Approved
by the Decision of the NHIC Management Board
no.2 on 15 december 2015
Chairman of the Management Board
_____ /Roman CAZAN/

Institutional Development Strategy of the National Health Insurance Company 2016-2020

CONTENTS

ABBREVIATIONS

PMC	primary medical care
HMC	hospital medical care
OSMC	outpatient specialized medical care
PHEMC	pre-hospital emergency medical care
MHI	mandatory health insurance
TA	territorial agency
MTBF	medium-term budget framework
NAC	National Anticorruption Center
NHIC	National Health Insurance Company
DCRP	Directorate of Contracts and Relationship with Provides
DEF	Directorate of Economy and Finance
GDQEC	General Directorate for Quality, Evaluation and Control
DIA	Directorate of Investments and Administration
LD	Legal Directorate
DSMHR	Directorate of Strategic Management and Human Resources
DPC	Directorate of Preventive Care
DRB	Directorate of Relationship with Beneficiaries
DIS & eT	Directorate of Information Systems and eTransformation
MHIF	mandatory health insurance funds
FPM	fund of preventive measures
HIS	health and sanitary institution
MF	Ministry of Finance
MH	Ministry of Health
WHO	World Health Organization
GDP	gross domestic product
SAHE	Section of Analysis and Health Economy
IAS	Internal Audit Service
MHIS	mandatory health insurance system
IS	information system
SICM & S	Service of Information and Communication with Media and Spokesman
SM	Section of Drugs
SIR	Service of International Relations

INTRODUCTION

The NHIC was established under the Government Decision no. 950 from 07 August 2001 *„On establishment of the National Health Insurance Company”* in order to implement the Law no. 1585-XIII from 27 February 1998 Law *„On Mandatory Health Insurance”*.

The NHIC operates under the Statute approved by the Government Decision no. 156 from 11 February 2002 *„On approval of the Statute of the National Health Insurance Company”*.

Since 2004 the MHI system has been implemented in the Republic of Moldova, thus allowing the health system going out of the financial collapse by strengthening the resources of the medical and sanitary institutions. Since then, the MHI has become a financial instrument indispensable for the country's health system for its viability. In this respect, development of the MHI system shall be examined in accordance with the reform of the whole health system.

As an institution, the NHIC has passed the first decade of development and performed the main tasks of creating and managing the MHI system. Subsequently, the need of the NHIC and the MHI system to pass to the next level of development has appeared. Current initiatives need to be well integrated and shall support implementation of reforms in the health system of the Republic of Moldova.

The *Institutional Development Strategy of the NHIC 2016-2020* (hereinafter – the Strategy) is the main document for management and strategic planning of the institution's activity in the medium term, and determines the development objectives of the NHIC - manager of the MHI system, establishing priority measures and actions. The provisions of the Strategy inherently cover the health system.

The strategic document is based on the Government policies of social and economic development of the country in the context of aligning to the EU standards, and on policies that reveal the needs of the health sector.

The initiatives set out in the Strategy are complex actions that are feasible in cooperation with public partners in order to develop health protection system adjusted to the needs and expectations of society. The quality of inter-sector collaboration and performances of each public partner are crucial for successful implementation of the Strategy.

The actions set out in the Strategy are based on provisions of the policy documents on the health sector and the WHO recommendations, to which the Republic of Moldova is a party. The following documents that are strategic for health sector have been examined:

- the Government Decision no. 886 from 06 August 2007 *„On approval of the National Health Policy”*;
- the Government Decision no. 1471 of 24 December 2007 *„On approval of the Health System Development Strategy 2008-2017”*;

- the Government Decision no. 1032 from 20 December 2013 *„On approval of the National Public Health Strategy 2014-2020”*;
- the Government Decision no. 122 of 18 February 2014 *„On Public Services Reform Programme 2014-2016”*;
- the Government Decision no. 339 from 20 May 2014 *„On approval of the Action Plan 2014-2016 on supporting reintegration of citizens returned from abroad”*;
- the Government Decision no. 406 of 02 June 2014 *„On approval of the Programme for integration of aging issues in policies”*;
- the Government Decision no. 730 from 08 September 2014 *„On approval of the National Programme in the field of food and nutrition 2014-2020 and the Action Plan 2014-2016 for implementation of the national programme”*.

1. CONTEXT

The financial stability of the health system has increased and public access to the basic medical services has improved since implementation of the MHI. A number of issues addressed through challenges are stringent in the MHI system in the context of limited financial resources, being fuelled by increasing needs of the population upon accessing quality integrated healthcare services enhanced by social and economic gaps, technological development, demographic and environmental evolutions.

Degree of coverage of the population with the MHI

Although the Law no. 1585-XIII from 27 February 1998 „On mandatory health insurance" established mandatory nature of insurance, and annual laws grant 50% and 75% discounts for payment of the MHI premium by fixed amount, the share of uninsured population remains significant. Around 20% of the population is not integrated in the MHI system and does not benefit from all facilities and full financial protection upon access to medical services. The studies of the National Bureau of Statistics revealed that over 75% of the uninsured population are people of working age (age group of 25-54 years old).

State contribution in the MHI funds

The government plays the role of insured for 15 categories of persons (children, pupils, students, pensioners, unemployed, disabled people, etc.) that constitutes about 56.6% of Moldova's population. However, around a third of uninsured persons are part of the Ist quintile of income, thus state subsidy does not strictly target socially disadvantaged persons.

Level of public health expenditures

After implementation of the MHI, the public health expenditures increased about 5 times, from 1,105.2 mln. MDL in 2003, up to 5,890.5 mln. MDL in 2014, and make up 13.3% of the total national public budget of the Republic of Moldova. In the recent years, public health expenditures referred to the GDP decrease slightly exceeding 5%. The MHI funds make up 80.9% of public expenditures for the health system.

Indicators of evaluation of public health have not significantly improved and achievement of the Millennium Development Goals requires substantial efforts, particularly financial ones. The Republic of Moldova shall strategically use extremely limited public resources to face the challenges arisen as a consequence of various diseases inherent to both poor and developed countries.

Direct and informal payments

In the last decade the total health expenditures have considerably increased, the balance between the share of public and private expenditures have changed insignificantly, since the state covers from 52% in 2003 up to 55.6% in 2012 of the relevant expenditures. Subsequently, household expenditures in the health system are still considerable, especially for drugs and pharmaceuticals, which make up 72% of direct health payments.

Informal payments are widespread in Moldova, even among the insured population. The share of informal payments in direct payments in 2010 makes up 37% for services

offered in the primary medical care and specialized outpatient services, and 94% for hospital services. According to the 2013 Global Corruption Barometer prepared by „Transparency International", 38% of respondents from the Republic of Moldova say that, over the last year, they paid bribes for medical services. Informal payments discredit the MHI system.

On 1 January 2004 the MHI system implemented throughout the Republic of Moldova and has passed so far through several stages of development.

Since September 2010, the NHIC has proposed to shift the priority emphasis toward beneficiaries of the MHI system. The development objectives of the MHI system have been set out and are focused on: satisfaction of insured persons, monitoring the quality of medical care, information of the widest possible population about benefits of the MHI system, increasing the degree of the MHI coverage and transparency of the NHIC activity and contracted providers of medical services.

The need for further development of the MHI system imposed development of a document for management and strategic planning within the institution. Given the key role of the NHIC in funding the health system and the current and future challenges, development and implementation of the Strategy will strengthen the role of the MHI as a financial instrument promoting policies to achieve development objectives of the health protection system in order to increase satisfaction of beneficiaries with the system.

2. ENVIRONMENTAL ANALYSIS

This chapter covers the trends of development in areas of reference and expectations of the NHIC partners, with a potential impact for possible challenges of the institution. Possible risks and problems that the NHIC will face in the coming years are also presented.

2.1 Main Development Trends in the Republic of Moldova - PEST Analysis (analysis of political, economic, social and technological factors)

Political trends - political situation in Moldova has been stable over the recent years. In order to ensure sustainable development of the political environment in the country, the political parties and the president show an increasing collaboration. The general trend relates to the development of state policies for integration into the European Union. For the first time the will of the Republic of Moldova to join the European Union is officially stated at the Summit in Vilnius in November 2013, where the Association Agreement with the European Union was initialled, and in the summer of 2014, in Brussels, where the Association Agreement with the European Union was signed. Later, on 2 July 2014, the Moldovan Parliament ratified the Agreement.

The Government initiated restructuring of ministries, agencies and other subordinated institutions to improve efficiency of public services, optimize the functional activities and reduce administrative costs. Over the next years, the Government expenditures will be subject to increased record as per most sections, including health and mandatory health insurance sections.

One of the priorities of Chisinau Government is technological modernization of the governance (eTransformation), one of the pillars of public service reform in Moldova. By widely applying information and communication technologies, the Government aims to increase performance of authorities and transparency of state institutions, to increase access to information and to promote digitized services. eGovernment redefines the way in which the state interacts with the community, bringing it closer to the citizen and involving the latter in governance.

The overall objective of the reform is to provide some quality, timely, accessible, transparent and cost-effective services for a larger number of citizens.

In view of the above, the NHIC and the eGovernment Center in Moldova have signed a Cooperation Agreement, which objective is the eNHIC eServices Project. The eService of the eNHIC is available 24/24 on the government portal *www.servicii.gov.md* and the web-site *www.cnam.gov.md*. This service will save the time of legal entities and institutions responsible for activation or deactivation of the status of employees and 15 categories of persons insured by the Government.

The *Government Action Plan 2015-2016* provides for implementation of new economic and financial policies aimed at eliminating administrative constraints in the business environment that:

- will serve to create new jobs and will provide increased MHI coverage;
- will increase personal income and, respectively, contributions to the MHI.

Creation of a favorable investment climate for implementation of the public-private partnership projects in order to develop a modern and cost-effective health system is one of the priority actions in the health sector set out in the government policy documents. A number of the Government programs approved in 2010-2013 provide for several public-private partnership initiatives, which cover infrastructure and provision of public health services, and namely: radiology and imaging diagnostic services, services of cancer radiotherapy and dialysis services. Development of the public-private partnership in provision of health services will encourage competition and provision of quality services.

The political decision to ensure access to basic medical services of the entire population was materialized by amending the Unique MHI Programme in December 2010, by which persons not included in the system benefit from medical services provided as part of the pre-hospital emergency medical care, primary medical care and specialized outpatient and hospital medical care in the case of socially conditioned diseases with a major impact on public health. Thus, Moldova's MHI system is gradually aligned to the global good practices related to universal health insurance coverage.

This decision enabled application of the fundamental right of citizens to health services, while these changes have created dilemmas for different social groups on the need to obtain the status of insured.

Large gaps between income of rural and urban population affect their ability to pay the health insurance premium and people's access to quality healthcare services.

Economic trends - according to the updated forecast of the Ministry of Economy, in 2015 the GDP in comparable prices decreased by 2% as compared to 2014, in the coming years a slow and stable economic growth is expected, in a tempo with increase in consumer price index.

Table no. 1

Forecast of macroeconomic indicators of the Republic of Moldova for 2010-2018

Indicators in comparable prices, as compared to the previous year	Unit	2010	2011	2012	2013	2014	2015	2016	2017	2018
GDP	%	107.1	106.8	99.3	109.4	104.6	98.0	101.5	103.5	103.5
Average monthly salary, nominal	%	108.2	111.6	108.9	108.3	110.8	110.3	109.8	108.9	108.2
Payroll fund, nominal	%	104.2	107.6	108.7	107.3	109.9	110.4	109.7	109.0	108.2
Indicator of annual	%	107.4	107.6	104.6	104.6	105.1	109.5	111.4	106.9	104.9

average consumer prices										
Trade balance	mln. USD	-2314	-2974.5	-3051	-3064.1	-2977.4	-2150	-2100	-2150	-2250

Source: Ministry of Economy, as of 07 October 2015

The increase of consumer price index implies higher prices of energy, supplies, maintenance services, costs for remuneration of medical employees, etc., with significant impact on the costs of health services.

Fluctuation of foreign exchange rates increases uncertainty in purchase of drugs and investments in medical technologies. An overall increase in costs for medical services in the light of optimization of medical infrastructure is expected.

The trend of decrease in the share of the Government allocations in the MHIF revenues (from 66.7% in 2004 to 56.9% in 2014), increase in the number of categories of persons insured by the Government may result in long-term instability of funding of health services and, therefore, the MHI system. Thus, efficient functioning of the MHI system is possible provided the MHI premium increases in the percentage share, thus allowing (maintenance of public access to medical services provided within the MHIS) avoiding worsening of the economic and financial situation of medical service providers.

In 2014 the MHI premium in the percentage share has increased up to 8%, in 2015 - 9%. At the same time, the efficient operation of the MHI system is possible provided the MHI premium increases continuously in the percentage share, which will allow avoiding worsening of the economic and financial situation of medical service providers.

To minimize the risks and keep the positive dynamics of development of the health system, it is required to:

- maintain at least the existing share of 4.5% in the GDP of the MHIF;
- increase the premium from 9 to 10 percent.

However, the insurance premium remains the lowest as compared to the European countries.

Social and demographic trends – over the recent years a negative trend of migration of people from Moldova has been recorded mainly among young people and adults of working age. Primarily, the decision of people influenced the economic situation and the need to provide the family with financial support. The health sector is not an exception, and the same trend is noticed among doctors and nurses. Unstable social and economic situation, underdevelopment of the labor market, low salaries in the country and possibilities of free movement at least in the medium term will stimulate negative external migration.

According to the National Bureau of Statistics, in 2013 332.5 th. persons of the active population of the Republic of Moldova were working or looking for a job abroad, including 216.9 th. men and 115.6 th. women. In 2014 there is a slight increase in labor migration abroad, thus 341.9 th. persons migrated, of whom 219.0 th. were men and 122.8 th. women.

The number of stable population of the Republic of Moldova as of 1 January 2015 made up 3,555.2 th. persons, which is a decrease compared to the same period of 2014 by 2,475 persons. The distribution of population by gender is as follows: 51.9% - women (1,844.9 th. persons) and 48.1% (1,710.3 th. persons) - men, thus maintaining the proportions of the last year.

The age structure of the population reveals the intense phenomenon of demographic aging, mainly due to decrease in birth rates in the recent years, which resulted in absolute and relative reduction of the young population as compared to 1 January 2000, the share of children (0-14 years old) has been reduced from 23.8% to 16% (-297.9 th. persons), and the increase in the share of old people (65 yeas old and over) from 9.4% to 10.3% (+26.0 th. persons). Thus, young people, who are fewer in number, will have to care about the increasingly larger number of old people.

In the IInd quarter of 2015 the economically active population (employed and unemployed people) of Moldova made up 1,339.2 th. persons, matching approximately the number of 2014 (+ 0.8%). Structure of the active population has changed as follows: the share of employed population fell from 96.4% to 95.9% and the share of unemployed population increased from 3.7% to 4.1%.

The average life expectancy in Moldova in 2014 was 71.5 years old, including men - 67.5 years old and women - 75.4 years old.

At the beginning of 2015, 576.6 th. people aged 60 and over lived in Moldova, making up 16 percent of the total stable population. In the recent years, the share of people aged over 60 has increased, in 2014 the coefficient of population aging compared to 2013 increased by 0.5 pp and constituted 16.2%.

Aging of population raises highly complex problems for the social and medical insurance system, with increase in expenditures on pensions, social assistance and health.

Given the current demographic changes and increase in financial constraints, healthy aging and active aging are the key factors of the future sustainability of the health system.

Technological trends - the development of information technologies has a major impact on behavior of population and development of healthcare services. The need of a unique integrated information medical system that will provide accurate data to various partners in the sector is obvious. Information technologies positively influence the growth of accurate perception by the population of health issues and create a positive pressure on providers, in order to ensure transparency and accurate information about service provides.

The need for new medical technologies is obvious in the health sector in Moldova, which produces a financial pressure on consumers and providers of medical services. Implementation of new modern technologies will significantly impact the quality and efficiency of services (reduction of the average length of hospitalization, new opportunities for outpatient treatment, fewer complications of treatment, etc.).

2.2 Reforms and Trends of the Health System in the Republic of Moldova

Given the policy documents, Moldova shall undergo significant reforms in the field of health, impacting the MHI system, where the role of the NHIC is particularly important.

Reputation of the MHI system in Moldova has improved in the recent years. Confidence of the population in the NHIC services and role shows a positive trend and shall be maintained in order to expand the MHI coverage. The objective of increase in the MHI coverage of up to 85% of the population over the next 5 years, as compared to 82.1% in 2012, is to be achieved by observing the pre-condition of maintaining the principle of equality for participants in the MHI system.

The data presented below show the health system resources and their use over the last 10 years.

Table no. 2

Indicators	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number of beds (abs.)	22961	22471	21892	21798	21938	22021	22031	22162	20760	20131
Beds for 10,000 persons	64.0	62.7	61.3	61.8	61.6	61.8	61.9	62.3	58.4	56.6
Average annual length of use of bed (days)	259	269	277	286	281	280	284	281	292	289
Average length of hospitalization (days)	9.8	9.8	9.7	9.6	9.5	9.6	9.5	9.5	9.3	8.9
Number of family doctors per 10,000 persons	5.8	5.7	5.7	5.5	5.4	5.3	5.3	5.2	5.0	4.9
Number of visits to family doctor per 1 person	2.8	2.7	2.8	2.8	2.9	2.9	2.8	2.8	2.9	2.9
Number of visitors to specialist per 1 person	3.2	3.3	3.4	3.5	3.4	3.6	3.6	3.7	3.6	3.5
Number of emergency patients per 1000 persons	254.6	266.2	281.4	282.7	301.9	282.7	279.5	271.1	270.9	269.5
Number of doctors	12577	12674	12733	12684	12783	12780	12914	12794	12946	12880
Number of average of medical staff	27966	29971	27667	27378	27449	27519	27448	27407	26781	25938

Source: Ministry of Health (National Center for Health Management)

Despite alternative funding options, such as supplementary private insurances, the MHI certainly shall and will remain the main health system funding instrument. Pressures

on reduction of direct payments and especially informal payments will bring positive effects for the next 5 years, and the NHIC role in this process is crucial.

Maintaining equitable access of population to medical services will be a challenge for all actors of the health sector, especially for the NHIC. Reduction of infrastructure and potential increase in treatment costs should be compensated by increase in the quality of services, elimination of unuseful services, protection of patient's rights throughout the treatment in the system and better performance of contractual obligations by providers of medical services.

Modernization of the hospital infrastructure will help to increase efficiency of services provided to beneficiaries of the MHI system in hospitals. The number of hospital beds in acute condition will decrease significantly, hospitals will be merged and the number of mono-profile hospitals will be reduced. The average length of hospitalization will be reduced; the emphasis will be put on improvement of the quality of services and provision with high-technology equipment in order to accurately establish diagnoses. Modernization of medical equipment is inevitable like the increase of salary of medical staff and will lead to increase in the costs of services. Management of hospitals, as economic entities, shall be significantly improved.

Further importance of primary medical care will increase - as a „keeper" in the system and of avoidance of unfounded hospitalizations. Actions are taken in terms of „decentralization" through direct execution of contracts, which will provide autonomy and hence will endure development of health centers in order to improve access of population to medical care services. Introduction of performance-based funding mechanisms will require greater responsibility of family doctors for rendered services. Also, primary medical care will be of particular importance in providing preventive services and in promotion of health, positively influencing public health. As a result, there will be fewer visits to specialists, by directing people to family doctors.

As hospital treatment will become more efficient, there will be a need for rehabilitation, long-term care at home. Currently, these services are underdeveloped and shall be planned carefully and covered with relevant funding instruments.

In order to increase cost-efficiency of use of financial resources of the health system, a new mechanism for funding hospital medical care is implemented based on homogeneous groups of diagnosis - DRG (CASE-MIX), which provides for funding of providers of hospital medical care services depending on the complexity of treated case. The DRG payment system has been expanded throughout the country since 2013 and the NHIC become the institution empowered to manage this payment mechanism.

Since 2014 the system of free choice by insured persons of district hospitals has been implemented in 9 health zones. Thus, the patient is free to choose the hospital for scheduled admission and has the possibility to choose the optimal variant of hospitalization.

Data from reports of national and international organizations show that informal payments are widespread in Moldova and even show a small increase. Existence of

informal payments in the health system become even more absurd since a large number of citizens of this country are insured within the mandatory health insurance system that provides guaranteed access to medical care and primary medical care, and pre-hospital emergency is free of charge for all persons, regardless of whether they are insured or uninsured. Particularly alarming is the problem of hospital services and payment for drugs in hospital.

Table no. 3.

Indirect monthly expenditures per capita per type of healthcare

(MDL)

	Total expenditures, of which:								
				formal payments			**informal payments**		
	2008	**2009**	**2010**	**2008**	**2009**	**2010**	**2008**	**2009**	**2010**
Primary medical care and medical care of profile medical specialists	7.06	4.77	6.28	4.93	3.79	4.36	2.13	0.98	1.92
Dental care	6.9	14.7	4.7	6.25	14.66	4.65	0.63	0.00	0.01
Hospital care	3.4	6.8	4.9	2.0	3.6	0.6	1.4	3.2	4.2
Drugs	51.6	61.0	62.1	-	-	-	-	-	-

Source: Sergey Shishkin and Matthew Jowett – „An analysis of reforms in health funding in the Republic of Moldova"

The quality of medical care services requires capital investments in the technical and material base and skills to use high technologies. By creating the fund for development and modernization of public medical service providers, the NHIC gives to public institutions an additional chance to improve both the technical and material base as well as the practical application of modern medical standards, adapted to the European level. This activity of the NHIC is a short-term solution and a platform for development of capacities of founders of medical and sanitary institutions to achieve the sector investment management.

For the contracting process to become pro-active, contracting procedures and mechanisms shall continue at all levels of medical care by: focusing mainly on quality and results of the MSI activities, reporting and transparent evaluation of services, protection of rights of insured persons and clarity of responsibilities.

2.3 Beneficiaries and Partners of the NHIC and their Expectations

The NHIC interacts with several partner groups, with which it has convergent and divergent points on segments of activity of the institution and the MHI system. The relationship between the insured, health service provider and the insurer requires balancing the expectations and needs.

This chapter describes the expectations and the needs of partners.

Insured persons need guaranteed enjoyment of health insurance upon occurrence of the insured risk and throughout the whole period of access to medical services, guaranteed right to be treated and serviced correctly in the health system and the right to free choice of provider, knowledge of rights and benefits of the MHIS, the volume of services and subsidized drugs included in the Unique Programme from safe sources adapted to the level of consumer's perception.

However, insured persons expect from medical service providers facilitation of access to primary medical, outpatient specialized, high performance services and elimination of bureaucratic barriers and informal payments.

Uninsured persons are awaiting more conditions for facilitation of inclusion in the MHI system: increase in the deadline for payment of the insurance premium, removal of fines and penalties for late payment of contributions, payment of the premium in instalments. Meanwhile, people agree to keep the discounts applied in paying premiums for mandatory health insurance. In terms of information, they have the same expectations as the insured persons.

In the MHI system, the uninsured benefit from a package of essential services, using the advantage of insured comfort and do not see the need to fully enter the system.

Reluctant confidence in state institutions impacts the MHI system and degenerates into mass prejudices, according to which, to access a quality service, informal payments are agreed, even in the case of holders of mandatory health insurance policies.

Medical service providers are awaiting implementation of a sustainable, flexible contracting process and compensation of services rendered under contract. Some providers would accept the challenge of increased competition, while most of them would avoid this.

The Ministry of Health and the Government rely on: efficient management of the MHI system and increase in population confidence in the MHIS, compliance with provisions of policies and regulatory framework of the health system and, respectively, the support in implementation of reforms in the health system, monitoring and effective control of medical care and use of funds, increase in transparency, including through timely and high quality reporting of fund use.

3. INTERNAL ORGANIZATIONAL AND MANAGEMENT ANALYSIS OF THE NHIC – 7S OF McKINSEY

Strategy – the NHIC has a strategic development document, approved by the Decision of the Board on 30 December 2013. Annual operational planning with basic objectives and activities approved by the NHIC management is developed on the base of strategic subjects. The objectives and activities planned for 2015 have been achieved to the extent of 80%, the main reasons being reduced responsibility of heads of divisions and reduced collaboration between divisions.

Systems - systemic institutional approach argued analytically as per inter-sector dimensions to ensure efficient operational management is insufficient. Planning and reporting shall be supported by monitoring and evaluation capabilities, to ensure transparency of management and performance of institution.

To enhance the level of institutional approach and redistribute the relevant responsibilities from the bureaucratic routine of the top management, development of logistical support systems for management of information flow, information and communication technologies and human resources competitiveness is required. Basic and support processes of the NHIC have been identified, described, approved and implemented, which facilitated unified assurance of quality and results of services in territorial units.

Structure – the NHIC structure consists of central and territorial structural divisions. Activation of central structural divisions is overloaded with operational duties irrelevant to the state, and shall be decentralized in order to strengthen the functions of planning, monitoring, evaluation and internal audit. Territorial structural divisions responsible for provision of technical services in the insurance system need unified methodological support developed by central divisions to support routine operations. Coordination of activities between structures is underdeveloped and makes indispensable the reassessment of responsibilities and organization of inter-structural activity.

Style - administration in the NHIC is vertical and the management style is rather authoritarian, with elements of liberalism. Initiative of structural division managers in solving existing problems is insufficient. Rivalry continues and collaboration between heads of divisions persists is still poor. Team spirit is not sufficiently developed and horizontal cooperation is limited.

Staff – on 26 December 2013 the new structure of the NHIC and the list of territorial agencies have been approved.

Therefore, the maximum number of staff of the central office of the NHIC is 115 employees, except for technical and security staff, and territorial agencies are 7 in number, with 155 administrative employees.

Following approval of the new structure of the NHIC, its staff was uniformly distributed and regulations have been approved for divisions of the NHIC central apparatus, staff of territorial agencies and job descriptions.

Skills – the NHIC has poor skills of analysis and evaluation, and human resources management. The skills of the staff in speaking international foreign languages are poor. The staff development and training system does not meet their needs.

Common values - the Institutional Strategy determined common values of the NHIC staff that need to be strengthened by implementing an efficient management of internal communication.

4. SWOT ANALYSIS

The SWOT analysis integrates the above analysis and provides a summary of management, based on the data identified by other methods. The result of the SWOT analysis is concentration and not just listing of opportunities and external risks, but also the internal strengths and weaknesses.

Strengths:	***Weaknesses:***
• An institution with a history of 14 years and with improving reputation in the health system; • A certain organizational culture revised in accordance with the strategic goals; • Staff trained in different fields (in both medical field and in other related or complementary fields), which increases the ability of solving complex issues; • Willingness to work overtime; • Orientation towards development and performance; • Motivation of staff based on the evaluation system of individual skills and collective performances; • Internships abroad to gain new experiences.	• Reduced capacities for implementation of the Strategy; • Insufficient management system; • Poor analysis capacities; • Poor coordination of process management; • Non-competitive salaries; • An organizational climate that does not encourage teamwork • Management of undeveloped skills of the executive staff; • Low intrinsic motivation because of the weak capacity to make difference between people with different efficiency; • Lack of a career plan for employees, and promotion of a coherent training, retention and motivation of staff; • Poor working conditions; • Lack of an integrated fully functional information system free of administration errors; • Insufficient transparency of actions and results; • Reduced information support and lack of data required for management of basic processes.
Opportunities:	***Risks:***
• Health is an area with major social impact, which can provide arguments for adoption of some policies; • Ratification by all EU Member States	• Worsening of demographic trends, emigration from the country of people of working age, increase in the number of old people, etc.;

of the Association Agreement with the EU; • Joining the international MHI networks; • Creation of the MHI information system; • New government objectives on modernization of health system (quality of health services, public access to medical services, protection rights of insured persons) • Cooperation with international organizations and benefiting from development of skills of the NHIC staff; • Change of the behavioural attitude for health value from the part of population to promote a healthy lifestyle and prevention of diseases; • Increase in competition on the health service market, creation of value of quality and efficiency upon provision of services.	• Shortage of medical staff; • Changes of the needs of insured persons; • Economic instability of the country and danger for sustainable development of the MHI. High rate of unemployment and poverty; • Frequent changes in the structure and priorities of the Ministry of Health; • Low level of growth of the MHIF for sustainability of the health system and systemic reforms; • Poor legal culture; • Powerful lobbyism from the part of private insurance companies to liberalize the MHI system that can fragment funding of the health system and substantially reduce access to health services; • Harmful attitude and reduced confidence of the population and the media in the MHI system; • Adoption of some restrictive legal regulations or regulations with unfavourable impact.

5. STRATEGIC SUBJECTS

Based on the NHIC external and internal analysis, four strategic subjects for the next five years are formulated:

1. assurance of protection of rights of insured persons;
2. assurance of access to and improving quality of medical services;
3. assurance of sustainable development of the MHIF and increase in the MHI coverage of population;
4. NHIC - efficient institution.

6. VISION, MISSION, VALUES

Vision:

The population of the country has confidence in the quality of public services provided by employees of the NHIC that provide financial protection and ensure equitable access to quality medical services. The NHIC is an institution, which plays a key role in promotion and implementation of reforms in the health system of the Republic of Moldova. The MHI is the main source of funding of the health system.

Mission:

Provision of guarantee of safety and financial protection of insured persons upon accession to quality medical services.

Values:

- ***professional ethics and integrity*** – we perform professional duties with responsibility, efficiency, fairness and conscientiousness;
- ***cooperation*** – we create an atmosphere of confidence in internal collaboration and cooperation with partners;
- ***responsiveness*** - we are open and react quickly to the needs of beneficiaries of the MHI system;
- ***development*** – we are creative and oriented towards ongoing development of organizational skills and services rendered to promote and implement health reforms.

7. STRATEGIC GOALS, INDICATORS AND ACTIONS

The Strategy is developed by means of strategic mapping. Strategic map is an integrated vision of the four strategic issues listed in the previous chapter and ensures visualization of cause-effect relationships between goals. The strategic map of the NHIC for the next 5 years is given in Annex no. 1.

Each goal of the strategic map is determined by a set of indicators. Indicators have a benchmark level, in most cases the level of 2015 is used, in some cases the level of the years 2014, 2013 is used. For each indicator the level to be reached every year, until 2020 inclusive, is set. The set of indicators is presented in Annex no. 2.

The sources of information for indicators used are: the National Bureau of Statistics, the National Center for Health Management, the World Health Organization, the World Bank, the International Monetary Fund, studies, reports of the health system and other relevant sources.

The general strategic goal of the NHIC is **„Increase in satisfaction of persons insured with the MHI"**. The goal is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Satisfaction of insured persons with the quality of health services	56,0%	57%	58%	59%	60%	61%
Satisfaction of insured persons with the access to health services	35,4%	36,4%	37,4%	38,4%	39,4%	40%

7.1. Strategic theme: Assurance of Protection of Rights of Insured Persons

***Strategic goal*: Improvement of the support of the MHIS beneficiary in use of rights** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Complaints of the MHIS beneficiaries examined by the NHIC	585	600	600	500	500	500

The following general and specific objectives have been identified to ensure protection of rights of insured persons.

***Objective 1*: Improvement of the NHIC services for beneficiaries** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Satisfaction of the MHIS beneficiaries with the NHIC services	86,8%	86,8%	87%	87%	88%	88%
Average time of resolution of petitions filed by the MHIS beneficiaries	8 days	10	10	10	10	10

Share of submitted forms through electronic channels from the total number of submitted forms	10%	25%	30%	35%	40%	45%

To achieve this objective, the following actions are planned:

No.	Actions	Term	Responsible
1.	Increase of quality of beneficiary service in TA by developing and implementing quality standards	December 2016	DRB
2.	Preparation and implementation of registration at family doctor	December 2016	DRB
3.	Development and implementation of IS for management of relations with the MHIS beneficiaries, using data exchange through platform of interoperability, integration with the governmental IS for e-payments (M-Pay), development of electronic channels to serve MHIS beneficiaries	December 2019	DRB DIS & eT TA
4.	Exclusion of paper policies	December 2018	DRB
5.	Preparation and implementation of the mechanism for protection of rights of insured persons in court	June 2017	LD

***Objective 2*: Decrease in pocket payments** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Share of complaints filed to the NHIC on pocket payments of the total number of filed (written and verbal) complaints	1,2%	1,5%	2%	1,9%	1,8%	1,7%
Share of persons to whom provision of medical services has been conditioned	20,9%	21%	23%	22%	22%	21%

To achieve this objective, complex activities are required; the document provides for only the NHIC activities, hence they shall be considered as part of a joint effort coordinated between various partners.

The actions planned are as follows:

No.	Actions	Term	Responsible
1.	Organization of communication campaigns about the rights and obligations of beneficiaries within the MHIS and decrease of pocket payments	December 2016	SICM & S
2.	Preparation of a detailed report of pocket payments in cooperation with institutions concerned	December 2016	DRB SAHE
3.	Amendment of legal provisions in order to decrease pocket payments from the MHIS	December 2017	DRB

7.2. Strategic theme: Assurance of Access to and Improvement of Quality of Medical Services

Strategic goal: **Assurance of access and improvement of quality of medical services** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Average length of waiting at the family doctor	To be indicated					
Average length of waiting at cardiologist in outpatient conditions	To be indicated					
Average length of waiting for hip endoprosthesis	1 year 10 months	1 year 8 months	1 year 6 months	1 year 3 months	1 year	1 year
Average length of waiting for surgical treatment of cataract	3 months	3 months	2.5 months	2.5 months	2.5 months	2.5 months
Share of medical institutions that exceed the level of quality evaluation*						
Share of one-day surgical interventions of the total surgical interventions	3%					
Annual acute care hospital discharges per 100 persons						
No. of family doctors at whom over 2000 persons are registered	404					
No. of visits in outpatient conditions per 1 insured person	2.8					

**The indicator is used for monitoring only*

Objective 1: **Improvement of access and control of quality of medical and pharmaceutical services** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Share of evaluated institutions of the total no. of contracted institutions (MSI/providers of pharmaceutical services)	50.1/7.5	51.8/7.6	52.0/7.6	53.5/7.8	53.0/7.8	53.5/7.8
Share of penalized MSI of the total no. of audited MSI*	78	75	72	70	68	67
Share of amounts withheld following non-validation of medical services and de-allocation of financial means from contracted amount*	0.31	0.38	0.40	0.42	0.44	0.45

** The indicators are used for monitoring only*

To achieve this objective, the following actions are planned:

No.	Actions	Term	Responsible
1.	Audit of coding in hospital institutions with the ongoing growth of ICM in 2013-2015 with subsequent submission of proposals on adjustment of funding (reduction or increase) and introduction of penalties	December 2016	GDQEC
2.	Preparation of the mechanism for monitoring of contracts with pharmaceutical service providers	December 2016	SD
3.	Amendment of the regulatory framework governing legal liability for de-allocation of the MHIF	June 2017	LD
4.	Development of tools to minimize errors in prescription and issuance of prescriptions for subsidized drugs	December 2017	SD DIS & eT
5.	Evaluation of PMC to provide population with paraclinic services provided for in Annex no. 4 of the Unique Programme	December 2017	GDQEC
6.	Strengthening of the MSI control with emphasize on the process of prescription of subsidized drugs	December 2017	GDQEC
7.	Development of result and post-screening indicators (continuity after end of screening, subsequent actions)	February 2016	DPM GDQEC
8.	Improvement of methods for monitoring of services contracted and financed by means of the FPM	March 2016	DPM
9.	Monitoring of indicators of access to medical services	December 2016	DCRP
10.	Implementation of the Cervical and Colorectal Screening Programme funded by the MHIF	December 2017	GDQEC

***Objective 2*: Increase in efficiency of contracting and payment methods** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Share of execution of contracts based on payments for performance within the PMC	15%	15%	18%	20%	20%	20%
Share of execution of contracts based on payments for performance within the HMC*						
Share of scheduled hospitalizations in the total no. of hospitalizations	31,7%					

∗ *The indicator is used for monitoring only*

To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Review of the performance-based incentive program in the Primary Medical Care (PMC)	December 2016	DCRP
2.	Introduction of performance-based incentives to improve efficiency and quality in the Hospital Medical Care (HMC)	December 2016	DCRP
3.	Development and piloting of methodology for calculation of costs based on the DRG	November 2017	SAHE

4.	Development of the contracting function and improvement of the quality of relationships with TA providers	December 2016	DCRP
5.	Preparation of the mechanism for contracting providers of specialized outpatient medical care	October 2016	DCRP
6.	Strengthening relationships with pharmaceutical service providers	July 2017	SD
7.	Review and re-approval of the Regulation on other preventive activities and measures for prevention of risks of diseases, accepted for funding under the project	March 2016	DPM

Objective 3: **Increase in efficiency of allocations for subsidized drugs with special purpose** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Share of allocations for drugs subsidized from the basic fund of the NHIC	6,8%	7%	8%	9%	10%	10%
Share of expenditures for subsidized drugs from the total private health expenditures*	67%	66%	65%	65%	65%	65%
Number of penalties imposed for irregular prescription and issuance of subsidized drugs*	35	40	40	38	38	38
Average share of drug subsidy	74%	75%	75%	75%	75%	75%

**The indicator is used for monitoring only*

To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Analysis of the situation and identification of measures for improvement in the field of special purpose drugs	December 2016	SD SAHE
2.	Implementation of measures for improvement and development in the field of subsidized drugs	September 2017	SD SAHE
3.	Launching of electronic network	December 2018	SD DIS & eT

7.3. Strategic theme: Assurance of Sustainable Development of the MHIF and Increase in the MHI Coverage of Population

Strategic goal: **Assurance of sustainable development of the MHIF and increase in the MHI coverage of population** is evaluated and planned as follows:

Indicators	Base	2015*	2016*	2017	2018	2019	2020
Share of the MHIF in the GDP, %	4.5%	4.4%	4.4%	4.3%	4.2%	4.3%	4.4%

Increase in the MHIF expenditures	+10.7%	+7.3%	+12.2%	+7.6%	+6.9%	+6.9%	+6.9%
Real growth of the MHIF	+7.0 %	-2.2%	+0.8%	+0.7%	+2.3 %	+2.0%	+2.0%

** as of 10 November 2015*

Objective 1: **Increase in the number of insured persons per target groups in the MHIS** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Degree of the MHI coverage	85,6%	85,6%	85,7%	85,7%	85,8%	85,8%
No. of individually insured persons	48 307	48 000	47 500	47 000	47 000	47 000

To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Review of the mechanism for individual insurance of people	December 2016	DRB
2.	Development of the MHI premium payment mechanism in the case of change from one category of persons included in the MHIS to another category, in the course of the year	December 2016	DRB
3.	Review of mechanisms for motivation of population to be included in the MHIS	September 2016	DRB
4.	Preparation of the regulatory framework on inclusion of foreign nationals into the MHIS	December 2016	LD

Objective 2: **Assurance of financial sustainability of the MHIF** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Premiums paid to an insured person (MDL)	3,198.8	3,756.4	4,078.0	4,427.3	5,340.5	5,797.9
Premiums paid to an individually insured person (MDL)	1,881.9	2,508.8	2,734.4	2,956.0	3,565.1	3,869.9
Premium paid to a person insured by state (MDL)	1,401.9	1,561.7	1,669.4	1,751.2	1,872.1	2,001.2
Amount of the insurance premium in percentage share*	9%	9%	9%	9%	10%	10%

**to be established annually in the course of development of the MTBF and the annual MHIF law*

To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Review of the method for calculation of the amount of transfers from the state budget for categories of persons insured by the Government	December 2016	DEF
2.	Proposals for application of the principle of solidarity in collection of revenues in the MHIF from premiums paid by unemployed and self-employed persons	December 2017	DEF

3.	Review of the categories of people eligible to be insured by the Government so as the state subsidizes only socially disadvantaged persons	December 2017	DEF DRB
4.	Review of sources of income from which MHI premiums are calculated	December 2016	DEF

7.4. Strategic theme: NHIC – efficient institution

Appropriate operation of the MHI system and successful implementation of reforms need investments and development of human, financial and technical resources. Also, systematic efforts shall be made to improve the entire institutional context and preparation for implementation of complex actions.

Strategic goal: **Improvement of the quality and efficiency of the management** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Share of administrative expenditures	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%

Objective 1: **Improvement of organization of activity, cooperation and communication** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Share of positive media coverage of the NHIC	90%	90%	90%	90%	90%	90%
Increase in the no. of appreciations on social networks	1700	1900	2100	2300	2500	2700
Share of recommendations implemented following internal audits	85%	85%	90%	90%	95%	95%
Share of processes that do not match described and approved processes	40%	30%	20%	20%	10%	10%
Number of projects/contracts signed with international institutions	2					
Level of satisfaction with activity of structural divisions of the NHIC	78%	78%	80%	81%	82%	83%

To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Improvement of external communication channels, including the NHIC webpage	December 2016	SICM & S DIS & eT
2.	Development of financial management and control within the NHIC	May 2018	DSMHR
3.	Establishment of effective mechanisms for development, communication and monitoring of implementation of internal audit recommendations	January 2017	SAI

4.	Improvement of planning and execution of public procurement in accordance with strategic and operational priorities	December 2017	LD

***Objective 2*: Aligning the NHIC structure to provisions of the Strategy**. To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Evaluation of functions of the NHIC structural divisions and strengthening of the NHIC structure	December 2016	DSMHR
2.	Review of system and operational procedures	December 2016	DSMHR
3.	Provision of information technology support	December 2016	DIS & eT

***Objective 3:* Development of competences of the NHIC staff** is evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Level of competence of the management staff	2.75	3.0	3.0	3.5	3.8	4.0

To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Correlation of labor remuneration depending on competences	December 2017	DSMHR
2.	Optimization of the human resource management system	December 2019	DSMHR
3.	Strengthening of cooperation of the NHIC with international health institutions and aligning of the MHIS to international good practices in the field of MHI	December 2018	SIR

***Objective 4*: Improvement and development of new ISs** and evaluated and planned as follows:

Indicators	Base	2016	2017	2018	2019	2020
Degree of satisfaction of the NHIC structural divisions with information technology support	57.1%	65%	70%	75%	80%	85%

To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Development and implementation of the Help-Desk system for the IS support	Martie 2016	DIS & eT
2.	Purchase and implementation of „Record of Human Resources" IS	December 2020	DSMHR DIS & eT
3.	Reengineering of „Payment of Medical Services" IS	December 2019	DIS & eT
4.	Development and implementation of „Contracting Medical and	December	DCRP

	Sanitary Institutions" IS	2017	DIS & eT
5.	Development and implementation of „Record of Medical Services" IS	December 2017	DCRP DIS & eT

Objective 5: **Improvement of quality of data and analysis, strengthening of strategic and operational planning.** To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Optimization of the system of reporting, analysis and monitoring of implementation of the operational plan and Strategy	December 2016	DSMHR

Objective 6: **Optimization of development of the regulatory framework.** To achieve this objective the following actions are planned:

No.	Actions	Term	Responsible
1.	Changing the regulatory framework regarding the awarding skills of NHIC for the elaboration of proposals for amendments and additions to legislation concerning the mandatory health insurance	November 2017	LD
2.	Strengthening development and approval of draft regulatory acts	December 2018	LD

8. KEY-FACTORS FOR ASSURANCE OF IMPLEMENTATION OF THE STRATEGY

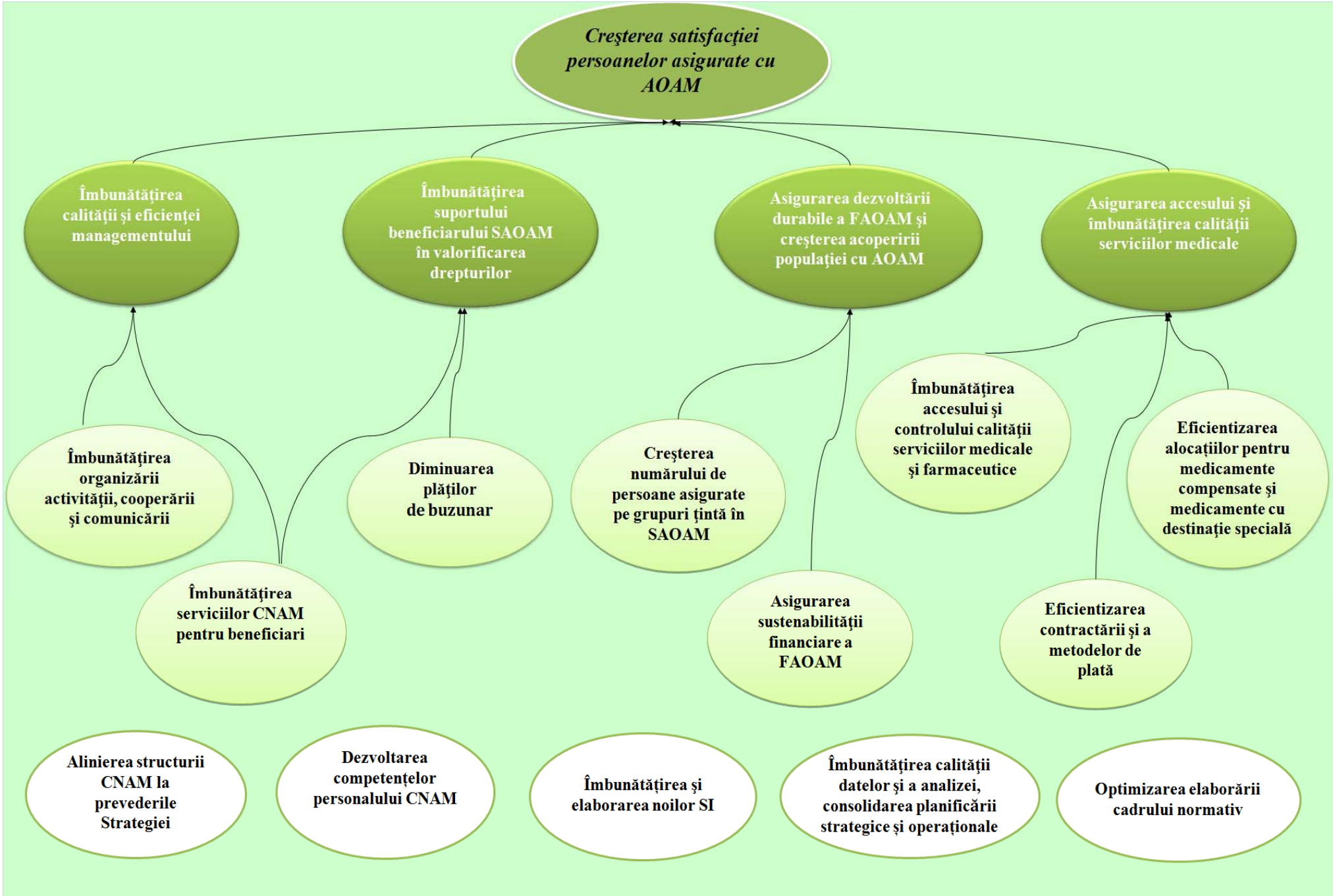
Data on international practice show that most institutions fail during their implementation of the institutional strategy. The main reasons are poor management of the strategy and insufficient institutional capacities for implementation and enforcement, rather than development of ineffective strategies. Here are the key factors that must be followed to succeed in implementing the Strategy:

- ***Leadership in implementation of the strategy*** - requires strong commitment of top management to manage implementation of the Strategy. The Strategy shall be managed by a manager with authority that shall promote collective cohesion of integrated coordination of strategic actions;
- ***Knowledge of the NHIC staff of the strategy and internal commitment of the staff in performance of*** joint ***activities*** require development of well-managed internal communication, enabling each employee to realize their potential of professional skills by personally contributing to achievement of goals, initiatives and indicators. Seminars, meetings on increase in awareness and knowledge of the Strategy shall be organized. A system for management of information about implementation of the strategy must be put in place;
- ***Introduction of salary schemes depending on the result*** in order to increase motivation and strengthening of personal relations between employees and the Strategy;
- ***Development of institutional capacities*** is essential for strengthening of the NHIC structural divisions, systems and processes, administration, management staff and all employees to improve institutional, team and individual performance;
- ***Budget correlated to the Strategy's needs*** consists in successful implementation of complex strategic initiatives and institutional capacity development of the NHIC for the coming years provided only an adequate budget coverage is in place;
- ***Cooperation with partners, governmental and non-governmental international institutions*** involves obtaining openness to cooperation of partners from and outside the system and has a leading role in achieving the objectives. A special role is played by relations of coordination with health institutions that develop and regulate policies in the field and those contracting providers of medical and pharmaceutical services;
- ***Quality of reporting and rolling planning*** involves reflecting activities exposed based on the set of indicators that will allow dynamic evaluation of achievement of objectives and strategic goal. The evaluation of the Strategy shall be systematic in nature and shall be carried out throughout the implementation period and shall include development based on monitoring indicators of annual progress reports and

the final evaluation report, identifying errors, eventual corrections of content and form in planned actions to be presented to the NHIC Board for information and approval;

- ***Transparency of institutional activity*** consists in ongoing information of the public about processes and results of the activities included in the Strategy and implementation of the feedback system.

Annex no.1


Creşterea satisfacţiei persoanelor asigurate cu AOAM
Îmbunătăţirea calităţii şi eficienţei managementului
Îmbunătăţirea suportului beneficiarului SAOAM în valorificarea drepturilor
Asigurarea dezvoltării durabile a FAOAM şi creşterea acoperirii populaţiei cu AOAM
Asigurarea accesului şi îmbunătăţirea calităţii serviciilor medicale
Îmbunătăţirea organizării activităţii, cooperării şi comunicării
Îmbunătăţirea serviciilor CNAM pentru beneficiari
Diminuarea plăţilor de buzunar
Creşterea numărului de persoane asigurate pe grupuri ţintă în SAOAM
Asigurarea sustenabilităţii financiare a FAOAM
Îmbunătăţirea accesului şi controlului calităţii serviciilor medicale şi farmaceutice
Eficientizarea contractării şi a metodelor de plată
Eficientizarea alocațiilor pentru medicamente compensate şi medicamente cu destinaţie specială
Alinierea structurii CNAM la prevederile Strategiei
Dezvoltarea competențelor personalului CNAM
Îmbunătățirea şi elaborarea noilor SI
Îmbunătăţirea calităţii datelor şi a analizei, consolidarea planificării strategice și operaționale
Optimizarea elaborării cadrului normativ

Creşterea satisfacţiei persoanelor asigurate cu AOAM	Increase in satisfaction of persons insured with the MHI
Îmbunătăţirea calităţii şi eficienţei managementului	Improvement of quality and efficiency of management
Îmbunătăţirea suportului beneficiarului SAOAM în valorificarea drepturilor	Improvement of support of the MHIS beneficiary in the use of rights
Asigurarea dezvoltării durabile a FAOAM şi creşterea acoperirii populaţiei cu AOAM	Assurance of sustainable development of MHIF and increase in the MHI coverage of population
Asigurarea accesului şi îmbunătăţirea calităţii serviciilor medicale	Assurance of access and improvement of quality of medical services
Îmbunătăţirea organizării activităţii, cooperării şi comunicării	Improvement of organization of activity, cooperation and communication
Diminuarea plăţilor de buzunar	Decrease of pocket payments
Creşterea numărului de persoane asigurate pe grupuri ţintă în SAOAM	Increase in the number of insured persons per target group in the MHIS
Îmbunătăţirea accesului şi controlului calităţii serviciilor medicale şi farmaceutice	Improvement of access and control of quality of medical and pharmaceutical services
Eficientizarea alocaţiilor pentru medicamente compensate şi medicamente cu destinaţie specială	Increase in efficiency of allocations for subsidized drugs with special purpose
Îmbunătăţirea serviciilor CNAM pentru beneficiari	Improvement of the NHIC services for beneficiaries
Asigurarea sustenabilităţii financiare a FAOAM	Assurance of financial sustainability of the MHIF
Eficientizarea contractării şi a metodelor de plată	Increase in efficiency of contracting and payment methods
Alinierea structurii CNAM la prevederile Strategiei	Aligning of the NHIC structure to provisions of the Strategy
Dezvoltarea competenţelor personalului CNAM	Development of skills of the NHIC staff
Îmbunătăţirea şi elaborarea noilor SI	Improvement and development of new ISs
Îmbunătăţirea calităţii datelor şi a analizei, consolidarea planificării strategice şi operaţioanle	Improvement of quality of data and analysis, strengthening of strategic and operational planning
Optimizarea elaborării cadrului normativ	Optimization of development of the regulatory framework

Set of Indicators

Purpose	Measure	Definition	Unit	Formula	Frequency	Responsible
Increase in satisfaction of persons insured with the MHI	Satisfaction of insured persons with the quality of health services	Opinion of insured persons about the level of quality of health services (surveys, questionnaires)	%	Share / weight of insured persons who are satisfied with the quality of health services / all respondents x 100	Annually	DRB
	Satisfaction of insured persons with the access to health services	Opinion of insured persons about the level/degree of access to health services (surveys, questionnaires)		Share / weight of insured persons who are satisfied with the level / degree of access to health services / all respondents x 100		
Improvement of support of the MHIS beneficiary in the use of rights	Complaints of the MHIS beneficiaries examined by the NHIC	Number of complaints filed to the NHIC	no.	Number of complaints per certain period of time	Annually	DSMHR
Improvement of NHIC services for beneficiaries	Satisfaction of the MHIS beneficiaries with the NHIC services	Level of satisfaction of beneficiaries of the NHIC services (surveys, questionnaires)	%	Share of insured persons pleased with the NHIC services / all respondents x 100	Annually	DRB
	Average time of resolution of petitions filed by the MHIS beneficiaries	Average time from receipt till sending of petition	days	Total no. of days for response / number of resolved petitions	Quarterly	DRB
	Share of submitted forms through electronic channels from the total number of submitted forms	Share of submitted forms through electronic channels from the total number of submitted forms	%	No. of 2-03/l, 2-04/l forms received through electronic channels / Total no. of 2-03/l, 2-04/l of recorded forms	Annually	
Decrease of pocket payments	Weight of complaints filed to the NHIC on pocket payments of the total number of filed (written and verbal) complaints	Share of complaints filed to the NHIC on pocket payments of the total number of filed complaints	%	No. of complaints filed to the NHIC on pocket payments /Total no. of complaints filed to the NHIC	Quarterly	DRB
	Share of persons to whom provision of medical services has been conditioned	Share of persons to whom provision of medical services has been conditioned	%	Share of persons to whom provision of medical services has been conditioned / number of complaints of the MHIS beneficiaries examined by the NHIC	Quarterly	DRB

Assurance of access and improvement of quality of medical services	Average length of waiting at the family doctor	Average time of waiting from record till access to medical services offered by family doctor	days	Time of waiting from record till access to medical services offered by family doctor	Annually	DCRP
	Average length of waiting at cardiologist in outpatient conditions	Average time of waiting from record till access to cardiologist	days	Time of waiting from record till access to medical services offered by cardiologist	Annually	DCRP
	Average length of waiting for hip endoprosthesis	Average time of waiting for hip endoprosthesis	month	Time of waiting from record till access to services of hip endoprosthesis	Annually	DCRP
	Average length of waiting for surgical treatment of cataract	Average time of waiting for surgical treatment of cataract	month	Time of waiting from record till surgical treatment of cataract	Annually	DCRP
	Share of medical institutions that exceed the level of quality evaluation	Share of medical institutions that exceed the level quality assessment	%	Contracted medial institutions that exceed the level of quality / total no. of contracted medical institutions x 100	Annually	GDQEC
	Weight of one-day surgical interventions of the total number of surgical interventions	Share of one-day surgical interventions of the total number of surgical interventions	%	Number of cases of one-day surgical interventions / total no. of cases of surgical interventions x 100	Annually	DCRP
	Annual acute care hospital discharges per 100 persons	The frequency of discharges for acute cases per 100 people	no.	No. of acute care discharges in the last year / the average of annual population x 100, taken from the National Bureau of Statistics	Annually	DCRP
	No. of family doctors at whom over 2000 persons are registered	Accessibility of population to services offered by family doctor	no.	Number of persons recorded at family doctor in the RM / Number of family doctors in the RM. Than we select the number of family doctors at whom over 2000 persons are recorded	Annually, at the time of contracting	DCRP, responsible for drafting the DIS & eT report
	No. of visits in outpatient conditions per 1 insured person	Accessibility of insured persons to services of medical specialists	no.	Number of visits in outpatient conditions of insured persons / Number of insured persons recorded in the RM	Annually	DCRP
Improvement of access and control of quality of	Share of evaluated institutions of the total no. of contracted institutions (MSI/providers of pharmaceutical services)	Share of evaluated institutions of the total no. of contracted institutions (MSI/providers of pharmaceutical services)	%	Number of non-validated cases following evaluation and control / total no. of validated cases x100	Quarterly	GDQEC

medical and pharmaceutical services	Share of penalized MSI in the total no. of audited MSI	Share of the MSI that following audits, have been penalized, of the total number of audited MSI	%	Number of penalized MSI / number of audited MSI x100	Annually	GDQEC
	Share of amounts withheld following non-validation of medical services and de-allocation of financial means from the contracted amount	Share of financial means of the MHIF used by the MSI contrary to purposes established in contractual clauses and provisions of legal and regulatory acts in force from total contracted means	%	Amount withheld as a result of failure to validate medical services and de-allocated means / contracted amount x100	Annually	GDQEC
Increase in efficiency and payments methods	Share of the MSI own rate that is the base of contracting as compared to the national one	Adjustment of the MSI rates to the national rate	%	% Own rate of the previous year + % National rate	Annually	SAHE
	Share of contracting based on payments for performance within PMC	Share of allocations for performance indicators from the PMC budget	%	Amount of allocations for PMC performance indicators / contracted amount in PMC x 100	Annually	DCRP
	Share of contracting based on payments for performance within PHEMC	Share of allocations for performance indicators in the PHEMC	%	Amount of allocations for the PHEMC performance indicators / amount contracted in the PHEMC x100	Annually	DCRP
	Share of contracting based on payments for performance within HMC	Share of allocations for performance indicators in the HMC	%	Amount of allocations for the HMC performance indicators / amount contracted in the HMC / amount contracted in the HMC x 100	Annually	DCRP
	Share of hospitalizations scheduled in the total no. of hospitalizations	Share of hospitalizations scheduled in the total no. of hospitalizations	%	Number of scheduled hospitalizations /total number of hospitalizations x 100	Annually	DCRP
Increase in efficiency of allocations for subsidized drugs with special purpose	Weight of allocations for drugs subsidized from the basic fund of the NHIC	Weight of allocations for drugs subsidized from the basic fund of the NHIC	%	Allocation for subsidized drugs / volume of the basic fund x 100	Annually	SD
	Weight of expenditures for subsidized drugs from the total private health expenditures	Share of expenditures for subsidized drugs from the total private health expenditures	%	Cash payments for drugs / total private health expenditures	Annually	SD
	Number of penalties imposed for irregular prescription and issuance of	Number of penalties applied to medical and pharmaceutical institutions	no.	Number of penalties applied for prescription and issuance of subsidized drugs	Annually	GDQEC

	subsidized drugs	in non-governed prescription and issuance of subsidized drugs				
	Average share of drug subsidy	Average share of subsidy	%	Total subsidized amount / total amount paid for drugs x 100	Annually	SM
Assurance of sustainable development of MHIF and increase of the MHI coverage of population	Weight of the MHIF in the GDP	Weight of the MHIF in the GDP	%	Expenditures of the MHIF / amount of the GDP x 100	Annually	DEF
	Increase in expenditures of the MHIF	Increase of expenditures of the MHIF as compared with the previous year	%	Amount of MHI funds for the current year / amount of the MHI funds for the previous year x 100		
	Real growth of the MHIF	Correlation between the rate of inflation and increase in expenditures of the MHIF with previous year	%	Level of increase in funds / level of inflation x 100		
Increase in the number of insured persons per target group in the MHIS	Degree of the MHI coverage	Share of insured persons in the total number of population	%	Number of insured persons / total number of persons x 100	Annually	DRB
	No. of individually insured persons	Number of individually insured persons	no.	Real number of individually insured persons	Quarterly	DRB
Assurance of financial sustainability of MHIF	Premiums paid to an insured person (MDL)	Average amount of contribution of an employed person	MDL	Amount of premiums accumulated in the percentage share with regard to the number of insured persons	Annually	DEF
	Premiums paid to an individually insured person (MDL)	Average amount of contribution of an individually insured person	MDL	Amount of premiums accumulated in fixed amount as compared to the number of individually insured persons		
	Premium paid to a person insured by state (MDL)	Average amount of contribution of the state budget for a person insured from the state budget	MDL	Amount of transfers for persons insured from the state budget with regard to the number of persons insured from the state budget		
	Amount of the insurance premium in the percentage share	Amount of insurance premium in the percentage share	%	Amount of insurance premium in the percentage share		
Improvement of quality and efficiency of management	Share of administrative expenditures	Share of administrative expenditures	%	Volume of administrative expenditures / volume of the MHIF x100	Annually	DEF

Improvement of organization of activity, cooperation and communication	Share of positive media coverage of the NHIC	Positive and negative report of media about the NHIC for a particular period of time	%	Positive appreciations of media / total no. of appreciations of the media for a particular period x 100	Quarterly	SICM & S
	Increase in the no. of appreciations on social networks	Appreciations of facebook pages of the NHIC and number of persons that saw any activities of the NHIC on the facebook page, among which postings, postings of other persons, advertising of appreciation of the page, mentions and visits	no.	Total number of appreciations of the facebook page and the total number of persons who viewed postings	Quarterly	SICM & S
	Share of recommendations implemented following internal audits	Share of recommendations implemented from the Action Plan on implementation of recommendations performed following the internal audit	%	Number of implemented recommendations /total no. of submitted recommendations x 100	Annually	SAI
	Share of processes that do not match described and approved processes	Share of processes evaluated within internal audits that do not correspond to the described and approved ones	%	Number of processes that do not correspond to those described and approved / total no. of processes evaluated within audit missions		
	Number of projects/contracts signed with international institutions	Number of projects/contracts signed with international institutions	no.	Number of projects/signed contracts	Annually	SIR
	Level of satisfaction with activity of structural divisions of the NHIC	Opinion of the staff about organization of activity, cooperation and communication within the NHIC structural divisions (questionnaires)	%	Staff satisfied at a certain level / all respondents x100	Annually	DSMHR
Development of skills of the NHIC staff	Level of competence of the management staff	Personal and professional level of competence of the management staff	score	Personal and professional level of competence of the management staff, according to Instruction on evaluation of professional competences of heads of internal divisions of the NHIC	Annually	DSMHR

Improvement and development of new ISs	Degree of satisfaction of the NHIC structural divisions with information technology support	Satisfaction of staff with the IS support to respond to IS needs and problems	score	Share provided according to the questionnaire of satisfaction (included in the main survey of satisfaction)	Annually	DSMHR