Lithuania (71.1 years) and Romania (72.6 years). Women's life expectancy of 73.2 years in 2008 was about eight years higher than that of men's. It is, however, much lower than the EU-27 average (82 years). In 2008, average life expectancy at 65 years was 13.6 years—12.1 years for men and 14.6 years for women.

1.3.3. Population ethnic structure

The ethnic breakdown of Moldova's population according to the 2004 Census shows that about three-quarters of the population are Moldovans, unlike Transnistria where three ethnic groups prevail: Moldovans, Russians, and Ukrainians. Their share in the total population is relatively equal (Table 1.2). In relation to Roma, according to the last Census they represent 12,300 people, constituting 0.36% of the total population, which is significantly lower than in other countries in the region such as Romania, Bulgaria, and Hungary. A recent survey (Cace et al. 2007) estimates the Roma population in Moldova to be 15,000 people, whereas some Roma leaders believe their total number is as high as 250,000 (circa 7% of population). However, there are no reliable sources to confirm that the Roma population is much higher than official figures. Due to this uncertainty, and considering that in most cases Roma do not identify themselves declaratively as being of Roma ethnicity, it is difficult to determine the exact numbers of Roma living in Moldova.

Table 1.2. ***Population ethnic structure***

Ethnicity	Census in Moldova	% in Moldova	Census in Transnistria	% in Transnistria
Moldovans	2,564,849	75.8%	177,156	31.9%
Ukrainians	282,406	8.3%	159,940	28.8%
Russians	201,218	5.9%	168,270	30.3%
Gagauz	147,500	4.4%	11,107	2.0%
Romanians	73,276	2.2%	-	-
Bulgarians	65,662	1.9%	11,107	2.0%
Others	48,421	1.4%	27,767	5.0%
Total	**3,383,332**	**100%**	**555,347**	**100%**

Source: NBS, Census of the Republic of Moldova and Transnistria, 2004

1.3.4. Population growth projections

According to UN forecasts (2007), the population of Moldova could drop to 2.8 million inhabitants, or by some 20%, by 2050. Starting from the period 2010–2012, the groups that will exit working age (56+ for women and 61+ form men) will be 1.5–2 times higher than the population groups aged 0–15 years, and will be numerically equal to the age groups reaching working age (Green Paper on Population, 2008). By 2050, compared to 2000, it is expected that the share of population among 15–59 year-olds in the total population will diminish from 62.6% to 55.5%, whereas the population over 60 years will increase from 13.6% to 31.9%. Consequently, both the number and share of the population at working age out of the total population will start diminishing. The beginning of this demographic crisis, which could intensify over the next decades, will have serious consequences for the economy. The labour market, which already suffers from insufficient skills in certain areas, will be subject to more pressure, especially if labour migration continues. Moreover, the demographic crisis will impact on the sustainability of the social fund, which in the near future will need to cover a large number of pensioners—much higher than that in previous generations.

1.4. Situation on the labour market

1.4.1. Employment and activity

In the early 1990s, prior to transition, the labour market was characterised by a considerably modest number of registered unemployed people (100 in 1991), and a level of employment equal to that of the active population (2.07 million in 1990). During the same decade, when many former Soviet Union countries experienced structural adjustments, Moldova's economy was slowly restructuring, characterised by labour market rigidity and the agricultural sector constantly absorbing about half of the employed population. Subsequently, in the first years of transition, the labour market response to the sharp drop in output did not consist of cutting jobs, but of lowering salaries. Hence in 1994, the GDP dropped by 60% compared to 1990, whereas the average salary was reduced by 75%. It was around this time that the underground economy started to flourish.

Unlike CEE countries, where the initial stage of transition was characterised by faster job destruction than job creation, resulting in growing unemployment rates and shrinking employment ratios, in Moldova, lower rates of job loss and limited creation led to an increase in underemployment and reductions in real wages, along with an increase in subsistence agriculture. In the second decade of transition in Moldova, as in other CIS countries, job creation during the period of economic recovery still remained limited, since growth was largely driven by remittances and by a limited number of capital intensive activities, as well as by the recovery of productivity in sectors where capacity had been underutilized in the earlier transition phase.

The working age considered by the NBS is 16–56 years for women and 16–61 years for men. In order to ensure data comparability with EU, the 15–64-year age group is used, although not routinely published in the periodic statistical editions.

Over the last decade, following the changes to the structure of the economy and crises generated by both internal and external factors, the population group employed within the economy decreased and the remaining workforce were subjected to serious redistributions between the various sectors. In 2000, agriculture's share of GDP, which employed most of the active population of Moldova, was 25.4%, while by 2008 it had dropped to 8.9%. As a result, the number of employed within the agricultural sector decreased considerably—from 50.9% of total employed in 2000 to 31.1% in 2008[11] (table 1.3). However, despite these changes in worker numbers, subsistence agriculture is still an important source of living for most of the poor people from rural areas. Small farmers comprise almost the majority of farms. More than 70% of the poor live in rural areas, mostly dependent on subsistence farming on their small land areas (1.6 hectares/household), or earn their living from casual farm labour.

Structural adjustments, migration, and shift of workers between sectors led to doubling of revenues in non-agricultural activities in the last three years, amid a decrease in the incomes generated by agricultural activities—in total of about one-fifth. While some workers became engaged in other sectors of the economy, particularly in construction, most of them emigrated. Unlike the agricultural sector, the industrial sector, which was unable to revive during transition, has nevertheless absorbed the labour force (particularly in the construction sub-sector) released from the agricultural sector (Table 1.3).

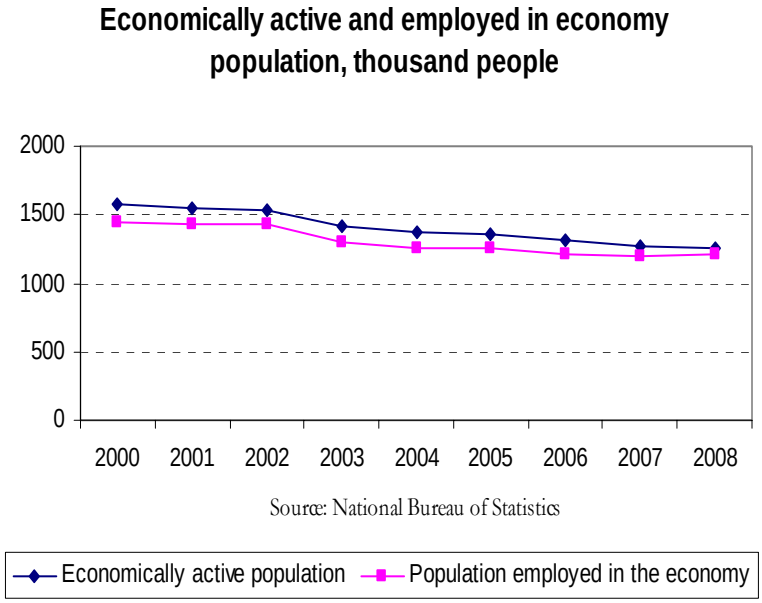
[11] Labour market statistics have been substantially revised following the 2004 census, the data now showing a higher degree of accuracy. Starting in 2008, the NBS publishes the main labour market indicators, estimated on a monthly basis, in the quarterly informative notes of the Labour Force Survey.

Table 1.3. ***Employment by economic sectors, % of the total employment***

Economy sectors	2000	2001	2002	2003	2004	2005	2006	2007	2008
Agriculture	50.9	51.0	49.6	43.0	40.1	40.7	33.6	32.8	31.1
Industry[12]	13.9	13.9	14.4	16.0	16.2	16.0	18.2	18.7	19.7
Services	35.2	35.1	36.0	41.0	43.7	43.3	48.2	48.5	49.2

Source: NBS

The labour market transformation has been accompanied by large productivity gains in almost all sectors of the economy. The largest increases have come in agriculture, as output has increased despite the sharp drop in agricultural workers. Compared to other countries in the region, Moldova has had the largest increases in productivity, although absolute productivity is likely still considerably below the EU average. The combination of productivity gains and low costs is possibly one of the main reasons for the recent increase in domestic and foreign investments. In the absence of the global financial crisis, these investments may have helped to speed up the labour transformation process, stimulating greater productivity and wage growth.



Along with the economy's structural adjustments and redistribution of the workforce, the main indicators characterizing the labour market have also changed essentially. Over 2000–2008, the economically active population and the population employed within the economy decreased by circa 316,000 and 228,000 respectively (figure 3). Most of the economically active population live in rural areas (55.1%), where wages are lower than in cities as is the profitability of economic activities.

Over the last eight years the activity rate[13] has been constantly declining, from 65.4% in 2000 to 49.4% in 2008—now below the EU-27 average (57.7%). According to distribution by sex, there are no major discrepancies, except for the population aged 55–64 years, with an activity rate for men in this age group of 51.2% compared to 47.7% for women. Moreover, only for this age group does the activity rate of 49.4% exceed that of the EU-27 of 48.5% (table 1.4).

Consistent with the activity rate, the employment rate has also been decreasing, from 59.6% in 2000 to 47.3% in 2008, and as such is much lower than that of the EU-27 (65.9%). In Romania, the employment rate was 59% in 2008, which is close to the rate recorded in Moldova in 2000. The higher employment rate in 2000 masked a large number of low quality, low productivity jobs and widespread underemployment. Migration has made the appropriate correction in this respect. The employment rate for persons aged 55–64 years (50.9%) was lower than the UE 27 average (53.5%) but higher than in Greece (49.3%), Italy (45.7%) and Hungary (46.2%). Four

[12] In this study the construction sector is included in the industrial sector according to NACE classification, although national accounts include construction under the services sector.
[13] Economically active people of 15 years and over as a share of total population.

out of five people aged 65 and over were engaged in agricultural activities (mostly subsistence farming). In relation to educational background, in 2008, some 45.7% of the population employed had professional secondary and vocational education and only 20.4% had higher education. Women prevail among employed persons with higher education (54.4%); three out of four are employed in urban areas.

1.4.2. Unemployment

Over 2000–2008, the unemployment rate decreased from 8.5% to 4.0%. This represents a very low rate when compared with that of the EU-27 (7%), and specifically Romania (5.8%), Lithuania (5.8%), Latvia (7.5%) and Estonia (5.5%). This reduction was, among others factors, related to the migration of both the skilled and unskilled population (see Section 5: Migration and remittances). Moreover, the low official unemployment rate is based on data that does not take into consideration unpaid leave, which is widespread in Moldova.

According to distribution by sex, significant disparities between the unemployment rate for males (4.6%) and for females (3.4%) have been recorded. In 2008, out of the total number of unemployed, 31.3% were long-term unemployed (unemployed for one or more years), and 14.8% of these fell into the youth category. The share of people who were unemployed for an extended period (24 months or more) represented 17.7% of the total number of unemployed. The share of unemployed youth in the total number of unemployed was 35.1%.

> To estimate the unemployment rate the Labour Force Survey, adjusted to ILO methodology, is used. The number of unemployed registered with the National Employment Agency can sometimes be 3–4 times lower than the LFS data.

The decrease in unemployment was accompanied by an increase in the economically inactive population[14]. During the period 2000–2008, the number of economically inactive increased by nearly 460,000. This category of population exceeds the economically active population. In 2008, some 1.3 million people aged 15–64 years were economically inactive. The biggest part of the inactive population is youth, most of whom choose to complete higher education rather than seek employment, followed by retired people (Table 1.4). In terms of relationship with the labour market, the inactive population is divided into two major categories: discouraged persons and persons who have been declared by households as working or in search of a job in other countries. The share of people discouraged to search for a job was less than 1.1% of the total inactive population, and the share of persons reported as working or in search of a job in other countries was circa one-fourth of the total inactive population.

Table 1.4. ***Distribution of inactive population of 15–64 age in2008, total and by gender, in %***

	Total	**Men**	**Women**
Total	**100**	**100**	**100**
Pupils and students	28.9	28.0	29.7
Retired	15.8	11.8	19.4
House keepers	9.0	0.6	16.5
Others	22.3	26.5	18.6
People left outside the country	24.0	33.1	15.8

Source: NBS

[14] The economically inactive population includes all persons, regardless of age, who have not worked at least an hour and were not unemployed in the reference period, falling into one of the following situations: pupils or students, pensioners (of all categories), housekeepers (carrying out only activities in the households); people supported by other people or by the state or people who support themselves from other incomes (rents, interest, etc.).

An analysis of the relationship between migration and inactivity suggests that persons in migrant households are more likely to be inactive due to home production activities (Görlich et al. 2007)[15]. This might be due to intra-household labour substitution between the migrant working abroad and the inactive members at home. Young adults in migrant households are much more likely to go to university, which explains their inactivity within the labour market.

1.4.3. Wages

Economic growth was accompanied by an increase in household incomes. Remittances have played a significant role in this regard. Moreover, migration led to a shortage of labour in many sectors, which, in turn, led to an increase in the real wages of these sectors, as well as productivity. The *average monthly wage* grew from €35.6 in 2000 to €124 in 2007 and €165 in 2008. In Moldova, where economic growth was accompanied by a decrease in the total number of employed people and consistent outflows of migrant workers, domestic wages grew due to a shrinking domestic labour supply. Despite this growth, the average salary is 1.5 times lower than in Romania, and 2.5 times lower than in Russia.

The lowest levels of remuneration are registered in agriculture and public services (Table 1.5). Low wages explain the low attractiveness of the labour market in Moldova. Real wages are not increasing as much as nominal wages. With high levels of inflation, population purchasing power is not growing. The increase in salary levels, in the context of insufficient investment to generate much higher productivity, represents a threat to the competitiveness of domestic products. However, the fact that workers moved from traditional sectors into other sectors of the economy has led to a depression in wage growth. Hence, the average wage at present is much lower than in neighbouring countries than it was a decade ago.

Table 1.5. ***Average salary by sector of the economy, €***

Sectors of economy	**2000**	**2007**	**2008**
Agriculture, hunting and forestry	21.9	66.2	95.3
Construction	47.0	178.9	232.3
Transport and communications	55.3	183.2	230.5
Financial activities	204.8	280.2	355.9
Education	21.6	81.4	109.1
Health and social assistance	20.0	102.7	147.9
Public administration	45.1	144.1	183.6
Exchange rate, euro/leu	**11.49**	**16.59**	**15.29**

Source: NBS, National Bank of Moldova

In 2006, the Government undertook a populist commitment to increase the average salary of the economy to US$300 (€188.7) by the end of 2008 (pre-electoral year)[16]. During this period, besides continuously raising public sector wages to the detriment of capital investments, the Moldovan Leu appreciated significantly. Continuing appreciation of the Leu would have helped the Government to reach its target, had the recent economic crisis not emerged, resulting instead in a much lower average salary (expressed in $US). In addition to increasing salaries, the Government has also undertaken a commitment to create 300,000 jobs by the end of 2009. These two commitments have, however, proven to be incompatible, as in order to increase salaries, companies have often resorted to cutting down personnel. At the same time, companies have invested in advanced technologies that require fewer workers. The world financial crisis, which has already had an impact on Moldova's economy, will certainly lower both the labour market

15 Pure subsistence farmers are also considered as inactive, but farmers who sell at least part of their products are not counted as inactive.

16 Government Decision nr. 1332 from 22.11. 2006. The government target was established in US$.

and salary level. The previous salaries are likely to drop because of a massive return of emigrants (see Section 5: Migration and remittances).

The gender pay gap in the formal economy is relatively high at 28.7% (2004)[17], and it can be assumed that it is even higher in the informal economy. The gender pay gap is most significant in those fields where women make up the majority of employees (agriculture, trade, and education). However, it is much lower in public administration and almost non-existent in real estate transactions.

1.4.4. Discrimination within the labour market

There is no reliable recent data relating to discrimination within the labour market. However, according to a 2004 sociological survey[18], human rights in Moldova are systematically violated, particularly the right to work. Breakdown on nationality reveals that most ethnic Ukrainian respondents (62%) believe their rights are violated, followed by a significant number of ethnic Moldovans (53%). In contrast, twice as many ethnic Russians compared to other nationalities believes that there is virtually no violation of their rights. As for the right to freedom of thinking and religion, more than half of respondents (60%) declared that there is no violation in these areas.

The Roma population represent a special group within the labour market. Most Roma are employed in jobs with low qualification requirements, particularly as temporary unskilled labour (Cace et al. 2007). Land processing for subsistence farming, widely practiced in Moldova to substitute low cash incomes with in-kind incomes, is not widespread among Roma—a fact that can partly be explained by land ownership issues and preferences for other types of activities such as trade. The most significant distinction between Roma and non-Roma employment is observed in the health and education sectors, as well as policing, where Roma are virtually non-existent (less than 1% of Roma surveyed worked in these sectors, compared to 5–10 % of non-Roma). This could partly explain the perceived discriminatory attitude voiced by Roma leaders during interviews in access to education, health, and public administration.

Unemployment is twice as high as the non-Roma population (Cace et al. 2007). Most of the unemployed Roma (70%) do not actively seek employment; however, occasional informal work might be widespread. On average, one active Roma supports 2.7 inactive persons, while for non-Roma this indicator is significantly lower; only 1.2 inactive persons. There is also a weaker participation of Roma women in the labour market—a fact that can be explained by a more traditional perception of the women's role as covering domestic duties, and by a generally lower level of education that is characteristic of the entire Roma population.

1.4.5. Labour market policies

In 2007, in order to promote labour market policies, the National Employment Strategy (NES) for the years 2007–2015[19] was adopted. The main institution responsible for implementing this strategy is the National Employment Agency (NEA), established in 2003. With a view to ensuring employment, reducing unemployment and assisting the unemployed, the NEA promotes both passive and active policies. The passive measures, which are designed to support identified groups within the population, consist of: granting the unemployment benefit while

[17] Source: UNECE Statistical Division Database, compiled from national and international (ILO) official sources.

[18] Survey conducted by the Centre for Sociological, Political and Psychological Analysis and Investigations, CIVIS, 2004.

[19] Government Decision nr.605 from 31.05.2007.

expanding the categories of beneficiaries of this type of assistance[20], allowances for professional integration and reintegration, and one-time support to persons released from detention.

Expenditure on labour market policies, however, is insufficient to tackle labour market problems, representing only 0.05% of GDP in 2008 compared to the EU average of circa 2% of GDP. In the same year, NEA offered jobs to almost half (48%) of the registered unemployed. Only 10.4% of this group benefited from the unemployment allowance, the average size of which was €47 in December 2008. Low unemployment benefits coupled with complicated registration procedures[21] has lead to a highly restricted number of registered unemployed compared to the real figure. In the first months of 2009, due to the financial crisis, the number of registered unemployed almost doubled when compared to the end of 2008. Most of those registered in 2008 (39.2%) were people who resigned from their jobs.

The NEA supports four disadvantaged groups in particular: young people (defined as 16–29 by the NEA), the disabled, former convicts, and trafficked victims. In 2008, of all registered disadvantaged groups, more than one-fifth of former convicts, less than one-fifth of trafficked victims, more than one-third of disabled, and more than one-half of young people were provided jobs through the NEA.

While for some years young people have been able to register as unemployed from the age of 16, the NEA has had very limited success in helping them find a job, as businesses are reluctant to hire inexperienced young employees. A further problem is that young people cannot be registered as unemployed when they leave school at the age of 15, exposing them to the risk of marginalization. The most disadvantaged group is young convicts who have committed a crime and are not adequately supported by the state in re-entering the community. For a number of years, the NEA has tried unsuccessfully to find ways to persuade businesses to hire disadvantaged individuals, particularly youth. In 2008, only 12 young graduates were employed by entrepreneurs, compared to 15 in 2007. Moreover, the scheme for provision of credits to businesses in exchange for jobs for young people has failed—in 2007, only one company benefited from credits by employing 10 young people and, in 2008, no credits were awarded or jobs created.

1.5. Migration and remittances

1.5.1. External migration

A range of factors escalated the emigration of Moldova's population including: the economic crisis, diminishing outputs, the transformation of agriculture, inflation, lack of employment opportunities, structural unemployment, and wage arrears. Besides these key "push factors" generated from within the country, there were also incentives generated by countries of destination or "pull factors", such as employment opportunities and high wages, which encouraged Moldovan citizens to emigrate (Cuc et al., 2005).

[20] Since 1 July 2005, these categories have been expanded and, currently, people who have stopped working at their own initiative benefit from unemployment benefits.

[21] In order to be registered as unemployed a candidate has to submit five certificates confirming: a lack of farmer household, a lack of entrepreneurial patent, the fact that they are not registered as associate or administrator, confirming social fund contributor status and health certificate. All these five certificates are obtained in five different institutions for a fee.

Currently, there are a number of government institutions dealing with registration and organization of migration in Moldova.[22] Despite the sizeable number of institutions involved in monitoring migration flows, the exact number of those who have moved abroad is unknown. This is due in part to the fact that migration is often informal and undocumented, and is also temporary and seasonal in nature. The results of the 2004 Population Census show that about 367,000 persons, or more than one-fourth of the active population of Moldova, have left the country to work abroad. Data obtained through the LFS in 2007 indicate some 335,000 emigrated persons, though other sources indicate a figure approximately twice as large or 600,000 persons (IOM, 2004)**.** One-third of emigrants are residing illegally, although a growing number of emigrants are legalising their status, particularly in Italy and Russia (CBS-AXA, 2008[23]).

Two-thirds of emigrants leave for CIS countries (CBS-AXA, 2008), though the geographical spread of emigration is much wider[24]. Less-educated, unemployed and poor people, and heads of households (fathers, mothers) tend to leave for Russia and Ukraine to work mostly in the construction sector (SIDA, IOM, 2007). Better-educated and wealthier individuals, and those who have less responsibility in their households, tend to leave for the EU. These trends highlight the dichotomy of motivations for migration: largely needs-driven migration to CIS countries versus opportunity-driven migration to the EU. Despite the fact that demand on the Russian labour market is significant, in particular in construction, the income earned (on average €300–350 per month) is no longer sufficient for a decent living. Emigrants are, therefore, heading towards Western European countries, where average wages are three times higher.

About two-thirds of those who go abroad are men from rural areas, with an average age of 35 years (compared to 28 years in 1999) and with secondary-level education. For this reason, Moldova has not suffered a significant "brain drain", as many people with higher education have chosen to stay in the country seeking well-paid jobs. In terms of labour distribution, in general, women are employed in the social services field and housekeeping, while men are employed in construction and repair activities. Of those who left the country, 67% were from rural areas and only 23% from urban areas; more than one-third were from Chisinau (Table 1.6). The highest share held by emigrants from rural areas is explained by limited job opportunities and low incomes, while the higher share of emigrants from towns other than Chisinau indicate the difficult situation with which they were faced, having neither employment opportunities such as those available in the capital city, nor land available in rural areas that could generate income, or at least for personal consumption.

Table 1.6. ***Distribution of current and potential emigrants by place of residence, thousands of people, 2005***

Regions	Persons who are currently abroad	Persons who were abroad recently	Persons planning to go abroad
Chisinau	23	34	73
Other urban areas	60	85	162
Rural areas	169	222	317
Total	252	340	551

Source: CBS-AXA

[22] National Bureau of Statistics, Ministry of Interior, Ministry of Foreign Affairs and European Integration, Ministry of Informational Development, Border Guards Service.

[23] Sociological Research Company located in Chisinau. Website: www.cbs-axa.org

[24] The priority destinations outside CIS are Italy, Greece, Spain, Portugal, and Israel. Men predominantly emigrate to the Russian Federation, Germany, Portugal and Ukraine, while women prefer Italy, Israel, and Turkey. The CIS countries are particularly attractive due to small migration costs.

Prior to the world financial crisis, the majority of Moldovan emigrant families had either settled or decided to settle in their countries of destination. As the crisis has affected both European and former Soviet Union countries where most emigrants live and work, particularly Russia and its construction sector, many of these emigrants will be forced to return—according to government estimations, some 100–150,000 emigrants will return from 2009 onwards. This poses a risk of increased unemployment in Moldova.

At the same time, the trends in the return of migrants are as yet unclear. In the first months of 2008, the number of temporarily returned migrants doubled from 4.9% to 9.1%, 8% of whom declaring that they have returned on a permanent basis. However, due to an expected lag in response to the crisis (possibly due to a desire to remain in the new countries and the utilization of coping strategies to achieve this) the mass return of migrants may take time to emerge. Female emigrants from Moldova, who typically work in the caring professions, will probably be less affected by the downturn, whereas illegal immigrants who reside in CIS countries in particular, are likely to represent the first batch of returnees to Moldova. Moreover, given the significant representation of young people in the migrant community and their rural origins, significant return could lead to detrimental effects on the employment of young people in rural areas and, in turn, to further worsening of rural poverty. The domestic unemployed will have to compete with returned emigrants at a time of falling domestic labour demand.

1.5.2. Migrant remittances and impacts of out-migration

Remittances accounting for €1.1 billion (27.4% of the GDP) in 2008, contributed to economic growth and poverty reduction in the country[25]. Between 2000 and 2005, absolute poverty was reduced by 2.3 times, from 67.8% to 29.1%. Between 2006 (which was the implementation year of the new methodology for estimating poverty) and 2008 it decreased by 3.8 p.p. This represented the largest reduction in poverty (when expressed as a percentage) in the Europe and Central Asia regions over this period. Increased remittances have played a significant role in this regard—it is estimated that in 2007 remittances reduced absolute poverty by 11.3 p.p.[26]. However, the poorest quintile has benefited the least from the transfers from abroad (receiving only 3.1% of the total)[27]. Average yearly remittances per migrant increased from €1042 in 2006 to €1216 in 2008 in nominal terms. The latter exceeds the gross domestic income per capita of the country.

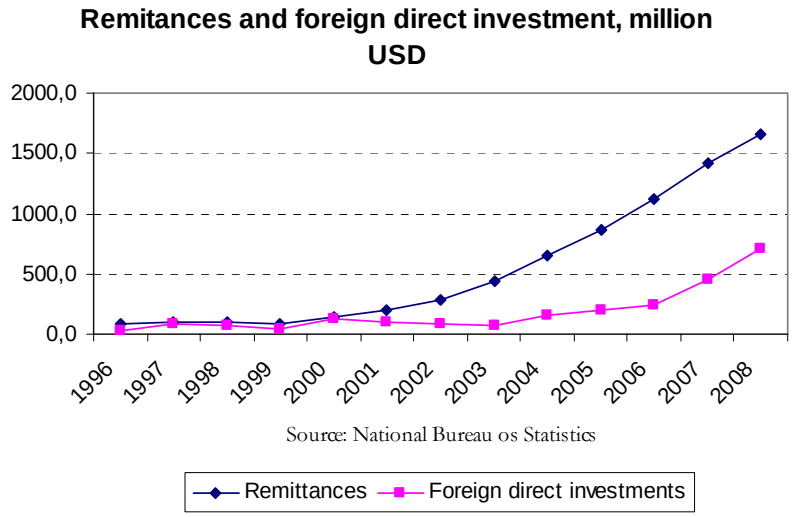
Foreign currency transfers made by Moldovan citizens working abroad and supporting their families in Moldova are thought to be sizeable, but not always officially recorded. According to the IMF, 53% of the currency being transferred into Moldova is done so officially, while the remainder (47%) occurs unofficially, through messengers. However, official data indicate that in 2008, 83% of transfers were made through the official international transfer (banking) system. Only in the last two years has the proportion of emigrants who resort to unofficial channels to send remittances fallen by a half.

[25] Moldova is one of the top beneficiaries of remittances from emigrants as a ratio to GDP (WB, 2008). Over one million Moldovans, or one-third of the population, excepting Transnistria, benefit from remittances (EBRD, 2007).

[26] Policy and Poverty Impact Analysis Report 2007, Ministry of the Economy and Trade of the Government of Moldova.

[27] Poverty update in Moldova, World Bank, June, 2006.

Economic growth commenced a few years after the onset of massive migration[28], and the fact that economic growth was predominantly based on remittances—and to a smaller extent on foreign direct investments—is demonstrated by the evolution of these indicators (Figure 4). Despite the short-term benefits, migration has tended to become a permanent phenomenon and has negatively affected the country's labour market by creating skills shortages, as well as increased inflationary pressures. Migration has also led to appreciation of the Moldovan Leu, resulting in difficulties associated with export promotion and growth in consumption-based imports, which, as a consequence, has deepened the trade balance and current account deficit. Migration contributes to an increased number of abandoned children[29] and trafficking in people[30]. In the absence of legal employment opportunities abroad, in particular in Western Europe, a great number of emigrants turn to intermediaries, creating opportunities for traffickers (Clert et al. 2005).



While remittances offer children the opportunity to spend more on consumption, the long-term effects of the prolonged absence of balanced parenting on their psychological and social development are potentially deleterious. Moreover, remittances destined for the needs of young dependents are not always used for this purpose. Caretakers, including close relatives and neighbours, often take advantage of the money and goods to satisfy their own needs[31].

Moldova's heavy dependence on migration and remittances will likely magnify the effects of the global financial and economic crisis, with huge implications for poverty levels and society. A recent survey[32] indicated that 45% of remittance beneficiaries received less money from abroad than in the previous year, and 20% stated that at least one family member was affected by unemployment. Official data (provided by the NBM) indicate that in the first quarter of 2009 remittances dropped by 30% compared to the same period in 2008, and 57% compared to the fourth quarter of 2008. Transfers in USD and Russian Rubles have decreased, whereas transfers in euros have increased. This is explained by the difficulties confronting the Russian construction sector, where many Moldovan emigrants work. The return of emigrants and cessation of remittances[33] is likely to contribute to changes in the pattern of economic growth—the current remittances model being unable to provide sustainability. Under the conditions of an inactive production sector, a cheap labour force becomes the main export of a country and source of economic growth.

---

[28] Circa 83% of current emigrants left the country as a consequence of the 1998 financial crisis (IMF, 2005).

[29] Between 150-270,000 children aged 0-14 were abandoned by one emigrant parent, while 40,000were abandoned by both parents (Prohnitchi, 2004).

[30] Moldova is one of the most affected countries in the world by human trafficking (US State Department, 2008).

[31] The impact of migration and remittances on communities, families and children, UNICEF/UNDP, Special Unit for SSC, 2007.

[32] CBS- AXA, 2009, March.

[33] According to IDIS Viitorul think-tank, remittances will drop by US$300 million in 2009. http://www.viitorul.org/public/1678/ro/Impact%20criza%20financiara.pdf

1.5.3. Internal migration

The transition years have been marked not only by the international migration phenomenon, but also by internal migration. This process is expressed by the movement of the population from smaller towns (occupied by the poorest groups) and rural areas towards the capital, Chisinau, and Balti. Despite covering a large territory and sizeable population as a share in the total, rural areas are characterized by poor physical infrastructure, particularly their roads and telecommunications, and a lack of employment opportunities in sectors other than agriculture. The act of internal migration is twofold: leaving an area and arriving at some other place. Approximately 180–200,000 acts of internal migration are being registered annually in official statistics, meaning that about 100,000 persons resettle each year in the process of migration between urban areas (town–town), between urban and rural areas (village–town and town–village), and between rural areas (village–village). The population migration rate within rural areas is marginal (only 15%)[34]. The majority of those immigrating to urban areas are youth, who study in towns and due to lack of employment opportunities in rural areas, choose to either stay in towns after graduation or emigrate.

> Internal migration is an important component of the overall migration process. However, as statistical reform (1994–1995) led to interruption of the census of this segment of the population, it is difficult to analyse the intensity and main directions of internal migration.

1.6. Informal economy

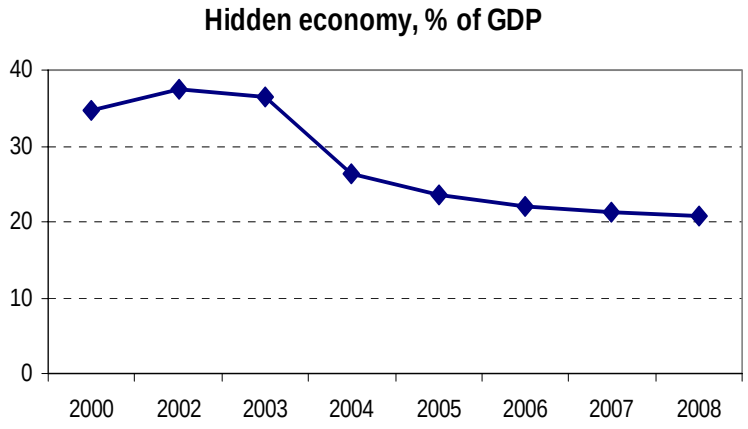
1.6.1. Main features of the informal economy

The crisis during the first years of transition saw the bankruptcy of many enterprises together with job loss. Government efforts to help the unemployed failed and people were forced to find jobs on their own in order to earn enough income to avoid poverty. This process was accompanied by the establishment of new underground economy structures in trade and services, as well as in some industries related to food products and consumer goods in demand. Initially, the most widely spread elements of the informal economy in Moldova were subsistence activities with no legal status, tax evasion, and illegal employment. Many people have agreed to work without an employment contract, and their working conditions are not subject to labour legislation and income taxation. At the same time, they have remained excluded from the social protection system and from certain benefits (such as notice and compensation in the event of dismissal, and paid annual and sick leave).

In 2008, according to the NBS, some 10.9% of all persons employed in the economy, including those in subsistence agriculture, worked in the informal sector and 31.1% had an informal job. At the same time, the data of the sociological survey carried out by the Labour Institute, supported by the International Labour Organization, revealed that every fifth employee of the 1400 respondents work without a collective labour contract, and 16.4% of these are not even aware of such a contract. Instead, every fourth respondent worked on the basis of a verbal agreement.

[34] The Population Green Book, 2008.

The survey revealed that men are more prone to be involved in the informal sector as either self-employed or members of production cooperatives, than women, who are performing unpaid home labour. The largest segment of the informally employed workforce is in agriculture, forestry and fisheries, and the smallest part is in public administration, education, health and social protection. The largest proportion of unofficial employees is in rural areas, where the greatest portion of the population is concentrated, being involved in subsistence farming. Significant differences exist between urban and rural areas in terms of informal employment distribution. In urban areas, the role of the official sector in generating informal jobs is greater than in rural areas, while in rural areas a significant part of informal employment involves production of agricultural products for own consumption. Workers who have informal jobs in the official sector have lower levels of education than people with formal jobs, while those employed in the informal sector have a lower level of education than those informally employed in the formal sector.



Source: National Bureau of Statistics

As with migration, the exact figure for those working in the informal economy is difficult to estimate[35]. According to the NBS, in 2008, the informal economy's contribution to the GDP was 20.8%, compared to 34.6% in 2000 (Figure 5). Some estimates report this figure as higher, with the share of the unobserved economy in GDP being 45.1% in 2000 and 49.4% in 2003 (Schneider 2004, 2006). This estimate of the contribution of the informal economy significantly exceeds the level of the 21 OECD countries (16.3%), and even the average of countries in transition (40.1%) considered in Schneider's survey.

1.6.2. Components of the informal economy

Once the informal economy began to retract, changes also occurred within its three estimated components. In the last eight years, the share of household production for own consumption dropped from 18.5% to 6.7% as a share of GDP, the biggest drop occurring due to a threefold shrinkage of production in agriculture, hunting, forestry, and fisheries (from 15.4% to 3.6%). This is the only component for which the share in the hidden economy dropped in 2008, indicating, among other things, the low profitability of the agricultural sector. Informal sector activities also decreased during 2000–2008, reaching a 7.9% share of GDP in 2008 compared to 9.1% in 2000. Similarly to household production for own consumption, the biggest reduction in informal sector activities occurred due to formalization of activities in agriculture, hunting, forestry, and fisheries. Compared to 2007, the share of informal activities in GDP increased by 0.1 p.p. in 2008. Ultimately, the final component,informal activities in the formal sector, reduced over 2000–2008, from 7% to 6.2% of GDP. However, there was a considerable increase over the 2007 figure, with the share of informal activities in the formal sector constituting 4.1% of GDP in 2008. Unlike the first component of the hidden economy that contributes to its expansion

[35] The NBS estimates three out of four components of the hidden economy–informal activities in the formal sectors, informal sectors, and household production for own consumption. The fourth component is the informal (criminal) economy that is not captured by the NBS.

mainly through agricultural activities, in the other two components the industrial sector is where most of the hidden economy is formed.

The contribution of the hidden economy to GDP is on a downward trend, and this can be explained by a number of factors. Firstly, in 2000, more than half of the labour force was employed in agriculture, and a large proportion of these workers were self-employed. Changes in the structure of the economy and re-distribution of the labour force saw the exodus of a significant number of workers from agriculture into other sectors or emigration to other countries. While, previously, agriculture (particularly subsistence farming) allowed farmers to cope with poverty, more recently it has ceased to generate the same level of income. Adverse weather conditions combined with poor application of advanced technologies in subsistence agriculture forced some of the labour force to abandon this sector or to diversify their incomes, mainly through emigration. In the last four years alone, revenues generated by individual farming more than halved, from 33.1% to 15.7% in total income. Secondly, the promotion of regulatory reform, commencing in 2007, resulted in reduced time and cost of doing business[36]. Nevertheless, the economic crisis and the fiscal responses of the Government, particularly tax increases, will likely lead to the escalation of the hidden economy. Informal activities in the formal and informal sectors are anticipated to increase, unlike household production for own consumption that, given the contraction of the level of incomes of the population, will probably continue to decrease in the medium term.

1.6.3. Underreporting and tax evasion

In regard to the underreporting of wages, there are no recent studies/surveys that indicate the approximate amounts of hidden money within the economy. Even if such surveys existed, they are likely to suffer from significant underreporting. Anecdotal evidence indicates that underreporting of income is widespread among employers, allowing them to minimise the amount of taxes paid. A study on corruption in the education system in Moldova (Valentino, 2007) indicates that teachers would need some 35% more over the average salary in the economy to adequately support themselves and their families. Assuming that teachers are managing to support their families, this discrepancy can only be explained by the underreporting of earnings, particularly in the private sector[37]. The same data shortage applies to tax evasion. With the exception of data obtained from tax inspections, it is not possible to estimate the extent of tax evasion. Data provided by the Tax Inspectorate indicate that in the first quarter of 2008 alone, the level of taxes evaded plus sanctions amounted to almost €1 million.

1.7. Educational system

In the decades prior to independence, Moldova's education system made substantial progress toward being available to all citizens. In 1990, the mean duration of schooling was six years, and 30% of the population aged fifteen and older had completed general secondary education. Moldova's transition to a market economy caused a number of disruptions to the education system, affecting both the quality of the educational process and the accessibility of educational services. Despite the fact that education reform started in 2000 (and is still going on), many problems remain unresolved.

[36] According to the MET (2009) both the costs and the duration of business registration procedures have been reduced. In 2008, registration took 5 days compared to 22 days in 2002, and the cost has dropped from €140 to €45.
[37] According to the 2005 Global Corruption Barometer, the education sector in Moldova is perceived as the fourth most corrupt sector out of fifteen. This places education after the police, customs and healthcare sector.

Spending on education has been growing steadily, reaching 8.7% of GDP in 2008 compared to 5.7% in 2000 and 5.6% in 1990. This level of spending is higher than that of the EU-27 (5.02%). However, the increase in spending has not translated into quality improvements, with inter and intra-sector distribution of expenditures being inadequate[38]. There is a huge gap in financing between the different levels of education (Figure 6) [39] —general compulsory education benefiting from almost one-half of the funds, and these are inefficiently used. Less than one-tenth of financing goes to secondary vocational education, which is insufficient for modernization and training of specialists for the labour market. These problems, together with labour migration, declining birth rates, and low incomes, have led to a reduction in the number of students in educational institutions at all levels.

Figure 6: Education system levels

	Levels	Population age groups
	Preschool education (ISCED – 0 level)	3-6 years
	Primary education (4 years) (ISCED – 1 level)	7-11 years
	Secondary lower (5 years) (ISCED – 2 level)	12-15 years
	Secondary high (3 years), secondary vocational (1-3 years) (ISCED – 3 level)	16-18 years
	Secondary professional education (2-4 years) (ISCED – 3 level)	16-20 years
	Higher education (I cycle – licentiate's degree, 3-4 years, II cycle – masters' degree, 1-2 years) (ISCED – 5 level)	19(21)-22(24) years
	Postgraduate education (doctoral and post doctoral 3 years and more) (ISCED – 6 level)	23(25)years and more

Source: Ministry of Education and Youth

1.7.1. Preschool education

Under central planning, pre-school services were widely available and usually provided through the place of work, but a large share of these facilities was closed down in the initial phase of economic collapse. Despite the fact that from 2000–2008 the number of kindergartens in Moldova increased by about 214, these facilities could not keep pace with the growing number of children in preschool education (an increase of 18.5% in the same period). Kindergartens in rural areas are most affected, and the majority of these are lacking financial resources to meet the growing demand. Despite improvement in enrolment rates since the early 2000's, equity in coverage was not ensured—urban areas have fewer childcare capacities at a time of increasing numbers of children.

1.7.2. Primary and secondary education

Unlike preschool institutions, the number of primary schools decreased over 2000–2008. A total of 47 schools were closed, the remaining being used at an average of 67% capacity[40], and the number of primary schools students fell even further (by 60%). Lower secondary education found itself in a similar situation. A considerable number of buildings are in disrepair, many schools lack central heating systems and appropriate sanitary facilities, and cannot afford capital investment or even maintenance. Moreover, despite the incentives provided by the Government to young teachers in rural areas, the low level of remuneration of teachers does not make the educational system attractive. Thus, in many rural schools the number of teachers is insufficient. This is not surprising, as the average salary in the education sector represents only 66% of the average salary in the economy. In the 2006/2007 school year, the number of teaching staff was 39,200; 1,704 less than in 2005/2006. Approximately 5,300 of those who work (or about 14%)

[38] Only 39% of education expenditures are used on system reform, the rest of the funds being spent on wages.

[39] The educational system covers preschool, primary, secondary general (lower secondary, higher secondary and secondary general schools), secondary vocational, secondary specialty (colleges), university, and post-university education. In addition, special education is available to orphans, abandoned children, and children from disadvantaged families. Classification of educational levels complies with the International Standard Classification of Education (ISCED-97). However, the NBS does not elaborate data on educational outcomes based on the 18–24 and 25–64 year categories. In special cases, selective studies are conducted using these age categories.

[40] The Draft Strategy on General Secondary Educational Institutions Network Optimization of the Republic of Moldova.

are pensioners. A continuous decrease in the student/teacher staff ratio (from 15:1 in 2000 to 12:1 in 2006) is a major impediment to the efficient use of institutional capacities and financial resources. For comparison, the pupil/teacher ratio in Romania is 14.7:1. Moreover, non-teaching staff continue to represent a disproportionately high share in the total number of staff (circa 37%).

A funding formula giving little flexibility to local public administration and school managers to more efficiently manage funds is still being used. In the medium term, the Government intends to initiate the optimization of the secondary general education institutions network by creating circumscription schools and improving the efficiency of funding, providing schools with more discretionary power to distribute funds. School network optimization at this level is also relevent to the recent forecast of a further reduction in the number of students for the 2014/2015 school year as compared with the 2006/2007 school year (by more than 24%). The latter will result in a decrease in public spending efficiency indicators and significant limitations on allocations for quality assurance in education.

1.7.3. Vocational education

Secondary vocational and secondary specialty education (also vocational education) continues to face the same problems inherent in all countries in transition, in particular, the difficulties of adjusting the educational system to accommodate permanent changes within the economy and society. In the 2008/2009 school year, Moldova had 75 secondary vocational education institutions and 47 colleges, the number of which has become smaller every year. At the same time, the number of students at this level of education is continuously increasing. Problems within the educational system also exist. On the one hand, the domestic education system produces a surplus of specialists**,** in particular in law, economy, and modern languages, while on the other hand the labour market struggles with acute shortages of seamstresses, painter-plasterers, welders, electricians, and other trades people.

To improve the system of training and education of a skilled labour force and adjust it to the flexible needs of business, a number of amendments to the concept of secondary vocational education development were introduced[41]. However, there is an acute need to update the Occupations Classifier, and to develop the National Qualification Framework for the entire vocational educational system, addressing concepts such as lifelong education, and accomplishing external evaluations/accreditations (EGPRSP Report, 2008). Moreover, the national quality assurance authority (based on the model used in other European countries), and membership of the European Network of Quality Assurance (ENQA), are yet to be established.

1.7.4. Higher education

In 2005, Moldova joined the Bologna Process and the legal and regulatory basis for higher education was revised and harmonized with the European model, which consists of two university cycles. Despite these developments, Moldova has delayed adopting the regulatory framework for distance learning and organization of practical internships in higher education, and lacks mechanisms to place university graduates from different cycles on the labour market. In 2007/2008, 31 institutions (compared to 47 in 2000 and nine state universities in 1990) formed the higher educational system, of which 12 were private. At the same time, the number of students is growing, having increased by 1.5 times in the same period. A significant number of

[41] Government Decision no. 922 of 13.08.2007 "*On Approval of Amendments and Completions to the Concept Of Secondary Vocational Education Development"*, approved by the Government Decision no.1334 of 3 December 2004.

university students could have been assimilated into the vocational educational system if the latter had offered quality educational services and appropriately equipped premises.

Under the planned economy, higher education was provided free of charge. During transition, the share of higher education students studying free of charge dropped significantly—about 80% of students now pay for their studies, with payment ranging from €130 to €480 a year. Some 15% of the free student places are reserved and distributed to candidates from low-income families. Despite state efforts in the second decade of transition to increase the number of places offered free of charge, in 2009, the Government reduced the number of places available in universities, including the number of fee-paying places. This undertaking, influenced by labour market imbalances, was an attempt to stimulate enrolment in vocational education. However, it may instead create not only disincentives for young people to continue studying, but also incentives to leave the country.

1.7.5. Special education

For children with special needs there are 68 residential institutions that fall under special education, providing educational and childcare services to these children. At present, institutionalization in residential institutions is still the main source of care for children with special needs, servicing those in particular from poor families (although the process of integration/reintegration of children with various difficulties into families was recently introduced).

1.7.6. Lifelong learning

All the prerequisites for the implementation of lifelong learning are in place—the Council for Continuing Professional Education and the State Institute of Lifelong Learning have been established, and the Regulation on the organization of continuing professional education has been approved along with more than 200 institutions and economic entities. However, mechanisms for lifelong training, as with the entire education system, are progressing slowly. Distance learning is not yet institutionalized. The Training Vocational Centre of the Chamber of Commerce's analysis of Moldovan needs on vocational training services recently ascertained that 41% of enterprises are not satisfied with the current situation in the vocational training area.

1.7.7. Minority languages

Under the Soviet education system, Moldova had parallel systems of Romanian and Russian language education through secondary school, although Russian was seen as the key to advancement. In the early 1990's, the Government restored the Romanian language in schools and added courses in Romanian literature and history to the curriculum. Currently, despite the fact that three-quarters of the population are Moldovan, only 65% of children study in Romanian. There is virtually no education in Ukrainian, Gagauz and Bulgarian, and these minority groups are forced to study in Russian, which is neither their native language, nor the official language of the country.

1.7.8. Education-related indicators

Despite all the problems faced by Moldova's educational system, the level of literacy and literacy rate of persons within the age group of 15–24 years is relatively high, reaching figures of 98.9% and 99.5% respectively. Within the same age group, Moldova is at the same level as

Greece, Portugal and Armenia, and exceeds such countries as Israel, Malta, Bulgaria and Romania (MDG Report, 2007).[42] Even with these literacy figures, gross enrolment rates[43] in primary and lower secondary education decreased from 99.8% and 92.2%, respectively, in 2003 to 93.6% and 89.3% in 2008. The main obstacles to enrolment during this period were: poor financial situation of families, parents migrating abroad, lack or non-operation of educational institutions in certain rural areas and, not least, a lack of incentives to continue education (EGPRSP Report, 2008). There are significant discrepancies in enrolment in primary education in urban and rural areas. In 2008, the gross enrolment rate in urban areas was 101.6%, as compared to 89.4% in rural areas. Unlike the enrolment rates in primary and lower secondary education, the enrolment rate in preschool education showed an increase from 44.1% in 2003 to 74.4% in 2008.

1.7.9. Corruption in education

Enrolment levels are also influenced by informal payments within the education system. Though the monetary amount of informal payments is unknown and can only be assumed[44], according to the Global Corruption Barometer (2006) 22% of respondents indicated that either they, or someone living in their household, have paid a bribe to an educational institution. Corruption in education particularly affects poor families, rendering some unable to ensure access by their children to education. Consequently, the enrolment level of children from poor families, particularly in rural areas, is lower than for children from wealthier families, and this disparity becomes even more pronounced at higher levels of education. In contrast, emigrants' children who are left behind without either one or both parents while having more means to afford education, tend to have lower attendance and higher drop-out rates than children from non-migrant families.

1.7.10. Vulnerable groups

Roma education represents a special situation. The participation of Roma in the education system is very low, and there are divergent viewpoints on the reasons for this. Some believe that low participation in school resides more in Roma culture and lifestyle (where education does not play a significant role). Roma children participate less in the education system, have early marriages, and often, but probably not to the same extent as non-Roma, migrate to other countries (Cace et al. 2007). In contrast, Roma themselves claim that a lack of financial resources, and the presence of health and school infrastructure-related problems together with discrimination prevent their children from attending school. They perceive that discrimination continues to be present in schools and some Roma leaders consider discrimination as the main reason for school dropout only in 2% of cases of school non-attendance.

The access to education of rural population is not limited. There is a sufficient number of kindergardens and schools in rural areas. However, the low level of incomes of many rural households represents an impedient to school attendance and graduation, as education expenditure in thouse households represents less than one percent of the total household expenditure. The problem of rural areas is not related to access, but rather to the quality of

---

[42] However, according to the Human Development Report (UNDP, 2008), the country is given a medium ranking of human development (ranked 111) among 177 countries, with a human development index of 0.708, placing it below the world average. HDI was 0.736 in 1990.

[43] In order to estimate access to general mandatory education, the gross rather than net enrolment rate is generally used, because according to estimation methodology, the gross enrolment rate indicates the level of enrolment in education regardless of age, while the net enrolment rate covers only those children whose age by law corresponds with the level of education for which the indicator is calculated and, as a rule, is mostly used internally. This transition is particularly relevant given the recent trend of starting school at an earlier age than seven.

[44] According to the executive director of Transparency International Moldova, unofficial payments total MDL 126 million (€8.24 million) a year.

education. Because there is a lack of teachers in rural areas and the motivation of young teachers to return to village after graduation is very low, the existing rural teachers, regarless of their performance, are preserved in the education system.

1.7.11. Impacts of the economic crisis

The impacts of the economic crisis on the educational system are likely to be heterogeneous. On the one hand, the return of migrants and consequent family reintegration might positively influence enrolment rates. On the other hand, the anticipated reduction in population incomes may narrow the access of vulnerable groups to education, where both formal and informal payments have been gradually increasing over the last few years. What is certain, is the fact that the economic crisis has a "human" element and has the potential to degenerate into a social crisis.

1.8. Territorial disparities

Transition to a market economy has caused significant disparities between the capital city and the rest of the country, between urban and rural areas and, more recently, between development regions. Such discrepancies have been caused by changes in the country's economic principles, where the market is functioning with inadequate or no state intervention, and previously developed regions have found themselves without means for development following economic collapse. The Government provided local authorities with discretionary powers, but did not provide any fiscal leverage to ensure efficient management, thus leading to significant development gaps.

1.8.1. Urban-rural disparities

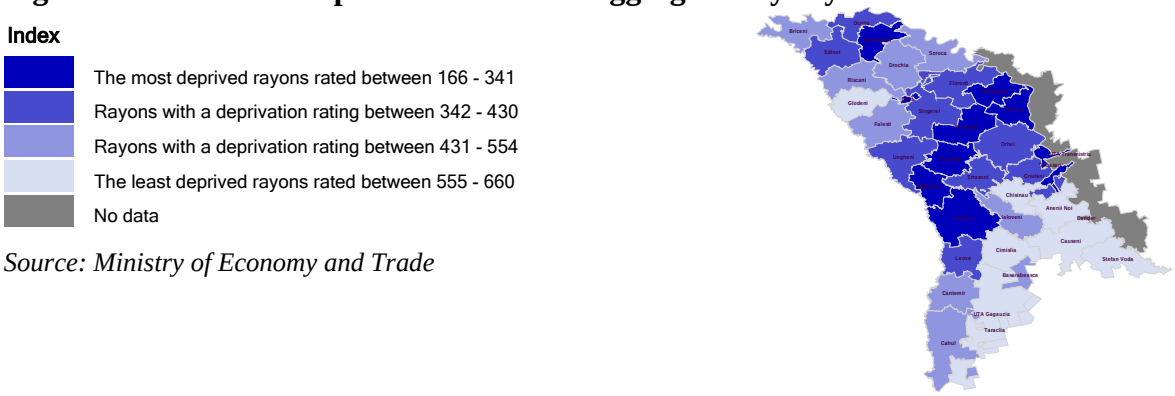
The biggest socio-economic gap is between Chisinau municipality and other administrative-territorial units (draft National Strategy for Regional Development 2009–2011[45]). Chisinau is the key point of not only consumption and revenues, but also public spending and well-being. The inhabitants of the capital city have a higher standard of living than the rest of the country. All available data shows that those living outside Chisinau are relatively less advantaged. Unlike Chisinau, which suffered less from the industrial collapse, other towns that depended on one or more industrial enterprises were more adversely affected.

The collapse of industrial enterprises and failure of reforms in the agricultural sector had a negative impact on the rural population. The gap in the economic and social well-being of rural versus urban populations is significant. Rural areas have suffered not only from their own decline, but also from that of urban Moldova. This makes the situation for the rural population even more uncertain. Currently, rural areas are dependent on a less productive, predominantly subsistence agricultural sector, which does not provide sufficient incomes to meet basic needs. While remittances from abroad largely supplement rural incomes, the major portion is used for consumption of goods and services. Based on varying measures—socio-economic group (farmers/agricultural employees versus non-agricultural employees, businessmen, pensioners, and others), and income source (individual farming versus other categories)—poverty is much more likely and severe in rural areas. The economic crisis and its potentially adverse effect on migration and remittances, which have strongly supported rural populations, will further increase the discrepancy between rural and urban areas.

[45] The strategy was finalised in April 2009 and is published for consultation on the web site of the Ministry of Local Public Administration, http://www.mapl.gov.md/doc.php?l=ro&idc=7&id=485.

Given the fact that poverty is multidimensional and taking into account the need to more comprehensively understand its causes, the Ministry of Economy and Trade (MET) developed the *Small Area Deprivation Index* (SADI)[46]. This index shows the geographical distribution of non-monetary poverty, or relative deprivation, in a number of domains. SADI is a complex index based on administrative data from rural communities (mayors' offices), but also includes official statistical data. Different aspects of deprivation are structured and combined in one multiple deprivation index (Figure 7). Most villages and communities regarded as poor from the viewpoint of unfulfilled needs—poor access to sources of income and unsatisfactory living conditions—are concentrated in the Central Region. This is largely because the capital city, which became an essential hub for investment absorption and a concentration of production forces including small business, does not favour development of adjacent territories.

Figure 7. Small Area Deprivation Index disaggregated by rayon



Source: Ministry of Economy and Trade

1.8.2. Regional disparities

The problems faced by each settlement in Moldova have rooted so deeply that they cannot be solved at the village level alone. Even the rayons (33 in number) are too small to overcome the difficulties exceeding not only their territory, but also their capacity to act. This situation has prompted the authorities to delineate six *development regions* within the territory of Moldova: North, Centre, South, Chisinau, TAU Gagauzia and Transnistria (Law on Regional Development of the Republic of Moldova, no.438-XVI of 28 December 2006). The Law defines the development regions, the mechanism of inter-regional cooperation, institutional framework, as well as necessary instruments and resources to establish and run the regions. The Law also complies with European integration aspirations of Moldova, stipulating the establishment of two European NUTS level II regions (North, Centre) and smaller regions at the NUTS III level (South, TAU Gagauzia, Transnistria and Chisinau). Creation of this regional structure is intended to provide cost-reduction opportunities (through the effect of economies of scale) and enhanced strategic planning capacities. However, the delimitation of a country as small as Moldova into six development

> The NBS started to compile data for five development regions (except Transnistria) in 2007. However, the compilation was undertaken on the basis of a territorial delimitation that ran against the Law on Regional Development, thus offering limited usefulness for the data obtained. Currently, the NBS is revising the data, using the constituent regions identified by the Government in the Law on Regional Development as a basis.

[46] Seven domains were identified for the analysis of the non-monetary poverty level in rural communities, each domain representing one aspect of rural deprivation, namely: deprivation by income, economic deprivation, demographic deprivation, healthcare deprivation, educational deprivation, deprivation by living conditions and geographic deprivation. Each domain was assigned a separate deprivation index before combining them all into one complex/total–SADI.

regions is unlikely to facilitate a consensus in the decision-making process between regional partners.

Comparing the North, Central and South regions, of note is that the most developed is the North region, while the least developed is the South, with the smallest industrial output per capita, the lowest level of investments in fixed capital, and the smallest number of reporting enterprises. However, based on demographic and infrastructure factors, the least developed is the Central region, with the lowest degree of urbanization and the poorest coverage in terms of water supply and sewerage systems. The North region is the most advanced based on the level of urbanization, largely due to the presence of the town of Balti. By territory and population, the Central region is the largest, while the South development region is the smallest.

There is also a large income gap between regions. Comparison of regions revealed that the average monthly wage in Chisinau municipality in 2007 was 40–50% higher than in the North, Centre, South and TAU Gagauzia regions, and exceeded the country's average monthly wage by 30%. At the same time, the average monthly wage in North, Centre, South and TAU Gagauzia regions was 81.3%, 74.6%, 68.6% and 68.8%, respectively, of the country's average monthly wage. The unemployment rate in the Centre, South and TAU Gagauzia regions was circa 1.5 times higher than in the North region and 2–3 times higher than in Chisinau municipality.

In the medium term the Government intends to focus its efforts on the development of the North, Centre and South regions aimed at diminishing inter and intra-regional discrepancies. Further, starting in 2011, the other two regions of Transnistria and TAU Gagauzia will be integrated into the regional development policy.

Conclusion and key challenges

Although it is a relatively young state, over almost the past two decades Moldova has undergone major changes that gave rise to inequalities in income and the level of well-being among regional areas. These changes also resulted in an enormous development gap when compared to some of the former Soviet republics and, certainly, European countries. In 2000, after almost ten years of economic recession, Moldova managed to improve its general economic standing and to enhance population living standards. However, the economic growth and poverty reduction stimulated by population migration was also associated with a decrease in the labour force and an increase in education drop-out rates of children from emigrant families. The high level of remittances, apart from supporting emigrant families and the economy as a whole, has also increased inflationary pressures, contracting the purchasing power of the population. Central public administration, regulatory, fiscal, and judiciary reforms introduced in recent years, resulted in some improvements but did not contribute to the reduction of corruption, although the hidden economy is now on a downward trend. The current pattern of national development, though producing certain short-term benefits, is not sustainable in the long run and affects the poorest and most vulnerable population groups and deepens regional disparities.

Among the main challenges that Moldova needs to address in the short to medium terms are the economic and political crises, the vicious circle of the latter having intensified since April with the failure of the newly elected Parliamentarian factions to reach consensus and elect a President. This situation has led to anticipated Parliamentary elections in July 2009, the political tensions deepening the economic crisis within the country to which a response has yet to be formalised. The political crisis and associated budget expenditures represent a further threat to the sharply declining economy, blocking the proper implementation of crisis management strategies to

support the private sector and vulnerable groups. Although Moldova has so far avoided a financial crisis—the global turmoil so far affecting only the real sector of the economy—a lack of adequate measures to stimulate the economy together with continuation of the political crisis will likely lead to a financial sector downturn. Political instability and its negative impact on potential foreign investors, who are looking for less risky and less politically biased capital investments, will further harm the economy.

The global financial and economic crisis has now infiltrated the Moldovan economy, originating from both within the country, which is highly vulnerable to external shocks, and from outside. Moldova's economic growth is based on imports and remittances. With the contraction of external demand and an increase in unemployment within those countries that are either trade partners or the host of Moldovan emigrants, the Moldovan economy is likely to respond accordingly, with a dramatic contraction in the months to come. Any stimulus package introduced by the Government will not be sufficient to address these concerns and may even further harm the economy and the population. If, for example, the emergent measures to safeguard the economy will widen the budget deficit the Moldovan authorities will have to resort to external aid in order to cover it and this will increase the debt burden of subsequent governments. Moreover, the fragile Moldovan economy will not be able to absorb its domestic workforce when burdened by the addition of thousands of returned emigrants. The outlook is for a contraction of the economy by at least 5% and an unemployment rate of up to 10%, with little prospect for recovery in the medium term.

Response to the crisis must contain both short-term measures that will increase internal demand and stimulate production and exports, as well as medium-term measures to strengthen government capacities to deepen reform processes. Public policies should be preceded by ex-ante impact assessment where a number of policy options are thoroughly analysed. The economic crisis represents an opportunity for the implementation of these much needed policies, such as fiscal decentralisation, providing more leverage to local authorities. The approach to allocating expenditure must be revised, avoiding centrally set expenditure norms, which are based on norms for available infrastructure rather than those based on real needs. In addition, in order to support agricultural producers, who still represent a large part of the population and the most vulnerable, both the way that subsidies are targeted and their size should be revised, avoiding protectionism in this field. Intervention by Government in the market in general, and in different sectors in particular, must be ensured, but only if there are market and Government failures. Intervention should also be the result of a rational and logical analytical process, where all risks are taken into consideration.

A special attention will have to be paid to returned emigrants, as given the significant representation of young people in the migrant community and their rural origins, significant return could lead to detrimental effects on the employment of young people in rural areas and, in turn, to further worsening of rural poverty. Moreover the domestic unemployed will have to compete with returned emigrants at a time of falling domestic labour demand. Temporary support to returnees may include provision of unemployment allowances, involvement in public works and support to launching a business, particularly to those returnees that have made savings.

Despite the progress made by Moldova in improving data collection and analysis, there are still many gaps, both in terms of definitions and methods of estimation. In order to improve the monitoring of certain indicators, particularly related to the labour market and education, there is a need to fill data gaps and to improve the quality of some indicators. Moreover, there is still a tendency among data providers and users to view data as necessary only for reporting, rather than for policy analysis. Many indicators continue to be calculated for formal reporting purposes,

although they are not relevant to users. Unless a strategy is developed and adopted for statistical collection, analysis and use, the link between statistics and policy will continue to be poor.

References

Cace S., V. Cantarji, N. Sali, A. Marin (2007) "Roma in Moldova", Chisinau, UNDP

CBS-AXA (2005) "Migration and Remittances in Moldova".

CBS-AXA (2006) "Migration and Remittances in Moldova".

CBS-AXA (2008) "Migration and Remittances in Moldova".

CBS-AXA (2009) "Migration and Remittances in Moldova".

Centre for Sociological, Political and Psychological Analysis and Investigations CIVIS (2004) "Human rights in Moldova".

Clert C., E. Gomart, I. Aleksic, N. Otel, (2005) "Human trafficking in South Eastern Europe: beyond crime control, an agenda for social inclusion and development", Social Development Papers, Conflict Prevention and Reconstruction Occasional Paper, World Bank, Washington DC, (February).

Cuc M., E. Lundback, and E. Ruggiero, (2005) "Migration and remittances in Moldova", Washington, D.C.: International Monetary Fund.

EBRD (European Bank for Reconstruction and Development) (2007) "Moldova National Public Opinion Survey on Remittances", (July).

Government of Moldova (GoM) (2007) National Development Strategy 2008-2011.

GoM (2007) "Report on Millennium Development Goals: new challenges – new tasks".

GoM (2008) "Economic Growth and Poverty Reduction Strategy Paper final evaluation report".

Görlich D., T.O. Mahmoud, C. Trebesch (2007) "Explaining Labour Market Inactivity in Migrant-Sending Families: Housework, Hammock, or Higher Education?" No. 1391, Kiel Institute for the World Economy (December)

ILO (International Labour Organisation) (2004) "Towards a fair deal for migrant workers in the global economy", International Labour Conference, 92nd Session, 2004, Report VI.

ILO, Bureau of Statistics in collaboration with the Department for Statistics and Sociology of the Republic of Moldova, Policy Integration Department Bureau of Statistics International Labour Office, Geneva (2004) "Employment in the informal economy in the Republic of Moldova", Working Paper No. 41, (December).

International Bank for Reconstruction and Development / The World Bank (2008) "Migration and remittances factbook".

IMF (International Monetary Fund) (2008) "Republic of Moldova: Selected Issues".

IMF and Government of Moldova (2007) "Memorandum of Economic and Financial Policies".
IMF (2006) "World Economic Outlook Database", http://www.imf.org, (April).

Law on regional development of Republic of Moldova, no.438-XVI, 28 December 2006.
Ministry of Economy and Trade of GoM (2007) "Report on Poverty and Policy Impact 2006", (November).

Ministry of Economy and Trade of GoM (2008) "Poverty in the Republic of Moldova 2007", Informative note Chisinau, (June).

Ministry of Economy and Trade (2008), operative data.

Ministry of Education and Youth (2008) "Draft Strategy on the optimisation of the secondary general education institutions in Republic of Moldova (2009-2015)".

Ministry of Local Public Administration (2007) „National Strategy for Regional Development 2009-2011" (draft).

NBS (National Bureau of Statistics) (2007) "Moldova in figures".

NBS (2007) "Statistical Yearbook".

Prohnitchi, V., (2004) "Poverty of the children of the Moldovan migrants", EXPERT-GRUP.

Schneider F., (2004) "Shadow Economies around the World: What do we really know?", Discussion Paper 16, (July).

Schneider F., (2006), "Shadow Economies around the World: What do we really know?", (September).

SIDA, IOM (2007), "Migration as it is: An overview of migration in the Republic of Moldova".

Timpul newspaper (2008), no. 829 (14 March).

Transparency International (2008) "Corruption Perception Report 2007".

UN (United Nations) (2007) "World population prospects: the 2006 revision population database", UN population database.

UNDP (United Nations Development Programme), (2008) "Human Development Report".

UNICEF/UNDP, Special Unit for SSC (2007) "The impact of migration and communities, families and children".

US Department of State (2008) "Trafficking in persons report", Office of the Under Secretary for Democracy and Global Affaires and Bureau of Public Affaires, (June).

Valentino V., (2007) "Managing corruption in higher education in Moldova", (April).

World Bank (2006) "Moldova Poverty Update", (June).

World Bank and Ministry of Finance of GoM (2008) "Evaluation of Public Expenditure and Financial Responsibility" (July).

Annex. Statistical data

Table 1.1. Main macroeconomic indicators

Indicators	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008
GDP, million €[47]	...	1393,7	1653,2	1757,6	1754,7	2089,7	2398,5	2926,7	3220,6	4305,6
of which agriculture %	36.1	25.4	22.4	21.0	18.3	17.6	16.4	14.5	10	8.9
of which industry[48] %	36.8	19.0	21.8	20.3	20.5	20.4	19.1	18.7	19.0	19.5
of which services%	27.1	55.6	55.8	58.7	61.2	62.0	64.5	66.8	71.0	71.6
GDP per capita, Euro	...	383	454	484	484	579	667	758	899	1151
Real growth of GDP, %	16.6	2.1	6.1	7.8	6.6	7.4	7.5	4.8	3.0	7.2
Inflation of consumer prices (annual average, %, with the exception of 1990 – end of year)	1.2	31.2	9.6	5.3	11.6	12.4	11.9	12.7	12.3	7.3
Export of goods, million Euro	4.9	511	632	681	698	792	877	838	979	1055
Import of goods, million Euro	5.0	840	996	1098	1239	1422	1842	2145	2692	3248
Balance of payments, million Euro	...	-106	-29	-20	-115	-37	-181	-302	-507	-663
Total external debt, million Euro	...	1864	1873	1923	1706	1513	1669	2013	2424	2681

Source: NBS

Table 1.2. Structure of GDP by resources and use, as a share of GDP, %

Economic activities	2000	2001	2002	2003	2004	2005	2006	2007	2008
GROSS DOMESTIC PRODUCT	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100**
RESOURCES									
Gross Value Added	**87.5**	**88.0**	**87.3**	**85.2**	**85.9**	**84.0**	**83.4**	**83.1**	**82.4**
Goods - total	41.7	41.1	38.3	35.9	34.7	32.2	29.2	24.2	23.4
Services - total	48.2	49.2	51.1	51.6	53.5	53.8	56.7	61.2	61.3
Services provided by financial intermediaries measured indirectly	-2.4	-2.3	-2.1	-2.3	-2.3	-2.0	-2.5	-2.3	-2.3
Net taxes on products and import	12.5	12.0	12.7	14.8	14.1	16.0	16.6	16.9	17.6
USE									
Total final consumption	**103.0**	**101.1**	**103.3**	**110.3**	**104.0**	**109.9**	**113.9**	**113.5**	**113.8**

Source: NBS

Table 1.3: Revenues and expenditures of the national public budget as a share of GDP (Gross Value Added in 1990), %

	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008
Revenues	23.3	33.9	32.1	32.5	34.1	35.6	38.6	39.9	41.8	40.6
Expenditures	24.2	36.4	31.5	34.3	33.1	35.1	37.0	40.2	42.0	41.6
Surplus(+)/Deficit(-)	-0.9	-2.5	0.6	-1.8	1.0	0.5	1.6	-0.3	-0.2	-1.0

Source: MF

Table 1.4. Population by area of residence

Years		% of total	
	Total (thousand)	urban	rural
1959*	2884.5	22.3	77.7
1989*	4335.4	46.6	53.4
1990*	4359.4	47.1	52.9
1995*	4345.7	46.4	53.6
1996*	4331.9	45.9	54.1

[47] In 1990 was the Gross Value Added, calculated in roubles. The figures for 1990 are not shown as they are not comparable with the other years.

[48] It includes the construction sector according to NACE classification, although national accounts include constructions under the services sector.

1997*	4317.5	45.8	54.2
1998	3655.6	41.7	58.3
1999	3649.9	41.6	58.4
2000	3644.1	41.5	58.5
2001	3635.1	40.9	59,1
2002	3627.8	40.9	59.1
2003	3618.3	41.0	59.0
2004	3607.4	41.0	59.0
2005	3600.4	41.0	59.0
2006	3589.9	40.9	59.1
2007	3581.1	41.3	58.7
2008	3567.5	41.4	58.6

Source: NBS

***** Data are provided for the entire country

Table 1.5. Life expectancy, 2008, years

	0 years	**15 years**	**30 years**	**45 years**	**60 years**	**65 years**
Total	69.36	55.49	41.11	27.9	16.89	13.56
Men	65.55	51.69	37.52	24.96	15.08	12.08
Women	73.17	59.27	44.64	30.63	18.34	14.65

Source: NBS

Table 1.6. Population ageing coefficient* (number of persons aged 60 years and above per 100 residents)

1970	**1980**	**1985**	**1990**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
9.7	10.7	11.7	12.8	13.1	13.1	13.3	13.5	13.6	13.6	13.6	13.9	13.9	13.8	13.6	13.5	13.7	13.7

Source: NBS

*****According to G. Bojio-Garnier's scale, the indicator value of 12 and above is defined as "demographic ageing".

Table 1.7. Population by participation in economic activity, according to 15-64 age group

	1990	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Total population, thousand	**4359**	**3639**	**3631**	**3623**	**3612**	**3603**	**3595**	**3585**	**3572**	**3567**
of total population										
Economically active population*, thousand	2071	1578	1543	1535	1417	1376	1362	1311	1268	1262
Population employed in the economy, thousand	2071	1438	1426	1425	1300	1260	1258	1211	1201	1210
Activity rate, %	...	65.4	63.3	62.1	57.0	54.8	53.8	50.9	49.7	49.4
Employment rate, %	...	59.6	58.5	57.7	52.3	50.2	49.7	47.1	47.1	47.3
Underemployed (working less than 40 hours/week), thousand	...	91	90	88	56	47	53	105	99,4	
Unemployed (ILO), thousand	...	140	118	110	117	116	104	100	67	
Inactive population, thousand	....	836	895	935	1070	1135	1168	1263	1281	1294

Source: NBS

*****Based on data of the Labour Force Survey in households

Table 1.8. Employed population by activity and age group, 2008, thousands

	15-24 years	**25-34 years**	**35-49 years**	**50-64 years**	**15-64 years**
Total	**124.3**	**254.2**	**515.2**	**316.7**	**1210.4**
Agriculture, hunting, forestry and fisheries	30.3	59.4	152.1	115.6	357.4
Industry	19.5	34.4	67.5	40.4	161.8
Construction	11.6	20.1	35.4	15.3	82.4
Wholesale and retail trade; hotels and restaurants	29.3	54.0	87.5	36.7	2007.5
Transport and communications	5.3	16.0	31.4	17.7	70.4
Public administration; education; health and social assistance	16.2	47.3	108.6	71.6	243.7
Other activities	12.1	23.0	32.7	19.4	87.2

Source: NBS

Table 1.9. Employment by type of production unit, occupational status, type of job (major activity), 2008, thousands persons

Type of production unit	Total economy			Self-employed, employer, member of a cooperative		Unpaid family support	Employees	
	Total occupations	Formal occupations	Informal occupations	Formal occupations	Informal occupations	Informal occupations	Formal occupations	Informal occupations
Total	**1251.0**	**861.4**	**389.6**	**132.0**	**238.9**	**29.8**	**729.4**	**120.9**
Companies in the formal sector	988.2	861.4	126.8	132.0	-	23.0	729.4	103.8
of which								
Public	330.3	330.2	-	-	-	-	330.2	-
Other	657.9	531.2	126.6	132.0	-	23.0	399.3	103.6
Companies in the informal sector[49]	136.9	-	136.9	-	117.5	6.8	-	12.6
Households	126.0	-	126.0	-	121.5	-	-	4.5

Source: NBS

Table 1.10. Employed population by education level, 2008, thousand

	Employed population, total	Education level					
		Higher (ISCED 5)	Secondary speciality (ISCED 3)	Secondary professional (ISCED 3)	Lyceum (ISCED 3)	Gymnasium (ISCED 2)	Primary (ISCED 1) or no education
Total	1251.0	255.7	206.3	319.0	252.3	203.0	14.8
15-24	124.3	20.5	8.8	24.8	27.4	40.8	2.0
25-64	1086.1	229.6	194	289.4	221.8	146.3	4.9
15-64	1201.9	241.9	207.3	304.2	250	189.5	7.4
65 +	40.7	5.7	3.5	4.7	3.1	15.8	7.9

Source: NBS

Table 1.11. Activity rate[50], total and by gender, %

		2000	2001	2002	2003	2004	2005	2006	2007	2008
EU27	**Total**	**…**	**…**	**…**	**…**	**…**	**57.1**	**57.3**	**57.5**	**57.7**
	Men	…	…	…	…	…	65.3	65.4	65.4	65.5
	Women	…	…	…	…	…	49.4	49.7	50.1	50.5
Romania	**Total**	**62.2**	**60.5**	**56.0**	**53.4**	**54.2**	**53.3**	**53.7**	**53.6**	**53.8**
	Men	69.8	67.7	63.6	61	61.6	60.9	61.9	61.5	62
	Women	55.1	54	49	46.3	47.4	46.3	46	46.1	46.1
Lithuania	**Total**	**59.1**	**58**	**57.3**	**57.2**	**56.9**	**56.3**	**55.4**	**55.9**	**57.5**
	Men	65.4	64.6	64	63.4	63.4	62.6	61.3	62.4	63.2
	Women	53.8	52.4	51.7	51.9	51.5	51.0	50.4	50.4	52.6
Moldova	**Total**	**65.4**	**63.3**	**62.1**	**57.0**	**54.8**	**53.8**	**50.9**	**49.7**	**49.4**
	Men	68.4	65.7	63.6	58.6	55.6	54.0	53.5	51.5	51.2
	Women	62.6	61.0	60.8	55.5	54.1	53.7	48.5	48.1	47.7

Source: Eurostat, NBS

Table 1.12. Distribution of the unemployed by age, gender and areas in 2008, in %.

	Total	Women	Men	Urban	Rural
Total	**100**	**100**	**100**	**100**	**100**
15-24 years	30.2	34.9	26.8	27.2	35.1
25-34 years	22.6	21.5	23.2	22.3	23.2
35-44 years	17.5	17.0	17.8	17.1	17.9

[49] Companies in the informal sector are defined as unincorporated enterprises (i.e. enterprises without a legal status), which are not registered.

[50] Labour in % of working age population of 15-64 years is used.

45-54 years	21.8	22.9	21.1	24.8	17.4
55-64 years	7.9	3.7	11.1	8.6	6.4

Source: NBS

Table 1.13. Contribution of hidden economy activities to formation of GDP, %

Economic activities	**Formal sector**								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Share of hidden activities in the formal sector of the total hidden economy *of which*	**7.0**	**6.6**	**5.5**	**6.8**	**5.8**	**4.9**	**4.4**	**4.1**	**6.2**
Agriculture, hunting, forestry and fisheries	0.2	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0
Industry	2.4	1.8	2.9	3.5	2.3	1.3	1.4	1.0	2.1
Construction	0.6	0.7	0.2	0.3	0.3	0.3	0.4	0.3	0.6
Wholesale and retail trade	2.2	2.1	1.2	1.6	1.5	1.8	1.5	1.1	1.6
Hotels and restaurants	0.1	0.1	0.1	0.2	0.2	0.2	0.1	0.2	0.4
Transport and communications	0.8	0.8	0.5	0.6	0.8	0.4	0.6	0.7	0.7
Other services	0.7	1.0	0.5	0.5	0.7	0.9	0.4	0.8	0.8

Economic activities	**Informal activities**								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Share of informal sector activities in the total hidden economy *of which*	**9.1**	**9.3**	**10.5**	**9.4**	**10.1**	**9.0**	**6.6**	**7.8**	**7.9**
Agriculture, hunting, forestry and fisheries	3.6	3.1	3.0	3.3	3.8	2.1	2.5	1.7	2.0
Industry	0.6	0.9	1.3	1.3	0.8	1.4	0.4	0.6	0.8
Construction	0.4	0.6	0.9	1.0	1.1	1.2	0.7	1.3	1.4
Wholesale and retail trade	3.5	3.6	4.3	2.9	3.1	2.6	2.3	3.0	2.6
Hotels and restaurants	0.1	0.1	0.2	0.2	0.1	0.1	0.1	0.1	0.1
Transport and communications	0.4	0.5	0.6	0.4	0.8	1.0	0.3	0.5	0.5
Other services	0.5	0.5	0.2	0.3	0.4	0.6	0.3	0.6	0.5

Economic activities	**Household production for own consumption**								
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Share of household production for own consumption in the total hidden economy *of which*	**18.5**	**15.8**	**15.8**	**14.0**	**10.5**	**9.6**	**11.0**	**8.7**	**6.7**
Agriculture, hunting, forestry and fisheries	15.4	12.9	12.2	10.7	7.7	6.9	8.8	5.7	3.6
Industry	0.8	1.0	1.6	1.3	1.1	1.0	0.6	0.6	0.6
Construction	0	0	0	0	0	0	0.1	0.1	0.1
Wholesale and retail trade	0	0	0	0	0	0	0	0	0
Hotels and restaurants	0	0	0	0	0	0	0	0	0
Transport and communications	0	0	0	0	0	0	0	0	0
Other services	2.3	1.9	2.0	2.0	1.7	1.7	1.5	2.3	2.4

Source: NBS

Table 1.14. Number of educational institutions and children attending education

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Number of pre-school institutions	1135	1128	1192	1246	1269	1295	1305	1334	1349
Number of children in pre/school institutions, thousand	93.7	96.5	104	106.5	109.7	113.1	116.2	120.1	123.9
Number of schools, gymnasiums, lyceums	1573	1584	1587	1583	1577	1558	1546	1541	1526
Number of pupils in schools, gymnasiums, lyceums, thousand	631.2	620.3	605.2	580.5	548.5	519	493.5	461	434.3
Number of institutions of secondary vocational education	80	82	83	83	81	78	78	75	75
Number of students of secondary vocational education, thousand	22.8	22.9	22.6	22.7	22.7	25.0	23.6	24.5	24.3
Number of higher education institutions	47	47	45	40	35	35	31	31	31

Number of students in higher education institutions, thousand	79.1	86.4	95.0	104.0	114.5	126.1	127.9	122.9	114.9

Source: NBS

Table 1.15. Public expenditure on education, % of GDP

	1990	1995	1997	1998	2000	2005	2008
Moldova	5.6	7.7	10.4	7.5	5.7	7.2	8.7
EU27	...	...	...	...	...	5.14	5.02

Source: Ministry of Finance, Eurostat

Table 1.16. Study of foreign languages in day schools, gymnasiums and lyceums (excluding schools for children with mental and/or physical disabilities)

	1999/2000	2006/2007	2007/2008
Number of schools, gymnasiums, lyceums, studying foreign languages	1469	1502	1496
Number of pupils studying foreign languages, thousand	564	448	419.8

Source: NBS

Table 1.17. Main features of development regions

	North	Centre	South	Chisinau	TAU Gagauzia	Transnistria	Total
Population, thousand inhabitants	967	1022	525	717	156	556	3942
Share, %	25	26	13	18	4	14	100
Urban population, thousand inhabitants	305	176	121	648	58	361	1669
Share	32	17	23	90	37	65	42
Surface, km2	10015	10636	7379	568	1848	3401	33846
Share, %	30	31	22	2	5	10	100
Density, inhabitants per km2	97	96	71	1263	84	163	116
Industrial output, million €	3472	2241	1187	9315	726	7716	24656
Share of industrial output, %	14	9	5	38	3	31	100
Share of agriculture, million €	3558	3477	2146	195	486	358	10219
Share of agricultural output, %	35	34	21	2	5	4	100

Source: Ministry of Local Public Administration

CHAPTER II. SOCIAL PROTECTION AND SOCIAL WELFARE SYSTEM

2.1. Overview of the Social Protection System

Until the 1990s, the social protection system in Moldova was unilateral—oriented mainly towards the elderly and disabled persons through different types of pensions with favourable conditions and rewards. There was no social assistance system before transition, justified by the view that a communist society did not have problems requiring special intervention. Some social services provided by kindergartens, summer camps for children, health care facilities and sanatorium treatments, were ensured by enterprises through trade unions with cost coverage of 50–100%. The principles underlying the social protection system were similar to other Soviet republics within the USSR, where the state was the exclusive administrator of financial resources, which were directed from the state budget.

After independence, the social protection system continued to carry elements of the old system, specifically: (i) pensions awarded under advantageous conditions and without previous contributions; (ii) compensatory payments to elderly, disabled and children at risk; and (iii) social services mainly focused on institutional care. Financial coverage of these measures, however, was frequently minimal or non-existent, generating financial incapacity of the system particularly after the Russian financial crisis in 1998. As a consequence, pension debts accumulated—in 1998 and 1999 only 40% of the elderly entitled to a pension received some benefit[51]—as did outstanding social payments, and there was raised demand for residential care services.

This prompted reform measures to the system and clear delineation of roles and competences, including identification of medium and long-term policy objectives for the purpose of establishing a social protection system that was equitable and efficient on the basis of access and cost. These reforms were initiated in 1998 with the adoption of the Strategy of Pension Reform[52] and the Strategy of Social Assistance System Reform[53].

During the period 1999–2003 the main laws were adopted on which the present social protection system is based, including: (i) Law on State Social Insurance Pensions[54], (ii) Law on the Public System of Social Insurance[55], and (iii) Law on Social Assistance[56], which are specific types of benefits, services, and resources and identify the main vulnerable groups, such as children, families with children, the disabled and elderly.

The reforms created a dual social protection system divided into: state social insurance policies, based on contributory principles, determined risks and solidarity between generations, and; social assistance policies, based on non-contributory principles stressing the social risks identified through assessment of needs and vulnerability, and expressed in cash benefits and social services.

The reforms launched during this period did not, however, produce the intended results, imposing a revision of the political objectives set for the social protection system and establishment of clear strategic goals within the framework of the mid-term reform. These goals

---

[51] WB. *Improving Public Expenditure Efficiency for Growth and Poverty Reduction. Public expenditure review of the Republic of Moldova.2007,* page 70

[52] Parliament's Decision nr. 141-XIV of 23.09.1998

[53] Decision nr. 416-XIV of 28.05.1999

[54] Law nr.156-XIV of 14.10.1998

[55] Law nr. 489-XIV of 8.07.1999

[56] Law of social assistance, nr. 547-XV of 23.12.2003

were first outlined in the Economic Growth and Poverty Reduction Strategy (2004–2006)[57], and focused on two main areas: making the social insurance system more efficient in terms of equity based on previous contributions, and making the social assistance benefits system more efficient by targeting the poorest people, including the development of the system of social services, which are an alternative to institutional care[58]. It is important to note, however, that due to lack of resources, implementation of the strategy was segmented leading to only partial reform outcomes. As a result, towards the end of 2008, the social protection system continued to be fragmented and inefficiently targeted.

Improving the social protection system by strengthening the management of available resources, decentralizing, modernizing its technical basis, and increasing access of the population to social services, were identified as one of the main objectives within the framework of the National Development Strategy (NDS) 2008–2011[59], and other sectoral strategies. Despite continually addressing social policies in the main strategic medium and long-term papers, the progress to achieving equity in social insurance and better targeting social assistance is very slow.

2.1.1. Institutional framework of the social protection system

The social protection system is managed by the **Ministry of Social Protection, Family and Child** (MSPFC), which plays a key role in development, co-ordination and implementation of social protection policies for vulnerable groups in the following areas: (i) protection of children and families at risk; (ii) protection of disabled people and elderly; (iii) adoption; (iv) gender equality; (v) prevention and combat of domestic violence and human trafficking. The MSPFC is also responsible for managing the performance of sectoral institutions that administer benefits and social services.

The social insurance system is administrated through the **National Social Insurance House**[60] (NSIH), which exercises functions of collection and distribution of financial resources generated from state social insurance contributions paid by employers and employees[61]. Overall the institutional framework of national social protection is made up of the following institutions, which are either under MSPFC or subordinated to it:

The **Republican Fund for Social Support of the Population** (RFSSP) is an autonomous body, which operates under the MSPFC that provides material and humanitarian aid to socially vulnerable layers of the population, including pensioners, disabled persons, families with many children, and persons at risk who require assistance[62].

The **Commission for Medical Examination of Vital Functions** (CMEVF)[63] is a state institution subordinated to the MSPFC, which evaluates and determinates from a medical point of view the dysfunctions of the human body, accompanied by reduction in activity and capacity of an individual of working age to handle vital tasks. The decision of the CMEVF provides for one of three grades of disability, which offers the right to either a pension in the public social insurance system, or to a social allowance.

---

57 Law No. 389-XV, dated 2.12.2004

58 Law No. 389-XV, dated 2.12.2004, p. 6.16, page 118.

59 Law No. 295-XVI, adopted on December 21, 2007

60 Government Decision no. 739 adopted on July 25, 2000, concerning the status of the NSIH of the Republic of Moldova.

61 The NSIH fulfils functions of accumulation (based on individual socials insurance codes) and distribution of financial means generated from the payments of the employees and insurers of state social insurance.

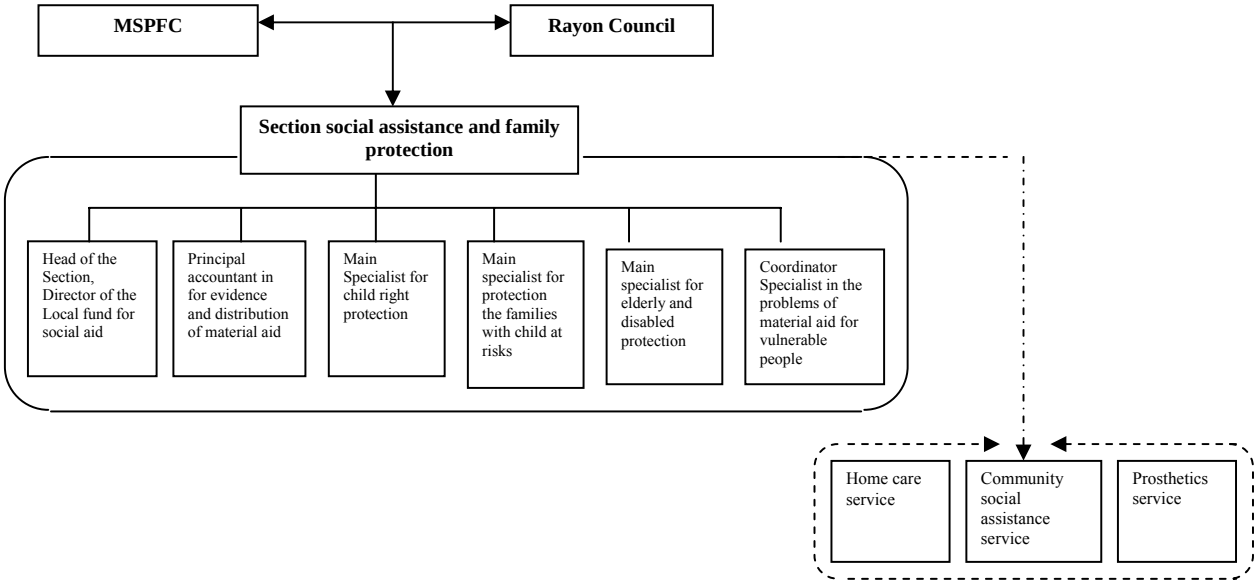
62 Law on Republican Fund and Local Funds for social support of the population, no. 827-XIV dated 18.02.2000.

63 GD No. 688 dated 20.06.2006, on medical expertise of vitality. MO no. 98-101, art. 740 dated 30.06.2006.

Experimental Republican Centre for Prosthetics, Orthopaedics and Rehabilitation (ERCPOR) represented at the local level by the prosthetics service, from the Sections of Social Assistance and Family Protection, provides either free or paid prosthetic and orthopaedic services, including repairs and adaptation of accessories for disabled people.

Sections of Social Assistance and Family Protection administer the social assistance system at the local level. These are the constitutive parts of public administration bodies at the rayon level. Their main functions are the identification of people in need, and the provision of support to services or cash benefits. The organisational chart of the Social Assistance and Family Protection Sections is presented below (Figure 2.1).

Figure 2.1. ***Organizational Structure of the Social Assistance and Family Protection Sections***



2.1.2. Centralization/decentralization of the social protection system

The current social protection system is still centralized from both a political and administrative perspective. Of note, is that over 2005–2007, as part of central public administration reform, MSPFC was reorganized twice, which had a significant impact on its institutional and political capacity[64]. As a result of the last reorganization, MSPFC received additional powers in the field of adoption, but so far no clear policy has been implemented with regard to transfer of powers for guardianship authority from the Ministry of Education and Youth (MEY), which were transferred at the rayon level (in 2008) to the Sections of Social Assistance and Family.

Locally, all NSIH, National Health Insurance Company (NHIC), NEA subdivisions report directly to the central bodies with no independent decision-making authority or opportunity to directly participate in implementation of local social policies. Only the deconcentrated social assistance entities are vertically subordinated to local public authorities, while methodologically they report to the MSPFC. Their capacities to participate in the process of identifying community needs are also insignificant (as most frequently the initiative comes from the central level), largely limited to making up lists for payments and provision of material and humanitarian aid.
As far as the capacities of local authorities are concerned, while they have a number of administrative rights and duties, their efforts are insignificant due to lack of tax-related capacities. Thus, local authorities find difficulties in distributing the resources allocated annually from the state budget for social development (since the social sector includes proxy policies,

64 Adam Smith International. *Moldova EGPRSP Policy Assessment Report for SIDA*. 2005

such as roads rehabilitation and building of kindergartens and schools, etc.). In addition, fiscal centralization does not allow local authorities to initiate and implement their own local social programmes, or maintain social services, including the contracting and purchasing of social services from service providers.

The decentralisation of the social protection system could be conducted in the same manner as the health care sector, by applying the procedure for direct contracting of primary healthcare by the NHIC[65]. Within the decentralization process of the system, a total of 19 providers of primary health care services were contracted directly. Further development of the proposed model will empower local authorities to increase the role and efficiency of primary health care in the provision of efficient services, especially in rural areas.

2.2. Financing of the social protection system

2.2.1. Financing and sustainability

The planning of resources for social protection is carried out annually according to the laws on the state social insurance budget and state budget and is managed by NSIH through six special-purpose funds. The process for strategic planning of financial resources for social protection policies was implemented through the introduction of the MTEF in 2004. Currently social protection within the MTEF is divided into nine programs that are reflected in the NDS.

As the MPSFC has limited capacity to estimate its own policies, costs continue to be estimated by the NSIH and by the Ministry of Finance (based on their internal use norms). The link between budgetary allocations for the social sector in the MTEF, state social insurance budget and the national public budget remains unclear, which diminishes the ability of MPSFC to monitor the implementation of reforms for each program separately and to evaluate their impact on vulnerable groups.

The cost of social protection programmes is continually growing. The social protection budget represents 60% (without pensions) of public expenditure on social needs[66]. In 2008, it had reached 30% of total expenditures of the national public budget and represented 12% of GDP, having grown by 15.5% from 2000[67] (***Table 2.1***). According to MTEF projections, social protection expenditures will continue to grow and by 2011, and will represent 12.7% of GDP or two-thirds of total social sector expenditures.

The general revenues of the state social insurance budget consist of four main groups: (i) mandatory state social insurance contributions; (ii) transfers from the state budget; (iii) interest (on deposits in commercial banks and state bonds); and (iv) other revenues (withdrawals, penalties, and fines). Up to 3% of SSIB revenues are annually allocated to the reserve fund, where the cumulative reserve may not exceed 50% of annually planned expenditures. In 2008, the contribution of employees increased by 3% over 2004[68], reaching 5% of insured income - employer contributions reduced simultaneously from 28% to 24% ***(Table 2.2.)***

---

65 Orders of the Ministry of Health No. 396 of Oct. 24, 2007 ”On Approval of the List of District Level Public Healthcare and Sanitary Institutions” and No. 404 of Oct. 30, 2007 “On legal delimitation of district level primary healthcare”, while on Nov. 06, 2007 the Board of the MH approved the mid-term Strategy for Development of Primary Healthcare.

66 CICO/CREDO for UNICEF. Budget analysis of the administrative institutions and sectorial policies in the social field, 2008

67 MTEF 2009–2011 (Annex 5), MET.

68 In 2005, the individual contribution was 2%, while employers’ was 27 %. Law No. 383-XV of Nov. 18, 2004

Social insurance contributions account for the main share in the structure of revenues, and in 2008, they reached 85.4% as compared to 74.8% in 2000. Transfers from the state budget account for 14.4%, falling significantly compared to 2000, when these accounted for 24.9%. This can be explained by the fact that revenues from social insurance contributions are growing faster than those of the state budget (***Table 2.3***).

The trend of faster growth of revenues as opposed to expenditures was maintained only up to 2004. A budget deficit occurred late in 2005, where total expenditures exceeded revenues by €0.11 million[69]. This trend was maintained during 2006–2007 when the deficit was minus 0.1%, and minus 0.2%[70] of GDP. Only in 2008, was the situation marginally redressed when revenues exceeded expenditures by 0.1% of GDP. This situation may, however, change over 2009–2010 due to the impact of the economic crisis (***Figure 2.2***). As a result of the contraction of national public budget revenues, massive return of emigrants, and increase in unemployed and vulnerable people, the SSIB deficit has the potential to increase to unprecedented levels.

Moreover, the sustainability of the system continues to be affected by demographic decline and labour market developments (reduction of the employed population, increase in unemployment and the large number of returning emigrants). The economic crisis, the effects of which are already visible, coupled with demographic and labour market issues will undermine the sustainability of the SSIB, possibly reflected in slower increases in the size of social benefits as well as the occurrence of arrears.

2.2.2. Role of donor financing

Donor assistance to the social protection sector was considerable over the last decade of transition and intensified over this period, which was characterised by reduced poverty amid massive emigration, the prevalence of human trafficking, and an increase in the number of abandoned children. The effectiveness of donor support varied, depending on the political will to implement a number of sensitive policies and the quality of advice provided. It was also dependent on donor coordination which initially was relatively weak.

The social protection system, its institutional framework and human resources, were consolidated by implementing projects of major importance funded by the WB, the United Kingdom Department for International Development (DFID), the Swedish International Development Cooperation Agency (SIDA), EU/TACIS, EU/PSA, UNICEF, and UNDP. The resources registered in the accounts, based on the co-funding principles within the framework of the Moldova Social Investment Fund (MSIF) 2, represented about 41%[71] of the total amount of donor contributions.

The fields benefiting from donor assistance in the social protection sector are divided according to the following priorities: (i) policy development; (ii) legislative support; (iii) institutional development; (iv) monitoring and evaluation; (v) consolidation of information and communication; (vi) human resources; (vii) community development; (viii) humanitarian aid; (ix) harmonization of donor efforts and social sector development; and, (x) dialog and cooperation with civil society.

To increase the effectiveness of donor support in implementation of strategic objectives in the area of social protection, a development partnership framework "Co-ordination and

---

69 NSIH operational information. 03/09-269 of Jan.16, 2007.

70 NSIH. Report on implementing the state social insurance budget for 2007. Letter. IX-03/09-519 of Feb. 15, 2008.

71 Idem.

Harmonisation of Government and Donor Practices for Aid Effectiveness in the Republic of Moldova"[72], was established in May 2006. One of the commitments made by donors was to increase the use of Sector Wide Approaches (SWAp) as one of the procedural means for advancing the use of common arrangements and procedures. To this end, a joint Social Protection Coordination Group was set up to facilitate the preparation of a SWAp in the social protection field, and ensure that ongoing and future donor funding (including through NGOs) is aligned with sectoral strategies and the NDS.

To obtain a comprehensive, up-to-date and easily accessible overview of the entire external assistance provided to the social protection sector in Moldova by international development partners through various aid modalities, a donor mapping survey was conducted between November 2007 and January 2008 (Table 2.4***)*** shows the overall levels of funding committed by donors to support the social protection sector, by year, and based on 13 out of 14 donor and agency returns received[73].

A total of at least €83 million of external assistance was directed into the social protection sector over an –year period, although this figure is far from robust. In many cases, the MSPFC is not the direct beneficiary of the funding, but project components and funding activities may be relevant to the MSPFC's areas of responsibilities and beneficiaries. It is estimated that around €57 million of total reported funding is provided directly to the MSPFC, or can be directly attributed to the social protection sector. Moreover, no attempt has yet been made to systematically account for non-governmental (charitable) funding that may be contributed to projects by non-governmental organisations (NGOs) or communities.

The main channels of funding are on-budget grants and loans (around €27.4 million equal to 33% of total funding), followed closely by funding channelled through MSIF2[74] (€26.9 million or 32% of total funding). The largest share of budget support is provided by the EC, allocated to the social protection sector[75].

The EC will provide over €27 million directly for social protection in Moldova in the years 2008–2010. From this amount €20 million will be in the form of social protection sector budget support (from the European Neighbourhood and Partnership Instrument (ENPI) National Action Programme 2007), and €6 million dedicated to the rehabilitation/establishment of social day-care centres and technical assistance for the MSPFC (from TACIS National Action Programme, 2005).

The remaining funding provided by donors is channelled through a number of different funding routes and mechanisms, as shown in Table 2.5. One major channel for funding is projects and programmes implemented by agencies such as IOM, UNICEF, and UNIFEM, accounting for around €12.5 million or 15% of total funding. Estimates suggest that funding implemented by UNICEF amounts to around €7.3 million, of which the EC and SIDA fund €5 million. The

[72] http://www.un.md/donors/harmonization/doc/esender02062006104457.pdf

[73] DFID/Oxford project. Donor Mapping Report, 2008

[74] The EC, Germany, SIDA, and the WB are contributing to the MSIF. MSIF aims to direct financial resources towards the needs of poor rural communities, small towns and disadvantaged groups. The MSIF2 has three objectives: (i) to increase the capacity of local government to organize the provision of improved social services, in partnership with community based organizations and civil society; (ii) to increase the capacity of local and central government to develop a coordinated network of integrated social services at district level, in partnership with civil society; and (iii) development of an institutional mechanism to reflect the experience of communities and the influence of national policy (dissemination and replication of best practice). The activities of the MSIF are supervised by a national board, on which the Government, Parliament, civil society and donors are represented, and are implemented by the MSIF Executive Office.

[75] Financing agreement signed on 2.07.2008 by the Prime Minister (immediately entering into force).

estimated total funding implemented by IOM is €3.5 million, of which other donors, including Denmark, EC, Norway and SIDA fund €1.8 million. Total funding implemented by UNIFEM amounts to around €1.3 million, of which ADC and SIDA provide all of the funds[76].

Other channels of funding include the procurement of technical assistance (around €12 million, or 15% of total funding), and funding provided directly to NGOs, estimated at around €3.9 million, equal to 5% of total funding. Of note, is that donors have not been able to specify, in all cases, particular classes of beneficiaries for the projects and programmes they are supporting by strengthening MSPFC and other public institutions, and the systems for delivery of social assistance and services (Table 2.6).

2.3. Types of benefits and services:

There are a number of social protection benefits and services to protect vulnerable groups in Moldova. The social insurance schemes include: (i) pensions and disability; (ii) unemployment and temporary disability; (iii) maternity; and (iv) health. The social assistance schemes include: (i) compensations and allowances; (ii) material and humanitarian aid, (iii) institutional protection services; (iv) rehabilitation and sanatorium and spa treatment; (v) prosthetic and orthopaedic services, and (vi) home care community services, warm meals and different types of centres and asylums. The effectiveness and efficiency of the most important and costly benefits are addressed below.

2.3.1. Social insurance benefits

The social insurance system extends to all participants the right to benefit from long-term protection (social insurance pension), as well as short-term protection (in the case of temporary incapacity of an individual to work). Social benefits based on contributions—derived from principles of social insurance founded on determined risks, and which are insured through contributions—have been introduced recently into the system of social protection in Moldova[77]. The social insurance benefits are summarised in the table below:

Table 2.7. ***Social insurance benefits***

Type	Eligibility	Size
Unemployment benefit	Granted to unemployed persons who have a contribution period of at least 6 months in the last 24 calendar months prior to registration and do not receive a taxable income.	30, 40 and 50% of the average wage per economy, depending on the circumstances in which the person has stopped working.
Allowances for temporary incapacity to work	Granted to insured persons for a period of up to 180 calendar days and begins from the first day of sick leave.	Depends on the period of contribution – from 60, 70, and 100%. In cases of tuberculosis, AIDS and cancer the size is 100%. *(Table 2.8)*
Maternity allowance	Granted to women on maternity leave, including to unemployed wives supported by husbands. Parental leave is also allowed.	100% of the average monthly income insured for the last 6 months prior to the insured risk.
Allowance for care of sick child	Granted to the mother of an ill child up to 7 years old or a child with disabilities up to the age of 16.	Depends on the period of contribution – from 60, 70, and 100%.
Disability allowance	Grated to a person with a disability grading caused by a work accident or occupational	Varies depending on the degree of disability, and is calculated from the

[76] Note that for several of these projects and programmes, the MSPFC is not the direct beneficiary. Other beneficiaries include the MEY, the MH, the Ministry of Justice, Ministry of Internal Affairs, MTE, and LPAs.

[77] Law no. 289-XV of 22 July 2004 on temporary work incapacity allowances and other social insurance benefits provides certain conditions for accessing temporary work incapacity allowances, such as the general period of contribution.

	disease.	average monthly wage in the last 6 months preceding the accident or disease.
Death benefit	Granted to insured persons, pensioners, unemployed, persons who have accumulated a contribution period of at least 3 years and family members who rely on insured persons.	A one-off benefit granted as a fixed amount – €52.3 in 2008.
One-off allowance on the birth of a child	Grated to insured women for childbirth.	A one-off allowance granted as a fixed amount of € 78.3 for the first child, and € 97.9 for the second child and subsequent children
Allowance for child care up to the age of 3 years	Granted to employed women and apprentices, as well as wives supported by husbands, on expiry of maternity leave.	20% of the average monthly income in the last 6 months preceding the risk, but not less than €12.7 in 2008. From 2009, 25% of the mentioned base, but not less than €15.8. *(Table 2.10)*

The size of social insurance benefits are on an upward trend and to some extent contribute to avoiding social exclusion. The size of the unemployment benefit does not create a disincentive to work and is being provided to about 10% of the unemployed. The registration procedure for the unemployed requires the submission of various documents provided by different bodies for a fee (s*ee Chapter I. General Overview*), presenting a disincentive for registration among the poor.

At the same time, benefits for child care and the allowance for childbirth are inadequate to stimulate childbirth in the country. The average size of other social insurance benefits is also small compared to those of EU member states. In monetary terms, pensions represent the largest part of social insurance benefits. Nevertheless, their small size coupled with inequity and a weak link between contributions and benefits undermines the sustainability of the pension system, and delays the introduction of the second pension pillar (*see Chapter IV. Pension System*).

2.3.2. Social assistance benefits

There are several classifications of social assistance benefits in Moldova used by different institutions including the MF, NBS, MSPFC and the NSIH[78]. The system of social assistance benefits in Moldova comprises 18 types of benefits regulated through various legislative and regulatory acts. The eligibility for benefits is based on the principle of membership of a population category and the payment is intended to be compensatory.

Only in the case of three benefits, is the income test applied to determine the eligibility of applicants (allowances for child care from the age of one and a half up to 16 years, material and humanitarian aid, and the new introduced poverty benefit - "social aid"). The other types of social benefits are not means tested. Duration of payment of each type of benefit is specified by law and varies from one to 10 years, and in some cases is life-long. In 2008, the cost of social assistance benefits was almost €57,000. Close to 95% of benefits are covered by the state budget through the SSIB, and only an insignificant portion are covered by the budgets of the administrative territorial units.

According to HBS survey data, social protection benefits present an important source of income for households after salary revenues. In 2008, its share was 14.9%, of which pensions were 12.8%, child allowances 0.4% and compensations 0.6%[79]. However, the impact of social assistance benefits on poverty is virtually insignificant, representing a difference of 1% for social

[78] WB. Improving Public Expenditure Efficiency for Growth and Poverty Reduction. A Public Expenditure Review for the Republic of Moldova. 2007.

[79] NBS. Quarterly Statistical Bulletin, January – March 2009.

assistance benefits compared to 11.9% for social insurance benefits (*See Table 3.17: Chapter 3*). Moreover, those from households whose main source of income is from social benefits register a high poverty risk (33.6%). The marginal impact of social assistance benefits on living standards can be explained by the categorical approach to access. However, the fact that households obtaining social benefits are considered as one of the poorest indicates that the problem does not reside only in targeting but also in the small size of benefits.

Non-means tested benefits

Most of social assistance benefits are non-means tested, instead based on categorical targeting. Benefits based on the category principle, though addressing the most vulnerable groups of the population, are not often targeted to the most vulnerable individuals. As such, this allocation scheme suffers both from inclusion and exclusion errors. The main features of the non-means tested benefits are described below (Table 2.9).

Table 2.9. ***Non-means tested social assistance benefits***

Type of benefit	Eligibility	Size
Targeted compensations	Granted to: (i) disabled adults; (ii) disabled children and disabled from childhood; (iii) WWII participants and their spouses; (iv) persons equated to WWII participants; (v) families of those who died as a result of participation in the emergency at Chernobyl atomic power plant; (vi) participants in military service in Afghanistan and other countries; (vii) Lone pensioners; (viii) families with four or more children under 18 years; (ix) persons who were active on the home front during WWII; (x) persons who were in Leningrad during blockade; and (xi) participants in military service for the defence of integrity of Moldova.	From 25% to 50% of the nominative cost of services to one person and depending on the category of beneficiary. Annual compensations for coal and wood during winter, are calculated at 50%, according to the annual price of one tone of coal and one cubic meter of wood (in 2008, this was €48.96 and €8.2, respectively).
State social allocations	Granted to persons who do not meet the requirements for a pension from the social insurance system: (i) disabled, including disabled children under 18 years and disabled from childhood; (ii) children who have lost their breadwinner; (iii) aged persons who have reached retirement age.	In 2008, averages were: disabled children - €15.05; disabled since childhood - €15.64; disabled - €5.36; those who have lost their breadwinner - €6.80; aged persons - €5.20 (*see Table 2.12*)
Allocation for care	Granted to persons offering home care to uninsured disabled children and adults with Grade I disability. Also offered to blind persons with Grade I disability from the social insurance system	In 2008, the monthly amount was €19.60.
Death allocations	Granted in the case of the death of a non-insured person provided that no other family member has the right to a death grant for the deceased person from the social insurance system.	In 2008, the size was €45.70.
State monthly allowance	Granted to war disabled, participants in WWII and their families simultaneously with other benefits of the social protection system.	(i) war disabled with Grade I - €39.17; (ii) war disabled with Grade II - €29.38; (iii) war disabled with Grade III - €24.48; (iv) war participants and former political prisoners - €19.58; (v) those awarded with orders and medals - €4.9; (vi) those who were in Saint-Petersburg during blockade - €19.58; (vii) spouses of disabled survivors of participants in WWII - €9.79; (viii) children of participants in WWII or military actions during peacetime, military persons killed in

		service, and participants in the clean-up of the Chernobyl accident who died - €9.79; (ix) disabled parent of a participant in military actions defending the territorial integrity of Moldova, Chernobyl accident, who died - €9.79 (*see Table 2.13*).
Nominative monthly state allowance	Granted to persons with state decorations and special state merits.	Varies depending on the category of beneficiary and, as constituted in 2008, is €1.60; €3.30 and €32.60.
One-off allowance on the birth of a child	Granted to uninsured woman for childbirth.	€ 78.30 - for the 1st child €97.90 - for the 2nd child and subsequent births
Allowance for child care up to the age of 1.5years	Granted to uninsured women	€9.79 per month (*Table 2.10*).
Allowances for tutorship/guardianship and adoption of children	Granted to tutors/guardians and adopters of children.	€31.80 per month, from local budgets, starting 1 May 2008.
Compensation to participants in the aftermath of the Chernobyl accident	Granted to persons who suffered as a result of the Chernobyl accident and those who participated in the clean-up, and their families	(i) the average price of spa-sanatorium treatment; (ii) a lump sum for damage to health in the amount of the average monthly salary in the economy, paid over 4 years in 25% annual instalments; (iii) a lump sum in the amount of 15 average monthly salaries in the country, set for the previous year, for those who lost their breadwinner; (iv) monthly allocation for care of Grade I disabled - €19.56.
Compensation instead of treatment vouchers for war invalids	Granted to veterans and war invalids.	Size is specified by legislation. In 2008, the average amount per beneficiary was €226.3.
Compensations for costs of urban, suburban and long distance transportation	Granted from local budgets to Grade I and II invalids of, disabled children and persons accompanying a Grade I disabled person.	Monthly cost of urban, suburban and long distance transportation (except taxi).
Compensations of transportation costs	Granted to persons with a disability of the locomotive system.	A one-off payment expressed as a fixed annual amount of €24
Compensation of costs for trips within CIS member states	Granted to veterans, war invalids and persons accompanying a Grade I war invalid.	A discount of 50% of the ticket cost, or a free trip once in two years when travelling within the CIS member states.

Targeted compensations

Targeted compensations were introduced as a programme that is compensatory in nature, and are related to the increase in prices for utilities and electricity in 2000[80]. Targeted compensations for utilities are provided to 11 categories of the population, which in turn, are divided into 21 subcategories[81]. By 2004, this was identified as the most expensive social programme, holding a share of total budgetary transfers of about 47%. In 2008, a total of 254,829 persons benefited from targeted compensations, among these the largest share was represented by disabled persons with a Grade II disability (36%), those disabled from childhood (12%), and lone pensioners (9%). The cost of compensations in 2008 was €21,864.23 or 92.3% of total expenditures on compensation benefits, and has increased by 43.4% over 2006 costs and by 62.2% over 2004[82].

[80] Law no. 933-XIV of 14 April 2000 on the special social protection of certain categories of population.

[81] Government Decision no. 761 of 30 July 2000 on the nominal compensations for certain categories of population, as amended.

[82] Based on data of the NSIH, including data of the MSPFC from the ASRs for 2004, 2005, 2006 and 2007.

This increase in costs can be explained by an increase in the tariffs for electricity and heating in recent years (Table 2.11).

Although targeted compensations do help certain vulnerable categories to cope with poverty and social exclusion, the fact that the system did not take into account the living standards of beneficiaries and their need for social assistance has led to certain failures where targeted compensations benefit both poor and non-poor households. For instance, in 2007, the richest two quintiles received one-third of targeted compensations. These inclusion errors forced the Government to replace targeted compensations with social aid, which based on means testing rather than the categorical approach, better targets the poor.

2.3.3. Means tested benefits

As mentioned, unlike non means-tested benefits, means-tested benefits are better at identifying individuals and families in need. These benefits are summarised in the table below:

Table 2.14. ***Means tested social assistance benefits.***

Means tested benefits		
Monthly allowance for child care between 1.5 and 16 years	Granted to low income families with children (In the case of a child under guardianship or custody means testing is not applied).	In 2008, the amount was €3.26 per child.
Social aid	Granted to poor families on the basis of the average global income of the family tested by applying a proxy means testing mechanism.	Varies from €1.6 to €65.3 per family.
Material and humanitarian aid	Granted to persons who cannot sustain themselves such as: (i) pensioners; (ii) disabled; (iii) families with many children ; (iv) families with disabled children; (v) single parent families; (vi) families who have orphan children in their custody; (vii) persons who take care of children up to three years; and (viii) orphans or children without parental care.	The medium average of material aid varies from €24 to €46 depending on the category of beneficiaries.

Social aid to replace targeted compensations

"Social aid" was introduced to target social benefits at individuals most in need. Introduced on 1 October 2008, national legislation now regulates the right to social aid among poor families[83], established on the basis of the average global income of the family tested by applying a proxy means testing mechanism, which consider all the income and savings related to this (except one-time benefits). This new mechanism of access to social state assistance was applied to substitute targeted compensations, which were only partially effective and efficient. The reform envisages, in the first stage, the coexistence of social aid with targeted compensations, the size of the latter being frozen and no new beneficiaries allowed. Subsequently, targeted compensations will be eliminated. This could happen by the end of 2009, depending of the outcomes of both the political and economic

According to the Law No. 133-XVI of 13 June 2008, "Social aid " is a monthly social asistance benefit provided to disadvantaged families.
A disadvantaged family is entitled to social aid if all the adult family members fall into at least one of the following categories:
(i) reached the age for the establishment of a pension; (ii) are persons with a disability; (iii) are registered as unemployed; (iv) take care of a child under 3 years; (v) take care of a family member/members with a Grade I disability in need of care

[83] Law no. 133-XVI of 13 June 2008 on social aid.

crises in Moldova. Of note, is that such mechanisms are already successfully implemented in EU countries (Lithuania, Hungary, Ireland, Romania, etc.) as well as Ukraine, Azerbaijan and Armenia.

The efficiency and effectiveness of the social aid mechanism in the first months of its implementation are yet unclear. The preliminary evaluation indicates that the number of beneficiaries in the second quarter of 2009 has increased almost four times over the first quarter, covering 1.3% of the total population. In terms of family size, 14% of the lone people, 43% of families with children, and 43% of families with one parent benefit from social aid. In terms of geographical distribution, social aid is largely provided to vulnerable groups in rural areas (85%), and less in urban areas (15%). Significantly, in rural areas social aid is directed mostly to families who obtain income from work activities (salaries, subsistence agriculture, remittances), whereas in urban areas the incomes of beneficiaries are mostly from social transfers (pensions, social benefits).

A positive element of social aid is the incentive extended to vulnerable people for social inclusion, by providing them with identification documents and supporting them in obtaining the papers necessary for applying h for social aid. Full assessment of the effectiveness of the implementation of the law will be possible only after full coverage of vulnerable groups. Moreover, given the fact that the minimum salary in the economy for unqualified workers (€38) and for qualified workers (€45) is smaller than the average level of social aid, there may be disincentives to work among the families who benefit from social aid.

Allowances for families with children

Allowances for families with children are paid out of the transfers of funds from the state budget and continue to play an important role in the cash assistance programme. Although the Household Budget Survey data show an insignificant impact of these benefits on poverty reduction, they continue to be the only permanent payments accessed on the basis of income testing. Over the last few years, the number of beneficiaries of allowances for children has been growing and by 2008, an increase of 64.2% was recorded compared to 2000, and the cost of paying these benefits increased by 4.8 times. The share of expenses related to these benefits in budgetary transfers continues to be small and, in 2008, were only 17% of total transfers.

Although, in recent years, various actions have been implemented to attract people to the social insurance system (opportunities for voluntary insurance), including annual increases in the size of benefits for children, their impact has been marginal. Thus, in 2008, the number of beneficiaries of allowances for children among the uninsured was 2.6 times higher than the number of insured persons[84], and the monthly amount of the allowances was just 30.5% of the subsistence level for children under one-year old, and 3.7% for children under 16 years old (Tables 2.10 and 2.15).

2.3.4. Social services

The most important social services provided by the state are residential care services, home care services and social canteens. Apart from these, the Government provides rehabilitation services and sanatorium and spa treatment to persons with disabilities, as well prosthetic and orthopaedic services and other locomotive aids to war invalids and participants. There are also community based services, which will be addressed below together with the most important state social services.

[84] MET/UNDP Final evaluation report on EGPRSP, 2004–2006 implementation.

Residential care services

> According to the Law on social assistance No.547-XV of 25 December 2003, Social services are the specialized activities carried out to people or families at social risks. The Social services are provided in specialized state institutions or in different community based centers as: day care centers, shelters, rehabilitation centers, home care services, etc. For cover the local social problems at the local level, the LPAs may initiate partnerships with NGOs in the development of the social services. The quality of social services is insured by the quality standards.

Residential care services provided by the social protection system are centralized through eight social institutions providing social-medical services—two of which are for children with severe mental disabilities. Residential institutions are one of the most requested and expensive forms of care. Most of the beneficiaries of residential care services are persons who, due to some physical, psychological, mental or sensory disorder, are not able to live an independent life without guardianship and cannot deal with challenging situations, requiring specialized care and assistance from the State. The annual cost of maintenance of social institutions is growing and, by 2008, reached a total amount of €12.6 million transferred from the state budget[85]. Despite the cost, the institutionalization rate is also increasing annually, and in 2008 its growth was by about 3% compared to 2004, and 18.1% compared to 2000[86]. The total number of institutionalised persons in 2008 was 2,799 (Table 2.16).

Home care services

Home care services for the elderly[87] are the most requested services at the community level following institutional services. A total number of 80 social home care units are operating at the local level, and comprise 2,430 social workers providing services to over 25,000 persons. The social worker/beneficiary ratio is: 1:10–12 in urban and 1:8–10 in rural areas**.** The number of persons in need of assistance is also increasing, and some 1000 additional social workers are required. In 2007, the number of home care beneficiaries increased by 27% compared to 2002. The major problem in the delivery of home care services is the limited number of persons who can benefit from home care services (single elderly and disabled since childhood). A large part of the population in need of home care services does not have access, generating a high demand for institutional care.

Social canteens

Social canteens provide free food to socially vulnerable persons and distribute warm clothes to the bedridden. The number of social canteens is increasing annually and reached 131 units in 2008 (compared to 37 units in 2000), providing services to 5884 elderly and disabled persons, as well as socially disadvantaged families[88]. Eligible persons can use social canteen services for a maximum period of 30 days quarterly, which ensures coverage of a larger number of socially vulnerable people in need of such services.

Community services in partnership with civil society

---

[85] Annex 3 to the Law no. 348-XVI of 23 November 2006 on the state budget for 2007. Total expenses for 8 residential institutions, plus rehabilitation services for elderly and disabled persons.

[86] Own calculation based on MSPFC data from Annual Social Reports.

[87] Provided based on Regulation no. 16 of 22 April 1994, approved by the order of the Minister of Labour and Social Protection in coordination with the MF and the Federation of Independent Trade Unions of Moldova.

[88] A total of 1578 persons receive warm lunches at home.

Since 2003, LPAs have been involved in the implementation of social services at the local level establishing partnerships with civil society and donors. Partnerships with LPAs are generally focused on providing social services (67%), or opportunities to use free of charge fixed assets (73%), and less on economic and social community development strategies (23%)[89]. By the end of 2008, a total of 174 social assistance units were functional (compared to 80 in 2004), of which: 59 were for elderly and disabled persons, and 114 were for children and youth. The total number of assisted beneficiaries was 6723.

> According to the Law No. 837-XIII of 17 May 1997, the NGOs are non-commercial organizations, independent of public authorities, voluntarily formed by at least two individuals, aimed to promote the intersts and the rights of the specific groups inthe in the specific areas as: human rights, social protection, justice, enviroment, culture, sports, etc.

The main beneficiaries of community social assistance services provided by NGOs are: children (74%), youth (54%), women (39%), and elderly persons (35%). Services for adult groups in situations of risk are less supported[90]. In terms of target beneficiaries, NGOs work with different risk groups, but most social services are provided to disabled persons (44%) and orphans (39%). This focus reflects a possible moral bias where services for former detained persons, drug or alcohol addicted persons, homeless, and people with HIV/AIDS are relatively less common and represent an average of 8% of the total social services provided within the market. [91]

The quality of services provided varies among providers. In the absence of a regulatory framework of social services[92], providers are confronted with outdated regulations constraining the delivering of services, and in most cases, the need to comply with the requirements of donors. Although during 2004–2008, six sets of minimum quality standards for services to children were developed and approved, and a further eight sets developed for services to adults with external support in 2007. The monitoring of social services is conducted by public authorities only on an outputs basis (counting number of services and beneficiaries), without assessing outcomes (the costs and social effects on the groups at risk). This lack of evaluation hinders the development of an accreditation mechanism focused on meeting quality and efficiency conditions.

Of mention, is that although the principles of administrative decentralization[93] determine the degree of competencies of the LPA in representing the interests of local communities, the current opportunities for financial planning and management for LPAs remain limited due to a lack of fiscal decentralization[94]. This situation essentially undermines local initiatives and opportunities to initiate and maintain social services. Consequently, the biggest obstacle to the development of partnerships between LPAs and NGOs is limited resources (only every fourth out of a total of 35 LPAs have funds in the local budget for the development of social services), and an

---

89 EC TACIS "Strengthening Civil Society Project", Study on NGOs operating within the social field in Moldova, 2006.

90 This proves again the dependence of social NGOs on external funding; most donors fund services for these categories of beneficiaries in particular.

91 EC TACIS. Database of NGOs operating in the social services field. 2007.

92 Outdated budgetary classifications that do not allow LPAs to plan and justify cash needs for services, including an outdated legal framework–the Law on public associations and the Law on Charity and sponsorships.

93 Law no. 453-XVI of 28 December 2006 on administrative decentralization.

94 For example, the same problem was identified in Romania in the period of pre-accession to EU, where even after the institutions from different ministries were transferred to the county councils (decentralization was legislated only in 1997), difficulties were largely due to the lack of financial decentralization. There was a crisis in 1998 where county councils had no funds allocated for social services and institutions, and the EU assisted with a humanitarian project, although reform had begun at that time.

inappropriate legal framework**.** Thus, the participation of LPAs in community development activities is more moral than financial, as stated by some local NGOs[95].

2.4. Social protection of vulnerable groups

The 2007 HBS data reveals that the most vulnerable population groups in Moldova are households with children headed by persons other than parents, families with multiple children, people from households employed in agriculture, the elderly, people without education or professional skills, and the unemployed (see *Chapter III: Table 3.12*). Moreover, according to the Law on Social Assistance the following categories of persons are considered vulnerable: (i) children; (ii) families with many children or with disabled children; (iii) disabled persons and (iv) elderly, especially lone. These groups, including Roma, who are one of the most vulnerable groups in Moldova, are analysed in more detail below.

2.4.1. Children and families with children at risk

Constitutional provisions[96] together with the national legislation framework regulate child and family rights to state protection and support (including children at risk)[97]. On ratifying the UN Convention on Children's Rights, Moldova committed itself to establish conditions to ensure children's rights in all social dimensions, including the promotion of special measures for eliminating all forms of abuse, neglect; and the social protection of children at risk.

The social protection of families with children, and of children at risk (including Roma children), is implemented through the provision of social benefits and services. The effects of the migration phenomenon contributed significantly to an increase in the number of children left without parental care, and institutionalised children. Despite the existence of this vulnerable group, institutionalization is still perceived by authorities as the main modality for protecting children at risk. Residential services are provided through 63 residential institutions which are under the MEY. There are different reasons for institutionalising children: 36% of children are placed in institutions due to some diseases or handicap, 16% due to the death of parents, 27% due to parental poverty, 19% due to problems in the family, and 4% due to parental unemployment. Of note, is that some children are institutionalised due to school failure (1.6%) and lack of primary educational institutions in their locality (0.2%)[98].

Surveys carried out on child needs in this area[99] discovered that the organization of residential institutions for children at risk (at the structural, functional, and technological levels) does not meet the needs of these children in compliance with present-day standards. The majority of these institutions do not have adequate physical conditions to fulfil their mission (e.g. high physical wear-and-tear, unconducive use of premises, and impersonalized care facilities). At the same time, the residential system is relatively expensive. The total cost of providing care varies from one type of institution to another, and also within institutions. The general estimates of annual care costs for one child from the residential system provide the following values: a minimum average of €369.5, a medium of €1689.9, and a maximum of €3840.7 (Table 2.17.).

---

95 Ibid. Some NGOs who have had a positive experience in working with LPAs, mentioned that the Coordination Council also comprises representatives of the LPA. The active leaders of NGOs are invited to participate as experts in the development of various programmes and strategies.

96 Art. 48 and 49 from the Republic of Moldova

97 Law No. 338-XIII dated 15.12.2004, on Children's Rights.

98 UNICEF. Residential System of Child Protection in Moldova. 2007

99 WB. The cost assessment of residential care. 2000; Institute of Public Policies. The situation of institutionalized children. 2004; EC FSP & Every Child. Database of children from institutions. 2004; UNICEF, Children in institutions.2004; UNICEF. Residential System of Child Protection in Moldova. 2007

Reform of the residential system started in 2007, and it aims to halve the number of children in residential institutions by 2012, integrating them into either their own families or a similar social setting. The impact of these reform measures was seen in the first year of their implementation, as a drop of 22% was achieved in the number of children placed in residential institutions. Reduction in the number of children placed in boarding schools and orphanages cannot take place without the concurrent development of family support services, community-based alternatives to residential institutions, and other measures for preventing further institutionalization.

The 15 Commissions for Protection of Children at Risk play a very important role in the "gate keeping" process. These commissions were established in 2007, acting as consultative entities at the local level to examine every case separately and make decisions on the protection of children identified at risk. Out of the all children identified in 2007 as being at risk, the commissions examined 1458 cases of which: (i) 51% were prevented from being institutionalised; (ii) 24% were reintegrated into their biological family; (iii) 6% were placed under guardianship/tutorship; (iv) 5% were placed in family-like orphanages; (v) 1% were placed in foster-parent families; and, (vi) only 13% of assessed children were admitted to the residential system.

2.4.2. Disabled people

Access to the system of state social guarantees for disabled and other marginalized groups is the key indicator of non-discriminatory treatment and equality for all members of society to take part in the labour market, and thus reduce poverty and exclusion risk.

In 2002, the total number of disabled people was 141,400 and by 1 January 2008, this number rose to 170,584[100] (Table 2.18). The share of disabled females in the total disabled population amounts to 43.2% and the share of disabled men amounts to 56.8%. Approximately 60% of disabled persons live in rural areas. The largest group of disabled is the 40–59 year-olds, accounting for almost two-thirds of disability cases. The main identified causes of disability cases over the period 2002–2008 are headed by cardio-vascular diseases (19.9%), malignant tumours (18.5%), psychological and behavioural dysfunctions (7.2%), and bone and muscle system diseases (8.3%)[101]. Social protection policies for disabled persons include the following: (i) pensions and other social benefits; (ii) social services; (iii) medical services; (iv) education and training; (v) employment in the labour market; and, (vi) tax allowances.[102]

According to the Law on Social Protection of Disabled No. 821-XII of December 24 1991, a person is deemed disabled who, due to limitation of vital functions as a result of physical or mental deficiencies, needs special protection. Depending on the level of the limitation, impairment of vital functions is divided into the following degrees: moderate, acute and distinctly acute impairment of vital function or III, II and I group of disability.

The number of disabled people benefiting from pensions via the public social insurance system is continuously increasing, and is currently 129,958 persons. Over the period 2002–008 the average size of the disability pension rose constantly, and in 2007 it was 2.8 times higher than in 2002 (€28 in 2007, which was 40% of the minimum subsistence level, and €11.8 in 2002). This increase was achieved by amendment to the guaranteed minimum pension index in 2003. Analysis of salary and disability pension growth over the same period reveals that disability pensions rose at a slower pace than salaries. In 2002, the average wage accounted for

[100] NSIH, upon request from the MSPFC via letter No.10/22, dated 14.01.2008.
[101] Activity Report of the Republican Council for Vitality Medical Expertise for 2007.
[102] Alfredas Zabieta. Analysis of social protection of disabled people in Republic of Moldova 2007. WB funded project TF. 055807

€47.7, while in 2007 it was €123.9, indicating a three-fold increase[103]. The average size of the disability pension in 2007 accounted for only 22.6% of the average wage in the country.

The number and the types of *social services* have also witnessed an increase and diversification, and by 2007, about 30 community centres for disabled children and teenagers were active in the country. At the same time, home care services are in high demand among disabled persons, who represented approximately 20% of the total number of 24,824 beneficiaries of such services in 2007. For the purpose of health recuperation and maintenance, elderly people and adults with disabilities benefit (free of charge) from rehabilitation vouchers once every three months. In the case of disabled persons with a Grade 1 disability, who have a high level of dependence, the escorting person can obtain a rehabilitation voucher for a 70% discount.

Those with disabilities are entitled to education and vocational training in educational institutions. Special studies are actually an integral part of the education system which covers: 11 pre-school institutions specialized for children with physical, sensorial, and mental disabilities, with a total number of 1,100 children, and 37 special institutions for disabled children with a total number of 5,500 children[104]. The education and training of disabled children is also organized at home when it is not possible to provide all the necessary conditions for children to be enrolled in educational institutions, taking into consideration parental needs. The previous year saw an increasing trend of parents enrolling disabled children in general education institutions. Moldova has some positive practices in this field, which are generally supported by the nongovernmental sector (sometimes in partnership with local public authorities) but they tend to sporadic.

Labour legislation provides for a list of functions and professions that may be held by disabled persons on a priority basis. It also establishes the standards for jobs reserved within enterprises, institutions, and organizations for disabled persons at a level of at least 5% of the total number of employees. Employers who do not reserve working places for disabled persons, or avoid employing them, are required to allocate disbursements to the unemployment fund accounting for an average annual wage for each uninsured (unreserved) working place. However, while this legislation is in place and defines the responsibility of different institutions for implementing it, there is not yet any coherent social policy for including disabled people in the labour market, or for ensuring them vocational training and professional orientation services.

Disabled persons also benefit from a range of tax allowances: the established amount for individual exoneration accounts is €600 per year, and social allowances are not subject to taxation[105]. Every person who takes care of a disabled person is entitled to an individual exoneration of €378 per year.

Although the national legislation on the protection of disabled persons (presented here) is relatively developed, and covers about 11 laws and regulations, these provisions exist only *"de jure*", as such they are not always enforced due to lack of resources, or because they are merely declarative statements**.** The mechanism for monitoring the rights of the disabled (to education, health assistance, labour, access to information and culture, etc) is insufficiently developed. The present system is favouring dependence of this group on social benefits rather than contributing to their active rehabilitation. Meanwhile, underdeveloped and unmodified infrastructure, a disability assessment mechanism that favours exclusion from the labour market, and a limited number of specialized social services in communities, all lead to marginalisation and/or exclusion of the disabled from active participation in society.

---

[103] MSPFC: Draft Strategy on Disabled Persons' Inclusion in the Republic of Moldova. 2008

[104] Ministry of Education and Youth, letter from 30.03. 07

[105] Tax Code, art. 33, paragraphs 1 and 2.

2.4.3. Roma population

Roma are considered a vulnerable group mainly because they are more at risk of social exclusion than other ethnicities **(**see Chapters I & III**).** In general, the share of social protection transfers is nearly equal for both groups—13% for Roma and 12% for non-Roma. However, Roma tend to receive more social assistance benefits than social insurance benefits. Thus, social assistance benefits (most noticeably child benefits) comprise 6% of Roma income versus 3% of non-Roma families. A higher number of children being born to Roma families, due to higher fertility and lack of family planning, could explain this fact. Conversely, the share of social insurance payments is lower among Roma. This is explained by lower salaries and lower activity rates in the official sector, which result in lower contributions and lower payments[106].

It is important to note that the extent of participation of Roma in the social insurance system and their inclusion in social assistance programmes is not adequately reflected in existing surveys. One of the reasons for the lack of data in this area is that the approach to social protection policies is based on contributory and participatory principles, or on categorical principles, and as such ethnicity is not taken into account. This makes it very difficult to monitor the access of this ethnic group to state social benefits.

2.4.4. Elderly persons

The current social protection programs for the elderly are mainly targeted at supporting veterans and war invalids. Thus, these groups of beneficiaries in addition to pensions receive a number of social compensatory benefits (because one beneficiary may get concomitantly up to 11 types of benefits). In contrast, elderly people without honours from the state benefit only from the old age pension, which represents only 14.9% of household revenues and the small size of which covers only 55.4% of the survival minimum. This situation does not allow for a decent living in retirement, as the effects of annual indexation of pensions are insignificant.

2.4.5. Groups excluded from social assistance

Although social protection programs include a considerable number of beneficiaries and benefits, they do not contain measures of adult protection in situations of risk. Young people who have left a residential institution enter the excluded groups. Thus, due to low levels of education, skills for independent living and lack of qualifications, they cannot integrate into the labour market. Furthermore, lack of housing, resources to survive and a passive degree of involvement of local authorities influences them to seek other ways of survival that are not always legal.

Another group believed to be excluded are those released from places of detention. When released from prison, institutions grant detainees only a single allowance for employment, and as in the case youth released from residential institutions, they are forced to manage on their own.

2.5. Conclusions and key challenges

The current social protection system is overly complex in terms of benefits and the number of beneficiary groups. Although expenditure on social protection represents the largest part of the

[106] UNDP. Roma in the Republic of Moldova, 2007

national public budget, the effectiveness and efficiency of social protection is lagging behind. One reason for this is the fact that social protection, particularly social assistance, is poorly targeted and the size of benefits is not sufficient to cover the most important population needs. As a result, social protection benefits, though targeting certain vulnerable categories, do not target vulnerable individuals, the richest population quintiles also benefiting from social protection transfers.

From an administrative point of view, the system continues to be largely centralized, while the analytical and strategic planning capacities, including the capacity to assimilate external assistance, need to be strengthened. Implementation of administrative decentralization without fiscal decentralization undermines the capacity of LPAs to support the sustainability of community-based social services. The social services market continues to be underdeveloped and non-uniform in terms of coverage of vulnerable groups that need assistance. There are no mechanisms to measure the quality of services, and no mechanisms to contract or procure services from private providers.

Although in the last two years measures have been taken to improve social assistance targeting, the lack of financial resources to cover all vulnerable people is of particular concern for the Government. The resource shortage is likely to be exacerbated by the economic crisis in Moldova, given the reduction in budget revenues amid an increase in the vulnerable and persons at risk. The increase in the number of unemployed and poor people will require larger transfers that will be more difficult to ensure during the crisis. Therefore, the greatest challenge in the short term will be to supplement SSIB funds, while emphasising an increase in social protection coverage rather than the size of the social protection benefits. In the medium term, the Government should initiate bilateral and multilateral negotiations with the country's development partners in order to obtain financial or technical support in the field of social protection.

References

Adam Smith International (2005), "Moldova EGPRSP Policy Assessment Report for SIDA";

Alfredas Zabieta (2007), "Analysis of social protection of disabled people in Republic of Moldova", WB funded project;

Andrew Wyatt & Katariana Kotoglou (2008), "Social Protection Coordination Group: Donor Sector Mapping – Interim Report",. DFID/SIDA Oxford Policy Management project „Support to the Delivery of effective and sustainable Social Assistance Services, January;

CICO/CREDO for UNICEF (2008), "The budget analysis of the administrative institutions and sectorial policies in the social field";

ECORYS Health Consortium (2007), "Development of a framework for the implementation of a sector wide approach (SWAP) to support the health system in Moldova. Final Report", Rotterdam, Netherlands;

EU TACIS Strengthening civil society in Moldova (2006), "Survey of the NGOs active in the social sector in the Republic of Moldova";

EU TACIS Strengthening civil society in Moldova (2007), "Data base NGOs operating in the field of social services";

EU TACIS Addressing needs of vulnerable layers of the population in the Republic of Moldova (2009), "Evaluation the implementation of the Law on social aid, for the 1st semester 2009";

IOM (2009), "The socio-economic impact of the economic crisis on migration and remittances in the Republic of Moldova;

Government of Moldova (GoM) (2006), "Annual Report on Implementation EGPRSP 2006";

Government of Moldova (GoM) (2008), "EGPRSP final evaluation report 2004-2007";

Government of Moldova (GoM) (2007) National Development Strategy 2008-2011;

Ministry of Finance of GoM (2006), "Republic of Moldova PEFA Assessment and PFM Performance Report";

Ministry of Economy and Trade of GoM (2005), "Report on Poverty and Policy Impact 2004";

Ministry of Economy and Trade of GoM (2006), "Report on Poverty and Policy Impact 2005";

Ministry of Economy and Trade of GoM (2007), "Report on Poverty and Policy Impact 2006",

Ministry of Economy and Trade of GoM (2008), "Operative information regarding the social-economical evolution on 12 month of 2007 year";

Ministry of Economy and Trade of GoM (2008), "Preliminary prognosis of the macroeconomic indicators 2009-2011";

Ministry of Social Protection Family and Child of GoM (2004), "Annual Social Report 2003";

Ministry of Social Protection Family and Child of GoM (2005), "Annual Social Report 2004";

Ministry of Social Protection Family and Child of GoM (2006), "Annual Social Report 2005";

Ministry of Social Protection Family and Child of GoM (2006), "Results of the Pilot project on testing the new targeting mechanism for nominative compensations", (Informative Note) ;

Ministry of Social Protection Family and Child of GoM (2006), "Concept paper regarding national network of social workers", (internal paper);

Ministry of Social Protection Family and Child of GoM (2007), "Annual Social Report 2006";

Ministry of Social Protection Family and Child of GoM (2008), "Annual Social Report 2007";

Ministry of Social Protection Family and Child of GoM (2009), "Annual Social Report 2008" - draft;

Ministry of Social Protection Family and Child (2008), "National Strategy on founding the system of social integrated services";

Ministry of Social Protection Family and Child (2008), "Draft Strategy on Disabled Persons' Inclusion in the Republic of Moldova";

Ministry of Social Protection Family and Child (2009), "Activity balance report 2007-2008";

National Bureau of Statistics (2008), "Household incomes and expenditures 2007";

National Bureau of Statistics (2009), "Information note. Subsistence minimum for 2008"

National Bureau of Statistics (2009),, "Moldova in figures for 2009"

National Bureau of Statistics (2009),, "The socio-economic situation of the Republic of Moldova in January-March 2009";

National Social Insurance House (2008), "Report on execution of State Social Insurance Budget for 2007";

Ruige A., V. Craievschi, N. Sali (2006), "Identification of the needs of the Ministry of Health and Social Protection for better cooperation with civil society actors, active in the social sphere", EU TACIS Strengthening civil society in Moldova;

UNDP (2007), "Roma in the Republic of Moldova",;

UNICEF (2007), "Residential System of Child Protection in Moldova";

The State Register of the Juridical Acts of the Republic of Moldova www.justice.md, or www.moldlex.md;

World Bank (2004), "Recession, Recovery and Poverty in Moldova", Washington;

World Bank (2007),"Improving Public Expenditure Efficiency for Growth and Poverty Reduction. Public expenditure review for the Republic of Moldova".

Annex. Statistical data

Table 2.1: ***Trends in social protection expenditures***

	2000*	2001	2002	2003	2004	2005	2006	2007	2008
Share of expenditures for social assistance and support in the national public budget,%	27.6	26.7	28.7	28.1	29.0	30.3	27.8	27.3	30.0
Expenditures for social assistance and support as a share of GDP, %	10	8.4	9.8	9.3	10.2	10.9	10.9	11.2	12.0
Real SSIB expenditures as a share of GDP, %	8.4	7.2	8.4	7.9	8.7	9.8	9.9	9.8	10.1

Source: MF MTEF, NSIH

*The are not available comparable data before 2000 due to this fact that the pension system was indivisible from social assistance system

Table 2.2: ***Trends in shares within social insurance schemes***

	2003	2004*	2005	2006	2007	2008
Tariffs of mandatory state social insurance contributions, total %	30	29	29	29	29	29
Mandatory contributions of the employer	29	28	27	26	25	24
Mandatory contributions of the employee	1	1	2	3	4	5

Source: MSPFC, NSIH

*Since 2004 the policy of redistribution of contribution is implemented

Table 2.3: ***Trends in real SSIB revenues***

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Mandatory social insurance contributions, %	74.8	81.0	80.9	83.4	83.6	79.8	84.2	84.0	85.4
Transfers form the state budget for social payments, %	24.9	18.7	18.4	16.4	15.4	19.4	15.2	15.4	14.2
Interest. %				0.1	0.8	0.7	0.48	0.60	0.4
Other revenues, %	0.3	0.3	0.6	0.2	0.2	0.1	0.08	0.02	0.02

Source: MSPFC, NSIH

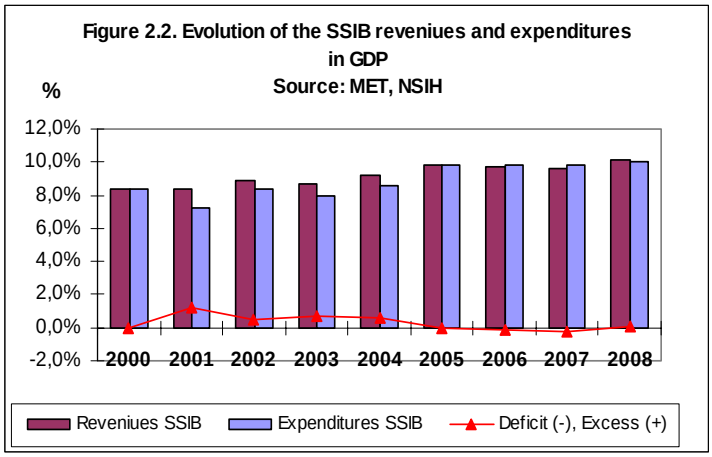


Table 2.4: ***Total committed funding (€000)***[107]

107 All amounts have been converted to euros, at the prevailing rate on 17 January 2008, for consistency of presentation. Although the survey asked for figures for years prior to 2007 only for projects or programmes that are still current, some completed projects (estimated at around €12 million) were included by respondents.

Year	2004	2005	2006	2007	2008	2009	2010	2011	Total
Donor									
ADC			← 522 →						522[1]
~~DFID~~		146		778	933	800			2.657
EC	← ~~37.888~~ →								37.888
Germany		50	70	80	30				230
SDC	559	621	807	870	807				3.664
SIDA	← 15.711 →								15.711
USAID									__
WB		← 16.892 →							16.892
WHO	192	192	143	143	382	382			1.434[4]
Implementing agency									
IOM			← 1.732 →						1.732[5]
OSCE									__
UNICEF				← 2.325 →					2.325[7]
UNIFEM									__
								Total	**83.056**

Source: DFID/Oxford Donors mapping report

Table 2.5: ***How funding is channelled by donors in the social protection sector 2007***

Funding route	(€ 000)	% of total
Grants or loans paid to the Government of Moldova (on budget):	27378	33
Technical assistance for the Government or State Institutions of Moldova:	12466	15
Project or programme implemented by UN agency/multilateral organisation:	12074	15
Moldova Social Investment Fund:	26969	32
Non-Governmental Organisations:	3948	5
Unspecified	218	0.3
Total	83056	100

Source: DFID/Oxford Donors mapping report

Table 2.6: ***Beneficiaries of donor' support***

	Project/programme
ADC	1. Response to drought crisis[1] 2. School feeding project, Cantemir 3. Development of inclusive educational model
DFID/SIDA	Support for the delivery of effective and sustainable social assistance services
IOM[2]	National Referral System
OSCE	Anti-Trafficking and Gender Programme
SDC	1. Milk powder 2. Rehabilitation of social institutions 3. Fight against child trafficking
USAID	1. Anti-trafficking initiative 2. Better Opportunities for Youth and Women
WHO	Biannual collaborative initiative between WHO and Ministry of Health

Source: DFID/SIDA Oxford Policy Management. Donor Sector Mapping – Interim Report

[1] Support to the drought crisis included funding from donors such as ADA (€100000), the European Commissions' Humanitarian Aid Office (ECHO) (€3000000), and SIDA (€1,084,615), and managed by the UNDP (€192000).

Table 2.8: ***Trends in beneficiaries and expenditures for temporary incapacity allowances***

	No. of Beneficiaries (thou. pers.)			+/-%	Amount paid (th. €)			+/-%
	2004*	**2006**	**2008**		**2004**	**2006**	**2008**	
Sickness or traumatism allowances	312.9	308.5	358.4	14.5	8102.4	13625.5	24074.8	197.1
Allowances for work accidents or professional sickness	0.2	0.7	0.8	300	28.4	77.6	62.9	121.5
Allowances for the care of sick children	12.8	10.4	13.9	8.6	186.3	251.6	547.4	193.9
Maternity allowances	17	14.3	21.4	25.8	1688.6	3614.2	7773.7	360.4
Other allowances	1.5	0.4	0.9	-40	45.8	39.4	140.6	206.7
Total allowances	344.5	338.8	395.4	14.7	10051.5	17608.3	32599.4	224.3

Source: MSPFC, NSIH, ASR

*The programme started to be implemented from 2004.

Table 2.10: ***Trends in average payments per child for insured and uninsured, €***

Type of allowance	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Insured persons									
One-time allowance upon birth of child	10.64	17.00	18.11	18.73	20.90	30.75	43.01	57.41	83.06
Monthly allowance for child rearing up to the age of 3 years	32.78	24.39	18.97	67.63	63.42	106.36	123.57	156.39	190.24
Monthly allowance for care of a child between 3 and 16 years old	16.88	15.71	9.47	17.71	32.44	38.32	36.80	36.01	93.23
Total	20.22	19.10	14.36	35.27	42.46	72.46	89.66	117.35	153.45
Unisnsured persons									
One-time allowance upon birth of child	15.65	23.72	20.17	29.86	19.44	30.80	44.24	58.84	90.28
Monthly allowance for child rearing up to the age of 1,5 years	30.36	45.12	44.71	178.29	57.87	83.02	75.22	70.19	122.65

Monthly allowance for care of a child between 1,5 and 16 years old	27.93	65.56	51.66	297.31	30.06	52.43	36.83	37.29	69.20
Total	26.46	52.24	44.88	139.64	34.96	56.54	47.70	50.18	93.40

Source: own calculations based on NSIH

* since 2004 – insured persons up to the age of 3 years

Table 2.11: ***Trends in expenditures for targeted compensations***

Description of category	Amounts paid, thou. €				
	2000	**2002**	**2004**	**2006**	**2008**
Total Disabled *	3043.2	8692.8	5346.3	8167.7	141121.7
WWII participants and their spouses	933.5	3222.7	2160.1	1964.9	2389.8
Persons equalled to WWII participants	216.5	824.8	529.7	31.7	66.2
Families of those who died as a result of participation in the emergency at Chernobyl atomic power plant	23.9	101.8	40.3	51.1	79.6
Participants in military actions in Afghanistan and in other countries	0.0	0.0	0.0	531.5	881.1
Lone pensioners	922.7	2100.0	1386.8	1518.6	2014.4
Families with 4 and more children under 18 years	445.9	1025.9	619.4	578.8	789.3
Persons who were active on the home front during WWII	0.0	39.7	46.1	62.1	68.8
Persons who were in Leningrad during blockade	0.0	1.6	2.3	4.3	6.1
Participants in military actions for the defence of integrity of RM	0.0	0.0	609.5	827.8	1447.2
TOTAL	**5585.7**	**16009.3**	**10740.5**	**13738.5**	**148864.2**

Source: NSIH, ASR 2007

*including disabled children under 18 years and disabled from childhood.

Table 2.12: ***Trends in state social allocations and the expenses for their payment***

Type of state allocation	**No. of beneficiaries, pers.**				**Monthly paid amount, th. €**			
	2000	**2004**	**2006**	**2008**	**2000**	**2004**	**2006**	**2008**
For disabled children under 16 years	10361	12 860	12 628	14 148	52,8	84,0	135.0	213.0
For disabled from childhood	4507	22212	23900	24274	21.2	134.2	236.5	355.4
For disabled	660	2163	2715	3421	3.1	6.6	10.3	18.3
Upon loss of breadwinner	493	2466	2 794	3221	2.9	9.6	13.5	21.9
For elderly persons	63	4458	4144	3248	0.2	13.1	15.3	16.9
TOTAL	**16084**	**44159**	**46181**	**48312**	**80.2**	**247.5**	**410.7**	**625.4**

Source: NSIH, ASR 2001, 2005, 2007, 2008

Table 2.13: ***Trends in monthly state allocations and the expenses for their payment.***

	2001*	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
No. of beneficiaries, thou.	17727	25446	25000	24685	19979	17690	15775	14070
Total annual expenditures, thou. €	1848.1	5653.7	3587.5	3275.0	3292.4	2550.0	3118.2	3401.4
Average payment / beneficiary, €	104.3	222.2	143.5	132.7	164.8	144.1	197.7	241.7

Source: MSPFC, NSIH ASR

* There are not available data before 2001.

Table 2.15: ***The value of the allowances for children as a share from the monthly subsistence level for children (%)***

	2004*	**2005**	**2006**	**2007**	**2008**
Monthly allowance for child-care and growth					

insured persons (up to 3 years old)	39.7	55.0	54.8	58.5	65.7
uninsured persons (up to 1,5 years old)	29.8	36.6	30.0	25.4	30.5
Monthly allowance for child-care of 1,5 (3) - 16 years old	7.8	7.0	5.9	5.0	3.7

Source: NBS
* Started to be monitored from 2004

Table 2.16: Trends in people from residential care system*

Groups of beneficiaries	**2000**	**2002**	**2004**	**2006**	**2008**
Children with mental disabilities, persons	496	536	610	679	668
Elderly and persons with physical disabilities	476	632	613	607	430
Adults with mental disabilities	1398	1398	1495	1669	1701
Total, persons	2370	2566	2718	2955	2799
Increase of wards comparing to the preceding year, %	4.1	8.3	5.9	8.7	-5.3

Source: MSPFC

* There are no available data on number of children from 63 residential care institutions under the Ministry of Education and Youth.

Table 2.17: ***Total number of disabled, by age, sex, area of residence and type of social benefit, in 2007***

Category of beneficiaries	**No. of persons**	**of which:**			
		men	**women**	**urban**	**rural**
Total disabled pensioners, from them:	129958	64022	65936	56646	73312
degree I	13680	7511	6169	6822	6858
degree II	89723	41975	47748	39266	50457
degree III	26555	14563	11992	10558	15997
Total disabled beneficiaries of state social allowances:	40626	21917	18709	15112	25514
TOTAL	170584	85939	84645	71758	98826

Source: NSIH

Table 2.18: ***Costs for children in the residential system 2006***

No. d/o	**Type of institution**	**Total Budget,**	**Overall cost per child €**		
		thou. €	*Minimum Cost*	*Average Cost*	*Maximal Cost*
1	Orphanages /Boarding schools / for orphan children and those left without parental care	4939.4	1039.5	1543.8	2982.0
2	Orphanages /Special schools for children with physical and sensorial disabilities	1433.4	1887.8	2790.5	3840.7
3	Sanatorium-type boarding schools	646.6	369.5	693.6	1729.3
4	Boarding schools for children with serious misbehaviour	108.3	2008.9	2008.9	2008.9
5	Auxiliary boarding schools and semi-boarding schools	3323.8	766.8	1863.9	3074.5
6	Temporary Placement Centres and Centres for Rehabilitation of early age children / Specialized municipal house	1093.4	2686.2	3154.1	3600.5
7	Orphanages for children with severe disabilities	1017.2	1576.5	1681.9	1790.6

	TOTAL	12562.1	369.5	1689.8	3840.7

Source: UNICEF

CHAPTER III. POVERTY AND SOCIAL EXCLUSION

3.1. Introduction and objectives

The severe economic and social crisis of the early 1990s, led to increased inequality in the standard of living of Moldova's population, with poverty taking an even stronger foothold. At the end of the decade, Moldova was among the poorest countries of the former Soviet Union, along with Tajikistan and the Kyrgyz Republic. Among the poor were not only the traditionally vulnerable population groups (such as the elderly, those without education and skills training, and the long-term unemployed), but also qualified persons of working age. A large proportion of employees in the national economy and those with education were also poor, including those who possessed production technologies and durable goods. Families with children were faced with a much heightened risk of poverty. Characteristic of this period was a higher risk of poverty in small towns, exceeding rural poverty.

With the aim of stabilizing the socio-economic situation and addressing the problems associated with poverty, successive governments implemented a number of national programs. These efforts focused on boosting the economy, job creation and social security, and raising living standards. Salaries, pensions and social allowances were also increased. Increasing real incomes of the population had a positive impact, with the poverty rate registering decreasing trends. In order to assess the complex impact of policies introduced to target anti-poverty programs mechanisms for monitoring and evaluation of poverty were developed over 1998–2008.

Presently, analysis of poverty in Moldova is based largely on the absolute poverty measure[108]. Accordingly, the following analyses are focused on poverty trends at the national level. Regional disparities and poverty trends in rural and urban areas will also be explored, while urban areas are broken down by small towns and big cities, as poverty has different characteristics in these areas. The groups facing the greatest poverty risk are identified, together with an assessment of the economic and social policy impact on their welfare and the population as a whole.

To date, some attempts have been made to evaluate social exclusion in Moldova, but these have focused mainly on analysis of poverty, access and inequality. The outcome of promoted policies on social inclusion has been covered to a lesser extent. This shortcoming needs to be addressed further, as the concepts of exclusion/inclusion are a continuous reference framework for analysis of social problems. Development of a set of indicators for measuring social exclusion/inclusion and methodologies for their calculation are important for Moldova as a tool for substantiation of social policies, description of the level of development achieved, and identification of current problems.

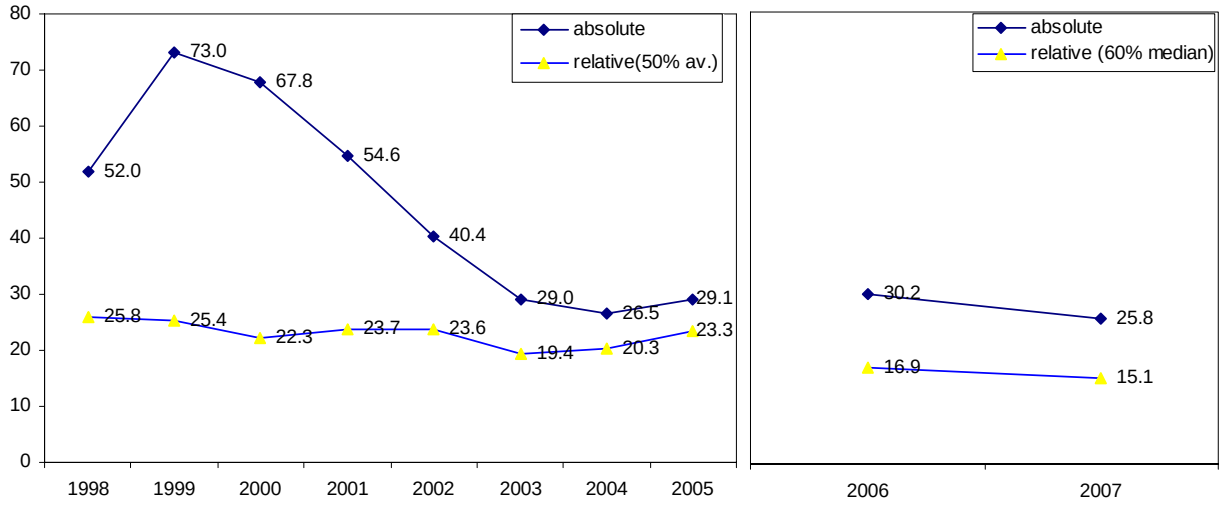
Poverty trends in this chapter cover two time periods—1998 to 2005 and 2006 to 2007—reflecting the use of different data collection methods, research methodologies, and tools used in the HBS, conducted annually by the NBS. Estimation of the poverty rate and other poverty indicators is based on consumption expenditures using two poverty lines, the absolute (administrative) poverty line and the relative poverty line. The methodology and main data sources used for assessing the poverty level in the country are shown in Annex II.

[108] Government Decision No. 851 "Poverty monitoring and assessment of anti-poverty policy impact"

3.2. Trends in poverty and social inclusion since the beginning of transition

In 2006, the absolute poverty rate, assessed on the basis of the new data sample, was about 30%, and a decreasing trend was observed into 2007, with a rate of 25.8%. Figure 3.1 highlights this earlier trend observed over 1998–2005 and during 2006–2007, which is significantly lower than in other countries in the region such as Romania, Bulgaria, and Hungary.

Figure 3.1. ***Evolution of absolute and relative poverty in the periods 1998–2005, 2006–2007***

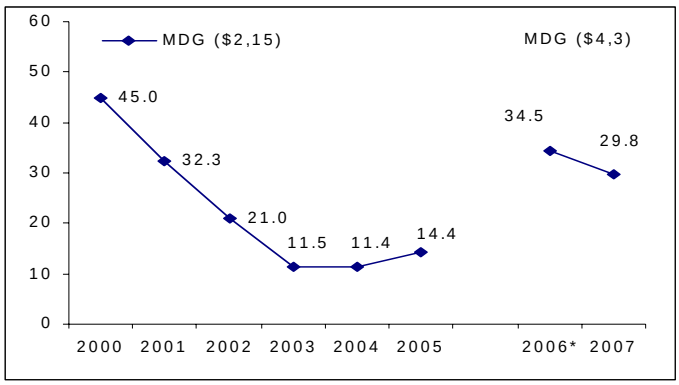


Source: Poverty and Policy Impact Reports 2006, 2007; MET

Analysis of trends in poverty incidence, calculated as a total for the country, shows a sudden growth in 1999 of absolute poverty—73% of the population was under the absolute (administrative) poverty line. This extremely high incidence of poverty at the time reflects the serious impact of the Russian financial crisis on Moldova. However, following economic revival and an increase in real incomes of the population, from 2000 Moldova recorded a significant reduction in the percentage of the population under the absolute poverty line—the economic growth achieved during this period having a direct impact on the reduction of this phenomenon. The poverty rate decreased noticeably from 1999–2005 by over 40 p.p. The incidence of poverty over 1998–2005 and 2006–2007, calculated on the basis of other thresholds, as well as other measures of poverty (depth and severity), showed a similar trend (Table 3.1).

The incidence of extreme poverty in 2006 was relatively low (4.5%), indicating that the problem of food poverty will be less relevant for Moldova in coming years. As a result, starting in 2006, calculation of a more generous threshold to measure poverty in the national context was proposed. Thus, for future analysis of the welfare of the population, the "upper threshold" of absolute poverty[109] will be used.

Figure 3.2. Achievement of MDG on poverty reduction



Source: Poverty and Policy Impact Reports 2006, 2007; MoET

The incidence of poverty in the context of achieving the MDGs in Moldova is also recording a downward trend (Figure 3.2).

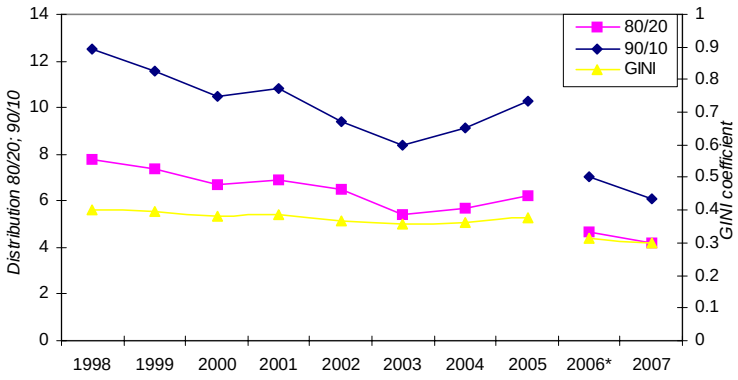
[109] Poverty and Policy Impact Report, Annex C: Alternative estimates of poverty

The share of population *with consumption* below MDG thresholds decreased in 2006 and 2007, accounting for 34.5% and 29.8%, respectively, of the total population. A time dynamic for the poverty indicators cannot be carried out in the context of MDGs due to the fact that in the process of developing and consulting on the NDS in 2007, the MDG indicators were revised and adjusted, and new objectives were set for the years 2010 and 2015[110].

In the first national MDG report of Moldova[111], the share of the population with *an income* under €1.7 in 2005 (US$ 2.15 per day, adjusted to Purchasing Power Parity (PPP)) has been used to set up the targets for medium and long-term goals. According to HBS data, in 2006, 13% of the population had *an income* below the threshold of €1.7 (US$ 2.15 per day/person, adjusted to PPP). The interim target set for this indicator for Moldova was achieved, exceeding it by more than 2 times (13% compared to 28%)(GoM, 2008), and the analysis of HBS data in 2006 confirmed the relevance of the shift to the new threshold of €3.43 (US$ 4.3 per day/person, adjusted to PPP), with a rate of poverty close to that estimated in accordance with the national threshold (Table 3.1). The relevance of this transition was also confirmed in the process of drafting and consulting on the NDS for 2008–2011.

Inequality in Moldova is measured using the Gini coefficient[112]*and the distribution of 90/10*[113]**.** In 2007, the Gini coefficient decreased from 2006, reaching the lowest value for the entire period under survey (0.298)—this fact indicating a decrease in the difference in consumption expenditure between the rich and the poor.

Figure 3.3. Dynamics of inequality indicators



Source: Poverty and Policy Impact Reports 2006, 2007; MoET

The decrease in inequality is also confirmed by the 90/10 distribution of the average expenditure per adult equivalent, which recorded values equal to 7.0 and 6.1 in 2006 and 2007, respectively. According to the Gini data, inequality had increased over 2004–2005 (Table 3.2). The cause of this increase in inequality is related to the increase in the gap between the income and/or consumption of the rich and poor, particularly as a result of more rapid development of urban areas than rural areas. The dynamics of inequality indicators within the national context are shown in Figure 3.3, together with the distribution of 80/20[114], which reflects almost the same trends.

Over 2006–2007, *poverty assessed on the basis of a relative threshold of 60%* of median consumption expenditure per adult equivalent revealed a decreasing tendency (1.8 p.p.), with 15.1% of the total population of the country recorded in 2007. The relative poverty rate recorded maximum values of approximately 25% during 1998–1999, the minimum of 19.4% seen in 2003[115].

In addition to using NBS data for the assessment of poverty in Moldova, which underpins the main indicators of poverty alleviation produced annually[116], the MET estimates the Small Area Deprivation Index and prepares the Informative Note on Poverty in the country and the Poverty

[110] http://gov.gov.md/www.gov.md/file/materiale %20utile/md/Raport %20preliminar_ODM_revizuit.doc

[111] http://www.un.md/mdg/mdg_in_moldova/Millenium_ENG.pdf

[112] The Gini coefficient is calculated on the basis of consumption expenditure per person (without equivalence scale, and calculated per capita)

[113] The ratio between the average consumption expenditure of 10% of the richest population and 10% of the poorest population

[114] Author's calculations, annual reports on poverty and policy impact, MET

[115] In the period 1998–2005, the relative threshold was calculated as 50 % of average consumption expenditure per adult equivalent, for 2006–2007 the poverty line was estimated at 60 % of median consumption expenditure per adult equivalent; the old OECD equivalence scale (1; 0.7; 0.5) was used for both periods

[116] "Informative note on the 2006 Household Budget Survey", www.statistica.md

and Policy Impact Report for each reference year. For an overview of research undertaken on poverty and social inclusion in the country see Annex III**.**

3.3. Government policies and strategies aimed at reducing poverty and social exclusion

A number of national programmes and legislative and regulatory acts were implemented leading up to 2007 to monitor poverty and alleviate its effects[117].

In 2007, the NDS 2008–2011[118] was developed and approved. The fundamental objective of the strategy is to create conditions for improving quality of life by strengthening the foundation for robust, sustainable and inclusive economic growth. Promoting social inclusion is recognized in the NDS as a major priority of sectorial and regional policies. Efforts have been directed at improving statistical records as available data necessary for determining the level of inequality and disparities existing in the country are inadequate. In 2008, a joint project "Strengthening the National Statistical System" was launched by the UNDP and the Government of Moldova. One of the main activities of the project is improving data quality for the purpose of evaluating the impact of policies promoted through the NDS, and developing recommendations for additional measures needed for harmonization of social policies with EU standards.

3.4. Profiles of poverty and social exclusion

3.4.1. Absolute poverty versus relative poverty approach

Within the EU, the relative poverty line is estimated as 60% of the median income/consumption expenditure per adult equivalent, using the modified equivalence scale: 1; 0.5; 0.3. The NBS does not use the modified equivalence scale to compare the well-being of households at the country level. Instead, for this report, a new relative poverty line was calculated for the necessary assessments. The resulting poverty profile is presented at the national level, and includes evaluation results according to the relative line calculated using HBS data and the OECD modified scale.

During the period 2003–2007, the absolute poverty rate recorded a yearly fluctuation of about 3 p.p, ranging between 30% and 26%. This can be partly attributed to both external shocks (increase in fuel prices and natural gas, introduction of restrictions on exports of alcoholic products), and adverse natural events (heavy rains, hail, drought and floods), which have afflicted Moldova over the last few years. The influence of these natural factors on the standard of living continues to be considerable, as almost 60% of the resident population live in villages, and agriculture is the basic activity of over one-third of the employed population[119].

As mentioned, a significant reduction in absolute poverty (of 4.4 p.p.) was registered in 2007 compared to 2006. This improvement happened along with a rise in economic development, creating new work places, especially in cities, and a consequent rise in salaries and pensions.

---

[117] Decision of the Government of the Republic of Moldova no. 460 of 22 July 1993 on approving the temporary module for determining and calculating the minimum consumption budget

Decision of the Government of the Republic of Moldova 564 of 14 June 2000 on approving the National Programme on Poverty Alleviation

Decision of the Government of the Republic of Moldova no. 902 of 28 August 2000 on approving the Regulation on the method of calculating the subsistence minimum.

Decision of the Government of the Republic of Moldova no. 619 of 16 May 2002 on approving the Action Plan on strengthening the capacity of monitoring and evaluation of poverty in the period 1 June 2002–31 May 2005.

Law no. 398-XV of 2 December 2004 on approving the Economic Growth and Poverty Reduction Strategy for 2004-2006

[118] Law no. 295 of 21 December 2007 on approving the National Development Strategy for 2008-2011.

[119] Statistical Yearbook of the Republic of Moldova, 2006

Also contributing was the support provided by international organisations and income from remittances.

Relative poverty, evaluated using the OECD modified equivalence scale, also reduced in 2007 compared with 2006, registering 15.4% and 16.1% respectively.

3.4.2. Poverty profile by area of residence

Rural areas. The absolute poverty profile in Moldova is characterized by a significant difference between urban and rural areas—12.9 p.p. registered in 2007. According to 2006 and 2007 HBS data, the highest poverty rates of 34.1% and 31.3% respectively, were registered in rural areas.

The same essential differences between urban and rural areas were recorded in 2005, when poverty in rural areas increased by about 4.8 percentage points as compared to the previous year. In 2005, the poverty risk of the population in rural areas was 36%. An increase in the depth of poverty in rural areas compared to previous years was also recorded (Tables 3.3 & 3.4). According to the "Study on rural poverty in the Republic of Moldova 2005", conducted by the Business Consulting Institute (BCI, 2006), employees in the agricultural sector and farmers in rural areas face the highest risk of poverty (over 44% of this group)—these also representing a share of over 62% of the population in rural areas. The incidence of poverty in 2005 was also higher for those whose main source of income was individual agricultural activity, which accounts for 41.5% of the rural population (Table 3.5). Consumption expenditure of households in rural areas is mainly oriented towards satisfying basic needs (Table 3.6). Expenditures on food products in 2005 amounted to 62% of total expenditures, followed by expenditures on utilities and housing maintenance (16.1%). Expenditures on education were the lowest at 0.2%, and those on health were 3.6%.

Ownership of land, including agricultural land, does not in itself improve the material situation of households. In Moldova, 99% of households in rural areas have agricultural land and over 70% in small towns, both poor and non-poor households. This indicates to a subsistence agriculture, which does not offer a major opportunity to escape poverty for those households with self employment in agricultural sector as a main source of income. However, it is estimated that without the income from agriculture the incidence of poverty would be about 43%[120]. Of note is that the income from individual agricultural activity is relatively small for an agrarian country, where, in 2007, it was only 15.6% of the average disposable income (this compares to 17.7% for income from remittances and 40.8 % for the actively employed)[121].

Small towns. The absolute poverty risk is also relatively high in small towns, representing 30.1% in 2006, and 23.8% in 2007 (Table 3.3).

In 2005, about 34% of the population in small towns was living in poverty according to the absolute poverty line, maintaining the level observed in 2004. The difference in living conditions between cities and towns was exacerbated over 2000–2004, which supported the existence of the republic's de-urbanization phenomena, with all its negative aspects. The highest poverty rates were recorded in small towns, which suffered the most from the economic decline of 1999, with a reduction in the minimum access of the population to goods and services, employment opportunities and, finally, subsistence resources. The majority of small towns were mono-structural and dependent on the activity of a small number of enterprises located in their region (or factory alone). The liquidation or substantial reduction in production volume, of these enterprises caused mass unemployment. Insufficient development of services and infrastructure hindered the attraction of investments and economic rehabilitation of many small towns, leading to a high level of poverty. A lack of land plots, which would have ensured at least the minimum necessary food consumption, further aggravated the quality of life of the population. However, positive trends in economic development and the rehabilitation of social infrastructure have had a significant impact on poverty, which decreased to 34.2% by 2005 in small towns, compared to 36% in rural areas.

The economy of big cities, especially that of the country's capital, maintained and even boosted their relative advantage through diversification of production, and development of infrastructure

[120] HBS 2007, authors' calculations: based on these estimations circa 24% of non-poor being poor and 0.2 of the poor can be non-poor (confusing). The last figure is not significant but this attests to the fact that the investments of households in agriculture are high, sometimes, higher than income, and negatively influences household wellbeing,

[121] Report on Poverty and Policy Impact, 2007, Table A.9. Structure of disposable incomes of households in 2007

and the services sector. The inhabitants of large cities, in contrast to small towns, have wider opportunities for employment, training, establishment of a private business, and other business activities. Within the NDS, the Government identified the development of small towns as a national priority, mentioned as a separate objective[122]. The economic growth registered in recent years, together with government policies oriented towards the socio-economic development of small towns (infrastructure rehabilitation, enterprise re-launching, new businesses stimulation), had a positive impact on the population's quality of life. The absolute poverty rate in small towns decreased in 2007 compared to 2006 by 6.3 p.p. (6.6 p.p. in cities, 2.8 p.p. in rural areas).

Geographical regions. There are significant regional disparities in the country, hindering balanced socio-economic development. The analysis of key indicators in these regions reveals the existence of disparities, especially between Chisinau municipality and the other regions.

Starting in 2006, the HBS began providing data at the regional statistical level[123]: Northern, Central, Southern and Chisinau municipality, which are close to the development regions established officially by the law on regional development. The estimates of absolute poverty at the regional level indicate an uneven distribution of population living standards. The highest percentage of poor in 2006 was recorded in the Southern region (34.1%), followed by the Central region (33.7%). In 2007, the poverty level in the Northern, Central and Southern regions was approximately the same (about 30%), contrasting with Chisinau's poverty rate of 11%—almost 3 times lower than in other regions (Table 3.7).

Job opportunities and employment are factors inextricably linked to poverty. The employment level in agriculture was 61% in the Central region, 56% in the Southern region and 44% in the Northern region. Other statistical data reveal the same trend**.** Thus, the average monthly salary, as compared to the average salary of the economy (December 2007), recorded the lowest value in the same regions: 68% in the Southern region, 70% in the Central region, and 81.8% in the Northern region[124]. The highest level of unemployment was recorded in the Central and Southern regions. The unemployment rate was about 1.5 times higher in these regions than in the Northern region.

Community deprivation. According to the Small Area Deprivation Index, the poorest rural communities are within the Central development region, followed by the Northern region of Moldova (Table 3.8). The most successful region is the territorial administrative unit of Gagauzia, where studies registered pronounced development in the majority of domains analysed. Poor regions are characterized by larger rural populations, low infrastructure development, and a decreased level of access to education and health services. According to the Law on Regional Development, the development regions are further divided into rayons. Those rayons that include small villages and which are peripheral (distant from cities, the national road system, markets, and rayon centre), are considerably poorer, and their residents exposed to the risk of social exclusion [125] . The SADI offers the opportunity of assessing the regions/rayons/localities where community poverty is concentrated.

---

122 National Developmnet Strategy, priority 5 "Regional Development" ; objective 5.2 "Creating urban centers of economic growth that will complement existing national urban centers and ensure the consolidation of small towns"

123 The Southern statistical region includes both South and Gagauzia in the developing regions

124 Statistical Report on Social Economic Development of the Republic of Moldova, 2007

125 The most poorly developed district in Moldova is situated in the Central region (Nisporeni rayon), but the largest variation of the SADI between rayons is registered in the Southern region of the republic**.** The most deprived localities are located in the rayons of Străşeni, Călăraşi and Nisporeni. The most successful localities are situated in Gagauzia and Taraclia. Technical note, Multiple deprivation in the rural areas of Moldova, Chişinău, December 2008.

Subjective poverty. Subjective poverty in Moldova is measured by determining a threshold of poverty deemed as minimum in order to survive according to the needs of each household (Leiden method). For this purpose, HBS data on the reported amount of money required by a household for a minimum standard of living is used. The subjective poverty rates are different from the monetary poverty rates. In 2006, the subjective poverty rate in rural areas was 4.3%, which is close to extreme poverty. In urban areas, subjective poverty is at the same level as absolute poverty (24.4%). The same tendencies are registered in 2007 (Table 3.9).

Another approach to the evaluation of subjective poverty is *self-assessment*[126], as used in the HBS survey in 2006. According to the results of this survey, 40% of households interviewed considered themselves poor—43.5% of urban households and 38% of rural (Table 3.9).

Voices of the poor. In order to better understand the causes of poverty variations in size of (relative) deprivation and according to region, the study "Voices of the Poor" was conducted in 2006, with the aim of developing community-based anti-poverty initiatives and promoting social inclusion[127]. The basic issues addressed by the study were: (i) the prospects and options of the poor, and (ii) the development strategies that can be achieved in their communities. The study confirmed that the main risk factors of living in poverty are the following: lack of employment, low income, and inability to work (Table 3.10.). The categories of the population considered as poor by respondents of the study (e.g. the elderly, disabled and unemployed) confirm the results of analysis carried out using HBS data (Table 3.11). Self-processing of land in rural areas is especially linked to poverty due to limited access to the market, cost of agricultural products that do not cover incurred expenses, and lack of profitability—the latter leading to a tendency to leave land unprocessed.

According to participants in the study, a job with decent pay is the main way to ensure a minimum standard of living, and working abroad is perceived as a realistic option for escaping poverty. Several respondents indicated, however, that while work abroad is beneficial in terms of material gain for the family, it has a negative impact on the integrity of the family, children's education, community development and economic growth of the country. It was also noted that human resources are not valued and under such circumstances people who are skilled/trained and with initiative prefer to work abroad where better working conditions are provided.

The study also identified specific population groups suffering the most from social exclusion: (i) children abandoned by parents who have gone abroad in search of work (according to neighbors "children are left without any care"), (ii) women whose spouses have left to work abroad ("women are insecure at home alone"); and (iii) individuals without shelter in rural or urban areas.

At the same time, 68.5% of respondents believe that poverty in Moldova can be reduced. For this to occur, they believe that it is necessary to develop the economy, to create new jobs (32.8% respondents) and provide decent salaries, to support local manufacturers, to attract more foreign investors, to develop the market and, to this end, maintain cooperation with other countries (neighbouring countries in particular) and the EU. For economic growth, it was considered

[126] A special module was attached to the HBS, and administered to a sample of 470 households. Poverty is evaluated according to an individual's perception of whether they are poor or not.

[127] "Voices of the Poor" is a social anthropological study on the subjective perception of poverty in Moldova. The study was conducted by the Centre for Sociological Research and Marketing CBS AXA, contracted under the framework of the Joint Programme "Support in the development, monitoring and evaluation of strategic policies in the Republic of Moldova", implemented by the Government of the Republic of Moldova and UNDP Moldova. The sociological survey was carried out using qualitative research in five localities: two towns and three villages. Data was collected through: focus group, case studies, and complex and semi-structured interviews. The selection criteria for the localities were based on: geographical distribution, type and size of the locality, and living standard of the locality.

necessary to subsidize agriculture, upgrade technologies for land processing, use material and human resources efficiently, combat corruption, respect the law, and provide credits with lower interest rates.

3.5. Vulnerability and social inclusion

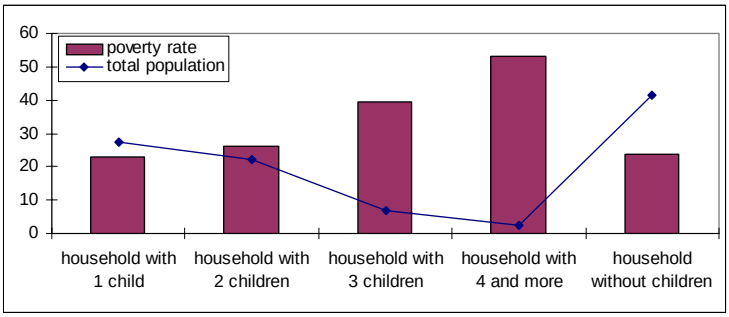
3.5.1. Vulnerable population groups

The results of poverty analysis based on 2007 HBS data reveal that the most vulnerable groups of the population in Moldova are households with children headed by persons other than parents, families with multiple children, people from households employed in agriculture, the elderly, people without education or professional skills, and the unemployed (Table 3.12).

Other households with children. Households with children headed by persons other than parents present a high poverty risk (31.6%). These are families with children placed under the guardianship of grandparents, relatives**,** neighbours, guardians/tutors as well as adoptive families**.** This group also includes households in which two or more family couples live, mostly headed by pensioners, or young couples who do not have a stable place of work or are students, and with children up to 18 years. This group represented more than one-third of all poor people (38.9%) in 2007.

Families with multiple children. In 2007, 27.4% of the total number of children in the country faced absolute poverty. Research demonstrates that the incidence of poverty correlates highly with the number of children in a household. Thus, a child joining a family increases the poverty risk for the household.

Figure 3.4. Poverty rates and incidence of households with children, 2007



Source: Poverty and Policy Impact Report, 2007; MoET

A high poverty rate is registered in households with four or more children, and for this group it becomes double the absolute poverty rate for the country (Figure 3.4)—although the share of the total population of such households represents less that 3%. The lowest poverty risk is among those with only one child in their household, followed by households without children.

A child's risk of living in poverty is especially high in rural areas (33.2%), with the most vulnerable groups being children less than 5 years of age (35.4%), followed by those aged 5–9 years (34.4%) (Table 3.13). The majority of these rural children live in young families, a fact confirmed by the high poverty rate registered among economically active people aged 19–29 and 30–39 years from rural areas (30.2% and 31.6%, respectively). In urban areas, the highest incidence of poverty is recorded among children aged 10–14 years, 51% of whom live in households headed by persons other than a parent. The majority of these households are headed by elderly people whose incomes are derived mainly from pensions and social payments. These small amounts, together with a lack of other income, such as income similar to households in rural areas, are not sufficient to cover the expenses necessary for the maintenance and education of children of this age.

According to the results of a study carried out by the Expert-Grup Analytic Centre in 2005 (Expert-Grop, 2006), 28% of the poor population were children, making them a highly vulnerable group. A total of 56% of Moldovan households have at minimum one child less than 18 years. In 2005, 80% of poor children lived in rural areas. Children under 3 years old faced a higher poverty risk than other categories. Circa 16% of children less than 18 years old lived in families where a minimum of one parent was a working emigrant. In these families the financial situation of the children was far superior to families with no emigrants. But qualitative research shows that these children suffer from emotional poverty and their performance at school is compromised. Children's participation in preschool education improved over 2000–2005, but at higher levels of education the rate of involvement decreased. Among 15–17 years-olds only 58% of poor children were included in the educational system, compared to 81% of the children unaffected by poverty.

Employees of the agricultural sector and farmers. Highly affected by poverty are those from households led by employees in the agricultural sector and farmers**.** This category makes up one-fourth of the total population and 37% of the total number of poor persons. The poverty incidence among farmers whose main source of income is self-employment in the agricultural sector is 35%. The poverty rate of persons from the families of employees in agriculture is higher at 39.9%, and this group comprises 7% of the total populations of the country. This is consistent with the fact that the agricultural sector continues to register low efficiency and productivity due to its vulnerability to weather conditions and natural disasters. More than 390,000 farms are operating in Moldova, and the majority of them practice subsistence agriculture due to insufficient government subsidies for necessary resources, limited application of advanced technologies, reduced accessibility to credit sources and markets, and other unmet needs.

Beneficiaries of social protection. People from households whose main source of income is from social benefits also register a high poverty risk (33.6%). The majority of this group are pensioners who make up 25% of the total population and 33% of persons from poor households. The incidence of poverty is highest among persons living in households headed by welfare recipients (34.8%), although they constitute only 0.6% of the poor. Neither retirement income nor other social payments provide relief for recipients from living in poverty.

Elderly. The age of the household head also influences the standard of living. Elderly people are the most susceptible to poverty, especially those who have reached the age of 65 and above, and the absolute poverty rate of this type of households is 35.5% (Table 3.12). Households led by those aged 35–54 have a lower poverty risk. In addition to growing proportionally with age, poverty incidence differs according to area of residence (Table 3.13). The highest incidence is observed among 70–75 year-olds living mostly alone in urban areas (43%), whose main source of income is from pensions.

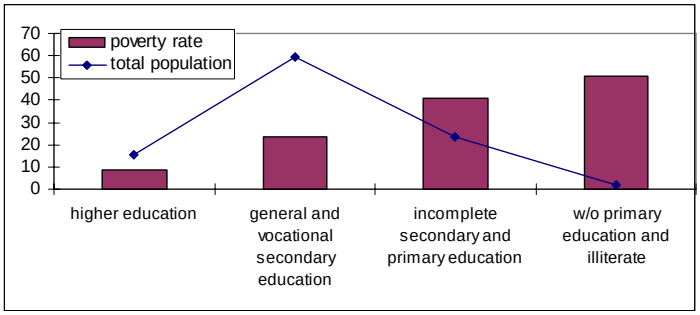
Gender differences. The impact of poverty on households led by women is greater than that of households led by men, with an especially high poverty rate (36.3%) among aged women living in rural areas (Table 3.13). The category of households headed by elderly women includes aged persons whose main income source is pensions, and households with three or more children. These groups were previously identified as vulnerable according to HBS 2007 data**.**

Employment. Households with unemployed members also register a high poverty risk of about 30%**.** However, it should be mentioned, that in households with three or more employees the poverty rate increases (35.8%). According to HBS data, this group is formed largely of households from rural areas with multiple children and income from self-employed agricultural sector activity, confirming the vulnerability of these households (53.9%). In urban areas, those at risk include households headed by elderly persons who work, consisting of two or more generations, and most of which have children residing there. In these households, young people who work are unlikely to have a stable place of work or are poorly paid due to limited education or lack of employment opportunities. This group is particularly vulnerable within households led by persons self employed in the non-agricultural sector (30%).

Education. Education remains one of the main factors that determine the level of household vulnerability. Poverty risk is dependent on the education level of the household head, decreasing substantially as the education level of the household head increases.

The poverty rate of households led by persons with incomplete secondary and primary education is relatively high (40.7%), making up a quarter of the total population. Members of households led by those without primary education register the highest poverty incidence of 51.0%, but they represent only 1.7% of the total population.

Figure 3.5. Absolute poverty incidence related to the household head educational level, 2007



Source: Poverty and Policy Impact Report, 2007; MoET

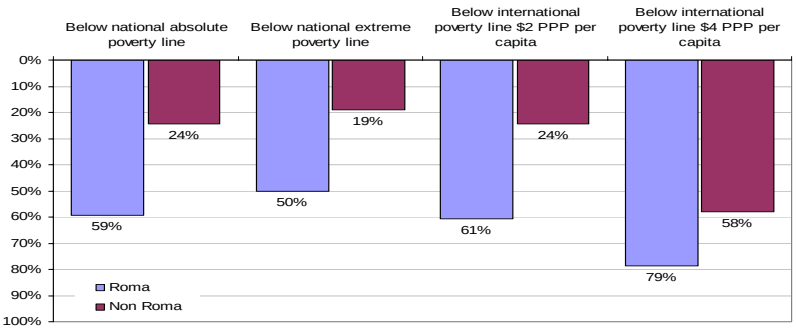
Disabled persons[128]. Poverty incidence is 2 p.p. higher for disabled people than for the total population. The most affected by poverty are the disabled from rural areas, with a poverty rate of 32.3% (Table 3.14).

Roma poverty. The social exclusion of vulnerable groups and the high poverty rates among them is a factor that could compromise policies introduced for social and economic development. Roma are considered as a special group deserving particular attention in this context.

Given the dearth of information on this disadvantaged group, the UNDP Moldova supported a quantitative study in 2005, which covered 600 Roma and 600 non-Roma households in 81 localities (CBS AXA, UNDP, 2007) . The study provided basic quantitative data and statistics on the Roma situation in terms of incomes and expenses, education, employment, health, housing, security and migration. This information can serve as a benchmark for the development of Roma social inclusion programmes, policies aimed at socio-economic development, access to education, health, and the attenuation of other negative social effects.

Although poverty at the national level was considerably reduced between 1999 and 2005, survey data estimate that Roma face a risk of poverty that is two times higher than that among non-Roma.

Figure 3.6. Poverty rate among Roma and non-Roma, 2005



Note: Welfare measure is total consumption per adult equivalent. National poverty thresholds are used.
Source:CBS AXA, UNDP, 2007.

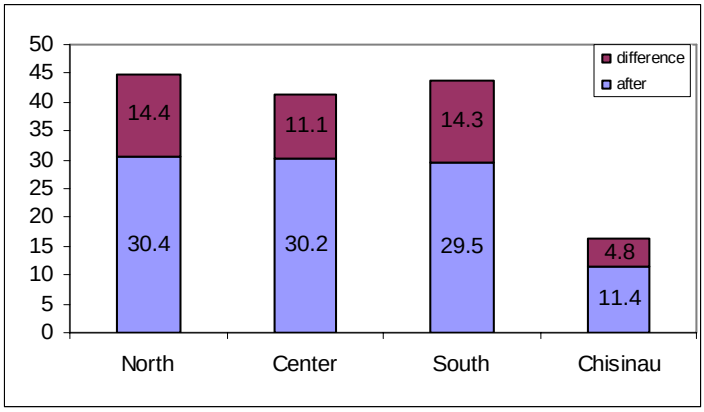
The poverty status of Roma families is determined by poor education, large household size, area of residence and low employment levels. The incomes of Roma households are mainly derived from transfers from abroad, "unofficial income" from the sale of personal possessions, collection of disposable items, welfare transfers from the state, as well as from informal activities such as gambling, begging and fortune telling. The expenditures of Roma are largely oriented towards the procurement of food products (54% of the Roma family budget). One-third of Roma households have insecure dwellings. More than 80% of Roma do not benefit from basic housing conditions such as potable water, a bathroom and sewerage (CBS AXA, UNDP, 2007).

[128] People with disabilities are those who have declared their invalidity of grade 1, 2 or 3 to HBS, Law Nr. 821 24.12.1991, regarding the social protection of invalids

Migration. Income from remittances has a significant and obvious impact on the population's living standards. Households whose main source of income is remittances have the lowest degree of poverty risk (16.7%). Higher labour migration and larger amounts of money transferred from abroad have increased population incomes and expenditures considerably. In 2007, remittances accounted for 17.7% of the available income of households. According to the survey, over 40% of the country's population lived in households that received remittances. The survey recorded a direct impact of income from remittances on poverty incidence. Their ex-ante analysis shows a reduction in the poverty rate of 8 p.p. for the total population (from 38 to 30%), being more prominent in rural areas (8.7 p.p.). These trends were maintained in 2007 (Table 3.15).

The impact of remittance income on the poverty rate varies by statistical region (Figure 7). It is highest in the Northern region (44.8% before transfers and 30.4% after transfers), followed by the Southern region (43.8% before transfers and 29.5% after transfers) (Table 3.15).
Migration is identified as one of the options of the poor to escape poverty, and members of households who consider themselves poor are more likely to go abroad to work than those from non-poor households (Görlich and Trebesch, 2008). This seems to contribute significantly to improving the standard of living of the poor.

Figure 3.7. Impact of remittance income on poverty rates by statistical region, 2007*



Source: Poverty and Policy Impact Report, 2007
/ **after** - poverty incidence after receiving remittances, %; **difference** – the difference before and after receiving remittances, percentage points*

The return of those who left to work abroad and lack of employment opportunities for them, reduction of the necessary finances to cover household expenses, and an increase in the number of persons seeking social protection, are all factors that will contribute to an increase in the number of people under the poverty line. A more pronounced effect may be seen in villages (Table 3.15), the impact of remittances on income poverty incidence being more severe in rural areas (13.6 p.p. in 2007).

*Population access to public services.*Access to public services differs for poor and non-poor persons, as reflected in a lower number of visits to these institutions by poor persons (Table 3.16). A major issue for the poor is that due to their concentration in localities with poorly developed infrastructure, they have larger distances to public services.

Access to social insurance and social assistance. Payments for social insurance in Moldova are based on contributions and are provided to insured persons, offering necessary health and social resources for the elderly, persons with disabilities and other categories made up of those incapable of work. Poverty incidence among these groups depends on the efficiency of the social protection system. At present, every fifth inhabitant of Moldova is a beneficiary of a pension or social assistance. According to HBS data, social protection makes up 48% of the disposable income per capita in households headed by persons aged 65 years and over, and 27.5% of 60–64 years-olds (NBS, 2008). Ex-ante analysis of social insurance shows a pronounced impact on the poverty rate, the difference before and after the receipt of social benefits being 9.4 and 11.9 p.p. in 2006 and 2007, respectively.

Social assistance policies include a number of programmes providing either cash benefits or social services directed at protecting socially vulnerable groups of the population. As mentioned in the previous chapter, social assistance registers no significant influence on poverty

(contributing about 1% to reduction in absolute poverty) because of the small amount and inefficient targeting of available resources (Table 3.17).

3.5.2. National social inclusion policies

The last few years have seen the majority of national policies concentrate on economic development and on poverty reduction. Poverty reduction objectives have focused on increasing the access of poor population groups to education, health, social protection and the labour market, all of which represent the key sectors in which the level of social inclusion and inequality can be measured.

Education. Measures were taken within the education sector for improving access and quality of education at every educational level. Strategic documents and legal acts were developed and implemented[129], which formulate strategic sectoral objectives over the medium term, including increasing quality of education, and access to different levels of the public education system by children from poor families and children with special needs. A number of documents and acts have also been developed that promote social inclusion, respect for diversity in gender, race, religion, ethnicity, culture, language, family structure, socioeconomic level, age, skills, and which create equal opportunities for children with special development needs in education[130]. The following priority actions have been formulated: the creation of mechanisms for inclusion of school children with poor parental supervision, ensuring a legal and regulatory framework for promoting community services for vulnerable families and families with children at risk, provision of coaching within primary class hours for students from socially vulnerable families, and involvement of NGOs in providing professional counseling services. In this context, a number of measures related to improving the quality of preschool institutions have also been implemented such as: review of both structure and work schedules, enhancement of technology-oriented educational approaches, and an increase in the norms regarding financing for the education of children. In small villages deprived of the opportunity to open and maintain kindergartens, community educational centers for children and socially vulnerable families have been established, where children can benefit from pre-training for school. In the context of general education, in order to reduce the burden of expenses for school attendance, especially among poor families, the state covers expenditures on food for about 99.8% of children in grades I–IV, and approximately 42% in grades V–XII. Students in grades I–IV receive textbooks free of charge, and students in grades V–XII from poor families receive rental subsidies for textbooks from local government. With financial support from the WB, the project "Quality educational in the rural areas of Moldova" will run from 2006–2010. The objective of this project is to improve the quality of the educational system in rural areas. The MEY has also undertaken mapping of the whole network of pre-university education institutions. In addition, the plan for optimization of the network of educational institutions was elaborated, stipulating reorganization of medium-level schools (primary education), lyceums and gymnasiums, on the basis of number of children, technical resources, and the competence of teaching personnel. The strategy for the optimization of the network of pre-university institutions also facilitates the creation of district schools, provision of transport services, and extracurricular education. Moldova is committed to participate in the PISA project in 2009[131] for inclusion in the international system of school performance evaluation. In higher and professional education, the mechanism for granting scholarships to students has been improved as a means to support the socially disadvantaged[132]. Currently, three types of scholarships, funded from the state budget, are assigned: merit scholarships, simple scholarships, and social scholarships. Social scholarships are granted on request to students in Cycle I and II, integrated studies, medical and pharmaceutical education, and those from socially vulnerable families who have already obtained a simple scholarship. The

129 Educational Strategy "Education for All"; Institutional Development Plan for 2009-2011, http://www.edu.gov.md/

130 Learning and development standards for 5-7 years old child, UNICEF, MET

131 http://www.edu.gov.md/files/unsorted/PISA2009.doc

132 Government Decision nr. 1009, from 01.09.2006

scholarships are determined according to the share of income of an incumbent member of the family.

Children and young persons. The problem of vulnerable children in high-risk situations has been addressed through government policies directed towards reducing the rates of institutionalization, moving to alternative community-level options such as maintaining children in their families or in family-type institutions[133]. Children's right to be raised by their family is approached in a comprehensive way in the National Strategy and National Action Plan in order to reform the system of residential child care over the years 2007–2012[134]. Accordingly, in addition to other strategies, family-type homes are being created, social worker units introduced, and conditions created to enable children from residential homes to attend school in the community. It is anticipated that these measures will prevent institutionalization, reintegrating children into their biological and extended families, and result in more efficient use of public finances. At the same time, the Government is directing much attention to solving the problems of youth and extending services for this important group, especially in view of the fact that unemployment among this population group is on the continual rise. Despite the fact that 2008 was declared by presidential decree as "Year of the Youth"[135], and saw the adoption of an action plan dedicated to this special year[136], the impact was minor. Targeted actions were largely declarative and financing was modest. In order to continue to promote policies in this area the National Strategy for Youth, 2009–2013[137], was developed and approved with objectives such as: ensuring young people access to education and information, developing health services and social protection, providing opportunities for participation of youth in public life, and promoting active citizenship and strengthening institutional capacities for them. The overall aim of the strategy is to increase the quality of life of young people by creating the necessary conditions for education, development, participation and socio-economic integration.

Health care assistance. Over 2004–2006 the health care sector was subjected to substantial reforms. Thus, for the purpose of improving access of the poor population to health care services, the obligatory medical assistance insurance system was introduced, which covered about 75% of the population in 2007. The primary care medical assistance network was also extended and the process of decentralizing the system set in motion. Each year, the basic package of health services is expanded, with a focus on children, women, elderly and other vulnerable groups of the population. However, these changes have not prevented the emigration of highly skilled specialists in response to the inadequate infrastructure of medical institutions and unattractive salaries, significantly compromising the capacities of medical services, particularly in rural areas.

Social protection. One of the approaches to protecting the population from the risks of poverty is promoted through the state social insurance system. The reality is, however, that this system faces major challenges, such as worsening demographic indicators, continuing internal and external migration, a low replacement rate, and non-uniformity of tariffs and contributions from some economical sectors—especially the agricultural sector. Over 2004–2007, implementation of the personified contributors' evidence system was launched, some tentative efforts were made to unify pension norms, state measures were introduced to support increased contributions from the agricultural sector, and annual indexation of pensions was introduced. As a result of these

---

133 Government Decision nr. 957 from 20.08.2007, National Strategy on community actions for supporting children in difficult situations for the years 2007–2009.

134 Government decision nr.784 of 09.07.2007

135 President of RM Decree nr. 1451-IV of 26.12.2007, on declaring the year 2008 youth year

136 Government decision nr. 333 of 20.03.2008, on the approval of the Action Program dedicated to the Youth Year

137 Law on the approval of the National Strategy for Youth, 2009–2013, nr. 25-XVI din 03.02.2009, Official Monitor nr.68/192 as of 07.04.2009

reforms, the average pension level rose by 97% (in nominal terms) in 2008 compared to 2004. The policies promoted in the field of social assistance are extremely important for population groups considered most exposed to the risk of poverty. Currently, from 18 types of cash benefits a total of 14 represent compensatory payments, which due to their small amount and inefficient targeting have had an insignificant impact on poverty reduction, generating at the same time inclusion/exclusion errors and dependence on the system. This situation was especially noticeable in rural areas where only 17% of the poorest households benefited from compensatory payments, compared to 28.2% of wealthy households (Expert-Grup, 2006). Cash benefits for children had the same marginal impact. The introduction of a new cash benefit for poverty granted on the basis of needs-testing and optimization of the targeting of compensatory cash benefits was necessary. This lead to the development of a primary mechanism of virtual testing of the incomes of nominated compensation beneficiaries, applied within the framework of four pilot projects during 2006. The results obtained allowed the identification of problems and necessary adjustments to this system. Commencing on 1 October 2008, national legislation now regulates the right to social aid for poor families[138], which is established on the basis of the average global income of the family, and includes all income and savings related to this. A further regulation on the establishment and payment of social assistance benefits was also approved [139]. This new mechanism of access to social state assistance was applied to substitute the previous compensatory model with one based on income-testing, and to achieve the consequential unification of social benefits programmes into one "social aid for the poor" approach. In the same period, the MSPFC also established 80% of the national network of social workers and carried out the initial mapping of existing social services at the national level developed by the associative sector with donor support—data from which served to identify fundamental objectives for establishing the national system of integrated social services, and the types of quality standards for monitoring these services. By the end of 2008, 174 centres were activated at the national level, offering social assistance services to different high risk groups[140]. The durability of these services, however, is limited due to a lack of fiscal decentralization and mechanisms for contracting or purchasing services from private providers.

Migration. Evolution of the migration phenomenon over the past few years has generated the need to improve mechanisms for regulation of labour force migration flows, directed towards the protection of the rights of Moldovan citizens who emigrate for work. State policies in this field have concentrated on the protection of migrant rights according to international norms by forming partnerships with the destination countries, signing bilateral agreements in the field of labour migration and harmonizing national legislation with international standards. In 2008, a Joint Declaration on Pilot Partnership Mobility RM–EU was signed, supported by the EC, to strengthen cooperation between Moldova and EU Member States on the regulation of migration by: creating new common tools for managing migration flows, improving the combat of illegal migration, and developing institutional capacities for implementing migration policies at the national level. In the same year, a new law regulating conditions of provisional employment of Moldovan citizens abroad was introduced[141], as was an action plan for supporting migrant workers returning from abroad[142]. The NDS also identifies a series of actions dedicated to ensuring the rights of migrants to social guarantees through signed agreements on recognizing social insurance contribution periods and labour security with the main destination countries. The NDS also promotes the development of opportunities for the investment of remittances in the development of entrepreneurship.

138 Law nr. 133-XVI from 13.06.2008, on social asistance.
139 Government Decision *nr. 1167, from 16.10. 2008*
140 MSPFC, Annual Social Report, 2008 (draft).
141 Law nr. 180-XVI from 10.07.2008 on labor migration
142 Government Decision nr. 1133 from 09.10.2008

Employment. Amplification of migration processes has motivated the Government to pay special attention to labour market policies. In accordance with Government decision nr.1332 (2006), ministries and central administrative authorities are required to create 300,000 new job units by 2009[143]. Accordingly, the National Strategy on Employment in Moldova, 2007–2015, was developed[144]. Achieving this strategy will contribute to increasing employment, liquidating imbalances in the labour market, reducing unemployment, developing human potential by reforming the job qualification system, and retraining and increasing labour mobility. To this end, new jobs were created, the work place market was organized, and services and improved training for the unemployed were provided, especially targeting representatives of socially vulnerable groups and persons from rural areas. The unemployment rate, calculated according to ILO methodology, fell from 7.3% in 2005 to 4.0% in 2008 (NBS, 2009). However, as this occurred under the conditions of massive emigration, these figures do not reflect the real situation on the labour market. Poor salaries do not make national work places attractive, fostering the continued draining of the labour force, and the global economic crisis has resulted in a preference for employing the lower qualified abroad.

Remuneration of labour. In 2007, the Government launched a new labour remuneration system within the budgetary sector, which ensured real growth in employee incomes. Following the first stage of implementation of this measure, 40% of teaching staff salaries were increased, 30% of public servant salaries, and 20–80% of salaries for employees from other budgetary branches. A number of changes were also made to the wage system in the budget sector in 2008. Thus, the average monthly salary of a worker from the national economy in the same year was €165, an increase of 22.6% compared to 2007. Real salaries increased by 9%. Within the budgetary sector, the average salary increased by 21% to €125. The level of the minimum state salary guarantees increases in this sector of the economy by improving the tariff system. The existing incentives do not, however, ensure growth in the labour force—the remuneration level in the majority of economic sectors remaining at a lower level that does not guarantee a life free of poverty.

Agricultural sector. As mentioned, the risk of poverty is especially high for farmers and employees from the agricultural sector. This fact is explained by the extreme vulnerability of the agricultural sector to climatic factors, slow development and instability of the private agricultural sector due to simplification of the product structure in agriculture, an increased level of imports of agro-alimentary products, and insufficient crediting. In order to decrease the effects of these factors, a set of strategy documents was developed and implemented including: the National Program for Agricultural Development in Moldova (2009–2011), the National Strategy for Sustainable Development of the Agro Industrial Complex (2008–2015), the concept of a subvention system for agricultural producers for 2008–2015**,** and regulations on the process of managing resources for the subvention fund of the agriculture producer.[145] The objectives of these strategies are being implemented though the following agriculture policies: revising and improving the existing subvention system in agriculture, continuing the adaptation of national standards to EU standards and ensuring alimentation safety, developing institutional capacity in the county in the agricultural sector and, in addition, development of agriculture markets.

Supporting the Roma population. For the purpose of reducing poverty risks and promoting social inclusion, over 1991–2006 the Moldovan Government approved a series of decisions dedicated to the development of the national culture of Roma. The National Bureau of Interethnic Relations elaborated an "Action Plan on supporting the Roma population in Moldova for the years 2007–2010", adopted in December 2006 through Government Decision nr. 1453. The plan includes a set of actions directed towards supporting the Roma population in the fields of: education and science,

143 http://www.mec.gov.md/sector/123
144 Government Decision nr.605 from 31.05. 2007
145 http://www.maia.gov.md/

culture, health and social protection, employment, and public security. Different institutions, ministries and departments are involved in the process of addressing Roma problems. Within local administrations, at the municipal and district level, there are now specialists in interethnic relations. Actions towards the achievement of the annual plans to support Roma are provided for in the general budget, and from special funds. Funding is also provided by international organizations[146]. Of note is that, in 2008, the "Dosta" campaign was expanded in Moldova and Ukraine with the aim of bringing Roma citizens closer to non-Roma citizens, thus contributing to their social inclusion. Moldova is included in the Dosta calendar of activities for the years 2008–2009[147].

3.5.3. Available indicators of social inclusion

Primary indicators. The indicators of social inclusion ("Laeken indicators")[148] can be almost fully provided by HBS data. A general comment of note is that all assessments and analysis of poverty, welfare, and social inclusion carried out in the country are based on the unit of adult equivalent, counted in accordance with the old OECD equivalence scale (1; 0.7; 0.5). The relative poverty line at the national level is calculated in the same way, estimated according to the old equivalence scale of 60% of the median consumption expenditure per adult equivalent.

Based on EU recommendations and Laeken indicators methodology, an estimate of a new relative poverty line was needed for this report, using the OECD modified equivalence scale (1; 0.5; 0.3). The year 2006 represents the baseline for the indicators calculated using HBS data, as research on a new sample was launched in that year, and the methodology and tools for data collection have been improved. Table 3.18 presents the indicators with reference to data sources, and comments on the accessibility of information.

Material deprivation. The 2006 HBS includes a set of data that permits the analysis of population accessibility to non-perishable goods, social services, education, health care and also the possession of a plot of land.

Material deprivation can be assessed based on information on household access to sustainable goods. These can be:

1. Share of the population from households that do not possess a colour TV set—about 40% of poor people and about 13% of non-poor.
2. Share of the population from households that do not have a computer—only 1% of poor people and about 12% of non-poor people declared that have computers at home.
3. Share of the population from households that do not own a mechanical or automatic washing machine (data on mechanical washing machines is included because in many rural areas there is no water pipe for an automatic machine)—66% of the total number of poor people and about 33% of those better-off do not have any type of washing machine.
4. Share of the population from households that do not posses vacuum cleaners—only about 15% of poor people and about 50% of non-poor people posses vacuum cleaners.

Housing. Living conditions and housing indicators allow the measurement of a population's access to a reasonable standard of living. The set of indicators can be the following:

1. Share of the population from households that do not have access to a mains water supply—only 43% of the population have access to a mains water supply and only a quarter of poor people.
2. Share of the population from households that do not have a sewerage system—56.3% do not have access to a sewerage system, and over 70% of poor people.

---

146 http://lex.justice.md/document_rom.php?id=7C2CFD92:F34F089B

147 http://www.coe.int/T/DG3/RomaTravellers/source/Dosta_calendars/2008DostaCalendar.doc

148 Portfolio of overarching indicators and streamlined Social Inclusion, Pension, and Health portfolios, Brussels, 7 June 2006; EC Employment, Social Affairs and Equal Opportunities DG

3. Share of the population from households that do not have toilet facilities inside the house—68.3% live in such conditions, and over 75% of poor people.
4. Share of the population from households that do not have access to hot water—68.6% of the total population and around 85% of poor people.
5. Share of the population from households that do not use natural gas—17% of the poor and 4.2% of the non-poor.
6. Access to a heating system—the majority of houses in rural area are warmed using coal, wood or an alternative fuel, and natural gas when they have access. This indicator can be more useful disaggregated by rural/urban areas.
7. Share of the population from households that are not equipped with a bathroom or shower—61.8% of the total population and over 75% of poor people.
8. Share of the population from households that are not endowed with land-line telephones, representing 22% of the total population and about half of poor people.

The listed indicators, calculated on the basis of 2006 and 2007 HBS data, and the relative poverty lines estimated using OECD modified equivalence scales, are presented in Table 3.12.

3.6. Conclusions and key challenges

Research in the field of poverty and social inclusion undertaken by various groups point to similar results—poverty is more evident in rural areas. The most vulnerable social categories are households with children headed by persons other than parents, families with multiple children, the elderly, especially women, farmers and employees in the agriculture sector, persons with a low educational level, and those dependent on social protection. Emigration is believed to be a real option for the poor to improve their standard of living; however, this phenomenon has multiple adverse social impacts.

The global economic and financial crisis, however, has led to a loss of jobs by emigrants and their return to Moldova on a massive scale, a decrease in the working day and a significant number of employees forced to leave work. The groups traditionally considered vulnerable have been even further impacted upon, including those close to retirement age, women, young people without professional training, and trained youth who have not acquired practical skills.

The situation in rural areas is of major concern, where agricultural activities are largely practiced, and small and medium business is focused on services rather than production. The financial and economic crisis is mostly affecting employees in agriculture, especially young families, who do not have land that can ensure the minimum required consumption.

To address this situation urgent action is required to develop and implement anti-crisis programs, including the reintegration of temporarily and permanently returned migrants, and the creation of opportunities to attract remittances for the development of the business environment.

The main challenges for the country are the implementation of social inclusion policies that will contribute to the reduction of poverty and inequality among vulnerable social groups, thus diminishing migratory processes by creating more work places and providing competitive salaries. Also critical is improving access of the population to quality health and social care services through the development of infrastructure, especially in rural areas, and ensuring the competitiveness of agricultural production, access to markets, and introduction of further policies to decrease the vulnerability of the agricultural sector.

In order to achieve these outcomes it is crucial that a set of indicators is adopted at the national level to measure the impact of implemented policies. As a step in this direction, in 2008, the NBS and the MET determined a set of activities for the development of indicators for to measure

social inclusion. The HBS was also extended through the inclusion of a special module in order to calculate a set of national social inclusion indicators. Development of a comprehensive survey will be supported in this context up to the end of 2009.

3.7.References and tables

References

1. Business Consulting Institute (2006) "Rural poverty in the Republic of Moldova 2005"
2. Expert-Grup Analitic Centre (2006) "Child poverty in the Republic of Moldova 2005"
3. NBS (2006) Informative note "Children situation in Moldova 2005", nr. 08-01/65, 01/06/2006
4. CBS AXA, GALLUP International (2006) Sociological study "Voices of the Poor 2005"
5. MET, UNDP, UNICEF, SIDA (2007) (2008) "Poverty and policy impact report"
6. NBM (2007) Annual Report http://bnm.md/
7. CBS AXA (2006) The Kiel Institute for the World Economy www.ifw-kiel.de "Models and tendencies of migration and remitencies in Republic of Moldova"
8. Dennis Görlich and Christoph Trebesch, The Kiel Institute for the World Economy; Free University of Berlin and Hertie School of Governance (2008) "Seasonal Migration and Networks—Evidence on Moldova's Labour Exodus"
9. Human Development Sector Unit, Ukraine, Belarus and Moldova Country Unit, Europe and Central Asia Region (2006) "Moldova: Poverty Update", Document of the World Bank
10. NBS "Cu privire la totalurile Recensamintului populatiei din 2004 vizind migratia poulatiei" , http://www.statistica.md/recensamint/migratia_ro.doc
11. CBS AXA, UNDP (2007) "Roma in the Republic of Moldova"
12. JPPM/MET (2004) Poverty and policy impact report
13. JPPM/ MET (2005) Poverty in Moldova 2004, Briefing Note
14. JPPM/ MET (2004) Poverty in Moldova 2003, Briefing Note
15. Ministry of Economy (2003) Poverty in Moldova 2002, Poverty and Policy Monitoring Unit
16. GoM (2004) "The Economic Growth and Poverty Reduction Strategy Paper, 2004–2006" Chisinau
17. GoM (2008) "Economic Growth and Poverty Reduction Strategy Paper 2004–2006 final evaluation report".
18. GoM (2007) "National Development Strategy 2008-2011" Chisinau
19. GoM (2007) "Report on Millennium Development Goals: new challenges – new tasks".
20. CBS-AXA Consulting for International Organization of Migration mission in Moldova, European Commission Food Security Programme Office in Moldova and International Monetary Fund Office in Moldova (2005) "Migration and Remittances in Moldova"
21. NBS (2008) "Aspects of the living standard of the population in 2007", Chisinau
22. Council of Europe (14 May 2004) Second report submitted by Moldova, Pursuant to article 25, paragraph 1, of the framework convention for the protection of national minorities
23. NBS (2009) "Moldova in figures"

Annex I. Statistical data.

Table 3. 1. Poverty indicators (rate, gap and severity) in 1998–2007

Indicators and sources	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Absolute Poverty Line, (€ p.a.e. per month)	***21.4***	***16.0***	***20.4***	***22.3***	***21.1***	***19.2***	***21.3***	***22.6***	***45.3***	***50.5***
Poverty rate, %	52.0	73.0	67.8	54.6	40.4	29.0	26.5	29.1	30,2	25,8
Poverty gap, %	19.5	32.3	27.0	19.3	12.4	7.3	6.8	8.0	7.9	5.9
Poverty severity	9.8	17.7	13.7	9.1	5.2	2.7	2.5	3.2	3.0	2.1
Extreme Poverty Line (€ p.a.e. per month)	***16.8***	***12.5***	***16.0***	***17.5***	***16.5***	***14.9***	***16.8***	***17.8***	***24.5***	***27.3***
Extreme Poverty Rate, %	37.4	59.7	52.2	38.0	26.2	15.0	14.7	16.1	4.5	2.8
Relative Poverty Line (€ p.a.e. per month) 50 % of the mean consumption expenditures per adult equivalent	***13.6***	***7.2***	***10.1***	***13.7***	***15.8***	***16.3***	***19.2***	***20.4***	***n/a***	***n/a***
Poverty rate. %	25.8	25.4	22.3	23.7	23.6	19.4	20.3	23.3	*n/a*	*n/a*
Relative Poverty Line (€ p.a.e. per month) 60 % of the median consumption expenditures per adult equivalent	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***35.9***	***42.5***
Poverty rate. %	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	16.9	15.1
International Line (€ per capita/month), €1.7 (***$2.15) PPP per capita/day***	***15.22***	***11.38***	***14.59***	***15.96***	***15.09***	***13.71***	***15.62***	***17.10***	*n/a*	*n/a*
Poverty rate (expenditures p.a.e.). %	31.9	53.2	45.0	32.3	21.0	11.5	11.4	14.4	*n/a*	*n/a*
International Line (€ per capita/month), €3.43 (***$4.30) PPP per capita/day***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***n/a***	***36.63***	***40.78***
Poverty rate (expenditures p.a.e.). %	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	34.5	29.8

Source: Poverty and Policy Impact Reports, 2005, 2006, 2007,2008, MoET

Table 3. 2. Inequality calculated in the national context

Indicators and sources		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Income inequality[1]	90/10	12.52	11.59	10.45	10.85	9.4	8.39	9.1	10.28	7.01	6.11
	80/20	7.79	7.40	6.69	6.93	6.52	5.41	5.69	6.25	4.64	4.20
Gini coefficient[2]		0.399	0.396	0.380	0.388	0.369	0.356	0.361	0.376	0.315	0.298

1\ calculated using average of consumption expenditure per adult equivalent
2\ by consumption expenditure per capita

Table 3.3. Absolute poverty trends by area of residence, %

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
total	52.0	73.0	67.8	54.6	40.4	29.0	26.5	29.1	34.5	25.8
city	25.0	43.1	40.0	30.0	16.5	12.8	6.9	5.9	20.6	14.0
town	58.4	80.5	80.7	73.1	46.8	42.4	34.9	34.2	30.1	23.8
rural	59.1	81.0	73.9	58.2	45.1	31.1	31.2	36.0	34.2	31.3

Source: Poverty and Policy Impact Reports, 2007, 2008, MET

Table 3.4. Absolute poverty gap and severity in rural areas (weighted), 2003-2005, %

	2003	2004	2005
Poverty rate	31.1	31.2	36.0
Poverty gap	7.8	8.3	10.3
Poverty severity	2.8	3.2	4.3

Source: "Rural poverty in the Republic of Moldova 2005",Business Consulting Institute, 2006

Table 3.5. Poverty rate by income source and occupation in rural areas, %

	2003		2004		2005	
Main income source of the household head	**poverty rate**	**structure**	**poverty rate**	**structure**	**poverty rate**	**structure**
Remunerated activity	34.9	20.3	31.6	22.5	29.8	19.1
Individual agricultural activity	29.1	56.3	33.1	52.6	41.5	50.4
Self-employment	17.9	0.8	3.2	0.1	-	-
Social benefits	47.8	19.0	41.6	22.0	43.8	27.1
Other	17.8	3.6	12.8	2.7	23.5	3.4
Socio-economic groups						
Farmers	29.1	31.4	35.3	39.9	44.8	46.4
Agricultural workers	45.4	24.8	37.2	17.6	44.2	16.0
Non-agricultural workers	25.5	13.8	23.8	12.6	21.6	9.3
Self-employed in non-agricultural activities	-	-	-	-	-	-
Pensioners	31.2	29.2	33.2	29.5	35.6	27.7
Other	14.5	0.8	9.5	0.5	16.8	0.6

Source: "Rural poverty in the Republic of Moldova 2005",Business Consulting Institute, 2006

Table 3.6. Structure of consumption expenditures, 2003–2005, %

Consumption expenditures	**2003**		**2004**		**2005**	
	National	**Rural**	**National**	**Rural**	**National**	**Rural**
Total	**100**	**100**	**100**	**100**	**100**	**100**
food products	56.4	62.5	56.9	64.3	55.0	62.0
alcoholic drinks, tobacco	3.4	4.1	3.1	3.8	2.7	3.6
clothes and shoes	8.5	7.7	7.9	7.0	7.7	6.0
public utilities	15.4	13.4	15.2	13.0	17.0	16.1
health care	4.5	4.3	3.8	3.4	3.6	3.6
transport and telecommunications	5.3	3.9	6.2	4.7	7.1	5.3
education	1.1	0.9	1.0	0.8	0.9	0.2
other goods and services	5.4	3.1	5.8	3.1	6.2	3.2

Source: "Rural poverty in the Republic of Moldova 2005",Business Consulting Institute, 2006

Table 3.7. Poverty rates by region, %

	statistical region							
	North		**Centre**		**South**		**Chisinau**	
	2006	2007	2006	2007	2006	2007	2006	2007
EU poverty line	17.7	19.5	19.2	18.3	15.5	16.3	10.7	5.5
Absolute poverty	32.8	30.4	33.7	30.2	34.1	29.5	19.7	11.4
Extreme poverty	4.9	3.1	6.1	3.9	3.5	3.1	2.7	0.6

*Source: **Poverty and Policy Impact Reports, 2007, 2008, MoET***

Table 3.8. Weighted average deprivation index of development regions, 2007

	IDAM	**Income**	**Demographic**	**Economic**	**Health**	**Education**	**Housing**	**Geographic**
North	465	573	479	432	465	431	285	541
Centre	338	332	446	234	533	324	445	435
South	500	420	326	526	495	394	523	384
TAUG	701	478	136	470	641	545	758	452
Mun. Chisinau	486	240	639	23	465	260	672	569

*Source: **Poverty and Policy Impact Reports, 2008, MoET***

Table 3.9. Poverty rate in urban and rural areas, %

	Total		**Urban**		**Rural**	
	2006	**2007**	**2006**	**2007**	**2006**	**2007**
Extreme poverty	4.5	2.8	4.1	1.2	4.7	3.9
Absolute poverty	30.2	25.8	24.8	18.4	34.1	31.3
Subjective poverty	9.2	7.4	24.4	18.6	4.3	5.6

Self-assessment	40.0	-	43.5	-	38.0	-

Source: Poverty and Policy Impact Reports, 2007, 2008, MoET

Table 3.10. People's perception of "poverty" concept

What does "being poor" means, in your opinion?	**Answers**	
	Nr.	**%**
Having low income (wages, pension etc.)	63	21.4
Having no job	50	16.9
Having no food	48	16.3
Being not able to work (elderly, disabled etc.)	40	13.6
Having no clothes / shoes	16	5.4
Having no one to help you	15	5.1
Having some vices	11	3.7
Not having what you need	8	2.7
Not having own land or a place to sell products	7	2.4
Other	37	12.5
Total	**157**	**100.0**

Source: *Sociological study "Voices of the Poor 2005" CBS AXA, GALLUP International, 2006.*

Table 3.11. Categories of vulnerable persons in people's opinion

Who can we generally refer to as poor?	**Answers**	
	Nr.	**%**
The elderly, the lonely, pensioners	68	23.7
The disabled	59	20.6
The unemployed	39	13.6
Families with many children, with one parent	35	12.2
Persons with negative qualities, such as lazy people, alcoholics, drug addicts etc.	32	11.1
Public sector employees (those employed by the state)	12	4.2
Young people, students	9	3.1
Peasants, those without land	7	2.4
Other	26	9.1
Total	**287**	**100.0**

Source: Sociological study "Voices of the Poor 2005", ***CBS AXA, GALLUP International, 2006.***

Table 3.12. Poverty rate and structure by main household characteristics, 2007, %

	Absolute poverty line		**EU poverty line**		**Total population**
	Structure	**Poverty rate**	**Structure**	**Poverty rate**	**Structure**
Residence					
Urban	30.0	18.4	27.0	9.8	42.2
Rural	70.0	31.3	73.0	19.4	57.8
Total	100.0	25.8	100.0	15.4	100.0
Household type					
One-member household	8.1	25.8	14.6	27.8	8.1
Couple without children	14.1	26.1	16.6	18.3	14.0
Couple with children under 18	19.9	22.1	15.1	10.0	23.2
Lone parent with children under 18	3.1	21.9	2.2	9.3	3.7
Other households with children	38.9	31.6	33.7	16.3	31.8
Other households without children	15.9	21.3	17.7	14.2	19.2
Total	100.0	25.8	100.0	15.4	100.0
Household composition					
Households with 1 child under 18	24.1	22.9	20.7	11.7	27.2

Households with 2 children under 18	22.6	26.1	17.9	12.3	22.3
Households with 3 children under 18	10.3	39.4	8.2	18.6	6.7
Households with 4 or more children under 18	5.0	53.2	4.3	27.3	2.4
Households without children under 18	38.1	23.8	49.0	18.2	41.3
Total	100.0	25.8	100.0	15.4	100.0
Socio-economic group					
Farmers	26.1	35.0	27.8	22.2	19.2
Agricultural workers	11.3	39.9	12.3	25.9	7.3
Non-agricultural workers	23.5	16.2	17.6	7.2	37.3
Self-employed in non-agricultural activities	-	-	.	.	.6
Pensioners	32.6	33.5	36.4	22.3	25.1
Others	6.6	16.4	5.9	8.7	10.4
Total	100.0	25.8	100.0	15.4	100.0
Main source of income of the household head					
Remunerated activity	34.8	20.1	29.9	10.3	44.6
Individual agricultural activity	26.1	35.0	27.8	22.2	19.2
Individual non-agricultural activity	4.2	18.3	4.0	10.4	5.9
Social benefits	33.3	33.6	37.5	22.5	25.6
Remittances	1.4	9.2	.5	1.8	4.0
Other sources	.2	9.7	.4	9.7	.6
Total	100.0	25.8	100.0	15.4	100.0
Number of workers					
Households with 1 person					
Without workers	6.1	29.6	10.9	31.4	5.3
1 worker	2.0	18.5	3.8	20.8	2.8
Households with 2 or more persons					
Without workers	13.4	27.0	13.8	16.6	12.8
1 worker	23.2	23.3	21.7	13.0	25.7
2 workers	35.6	23.5	31.9	12.5	39.1
3 or more workers	19.8	35.8	18.0	19.4	14.3
Total	100.0	25.8	100.0	15.4	100.0
Educational level of the household head					
Higher education	5.1	8.7	4.7	4.7	15.3
Secondary general and vocational education	54.4	23.6	48.2	12.4	59.5
Incomplete secondary and primary education	37.1	40.7	42.7	27.8	23.5
No primary education	3.3	51.0	4.4	40.6	1.7
Total	100.0	25.8	100.0	15.4	100.0
Age of the household head					
under 25 years	1.4	13.7	1.4	8.2	2.6
25-34 years	9.4	19.6	7.8	9.6	12.4
35-44 years	19.7	24.3	16.6	12.2	20.9
45-54 years	26.7	24.6	25.8	14.1	28.1
55-64 years	16.7	25.4	17.0	15.4	17.0
65 years and over	26.1	35.5	31.4	25.5	19.0
Total	100.0	25.8	100.0	15.4	100.0
Sex of the household head					
Male	66.1	25.9	63.8	14.9	66.0
Female	33.9	25.7	36.2	16.4	34.0
Total	100.0	25.8	100.0	15.4	100.0

Source: ***Poverty and Policy Impact Reports, 2008, MoET***
HBS, ***NBS***

Table 3.13. Absolute poverty rate by age and area of residence, 2007, %

	Absolute poverty line			**EU poverty line**		
	Total	**Urban**	**Rural**	**Total**	**Urban**	**Rural**
Population, total	25.8	18.4	31.3	15.4	9.8	19.4
including:						
Children	27.4	18.2	33.2	13.5	7.7	17.1
Under 5	28.3	18.2	35.4	14.6	8.6	18.9

5 – 9	27.0	13.7	34.4	11.7	5.3	15.3
10 – 14	29.2	21.7	33.4	13.3	7.4	16.5
15 – 18	25.1	18.2	30.2	14.2	9.0	18.0
Economically active						
Total	22.8	15.4	29.1	13.1	7.8	17.6
19 – 29	21.3	12.8	30.2	11.2	6.1	16.5
30 – 39	24.0	14.9	31.6	12.7	7.3	17.3
40 – 49	24.1	17.4	29.4	13.9	8.2	18.4
50 – 59	22.3	17.2	26.0	14.8	9.9	18.2
Men	23.6	15.1	30.3	13.9	8.1	18.5
19 – 29	21.6	12.3	30.9	11.6	6.8	16.5
30 – 39	25.2	14.5	33.9	14.5	7.5	20.2
40 – 49	24.9	16.8	30.6	15.1	8.4	19.8
50 – 59	23.4	17.9	26.9	14.9	10.1	18.0
Women	22.2	15.6	28.0	12.5	7.5	16.8
19 – 29	21.0	13.2	29.5	10.8	5.6	16.5
30 – 39	22.9	15.3	29.7	11.2	7.2	14.7
40 – 49	23.6	17.8	28.4	12.9	8.0	17.1
50 – 59	21.6	16.6	25.3	14.6	9.8	18.3
Elderly						
Total	33.1	30.6	34.5	25.4	21.4	27.6
60 – 69	27.3	24.7	28.8	19.2	17.4	20.4
70 – 75	39.1	43.0	37.1	30.6	30.8	30.5
Over 75	37.9	30.2	41.9	31.5	20.1	37.5
Men	31.9	31.9	31.9	22.4	20.4	23.6
60 – 69	27.8	26.9	28.3	18.7	18.1	19.1
70 – 75	35.1	43.1	31.3	24.9	26.7	24.0
Over 75	37.3	31.9	40.5	27.9	19.2	33.1
Women	34.0	29.7	36.3	27.4	22.1	30.3
60 – 69	26.9	23.1	29.2	19.6	16.8	21.3
70 – 75	41.8	43.0	41.2	34.5	33.4	35.2
Over 75	38.3	29.2	42.7	33.6	20.7	39.9

Source: ***Poverty and Policy Impact Reports, 2008, MoET***
HBS, NBS

Table 3.14. Poverty rate for disabled persons by area of residence, 2007, %

	Total		**Urban**		**Rural**	
	yes	**no**	**yes**	**no**	**yes**	**no**
Absolute poverty	27.7	25.7	21.2	18.2	32.3	31.2
EU poverty line	18.4	15.2	13.4	9.6	21.9	19.3

*/ individuals reported disability degree on HBS
Source: HBS , NBS

Table 3.15. Impact of income from remittances, %

	Poverty rate absolute					
	2006			**2007**		
	Before	**After**	**Difference**	**Before**	**After**	**Difference**
Total	38.2	30.2	8.0	37.1	25.8	11.3
Area of residence						
- urban	31.6	24.8	6.8	26.4	18.4	8.0
- rural	42.8	34.1	8.7	44.9	31.3	13.6
Statistical region						
- North	42.8	32.8	10.0	44.8	30.4	14.4
- Centre	40.2	33.7	6.5	41.3	30.2	11.1
- South	45.7	34.1	11.6	43.8	29.5	14.3
- Chisinau municipality	24.3	19.7	4.6	16.2	11.4	4.8

Source: Poverty and Policy Impact Reports, 2007, 2008, MoET

Table 3.16. Access of population to public services, absolute poverty

	2006		2007	
	Poor	**Non-poor**	**Poor**	**Non-poor**
Family medical office				
- average distance (km)	1.35	1.32	1.27	1.28
- number of de visits (per month)	0.21	0.29	.17	.24
Sectorial policlinic				
- average distance (km)	11.83	9.70	12.62	9.53
- number of de visits (per month)	0.18	0.52	.20	.49
Hospital				
- average distance (km)	14.77	12.84	16.28	12.82
- number of de visits (per month)	0.23	0.31	.21	.34

Source: Poverty and Policy Impact Reports, 2007, 2008, MoET

Table 3.17. Impact of social benefits to absolute poverty

		Poverty incidence, %		Difference	%
		Before	**After**		
	Total social protection	40.4	30.2	10.2	25.2
2006	Social insurance	39.6	30.2	9.4	23.7
	Social assistance	30.9	30.2	0.7	2.3
	Total social protection	38.4	25.8	12.6	32.8
2007	Social insurance	37.7	25.8	11.9	31.6
	Social assistance	26.8	25.8	1.0	3.7

Source: Poverty and Policy Impact Reports, 2007, 2008, MoET

Table 3.18. Social inclusion indicators based on HBS data
Primary indicators

		EU poverty line[149]	
Indicator		**2006**	**2007**
Poverty line, €		43.3	51.5
At-risk-of poverty rate, %		16.1	15.4
***Dispersion*, %**			
50% of median		9.2	8.0
70% of median		24.4	24.3
By age group, %:			
0-17		15.0	13.2
18-64	Total	14.1	13.5
	Male	14.4	14.3
	Female	13.8	13.1
65+	Total	27.5	27.3
	Male	24.6	23.6
	Female	29.4	29.8
One-person household, %		27.2	27.8
Two adults with two children, %		14.4	9.6
Poverty gap index[150]		**3.8**	**3.2**
By age group:			
0-17		3.7	2.8
18-64	Total	3.3	2.8
	Male	3.4	3.0
	Female	3.2	2.7
65+	Total	6.2	5.7
	Male	5.2	4.6
	Female	6.9	6.4

149 Calculated as 60% of median of equivalised consumption expenditure, OECD modified scale 1, 0.5, 0.3

150 Calculated as (sum for poor (poverty line–expenditure per equivalent)/poverty line)/ total population

Population living in jobless households			
By age group, %:	Total	25.5	20.9
0-17		14.7	8.0
18-64	Total	22.4	14.8
	Male	26.0	17.2
	Female	20.7	13.7
65+	Total	30.2	28.6
	Male	27.7	24.6
	Female	31.8	31.1
Inequality			
Gini		0.301	0.285
Distribution 80/20		4.55	4.14
Proposed additional indicators, poverty rate			
***Residential area*, %**			
	City	12.5	7.1
	Town	15.7	13.2
	rural	17.6	19.4
***Socio-economic status of household head*, %**			
	Farmers	18.3	22.2
	Agricultural workers	22.4	25.9
	pensioners	26.0	22.3
***Main source of income of household head*, %**			
	Social protection	26.1	22.5
	Self-employment in agricultural sector	18.3	22.2
***Labour force*, %**			
	One person household, not worked	31.7	31.4
	One person household, worked	18.0	20.8
	Household with 2 or more persons, not worked	22.7	16.6
***Education of household head*, %**			
	Without primary	34.2	40.6
	Primary	26.9	27.8

***Source**: HBS, BNS*

Material deprivation indicators (% pers.)

		EU poverty line			
		2006		2007	
		poor	non-poor	poor	non-poor
Colour TV-set	**0 no**	42.9	13.5	34.0	8.8
	1 yes	57.1	86.5	66.0	91.2
Total		100	100	100	100
Computer	**0 no**	99.1	88.2	99.4	87.1
	1 yes	0.9	11.8	0.6	12.9
Total		100	100	100	100
Hand-operated or automated washing machine	**0 no**	66.8	33.6	67.2	32.9
	1 yes	33.2	66.4	32.8	67.1
Total		100	100	100	100
Vacuum cleaner	**0 no**	85.3	50.2	86.2	50.0
	1 yes	14.7	49.8	13.8	50.0
Total		100	100	100	100

Source: HBS, NBS

Housing indicators, (%, pers.)

		EU poverty line			
		2006		2007	
		poor	non-poor	poor	non-poor
Water supply	1 Running water	27.5	46.0	19.6	47.9

	2 Water spring	7.7	5.6	8.5	8.1
	3 Water well	63.5	46.2	69.0	41.8
	4 Other	1.3	2.2	2.9	2.2
Total		100	100	100	100
Sewerage system	1 Public	23.5	31.9	14.8	33.5
	2 Private	4.8	14.6	6.2	15.4
	3 No	71.6	53.4	79.0	51.1
Total		100	100	100	100
Bathroom+WC/WC	1 Indoor	23.1	33.4	14.9	35.7
	2 Outdoor	76.9	66.6	85.1	64.3
Total		100	100	100	100
Hot water	1.00 Public	9.5	12.9	3.4	10.9
	2.00 Private	5.7	21.6	6.0	24.7
	3.00 No	84.8	65.5	90.6	64.4
Total		100	100	100	100
Gas supply	1 Central	33.1	48.5	26.5	51.2
	2 Gas bottle	49.9	47.3	56.4	45.7
	3 No	17.0	4.2	17.1	3.1
Total		100	100	100	100
Heating	1.00 Public	15.0	19.3	9.7	20.0
	2.00 Private	7.3	18.3	5.8	17.7
	3.00 Stove, electric heater	77.2	62.2	83.8	62.2
	4.00 No	0.5	0.1	0.7	0.1
Total		100	100	100	100
Bathroom or shower	1 Yes	23.1	41.0	17.1	43.6
	2 No	76.9	59.0	82.9	56.4
Total		100	100	100	100
Telephone	1 Yes	50.1	83.4	54.9	88.4
	2 No	49.9	16.6	45.1	11.6
Total		100	100	100	100

Source: HBS, NBS

Annex II. Methodological issues.

Poverty monitoring and evaluation in *Moldova* is based on a system of indicators and detailed information which characterizes the quantitative and qualitative aspects of this concept.

The main data source for poverty analysis is the HBS, implemented annually by the NBS since 1997. The survey does not cover Transnistrian rayons.

Poverty in Moldova is measured using a 'basic needs' approach and uses household consumption expenditure as a welfare indicator, comprising expenditures for food consumption (including imputed market value of items taken from household production), non-food items and payment for services. Nominal consumption expenditures were adjusted for inflation as well as for regional price differences through a Paasche price index, estimated using data collected in the survey as well as information on the Consumer Price Index. To ensure the comparability of households of various sizes and compositions, the *OECD* equivalence scale is used (1.0; 0.7; 0.5).

Starting in 2006, the NBS made substantial changes to the HBS. These changes consisted of a new sampling framework, improvements to the data collection toolkit, (questionnaires) and creation of a unified data collection network for social surveys. A substantial increase in the number of primary sampling units, from which households are selected for HBS, ensures a much better coverage of localities in Moldova. The sample contains 9768 households distributed equally (by 814 households) over 12 months, using a monthly rotation system. Provision was made for data representativeness across various levels: *urban-rural*, *city-town-rural*, and *South-Centre-North-Chisinau municipality*. Changes made to the HBS in 2006 contributed to the improvement of data quality and to the alignment of poverty measuring methodology with international standards. However, the negative aspect of these changes is the non-comparability of 2006 data with previous years.

Householder opinion about poverty. Equally important when analysing poverty is assessment of the situation as perceived by the population itself. Listening to the voices of the poor about the main causes of poverty in their opinion, from their experience of the concept of "being poor", provides important information on people's expectations. Qualitative data was obtained from the selective survey "*Household opinion about the poverty phenomenon*", conducted annually in August by the NBS from 2001 to 2006, with the support of UNDP (within the HBS network based on the monthly survey sample). In 2006, the sample included 470 households. A module on subjective poverty has been added to HBS which started in 2006.

Poverty measures. In order to streamline poverty reduction policies in the country, instruments for measuring this phenomenon were established by applying different poverty lines[151] at the national level: *the extreme poverty line*, based on the monetary value of food items only, defined in terms of the minimum daily calorific intake, and *the absolute poverty line*, estimated on the basis of total consumption expenditures. To ensure comparability at the international level the following are used: *poverty line* defined by the MDGs as €2.15 per capita per day (for 1998–2005), and €4.3 per capita per day, adjusted for purchasing power parity (2006–2007), relative poverty lines at 50% of the average of consumption expenditure per adult equivalent (1998–2005), and 60% of the median consumption expenditure per adult equivalent (2006–2007). In addition, *subjective and participatory methods of poverty assessment* are used, based on self-perception of welfare, which play a key role in understanding the poverty situation, and *the subjective poverty line*, estimated using self-assessments of material well-being according to the Leiden method[152], using HBS data and the *self-assessment method*.

---

[151] Decision of the Government of the Republic of Moldova no. 619 of 16 May 2002 on approving the Action Plan on strengthening the capacity of monitoring and evaluation of poverty in the period 1 June 2002–31 May 2005.

[152] Van Praag, B.M.S., and Frijters, P., 1999. The measurement of welfare and well-being; The Leyden approach. In: Kahneman, D., Diener, E., and Schwarz (eds.). *Well-being: The Foundations of Hedonic Psychology*. Russell Sage Foundation, New York.

Another aspect of poverty is "*community poverty*", reflecting a low level of access to infrastructure, public utilities and housing amenities, as well as poor access to education and health services. In this context, the MET developed the SADI. In order to evaluate non-monetary poverty and to calculate the SADI, a combination of data from various sources is needed. To this end, a special form is used, namely "Socio-economic indicators describing the living conditions of people from local communities (commune, town)". The forms are filled in and submitted by rural communities (mayoralties). Other data provided by the finance divisions of local public authorities includes: local budget expenditures and revenues, the number of social benefit recipients by type of benefit (the National Social Insurance Office), the total area of land plots and soil quality (the National Agency for Geodesy, Mapping and Cadastre), and the Codebook of Administrative-Territorial Units of Moldova (the NBS). The aggregated database is managed by the MET.

Annex III. Overview of research on poverty and social inclusion in the country

The first poverty studies in Moldova were carried out in 1998, after the launching of HBS in 1997. Surveys were conducted by the MET jointly with the Department of Statistics and Sociology, with the support of the WB and UNDP. Poverty and inequality were assessed using HBS data and the poverty line estimated in lei as 50% of average consumption expenditures. Both household consumption expenditures and their disposable income were analysed as welfare indicators.

The studies were resumed in 2000, under the National Poverty Alleviation Programme, financed by UNDP Moldova through the establishment of the Poverty and Policy Monitoring Unit (PPMU) at the MET. The PPMU developed a number of analytical reports on poverty trends in Moldova throughout 1998–2002 (JPPM/MET, 2004). These activities included the analysis of poverty and people's access to goods and services, based on HBS data, and periodical research and additional surveys on poverty. Analytical reports developed by PPMU included various assessments of the relative and absolute poverty lines, evaluation of persistent and transient poverty based on the HBS panel of households, the review of poverty profile, and impact of implemented policies on living standards. During 1997–2001, on the basis of HBS, different poverty lines, both absolute (based on normative methods) and relative, were used and the first studies to measure poverty and its profile were undertaken. Since 2002, poverty has been assessed in Moldova by applying the absolute method for its measurement, using both normative and estimative approaches.

In 2005, poverty analysis efforts were continued under the Joint Programme for Policy Monitoring (JPPM) through "Support to Strategic Policy Formulation, Monitoring and Evaluation in the Republic of Moldova", a project funded by UNDP, UNICEF, and SDC. Under the JPPM project, the methodology for calculation of poverty lines and Moldova's MDG indicators was revised, and a number of annual analytical reports on poverty were developed.

Analytical information and reports on living standards were developed by various non-governmental institutions and organizations[153]. Periodic reports on poverty trends in Moldova are produced by the Human Development Sector Unit, Ukraine, Belarus and Moldova Country Unit, Europe and Central Asia Region, WB[154].

153 www.expert-grup.org, http://www.cbs-axa.org

154 http://siteresources.worldbank.org/INTMOLDOVA/Resources/MDPovertyUpdateEng.pdf

CHAPTER IV. PENSION SYSTEM

4.1. Introduction and objectives

The issue of pension provision has always been a sensitive one for the population. The quality of pensioners' lives depends significantly on the way in which the authorities address this issue, taking into account the social, economic and demographic factors that influence the pension system.

The Moldovan pension system has undergone numerous adjustments and systemic changes over the last two decades**.** Reform of the pension system started in 1998, with enactment of the Law on State Social Insurance Pensions.[155] The reform law, aiming to increase compliance and improve system transparency and equity, pushed up the retirement age, changed the benefit formula, and mandated that pension benefits should be determined in proportion to paid contributions rather than declared wages.

According to the adopted rules of pension insurance, Moldova preserved a one-level distributive pension system. Reform of the public pension system aimed at creating an equitable redistribution and improving the balance between paid contributions and received amounts, leading to an increase in the general level of individual payments through this harmonization process. A further aim was to improve long-term system sustainability. The reform process recommended substantial changes in order to generate a pension system offering more long-term equity and viability, including the development of a distribution system and creation of non-governmental pension funds through capitalization (voluntary contributions).

Despite these intentions, reform of the system, initiated in 1998, cannot be qualified as either radical or consistent. This is because political realities generated certain deviations from the initial pension reform strategy, reflected in a series of amendments, introduced by the Parliament in the main pension law of 1998 (such as a temporary halt to the retirement age and re-establishment of a series of advantages upon retirement that had previously been cancelled). The resulting pension system of Moldova is a quite complex hybrid, including a series of elements from the old pension system and elements of the new insurance system. As such, the prevailing pension system represents a product typical of a transition economy, requiring continuous improvement and ongoing adjustment to the changing economic realities.

Therefore, the result is, perhaps inevitably, a very complex and poorly understood system that is far from transparent, making it inherently difficult to explain to new generations of workers and retirees exactly how "their" system works.

What is known is that persons retiring today (new pensioners) are in a worse situation than those who retired a year earlier. This is because a number of factors continue to compromise the pension system in the country: a) while fiscal sustainability has improved, the pension system is not fully prepared for the inevitability of population aging and mass migration; b) although the linkage between contributions and benefits has been strengthened, and the pension system is better suited to market conditions, the provision of preferential pensions and a large redistribution to farmers create discrepancies; c) the level of income replacement is generally inadequate for common categories of pensioners and represents less than one third of the current average net salary, while the minimum pension stands at an exceptionally high 70% of the average pension, reflecting efforts to protect the living standards of low-income individuals (including those with intermittent formal sector employment or low lifetime wages); d) pension equity is compromised as different categories of retirees are treated unequally with regard to their retirement—the pension system requires all members of the same category to contribute equally (from salary or flat-rate fees), while at the same

[155] Law no.156-XIV, adopted on October 14, 1998.

time applies different retirement formulas (inequities that have been maintained over the past 10 years).

In order to update the system, the Government recently assessed opportunities to implement a broader set of pension reform options, and study the possible effects of the introduction of a second fully-funded pension pillar. However, a mandatory-funded pillar requires a sustainable first pillar, functioning capital markets and framework, and adequate administrative capacity. It also requires a sound and stable macroeconomic base, diametrically opposed to the one resulting from the current rumbling global recession. All these conditions have still not been met in Moldova.

The reform of the pension system has the following key objectives:

- Provision of adequate material support when reaching old age, or in case of loss of either work capacity or the breadwinner, which means that the majority of citizens, upon appearance of the insured risk, will have an adequate income through the combination of the state pension and the private pension. Only an insignificant number of citizens, from underprivileged population groups, will be insured through social support programmes;
- Observance of the social equity principle, which means that the majority of citizens will receive pensions according to their contribution to the pension system, which should be transparent and accessible to everyone;
- Provision of a balanced financial system and observance of financial order, to ensure that all the payments from the pension system are made on time;
- Establishment of a pension system suitable for all generations.

4.2. Historical perspective

The historical development of the pension system in Moldova can be conventionally divided into two time periods—before 1 January 1991, and between 1 January 1991 and 1 January 1999.

A) Before 1 January 1991: the period before adoption of the national pensions law
The Moldovan pension system was created in 1921, and afterwards was subjected to essential modifications, according to USSR laws on: state pensions (14 July 1956), and pensions and benefits for members of collective farms (15 July 1964).

At the same time, according to a series of normative acts, there were pensions for judges and prosecutors, for persons with special merits from the state (personal pensions), for scientists, re-employed servicemen, and employees of the Ministry of the Interior and of the State Security Committee.

These legislative acts were consolidating the elements of social insurances in general (insured health care, provision of pensions and industrial accident insurance) into a unique system, supported by the state budget.

B) 1 January 1991 to 1 January 1999: the period preceding reform of the pension system
The first national law of the Republic of Moldova—the Law on State Pensions—was adopted by Parliament on 27 December 1990[156]. Pension amounts depended on the average monthly salary and work history, and in some cases bonuses were provided to persons supporting and looking after those who were unable to work.

The basic quantum of the pension made up 55% of the average monthly income, calculated using the average monthly salary received over the last five consecutive years of the last 15 years worked

[156] Law on State Pensions in the Republic of Moldova no.437 of 27.12.1990

before retirement, plus 1% of this income for each year worked after reaching 25 years of work history for men and 20 years of work history for women. War disabled or war participants, blood donors and other recipient categories received supplements and bonuses in addition to the old-age or disability pension.

Those who were not eligible for work pensions could receive social allocations (social pensions). Of note, is that, according to the norms of this period, work history included periods not necessarily relevant to paid employment, such as years of study in higher education institutions and periods of time spent caring for persons such as those unable to work. Some work periods were doubled or tripled.

Retirement age was established at 60 years for men and 55 years for women for some categories of the population (such as those involved in hard or dangerous work, mothers with many children, and war disabled) the retirement age was between 45 and 59 years.

In 1998, the last year for which the law on state social pensions in Moldova was applied, the minimum amount of the old-age pension was €13.6, the average €14.4, and the maximum pension could not exceed €27.2 (without supplements and increases for dependants). Due to the provision of differential compensations and benefits, the average pension amounted to only 30% of the total amount of social benefits received by the pensioner**.** Evolution of pension amounts and number of pensioners in the period 1992–1997 are shown in Table 4.1.

Table 4.1. ***Number of beneficiaries and size of the average pension by pension categories, 1992–1997***

	Number of beneficiaries, thousands					**Pension size, €**				
	1993	**1994**	**1995**	**1996**	**1997**	**1993**	**1994**	**1995**	**1996**	**1997**
old-age pension	562.3	563.9	562.9	562.7	560.4	11.74	12.00	11.37	13.96	16.44
disability pension	94.9	97.6	102.3	105.6	109.2	10.85	11.17	10.75	13.40	15.60
survivor pension	37.5	36.4	36.2	36.4	36.3	7.23	8.37	8.78	11.29	12.50
social pension	40.3	38.8	38.0	38.3	38.4					
minimal pension	222.2	34.7	30.4	28.8	25.9	0.08	8.86	8.49	10.61	11.83
maximal pension						40.25	26.20	22.72	28.10	31.33

Source: Strategy for pension system reform

4.3. Existing pension system

The Law on State Social Insurance Pensions of the Republic of Moldova provides for the full payment of the following types of pensions from social insurance funds[157]: old age, disability, and survivor pensions. According to the current pension law, all insured persons with a domicile in Moldova have the right to a pension, including those working in agriculture.

4.3.1. Types of pensions and assignment criteria

1. Old-age pensions

The mandatory conditions for receiving the full pension at old age are reaching *retirement age*—set by legislation—and the full completion of the necessary *contribution period*.

[157] In order to enhance the efficiency of both payments and contribution collection, the NSIH was created in 2001. It was set up as a national autonomous public institution, administrating and managing the public system of social insurance, and responsible for recording and regulating contributions, as well as the payment of benefits. A separate task of the NSIH is the creation and implementation of the information system of the Individual Data Register.

Retirement age. Following Moldova's adoption of the Law on State Social Insurance Pensions in 1998, the retirement age for both men and women began to rise the following year.[158] The mandatory contribution period was raised accordingly. The retirement age is 62 years for men and 57 years for women and the only exceptions to this common rule are the following categories :

- Mothers of five or more children are entitled to the old-age pension at an earlier age, which has also gradually risen to 54 years;
- Persons involved in very harmful and very difficult work (included on the list of these production units, works, professions, functions and indicators) are entitled to the old-age pension under special conditions, and whose pension age rose from 50 years for men and 45 for women to 54 and 49 years respectively. To receive the pension under these conditions, beneficiaries have to prove, additionally, special experience acquired in a full-time work program involving very harmful and very difficult work over a 10-year period for men and seven years and a half years for women.

Suspension of increases in the retirement age has lead to a significant rise in the number of newly assigned old-age pensions. According to NSIH records, the number of new pension recipients in 2003—the first year after halting increases in the retirement age—was 2.5 times higher than the previous year. In following years, the number of new old-age pensions continued to rise, although to a much lesser degree. Notably, the considerable growth of newly assigned pensions is connected not only to the halt in growth of the retirement age, but also to the "cohort" effect, where a large cohort of the population reached retirement age.

Contribution history. According to common rule, a person's contribution history includes all the activity periods during which social contributions were transferred into the pension fund. Contribution history also includes non-contribution periods, during which a person did not make any social contributions. According to the legislation, these periods refer to the most typical scenarios for women, (e.g. periods of time looking after children up to three years of age, persons with a Grade 1 disability, disabled children up to 16 years of age, and persons above 75), as well as the most common ones for men (e.g. mandatory military service). As both men and women are taken into consideration in relation to these periods of time, to some extent, gender equality is supported.

For persons who carried out activities in other countries and were subject to social insurance in these states, the period of work conducted abroad is included in their contribution history, if this is provided for in the agreement signed between Moldova and these states or by international conventions. Work carried out in the former USSR before 1 January 1992 equates to work carried out in Moldova, with payment of pensions from the social insurance budget.

Duration of the necessary contribution period. The condition for receipt of a partial old-age pension is a minimum contribution period of 15 years. This period is 30 years for a full pension.[159]It is important to note that legislation provides for conditions that encourage workers to reach a contribution history of 30 years or more. Thus, for each contribution year surpassing 30 years, a pension rises by 2% of the insured income, while for each contribution year from 25 to 30 years it

[158] Starting 1 January 1999, the retirement age rose by 6 months annually. Therefore, based on the previous retirement age of 60 years for men, and 55 for women, by the year 2008 retirement age should have reached 65 years for men and 60 years for women. However, following the introduction of modifications to the Law on State Social Insurance Pensions, the pension age was "frozen" at the 2002 level, and is now 62 years for men and 57 for women.

[204] According to legislative regulations, starting January 1, 1999, the contribution history required to award the old age pension was 26 years for men and 22 years for women. Every year, the insured period was raised by one year for men and two years for women, and starting from January 1, 2004, raised by 1 year for both men and women, until the age of 35 years is reached. However, increase in the necessary contribution history was suspended, as well as the rise in retirement age. Starting in 2003, the contribution period was established as equal for men and women at 30 years.

rises only 1.4%. Moldovan pension legislation also encourages citizens to exercise the right to a pension at an even later stage in life. In this case, the size of pensions increases to 2% of insured income for each insured year worked after reaching retirement age.

2. Disability pensions.

Disability pensions are awarded to insured persons in the case of total or partial loss of work capacity[160] caused by: common disease, industrial accident, or professional disease. In order to receive a disability pension for a common disease when the disability is established, insured persons (both men and women) need to have made contributions for one to five years depending on age: one year for those aged up to 23 years, 2 years for those 23 to 26, three years for those 26 to 31 years, and five years for those aged over 31 years.The disability pension for an *industrial accident or a professional disease* is granted *regardless* of the achievement of the contribution history.

3. Survivor pension

The right to a survivor pension is granted if the deceased was retired or was otherwise eligible for a pension. The survivor pension can be granted to children under 18 years, or older, if they are in full-time education in higher or secondary education institutions, up to graduation, but not more than 23 years; to the spouse who was married to the deceased for at least 15 years and did not remarry, if upon the death or not later than five years after the death, the deceased reached retirement age, or received a first or second degree disability; to the spouse or the guardian or tutor, who takes care of the children of the deceased bread-winner, only if these do not have incomes susceptible to state social insurances. Children are granted full pensions in all of these cases.[161]

4. Pensions of some categories of citizens

The pension system reform strategy provides for the unification of retirement norms for all categories of beneficiaries of the same type of pension. For this purpose, some modifications to the basic law were adopted in 2003, which supplemented the Law on State Social Insurance Pensions with a separate chapter[162], regulating the conditions for establishing pensions for certain categories of citizens, such as members of Parliament, members of government, civil servants, and elected representatives. The basic condition for establishing eligibility for the pension among these categories of beneficiaries is reaching the established *retirement age*, as well as completion of *total and special work history*.

Accordingly, MPs and members of government should be in their respective positions for at least two years (having reached retirement age and achieved the necessary contribution history), in order to have the right to a pension calculated at an amount of 75% of the average insured monthly income of an actively working MP or member of government.

Civil servants must confirm at least 15 years of the total contribution history in the public service in order to obtain the pension calculated at an amount of 75% of the average insured monthly income, and elected representatives not less than eight years. Public servants also have the option for an early pension, which depending on the circumstances can be granted either two or five years before

[205] According to the legislation, a disabled person is a person who, due to the limitation of vital activity as a result of physical or mental deficiencies, requires help and social protection. Limitation of vital activity is defined as complete or partial loss of capacity or possibility to help himself/herself, move, orient, communicate, control his/her behavior, and work. Disability is established if the degree of limitation exceeds 25%. Moderate, pronounced and strongly pronounced limitation are classified as grade III, II, and I disabilities, respectively.

[161] Depending on the category, the survivor pension can be calculated at the amount of 50%–75%–100% of the pension or potential pension of the breadwinner.

[162] This measure simply incorporated the provisions from separate acts into a single law.

reaching the legal retirement age. A total of 50% of the pensions granted to these categories of citizens are covered by the state social insurance budget, and 50% from the state budget.

5. Pensions paid from the state budget

Apart from state social insurance pensions, eligible Moldovan citizens can also be granted pensions *from the state budget including* serving members of the armed forces and their families, and participants in the Chernobyl aftermath. The Moldovan pension system does not accommodate the simultaneous receipt of different types of pensions. A person entitled to different types of pensions can choose to receive only one type.

4.3.2. The minimum pension

The minimum pension represents the amount awarded to entitled persons in those cases where the amount of the integral pension does not reach this level. The minimum pension level is set for several categories of beneficiaries (Table 4.2.), and is established irrespective of the minimum subsistence level or other social indicators. However, the minimum pension stands at an exceptionally high 70% of the average pension, reflecting the Government's efforts to protect the living standards of low-income individuals. Since 2004, the minimum pension has been indexed at a rate equal to the standard indexation rate**.** The minimum amount of the survivor pension is determined as a percentage of the minimum quantum of the old-age pension.

Table 4.2. ***Minimum pension size, €***

	2003	2004	2005	2006	2007	2008
Adjusted minimum pension, as of 1 April						
old age (farmers)		11.42	16.49	18.16	21.78	27.66
old age (non farmers)		12.85	18.52	20.40	24.46	31.07
disability I			13.18	14.51	17.40	22.10
disability II			12.73	14.01	16.81	21.34
disability III			8.96	9.87	11.83	15.03

Source: Government decisions on pension indexations

4.3.3. Indexation of pensions

Legislation provides for the annual indexation of state social insurance pensions and, every year from 2004, indexation is made systematically on April 1. The indexation coefficient is the average of the annual rise in the consumer price index and the annual rise in the average salary for the economy in the previous year (Table 4.3).

Table 4.3. ***Indexation coefficients***

	2003	2004	2005	2006	2007	2008
Salary increase, %	33.3	28.9	23.9	19.5	28.7	21.7
CPI, %	5.2	15.7	12.4	11.9	12.7	12.3
Indexation coefficient, %	**19.3**	**22.3**	**18.2**	**15.7**	**20.7**	**17**

Source: own calculations based on NBS data

4.3.4. Insurance contributions and taxable base

The pension system is financed by the social insurance contributions paid by employers, employees and the self-employed. Contribution rates and the taxable base differ across sectors. In the previous

year, the social insurance contribution rate for employed persons was 29% and for those employed in the agricultural sector it was 24% (raised to 28% in 2009). The share of pension insurance in overall contribution is approximately 86%. The self-employed and farmers pay their contributions in fixed amounts, which are determined annually.

The taxable base is different for employees and employers. Employers pay according to the amount required by the remuneration fund, the size of which is not bounded, while the highest annual individual contribution base amounts to 60 average salaries of the economy. All contributions are collected by tax administration. Contribution rates are annually adopted by the Parliament under the *Law on State Social Insurance Budget*. Gross rates of social insurance contributions for 2007–2009 are shown in Table 4.4.

Table 4.4. ***Social insurance contributions***

Category	contribution rate		
	2007	2008	2009
Individual/Employee contribution	4% of salary	5% of salary	6% of salary
Employer	25% of the salary fund	24% of the salary fund	23% of the salary fund
Employer in agricultural sector, including	20% of the salary fund	20% of the salary fund	22% of the salary fund
- from the employer	16% of the salary fund	16% of the salary fund	16% of the salary fund
- from the state budget	4% of the salary fund	4% of the salary fund	6% of the salary fund
Self-employed persons working abroad (except pensioners, disabled)	€139.6 on annual basis for individual insurance	€190.9 on annual basis for individual insurance	€243.9[163] on annual basis for individual insurance
Self-employed in agriculture (except pensioners, disabled)	€34.7 on annual basis for individual insurance	€47.4 on annual basis for individual insurance	Not compulsory. For voluntary insurance the tax is €60.5.

Source: Laws on State Social Insurance Budget, 2007–2009

An important tenet of the pension system in Moldova is that it provides for the successive transfer of the burden of insurance contributions from employers to employees. It is intended that the size of the employer's contribution will reduce by 1% each year, while the size of the employee's contribution will increase by 1% until it reaches the pre-determined rate of one-third of the total contribution rate.

Although initially there were a considerable number of contribution types, the system is developing and the general trend is towards the establishment of a common percentage, set for all employers and employees, and those who do not fit into one of these categories will pay a fixed annual tax.

4.3.5.1. Number of pensioners

Analysis of the number of pensioners

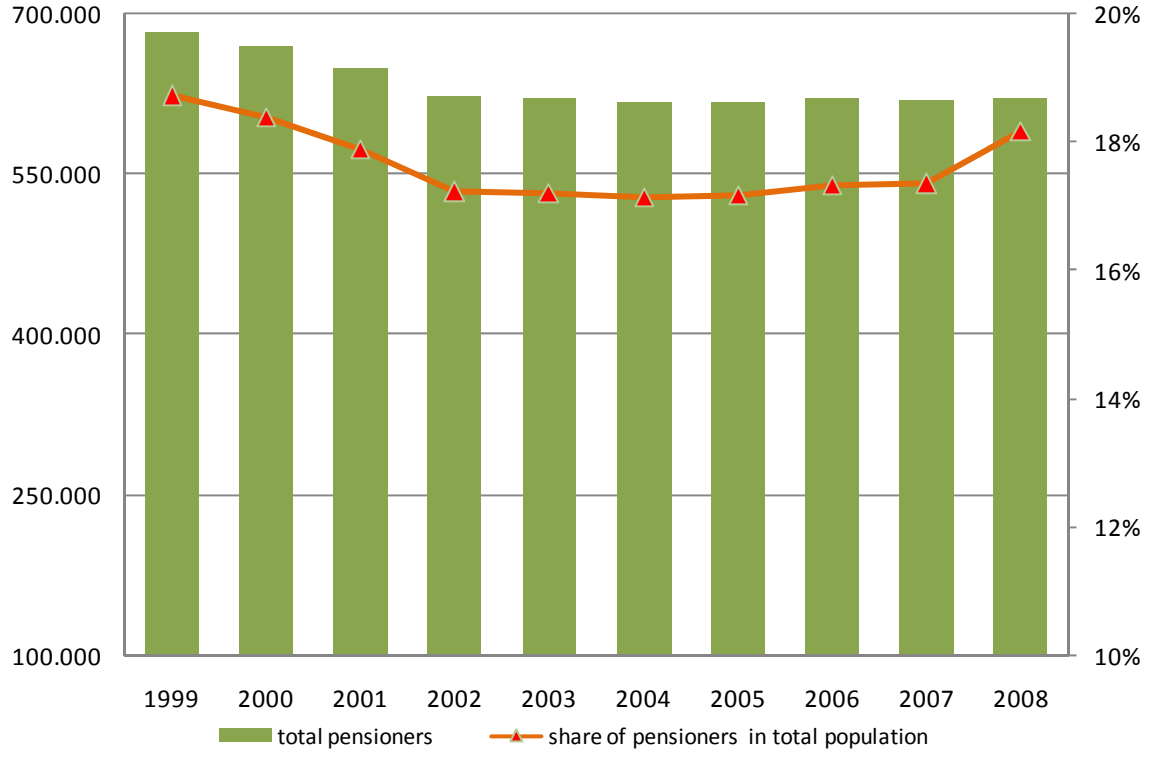
[163] The 2008 data was used as the basis for conversion, since there is no data for 2009 on the €/US$ exchange rate

Old-age pension benefits prevail in the overall number of pension benefits—at the end of 2008 there were 462,093 old-age beneficiaries, or 75% of all pensions. At the same time the number of disability beneficiaries stood at 128,145 with their share in the total reaching 20.7%, up from 16.4 in 1999 (the structure of old age and disability pensioners by age groups is shown in Annex G).

The number of survivor pensions is relatively small at 25,884 (or 4.2%)—the result of a high female employment rate in the past—and strict conditions for receipt of a survivor pension after the death of a spouse. From the overall number of pension beneficiaries, women account for some 64% (Annex F). This can be explained by a combination of longer life expectancy and high employment rates in the past (the actual employment rates are shown in Annex H).

Over 1999–2008 a considerable reduction and stabilization of the number of retired persons was recorded. The data provided in Figure 4.1 show that during this period the number of pensioners fell by nearly 10%. Up to 2004, the number of pensioners decreased more significantly than reduction of the population in Moldova. Subsequently, the share of pensioners in the total population decreased to 17.1% in 2003 (from 18.7% in 1999). However, this trend reversed and between 2005 and 2007 the number of pensioners increased and settled at a level of 17.3%, rising to over 18% in 2008. It is assumed that the variation in the relative number of pensioners, apart from demographic causes, is explained by the increase in the retirement age adopted in Moldova over 1999–2002.

Figure 4.1. Number of pensioners, 1999–2008



Source: Annual social reports, 2004–2008

The number of pensioners has been stable at around 620,000, yielding a system dependency ratio of 59 pensioners per 100 insured persons.[164] This is above many other more developed CEE countries, due in part to a relatively young population in the country indicated by a population dependency ratio of 13.7%.[165] Unlike contribution coverage, almost full pensioner coverage is due to nearly

[164] The pension system dependency ratio is defined as the ratio of pensioners to insured individuals.
[165] The population dependency ratio is defined as the ratio of the 65+ population to the 15–65 population.

universal labor force participation and full contribution coverage under the planned economy regime.[166] Table 4.5 shows the trends in the number of pensioners by type of pension (Annex B contains more detailed information).

Table 4.5. ***Total number of pensioners by type of pension, 1999–2008***

Type of pension	Number of pensions granted									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Old-age pension	535186	516861	495841	472556	468135	460822	457320	459717	458795	462093
Cabinet members – total	0	64	68	70	66	80	83	84	84	85
MPs – total	0	66	71	76	96	96	102	108	116	117
Public servants– total	0	666	944	1131	1430	3490	4357	4773	5266	5532
Mayors, chairmen and vice chairmen of rayon councils	0	0	0	0	15	194	290	317	354	387
Disability pension, out of which:	111735	113022	115526	115220	117085	119925	123719	125676	126538	128145
Grade I	15792	15540	15244	14138	13.827	13770	13619	13369	13183	13298
Grade II	81892	83911	86166	82128	82.443	84064	86753	86922	87089	87948
Grade III	14051	13571	14116	18954	20.815	22091	23347	25385	26266	26899
Survivor pension	34493	37470	36012	33515	33019	31889	30505	29779	28157	25884

Source: Annual social reports, 2004-2008

By 2008, the number of new old-age pensioners increased by about 4 times over that recorded in 2002, reaching a total of 28,864 people (Table 4.6, Annex C). Such a dramatic increase was caused, firstly, by the change in the retirement age and, secondly, by the cohort effect.

Table 4.6. ***Number of new pensioners by type of pension, 1999–2008***

Type of pension	Number of pensions granted									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Old-age pension	7282	4343	3964	6670	16820	22126	24636	27302	27429	28864
Cabinet members		64	6	5	1	18	7	2	8	3
Deputies		18	7	5	22	17	11	8	8	7
Public servants		120	184	157	272	2607	1254	626	791	778
Mayors, chairmen and vice chairmen of rayon councils	0	0	0	0	5	177	89	41	48	43
Disability pension, out of which:	8134	6834	7770	7497	8438	9521	11054	9537	9646	9876
Grade I	798	766	722	680	737	863	871	784	794	870
Grade II	6436	5521	6147	4695	5301	5972	7058	5750	5913	6014

[166] Pension coverage is defined as the ratio of pensioners aged 65+ to the population aged 65+. The estimated pension coverage for Moldova in 2008 stood at 94%. At the same time the ratio of old-age pensioners in the population aged 57+/62+ is arround 86%.

Grade III	900	547	901	2122	2400	2686	3125	3003	2939	2992
Survivor pension	2833	2105	2148	2459	2706	2582	2968	2433	2045	2103

Source: Annual social reports, 2004-2008

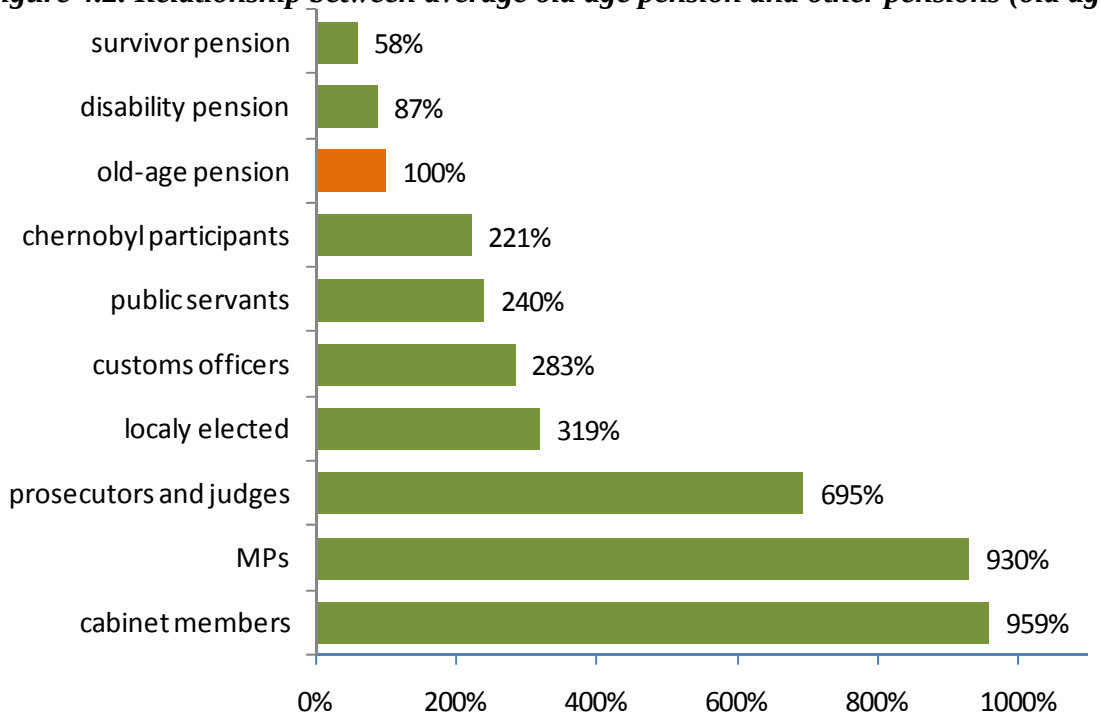
Although, between 1999 and 2008, the number of new pensioners increased, this was not sufficient to compensate for the decrease in the total number of pensioners due to mortality.

4.3.5.2. Pensioner living standards

The average size of assigned pensions

The special rules for determining pension entitlements for various categories of the population obviously have an impact on pension size. Data on the average size of some types of pensions in relation to the average old-age pension, as of 1 January 2009, shows large discrepancies between the different groups of pensioners (Figure 4.2).

Figure 4.2. Relationship between average old age pension and other pensions (old age=100%)



The amount of an old-age pension is obtained by multiplying the *pension base* (the average gross wage earned across all working years) by the percentage determined by the length of the contribution period. The pension base is calculated differently for periods before and after 1998. The pension base for the period *before* 1998 is valorized with wage growth until the year preceding the year of retirement. For wages earned after 1999, the pension base is calculated as the average of nominal wages, without valorization based on wage price inflation in that period. Non-valorization of past earnings affects initial replacement rates and creates large differences between new and old pensioners.[167]

Over 1999–2008 the nominal size of the average old-age pension in Moldova increased by more than 6 times. During the same period, the average salary increased by more than 14 times. The synchronized increase in the size of different pension types is largely due to the complex legal

[167] After 20 years of contribution history in the new system, only wages earned after 1999 will be used for calculation of the pension base. If non-valorization continues, initial replacement rates of new pensioners will be further devalued.

regulation that (in general) stipulates their simultaneous change. This has led to the maintenance of a rather stable correlation between pension sizes of different types over a long period of time.

Table 4.7. ***Average size of monthly pensions***

Type of pension	Average size of pension, €									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Old-age pension	7.62	7.50	12.18	13.00	13.85	21.97	25.30	27.74	34.09	43.57
Cabinet members		118.78	120.39	108.28	93.60	216.41	231.25	290.75	335.82	395.92
MPs		101.46	105.30	97.92	98.34	129.75	191.42	282.91	326.73	384.11
Public servants		38.90	40.58	37.66	36.04	54.30	62.07	66.43	77.85	99.04
Mayors, chairmen and vice chairmen of rayon councils					47.25	67.12	74.22	84.16	101.47	131.77
Disability pension, out of which:	7.16	7.15	12.11	12.71	12.40	19.14	21.51	23.10	28.16	35.84
Grade I	8.53	8.49	14.77	15.37	15.10	23.52	26.63	28.94	35.39	45.47
Grade II	7.31	7.29	12.36	13.25	12.99	20.15	22.74	24.62	30.09	38.32
Grade III	4.71	4.73	7.75	8.38	8.27	12.58	13.96	14.84	18.14	23.00
Survivor pension	5.74	5.50	7.66	8.36	8.83	13.64	15.38	16.40	19.22	24.04

Source: Annual social reports, 2004-2008

Comparing the size of the average monthly pension (Table 4.7, Annex D) with the size of newly-assigned pensions (Table 4.8, Annex E), reveals that the size of newly assigned pensions is now smaller than that of the average monthly pension (total pensioners). This applies to all types of "non-privileged" pensions.

Table 8. ***Average size of newly-assigned pensions***

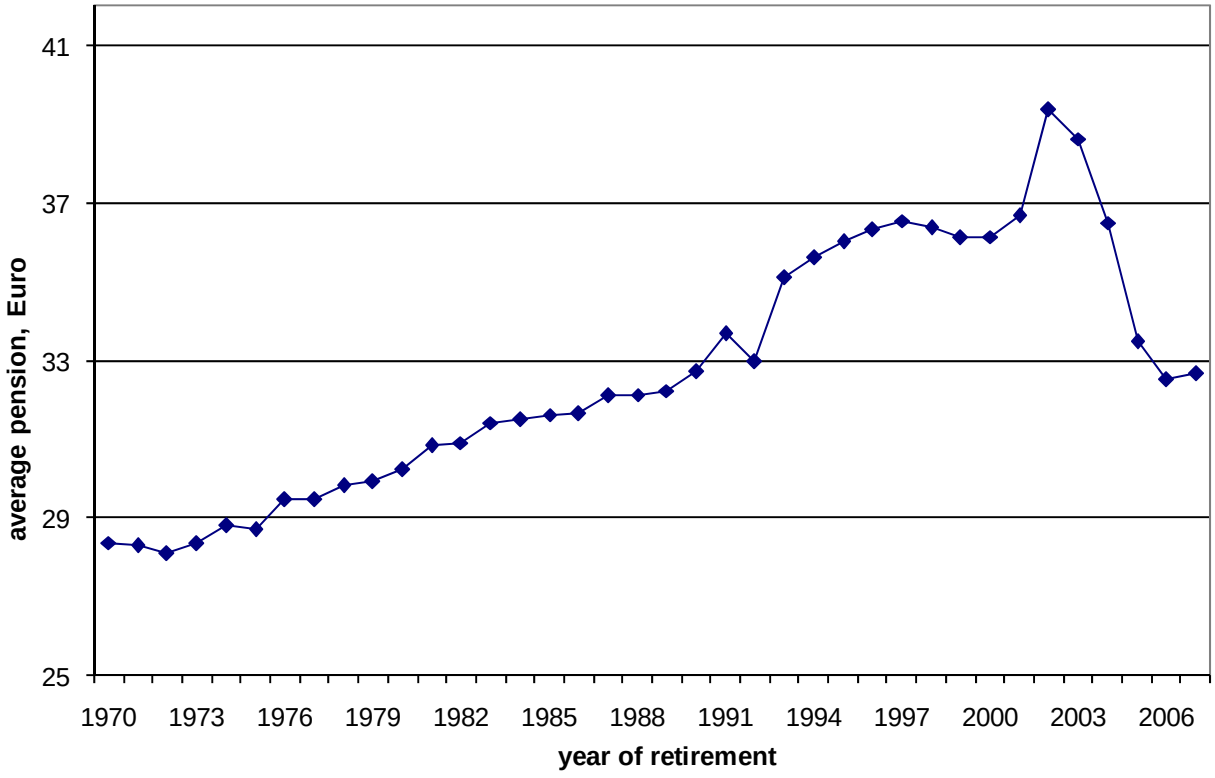
Type of pension	Average size of pension, €									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Old-age pension	9.16	8.31	13.62	14.88	14.29	21.63	23.07	24.68	32.88	40.06
Cabinet members		118.78	119.71	115.34	116.93	211.01	218.53	305.61	336.62	395.53
MPs		112.57	114.34	128.04	110.99	188.33	180.95	268.71	324.20	370.35
Public servants		42.19	45.06	43.33	37.16	54.99	67.98	79.21	95.41	129.16
Mayors, chairmen and vice chairmen of rayon councils					54.93	67.33	77.36	130.48	138.92	196.56

Disability pension, out of which:	7.56	8.34	12.25	12.21	11.51	16.55	16.57	17.71	23.44	30.07
Grade I	8.93	9.69	14.68	15.24	15.19	21.06	21.04	23.04	31.98	43.82
Grade II	7.81	8.48	12.58	13.57	12.59	18.11	18.28	19.66	26.14	33.10
Grade III	4.54	5.02	8.09	8.25	8.00	11.63	11.47	12.59	15.70	19.98
Survivor pension	5.99	6.39	8.87	9.42	9.43	13.42	13.24	14.04	17.92	23.49

Source: Annual social reports, 2004-2008

Data on the average size of the old-age pension by year of assignment[168] (Figure 3) shows that for pensioners who retired before 1991, the longer the period of pensioner status, the lower the pension size. After 1991, this previous trend was no longer valid. The sizes of newly assigned pensions started to vary. This was due to the unstable economic conditions that characterized this period for almost all states of the former Soviet Union, including Moldova. Moreover, the promotion of pension reform within the country led to changes in the criteria for assignment of new pensions, which in turn, prompted the changes to the size of newly assigned pensions. As shown in Figure 4.3, it is clear that after 1991 the trend in average pension size became less stable, indicating that the average pension size for adjacent cohorts can differ fundamentally—the downward trend in the average size of newly assigned pensions that occurred in recent years providing a good example of this.

Figure 4.3. Average size of the old-age pension by year of retirement, 1970–2007



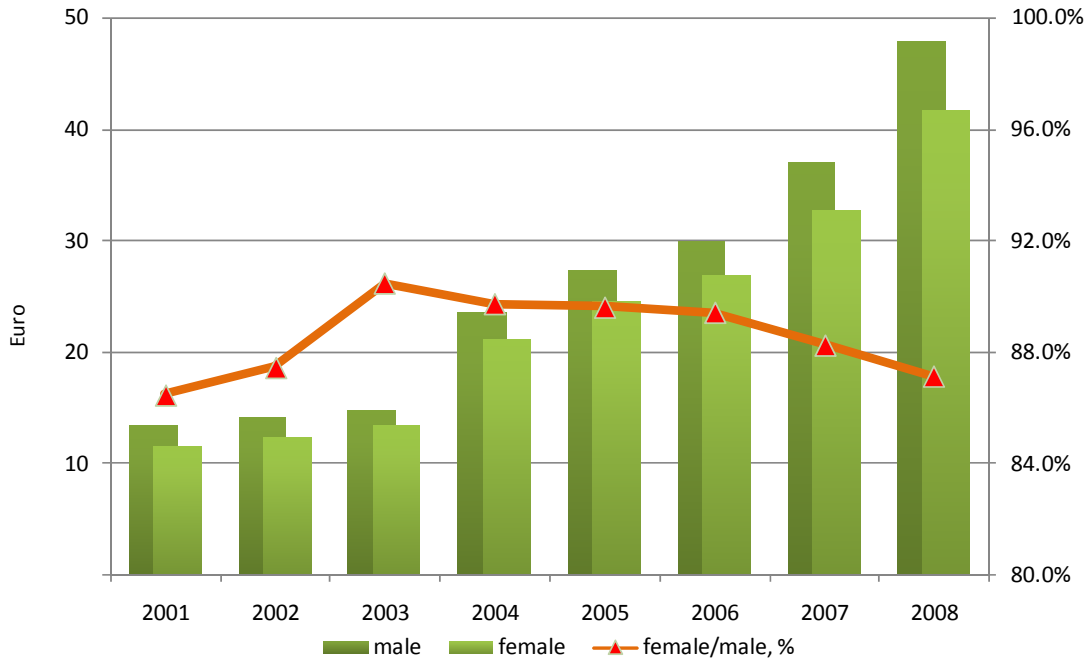
Source: own calculation based on NSIH data

Age and sex as factors in pension size

[168] Old age pensions that were being paid at the end of 2007 were distributed by year of establishment and their average amount was calculated**.**

There are significant differences between the size of pensions according to sex (Figure 4.4). Calculations show that between 2001 and 2008, the size of the average old-age pension for women was 10–15% lower than that of men.

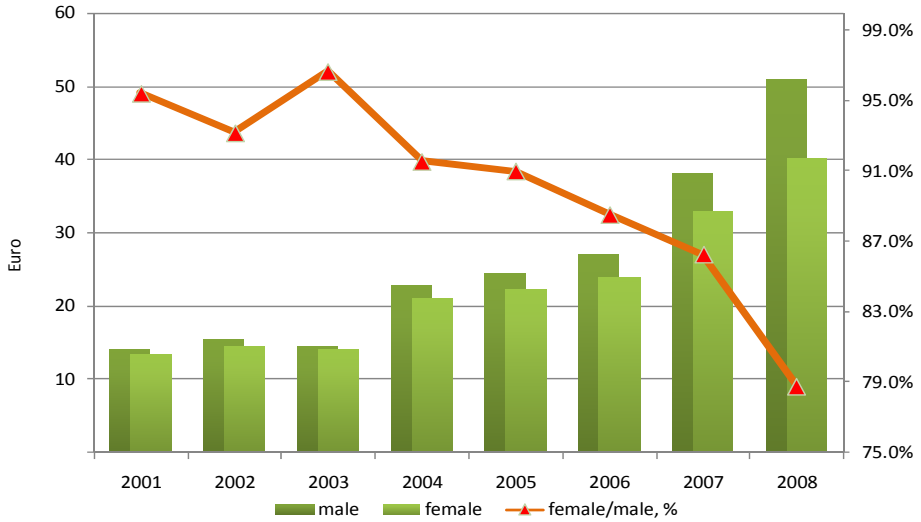
Figure 4.4: The size of the average old-age pension, €



Source: own calculation based on NSIH data

The trend characterizing the changing relationship between the pension size of men and women in the respective period was insignificant. At the same time, the new formula for calculating pensions, which places greater dependence of the size of a pension on the salary and contribution payment period, will lead to an even greater difference between the pensions of men and women (Figure 4.5). This is due to the fact that women usually have lower salaries and retire five years earlier than men on average, significantly reducing the contribution period. In addition, the prevalence of non-contribution periods is higher among women than men, reducing even further the contribution period and, consequently, the size of the pension.

Figure 4. 5. The size of the new average old-age pension, €

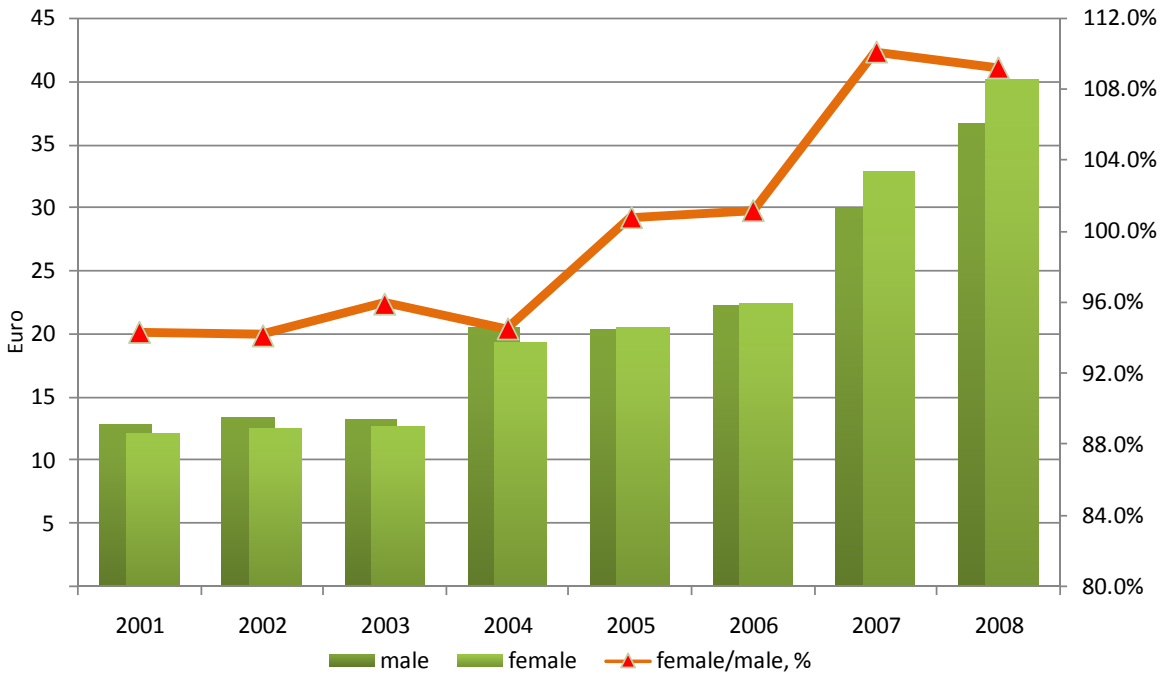


Source: own calculation based on NSIH data

This disparity between men and women does not happen for all types of pensions and, in fact, the average size of newly assigned pensions of men and women are gradually approaching each other (Figure 4.6). Thus, while in 2001 the difference between these pensions (for all categories of new pensions) was around 7%, by 2008 this figure fell to less than 2%. However, analysis of this relationship by type of newly assigned pension shows that for almost each category the size of the average male pension is higher than that of females. This paradox is due to the difference in the structure of pension beneficiaries. Beneficiaries of non-agricultural pensions prevail among women, and they have the highest level of pensions. In the same period (2001–2008), more than 36% of male pension beneficiaries were receiving the disability pension, which is a lower average pension than the old-age pension. This led to a closer approximation between the average size of newly assigned pensions of men and women, consequently reflected in the relationship between pensions of men and women in general.

Equalization of the average pension size for new pensioners is generally due to the fact that the structure of male pension beneficiaries allows for prevalence of disabled persons and old-age pensioners who receive agricultural pensions, while the structure of female pension beneficiaries allows for prevalence of old-age pensioners who benefit from non-agricultural pensions, the size of which is usually higher.

Figure 4.6: Average size of newly-assigned pensions, €



Source: own calculation based on NSIH data

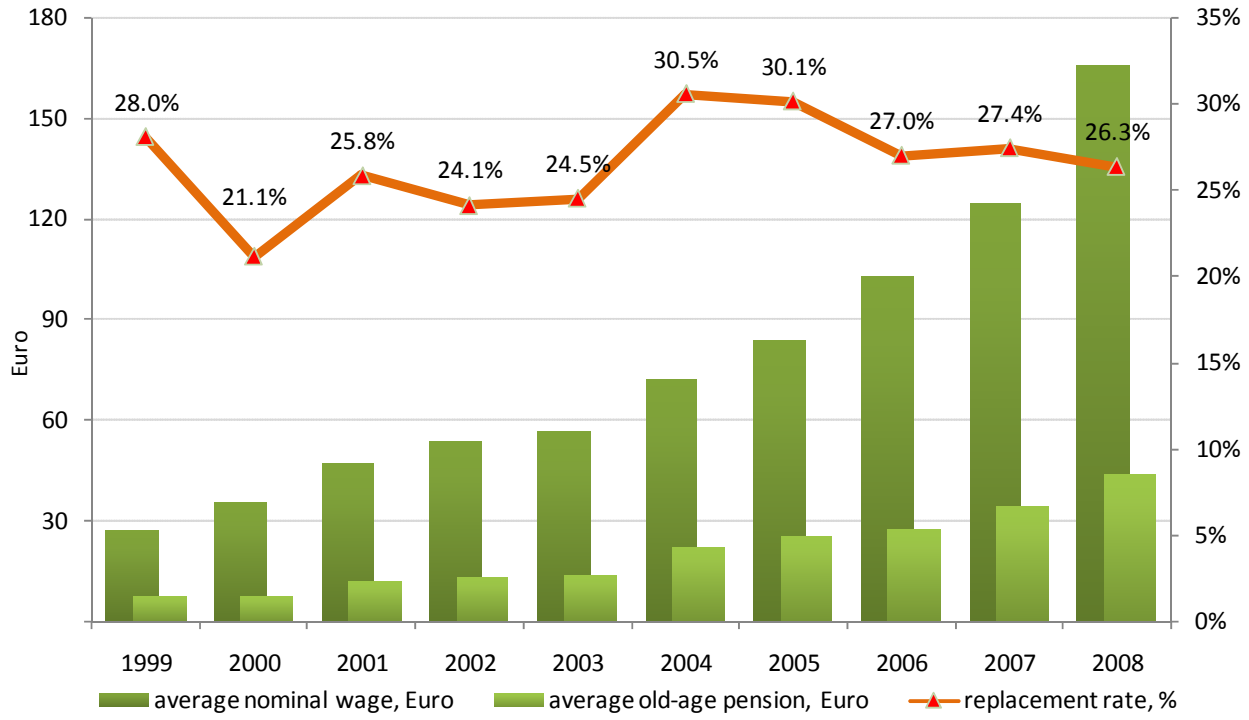
Replacement rate

Compensation for lost salary and protection against poverty are important functions of every pension system. The main criterion for which the level of insurance with pensions of a country is evaluated is the replacement rate of lost salary. At the outset, it should be highlighted that there are different evaluation methods for the replacement rate. The figures that are used in this report are based on the correlation between the average pension and average calculated salary.

The trends and relationship between the average old-age pension and the calculated average salary are shown in Figure 4.7. These indicate that over 2001–2003 the correlation between the average pension and the average salary was gradually maintained at approximately 25%. The large-scale action in 2004 of recalculating the established pension, was intended (according to legislation) to increase pensions by at least 25%, as was the adjustment in April of the same year of 22.3%, which allowed an increase in the size of the average pension of more than 50%. As a consequence, the replacement rate increased to 30.5%. In subsequent years, however, the replacement rate dropped again reaching a level of 27% in 2006 and 26.3% in 2008. The recent decreases in the replacement rate are, to a large extent, related to the fact that salaries in Moldova have increased at a higher rate than pensions. Presently, pensions are adjusted by 50% of the annual increase in the consumer price index and 50% of the annual increase in the average monthly salary for the last year. On this basis, permanent decreases in the replacement rate are inevitable. The situation is aggravated by lower amounts of newly assigned pensions, which is a product of the pension formula used.

At first glance, paradoxically, the net average rate of replacement in agriculture in 2008 made up about 45.4%, given the average old-age pension for agricultural workers of €39.1, and the net average salary for 2008 in agriculture of €86.1. This shows the negative effects of unequal distribution.

Figure 4.7: Trends and relationship between the average monthly salary and average pension



Source: NSIH and NBS data, author calculation

4.4. Main reforms and drivers of change

The Government drafted a set of pension reform strategy papers in 2008. These papers (*Unification of Pension System Strategy; Farmers' Pension System Reform Strategy; and Strategy of Reform of the System for Social Protection of Persons with Disabilities in the Republic Moldova*), prepared by the relevent ministries and agencies of Moldova, set the development of a common legal framework for all persons covered by state social insurance as the basic goal of further reform of the Moldovan pension system. The list of proposed policy measures declared in the documents includes:

- Equalization of general conditions for acquiring old-age pension benefits for all insured persons;
- Equalization of social insurance contribution rates for all insured persons;
- Linkage of pension insurance for farmers and self-employed to the amount of earned income (or potentially earned);
- Modification and streamlining of the pension benefit formula;
- Redefinition of disability in compliance with the ILO definition and stimulation of employment among disability pension beneficiaries with lesser degrees of disability; and
- Transparency of record keeping on revenues and expenditure for every social fund.

While these are largely steps in the right direction—already taken by many European countries—the measures are too general and lack estimates of their social and fiscal impact. Along with the proposed strategies, the Government is exploring the option of supplementing the current pension system with a mandatory fully-funded pension pillar.

Finally, the proposed strategies include several proposals that may contradict the objectives and other policies proposed, such as:

- Separating insurance for self-employed persons and farmers from the general public pension system; and
- Calculating disability and survivor pension benefits only on the basis of the actual insurance (contribution) period.

4.5. Pensions, exclusion and vulnerable groups

Among the beneficiaries of pensions in the country, there is another large category—beneficiaries of social benefits. These groups receive benefits that are financed by the state budget and are not regulated by the Law on State Social Insurance Pensions. The right to social benefits is enjoyed by persons who *did not earn* this right within the social insurance system including: disabled children up to 16 years of age; disabled persons, including children aged between 16 and 18 years; children up to 18 years who have no contribution payment history allowing for a disability pension; children below 18 (pupils and students of secondary and higher education institutions) who lost their bread-winner but are ineligible for a respective pension; and elderly people who are not eligible for pensions from the state social insurance system.

Those working abroad[169] are one of the most vulnerable groups. Some of these emigrants remain formally employed, while others decide to work abroad informally, perceiving opportunity costs (such as less years of insurance coverage) as marginal.

One of the main objectives of the Government in social security, based on the need to fulfill the provisions of article 24 of the EU-Moldova Partnership and Cooperation Agreement, is the signing of bilateral agreements for the protection of social and economic rights and interests of Moldovan citizens who are permanently or temporarily domiciled in European community states.

---

[169] The priority destinations outside CIS are Italy, Greece, Spain, Portugal, and Israel. Men predominantly emigrate to the Russian Federation, Germany, Portugal and Ukraine, while women prefer Italy, Israel, and Turkey. The CIS countries are particularly attractive due to small migration costs. Nearly 52% of those abroad in 2006 worked in Moscow, with 59% in Russia as a whole. Italy received the second largest group of migrants (17%). Mobility and its human costs in the Republic of Moldova, UNDP, Chisinau, 2009.

The social protection agreements to which Moldova is party, especially with countries from the post-Soviet zone—Ukraine, Russian Federation, Belarus, Uzbekistan, Azerbaijan, and Romania—are based on the territoriality principle. As such, a major objective for Moldova is the signing of agreements of a new type underpinned by modern principles. Agreements with Bulgaria and Portugal have, consequently, been signed and the country is involved in ongoing negotiations with the Czech Republic. Greece, Italy, and the Grand Duchy of Luxembourg have also indicated a willingness to commence dialogue on this issue. Despite these efforts, however, most immigrants working in the informal sector are unable to benefit from the agreements.

4.6. Sustainability of pension systems

Between 1999 and 2008, the dependency ratio of pensioners decreased from 2.0/2.42 to 1.7, and there are no signs that this indicator will increase in the coming years. Expenditures for the payment of pensions and management of the pension system are on the constant increase, and in recent years these represented about 7.4% of GDP (Annex A)—2% higher than in 1999–2001. At the same time, social insurance income has seen smaller increases, indicating that from 2005, income from the system is lower than expenditures. Although for the moment the deficit is covered from savings made in previous years, any shortfalls experienced in funding will be covered by transfers from the state budget. This situation is the product of a combination of factors including: demographic pressures and a continuous decrease in the number of contributors (about 25% over the last 10 years), the halted increase in the retirement age, the high costs to employers of social insurance contributions (which has lead to concealment or reduction of the contribution base), and insufficient coverage by the system for self-employed persons.

Raising concern for the social insurance system, and implicitly for the pension insurance system, is the large group of emigrant workers (see Chapter I: Migration and remittances). While many of these workers will contribute to the social security system of the host country, as there are no mutual arrangements (agreements) between countries they will not benefit from these contributions when retiring in Moldova. Also at risk is a significant population group working within the hidden economy sector that do not contribute to either a foreign or Moldovan pension system, exposing these individuals to the risk of a low pension income on retirement or eligibility for social assistance only.

For the pension system of the republic, created on the principle of generational solidarity, the prevalence of unofficial employment directly compromises its basic parameters—the number of contributors in the social insurance system, the size of pension contributions, the pension burden established in the country, and the relationship between population officially employed in the economy and the number of old-age pension beneficiaries.

The high level of unofficial employment among members of the population can influence the pension system in two ways. Firstly, all other conditions being equal, the higher the level of unofficial employment, the lower the flow of financial resources into the pension fund, limiting the ability of the pension system to increase the monetary value of pensions. Secondly, employees working unofficially and today “invisible” to the pension system, will face great difficulties confirming a contributions payment record in the future—a requirement of beneficiaries of the old-age pension.

A solution also needs to be found to the critical problem created by poor contributions from the agricultural sector. A number of factors combine to favour pensioners from this sector through the

necessary redistribution of financial resources for pensions, including a lower rate[170] of insurance contributions set for the agricultural sector, an inefficient system of collection of contributions from owners of agricultural land, and a limited accumulation of contributions from the sector. Thus, according to NSIH data, in 2008, the agricultural sector contributed little more than 4.8% of the total amount of income made, but the pensions and compensations that this sector received made up 40% of the total amount of income. Due to their low pension contributions, however, most acquire minimum pension benefits. Based on the actual value of the minimum pension, farmers acquire pension benefits that are 2.5 times higher than the pension benefits they are entitled to on the basis of their contributions. The advantage farmers are afforded through the social redistribution of the pension system occurs at the expense of insured individuals who pay average to above-average contributions.

Importantly, reduction of the population alone is not a key factor in the stability of a country's pension system. Instead, more significance is attached to the ratio of the number of elderly to that of the working age population (see Chapter I: Situation on the labour market).

From this perspective, migration has important implications for the financial soundness of the pension system. A common expectation is that the young population, even if low-skilled, will help society pay benefits to the existing elderly. Unfortunately for Moldova, a large proportion of emigrants and potential emigrants are young (see Chapter I: Migration and remittances).

4.6.1. System losers

Halting pension reforms is likely to result in the deterioration of living standards of all future pensioners. Two factors are driving the replacement rate to a socially unsustainable level: the indexation pattern, and the lack of wage valorization in initial pension determination. With fifty-fifty wage-price indexation, the replacement rate falls more slowly than the most common price indexation of pensions. But in Moldova, the starting replacement rate is already low, and over a long period this rate will fall to a very low level. The un-valorized pension base causes large differences between new and existing cohorts of pensioners. In 2020, when the formula will take into account only the post-1999 un-valorized pension base, the initial replacement rate will fall further below the average. Another factor that could negatively affect new replacement rates of future cohorts is shorter service periods due to emigration and unemployment.

4.6.2. Effect of the economic crisis

It is still too early to accurately predict the impact of the global crisis on the pension system, but given its severity, it is highly unlikely that pensions will escape being advsersely affected. The effects will depend on a number of factors, including the impact of the crisis on the financial sector and the economy, the labour market and migration.

The current pensions scheme is largely paid for by worker contributions. A serious economic downturn may increase the need for policy adjustments to secure long-term sustainability, while in the shorter term, pension levels are likely to remain the same and any adjustments for the longer term gradually phased in.

[170] The owners of agricultural land, as well as those who rent or use agricultural lands, who cultivate the land themselves, paid insurance contributions according to the area of agricultural land used and its fertility (quality of the soil)—a rate of 1.7 lei per unit/hectare prior to 2005. A fixed annual tax was established for this category of payers in 2006.

Growth in unemployment and, subsequently, of the number of people who no longer contribute to the State Social Insurance Budget, decrease in private sector salaries, and the freezing of salaries within the state sector, are three factors that will have a negative influence on incomes within the state social insurance system. In addition, pension expenditures will likely increase as more individuals retire from the labor force and seek pension benefits in the face of an economic downturn. Disability claims may also increase in response to higher unemployment.

In the first five months of 2009, the monthly funds collected in the social insurance budget were 5% smaller than the funds required for pension payments. Despite the fact that differences are still covered by savings made in previous years, the deadlines for the payment of pensions have been shifted from the first to the second half of the month in order to provide a respite in collections.

Importantly, the increase in pension size in 2009 was not calculated in the same way as previous years (on the basis of the average salary against inflation), due to the influence of parliamentary elections. With a 7.3% inflation rate and an increase in the average salary of almost 23%, the pension should have been increased by 15%, but was instead increased by 20%, creating additional pressure on the system.

According to some estimates[171], the authorities will be unable to pay the pension in autumn if they are not able to cover the deficit with transfers from the state budget. On the basis of the same estimates, it is foreseen that the social insurance budget will have by the end of the year a deficit about 20% of the budget approved for 2009.
The impact on pensioners will depend on how Government deals with the shortfall in revenues. It could finance pension-scheme deficits in full from the state budget or partially default on pension promises by delaying pension payments or failing to index pensions, for example. The balance between the two options will be politically determined as pensions are just one of a range of competing demands for limited public resources.

4.6.3. Public awareness and acceptance

No studies have been conducted in the country on people's awareness of or attitude towards the pension system. Both line ministries and independent analysts are working on finding out why people do not trust private pension systems. There are real obstacles to participation in the pension system. Firstly, there is serious competition from the banking sector, which provides the option of opening deposit accounts from which people can retrieve all or some of their money at any time.

Accessing money is more complicated in the case of private pension **insurance,** where a contract is signed on a long-term basis from 10 to 35 years. This deters people who are reluctant to give their savings to an institution that they are unsure of, and may also have reservations about committing their money for so long.

Secondly, is the issue of the general mindset of the population regarding financial planning, which is not common practice in Moldova. A concerted effort is required to raise awareness of the options for citizens and the time factor is critical for enhancing participation in the pension system.

The Government must also actively promote measures to ensure that the development of the private pension system in Moldova will minimize pressure on the state social insurance budget, stimulating economic growth by investing accumulated amounts in the economy, thus creating new jobs and reducing unemployment.

[171] IDIS Viitorul, *The Economic Monitor: quarterly analyses and prognoses, Number 16 / Q2 2009*

4.7. Conclusions and key challenges

The current Moldovan pension system under-performs on the adequacy of pension benefits, struggles with compliance and collection, and weakens the incentive to participate and contribute to the system. Parametric measures to address these system flaws were introduced in 1998 and, after a few years of successful implementation, were suspended in 2003.

The Government has recently contemplated continuing the 1998 reforms within a broader set of pension reform options, and is trying to study the possible effects of the introduction of a second fully-funded pension pillar. However, a mandatory-funded pillar requires a sustainable first pillar, functioning capital markets and framework, and adequate administrative capacity. It also requires a sound and stable macroeconomic base, diametrically opposed to the one resulting from the current rumbling global recession. All these conditions have still not been met in Moldova.

Structural problems within the current system need to be addressed first. Re-establishing valorization of past earnings in the pension formula accompanied by a lower **accrual rate**—the accrual rate is 1.4% of gross wage for up to 30 years of service, and 2% for over 30 years of service—would yield more sustainable long-run replacement rates and reduce differences among cohorts of pensioners. Strengthening incentives in the current pension system through a tighter link between contributions and benefits, avoiding contribution forgiveness, and adjusting minimum pension and contribution levels for the self-employed and farmers, would improve system finances and provide additional fiscal space for improvements in benefits, contribution rate reduction, and/or second pillar introduction when the time is right. Further reforms to cope with population ageing should focus on extending labor force participation by the elderly to avoid benefit cuts that could undermine adequacy and very high contribution rates that could discourage formal sector employment.

Although data on expenses related to the payment of benefits from the pension system is sufficient, data on system incomes is significantly inferior. Only aggregate data is available that cannot be used for a deeper analysis of taxpayer income structure, salary profiles, and other measures.

References

Baskakov V. (2007), Pension system of the Republic of Moldova: actuary expertise*;*

Baskakov V. (2005), The Republic of Moldova's pension system: model and scenario of development*;*

Baskakova M. (2007), Gender aspects of the Republic of Moldova's pension system*;*

IDIS Viitorul, The Economic Monitor: quarterly analyses and prognoses, Number 16 / Q2 2009*;*

Ministry of Social Protection Family and Child of GoM (2004), "*Annual Social Report 2003";*

Ministry of Social Protection Family and Child of GoM (2005), *"Annual Social Report 2004";*

Ministry of Social Protection Family and Child of GoM (2006), *"Annual Social Report 2005";*

Ministry of Social Protection Family and Child of GoM (2006), "Strategy on reform of the pension system for persons acting in agriculture", (Draft) *;*

Ministry of Social Protection Family and Child of GoM (2007), *"Annual Social Report 2006";*

Ministry of Social Protection Family and Child of GoM (2007), "Strategy for unifying the pension system", (Draft);

Ministry of Social Protection Family and Child of GoM (2008), "*Annual Social Report 2007";*

Ministry of Social Protection Family and Child of GoM (2008), "*Annual Social Report 2008";*

National Bureau of Statistics (2007) "*Statistical Yearbook"*;

National Socila Insurance House (2004-2008), operative data*;*

OECD (2009), Private Pensions and Policy Responses to the Financial and Economic Crisis*;*

Peleah M., Sinchetru A. (2003), Background paper on farmer pensions*;*

World Bank (2009), The Financial Crisis and Mandatory Pension Systems in Developing Countries*;*

Zabieta A. (2007), "Analysis of social protection of disabled people in the Republic of Moldova"

Annex. Statistical data

Table 4.1. General data on the social insurance system, 1999-2008

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
total population (end of the year)	3644070	3635112	3627812	3618312	3607435	3600436	3589936	3581113	3572703	3419403
population 15-64	2436553	2463366	2490861	2514650	2538807	2561173	2578953	2562110	2575848	2592561
population 65+	341704	343555	349108	353479	355388	355590	353107	368618	368995	365530
average gross wage nominal growth %	122	134	133	127	129	124	120	129	122	127
average gross wage real growth %	87	102	122	121	115	110	107	114	108	113
pension indexation %					19.3	22.3	18.2	15.7	20.7	17
total number of insured persons (contributors)	1371102	1306932	1460140	1490872	1238263	1268852	1231958	1059731	1048486	1050000*
total number of farmers (contributors)					332408	351196	304265	22753	191773	197684
total number of pensioners	697432	683925	663287	634533	627553	620692	618277	621402	619433	621351
total number of pensioners (Law on the state social insurance pensions)	682217	668127	648157	622007	616632	612636	611509	615172	613490	616122
total number of old-age pensioners	535186	516861	495841	472556	468135	460822	457320	459717	458795	462093
total number of invalidity pensioners	111735	113022	115526	115220	117085	119925	123719	125676	126538	128145
total number of survivors pensioners	34493	37470	36012	33515	33019	31889	30505	29779	28157	25884
share of old-age pensioners	0.78	0.77	0.77	0.76	0.76	0.75	0.75	0.75	0.75	0.75
share of invalidity pensioners	0.16	0.17	0.18	0.19	0.19	0.20	0.20	0.20	0.21	0.21
share of survivors pensioners	0.05	0.06	0.06	0.05	0.05	0.05	0.05	0.05	0.05	0.04
total number of new pensioners	18993	13937	14315	17099	28543	34295	38802	39313	39775	40942
number of new old-age pensioners	7282	4343	3964	6670	16820	22126	24636	27302	27429	28864
number of new invalidity pensioners	8134	6834	7770	7497	8438	9521	11054	9537	9646	9876
insured persons relative to total number of pensioners	1.97	1.91	2.20	2.35	1.97	2.04	1.99	1.71	1.69	1.69
insured persons relative to total number of pensioners (Law on the state social insurance pensions)	2.01	1.96	2.25	2.40	2.01	2.07	2.01	1.72	1.71	1.70
number of contributors relative to population 15-64	0.56	0.53	0.59	0.59	0.49	0.50	0.48	0.41	0.41	0.41

total social insurance revenues (contributions, state budget transfers etc), €	80970.0	116976.2	139214.0	172666.9	173722.2	192311.1	235447.0	263625.0	310702.6	416100.2
contribution revenues, €	69676.9	87514.0	110620.5	124834.1	125267.7	160755.1	187873.5	222020.1	261025.3	355091.2
total social insurance expenditures, €	78490.7	115506.5	126134.6	147329.1	138257.9	180635.1	235560.0	265468.9	315963.9	412981.6
pension expenditures (social insurance budget), €	47269.9	70871.6	74442.2	92511.2	94692.4	124017.1	176412.7	189541.5	226018.7	296630.3
pension expenditures relative to total social insurance contributions	0.68	0.81	0.67	0.74	0.76	0.77	0.94	0.85	0.87	0.84
pension expenditures relative to total social insurance expenditures	0.60	0.61	0.59	0.63	0.68	0.69	0.75	0.71	0.72	0.72
average old age pension, €	7.6	7.5	12.2	13.0	13.8	22.0	25.3	27.7	34.1	43.6
average replacement rate of old- age pension (average pension to average gross wage)	0.28	0.21	0.26	0.24	0.24	0.31	0.30	0.27	0.28	0.25
total expenditures relative to GDP	0.071	0.083	0.076	0.084	0.079	0.086	0.098	0.091	0.098	0.096

Source: own calculations based on NBS and NSIH data

*preliminary data

Table 4.2. Total number of pensioners by type of pension, 1998-2008

Type of pension	Number of pensions granted										
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
1.1. Old-age pension – total	555970	535186	516861	495841	472556	468135	460822	457320	459717	458795	462093
including women							306427	306022	311694	316765	322899
Minimum size	21824	63331	59097	9	0	0	0	15993	15495	25070	30777
Working pensioners	38273	32828	32086	32942	35180	41892	49196	59706	71272	82743	95481
General conditions total	403366	387022	375632	432328	412636	408644	401582	389523	393680	395045	400629
Privileged conditions (anticipated) – total, out of which:	152604	148164	141229	63513	59920	57148	54673	62266	60113	57217	54600
Mothers with 5 or more children total	71018	66687	61256	58825	55476	52860	50512	48626	46978	44763	42729
Cabinet members – total			64	68	70	66	80	83	84	84	85
MPs – total			66	71	76	96	96	102	108	116	117
Public servants– total			666	944	1131	1430	3490	4357	4773	5266	5562

Mayors, chairmen and vice chairmen of rayon councils						15	194	290	317	354	387
1.2. Disability pension – total (1.2.1+1.2.2 +1.2.3.):	112374	111735	113022	115526	115220	117085	119925	123719	125676	126538	128145
including women							62850	64893	65543	65720	66223
Grade I	16922	15792	15540	15244	14138	13827	13770	13619	13369	13183	13298
Grade II	81912	81892	83911	86166	82128	82443	84064	86753	86922	87089	87948
Grade III	13540	14051	13571	14116	18954	20815	22091	23347	25385	26266	26899
Working pensioners	15607	16094	17077	18776	19896	21600	23912	26815	28862	30307	31677
1.2.1. General disease - total, out of which:	107738	107274	108679	111327	111211	113168	116044	119875	121892	122865	124508
Grade I	16454	15359	15114	14844	13758	13456	13409	13257	13000	12836	12968
Grade II	79939	79974	82033	84313	80415	80708	82319	85005	85200	85390	86208
Grade III	11345	11941	11532	12170	17038	19004	20316	21613	23692	24639	25332
1.2.2 industrial accidents - total, out of which:	4636*	4461*	3971	4156	3971	3872	3819	3772	3704	3587	3540
Grade I	468	433	381	396	377	367	356	356	361	340	322
Grade II	1973	1918	1667	1830	1698	1712	1719	1714	1681	1654	1688
Grade III	2195	2110	1923	1930	1896	1793	1744	1702	1662	1593	1530
1.2.3. occupational disease – total, out of which:			372	43	38	45	62	72	80	86	97
Grade I			45	4	3	4	5	6	8	7	8
Grade II			211	23	15	23	26	34	41	45	52
Grade III			116	16	20	18	31	32	31	34	37
1.3. Survivor pension – total:	35963	34493	37470	36012	33515	33019	31889	30505	29779	28157	25884
including women							6802	6491	6319	6033	5551
1 survivor	24476	23596	26521	25706	23761	23649	23312	22468	22597	21587	5551
2 survivors	8530	8249	8393	8036	7746	7493	6924	6465	5794	5294	19978
3 or more survivors	2957	2648	2556	2270	2008	1877	1642	1572	1388	1276	4752
1.4. Seniority	787	803	774	778	716	736	707	664	642	713	713

Source: Annual social reports, 2002-2008

* industrial accidents and occupational disease pensions

Table 4.3. Number of new pensioners, by type of pension, 1998-2008

Type of pension	Number of pensions granted										
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
1.1. Old-age pension – total	22189	7282	4343	3964	6670	16820	22126	24636	27302	27429	28864
including women							10223	15724	20033	26076	20953
Minimum size	143	355	83					9666	6614	7172	7515
General conditions total	15009	6402	4219	3840	6434	16591	18152	21903	25442	25047	27075
Privileged conditions (anticipated) – total, out of which:	7180	880	124	124	236	229	975	1428	1166	1029	913
Mothers with 5 or more children total	1063	335	91	88	204	192	821	1245	1011	901	774
Cabinet members – total			64	6	5	1	18	7	2	8	3
MPs – total			18	7	5	22	17	11	8	8	7
Public servants– total			120	184	157	272	2607	1254	626	791	778
Mayors, chairmen and vice chairmen of rayon councils						5	177	89	41	48	43
1.2. Disability pension – total (1.2.1+1.2.2 +1.2.3.):	11803	8134	6834	7770	7497	8438	9521	11054	9537	9646	9876
including women							4570	5210	4327	4337	4400
Grade I	1910	798	766	722	680	737	863	871	784	794	870
Grade II	8694	6436	5521	6147	4695	5301	5972	7058	5750	5913	6014
Grade III	1199	900	547	901	2122	2400	2686	3125	3003	2939	2992
1.2.1. General disease - total, out of which:	11626	8031	6785	7717	7433	8330	9394	10928	9446	9549	9738
Grade I	1882	792	762	720	675	730	857	859	773	786	860
Grade II	8610	6367	5495	6116	4673	5245	5910	6994	5706	5865	5938
Grade III	1134	872	528	881	2085	2355	2627	3075	2967	2898	2940
1.2.2 industrial accidents - total, out of which:	177*	103*	47	47	55	102	117	115	86	89	127
Grade I	28	6	4	2	5	6	6	12	11	8	10
Grade II	84	69	26	27	19	53	59	61	42	44	72
Grade III	65	28	17	18	31	43	52	42	33	37	45
1.2.3. occupational disease – total, out of which:			2	6	9	6	10	11	5	8	11

Grade I						1					
Grade II				4	3	3	3	3	2	4	4
Grade III			2	2	6	2	7	8	3	4	7
1.3. Survivor pension – total:	3466	2833	2105	2148	2459	2706	2582	2968	2433	2045	2103
including women							660	720	612	539	574
1 survivor	2029	1625	1208	1276	1450	1652	1588	1911	1618	1343	1434
2 survivors	1017	876	653	657	751	787	737	797	621	530	514
3 or more survivors	420	332	244	215	258	267	257	260	194	172	155
1.4. Seniority	66	45	23	48	183	208	357	33	17	498	45

Source: Annual social reports, 2002-2008

* industrial accidents and occupational disease pensions

Table 4.4. Average size of the monthly pensions, Euro

Type of pension	Average size of pension, €										
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
1.1. Old-age pension – total:	14.47	7.62	7.50	12.18	13.00	13.85	21.97	25.30	27.74	34.09	43.57
including women							21.17	24.40	26.75	32.73	41.71
Minimum size	10.03	5.78	5.65	5.64				17.36	18.16	22.93	27.81
Working pensioners							26.10	29.25	31.38	40.12	51.09
General conditions total	14.56	7.58	7.50	12.43	13.23	14.03	22.27	25.56		34.49	44.08
Privileged conditions (anticipated) – total, out of which:	14.23	7.71	7.50	10.44	11.40	12.55	19.73	25.18	26.01	31.33	39.81
mothers with 5 and more children total						12.32	19.35	22.25	24.41	29.39	37.31
Cabinet members – total			118.78	120.39	108.28	93.60	216.41	231.25	290.75	335.82	395.92
Deputies – total			101.46	105.30	97.92	98.34	129.75	191.42	282.91	326.73	384.11
Public servants– total			38.90	40.58	37.66	36.04	54.30	62.07	66.43	77.85	99.04
Mayors, chairmen and vice chairmen of rayon councils						47.25	67.12	74.22	84.16	101.47	131.77
1.2. Disability pension – total (1.2.1.+1.2.2+1.2.3.):	13.39	7.16	7.15	12.11	12.71	12.40	19.14	21.51	23.10	28.16	35.84
including women							18.73	21.51	22.67	27.50	34.95
Grade I	16.22	8.53	8.49	14.77	15.37	15.10	23.52	26.63	28.94	35.39	45.47
Grade II	13.56	7.31	7.29	12.36	13.25	12.99	20.15	22.74	24.62	30.09	38.32

Grade III	8.80	4.71	4.73	7.75	8.38	8.27	12.58	13.96	14.84	18.14	23.00
Working pensioners							19.25	21.13	22.41	27.57	35.13
1.2.1. General disease - total, out of which:	13.45	7.19	7.18	12.16	12.75	12.44	19.20	21.55	23.14	28.21	35.90
Grade I	16.21	8.52	8.49	14.75	15.36	15.10	23.49	26.59	28.90	35.35	45.41
Grade II	13.55	7.31	7.28	12.35	13.24	12.98	20.14	22.72	24.59	30.06	38.29
Grade III	8.75	4.69	4.70	7.71	8.36	8.26	12.54	13.88	14.73	18.04	22.88
1.2.2 industrial accidents - total, out of which:	11.95	6.35	6.25	10.88	11.47	11.21	17.57	20.09	21.37	26.56	33.78
Grade I	16.71	8.89	8.64	15.29	15.93	15.51	24.36	27.86	30.36	36.75	47.30
Grade II	14.08	7.43	7.29	12.93	13.74	13.30	20.74	23.61	25.71	31.08	39.24
Grade III	9.02	4.84	4.87	8.03	8.55	8.35	13.06	14.92	16.29	19.70	24.90
1.2.3. occupational disease – total, out of which:			7.30	11.70	14.22	12.83	19.45	21.11	22.73	30.76	40.99
Grade I			9.40	17.36	19.66	19.01	32.47	32.48	32.05	46.74	61.23
Grade II			8.23	13.96	21.16	15.39	25.04	26.11	26.92	37.08	49.22
Grade III			4.80	4.34	8.20	8.98	12.66	13.67	14.79	19.12	25.06
1.3. Survivor pension – total:	10.87	5.74	5.50	7.66	8.36	8.83	13.64	15.38	16.40	19.22	24.04
including women							13.05	14.70	15.56	18.13	22.43
1 survivor	7.96	4.40	4.36	6.49	7.18	7.58	11.92	13.59	14.74	17.43	22.43
2 survivors	14.89	7.76	7.52	9.98	10.63	11.33	17.48	19.52	20.79	24.24	21.95
3 and more survivors	23.29	11.44	10.68	12.79	13.53	14.62	21.99	23.98	25.17	28.53	30.09
1.4. Seniority	20.94	11.35	12.43	14.86	17.56	19.45	32.61	38.73	42.62	140.81	187.35

Source: Annual social reports, 2002-2008

Table 4.5. Average size of the newly assigned pensions, Euro

Type of pension	Average size of pension, €										
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
1.1. Old-age pension – total:	15.38	9.16	8.31	13.62	14.88	14.29	21.63	23.07	24.68	32.88	43.01
including women							20.76	22.31	23.88	32.88	40.06
Minimum size	9.75	5.73	5.66					17.34	18.16	22.94	29.12
General conditions total	15.24	9.27	8.32	13.65	14.98	14.32	21.89	23.38	24.88	33.13	43.29
Privileged conditions (anticipated) – total, out of which:	15.67	8.34	8.29	12.55	12.14	12.04	16.82	18.38	20.17	27.01	34.81

mothers with 5 and more children							15.65	17.08	18.39	24.51	30.86
Cabinet members – total			118.78	119.71	115.34	116.93	211.01	218.53	305.61	336.62	395.53
MPs – total			112.57	114.34	128.04	110.99	188.33	180.95	268.71	324.20	370.35
Public servants– total			42.19	45.06	43.33	37.16	54.99	67.98	79.21	95.41	129.16
Mayors, chairmen and vice chairmen of rayon councils						54.93	67.33	77.36	130.48	138.92	196.56
1.2. Disability pension – total (1.2.1.+1.2.2+1.2.3.):	14.47	7.56	8.34	12.25	12.21	11.51	16.55	16.57	17.71	23.44	30.07
including women							15.85	15.81	16.70	21.47	27.92
Grade I	17.47	8.93	9.69	14.68	15.24	15.19	21.06	21.04	23.04	31.98	43.82
Grade II	14.62	7.81	8.48	12.58	13.57	12.59	18.11	18.28	19.66	26.14	33.10
Grade III	8.59	4.54	5.02	8.09	8.25	8.00	11.63	11.47	12.59	15.70	19.98
1.2.1. General disease - total, out of which:	14.49	7.57	8.34	12.26	12.18	11.52	16.56	16.59	17.72	23.45	30.09
Grade I	17.48	8.94	9.69	14.69	15.19	15.19	21.02	21.01	23.04	32.00	43.64
Grade II	14.62	7.81	8.47	12.57	13.52	12.59	18.11	18.30	19.67	26.13	33.12
Grade III	8.58	4.54	4.98	8.09	8.20	7.99	11.62	11.47	12.60	15.70	20.01
1.2.2 industrial accidents - total, out of which:			8.75	11.90	20.09	10.41	15.99	15.03	16.77	21.53	28.46
Grade I			8.71	11.63		14.15	26.18	22.73	22.99	29.69	59.10
Grade II			10.55	14.57	45.42	11.89	18.36	15.74	18.32	25.19	30.22
Grade III			6.01	7.91	7.43	8.05	12.13	11.62	12.71	15.41	18.83
1.2.3. occupational disease – total, out of which:	12.95	6.77	7.53	11.79	15.10	15.18		12.80	11.79	29.57	29.77
Grade I	17.17	7.97	8.71	13.02	21.78	18.70					
Grade II	14.82	7.63	10.55	14.28	19.26	14.69	19.19	23.21	14.67	43.87	53.67
Grade III	8.71	4.38	6.16	7.81	11.47	14.16	10.95	8.89	9.86	15.24	16.10
1.3. Survivor pension – total:	12.73	5.99	6.39	8.87	9.42	9.43	13.42	13.24	14.04	17.92	23.49
including women							12.63	13.11	13.67	16.72	22.02
1 survivor	8.40	4.84	5.11	7.38	7.76	7.77	11.39	11.46	12.43	16.44	21.41
2 survivors	15.99	6.96	7.75	10.61	11.14	11.12	16.19	9.37	16.81	20.16	26.65

3 and more survivors	25.27	9.03	9.07	12.40	13.74	14.71	18.05	18.62	18.58	22.54	32.23
1.4. Seniority	20.89	15.06	20.42	27.75	33.24	35.77	36.47	42.34	52.35	187.02	169.56

Source: Annual social reports, 2002-2008

Table 4.6. Structure of the pensioners by type of pension and sex

	2001		2002		2003		2004		2005		2006		2007	
	male	female	male	female	male	female	male	female	male	female	male	female	male	fe
	Row N %	Row N %	Row N %	Row N %	Row N %	Row N %	Row N %	Row N %	Row N %	Row N %	Row N %	Row N %	Row N %	Ro
Old-age	31.9	68.1	32.2	67.8	32.8	67.2	32.8	67.2	32.2	67.8	31.3	68.7	29.9	
Public servants	37.9	62.1	35.9	64.1	36.2	63.8	35.8	64.2	36.8	63.2	37.2	62.8	36.5	
MPs	87.7	12.3	89.9	10.1	87.7	12.3	90.1	9.9	90.1	9.9	89.5	10.5	89.1	
Cabinet members	91.0	9.0	90.0	10.0	90.9	9.1	90.5	9.5	91.6	8.4	92.8	7.2	91.6	
Mayors, chairmen and vice chairmen of rayon councils					76.9	23.1	84.8	15.2	84.9	15.1	85.4	14.6	84.4	
Disability Grade I	53.1	46.9	53.4	46.6	53.9	46.1	53.9	46.1	53.9	46.1	53.8	46.2	54.3	
Grade II	46.1	53.9	46.2	53.8	46.0	54.0	45.9	54.1	45.8	54.2	46.4	53.6	46.4	
Grade III	64.8	35.2	58.6	41.4	56.0	44.0	55.9	44.1	55.0	45.0	54.8	45.2	54.8	
Survivor pension	79.0	21.0	78.9	21.1	79.0	21.0	78.9	21.1	79.0	21.0	80.0	20.0	79.2	
Total	37.4	62.6	37.7	62.3	38.1	61.9	38.2	61.8	37.7	62.3	36.5	63.5	35.9	

Source: own calculations based on NSIH data

Table 4.7. Structure of the old age and disability pensioners by age groups

age	2001		2002		2003		2004		2005		2006		2007	
	old-age	disability	old-age	disability	old-age	disability	old-age	disability	old-age	disability	old-age	disability	old-age	disability
	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %	Column N %
<= 20		0.1		0.1		0.1		0.1		0.1				
21 - 25		0.7		0.5		0.5		0.4		0.5		0.5		0.5
26 - 30		2.4		2.1		1.9		1.6		1.5		1.4		1.2
31 - 35		4.4		4.2		3.9		3.7		3.6		3.4		3.1
36 - 40		8		7.4		6.9		6.4		6.1		5.8		5.5
41 -		13		12.7		12.1		11.5		10.8		9.9		9.2

45														
46 - 50	0.1	17.3		16.7		16.7		16.6		16.7		16.5		16.3
51 - 55	2.4	18.8	1.5	21.4	1.1	23.4	0.7	23.3	0.6	22.5	0.6	21.7	0.5	21.2
56 - 60	13.5	12.5	11.2	11.6	9.8	11.6	9.3	13.2	10.2	16.4	13.2	19.5	15.3	21.8
61 - 65	24.4	9.6	24.6	10.5	25	10.4	24.2	10.3	22.8	9.7	20.8	8.9	17.8	8.3
66 - 70	22.9	5.9	23.9	5.8	24.2	5.6	24.8	5.9	24.6	5.6	23.3	5.9	23.8	6.3
71 - 75	18.9	4	19.7	3.8	20.1	3.7	19.5	3.5	19.6	3.3	19	3.3	19.4	3.4
76 - 80	11.1	2.2	11.4	2.1	11.9	2	12.9	2.1	13.2	1.9	13.8	2	13.9	1.9
81 - 85	4.3	0.8	5.3	0.9	5.9	0.9	6.3	1	6.6	0.9	6.7	0.9	6.6	0.9
86 - 90	1.8	0.3	1.7	0.3	1.5	0.2	1.7	0.2	1.7	0.2	1.9	0.2	2.2	0.2
91 - 95	0.5	0.1	0.5	0.1	0.5	0.1	0.5	0.1	0.5	0.1	0.5	0.1	0.4	0.1
96 - 100+	0.1		0.1		0.1		0.1		0.1		0.1		0.1	

Source: own calculations based on NSIH data

Table 4.8. Structure of employment by age group and sex

	2000	2001	2002	2003	2004	2005	2006	2007
total	**54.8**	**53.7**	**53.3**	**47.5**	**45.7**	**49.0**	**42.9**	**42.5**
15-19	20.2	18.1	17.0	11.3	9.4	21.8	18.9	17.7
20-24	44.2	41.9	39.5	33.1	30.2			
25-29	64.1	61.6	60.7	52.8	50.9	59.8	51.6	51.4
30-34	72.5	72.0	71.6	66.2	62.2			
35-39	75.1	73.8	74.1	68.8	65.7	69.7	62.9	61.7
40-44	77.2	75.0	72.9	67.4	65.8			
45-49	76.9	77.4	76.3	71.9	68.9	72.0		64.4
50-54	75.7	75.7	76.4	71.4	69.4			
55-59	60.2	60.0	63.4	60.4	62.0	56.6	48.6	49.9
60-64	40.5	42.7	43.7	38.3	38.9			
65+	21.7	20.6	22.5	15.4	15.1	16.1	12.6	11.9

males	**57.7**	**56.2**	**55.1**	**49.3**	**46.6**	**50.4**	**45.5**	**44.8**
15-19	23.3	19.9	19.0	13.7	11.3	22.9	21.2	20.1
20-24	45.6	42.4	37.8	32.8	29.7			
25-29	65.9	61.0	59.3	50.3	48.7	57.5	53.5	52.4
30-34	70.6	71.3	70.2	64.6	58.4			
35-39	74.2	72.9	73.6	68.6	63.1	67.0	62.2	59.5
40-44	76.7	73.4	69.5	63.7	62.3			
45-49	77.1	77.4	75.4	71.1	68.3	73.0		63.1
50-54	80.5	80.5	79.3	73.6	70.9			
55-59	75.0	75.6	77.8	73.5	71.3	68.1	59.9	61.1
60-64	49.7	54.5	58.0	51.5	51.0			
65+	25.3	25.4	27.5	19.4	19.0	19.5	16.8	16.5
females	**52.2**	**51.4**	**51.7**	**46.0**	**44.9**	**47.7**	**40.5**	**40.5**
15-19	17.1	16.2	15.0	9.0	7.5	20.5	16.7	15.3
20-24	42.7	41.4	41.2	33.5	30.7			
25-29	62.5	62.3	62.1	55.4	53.4	62.1	49.6	50.3
30-34	74.3	72.6	73.0	67.6	65.4			
35-39	75.9	74.6	74.6	69.0	68.1	72.2	63.6	63.9
40-44	77.6	76.4	76.1	70.9	69.1			
45-49	76.7	77.5	77.1	72.6	69.5	72.5		65.6
50-54	71.5	71.5	73.9	69.4	68.1			
55-59	49.0	48.2	52.3	50.6	54.7	47.5	39.8	41.1
60-64	33.8	34.3	33.2	28.7	30.4			
65+	19.5	17.6	19.5	12.9	12.6	13.9	10.2	9.0

Source: Statistical reports of NBS according to data of Labour Force Survey in households

CHAPTER V. HEALTH CARE AND LONG-TERM CARE

5.1. Historical Perspective

Inherited from the USSR, the Semashko model of health care implemented in the country failed to adapt to changing conditions and challenges. Under the old system, district hospitals received budget funds from local governments according to the maintenance needs of a huge number of health institutions. The old funding system did not reflect the growing need for effective management of patient pathways within the system. Simple payment of utility and wage bills was not intended to regulate the quality or volume of care. Moreover, with worsened overall financial conditions, the state could not finance the overcapacity and ineffective performance of the health sector.

Since 1992, the Moldovan health care sector has suffered from a sharp decline in health care expenditure in the country due to social and economic disruptions, and the dismantling of old management and financing systems. By 2000, public health expenditure had dropped to 2.9% of GDP . From 2001, however, along with resumed economic growth, the public share of health care expenditure grew steadily. In 2007, the Government spent 4.8% of GDP[172], or €31 per capita (Statistical Data, Table 7). In 2008 the growth trend in public health expenditure continued, reaching 5.4% of GPD[173].

The period 1992 through 2000, in addition to a deteriorating financial situation within the health sector, was characterized by growing rent-seeking behaviour among medical personnel, declining quality of health care services and worsening health indicators for the country. Although a whole range of reforms was pushed forward, there was still a great number of problems to be tackled to help improve the health status[174] of the population.

The inherited overcapacity of the health care sector became one of the first targets of the reforms launched by the Government in the late 90s to tackle the problem of the deteriorating and indebted health sector. Reduction of overcapacity within the framework of health sector reform primarily targeted old and duplicated tertiary and local services. Between 1990 and 2003, the number of hospitals within the system managed by the Ministry of Health (MH) was reduced from 309 to 65[175]. Further reduction was moderate, and by 2008, there were 62 hospitals in the system managed by the ministry[176].

The largest share of downsizing occurred during 1998–2000, when the Government negotiated conditions for structural adjustment credit with the WB. At that time, the Government, with the assistance of a WB loan and Dutch government grant, created the Health Investment Fund. This fund channelled around €20 million into health care reforms in Moldova. Considerable downsizing of the health care sector, including both primary and hospital care, was the condition for funding. Development of strong primary care and emergency service rehabilitation were set as top priorities, while only limited resources were directed to the hospital sector. As part of the

[172] Strategy for Health Care Sector Development 2008-2017, approved by Government Decision Nr. 1471 from December 24 2007.
[173]Ministry of Health, Annual Health Report 2008, 2009
[174] The level of health of the individual, group, or population as subjectively assessed by the individual or by more objective measures.
[175] Annual Statistical Handbook Public health in the Republic of Moldova in 2003, Ministry of Health, 2004.
[176] Data of the Ministry of Health for 2008.

same project, more than 700 physicians and 1500 nurses were trained as general practitioners, and GP curricula was introduced into the Medical University.

Underdeveloped in the former USSR, primary care started to take on a different form through the unfolding health sector reform. The health sector reform strategy gave primary care a special role as a tool to improve access to health care services at the local level. Total public health expenditure on primary care had reached 30% by 2006 (Statistical Data Table 9), compared to 10% in 1999[177], while hospital capacity and spending declined proportionally. As independent legal entities, starting from 2008, local primary health care centres—originally existing within district departments of health care—were allotted new functions and responsibilities, including gate-keeping and control of immunization, cardiovascular diseases, diabetes, HIV/AIDS, TB, and other chronic conditions.

As a part of the effort to improve the efficiency of the health care sector and provide equal access to a minimal set of health care services, in 1999, the Government passed the "Minimum Package of Free Medical Assistance Guaranteed by the State" and "Regulation on Fee for Health Services". These regulations set the tariff levels for health services and introduced official 'fee-for-service' in health care. At that time, a large share of health care expenditure burden was transferred to patients—this before health insurance was introduced.

Compulsory health insurance has been considered the primary tool to improve health sector financing and performance since 1998, when the *Law on Compulsory Health Insurance* was adopted by Parliament. It took a further 6 years to create the minimal social, legal and economic premises for compulsory health insurance to be introduced in the country. The NHIC was founded in 2002, and started paying providers in January 2004.

5.2. Health Outcomes

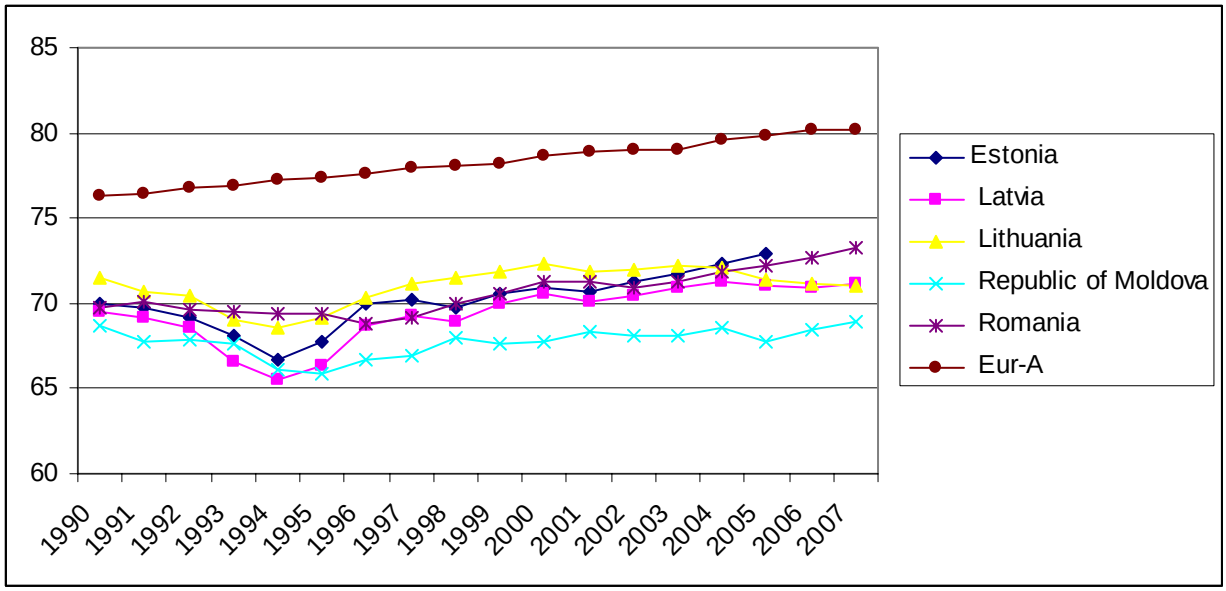
5.2.1. Demographic changes

The national trend for life expectancy over the last 15 years has been positive overall. After a sharp decline in the 1990's, this indicator grew from 1999 through 2008. In 2008, life expectancy reached 65.5 years for males and 73.2 years for females. Still, life expectancy of both genders in Moldova is 10 years lower than the EU-A[178] average of 79 years (Figure 5.1.)

[177] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies

[178] EU-A: 27 countries in the WHO European Region with very low child and adult mortality (Andorra, Austria, Belgium, Croatia, Cyprus, Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland, United Kingdom), World Health Report 2004, Changing History, Geneva, WHO, 2004 (http://www.who.int/whr/2004/en/)

Figure 5.1. Life expectancy at birth, years, 1990–2007



Source: European HFA Database

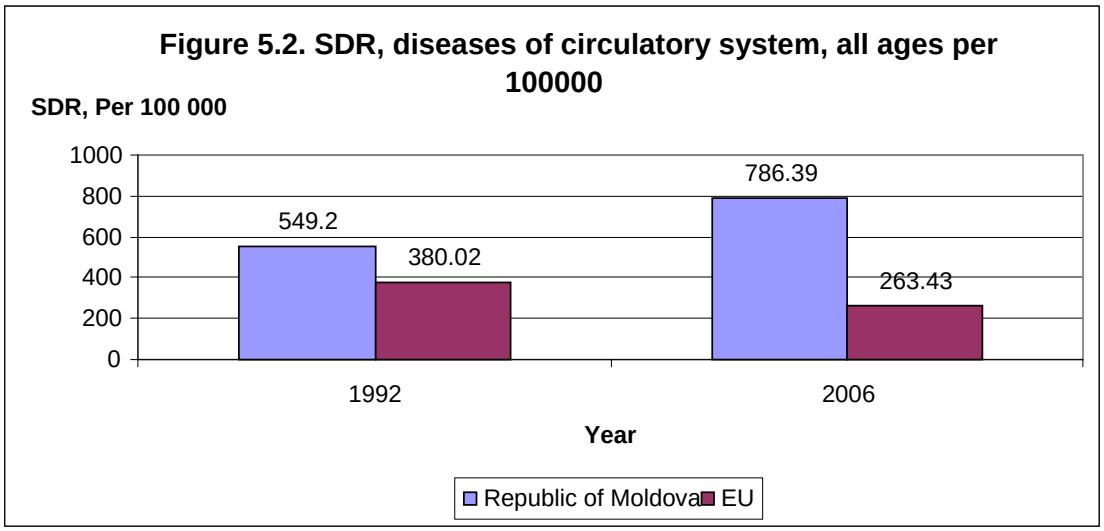
The natural growth rate of the population declined to a negative figure of -1.4% in 2003 from 0.5% in 1991, and resumed a slow positive trend after 2003 reaching -1.1% by 2006[179].

The overall mortality rate increased from 11.8 to 12 per 1000 between 1997 and 2007, while the birth rate declined by 15% during the same period.

Considerable regional differences are found in mortality rates between the capital and the districts of the country, as well as between urban and rural areas. The Chisinau municipality mortality rate was twice as low as that in the district of Donduseni in 2007. While the birth rate in rural areas prevails over the urban rate by 24%, the mortality rate in rural areas was still 55% higher than in urban areas in 2006.

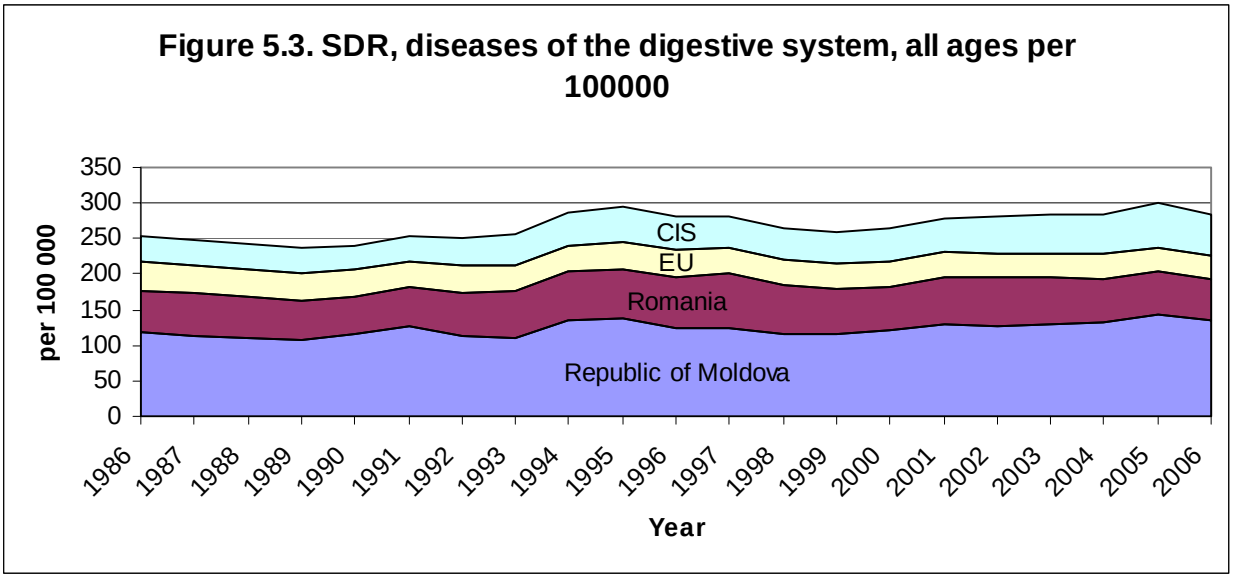
The top five causes of death in 2008 were: cardio-vascular diseases, malignant neoplasm, diseases of digestive organs, traumas and poisoning, and diseases of the respiratory system[180]. Cardio-vascular diseases (CVDs) have been the major cause of death in the country over the last 15 years. CVD mortality in the country grew more than 40% from 1992, while EU CVD mortality rates improved considerably during the same period of time (Figure 5.2). While the CVD mortality rate between 2006 and 2008 remained flat, the death rate from cardiac infarction grew by about 20%[181].

[179] WHO estimates for country NHA data
[180] Annual Activity Report of the Ministry of Health 2008, Chisinau, 2009
[181] Annual Activity Report of the Ministry of Health 2008, Chisinau, 2009



Source: European HFA Database

Diseases of the digestive organs in Moldova persist on the list of main causes of death. Alarming is the comparison of this indicator with regional country averages—it exceeds the EU average by more than four times (Figure 5.3). Chronic hepatitis and cirrhosis were responsible for 91.1 deaths per 100,000 in the country in 2008.



Source: WHO/European HFA Database

5.2.2. Infant and Maternal Mortality

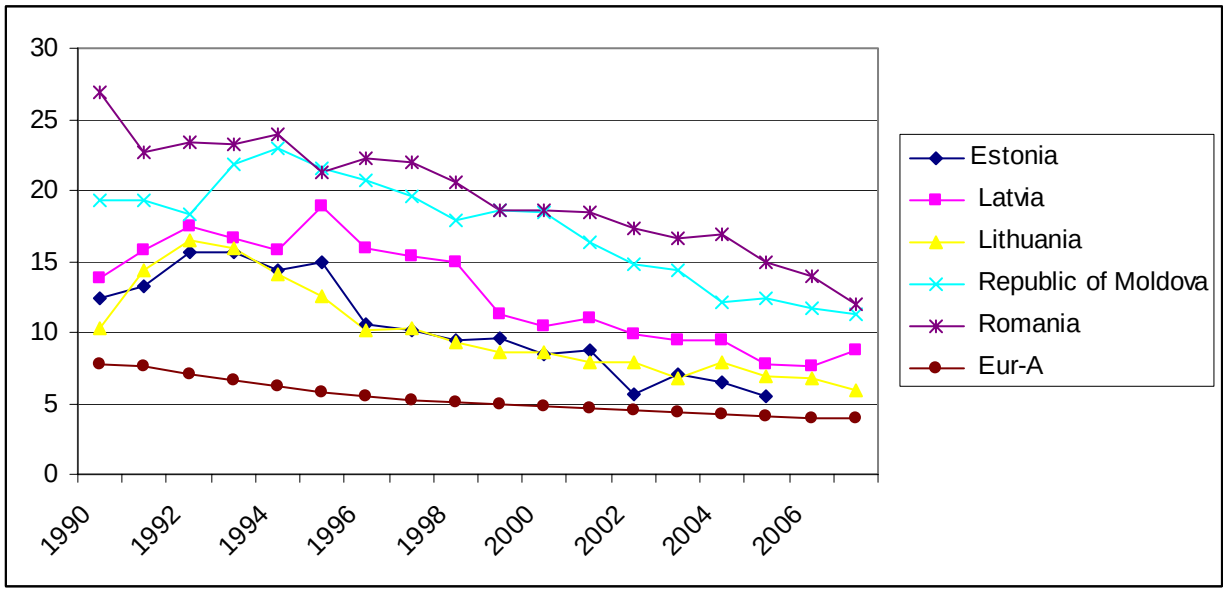
Child mortality has long been of concern to international donors. By signing the MDGs, Moldova internationally declared its intention to achieve medium and long-term targets in improving the well-being of the population. Despite some progress, both the MDG First National Report and the 2007 progress report on MDGs "New Challenges – New Tasks" point out that the child mortality situation in the country is still critical, and ongoing reforms are needed to ensure a further reduction in child mortality. Both reports outline a low level of parental education as the cause of high prenatal morbidity and child mortality due to traumas and intoxication.

According to the MDG Report, Moldova accepted the obligation to reduce infant mortality to 9.6 by 2010, and 6.3 by 2015. According to the NBS, the country surpassed the 2006 target of 12.6 deaths/1000[182] of newborns (11.76 in 2006[183]).

Change in the methodology used to calculate infant mortality, introduced by the Government in 2008, is expected to result in a technical increase of this indicator[184]. In accordance with these methodological changes and capacities of perinatal care, the Government has revised national targets for both infant and child mortality[185].

Moldova has performed better than other CIS countries and neighbouring Romania in improving the infant mortality situation in the country. However, considerable effort is required in order to reach the EU average.

Figure 5.4. Infant death, per 1000 of newborn



Source: WHO/European HFA Database

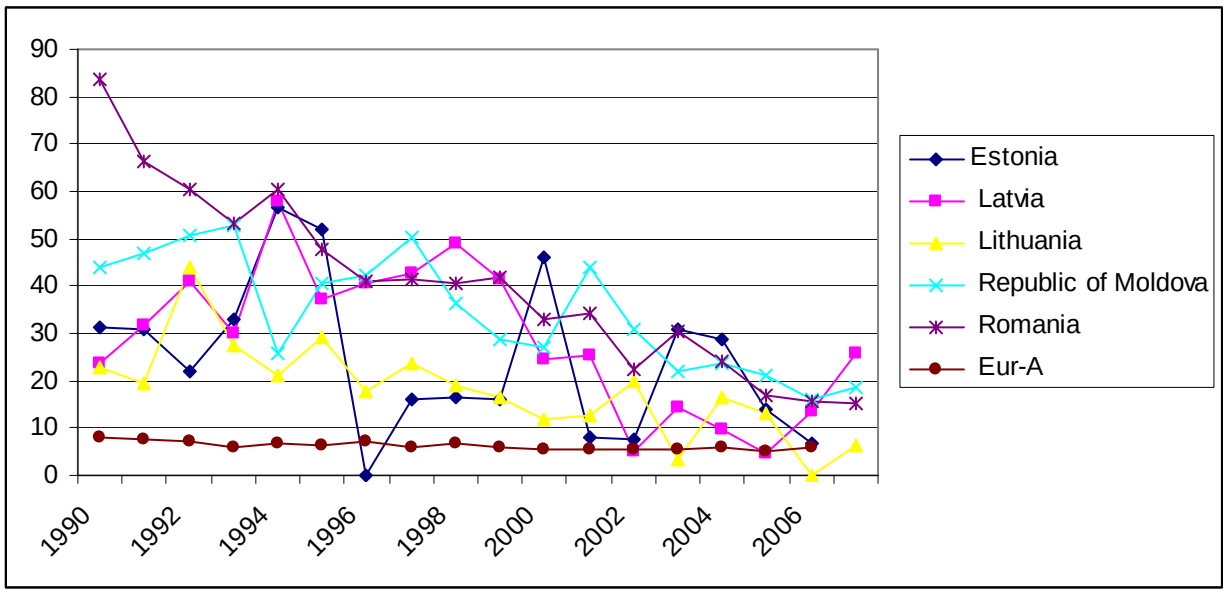
Of note, is that prior to 1998, infant mortality in rural areas exceeded urban areas. However, this situation changed after 1998, and in 2002, the infant mortality rate was 15.5 in urban areas, and 14.4 in rural areas[186]. This trend persisted through 2007 with urban infant mortality being 14.9 and rural 9.9[187], deepening in 2008 to 17.8 in urban areas and 9.6 in rural[188].

The opposite situation is observed for the under-5 mortality rate. According to WHO estimates for the country (2005), there is a 50% higher under-5 mortality rate in rural areas.

[182] The First National Report, Millennium Development Goals in the Republic of Moldova, June 2005
[183] WHO/European HFA Database
[184] This transition is due to the change in child mortality estimation methodology, recommended by WHO, and stated in the framework of the "EU-Moldova" Action Plan. The new methodology stipulates that birth is defined as birth after 22 weeks of pregnancy (instead of the previous 30), and child mass from 500 gm (previously 1000 gm). Moldova started calculating this rate, according to the new methodology, from 2008. It is expected that child mortality will jump due to this methodology change.
[185] http://www.undp.md/mdg/MDG4/child.shtml
[186] Millennium Development Goals First Country Report, Moldova 2005
[187] Statistical Yearbook Public Health in the Republic of Moldova 2007
[188] Annual Activity Report of the Ministry of Health for 2008, Chisinau 2009

Maternal mortality rates in Moldova have varied widely over a downward trend in the last two decades (Figure 5.5), from 52.9 per 100,000 live births in 1993 to 16.0 in 2006, and 38.4 in 2008. Despite this progress achieved through 2006, the maternal mortality rate remains much higher than EU averages. Of note in relation to this indicator, is that the absolute figure for maternal mortality in Moldova is 15 women (2008), potentially triggering high annual variations due to the low number of cases.

Figure 5.5. Maternal mortality, per 100 000 life birth



5.2.3. Morbidity

Over the last 15 years, both old and new health threats have continued to transform the pattern of morbidity in the country. The influence of non-communicable diseases on morbidity has been on the rise, while morbidity due to infectious diseases still presents a serious danger to public health.

- Between 1994 and 1996, Moldova suffered an outbreak of diphtheria and over 700 people were infected.
- A cholera outbreak occurred in 1995.
- Due to failure of the immunization programme between 1989 and 1994 all 400,000 children born during this period were at risk, and a **mumps epidemic** emerged in the country in January/February 2008. More than 4500 children and young people were infected during this period. Intervention by UNICEF and WHO helped to stem the spread of this epidemic in the country.

Infectious and communicable diseases

The decade between 1990 and 2000 was a critical period for the country, as there were several outbreaks of serious infectious diseases, an alarming growth in sexually transmitted infections (STIs) and TB, and development of a negative trend in HIV/AIDS control.

Prevalence of STIs jumped between 1990 and 1999**.** Since 2000, STI morbidity has followed a decreasing trend, although levels are considerably higher than those of the EU (Table 5.1).

Table 5.1. ***STI Morbidity in 2007, Moldova-EU, per 100 000***

	Syphilis incidence	Gonococcal infection incidence
Moldova	77.33	48.84
EU	4.26	7.63

Source: WHO/European HFA Database

Moldova has relatively few reported HIV/AIDS cases,the majority occurring among injecting drug users (IDUs). However, studies suggest that HIV/AIDS cases are occurring more frequently through sexual activity among the general population[189]. According to data from the MH, the ratio of IDUs among the HIV-positive population decreased from 78.1% in 2001 to 42.4% in 2004, while infection through heterosexual contact increased from 18.6% in 2001 to 55.4% in 2004[190]. The female share in the population of HIV-positive status grew along with the number of pregnant HIV carriers.

Although on a declining trend, hepatitis B morbidity in Moldova is three times higher than the EU average (11.43 versus. 3.09 in 2005[191]). Unsafe injection practice[192] is thought to be the main reason for these high figures.

The tuberculosis situation, although improving slightly, is still much worse than within the EU region. Despite conditions of coverage with BCG remaining high, the prevalence of tuberculosis continued to rise from the early 1980s through 2000. Along with the implementation of the DOTS strategy, the TB detection level almost doubled from 2000 to 2006, contributing to the continuous growth of the overall incidence of tuberculosis in Moldova from 2003 to 2005.

The pocketed distribution of tuberculosis in prisons is directly tied to the living conditions of prisoners. In 1999, a rate of 2,640 cases per 100,000 of the prison population was recorded in one of the country's prisons[193]. An incidence of 85% of the prison population infected with TB was also observed for some prisons in 1998[194].

Non-communicable disease morbidity

Along with infectious diseases, non-communicable morbidity in the country represents a growing threat to the health of the nation. Worsening morbidity trends for cardiovascular disorders, malignant neoplasm and diabetes are severely compromising population health.

Cardiovascular morbidity is widespread in Moldova. Annually, around 2% of the population is newly diagnosed with a cardiovascular disease. **The diabetes** situation in the country has steadily worsened. The number of diabetes cases in 2007 reached 49,080, compared to just over

[189] Review of Experience of Family Medicine in Europe and Central Asia (in five volumes) Volume V: Moldova Case Study May 2005, Report No. 32354-ECA

[190] Annex nr. 1 to Government Decision nr.948 from 5.09.2005 "National Programme of prevention and control of HIV/AIDS infection and sexually transmitted infections for the period 2006–2010

[191] European health for all database (HFA-DB), World Health Organization Regional Office for Europe

[192] Svetlana Nichita, Social and economic aspects of chronic viral hepatitis in the adult population of the Republic of Moldova, USMF, 2008

[193] WHO Regional Office for Europe, National Tuberculosis Programme Managers' Meeting, Report on the fifth meeting, Wolfheze, Netherlands, 7–9 June 2002

[194] The Anti-plague System in the Newly Independent States, 1992 and Onwards, James Martin Center For Nonproliferation Studies, April 11, 2006

20,000 in 1980[195]. **Malignant neoplasm** morbidity grew from 152.6 in 2000 to 209 in 2007. Along with accelerated growth, first-time diagnosis of stage four tumours make up 27% of newly diagnosed cases. **Mental health** disorders have been one of the major causes of disability in the country. Out of 60,000 persons with mental disorders registered, approximately 50% are disabled. State policy considers the mentally disabled to be among the most vulnerable groups in society. The national **suicide rate** reached 30 per 100,000 in some locations (2006) [196], compared to the country average of 18.25 cases per 100,000 in the same year. While the suicide rate for females is comparable to the EU average, the male suicide rate was 74% higher than in the EU in 2007, falling below 30 cases per 100,000 for the first time since 1991.

5.2.4. Health determinants

Alcohol, smoking and drugs

According to WHO, in 2006, the most critical risk factors for morbidity, disability and mortality in Moldova were alcohol, hypertension, cholesterol and tobacco smoking.

Alcohol consumption in Moldova was on the rise from 1991 to 1998. Although declining among the 15+ population, alcohol consumption per capita is still much higher than the average for the EU and CIS—13.5 litres (11.05 and 7.52 litres respectively) in 2002, and more than 30% higher than in neighbouring Romania. In 2008, comparative studies of alcohol consumption habits place the Moldovan population among the top five alcohol consumers in the world.

The last several years also registered growth in the number of chronic alcoholism cases. The incidence of chronic alcoholism increased from 81.0 in 2003 to 106.8 per 100,000 of population in 2006. There are strong regional differences, where, for example, in the districts of Stefan Voda (217.9), Singerei (200.9), Anenii Noi (197.1), Cimislia (196.3), and Basarabeasca (195.9) the average incidence of chronic alcoholism is twice as high.

Chronic liver disease and cirrhosis are among the major causes of mortality in Moldova (116.0 per 100,000 among males and 99.4 per 100,000 among females in 2005), which is strongly tied to excessive alcohol consumption in the country and, as mentioned earlier, endemic conditions for the spread of hepatitis B.

In 2006, mortality from smoking and alcohol-related causes was among the highest in the entire WHO European Region (Figures 5.6 and 5.7).

[195] WHO/European HFA database, World Health Organization Regional Office for Europe
[196] National Programme on Mental Health for 2007–2011

Figure 5.6. SDR, selected alcohol-related causes, per 100 000

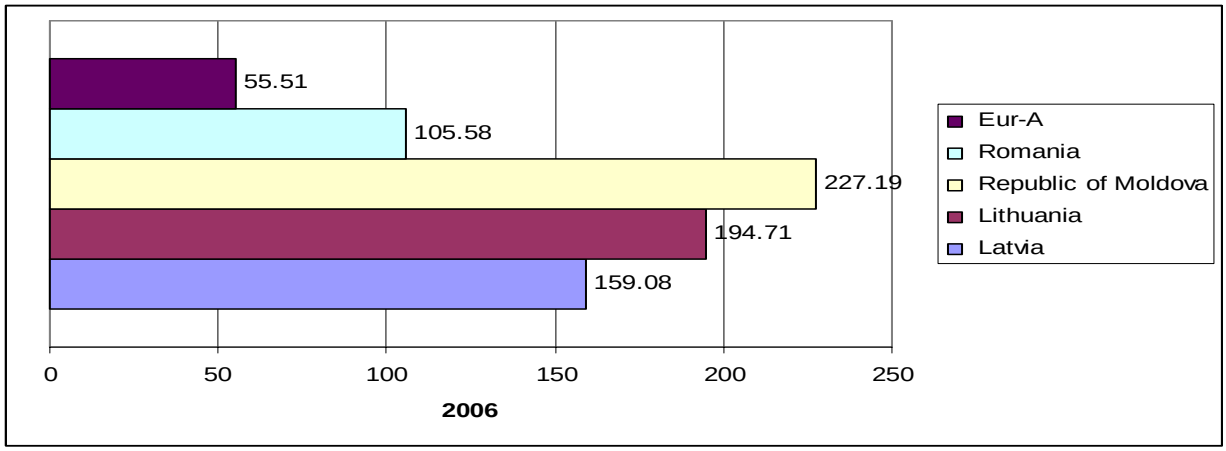
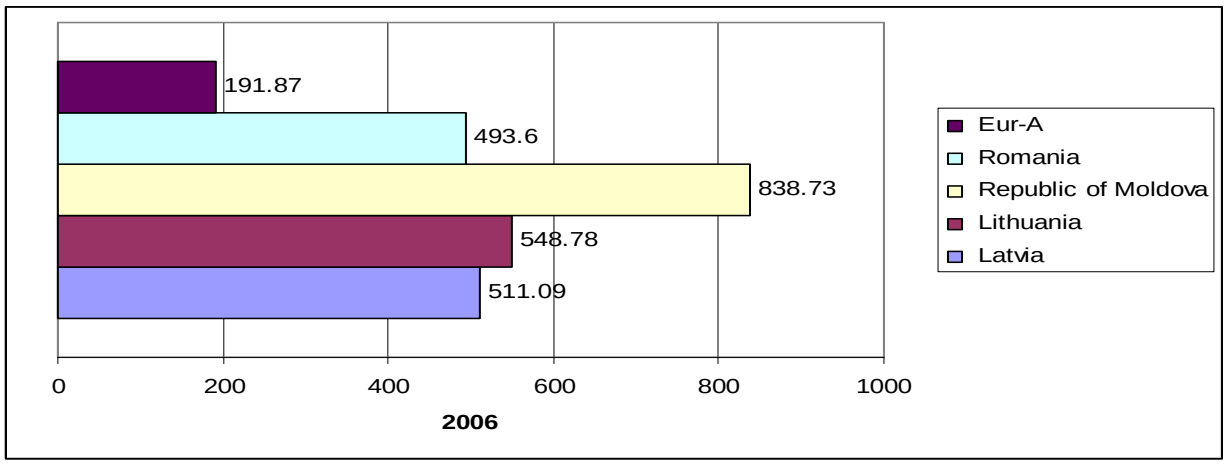


Figure 6, selected smoking related causes, per 100 000



Source: WHO/European HFA Database

Comparision of the smoking prevalence rates in 2004[197] with WHO estimates for the NHA for Moldova (2006 data), shows that smoking prevalence more than trippled among women between 2000 and 2006 (from 2.0% to 7.1%), while an increase among the male population was less pronounced (from 40% to 51%)[198].

The drug use incidence rate within Moldova reached 27.9 per 100,000**,** and prevalence was 209.2 per 100, 000 (2006). A total of 95% of drug users are less then 30 years old[199]. There are regional disparities in distribution with higher rates in urban areas and lower penetration in rural settlements. To date, IDUs have been the main HIV risk group.

Water and sanitation

Water is a fundamental requirement of human life and well-being. The link between quality of water and quality of life has been evidenced internationally from both a social and economic perspective. Over the last 10 years, a large portion of the drinking water supply in Moldova was of poor quality, and even dangerous to health.

[197] Joceline Pomerleau, Martin McKee, Richard Rose, Dina Balabanova and Anna Gilmore Dimension: Health conditions and health behaviours, June 2003, Living Conditions, Lifestyles and Health, EU Fifth Framework Project, 2000-2003

[198] WHO/European HFA Database

[199] Data of the Ministry of Health

In 2002, 41% of homes were connected to a main water supply system, and huge discrepancies in access between urban and rural areas persisted: 78% of urban homes versus only 9% of rural homes[200]. Although the National Scientific and Applied Centre for Preventive Medicine reported that over 92% of urban and 91% of rural households had sufficient access to potable water in 2005, the fact remains that well water is the main water supply used in rural areas. In 1999, 75% of all well water did not meet sanitary and bacteriological safety standards. There is a similar urban/rural discrepancy in access to hygienic means of sewage disposal, which is available to 91% of the urban population but only 67% of the rural population. Only 5.1% of rural residents had toilets inside their homes in 2006[201]**.** During 2007, contamination of both natural water sources and the centralized drinking water supply increased**.** The ratio of poor quality[202] samples from centralized underground water sources in settlements located on the right river bank of the Nistru was 61.4% compared to 59.1% in 2006. In some areas this ratio reached up to 100%[203].

5.3. Governance and Financing

Over the last 4 years, while the health care sector was largely decentralized, central government increased its influence on funding for health care institutions through creation of a purchaser/provider split, and the introduction of compulsory health insurance as the main buyer of health services. Presently, all accredited public and private primary care institutions are paid for the services they deliver to the population by compulsory health insurance or they charge a 'fee-for-service' to patients, with the exception of some departmental health care facilities[204]. While the system of incentives is still not clear, the trend towards more effective health service provision is certainly present.

5.3.1. Regulations and administrative bodies

The right of citizens of Moldova to health care is embedded in the country's constitution, and the underlying laws, strategies, and policies, determine the organizational structure of the system that develops and delivers health care services, manages resources, and monitors and evaluates health status and health services for the population.

Signed in 2006, the EU–Moldova Action Plan formally placed Moldova on the road to reforms to harmonize the national legislative framework with European standards and norms. Changes in the health care sector are intended to lead to better access of the population to quality health care services. Following the Economic Growth and Poverty Reduction Strategy, the goals related to ensuring better health outcomes for the population are outlined in the NDS 2008–2011. In addition, the strategic planning process was considerably improved by the introduction, in 2003, of the MTEF—a medium-term budget planning mechanism for improving the management of public funds.

The NDS 2008–2011[205] acknowledges both results and drawbacks of previous reforms in health care, covering access, quality, and equity issues. Development of healthy human capital is set

[200] WHO/European HFA Database

[201] The contribution of human resources development to migration policy in Moldova, European Training Foundation, December 2007

[202] Non-compatible by sanitary-epidemiological characteristics (transparency, contamination, residue, hardness)

[203] Sanitary-hygienic and epidemiological situation in the Republic of Moldova in 2007, SSES Chisinau 2008

[204] Facilities founded by other ministries and departments, and financed directly through the state budget

[205] The Law on Adoption of the National Development Strategy for 2008–2011 nr. 295-XVI from 21.12.2007

among the top priorities of the NDS. The plan envisages a wide set of instruments to improve public health, and create means for better access of the population to equitable health services of high quality. Along with the broader NDS, supported by monitoring tools, the MH identified its longer-term development goals in the National Strategy for Health Sector Development 2008–2017.

Health sector management in the country involves many stakeholders actively influencing health care policy.

The **Ministry of Health** proposes, develops, and implements the health care policy in the country. By law[206], the MH is assigned to control and manage: i) regulation, organization and functioning of the health care system; ii) elaboration of national policies and strategies to ensure public health; iii) monitoring and evaluation of the policies created in order to raise the social, economic, financial impact of these; iv) analysis of the policies to ensure harmonization at the national level, and with the priorities of European integration; v) monitoring and evaluation of the health status of the population along with the adoption of measures for improving health status; vi) quality of health services through monitoring and evaluation, and accreditation of health care and pharmaceutical institutions; vii) together with specialized bodies within central and local public administrations, satisfactory human resource and material supplies needed for the functioning of health care institutions; viii) collaboration with government and non-government partners on the implementation of educational programmes for the population on prevention and combat of diseases; ix) implementation, within the framework of the legislation, of international programmes of financial assistance in order to support reforms of the health care system and improve the quality of health care services provided to the population; x) representation of the Republic of Moldova, within the framework of the legislation, in relation to WHO, Environment Commission, Health and Consumer Protection Commission of the European Commission, Directorate General for Health, and other international bodies in the areas of interest.

The **NHIC** manages the compulsory health insurance funds, participates in the development of annual tariffs for health care services, and manages insurance policies for the insured. The budget of the NHIC is set by the Parliament together with the state and social insurance budgets. The NHIC is an autonomous state institution managing the non-profit compulsory health insurance system for the population. In its work, NHIC uses authorized[207] processes and mechanisms in accumulation of financial resources and financing the volume of health care services to the population according to the Unified Programme of compulsory health insurance, adopted annually. The company controls the quality of health services delivered, and implementation of regulations with regard to health insurance.

LPAs oversee and direct implementation of health care policy at the local level. Through the network of district and municipal health care institutions, owned by local authorities, LPAs participate in the organization of health services at the local level in accordance with recommendations from the MH. In cooperation with the ministry, local authorities create the necessary conditions for implementation of public health services. LPAs are considered to be the main drivers of the expansion of community services, including home and long-term care.

The **MSPFC** and the **MEY** actively participate in creation and implementation of health policy in the country, and in discussion and development of new health care legislation and

[206] Government Decision nr. 326 from 21.03.2007, regarding adoption of the schedule, structure and responsibilities of the central apparatus of the Ministry of Health

[207] Government Decision nr. 156 from 11.02.2002 regarding adoption of the Statutes of the National Health Insurance Company

programmes. The ministries are the main players in the fields of long-term care for the disabled, the elderly, and children.

The State Agency for Material Reserves and Humanitarian Assistance manages state reserves, and stocks and distributes humanitarian aid received by Moldova. The Agency acts on the decisions of Government, managing the distribution of reserves and humanitarian aid, which often includes medical equipment, furniture, medicines, and supplies for hospitals.

The **Ministry of Finance** participates in the development of the annual health care budget, including the budget of the NHIC. The ministry also receives proposals and negotiates with stakeholders on the MTEF. The MF physically performs transfers from the central budget to LPAs, NHIC, and the National Social Insurance Fund.

5.3.2. Institutional structure and ownership

Delivery of health services to Moldova's population is based on the following pillars: public health service, emergency service, and primary, secondary and tertiary care institutions. The growing role of public health within the population health service structure will strongly influence primary, hospital, consultative and emergency care in the future while also extending its influence over other sectors of the economy.

5.3.2.1. Public Health Service

Public health services are provided through the newly established[208] State Public Health Surveillance Service within the MH.

Before the adoption of the new public health law, the National Centre for Preventive Medicine (transformed into the State Public Health Surveillance Service following the adoption of new legislation), through the network of 36 territorial branches, and in close cooperation with public administrations and health care providers, implemented standards and guidelines for environmental health, communicable diseases and occupational health. According to the new law, health promotion and non-communicable disease control are now also the responsibility of the service. According to the law, the Public Health Service has new supervisory functions, and has become more centralized and independent of local authorities.

Apart from other duties, implementation and control of immunization programmes in the country is the direct responsibility of the service. Since 1994, immunization has been targeted as a priority measure through the National Immunization Programmes for 1994–2000, 2001–2005, and 2006–2010.

5.3.2.2. Emergency Service

The present structure of the emergency service in the country was approved by Government Decision of July 17, 2003[209], marking the commencement of reform in emergency care.

In order to improve the quality of services provided to the population, professional training and research standards, as well as standards for emergency care, medical vehicles, special and

[208] According to the Law on State Public Health Surveillance 10-XVI from 03.02.2009 that replaced Law nr.1513-XII from 16 June 1993, on sanitary-epidemiological services for the population
[209] Government Decision nr. 891 from 17 July 2003 "Regarding creation of the Emergency Service of Moldova"

medical equipment were developed. To date, resourcing of the emergency service has lagged behind in relation to special and medical equipment.

According to the new structure, emergency care within the country is provided nationwide by the state emergency service through one national emergency hospital and four zone stations. Zone stations and substations assure a maximal coverage radius of 25 km to the closest emergency service.

Two hundred and fifty emergency teams operate within the emergency service. Of these, 158 teams are generalist and 8 paediatric. A total of 69 teams are staffed with medical attendants only. A total of twenty-two teams provide specialized emergency care.

All calls are handled through one nationwide phone number—903—and calls are received locally in zone stations. In parallel to the state service, a private emergency service provides paid services to the general public within the municipality of Chisinau. To date, progress of the NHIC in the purchasing of emergency services from private providers has been limited.

The counselling and information service—965—within the emergency service structure provides telephone assistance and consulting to patients. Also provided as part of the emergency care is the "AVIASAN" specialized emergency service, which consults to local hospitals over the phone and deploys teams of highly specialized professionals from republican and municipal institutions on demand for surgical and other emergencies.

Emergency services at the pre-hospital stage are free for all citizens of the country. Insured persons also are eligible for further hospitalization and treatment according to the Unified Programme.

5.3.2.3. Primary Care

In Moldova, primary health care is provided by the family medicine centres (former polyclinics), primary care centres (based on former rural clinics) and health centres. In 2007, there were 2027 primary care doctors servicing 1226 primary care institutions[210].

National health policy locates primary care services so that they are universally accessible to everyone in Moldova. Free access to primary care doctors was legally enacted along with the adoption of the basic package of medical services provided to the population, both for the insured and non-insured. Funding for primary care services to the non-insured is provided by the central government through the NHIC. The volume of services available to the non-insured according to the basic package includes only a free consultation with a family doctor, assistance in major emergency cases at the pre-hospital stage, and services within the limits of national programmes[211]. This level of servicing triggers considerably higher out-of-pocket formal and informal spending for this group in health institutions.

As mentioned, within the primary care network, 1226 institutions provide services to the population. With 49 family medicine centres in urban locations, the system includes subordinated (307) and autonomous (24) rural health centres. In rural locations, within the network of subordinated institutions, 352 offices of family doctors and 287 health offices provide care. Autonomous rural health centres also include 27 offices of family doctors.

[210] Annual Activity Report of the Ministry of Health for 2007, Chisinau, 2008
[211] See 5.3.3 National Programmes

In terms of ownership, most primary care institutions are public institutions. Local public health care institutions are usually managed by LPAs and the MH. Public and private institutions must be accredited by the ministry to be eligible to sign direct service contracts with the NHIC.

Prior to 2008, due to the organizational structure of the district health care system, comprising of the territory's primary and hospital care institutions and headed by the Chief Medical Officer of the district hospital, up to 25% of primary care resources did not reach their destination, remaining at hospital level. This was addressed in January 2008, when primary health care centres were transformed into separate legal entities with contractual obligations to the NHIC, ensuring proper funding of primary care.

While raising the profile of family doctors, the MH introduced performance incentives in primary care. Now family doctors are assigned more active roles in national programmes and public health activities. Rewarding performance, using incentives such as topping-up salaries and providing bonuses, the ministry, through the NHIC, has stimulated GPs to actively diagnose TB, AIDS/HIV and cancer at the primary level, and raise the level of care at the primary level for pregnant women and children, and other population groups[212].

5.3.2.4. Secondary (district) and tertiary (republican) hospital care

At the secondary level, health care services are provided by the network of district and municipal hospitals. At the end of 2008, there were 82 hospitals, including 72 public and 10 private, with 19,997 beds[213] in the country. The MH managed 62 hospitals in 2007. The secondary-level of care includes 34 district hospitals, and 10 municipal inpatient facilities. The network of Republican (National) institutions consists of 18 entities, three located outside Chisinau (psychiatric hospitals in Orhei, Balti and Vorniceni). Clinical education and research departments of the University of Medicine and Pharmacy of Moldova are incorporated in the structure of most republican and municipal institutions in Chisinau**.**

In 2008, there were 611 beds per 100,000 of population. Republican facilities assured 41.1% of beds, district hospitals 41.5%, and municipal inpatient hospitals 17.4%. A total of 46.8% of all beds were located in Chisinau in 2008[214]. In total, 636,239 people were admitted to hospitals in 2008. The average bed utilization length reached 291 days compared to 241 in 2004. Since 2004, the hospitalization rate slightly increased reaching 17.8 per 100 of population. In 2008, the average length of stay of 9.6 days did not change significantly compared to previous years.

Reduction of hospital capacity financially supported the restructuring of health expenditure in the country and rolling-in of reforms within the health sector. However, in 2006, although less than in the CIS region, the provision of beds for the population of Moldova (626.8 per 100 000) was still higher than for EU countries (576.1 per 100,000).

The downsizing of hospital care affected not only the number of hospitals but also the structure, which, according to the hospital restructuring plan, limits district hospitals to five main specialties: internal medicine, surgery, gynaecology and obstetrics, paediatrics and infectious diseases (up to 90 000)**.** The 10-year plan envisages creation of three regional centres of excellence (Balti in the north, Chisinau in the centre, and Cahul in the south) to improve regional access of the population to specialized hospital care services.

[212] Order of the Ministry of Health 426/214A from 14 December 2007, regarding approval of methodology of application of the Unified Programme of compulsory health insurance allowances in 2008
[213] Ministry of Health data for 2008
[214] Annual Activity Report of the Ministry of Health for 2008, Chisinau 2009

The expected reduction in capacity of republican and municipal facilities did not follow the reduction in secondary hospital capacity (which consisted mostly of rural hospitals), and still represents a reserve for optimization of the public health care provider structure. Financial gains on reducing the overcapacity of republican institutions located in Chisinau, is a potential source of financing of regional centres of hospital excellence .

Ten hospitals with a total of 2044 beds and 91 outpatient facilities are owned, financed, and managed by the corresponding state ministries and agencies[215], such as the Ministry of Internal Affairs, Information and Security Service, Border Department, and the Ministry of Justice. These institutions receive a direct portion of the state budget to provide a full range of services free of charge to identified groups of the population who are already insured by the State, or who are contributing to health insurance funds, such as soldiers, military and law enforcement retired officers, civil service personnel and pensioners. Following public discussion on whether these population groups should attend regular health care facilities financed by health insurance, or continue to receive care in these institutions (and how the duplication of funding can be avoided), these institutions are gradually signing contracts with the NHIC to obtain reimbursement for servicing these categories of insured population previously funded from the state budget.

Specialzed ambulatory care is provided by a network of more than 250 outpatient institutions that also include approximately 50 primary care centres. Within districts, consultation sections are usually attached to district hospitals and former polyclinics. Moldova's population visit outpatient facilities on average 4.7 times per year, out of which, 2.8 visits are to a family doctor.

5.3.2.5. Private health care institutions

Private investment in health care institutions targeted mostly outpatient consulting facilities, dental care and the pharmaceuticals market. By 2007, out of 474 private health care institutions, there were 11 private hospitals with a total capacity of 151 beds, and one independent emergency service. Of note, is that along with 1328 doctors, there were only 927 nurses and medical attendants empoyed in private institutions. Private health care institutions employ more than 600 dentists and provide a large part of the dental care in Moldova.

With the development of evaluation and accreditation mechanisms for health care institutions, and consolidation of the legal framework for contracting the NHIC for services, the share of private capital at the health care provider level is expected to increase. In 2008, private accredited health care institutions and pharmacies were permitted to sign contracts with the NHIC, stimulating demand for health care institution accreditation. Pharmacies are mostly private, and some already participate in NHIC reimbursement programmes for drugs prescribed at the primary care level.

5.3.3. National Programmes

Thirteen national programmes on health care direct state interventions in identified health care priority areas, set medium-term objectives and priority actions, and specify funding and monitoring of expected results in a range of priority areas identified by the MH**.**

[215] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies

National programmes on combating and managing HIV/AIDS, STIs, and tuberculosis were developed in keeping with the MDGs to manage and monitor progress and consolidate funding. National programmes for the prevention and control of malignant neoplasm, diabetes, and mental health were implemented in response to the worsening epidemiological situation in these areas. Other programmes improve management, planning and funding augmentation in the areas of health and healthy lifestyle promotion, blood transfusion security, immunization, and modernization of identified areas in health care, such as emergency services.

National programmes are financed by the state budget and donors, and managed by the MH. Funding of these programs continuously increased over 2000–2006 (Statistical Data Table 8). International expertise suggests that these funds can be managed by the NHIC to avoid duplication of responsibilities by the MH and the NHIC. Benefits of the national programmes are included in the basic package of medical services available to all citizens.

5.3.4. Wages and incentives in health care sector

All through the transition period, health care personnel salaries remained inadequate for a satisfactory standard of living. In 2000, the average monthly salary of a doctor was around €32.5 per month, nurses and support personnel earning less[216]. By 2007, the average doctor's salary increased considerably to around €180 per month[217], which was still very low given the accompanying increases in the cost of living. The salaries of nursing personnel are even lower. In 2007, the average monthly salary of a nurse was €87.8 per month.

Wages of health professionals in the public sector are still determined by the Law on Remuneration of Moldova (1994). The law does not provide any link between wages and performance—incentives not used by legislation in general.

A system of bonuses for performance, meeting certain quality indicators, has been introduced into the activity of family doctors (see 5.3.2.3. Primary Care), and primary care nurses also attract payments through a system of bonuses in the same way as family doctors. In addition, since 2004, the Government has allowed public health care institutions to redirect up to 50% of revenues from fees for services collected to remunerate health professionals.

Insufficient pay and weak professional ethics continues to stimulate informal payments in the sector.Therefore, the personnel policy should ensure a merited compensation for health professionals, improve professional ethics and prevent corrupt behaviour among health care personnel.

5.3.5. Health care education

Education within the health sector is coordinated by the MH. The State University of Medicine and Pharmacy of Moldova (USMF) has been responsible for administering medical education and re-training of graduate health professionals since 1945.

Prior to 1999, eight nursing colleges produced middle-level health care personnel. After downsizing in 1999, five nursing colleges provided education and training for nurses and midwives. Conversely to higher medical education, over last few years, nursing colleges

[216] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies
[217] MH Data

increased enrolments of students who pay privately for their education (44 students in 2003 versus 361 in 2006).

In 2007, the first Masters of Public Health group graduated the two-year programme from the School of Public Health within the USMF. The main purpose of the course is to train health professionals in health care economics, epidemiology, communication and other issues related to Public health and health care management.

Continuous education of doctors is organized by the USMF on the request of the MH. Re-training and continuous education are integral to the activity of health care professionals in the country, and passing state examinations is required for certification. However, concerns about the quality of the training curricula have been raised, and strategies to broadly tackle the re-training curricula are under development.

5.3.6. Breakdown of funding sources

5.3.7. Provider network reimbursement

Health care providers within the MH network are reimbursed for health care services provided to the population by the NHIC, and through out-of-pocket payments from citizens. A small share of funds comes from private insurance (prepaid and risk-pooling plans).

In 2006, public health expenditure in Moldova was reported at 4.8% of GDP, rising to 5.4% in 2008. Introduced in 2004, compulsory health insurance collected and managed 32.5% of total health care expenditure (both private and public) in 2005. The share of state budget transfers to the compulsory health insurance budget constantly declined from 66.7% in 2004 to 59.6% in 2007[218].

Funding of primary care following the introduction of health insurance has grown steadily, and presently accounts for 31% of total health insurance transfers. In absolute figures, primary care received €31.2 million in 2007. The figure planned for 2009 is €67.1 million[219].

Private health insurance schemes are underdeveloped in Moldova, as the introduction of compulsory health insurance released employers from the obligation to insure its personnel with private health insurance companies—now all legal employees are insured by default. Under the prevailing system of widespread informal payments, patients often prefer to "insure" service by direct payments to doctors. The contribution of private health insurance to total health expenditure in the country was 1.6% in 2005[220] compared to a 13% estimate for under-the-table payments in health care.

Subordinated to other ministries and agencies, health care institutions, representing about 10% of all health care capacities in the country, are directly financed from the state budget. In 2006, the state budget allocated €2.5 million, or 3.3% of general government expenditure[221], to those institutions.

[218] Annual Activity Report of the National Health Insurance Company for 2007, Chisinau 2008
[219] Law nr. 263-XVI from 11.12.2008 on compulsory health care insurance funding for 2009
[220] "Improving Public Expenditure Efficiency for Growth and Poverty Reduction", A Public Expenditure Review for the Republic of Moldova, Report No. 37933 – MD, February 12, 2007, WB, p. 50
[221] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies

5.3.7.1. Health Insurance

In 1998, the law on compulsory health insurance was introduced to develop a sustainable instrument for the collection and distribution of health care sector funding. On January 1, 2004, Moldova launched compulsory health care insurance on a solidarity basis**.** It was expected that compulsory health insurance would help increase funding of the health sector by becoming the largest purchaser in the newly created purchaser/provider split.

Introduction of compulsory health insurance, on the wave of resumed economic growth in the country, helped channel larger resources to the health sector, as well as shift some of the government health care expenditure burden onto employers and employees. Related issues, including coverage and management of the volume and quality of services insured, still have to be improved.

Further development of this scheme, envisaged by the MTEF 2008–2010, increases the burden of health care expenditure of the employer and employee, increasing contributions from a 2+2 % formula in 2004 to 3.5+3.5 % of the wage fund by 2010 (already introduced in 2009), and a corresponding growth in public contributions.

On the basis of the solidarity health insurance system in Moldova, the NHIC collects and manages funds that arrive from employer/employee contributions, state transfers for some categories of the population, and voluntary insurance policies sold by the NHIC to the inactive (not officially employed) share of the population.

The state provides free health insurance to pre-school and school children, students of secondary professional schools and colleges, university students, participants in compulsory postgraduate education, children not enrolled in education up to 18 years, pregnant women, the disabled, pensioners and registered unemployed persons.

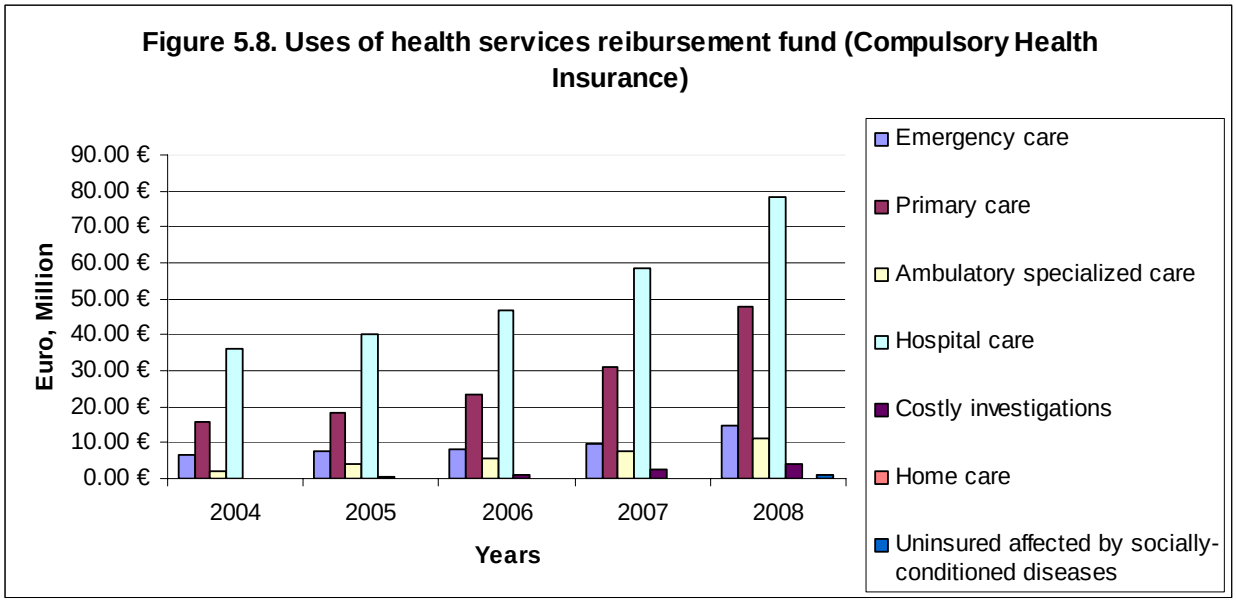
The NHIC is directly subordinated to the Government, and managed through the Administrative Council and Executive Directorate. The Director of the NHIC is assigned by government decision for a period of five years.

Several funds operate under the NHIC structure (2007):

- Health Service Reimbursement Fund—94%
- Reserve Fund—2%
- Preventive Measures Fund—2%
- Administrative Fund—2%

The total budget managed by the NHIC increased from €63.7 million in 2004 to €168.3 million[222] in 2008. More than 30% growth (to €235.5 million) is stipulated for 2009.

[222] Law Nr. 268 from 07.12.2007 on the funds of the compulsory health insurance for 2008



Source: Ministry of Health, NHIC

The NHIC operates through its 11 regional branches that assure company outreach to regional areas. The branches conduct and manage the process of health insurance administration locally, the registration of payers and data management, and control quality and volume of services delivered by assigned health care institutions.

Compulsory health insurance provides partial cost coverage for patients basing on the Unified Programme, which is revised annually. According to the package, compulsory insurance policies cover all primary and specialized ambulatory care consultations, as well as medical services and drugs at the hospital level. In practice, both insured and non-insured patients are often paying for diagnostics, treatment and drugs formally and informally.

The issue of out-of-pocket costs, including the informal payment phenomena and official 'fee-for-service', will be discussed separately.

Outstanding issues persist in health insurance resource management. Since 2004, more than €28 million collected was not used to provide health care goods and services to the population. In 2008, more than €7.4 million was again not utilized[223]. At the same time, annual expenditure on drugs covered by health insurance at the primary level of care was little more than €2.4 million in 2007[224]. An amount of €3.3 million was spent for the same purpose in 2008[225].

The size of voluntary premiums, and corresponding contributions from the state budget, have grown progressively over the last three years. From a figure of €59 per year in 2004, premiums reached €178.9 in 2009.

Between 2000 and 2008, the share of health insurance in total health expenditure in the country grew considerably, while private expenditure was falling in relative figures.

[223] Annual Activity Report of the National Health Insurance Company for 2006, Chisinau, 2007
[224] Annual Activity Report of the National Health Insurance Company for 2006, Chisinau, 2007
[225] Annual Activity Report of the National Health Insurance Company for 2008, Chisinau, 2009

5.3.7.2. Out-of-pocket

In Moldova, out-of-pocket payments include direct payments for goods and services not covered by compulsory health insurance, official user co-payment fees for goods and services covered by compulsory health insurance, and informal payments direct to doctors for the services that should actually be fully paid for by other means. Gifts and gratitude payments were common under the Soviet system. Following the collapse of state funding, informal payments filled the gap during the financial crisis. The average per capita out-of-pocket expenditure in 2000 was €1 per month[226] per household, amounting to approximately €18.4 million or 50% of total health expenditure in 2000.

At that time, up to 80% of out-of-pocket expenditure went towards the purchase of medicines—payment for investigations made up 12%, consultations 6% and transport expenditure 3%. Informal payments grew as public financing of the health care system shrank. In 1999, user fees were introduced for some diagnostic procedures and inpatient care. Formal fees were introduced in order to channel the funds into health care institutions and to prevent informal collections by health care personnel. Consequently, there has been much emphasis on improving transparency within the system. In order to raise consumer awareness of the formal pricing for services and procedures, health authorities have ensured that price lists for health services are clearly displayed in health care institutions.

Although decreasing, private expenditure, as a proportion of total health care spending in Moldova, is very high. In 2005, €88 million or 42.3% of total health expenditure was from formal out-of-pocket payments. Medicines and medical goods for outpatient care accounted for €77 million, or 36.9% of total health expenditure. Official payments for services provided by medical institutions accounted for €11 million, or 5.4% of total health expenditure. These were almost entirely made up of private dentist services. The WB estimated that informal payments equalled €26.77 million in 2004 and €27.9 million in 2005[227]. Urban areas tend to spend more (out-of-pocket) on health care compared to rural areas.

Public opinion surveys financed by the WB in 2002 and 2003 found that unofficial payment to doctors, nurses and other medical personnel was widespread, with over half of respondents in 2003 saying that they had made under-the-table payments. Respondents were in favour of introducing official tariffs to replace informal payments. Although almost half (48%) believed that they will have to make dual payments for treatment—informally in addition to formal fees.

Transparency International reported 65.4% of respondents paying informal fees in health care facilities in 2006. The most recent estimation of this figure was 42.5% in 2007. The organisation also estimated unofficial payments in the amount of €9.2 million paid by patients in health care institutions in the reporting period.

5.3.8. State and local budget non-insurance contributions: Health and Social Investment Fund

In addition to the financial resources accumulating through the NHIC, other types of funds arrive at health care institutions. These include state budget resources allocated via national programmes and strategies, investment and maintenance support from local public administrations, and investments supported by donors. The share of private sector investment in

[226] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies

[227] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies

health care services is still minor, and the majority of private investment funding goes into the pharmaceuticals market, dentistry, diagnostics, and consultative care.

The MH directs public funds to subordinated republican institutions for investment purposes and national programmes. Local public administrations are responsible for the modernization and investment in health care facilities belonging to them—district and municipal health care providers publicly owned. Community investment and public-private partnerships at the local level are still underdeveloped. The amount of local investment in health care facilities is limited and, in many cases, modernization of health care facilities relies on donor funding, if available.

The Moldovan Social Investment Fund (MSIF), created with the support of the WB and Moldovan bilateral partners (SIDA, DFID, JSDF), contributes considerably to the improvement of social infrastructure, including rehabilitation of health and social care facilities, infrastructure development, and creation of community-based services, improving lives of mothers, children, the elderly and disabled, and other vulnerable layers of the population. The total cost of past and current MSIF projects is about €36.7 million. Contributions from communities and the Government amount to €5.2 and 1.9 million respectively.

MSIF support, for which local communities are in competition, assisted the most active of these (more than 1000 benefiting communities) in obtaining investment funds for social and economic infrastructure development. These projects also help to improve access and equity of health care by increasing access to water and sanitation, renovating primary health care facilities, and creating social care capacities for vulnerable groups at the community level. Through the application process for social development projects organized by the MSIF, localities, mostly rural, compete for project funding. The MSIF assists in the development of projects, prepares and announces tenders and monitors the utilization of the financial resources that are transferred directly to LPAs from the MSIF.

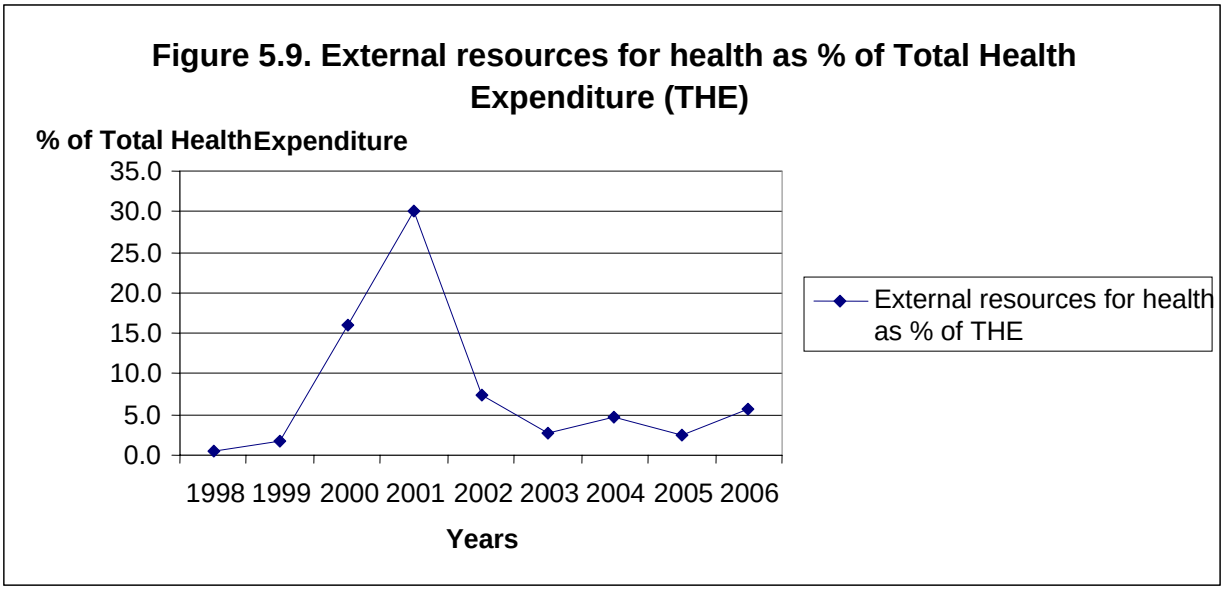
5.3.9. Donors

Health care reforms of the last decade have been strongly supported politically and financially by international and bilateral donors.

In 1999, the Government of Moldova and the WB launched the Health Investment Fund with an amount of €20 million to trigger a three-step reform including: development of primary care with simultaneous reduction in hospital overcapacity, modernization of emergency services, and, as a last step, modernization of district hospitals.

Figure 5.9 shows the evolution of external investment in health care in the country between 1998 and 2006. A strong inflow of external resources in 2000–2001 was enabled by deployment of provider network reform. Considering the substantial growth in total health care expenditure in the country since 2000, it is evident that the amount of donor help is continuously growing along with the total health expenditure. External assistance directed towards health care presently makes up about 6–7% of total external assistance to the country[228].

[228] Division for Coordinating Technical Assistance (NCU), Ministry of Economy and Trade.



Source: WHO NHA estimates for Moldova, WHOSIS

UN agencies partnered Government in the implementation of a number of programmes on HIV/AIDS, TB, STIs, and mother and child care, focussing on marginalized layers of the population. A range of on-going and planned projects target the strengthening of competencies and capacities of the recently built network of health care institutions, and raising the quality of health care services provided to the population at all levels of care. The US Millennium Challenge Corporation through the Moldova Governance Threshold Country Programme contributes to the improvement of quality management and monitoring capacities in health care. Through TACIS and, recently, the European Neighbourhood Policy (ENP)**,** the EU provides technical assistance and financial support at the central and local level. The Eastern Partnership, recently approved by the European Commission, should increase the amount of assistance to Moldova in addition to €209.7 million, envisaged for 2007–2010 by the ENP.

Within the framework of the Health Services and Social Assistance Project of the WB—a €3.3 million investment—37 rural health care institutions were refurbished, and the EU, through the TACIS programme, provided these primary care institutions with equipment worth €4.5 million. Helping Moldova to achieve the targets set by the MDGs, SIDA is implementing two large projects on regionalizing the paediatric emergency service and upgrading 10 perinatal centres in the country.

As part of the "Operation Provide Hope" project, health care institutions in Chisinau, Balti, Cahul, Tiraspol and Slobozia received medical equipment, medicines and supplies including twenty mobile dentistry equipment sets. Donor support for this project amounted to more than €15 million.

Presently, the Government is securing donor funding to help rehabilitate the Republican Clinical Hospital. So far, the preliminary list of agreed funders includes the WB, within the framework of the Health Services and Social Assistance Project, Council of Europe Development Bank, and the European Commission through the support offered by the Strong European Neighborhood Policy[229]. The total amount subscribed, as of February 2009, is more than €14 million, which

[229] Brussels, 05/12/2007 COM (2007) 774 final "A Strong European Neighbourhood Policy"

will allow significant modernization of the facility with 740 beds presently servicing around 25,000 people annually[230].

5.4. Access and equity

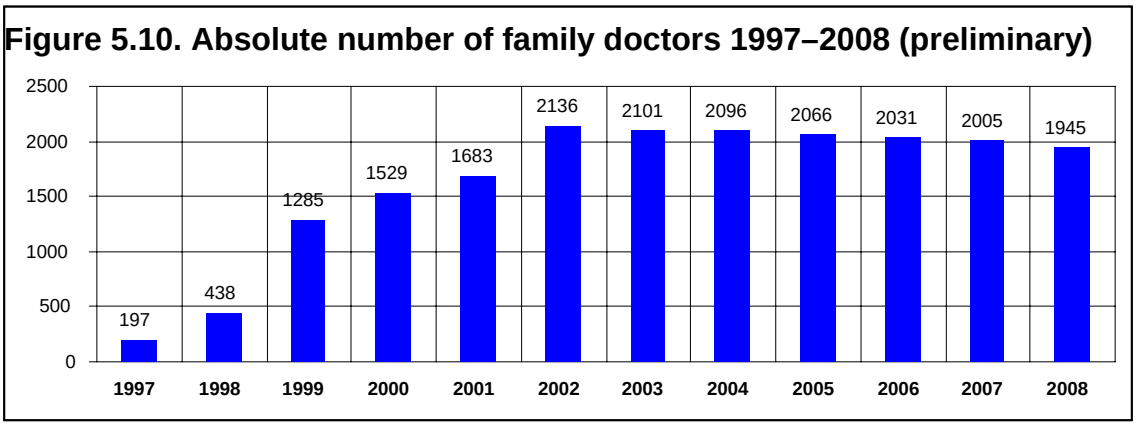
According to the Barometer of Public Opinion Survey[231], in 2002, the threat of poor health (disease) completed the top five threats in the list of primary personal threats perceived by the public. Despite the negative attitude towards the health care sector, by 2006, the share of respondents primarily fearful of illness more than halved from nine to 3.8%, excluding health threats from the top five on the list of primary threats. Less educated and poorer people and those in rural areas are more afraid of disease than better-educated and wealthier people, as well as people from urban areas.

Most Moldovan households have good geographical access to primary health care facilities. On average, 87% of households are located within 5 km and one hour's walk of the closest primary health care facility. The share of households within 5 km to a primary care centre was 93% in urban and 82% in rural areas[232].

Physical access of the population to primary care is affected by strong regional differences in the geographical distribution of medical personnel. Since the re-profiling of some health care specialists as family doctors during the reforms, the state failed to provide proper conditions for family doctors to operate under, especially in rural areas. In some regions of Cantemir, Rezina and Cimislia districts, coverage by family doctors is 50–60% of that needed. This situation is partly due to poor working conditions, underdeveloped infrastructure and lack of modern medical equipment. Low motivation and lack of incentives for primary care personnel are other major reasons for staffing deficiencies in primary care facilities, especially in rural areas.

Between 2003 and 2008, the number of family doctors in the country decreased from 2101 to 1945 (Figure 5.10). Of note, is that out of 331 graduates of family medicine residency in 2007, after nine years of education, only 207 accepted assignments.

Figure 5.10. Absolute number of family doctors 1997–2008 (preliminary)



Source: MH data

[230] Statistical data of the Ministry of Health for 2008
[231] Barometer of Public Opinion of Moldova 2002, 2006, IPP, Chisinau, Moldova, http://www.ipp.md
[232] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies

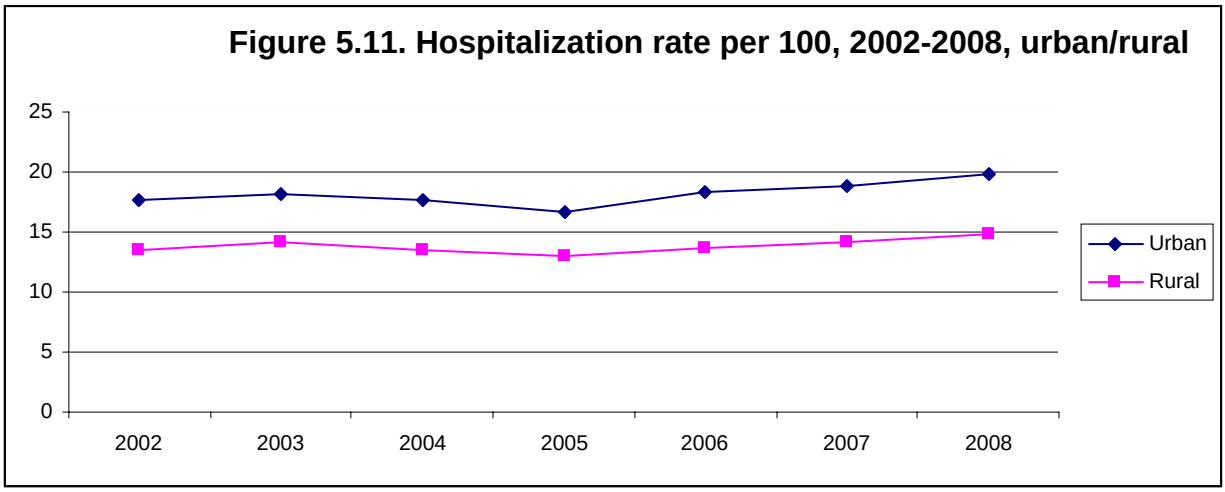
Inequality in access to health services is also conditioned by significant fluctuations in the number of registered patients per family doctor. A recent study[233] shows that the number of patients registered with a family doctor varied from less than 1000 to more than 3000. A significant majority of family doctors (77% of respondents) reported their patient base to be 1000 to 2000. The share of family doctors servicing less than 1000 persons is only 1.4%, while more than 10% of family doctors provide services to more than 3000 patients.

Public access to the emergency service improved after reforms in this area. Since 1999, the number of completed calls to the service has almost doubled—the major contribution to this growth occurring in 2004, when reforms were implemented and compulsory health insurance was introduced. During 2007, the number of completed emergency solicitations continued to grow. While strong regional disparities were observed in some areas, in general, rural access to emergency services improved. The number of completed solicitations per 1000 population from rural areas steadily increased, but remained 28% lower than in urban areas (2008). While most requests for emergency care in municipalities in the north of the country are completed by doctors, emergency medical attendants perform up to 90% of solicitations in some southern areas of Moldova.

Accessibility of emergency services in many areas of the country was also hampered by staffing issues. In 2007, only 60.2% or 1079 emergency doctor positions were filled, and only 70% or 1645 medical attendant positions were staffed[234].

The hospitalization rate for the rural population in 2008 was 153 per 100 inhabitants compared to 21.4 for the urban population, clearly demonstrating strong disparity in access to hospital care in urban and rural areas. In the regions of Anenii Noi, Ialoveni, Straseni, Taraclia and Telenesti, the hospitalization rate in 2006 was half of the average for the country**.** The trend favouring hospitalization among the urban population continued for a number of years (Figure 5.11).

Figure 5.11. Hospitalization rate per 100, 2002-2008, urban/rural



Source: MH data

Outpatient ambulatory care in 2008 continued to be less accessible to the rural population, compared to urban dwellers (4.7 compared to an avearage of 6.8 visits per person per year).

Introduction of compulsory health insurance did not allow for full health coverage—one-quarter of the population relies on the limited basic package guaranteed by the state, and

[233] Dr. Natalia Zarbailov, "The practice in family medicine in the Republic of Moldova: status, challenges and future needs in the opinion of family doctors", USMF, Chisinau 2008

[234] State Programme on Development of Emergency Service for 2006-2010, Approved by the GD Nr. 564 din 22.05.2006

individual/private funds to access health care facilities. Constraints in access to health services among the non-insured impact on up to 25% of the population, particularly among large segments of the poor within the agricultural sector. Access to health care services by the non-insured is strongly limited by the size of the basic package, and a large share cannot afford the high official and unofficial costs of health care encountered.

Insurance coverage among the active population differs according to age group and geography, but international studies report that mostly self-employed agricultural workers between 25 and 64 years of age are the least covered by insurance—up to 62% of those not covered are between 55 and 64 years old[235].

Although performing better than older generations, 25% of those aged between 15 and 24 are not covered by compulsory health insurance. Considering that children up to 18 years and students in higher education are all enrolled by the state in compulsory health insurance, those without cover among the 18–24-year age group can potentially be much higher than the 25% observed among 15–24-year olds. Around 50% of the population aged 25–44 did not benefit from compulsory health insurance in 2007[236].

Gender differences have been reported in compulsory health insurance coverage. While 78.5% of females are insured, only 72.4% of males benefited from compulsory health insurance in 2004. These disparities can be partially explained by a lower retirement age for women, longer female life expectancy (more female pensioners insured by the state), and wider coverage for some categories of women (pregnant).

Presently, the non-insured represent the largest share of those who cannot afford health care due to financial constraints.

Expanding the range of services covered by compulsory health insurance improved access by the insured to primary care. Insured people registered 3.4 visits per person to a family doctor per year compared to 2.7 visits among the general population[237]. The non-insured, at the same time, recorded only 0.8 visits per year.

Present per capita reimbursement to health institutions in primary care for the insured and non-insured differs by more than 10 times the amount (€0.8 compared to €14 in 2008). The same critical difference is observed in emergency care reimbursement. As the result of severely inadequate financing, the non-insured had much poorer access to all categories of health care.

A recent study of access to primary care in the districts of Calarasi and Criuleni found that 58.8% of the non-insured are either temporarily employed or unemployed, and 14.2% temporarily work abroad. Financial constraints were identified by 84% of the non-insured as barriers in access to health care[238].

Imperfect coverage by compulsory health insurance, along with limited quantity and quality of services and medicines included in the health insurance package, forces both insured and non-insured Moldovans to contribute their personal resources to the funds allocated through the NHIC. Out-of-pocket health care expenditure of households grew continuously from 3.7% in 1999 to 5.3% in 2006, as a share of the disposable income of households.

[235] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies
[236] EGPRS Implementation Final Report, Chisinau, 2008
[237] Data source: DS, presented in EGPRSP Final Evaluation Report
[238] Nicolae Lupu, Particularities of access to primary care in the non-insured population, USMF, Chisinau 2008

Private expenditure on health services represents a large burden for citizens of Moldova and, in 2005, the average citizen would top-up public funds by a similar amount.

Out-of-pocket payments are a significant barrier to accessing health care for both the insured and non-insured, especially for members of poor households. While the non-insured suffer the most from the costs of consultations, clinical and instrumental investigations, medicines and hospitalization, both formal and, in many cases informal, insured persons benefit from lower expenditure on hospitalization, clinical and instrumental investigations, and encounter less expenditure on medicines in hospital facilities.

Health insurance does not reimburse payments for most accessible medicines either of the insured or non-insured at primary and consultative facilities, with the exception of a limited range (updated annually) of free and partially compensated medicines for pregnant women, young children, and some categories of the chronically ill and disabled (patients with diabetes, hypertension).

Paying for pharmaceuticals out-of-pocket is particularly expensive as patients have to pay the full costs of drugs prescribed in outpatient care and sometimes for drugs needed for inpatient care, although, officially, drugs prescribed in secondary and tertiary care are covered by core funding.

Administrative constraints in access to pharmaceuticals were recently introduced in Moldova through the enforcement of an official prescription from a medical professional for the purchase of Rx-medicines. Prior to this, most medicines, with the exception of psychotropic and stupefacient drugs, could mostly be freely purchased in pharmacies, and there were little controls over doctors' prescriptions. Although this measure is intended to improve supervision over the sale of medicines, and control the misuse of certain drugs (such as antibiotics), sharp enforcement of the existing legislation has lead to limitations in access to medicines among the population. Doctors are not trained to correctly complete the prescriptions[239], and chronic and acute patients are often not able to obtain their precscribed medicines due to lengthy waiting times for family doctors. Pharmacists are forced into the position of having to choose between helping a patient and observing the regulations to avoid being punished for violation[240].

Regional distribution of official fees for service collected by health care institutions in 2008, suggests that there is still a huge disparity in access to health care services between the urban and rural areas. In Chisinau and Balti municipalities, a health care institution collects €4.77 in official fees per resident per year, which is double the average in rural areas. In some districts, this figure equals just €1.1[241] (Falesti). These differences can be explained by the accessibility of a wider range of services provided in better-equipped republican and municipal facilities in the more urbanized regions.

Special measures to increase coverage are not reflected in government policy documents. This suggests that the issue of access to health services among the non-insured will persist in the medium term, as since its introduction, compulsory health insurance has not initiated schemes that can considerably improve the coverage of one-quarter of the population, most of whom are poor or vulnerable. Private risk-pooling plans are also as yet underdeveloped.

[239] Three to four stamps are required for non-compensated prescriptions—previously neglected by doctors, who instead issued prescriptions on simple pieces of paper with a personal stamp.
[240] Pharmacists are sometimes trusted more than doctors, and many patients would go directly to a certain pharmacy to get both medicine and advice.
[241] Data of the Ministry of Health for 2008

Although increased from about 11% in 2000 to 27.5% of total pharmaceutical expenditure in 2007, public funding is still lower then private expenditure on medicines. At the same time, the share of pharmaceutical expenditure in total expenditures equaled 40.5% in 2007. Continually escallating private pharmaceutical costs remains a large barrier for citizens of Moldova to accessing to even essential drugs.

5.5. Quality of services

According to the BOP survey[242], in 2002, 84% of respondents were disssatisfied with the health care in the country—this figure falling to 70% of respondents by 2006. Satisfaction with health care services improved more in rural areas than in urban areas. These perceptions follow a similar trend to those observed by two surveys on perceptions of health care undertaken between 2001 and 2003[243, 244].

To a certain extent, growth in satisfaction can be attributed to the implementation of a publicity campaign on health sector reforms. The level of awareness of health sector reforms among the population increased by 16% to 60% over 2002–2003. More than 60% of the population accepted that having a personal family doctor is beneficial, although their full role was mostly unclear to respondents, who also raised concerns about the training level of general physicians.

Patient satisfaction and quality of health services is presently a top priority of the health care reform agenda. The MH, in cooperation with international donor organizations[245], is undertaking a range of measures to improve both the quality of health care delivered to the population and their satisfaction with health care services.

The MH considers communication tools to be extremely effective in improving access and quality of health services. In order to improve communication within the health sector, as well as making significant changes to the way it is disseminated to the general population, the ministry is working on a health care sector communication strategy. It is expected that improved communication in the sector and greater public awareness will help raise the quality of health care services, reduce corruption, and improve the public image of the sector.

Through the adoption of new laws in 2005, on patient rights and health care personnel responsibilities, the process of regulating relations between patients, health care institutions, and administrative bodies, was pushed forward. However, implementation of these laws is far from ideal, and legal stipulations are only just starting to get the mechanisms fundamental to implementation underway.

In its efforts to ensure quality of health services, Moldova is steadily moving towards better regulations for medical procedures, and developing clinical guidelines and protocols. The conditions for standardization of care at different access levels—thought to improve quality of care and improve patient pathways within the health care system—are yet to be completed.

---

[242] Barometer of Public Opinion of Moldova, 2002, 2006, IPP, Chisinau, Moldova, http://www.ipp.md

[243] Cercone JA, Ortiz C. Design and Baseline Data for a Monitoring and Evaluation System. Moldova Health Reform Program. Sanigest Internacional. December 2001.

[244] Review of Experience of Family Medicine in Europe and Central Asia (in five volumes) Volume V: Moldova Case Study May 2005 Report No. 32354-ECA

[245] See 5.3.5.5 Donors

Clinical protocols for perinatal and obstetric care, integrated management of childhood, STIs, TB, diabetes, hypertension, and breast and cervical cancer, were developed and have been in use by training programmes since December 2001, in accordance with the loan agreement with the WB. Over 2001–2006, a range of guidelines and standard treatment protocols were adopted[246]. With the support of the Millennium Challenge Corporation, the MH is working on the improvement of quality standards, internal quality and management control procedures, as well as the further development of clinical protocols for health care professionals.

Along with other constraints, a lack of comprehensive patient-oriented quality control programmes and an underdeveloped system of performance-based compensation for providers hold back improvements in the quality of health services. The measures stipulated in the 2008–2017 Health Care Sector Development Strategy include the introduction of a quality assurance system, re-enforcement of accreditation for health care institutions, and an emphasis on ensuring patient rights.

So far, accreditation is obligatory for those health care institutions signing contracts with the NHIC, and a range public health care institutions were accredited under condition to address deficiencies.

Between 1989 and 1994 the inherited immunization programme in Moldova failed, and the Government adopted and commenced implementation of the National Immunization Programme in1994. The programme sets rules and budget funding for the immunization of children. Upon adoption of the programme, with the support of donors, immunization coverage in the country improved and vaccination was maintained at a rate of 95–99% (Statistical Data Table 15). A new programme has been adopted for the period 2006–2010. In 2006, the Global Alliance for Vaccines and Immunization again contributed about €1 million of a total €7 million required for the programme. Starting in 2008, all funding was to come from the public budget.

Although official figures reported more than 90% coverage for all vaccines in 2007, there are some significant regional variations reported by WB studies[247], and reduced coverage among the Roma population[248]. The immunization programme is the only public health programme fully integrated into the health care system.

Availability of technology and the development of infrastructure play an important role in increasing the quality of health care. Financial constraints have not allowed the country to effectively modernize its health sector within existing financial and administrative capacities. Outdated, defective equipment is widely represented in republican (10% of equipment) and district hospitals (20% of equipment). A reported lack of necessary equipment at the local level (both primary and secondary) points to significant inequality in the standard of health care services provided in Chisinau, compared with services available at the local level, through the better equipped republican and municipal facilities. A total of 80% of primary care units lack necessary equipment and furnishings. Only 14% of institutions have operational vehicles (a total of 121 for the whole country; 60 of which were supplied at the end of 2006).

According to data provided by the MH[249], in 2006, 80% of primary care facilities were not connected to a water supply and sewage system, 38% did not comply with seismic requirements,

[246] Implementation Completion and Results Report**,** Health Investment Fund Project, May 24, 2007, Report No: ICR0000305, WB
[247] Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies
[248] Vasile Cantarji et. al, Roma in the Republic of Moldova, Chisinau 2007, UNDP
[249] Annual Activity Report of the Ministry of Health for 2007, Chisinau 2008

and 49% of facilities were built before 1980. Further still, 6.2% did not even have a telephone connection in the office. In rural locations, more than half of the institutions did not have self-heating systems.

Application of information and communication technologies (ICT) within the health care sector lags behind the desired level. To date, ICT in health care have been used for mostly administrative, financial and epidemiological reporting. Apart from pilot projects in several republican and private institutions, electronic health records are not used in the country. All health records and referrals are paper-based, and largely manual.

Growing access by the population to ICT facilitates growth of the demand for health information and services on-line. In Moldova, use of the internet as a lever for public health programmes, and for on-line health services has been essentially neglected. The number of healthcare institutions, including private, with their own web page did not exceed 5% in 2006.

The purchasing of new equipment is not based on international or national compatibility guidelines or standards requirements. Issues of system compatibility and data consistency may be compromised if such issues are not agreed and regulated beforehand. The present count of pieces of equipment in use within the health sector does not provide a full picture of the technological gap between Moldova and European countries.

Telemedicine and distance education in health care are at an experimental stage. Piloting of international and national teleconferencing lectures in medical and healthcare management issues in Moldova have proven to be an effective instrument for health care personnel training**.**

5.6. Health coverage of vulnerable groups

Despite the fact that the level of educational and health expenditure is quite high on the books of central and local governments, inequalities in both quality and access to health services persist. In rural areas, lack of human resources and funding has led to considerable deterioration in these areas of care. Access of rural populations to health services, although improved through the reforms in primary care and emergency services, is compromised by high rates of non-insured citizens in these areas.

Children

In order to assure access of all children to health care, the State funds 100% of health insurance contributions for children, pregnant women and some categories of mothers. Compulsory health insurance coverage includes college and university students during the course of their education. However, a segment of the population between 18 and 24 years old, who do not attend higher education institutions and do not have permanent employment, suffer considerably from limited access to health insurance.

As compulsory health insurance covers only a part of health care services and medicines, and informal payments are widespread, access to health care of children is reduced by the costs of medicines, chargeable services, and informal payments.

Children’s access to the social safety network has been the top priority of UNICEF and other donors in the country. The importance of this provision to Moldova is reflected in the adoption of the MDGs, among which mother and child health are highly prioritized.

The law on protection of children at risk sets the framework to improve access of abandoned children to social and health networks. Through legal means, special emphasis has been placed on development of community services, and improvement of services at the local level in exchange for institutionalization.

Roma

While there are no comprehensive studies of socioeconomic differences in health status among the various population groups in the country, the particular minority group with considerably worse health than the majority of the population are the Roma.

A recent study[250] of the Roma community in Moldova reconfirmed their vulnerable position, with considerable social exclusion and deficiencies in access, quality and affordability of heath care.

The study found that Roma have worse living conditions compared to non-Roma and, in general, lesser access to health care. Infant mortality per 1000 live births within the Roma community was 29 compared to 17 among the general population in 2006[251]. Although the birth rate in Roma communities is higher than non-Roma, a higher incidence of lost pregnancies together with concerning infant mortality data, may prevent Moldova from reaching the MDG targets, particularly within the Roma community. There is also evidence of lower immunization coverage among Roma—11% of Roma children were not covered compared to 3% among non-Roma**.** It is reported that the main reason for non-immunization is a lack of parental knowledge.

Financial barriers to health care have been considerable for the Roma community. Access to medicines (the main personal health expenditure in Moldova) by the Roma community is much lower than in the general population. A total of 75% of Roma who could not purchase required medicines stated lack of money as the reason, compared to 41% in the general population. Lack of money to buy health insurance was also stated by 75% of the Roma population, compared to 60% among non-Roma.

Although regulations of the NHIC provide guidance on dealing with persons who present without new identity documents, a lack of identity documents is reported as a major barrier for 9% of Roma in obtaining health insurance**.**

Farmers and rural workers

The solidarity principle of compulsory health insurance fails to include this large population group who cannot contribute to compulsory health insurance either through official employment, or the purchase of individual compulsory health insurance policies. The Government also fails to provide coverage for farmers and rural workers based on the premise that they are expected to contribute to compulsory health insurance as a part of the active population. Different sources report that low incomes and unofficial employment arrangements among agricultural workers make them one of the most vulnerable groups in accessing health care. While the issue is raising public attention, there is no clear solution to this or to the expansion of compulsory health insurance coverage in general. An attempt by the NHIC to sell individual insurance policies with a discount of 50% in the first quarter of the year (which represents an average health insurance contribution of an employed person in the country) has helped to sell some policies, but it has not significantly influenced the general trend.

[250] Vasile Cantarji et. al, Roma in the Republic of Moldova, Chişinău 2007, UNDP

[251] Data in this study does not reflect the official national infant mortality rate for 2006, due to differences in methodologies used.

5.7. Long-term care

There is no clear definition of long-term care in Moldova. Long-term care presently consists of a mix of health and social services provided to disabled adults and children, and elderly people in institutional settings and at home, over a long period of time.

No studies have been conducted to comprehensively estimate the demand for long-term care in Moldova. The present system is based on existing capacities of institutional care, and the network of social workers, who provide services on demand. Newly emerging community care instruments, such as day care centres, social canteens, palliative care, and homecare services, are evolving through the efforts of the international community and active non-government organizations.

The health and social services available in Moldova for the special population groups mentioned above on a long-term care basis are shown in Table 5.2.

Table 5.2. ***Long-term social and health services***[252]

Types of services	Beneficiaries	Institutions
Social and healthcare services provided in institutional settings (asylums)	Elderly, disabled adults, disabled children, orphans and abandoned children	Asylums for disabled adults and elderly – 6 institutions Asylums for disabled children – 2 institutions
Boarding-type educational institutions	Abandoned children and orphans	Orphanages, boarding-schools
Long-term social and health care provided at the community level (social workers, community solutions for children at risk, elderly and disabled	Elderly single, disabled adults and children, abandoned children	Department of Social Services –2434 social workers providing care for 25,200 elderly single and disabled persons. Day care centres, NGOs Palliative care, NGOs Shelters Primary health care institutions – home care

Institutional care

Six state asylums for disabled adults and the elderly provided institutional care to 2276 persons, and 2 asylums for disabled children cared for approximately 679 children in 2006[253]**.**

State budget financing of those institutions was limited in the 1990's, but improved by 2004[254]. However, asylums continue to be an expensive option for long-term care, and do not cater for individual needs. To date, long-term care institutions have failed to render individualized

[252] Numerical data – Statistical Yearbook of the Republic of Moldova 2007, data for 2006
[253] Statistical Yearbook of the Republic of Moldova 2007
[254] Social Report 2004, p. 95

services to beneficiaries. In addition, the relatively isolated location of institutions means longer travel for visitors and, in general, increases the risk of social exclusion for residents.

Home care and community services

The largest amount of social care is provided at the community level. Presently, social care at home for the lone elderly, disabled adults and children is provided by social workers employed by the MSPFC working in close collaboration with local public administrations. A total of 80 social home care offices employ 2434 social workers, and service around 25,000 single elderly, and disabled adults and children.

Also, the annual compulsory health insurance budget envisages reimbursement of services provided by primary care institutions to long-term and/or disabled patients at home (home care). Presently, this amount makes up about 0.1%[255] of the health service reimbursement budget. This figure is insufficient to cover the needs of the insured disabled and elderly.

In 2008, the National Centre on Gerontology and Geriatrics was created within the Clinical Republican Hospital to develop and direct health care services for elderly, including long-term care. In order to improve access of the lone elderly and disabled people to health care services at home, the MH together with the NHIC adopted a common order on contracting home care services**,** including the list of medicines and medical equipment used in home care[256]. Based on this framework, private and non-profit institutions can contract the state for home care services. A new concept in palliative care was developed with the active participation of non-profit organizations in this area, and it helped to develop legal grounds for this type of care in Moldova[257].

Relatively recently, community-based social services for children were prioritised on the social reform agenda to change the pattern of institutionalization of abandoned children and provide community services to children at risk. Specified programs have been financed from grants provided by the governments of Sweden (SIDA), Japan, and Great Britain (DFID), from a WB loan, contributions of the Government of Moldova and local communities. The Moldovan Social Investment Fund provided financial support to micro-project proposals oriented towards the creation of community-based services providing social and health services to vulnerable groups such as the elderly, women, youth, and children at risk. These micro-projects are innovative, based on social initiative, and carried out with community support.

Resources have been used for the establishment of 24 centres that provide social assistance services to children at risk and their families, five social inclusion community services, and one centre for individuals without shelter.

As there is no clear definition and structuring of long-term care in Moldova, the structure of this type of care remains vague. The Social Report 2003 suggests that high quality home care must be delivered through multifunctional teams of specialists, which include both health and social care specialists. Home care, believed to be preferential to institutional care, is underdeveloped in the country. The present level of education and training of social workers, as well as their low numbers, do not correspond to the needs of people who would benefit from home care.

[255] Order of the Ministry of Health 426/214A from 14 December 2007 regarding approval of methodology of application of the Unified Programme of compulsory health insurance allowances in 2008, calculations - self

[256] Order Nr.253(MH from 20.06.08)/ nr.115-A(NHIC from 01.07.08) on contracting of home health care services and adoption of primary medical evidence reporting forms

[257] Annual Activity Report of the Ministry of Health for 2008, Chisinau, 2009

There are no private mechanisms in the country to ensure proper funding for long-term care of the future elderly. As the Moldovan population is aging, there will be greater demand for long-term care, with a growing number of potential beneficiaries and loss of traditional support networks.

In past years, the elderly and disabled in the country were more integrated into family networks that helped them with their long-term ailments. New social and migration trends have lead to the disruption of old family relationships and, consequently, to lesser support from families. This has placed higher demand on long-term care services for society in the medium and long term.

In reviewing other possible forms of long-term care to be addressed, it is important to consider the growing morbidity caused by non-communicable diseases, such as hypertension, chronic obstructive pulmonary disease, cardiac ischemia, diabetes, and asthma. Management of the condition itself in these cases would be a more appropriate focus of the type of care needed. If addressed nationwide, management of chronic conditions can improve the lifestyles and social inclusion of people with chronic conditions.

Existing institutional settings and capacities do not reflect either the present or future needs of long-term care. Standardization of services that are a part of long-term care is an important consideration in assuring quality of services, and allowing development of community-based institutional and home care solutions by private investors, NGOs, and local public administrations.

Social and behavioural changes in the country are following general patterns seen in Europe, and, as such, will result in growing demand for long-term care services, both institutional and community-based.

5.8. Issues of sustainability

Health care policy management

In order to comprehensively respond to existing and newly arising health threats, and ensure future sustainability of the health system, the MH requires continuous development of its capacity for strategic planning and monitoring, and socioeconomic analysis of implemented and planned reforms. Quality and accountability of health care policy also depends on stakeholders' involvement in the process. Consultation at the local level increases local ownership of new policies and improves their implementation prospects, as a broader consultation does at the national and international level.

Ensuring that policies are consistent is important in view of obligations taken on by Moldova at the international level, and for internal policies. Presently, the process of European integration of Moldova is generally set by the EU-Moldova Action Plan framework. The previous country development strategy EGPRSP (2004–2007) mostly targeted network restructuring, ensuring financial sustainability, development of quality standards in the health sector, and achieving MDGs, while the EU–Moldova Action Plan approach is oriented towards wider application of public health measures to improve the health security and epidemiological safety of Moldova.[258] Improved access and quality of health care are stated as objectives in the NDS 2008–2011. Application of the Open Method of Coordination (OMC) principles and related indicators in

[258] EU-Moldova Actions Plan and the Economic Growth and Poverty Reduction Strategy Paper: Comparative analysis Arcadie Barbarosie, Dr, Catalina Barbarosie, MA, Institute for Public Policy, Chisinau 2005

EU–Moldova agreements can help improve the monitoring of progress, and align policies by using the strong lever of European integration of Moldova.

National programmes did not always benefit from adequate financing, endangering achievement and sustainability of the measures envisaged by the programmes. As a rule, donor aid is a temporary source of financing, and programmes adopted that are not in line with the MTEF without sustainable resources risk remaining on paper.

Out-of-pocket costs

The present list of medical goods and services reimbursed through compulsory health insurance entails additional private expenditure on health care of more than 40% of total health expenditure[259]. Although improved compared to 2000, these costs still represent a large burden on the population. Financial constraints continue to represent a substantial barrier to accessing health care in Moldova.

Procurement of medicines accounts for a large share of private expenditure on health. With the present volume of medicine reimbursement costs at the primary care level, patients of ambulatory services are forced to purchase most drugs. Over recent years, the list of drugs reimbursed at the primary level was expanded slightly, but out-of-pocket drug costs remained high. Improving and maintaining access to pharmaceuticals can strongly contribute to the reduction of out-of-pocket health care costs for the population.

Widespread corruption is one of the major obstacles to the population's access to health care services. In addition, persistence of institutionalised corruption within the health sector damages the reputation of health insurance as a tool to reduce private expenditures on health services.

Access to compulsory health insurance

The policy framework for future health care reforms[260] is oriented towards improving access and quality of health services.

To this end, lack of a clear vision for increasing the compulsory health insurance participation rate represents one of the major impediments to improving access to health services. Enrolment in compulsory health insurance among the active rural population represents both a great resource and a complicated issue for further sustainable coverage of the general population with compulsory health insurance. A concerted effort will be required to achieve the declared target of 85% coverage by 2010, and improve further on health insurance coverage.

Existence of a parallel Soviet-style system funded by the state budget

Antiquated, needs-based approaches to funding of state health care institutions affiliated with ministries and agencies duplicate costs for the state and only provide care for specific insured groups within the population. This situation is a strong impediment to reform from both a political and economic point of view.

Personnel and incentives

The MH sets wage policy in subordinated health institutions. To date, salaries in the public health care system have been low, usually among the lowest in the country, and prior to

[259] WHOSIS
[260] National Development Strategy for 200-2011, adopted by the Law nr. 295-XVI from 21.12.2007

structural reforms, the system had accumulated large debts in personnel wages. With the introduction of compulsory health insurance and creation of a purchaser/provider split, those arrears were cleared and, more recently, wages in the public health sector have risen, although they are still low.

There are few performance-based incentives, although some do exist. The personnel situation in primary and emergency care is critical, especially in rural areas. Poor work and living conditions, together with low salaries in primary and emergency care, push personnel out of the sector.

As mentioned earlier, the health care system produces services of an uncertain standard as quality control mechanisms are not in place. Health authorities, with donor support, are working on the development of clinical protocols and guidelines to standardize health care quality and volume at each level of care. Also, internal audit and control practices are under development to assure the delivery of standardized quality services in health care facilities. Adopted in 2005, laws regulating medical practice and patient rights are expected to play an important role in quality control, although mechanisms for public control over the quality of health services are not fully visible.

Since 2004, the state monopolized education in health care, and introduced rigid controls over enrolment in other areas of education. The only existing private medical education department within the private Free International University of Moldova was technically terminated. Although made to assure a higher quality of health education, this step can be considered as limiting the freedom of education and restricting competition both in education and health care. Despite the fact that the share of private capital in health care is constantly growing, health education still remains monopolized by the state.

Deficiencies in the curricula for continuous education in the health care sector, and a limited range of training interventions, jeopardizes the efforts of health care educational institutions to ensure proper professional training, especially for personnel from rural areas of the country.

Long-term care policy

Within the EU, little evidence of qualitative long-term care services is already seen as a growing social risk. Due to improvement in life expectancy and, subsequently, higher disability rates, the demand for long-term care services will grow with the aging of society. This phenomenon must be addressed in the Republic of Moldova to ensure that proper services are available to the population. Community approaches are usually more appropriate and effective for this purpose, as they help maintain a better social environment for the elderly and disabled in the community.

5.9. Drivers of reform

Communicable diseases and infections still represent a danger for Moldova. Controlling and combating TB, AIDS/HIV, STIs, and viral hepatitis B are serious challenges for health care sector reformers. Along with the threat of communicable diseases, Moldova faces the steadily growing burden of non-communicable diseases, especially cardiovascular.

Moldova's high country ranking on alcohol consumption is one of the more difficult problems to address. Along with drinking habits, smoking, poor diet, and growing drug use represent real risks to the health of the population. Improved housing conditions and access to proper water and sanitation can stimulate positive changes in the population's health status.

Success in the redevelopment of primary health care facilities, and provision of proper working conditions and remuneration for primary care personnel, especially in rural areas, will be critical for the overall improvement of access to qualitative health services for the population. Outdated hospital facilities require capital investment; however, considerable investment costs presume a careful approach in the rehabilitation of existing facilities. Modernization and wider application of information technology in health care are lagging behind the needs of the health care system and demands of the population.

Since 2004, a large share of health expenditure in the country has been financed through compulsory health insurance. So far, introduction of compulsory health insurance has helped channel more resources, both public and private, into the health care system. The MTEF envisages further growth of public health care expenditure in the country. It is planned that this growth will be combined with a decrease in out-of-pocket costs for the population by extending the list of health care services and drugs covered by compulsory health insurance.

Introduction of the purchaser/provider split and elaboration of the accreditation procedure for health care institutions have opened wider possibilities for private investment in health care. The health system in Moldova has just started to see the benefits of the introduction of competition for both private and public resources among health care providers.

Influence of the international financial crisis on Moldova's health sector

Evaluation of the impact of the financial crisis is difficult under the present conditions, as it will also depend on the strategy developed and implemented to address the situation, and the timing of implementation. The present lack of such a strategy points to the under-preparedness of the health sector administration for the present and future impact of the financial crisis.

There are no public studies on the impact of the international financial crisis on the health sector in the country to date. As mentioned earlier, the financial sustainability of the health care sector could become the primary victim of the crisis. Reduction in official employment and wage cuts are likely to trigger a diminution in contributions among the active population and employers to compulsory health insurance funds. The unemployed may lose access to health insurance benefits, joining the cohort of the population whose access to health care depends on their personal capacity to pay at the point of service. Further, as more then 90% of medicines are imported in Moldova, a possible depreciation in the Moldovan Leu is likely to increase the prices of medicines in the country.

The reported increase in return of labor migrants to Moldova is also likely to increase pressure on the health sector. Most of the returning migrants do not contribute to compulsory health insurance, limiting their access to most health care services if they cannot afford to pay formal or informal fees.

One of the measures currently being implemented by the Government to address the financial crisis is a reduction in the expenditures of central and local public administrations by 20%. If interpolated to health care, this measure could influence financing of the national programmes, resulting in reduced financing for the public health agency directly subordinated to the MH, and transfers of state funds to the NHIC according to the legislation.

By mid-June 2009, the country's health sector still lacked a viable strategy to mediate the impact of the crisis on the health of the population. The only order of the MH, publicly available on the

ministry's web-site[261], refers to the creation of a working group to develop a set of measures to support the sustainability of the health care sector under the conditions of the global financial crisis. Primary measures in the Order envisage optimization of communication expenditures in the health care sector, further development of distance and self-learning for health professionals, implementation of telemedicine as an alternative to patient consultations, elaboration of a programme ensuring an adequate supply of medicines for health care institutions, revision of medical equipment procurement plans, and general optimization of health care expenditure[262], including optimization of the personnel structure. Details of this exercise are as yet unknown.

5.10. Conclusions and key challenges

Since independence, the weight of social and economic disruptions experienced has negatively affected health indicators in the country. Gross inefficiencies in the health care system consumed an enormous volume of resources to the detriment of the population through the 1990's. More than a decade of reforms changed the relationship between patients, providers and the state in health care. Issues of overcapacity and financial inefficiency drove the processes of restructuring of the provider network and introduction of the purchaser-provider split. However, these measures did not foster the development of a full range of interventions capable of improving the health of the population.

Access for all to adequate health

Compulsory health insurance, as the instrument for reducing financial barriers in accessing health services, does not fully cover large layers of the population—mostly in rural areas—who rely on the minimal package and scarce personal resources to access health services. At the same time, expansion of the categories of the population insured by the state conceals the danger of inadequate growth in public health care spending.

Non-uniform distribution of health care facilities and personnel in the country hampers equal access to health services for the population in different regions. Still widespread are poorly equipped and understaffed primary care institutions, which do not have the capacity to provide adequate care at the local level. Although measures to attract medical personnel to rural locations are in place, positions in health care facilities in rural areas remain understaffed. Strong regional inequalities in access to emergency and hospital services between the rural and urban populations continue to persist in the country.

The percentage of out-of-pocket expenditure on health care in Moldova is still high. It was reduced with the deployment of compulsory health insurance, but formal and informal costs of services and pharmaceutical expenses still represent a large burden for the population.

The issue of unofficial payments to doctors persists in the country. Corruption in the health sector touches both the insured and non-insured. The share of non-official expenditures is huge, and it represents a significant barrier to health services. Combating illegal practices can help reduce this large share of private health care expenditure paid in bribes to medical personnel. The effect of anti-corruption measures should grow, if incentives to help raise the incomes of medical personnel are introduced in parallel.

[261] Order of the Ministry of Health Nr 137. from May 19, 2009 on the global financial crisis prevention measures
[262] Without reference to either private or public expenditure, but it can be expected that the decisions will mostly assist public expenditure (including the health insurance company) and, as a side-effect,the financial burden of health care expenditure on the population could increase.

Access to affordable medicines in the country is compromised by the low level of reimbursement of medicines at the primary care level, and limited availability in hospital settings. Most drugs for ambulatory treatment are still purchased by patients themselves. In hospitals, necessary medicines are not always available, triggering out-of-pocket expenditure for patients.

Over the last two years, more private providers entered the health care services market. Introduction of accreditation and evaluation for health care facilities opened wider opportunities for private practices to compete with public institutions for compulsory health insurance funds. Effective use of this instrument, along with the creation of public-private partnerships at the provider level should strongly improve competition at all levels of care, and stimulate delivery of better services to the population with simultaneous cost containment.

Several sources site different population groups as having limited access to compulsory health insurance. However, analysis and future actions in expanding access to health insurance should benefit from a comprehensive survey of non-participating groups of the population in compulsory health insurance.

Access to long-term care in Moldova is severely limited, as there are little institutional facilities, and home-care services are underdeveloped. At the community level, some long-term care is provided by primary care providers and social institutions (public and NGOs). Some standards for home-care and palliative care were developed, although development of long-term care policy is still pending. Introduction of the regulation on purchasing home-care services by the NHIC, has, so far, succeeded to channel a small part of compulsory health insurance resources to provide home-care services.

Quality in health care

Quality of health services is not properly controlled and further development and introduction of quality assurance mechanisms is needed. Along with rehabilitation of the physical network, raising professional capacities of health care personnel in primary care should contribute to improvement of health services for the population. Wider application of regularly updated standards, clinical protocols and guidelines should considerably improve the quality of care.

Upon adoption of legislation on patient rights and health professional responsibilities, viable mechanisms for the implementation of this important piece of legislation need to be created and introduced.

Growing volumes of health and administrative information in the health sector, as well as rapidly escalating access to ICT in society requires certain changes in health care. Globally increasing use of ICT in health care suggests that thoughtful application of existing ICT should considerably improve access, quality and equity in health care. Allocation of sufficient investment resources, application of effective ICT tools accepted by healthcare personnel, proper training, and further support are required to utilize the benefits of ICT in the field.

Controlling and combating communicable diseases remains an important element in providing quality health care services to the population. Additionally, in the future, lifestyle habits, poorly controlled instances of cardiovascular disease, diabetes, and malignant neoplasm, will strongly influence the health indicators in the country. Without wider application of public health programmes embracing epidemiological and managerial controls over communicable and non-communicable diseases, and wider health promotion activities, the cost of improving health outcomes for the population of Moldova will be exaggerated, if not inaccessible.

Quality of institutional services offered by public long-term care institutions is not adequate to meet individual needs. Although there are providers of long-term care in communities, the legal and regulatory framework regulating long-term care is fragmented and ineffective. There is no evidence of studies of quality of individually purchased long-term care services.

Financially sustainable health care

Introduction of a purchaser-provider split was the cornerstone in changing rules in the health care sector. Formerly financed directly through the state budget, health care providers are now independent legal entities responsible for the management of health, and human, material and financial resources. Although the MH and the NHIC impose strong controls over cost containment, staffing, wages and distribution of resources within the organization, now health care institutions can re-allocate resources to provide better care for the population and better working conditions for personnel. Improving management practices and techniques within health care facilities is one of the ways to gain higher efficiency of the scarce resources available.

The outdated infrastructure of health care facilities requires investment resources, and expanding investment sources can help modernize these facilities. Additional efficiency gains and financial resources for reforms can be obtained by restructuring municipal and republican hospital capacities. Reduction of outdated tertiary capacities is essential for the development of modern hospital facilities according to the Hospital Restructuring Plan.

More opportunities for the private sector have emerged in health care recently, and the sector can still benefit from development of public-private partnerships in the modernization of health care infrastructure. Attraction of private capital can become a reliable source of investment capital along with local and central investment funding.

Sustainability of compulsory health care insurance, which provides steady funding to health institutions, largely depends on cash flow from the state budget and other contributors. The insurance scheme was introduced on the wave of economic growth, and the expanding economy supported the growth of health expenditure in the country, both public and private. Conversely, an economic downturn can depress the amount of transfers to NHIC, reducing the payments to providers, and ultimately, endangering sustainability of the system.

The NHIC was created to improve the incomes of health care providers for services provided to the population; and through this process, the company is expected to provide the maximum services within the existing budget to the population. The fact that the NHIC did not utilize more than €30 million over the period of its operation, suggests that it lacked the administrative capacity to secure the purchase of more health services for the population.

Present employer/employee compulsory health insurance contribution rates are the highest since the introduction of compulsory insurance. The continuous growth of contribution rates has already increased the total burden of personnel costs for employers. Avoiding further increases in contribution rates in the medium term may help to reduce the risk of the negative impact of a growing tax burden.

Expanding health insurance contributions through the sale of individual policies and supporting measures that facilitate official employment can be strong sources of revenue, if public confidence in compulsory health insurance is maintained. Limitation of options to participate in contributions to compulsory health insurance through employment and individual purchase schemes presents a barrier to wider participation among some categories of the population. A

broader range of collection methods and strategies for attracting participation, together with specific approaches to targeting in rural areas could help increase the revenues of the NHIC, with subsequent growth in compulsory health insurance coverage.

References

Documents:

4. National Development Strategy for 2000–2011, adopted by the Law nr. 295-XVI from 21.12.2007
5. Strategy for health care sector development 2008–2017, approved by Government Decision Nr. 1471 from December 24 2007
6. Economic Growth and Poverty Reduction Strategy, Moldova 2005
7. National Health Policy, approved by the Government Decision nr. 886 from 6.08.2007
8. The law on adoption of the National Development Strategy for 2008-2011 nr. 295-XVI from 21.12.2007
9. Government Decision nr. 326 from 21.03.2007, regarding adoption of the Schedule, structure and responsibilities of the central apparatus of the Ministry of Health
10. Government Decision nr. 156 from 11.02.2002 regarding adoption of the Statutes of the National Health Insurance Company
11. Government Decision nr. 891 from 17 July 2003 "Regarding creation of the Emergency Service of Moldova"
12. Law of the Republic of Moldova Nr. 1585-XIII from 27 February 1998
13. Law Nr. 268 from 07.12.2007 on the funds of the compulsory health insurance for year 2008
14. Law Nr. 263-XVI from 27.10.2005 on patient rights and responsibilities
15. Law Nr. 264-XVI from 27.10.2005 on medical practice
16. Law Nr. 552-XV from 18.10.2001 on evaluation and accreditation
17. State Programme on Development of Emergency Service for 2006-2010, Approved by the GD Nr. 564 din 22.05.2006
18. Order of the Ministry of Health 426/214A from 14 December 2007 regarding approval of methodology of application of the Unified Programme of compulsory health insurance allowances in 2008
19. Order Nr.253(MH from 20.06.08)/ nr.115-A (NHIC from 01.07.08) on contracting of home health care services and adoption of primary medical evidence reporting forms
20. Order of the Ministry of Health Nr 137. from May 19, 2009 on the global financial crisis prevention measures
21. Government Decision on adoption of the Unified Programme of compulsory health insurance nr. 1387 from 10.12.2007
22. Law nr. 263-XVI from 11.12.2008 on compulsory health care insurance funding for 2009
23. Annex nr. 1 to the Government Decision nr.948 from 5.09.2005 "National Programme of prevention and control of HIV/AIDS infection and sexually transmitted infections for the period of 2006–2010
24. National programme of mental health for 2007-2011, approved by Government Decision nr. 353 from 30 march 2007
25. Other National Programmes
26. Communication from the Commission to the European Parliament and the Council, Eastern Partnership, COM(2008) 823 final, Brussels, 3.12.2008

Publications:

3. Health Investment Fund Project, Implementation Completion and Results Report, May 24, 2007, Report No: ICR0000305, WB
4. A Public Expenditure Review for the Republic of Moldova, "Improving Public Expenditure Efficiency for Growth and Poverty Reduction", Report No. 37933-MD, February 12, 2007, WB

5. The First National Report, Millennium Development Goals in the Republic of Moldova, June 2005
6. Final Evaluation Report of the implementation of the Economic Growth and Poverty Reduction Strategy 2004-2007, Chişinău, 2008
7. Review of Experience of Family Medicine in Europe and Central Asia (In Five Volumes) Volume V: Moldova Case Study May 2005 Report No. 32354-ECA
8. MacLehose, L. in McKee, M. (ed.) Health care systems in transition: Republic of Moldova. Copenhagen, European Observatory on Health Care Systems, 4(5) (2002)
9. Health Systems in Transition Vol. 10 No. 5 2008, Moldova Health System Review, European Observatory on Health Systems and Policies
10. Sergey Shishkin, Gintaras Kacevicius and Mihai Ciocanu, Evaluation of Health Financing Reform in the Republic of Moldova, Report to the World Health Organization European Office, 2006
11. European Training Foundation, The contribution of human resources development to migration policy in Moldova, December 2007
12. Report on water supply and sanitation in rural areas of EECCA 'Financing water supply and sanitation in EECCA', Conference of EECCA Ministers of Economy/Finance, Environment and Water and their partners from the OECD, 17-18 November 2005, Yerevan, Armenia
13. Joceline Pomerleau, Martin McKee, Richard Rose, Dina Balabanova and Anna Gilmore Dimension: Health conditions and health behaviours, June 2003, Living Conditions, Lifestyles and Health, EU Fifth Framework Project, 2000–2003
14. WHO Regional Office for Europe, NATIONAL TUBERCULOSIS PROGRAMME MANAGERS' MEETING, Report on the fifth meeting, Wolfheze, Netherlands, 7–9 June 2002
15. James Martin Center For Nonproliferation Studies, The Anti-plague System in the Newly Independent States, 1992 and Onwards, April 11, 2006
16. Vasile Cantarji et. al, Roma in the Republic of Moldova, Chişinău 2007, UNDP
17. Barometer of Public Opinion of Moldova 2002, 2006, IPP, Chisinau, Moldova, http://www.ipp.md
18. First Evaluation Round, Addendum to the Compliance Report on Moldova, Adopted by GRECO at its 36th Plenary Meeting (Strasbourg, 11–15 February 2008)
19. Annual Statistical Handbook Public health in the Republic of Moldova in 2003, Ministry of Health, 2004
20. Annual Statistical Handbook "Public Health in the Republic of Moldova in 2007", Ministry of Health 2008
21. Statistical Yearbook, Department of Statistics 2007
22. Annual Activity Report of the National Health Insurance Company for 2006, Chisinau, 2007
23. Annual Activity Report of the National Health Insurance Company for 2007, Chisinau 2008
24. Annual Activity Report of the National Health Insurance Company for 2008, Chisinau 2009
25. Annual Activity Report of the Ministry of Health for year 2007, Chisinau, 2008
26. Annual Activity Report of the Ministry of Health for year 2008, Chisinau, 2009
27. 2008 Annual Report on progress in the implementation of the National Development Strategy 2008-2011, Chisinau, 2009
28. Sanitary-hygienic and epidemiologic situation in the Republic of Moldova in 2007, SSES Chisinau, Moldova
29. Nicolae Lupu, Particularities of access to primary care in non-insured population, USMF, Chisinau 2008
30. Arcadie Barbarosie, Dr, Catalina Barbarosie, MA, EU-Moldova Actions Plan and the Economic Growth and Poverty Reduction Strategy Paper: Comparative analysis, Institute for Public Policy, Chisinau 2005

31. Hugh R. Waters at. al, Health Insurance Coverage in Central and Eastern Europe – Trends and Challenges, Baltimore School of Public Health, Triangle Health Economics Workshop, University of North Carolina 2007
32. Brussels, 3 April 2008, SEC(2008) 399 'Implementation of the European Neighbourhood Policy in 2007' Progress Report Moldova
33. The 2001 Annual Report of the UN Resident Coordinator, UN in Moldova, January 2002

Annex. Statistical data

Table 5.1. Life expectancy, by age/sex, 1990–2006

Indicator/year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Life expectancy at birth (years) both sexes	68.64	67.69	67.9	67.62	66.05	65.88	66.72	66.98	67.93	67.63	67.75	68.28	68.11	68.07	68.58	67.76	68.5
Life expectancy at birth (years) female	72.02	71.02	71.82	71.06	69.77	69.73	70.4	70.64	71.57	71.4	71.45	71.94	71.76	71.66	72.49	71.72	72.42
Life expectancy at birth (years) male	65.05	64.18	63.88	64.03	62.28	62.01	62.96	63.25	64.2	63.79	63.99	64.54	64.39	64.42	64.63	63.8	64.58
Life expectancy at age 1, in years	68.98	68.01	68.15	68.12	66.59	66.32	67.12	67.31	68.15	67.9	68.02	68.41	68.13	68.06	68.41	67.6	68.31
Life expectancy at age 1, in years, female	72.23	71.24	71.96	71.38	70.22	70.06	70.72	70.8	71.77	71.57	71.53	72.03	71.7	71.53	72.25	71.61	72.22
Life expectancy at age 1, in years, male	65.48	64.57	64.21	64.67	62.87	62.52	63.4	63.72	64.44	64.13	64.39	64.69	64.46	64.48	64.52	63.6	64.39
Life expectancy at age 15, in years	55.62	54.63	54.83	54.77	53.27	52.93	53.71	53.93	54.71	54.45	54.54	54.9	54.56	54.49	54.84	54.03	54.68
Life expectancy at age 15, in years, female	58.79	57.76	58.5	57.91	56.8	56.6	57.26	57.37	58.22	58.1	58	58.41	58.04	57.92	58.62	57.98	58.54
Life expectancy at age 15, in years, male	52.19	51.27	50.99	51.41	49.63	49.18	50.03	50.38	51.08	50.71	50.96	51.27	50.96	50.95	50.98	50.07	50.81
Life expectancy at age 45, in years	28.27	27.42	27.99	27.5	26.22	25.95	26.58	26.66	27.36	27.09	27.01	27.38	27	26.85	27.24	26.53	27.12
Life expectancy at age 45, in years, female	30.33	29.5	30.11	29.53	28.49	28.33	28.92	29	29.72	29.57	29.5	29.81	29.42	29.32	30	29.39	29.92
Life expectancy at age 45, in years, male	25.82	24.96	25.49	25.12	23.65	23.28	23.93	24.03	24.71	24.34	24.25	24.65	24.3	24.12	24.23	23.47	24.1
Life expectancy at age 65, in years	13.9	13.2	13.45	12.97	12.39	12.32	12.59	12.55	12.96	12.73	12.83	13.1	12.74	12.62	13.06	12.65	13.13
Life expectancy at age 65, in years, female	14.79	14.19	14.42	13.88	13.28	13.25	13.63	13.57	13.97	13.83	13.9	14.19	13.89	13.69	14.31	13.84	14.39
Life expectancy at age 65, in years, male	12.56	11.75	12.04	11.65	11.11	11	11.13	11.15	11.57	11.23	11.37	11.6	11.2	11.17	11.36	11.05	11.43

Source – WHO/European HFA Database

Table 5.2. Standard Death Rate, by gender, 1990–2007

Years	SDR, diseases of circulatory system, all ages per 100,000	SDR, diseases of circulatory system, all ages per 100,000, male	SDR, diseases of circulatory system, all ages per 100,000, female	SDR, malignant neoplasms, all ages per 100000	SDR, malignant neoplasms, all ages per 100,000, male	SDR, malignant neoplasms, all ages per 100000, female	SDR, diseases of the digestive system, all ages per 100,000	SDR, diseases of the digestive system, all ages per 100,000, male	SDR, diseases of the digestive system, all ages per 100,000, female
1990	583.27	681.61	519.23	163.68	224.4	122.12	114.39	127.67	104.65
1991	601.5	710.4	531.27	165.51	224.12	125.68	126.12	140.45	115.6
1992	549.2	662.92	478.92	162.05	221.32	121.47	113.7	132.68	99.81
1993	590.02	706.66	515.96	165.06	222.51	125.17	110.99	127.89	98.46
1994	674.53	803.64	589.33	167.13	229.88	123.62	135.63	155.42	119.95
1995	755.35	910.11	658.37	161.5	221.49	119.22	138.57	160.56	121.26
1996	794.6	961.25	694.75	159.38	217.98	118.87	124.48	146.11	107.12
1997	827.95	990.54	726.53	155.5	214.38	114.19	124.64	142.67	110.71
1998	777.26	932.51	682.29	154.4	211.24	114.47	114.86	138.27	96.47
1999	830.15	1005.11	719.2	147.95	195.76	114.58	116.57	137.6	99
2000	834.27	1001.02	730.72	146.98	196.31	112.1	120.91	143.89	102.84
2001	815.5	979.87	715.05	149.19	199.84	113.41	128.24	151.7	109.69
2002	855.7	1019.95	756.22	153.29	208.36	115.46	126.77	150.42	107.84
2003	857.56	1014.55	758.85	155.47	206.7	119.81	129.47	152.38	111.89
2004	805.2	965	700.75	158.41	219.38	116.98	130.91	152.65	113.33
2005	858.4	1023.78	750.2	161.24	221.17	119.36	143.17	170.45	121.77
2006	786.39	943.09	682.73	166.22	225.27	125.25	134.29	156.86	115.43
2007	749.33	879.94	656.26	161.89	216.31	123.86	127.47	147.82	110.23

Source – WHO/European HFA Database

Table 5.3. Standard Death Rate, by gender, 1990–2007 (continued)

Years	SDR, external cause injury and poison, all ages per 100,000	SDR, external cause injury and poison, all ages per 100,000, male	SDR, external cause injury and poison, all ages per 100000, female	SDR, diseases of the respiratory system, all ages per 100000	SDR, diseases of the respiratory system, all ages per 100000, male	SDR, diseases of the respiratory system, all ages per 100000, female
1990	112.09	178.28	55.66	79.13	119.2	51.99
1991	124.58	194.21	65.68	75.12	115.11	48.19
1992	130.2	216.29	54.85	66.23	102.49	41.9
1993	113.81	184.56	53.4	69.02	107.96	43.69
1994	124.14	202.8	58.04	88.19	135.46	55
1995	125.78	202.09	60.12	93.74	149.48	54.46
1996	119.32	192.36	57.8	88.54	140.16	53.47
1997	116.9	187.75	56.5	91.29	139.28	58.11
1998	110	178.68	51.85	83.05	128.67	52.24
1999	104.51	174.24	45.55	89.53	142.81	54.57
2000	101.07	167.28	44.81	87.12	134.41	55.05
2001	106.26	174.36	48.7	79.78	128.13	46.79
2002	106.15	174.82	47.93	91.71	148.9	55.27
2003	110.66	181.68	50.9	96.7	154.94	59.14
2004	107.67	179.35	47.54	81.92	132.88	47.93
2005	113.82	188.97	49.93	92.61	150.31	53.6
2006	109.03	180.57	48.49	83.6	132.65	50.14
2007	103.76	169.44	47.25	78.81	123.57	46.52

Source – WHO/European HFA Database

Table 5.4. Infant, maternal and under-five mortality, 1990–2007

Indicator	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Infant mortality rate (per 1000 live births) both sexes	19.23	19.32	18.25	21.85	22.89	21.5	20.65	19.63	17.86	18.54	18.44	16.38	14.79	14.31	12.12	12.42	11.76	11.27
Infant mortality rate (per 1000 live births) female	16.6	17.09	15.8	18.38	20.53	18.78	18.62	16.2	16.59	16.27	14.98	15	12.96	12.03	10.41	12.34	10.89	11.02
Infant mortality rate (per 1000 live births) male	21.72	21.43	20.59	25.14	25.1	24.07	22.56	22.89	19.03	20.71	21.61	17.67	16.49	16.43	13.72	12.48	12.58	11.5
Maternal mortality ratio (per 100,000 live births)	44.11	46.95	50.82	52.89	25.77	40.77	42.42	50.46	36.29	28.57	27.07	43.9	30.81	21.94	23.52	21.22	15.96	18.43
Maternal deaths, abortion per 100,000 live births	9.08	9.39	14.12	9.07	6.44	10.64	11.57	10.97	12.1	2.6		8.23	5.6	10.97	2.61	2.65	2.66	2.63
Maternal deaths, haemorrhage per 100,000 live births	5.19	2.68	8.47	9.07	6.44	7.09			4.84	2.6		2.74			2.61		2.66	
Maternal deaths, toxaemia pregnancy per 100,000 live births	1.3	1.34	7.06	4.53	3.22	3.55	7.71	2.19	2.42		8.12		2.8	2.74	5.23			
Maternal deaths, puerperium per 100,000 live births		14.75	14.12	6.04	4.83	3.55	3.86	13.16	4.84	7.79	8.12	8.23	5.6	2.74	2.61	7.96	2.66	
Neonatal mortality rate (per 1000 live births)		9.28	9.23	9.73	10.23	11.56	10.16	9.35	9.61	9.17	10.69	8.67	7.84	7.4	6.92	7.48	6.97	6.74
Under-5 mortality rate (probability of dying by age 5 per 1000 live births)	24.36	23.48	23.27	26.85	28.04	26.18	25.4	24.81	21.98	22.74	22.43	19.91	17.82	17.72	15.44	15.74	14.06	14.04
Under-5 mortality rate (probability of dying by age 5 per 1000 live births) female	21.15	20.79	19.55	22.35	25.22	23.12	22.88	20.75	20.04	20.14	18.91	17.62	15.66	15.17	13.59	14.96	12.85	13.65
Under-5 mortality rate (probability of dying by age 5 per 1000 live births) male	27.41	26.04	26.81	31.12	30.69	29.06	27.79	28.65	23.79	25.21	25.68	22.07	19.84	20.09	17.16	16.47	15.21	14.4

Source – WHO/European HFA Database

Table 5.5. Morbidity, main classes of disease

Years	Tuberculosis incidence per 100000	Number of new tuberculosis cases	Viral hepatitis incidence per 100000	Hepatitis C incidence per 100000	Viral hepatitis B incidence per 100000	Syphilis incidence per 100000	Gonococcal infection incidence per 100000	Diphtheria incidence per 100000	AIDS incidence per 100000	HIV incidence per 100000
1990	39.62	1728	289.89		57.59	15.8	101.59	0.1376	0	0.0229
1991	43.8	1910	192.16	1.63	47.43	20.3	89.6	0.3211	0	0
1992	42.17	1835	159.57	1.59	47.85	47.55	105.17	0.5056	0.046	0.046
1993	55.8	2426	152.94	3.68	47.49	93.72	111.61	0.805	0	0.023
1994	60.39	2626	285.62	6.21	49.82	118.1	115.5	8.65	0	0.069
1995	63.45	2753	286.81	6.02	40.79	174.5	100.33	9.63	0.0461	0.1613
1996	67.57	2922	190.51	7.77	30.15	200.85	80.61	2.17	0.0231	1.11
1997	67.47	2908	139.35	6.17	25.57	188.53	70.6	1.14	0.232	9.37
1998	61.09	2625	105.25	6.14	22.88	155.91	65	0.256	0.1396	9.5
1999	62.43	2675	83.15	4.36	18.48	115.87	61.63	0.2567	0.07	3.62
2000	68.72	2935			17.58	97.83	51.16	0.2342	0.0937	4.12
2001	84.82	3608			15.94	86.51	35.45	0.1175	0.2586	5.5
2002	88.98	3769			14.5	81.05	34.82	0.0236	0.4486	4.93
2003	100.17	3619			13.37	80.68	47.77		1.27	7.14
2004	133.35	4806			12.51	71.31	51.39		1.61	9.99
2005	143	5141		3.7	11.43	69.59	53.6		1.67	14.83
2006	139.18	4990				68.81	50.82		2.87	17.32
2007	135.79	4857		2.82	6.65	77.33	48.84			

Source: WHO/European HFA Database

Table 5.6. Morbidity, main classes of disease (continued)

years	Cancer incidence per 100000	Cancer incidence per 100000, male	Cancer incidence per 100000, female	New cases, diabetes mellitus per 100000	Mental disorders incidence per 100000	Alcoholic psychosis incidence per 100000
1990	183	196.12	171.05		350.02	6.37
1991	184.25	200.14	169.75		359.14	9.75
1992	171.56	188.73	155.89		273.21	5.1
1993	177.53	188.91	167.13		381.8	6.58
1994	176.08	185.07	167.85		511.79	7.43
1995	168.57	178.75	159.27		518.97	7.47
1996	162.18	168.83	156.1		542.58	10.73
1997	167.61	176.82	159.13		519.89	9.91
1998	161.31	166.67	156.38		554.37	12.36
1999	148.19	149.64	146.86		400.56	6.91
2000	158.9	163.02	155.11	70.76	439.39	8.2
2001	139.92	144.78	135.47	75.77	361.59	5.24
2002	143.54	148.54	138.95	90.87	409.04	4.91
2003	176.56	178.87	174.44	149.58	568.63	7.69
2004	190.1	194.42	186.12	167.21	452.39	14.29
2005	193.37	195.52	191.4	177.6	500.22	19.75
2006	205.32	205.97	204.71	190.45	552.16	20.84
2007	209.71	214.11	205.63	193.44	547.04	23.15

Source: WHO/European HFA Database

Table 5.7. Health expenditure ratios, public and private

Years	Total health expenditure as % of gross domestic product (GDP)	Public sector expenditure on health as % of GDP, WHO estimates	Private sector expenditure on health as % of GDP, WHO estimates	Public sector health expenditure as % of total health expenditure	Private sector expenditure on health as % of total health expenditure, WHO estimates	Total inpatient expenditure as % of total health expenditure	Public inpatient expenditure as % of total inpatient expenditure
1990							
1991	3.9						
1992	3.1						
1993	4.5						
1994	6.2						
1995	5.8						
1996	6.9						
1997	6			97			
1998	4.3	4.3	2.8	96.6	39.2		
1999	2.9	2.9	2.7	93	48.6		
2000	3	2.9	3.1	90.3	51.5		81
2001	2.9	3	3.1	87.1	51.3		88
2002	3.6	3.3	3.1	89.9	48.2		91.4
2003	3.96	3.5	3.4	91.1	49	73.2	92.1
2004	6.4	4.2	3.2	69.4	43.2	41.2	90.3
2005	8.8	4.2	3.3	51.9	44.5	40.6	90.6
2006	9.3			54.3		51.5	87.1
2007	8.7			65.2		53.3	94.7

Years	Total pharmaceutical expenditure as % of total health expenditure	Public pharmaceutical expenditure as % of total pharmaceutical expenditure	Total capital investment expenditures on medical facilities as % of total health expenditure	Public sector expenditure on health as % of total government expenditure, WHO estimates	Private households' out-of-pocket payment on health as % of total health expenditure	Private households' out-of-pocket payment on health as % of private sector health expenditure
1990						
1991	7.94					
1992	8.43					
1993	10	9.1	9.1			
1994	14.1	6.3	4.1			
1995	13.7	4	2.6			
1996	11.9	5.3	2.8			
1997	14	7.3	6.2			
1998	10.6	10	6.2	9.6	37.1	94.7
1999	11.3	11	4.2	7.9	46	94.5
2000	11.1	11	6.2	8.7	50.5	98
2001	11.6	16.4	5	10	49.7	96.9
2002	18	17.2	9.5	9.6	44.6	92.5
2003	17.8	19.4	8.5	10.5	45.8	93.4
2004	23.2	36.7	5.1	12.1	41.4	96
2005	45.6	20.1	5.4	11.3	42.9	96.4
2006	39.9	20.5	2.6			
2007	40.5	27.5	3.8			

Source – WHO/European HFA Database

Table 5.8. Health expenditure per capita, Euro

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Total expenditure on health per capita	21.2	28.2	33.9	25.3	14.8	20.4	24.5	28.0	30.1	39.5	46.6	54.3
General government expenditure on health per capita	14.6	20.5	24.0	15.4	7.6	9.9	11.9	14.5	15.3	22.4	25.9	30.6
Ratio (public/private expenditure)	2.2	2.6	2.4	1.6	1.1	0.9	1.0	1.1	1.0	1.3	1.2	1.3

Source – WHO/European HFA Database

Table 5.9. National Health Programmes expenditure 2000–2006 (approved), Euro

National Programme	2000	2001	2002	2003	2004	2006	2006 (approved
MoldDiab	328,706.7	308,760.2	640,797.7	499,995.9	599,386.8	704,404.2	1,001,084.8
Cancer prevention	27,291.4	39,094.0	190,515.8	192,467.1	161,400.2	179,475.7	205,247.2
Tuberculosis and bronchial asthma prevention	70,936.6	97,123.2	180,519.4	108,079.6	139,881.0	126,463.6	177,500.4
Endogenous mental diseases	17,146.4	27,500.3	100,828.8	163,815.8	167,308.2	119,114.6	183,541.0
Prevention and treatment of pathologies negative influence on people	30,896.5	34.7	175,790.0	147,524.3	52,767.6	18,940.2	30,324.3
High cost treatment,examinations and consumables	12,914.2	50,106.3	100,930.1	173,150.6	208,990.2	198,403.1	211,736.6
High cost operation on heart	79,853.8	165,921.7	428,060.7	324,885.8	382,180.2	392,002.6	440,242.5
Haemodialysis service and renal transplantation	259,947.1	221,113.3	390,661.9	352,091.2	560,802.3	868,033.6	1,102,762.2
Prevention of HIV/AIDS,sexual transmissible diseases and infections	67,505.6	86,492.8	127,755.9	88,236.8	33,778.6	43,404.9	52,503.5
Blood transfusion service			428,902.2	353,803.4	358,300.5	421,022.1	0.0
Immunization	101,119.1	125,066.1	282,984.4	228,652.2	348,949.5	313,996.3	425,116.7
Medical assistance to uninsured persons						2,349,617.2	1,819,459.4
Consolidation of technical and material resources of medicine	191,579.4	273,354.3	274,258.0	973,908.9	1,109,788.6	1,604,940.4	4,356,392.4
Total, Euro	**1,187,896.9**	**1,394,566.9**	**3,322,004.9**	**3,606,611.7**	**4,123,533.7**	**7,339,818.5**	**10,005,911.0**

Source - Ministry of Health

Table 5.10. Health care expenditure by level of care, 2001–2007

Prior to SHI introduction (State Budget expenditure)								After SHI introduction (SHI funds)					
	2001	**%**	**2002**	**%**	**2003**	**%**		**2005**	**%**	**2006**	**%**	**2007**	**%**
Kind of care	€		€		€			€		€		€	
Emergency pre-hospital (ambulance) care	976,035.46	3.1%	3,608,594.57	8.4%	6,150,548.80	12.0%		8,229,318.57	10.0%	7,890,389.14	9.0%	9,806,012.95	8.98%
Primary health care*	6,481,385.79	20.5%	8,096,594.55	18.9%	9,367,111.47	18.0%		23,718,299.58	30.0%	27,061,426.87	31.0%	31,203,868.44	28.57%
Outpatient specialized care								4,121,038.60	5.2%	5,658,518.89	6.5%	7,601,122.37	6.96%
High performance health care								1,250,346.08	1.6%	1,212,972.97	1.4%	58,266,235.08	53.35%
Hospital health care	24,139,334.48	76.4%	31,149,145.77	72.7%	34,384,153.09	68.9%		42,205,559.45	53.0%	45,541,070.01	52.0%	2,342,968.30	2.15%
Home provided health care										60,648.65	0.1%	162,331.20 **	0.14%**
TOTAL	31,596,755.73		42,854,334.89		49,901,813.37			79,524,562.28		87,425,026.54		110,210,860.35	100.00%
*compensated drugs included													
Source -NHIC and MH data								** Planned					

NB. Data in the left section of the table is estimated for comparative purposes only, as funding mechanisms changed considerably after 2003 when compulsory health insurance was introduced.

Table 5.11. Health care personnel, 1990–2007

Years	Number of physicians, physical persons (PP)	Physicians per 100000	Physicians, full-time equivalent (FTE) per 100000	Physicians, medical group of specialties (PP), per 100000	Physicians, surgical group of specialties (PP), per 100000	Physicians, obstetric & gynecological group of specialties (PP), per 100000	Physicians, pediatric group of specialties (PP), per 100000	% of physicians working in hospitals
1990	15485	355.02	413.41					41.94
1991	15192	348.41	414.16					42.31
1992	15271	350.96	413.15					43.08
1993	15459	355.54	406.21					42.79
1994	15498	356.43	406.41					42.91
1995	15242	351.3	392.67					43.23
1996	15406	356.23	392.84					42.26
1997	15440	358.23	415.23					42.34
1998	15599	363.05	443.21	102.29	49.29	24.44	38.82	38.8
1999	13928	325.04	385.34	113.02	48.56	23.69	31.37	39.93
2000	13580	317.98	384.55	113.94	47.98	22.1	27.18	38.84
2001	11520	270.82	328.13	101.56	41.73	17.98	17.63	35.01
2002	11431	269.87	358.66	104.94	42.78	17.07	13.27	38.71
2003	11246	311.28	406.44	124.14	50.65	19.71	15.08	38.92
2004	11116	308.44	377.2	124.23	50.2	18.78	13.76	36.3
2005	11083	308.27	371.5	123.78	49.54	18.75	13.68	33.3
2006	11153	311.08	376.83	123.62	49.2	18.24	13.83	30
2007	11167	312.2	367.41	123.15	50.6	18.34	12.97	38.2

Years	Number of general practitioners (PP)	General practitioners (PP) per 100000	Dentists (PP) per 100000	Pharmacists (PP) per 100000	Number of nurses (PP)	Number of nurses (FTE)	Nurses (PP) per 100000	% of nurses working in hospitals
1990	1527	35.01	44.71	77.49	42676	45880	978.42	52
1991	1521	34.88	43.57	76.35	43621	46011	1000.39	52.12
1992	1441	33.12	44.08	71.54	43825	44948	1007.19	52.8
1993	1494	34.36	43.63	70.24	44149	43981	1015.38	53.31
1994	1502	34.54	44.3	67.5	42977	43347	988.41	53.37
1995	1441	33.21	44.32		40788	41536	940.08	54.6
1996	1490	34.45	42.55		39070	40662	903.42	53.4
1997	1505	34.92	43.27		40110	39746	930.6	52.79
1998	1733	40.33	42.64		38902	41123	905.41	52.3
1999	2272	53.02	41.54		34569	36436	806.74	48.01
2000	2521	59.03	37.35		32834	34281	768.81	47.66
2001	2280	53.6	31.17	61.62	26765	28407	629.21	45.72
2002	2417	57.06	32.84	53.35	26644	28504	629.02	45.38
2003	2446	67.7	38.83	73.46	25848	28461	715.44	46.31
2004	2078	57.66	39.93	79.83	25370	26781	703.95	46.1
2005	2051	57.05	41.56	81.22	25397	25904	706.42	46.3
2006	2026	56.51	42.42	79.05	25192	26041	702.66	46.2
2007	2027	56.67	43.78	83.68	27002	26066	754.9	43.5

Source - WHO/European HFA Database

Table 5.12. Institutions and beds

Years	Hospitals per 100000	Number of hospitals	Primary health care units per 100000	Number of primary health care units	Total number of hospital beds	Hospital beds per 100000	Acute care hospital beds per 100000	Psychiatric hospital beds per 100000	Private in-patient hospital beds as % of all beds	Number of private in-patient hospital beds	Nursing and elderly home beds per 100000	Number of nursing and elderly home beds
1990	7.66	334	13.44	586	57347	1314.78	1091.47	97.55			80.24	3500
1991	7.68	335	13.49	588	57192	1311.62	1097.88	101.25			84.85	3700
1992	7.86	342	13.65	594	55653	1279.03	1077.13	99.74			85.03	3700
1993	7.8	339	14.17	616	54275	1248.27	1058.75	95.1			92	4000
1994	7.68	334	14.05	611	53140	1222.15	1037.81	95.1			87.39	3800
1995	7.72	335	14.11	612	52986	1221.22	1037.11	94.73			56.81	2465
1996	7.51	325	13.9	601	52457	1212.96	1029.41	93.88			62.32	2695
1997	6.82	294	13.71	591	50101	1162.41	980.79	91.64	0.01	5	68.56	2955
1998	6.42	276	14.55	625	48261	1123.23	938.39	93.56	0.05	26	67.38	2895
1999	3.5	150	11.09	475	35089	818.88	675.75	73.86	0.13	45	67.56	2895
2000	3.09	132	13.37	571	32423	759.19	627.62	69.24	0.17	55	61.7	2635
2001	2.59	110	12.81	545	25044	588.75	474.12	58.35	0.3	75	64.53	2745
2002	2.6	110	13.27	562	24443	577.06	467.23	55.05	0.38	94	64.8	2745
2003	3.07	111	15.97	577	24097	666.98	536.5	65.27	0.43	103	70.44	2545
2004	3.27	118	17.68	637	23113	641.33	520.76	60.82	0.5	115	73.53	2650
2005	3.23	116	18.22	655	22961	638.66	515.77	59.44	0.6	138	73.71	2650
2006	2.34	84	18.94	679	22471	626.77	506.25	58.43	0.72	162	81.06	2906
2007	2.32	83	19.74	706	21892	612.04	493.22	54.85	0.69	151	79.65	2849

Source - WHO/European HFA Database

Table 5.13. Hospital beds and patients, by institutions type, 2007–2008

	Number of beds, year end		Number of beds, year average		Total, day-bed		Including insured	
	2007	**2008**	**2007**	**2008**	**2007**	**2008**	**2007**	**2008**
Mun. Chişinău	2365	2365	2365	2365	750246	771513	666636	687238
mun. Bălți	1105	1105	1105	1105	302737	313612	262929	275439
Total municipalities	3470	3470	3470	3470	1052983	1085125	929565	962677
Total districts	8382	8303	8407	8303	2105217	2214557	2009640	2123253
Republican institutions	8004	8224	8027	8204	2427699	2513036	1917433	2030241
Total MH	19856	19997	19904	19977	5585899	5812718	4856638	5116171

Source - Ministry of Health

Table 5.14. Hospital admissions absolute/hospitalization rate per 100 of population, urban/rural, adults/children 2002–2008

	2002	2003	2004	2005	2006	2007	2008
Hospital admissions, total							
Absolute	553,070	573,842	548,819	554,950	562,459	576,924	60,401
per 100 of population	15.3	15.9	15.2	15.4	15.6	16.1	16.9
Hospital admission. urban							
Absolute	266,201	271,829	262,822	248,170	273,757	278,841	29,180
per 100 of population	17.7	18.2	17.6	16.6	18.4	18.8	19.8
Hospital admission. rural							
Absolute	286,869	302,013	285,997	274,488	288,702	298,083	31,221
per 100 of population	13.5	14.2	13.5	13	13.7	14.2	14.9
Hospital admission. adults							
Absolute	440,702	573,842	428,209	431,281	437,561	450,733	46,971
per 100 of population	15.6	21.1	15.9	15.8	15.9	16.4	16.8
Hospital admission. children 0-18							
Absolute		130,298	120,610	123,669	124,898	126,191	13,430
per 100 of population		14.5	13.2	14.1	14.8	14.9	17.2

Source: Ministry of Health

Table 5.15. Hospital bed utilization, 2004–2008

	2004	2005	2006	2007	2008
Bed occupancy rate, day/year	241	265	272	281	291
Average length of stay, days	9.1	9.8	9.8	9.7	9.6
Including average length of stay for insured			9.8	9.6	9.6

Source - Ministry of Health

Table 5.16. Vaccination (children)

Years	% of infants vaccinated against tuberculosis	% of infants vaccinated against diphtheria	% of infants vaccinated against tetanus	% of infants vaccinated against pertussis	% of children vaccinated against measles	% of infants vaccinated against poliomyelitis	% of infants vaccinated against hepatitis B	% of infants vaccinated against mumps	% of infants vaccinated against rubella
1990	95.7	81	81	81	94	91.1			
1991	95	81	81	81	93	89.3		85.6	
1992	92.2	83.5	83.5	83.5	72.6	93		83.2	
1993	91.8	69.5	69.5	69.5	64.3	92		79	
1994	94.4	85.7	85.7	85.7	84.5	94		64	
1995	95.1	95.5	95.5	95.5	90.6	97	19	23.3	
1996	97	96.8	96.8	96.8	90.4	99	81	0.8	
1997	97.3	97	97	97	94.5	98	87.2	80.3	
1998	97.8	97	97	97	92.7	98	92.8	79	
1999	98.5	97	97	97	92.6	98	94	94.2	
2000	98.8	91	91	91	89.1	97	88		
2001	98.6	90	90	90	94.1	98	84	94.1	
2002	99	97.1	97.1	97.1	94.3	98.3	98.8	94.3	91.3
2003	97.5	97.7	97.7	97.7	95.7	98.4	98.9	95.7	95.7
2004	96.2	97.5	97.5	97.5	96.3	98.2	98.8		96.3
2005	97.4	97.6	97.6	97.6	96.9	98.5	98.8		96.4
2006	99.2	97.4	97.4	97.4	96.4	97.6	97.7		96.4

Source – WHO/European HFA Database

VI. CONCLUSION AND KEY CHALLENGES

6.1. Main findings of the report

Despite its relative youth as an independent state, over almost the past two decades Moldova has undergone major changes that gave rise to inequalities in income and the level of well-being among regional areas. These changes also resulted in an enormous development gap when compared to some of the former Soviet republics and, certainly, European countries. From 2000, after almost ten years of economic recession, Moldova managed to improve its general economic standing and enhance population living standards. However, the economic growth and poverty reduction stimulated by population migration was also associated with a decrease in the labour force, an increase in education drop-out rates of children from emigrant families and expansion of vulnerable groups of the population. The high level of remittances, apart from supporting emigrant families and the economy as a whole, has also increased inflationary pressures, contracting the purchasing power of the population.

The current pattern of national development, though producing certain short-term benefits, is not sustainable in the long run and affects the poorest and most vulnerable population groups, and deepens regional disparities. Central public administration, regulatory, fiscal, social protection, health care and judiciary reforms introduced in recent years, have resulted in some improvements but have not contributed significantly to an increase in living standards, quality of public policies or to the reduction of corruption—although the hidden economy is now on a downward trend. This drop in underground activity was due largely to the redistribution of the labour force from the agricultural sector, which was responsible for a large part of the hidden output to other sectors of the economy, particularly construction. Redistribution of the labour force was also accompanied by worseninig of most of the labour market indicators, particularly the decrease in the economically active and employed population, along with the increase in the innactive population.

The social protection system has gone through several transformations since 1998. Social assitance is slowely reforming, aiming at better targetting vulnerable and poor people. Social insurance, particularly the pension system, was subjected to a number of changes, including expanded coverage, changes in benefit levels, increases in retirement contributions, alterations in retirement ages and contribution period, and application of highly sophisticated retirement formulas. However, these transformations, are not translating into significant improvements in social protection structures and increases in population living standards. Presently, households receiving social protection benefits are classified among the poorest.

The health care sector was has also been subjected to several significant transformations, the major reform being launched in the second decade of transition creating premises for introduction of compulsory health care insurance. The insurance model introduced aimed at improving access of the population to better health care services, but has left a quarter of the population relying on the minimal package of health services universally covered by the State and personal funds. Moreover, even the package of health services for the insured does not cover all necessary care, thus forcing the majority of the population to pay formal fees and informal "gratitude payments" for health services and medicines. Universal access to health care services is still compromised by strong regional differences and inequalities in access between urban and rural areas. Despite a slight increase in life expectancy and improvement of certain indicators, particularly infant and maternal mortality, the overall healthcare status of the population has not improved significantly.

6.2. Insufficient and poor use of financial resources

Most reforms conducted in Moldova, although based on effectiveness and efficiency in theory, have partially failed in practice due, among other reasons, to a lack of sufficient financial resources. The national public budget is formed largely from indirect taxes derived from imported goods and services. This is not a sustainable source of incomes. Due to the economic crisis and contraction of domestic demand imports and, subsequently, budget revenues have dramatically declined. This will certainly undermine the sustainability of initiated reforms. Foreign assistance, though playing a crucial role in financing development policies is only a temporary measure. Moreover, unlike grants and technical assistance provided by country development partners, credits are increasing the debt that has already heavily burdened the country.

The insufficient financial resources for the social protection and health care sector policies are of particular concern. For instance, although measures have been taken to improve social assistance targeting, lack of financial resources to cover all vulnerable people could increase poverty and social exclusion. At present only 1.3% of the population is covered by the social aid benefit, while almost one-third of the population is placed below the absolute poverty line.

This shortage of resources will be exacerbated by the economic crisis in Moldova, which will be followed by a reduction in budget revenues amid an increase in persons at risk. The increase in the number of unemployed and poor people will require larger transfers that will be more difficult to ensure during the crisis. As a result, the greatest challenge in the short term will be to supplement SSIB funds, while taking into account the scarce financial resources, emphasising an increase in social protection coverage rather than the actual size of social protection benefits. In the medium term, it is imperative that the Government initiates bilateral and multilateral negotiations with the country's development partners in order to obtain financial and technical support in the field of social protection.

Similarly, the health care system does not have sufficient resources to rehabilitate its outdated infrastructure and to ensure universal access to compulsory health care insurance. Sustainability of compulsory health care insurance, which provides a steady source of funding to health institutions, largely depends on cash flow from the state budget and contributions from economic agents and active labour — both affected by the international financial crisis. The insurance scheme was introduced on a wave of economic growth, and the expanding economy supported the growth of health expenditure in the country, both public and private. Conversely, an economic downturn can depress the amount of transfers to the NHIC, reducing payments to providers, and ultimately, endangering sustainability of the system.

Nevertheless, inefficient utilisation of scarce financial resources is of much greater concern than the limited amount of resources. This is because although expenditure on social protection represents the largest share of the national public budget, the effectiveness and efficiency of the social protection system is lagging behind. Although spending on education has been steadily growing, inter and intra-sector distribution of expenditures is inadequate. There is a huge gap in financing between the different levels of education—general compulsory education benefiting from almost one-half of the funds, and these are inefficiently used. Less than one-tenth of financing goes to secondary vocational education, which is insufficient for modernization and training of specialists for the labour market. Moreover, the fact that the NHIC failed to utilize more than €30 million over the period of its operation raises questions about the need to upgrade its administrative capacity to secure the purchase of more and better health services for entire the population.

One of the greatest challenges for Government, therefore, will be to both increase budget revenues and improve efficiency of spending in order to ensure that scarce public resources are targeting people in need. Providing incentives for creating and undertaking entrepreneurial activity is also of major importance. Without such measures public policies will continue to be ineffective and inefficient.

6.3. Political and economic crisis

Among the major challenges that Moldova must address in the short to medium terms are the economic and political crises, the vicious circle of the latter having intensified since April with the failure of the newly elected Parliamentarian factions to reach consensus and elect a President. This situation led to Parliamentary elections in July 2009, the political tensions deepening the economic crisis within the country to which a response has yet to be formalised. The political crisis and associated budget expenditures represent a further threat to the sharply declining economy, blocking the proper implementation of crisis management strategies to support the private sector and vulnerable groups. Although Moldova has so far avoided a financial crisis — the global turmoil so far affecting only the real sector of the economy — a lack of adequate measures to stimulate the economy, together with continuation of the political crisis, will likely lead to a financial sector downturn. Political instability and its negative impact on potential foreign investors, who are looking for less risky and less politically biased capital investments, will further harm the economy.

The global financial and economic crisis that has now infiltrated the Moldovan economy, is originating from both within the country, which is highly vulnerable to external shocks, and from the outside. Moldova's economic growth is based on imports and remittances. With the contraction of external demand and an increase in unemployment within those countries that are either trade partners or the host of Moldovan emigrants, the Moldovan economy is likely to respond accordingly, with a dramatic contraction in the months to come.

The groups traditionally considered vulnerable have been even further impacted upon by the economic crisis, including those close to retirement age, women, young people without professional training, and trained youth who have not acquired practical skills. The situation in rural areas is of major concern, where agricultural activities are largely practiced, and small and medium business is focused on services rather than production. The financial and economic crisis is mostly affecting employees in agriculture, especially young families, who do not have land that can ensure the minimum required consumption.

Any stimulus package introduced by the Government will not be sufficient to address these concerns and may even further harm the economy and the population. If, for example, the emergent measures to safeguard the economy widen the budget deficit, the Moldovan authorities will have to resort to external aid in order to cover it and this will increase the debt burden of subsequent governments. Moreover, the fragile Moldovan economy will not be able to absorb its domestic workforce when burdened by the addition of thousands of returned emigrants. The outlook is for a contraction of the economy in 2009 by at least 5% and an unemployment rate of up to 10%, with little prospect of recovery in the medium term.

6.4. Need for better policies

Lack of financial resources along with inefficient spending represents only a part of the multidimensional problem of inadequate policy implementation in Moldova. The other important aspect is the formulation of public policies without taking into account the real needs of society and the impact of policies on vulnerable categories of population. Moreover, policy formulation is not sufficiently correlated with budget elaboration, thus compromising the implementation of a series of sound public policies.

The economic crisis represents an opportunity for the implementation of needed policies that will lead to economic recovery and poverty reduction. Response to the crisis must contain both short-term measures that will increase internal demand and stimulate production and exports, as well as medium-term measures to strengthen government capacities to deepen reform processes. Public policies should be preceded by ex-ante impact assessment where a number of policy options are thoroughly analysed and the potential policy impacts assessed accordingly. Intervention by Government in the market in general, and in different sectors in particular, must be ensured, but only if there are market and Government failures. Every intervention should also be the result of a rational and logical analytical process, where all risks are taken into consideration. Otherwise the quality of implemented policies will continue to be poor.

To this end budget revenues and expenditures that have been affected by the economic crisis need to be managed more rationally. Tax increases that might affect both the population and active enterpreneurs have to be made with caution. Combating corruption, tax evasion and money laundering will be more effective in this regard rather than increasing the fiscal burden. In regard to expenditures, a more rational utilisation of scarce public resurces along with restraint in supporting protected regions and sectors is crucial. The overall approach to allocating expenditure, particularly in the field of social protection, must be revised, avoiding centrally set expenditure norms, which are based on norms for available infrastructure rather than those based on real needs.

As for the labour market, measures for the reintegration of temporarily and permanently returned migrants, and for the creation of opportunities to attract remittances for the development of the business environment are much needed. Public works need to be created in order to absorb the domesic unemployed as well as returned emigrants. Implementation of infrastructure projects, including road rehabilitation, construction of water and gas pipes, for which financing is already provided by donors will be crucial in this regard.

In the field of social protection both short term and medium term measures should consist of the implementation of social inclusion policies that would contribute to the reduction of poverty and inequality among vulnerable social groups, thus diminishing migratory processes by creating more work places and providing competitive salaries. Also critical is improving access of the population to quality health and social care services through the development of infrastructure, especially in rural areas, and ensuring the competitiveness of agricultural production, access to markets, and introduction of further policies to reduce the vulnerability of the agricultural sector. In addition, in order to support agricultural producers—who still represent a large part of the population and the most vulnerable—both the way that subsidies are targeted and their size should be revised, avoiding protectionism in this field.

The pension system is of particular concern, particularly in the light of contracting budgetary and population revenues. Strengthening incentives in the current pension system through a tighter link between contributions and benefits, avoiding contribution forgiveness, and adjusting minimum pension and contribution levels for the self-employed and farmers, would improve

system finances and provide additional fiscal space for improvements in benefits, contribution rate reduction, and/or second pillar introduction when the time is right. Further reforms to cope with population aging should focus on extending labor force participation by the elderly to avoid benefit cuts that could undermine adequacy and very high contribution rates that could discourage formal sector employment.

Although under development, the instruments to ensure quality of health services are still not in place. Along with rehabilitation of the physical network, raising professional capacities of health care personnel in primary care should contribute to the improvement of health services for the population. Wider application of regularly updated standards, clinical protocols and guidelines, should considerably improve the quality of care. Quality measures need to be addressed along with the provision of more attractive incentives for medical graduates and young professionals to work in rural areas.

6.5. Methodological and analitical problems

Despite Moldova's progress in improving data collection and analysis, there are still many gaps, both in terms of definitions and methods of estimation. In order to improve the monitoring of certain indicators, particularly those related to the labour market, education and social protection, there is a need to fill data gaps and to improve the quality of some indicators.

Using pension statistics as an example, although data on expenses related to the payment of benefits from the pension system is sufficient, data on system incomes is significantly inferior. Only aggregate data is available that cannot be used for a deeper analysis of taxpayer income structure, salary profiles, and other measures. Moreover, data on the measurement of social inclusion are also missing, although it is anticipated that this gap will be addresssed in the near future. The methodology for estimating labour market data needs to be fully harmonised with EU standards and routinely made publicly available, rather than on special request. These and many other methodological problems need to be solved in order to ensure full comparability with EU countries, as well as countries in the region that have already initiated the harmonisation process.

Lack of surveys and studies on issues critical to the country are also a major drawback. Basing analysis on anecdotal and empirical evidence is not sufficient for assessing effectiveness and efficiency of processes, reforms and systems. In contrast to the abundance of surveys on migration and remittances, there is a limited number of studies on the socially excluded population, labour market, health care and education. Moreover, existing studies are somewhat outdated or not comprehensive. Consequently, in most cases, the existing secondary data are not sufficient to provide an accurate and thorough assessment of identified groups or processes. At the same time, primary data or special analyses, though of better quality and more focused are expensive and cannot be always be obtained. This will continue to be an issue, unless data providers and users reorient their view of data as necessary not only for reporting, but also for policy analysis. Many indicators continue to be calculated for formal reporting purposes, although they are not relevant to users. At the same time, important policies are implemented without being preceded by proper analysis and accompanied by specific data. Unless a strategy is developed and adopted for statistical collection, analysis and use, the link between statistics and policy will continue to be poor.

Harmonization of Moldovan statistics with those of the EU will allow Moldova to benefit from vast experience in data collection, aggregation and analysis. It will also help Moldova to achieve a more advanced degree of integration into European bodies by basing policy development on comparable content and quality sets of data.