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ACCESS TO HEALTH SERVICES SURVEY IN THE REPUBLIC OF MOLDOVA

FINAL RAPORT
2015

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The Center for Health Policies and Studies provided data analysis and developed the report of the 2012 Access to Health Services Survey (2012 AHSS) desk review and qualitative research. 2012 AHSS was carried out as part of Moldova Multiple Indicator Cluster Survey (MICS) in 2012 by the National Centre of Public Health of the Ministry of Health, with support from the United Nations Children's Fund (UNICEF) and in collaboration with the National Bureau of Statistics, the Scientific Research Institute of Mother and Child Health Care, the Ministry of Labour, Social Protection and Family, the Ministry of Education, the National Centre for Health Management, and the National Centre for Reproductive Health and Medical Genetics. The Center for Health Policies and Studies provided data analysis and developed the report of 2012 AHSS. Financial and technical support was provided by UNICEF, with direct contribution of the Swiss Agency for Development and Cooperation.

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ACRONYMS

AIDS – Acquired Immune Deficiency Syndrome

AHSS – Access to Health Services Survey

AQHS – Access and Quality of Hospital Services in the Opinion of the Moldovan Population

CDC – Centers for Disease Control and Prevention

CEE/CIS – Central Eastern Europe/Commonwealth of Independent States

CNAM – National Health Insurance Company (Compania NAtionala de Asigurari in Medicina)

DHS – Demographic and Health Survey

DK – Do not know

DTP – Combined vaccine against diphtheria, tetanus, and pertussis

ECDI – Early Childhood Development Index

EPI – Expanded Programme on Immunization

GFR – General Fertility Rate

HepB – Viral Hepatitis B vaccine

HH – household

Hib – Infection with Haemophilus influenzae type b

HIV – Human Immunodeficiency Virus

IDD – Iodine Deficiency Disorders

km – kilometer

MDG – Millennium Development Goals

MICS – Multiple Indicator Cluster Survey

min – minute

MDL – Moldovan leu

MMR – Measles, Mumps & Rubella Vaccine

NCPH – National Centre for Public Health

NCHS – National Centre for Health Statistics

NIP – National Immunization Programme

NBS – National Bureau of Statistics

NCD – Non-communicable disease

NHBS – National Household Budget Survey

OB/GYN – Obstetrics-Gynecology

OOP – Out-of-pocket

OPV – Oral Polio Vaccine

ORT – Oral Rehydration Treatment

PHC – Primary health care

PSU – Primary Sampling Unit

St. dev. – Standard Deviation

SDC – Swiss Agency for Development and Cooperation

SPSS – Statistical Package for Social Sciences

TB – Tuberculosis

UN – United Nations Organisation

UNFPA – United Nations Population Fund

UNGASS – United Nations General Assembly Special Session

UNICEF – United Nations Children's Fund

WHO – World Health Organization

SUMMARY TABLE

OF FINDINGS ACCORDING TO TANAHASHI'S DIMENSIONS OF ACCESS TO HEALTH SERVICES

Dimension	Indicator	Population group	Insured	Uninsured	Urban	Rural	Total	Total number of households
Availability coverage								
	Knowledge of a place for HIV testing (%)	Men	…	…	79.3	55	64.6	1545
	Knowledge of a place for HIV testing (%)	Women	…	…	85.5	73.4	78.5	6000
Accessibility coverage								
Geographic accessibility								
Distance Travel time	Distance <5 km to nearest health facility (%)	General population	…	…	94.6	98.6	97.1	11256
	Traveled distance to PHC facility at last episode of illness (km)	General population	…	…	2.8	2.9	2.9	365
	Traveled distance to medical specialist at last episode of illness (km)	General population	…	…	19.2	36.7	36.7	197
	Traveled distance to hospital at last episode of illness (km)	General population	…	…	22.7	45.1	32.8	375
	Travel time to PHC facility at last episode of illness (minutes)	General population	…	…	24.9	26.1	25.4	357
	Travel time to medical specialist at last episode of illness (minutes)	General population	…	…	52.2	77.8	69.9	197
	Travel time to hospital at last episode of illness (minutes)	General population	…	…	43.2	62.6	66.6	196
Waiting time	Waiting time in the PHC facility to see a doctor at last episode of illness (minutes)	General population	41.4	32.9	36.1	44.8	39.9	327
	Waiting time between referral and hospital admission at last episode of illness (days)	General population	16.3	0.9	16.7	13.2	15.1	210
	Waiting time in the hospital to be admitted to ward at last episode of illness (minutes)	General population	50.4	27	44.3	52.3	47.8	341
Financial accessibility								
Health insurance coverage	Percent of household members who had health insurance	General population	…	…	85.9	72.5	77.5	11256

Dimension	Indicator	Population group	Insured	Uninsured	Urban	Rural	Total	Total number of households
Not seeking care due to anticipated costs	Percent of household members renouncing to health care in past 12 months due to anticipated costs (partially and totally)	General population	23.5	26.4	21.2	25.9	24.2	11256
	Percent of household members with a chronic condition that renounced to health care in past 12 months due to anticipated costs	General population with a chronic condition	4.5	12.5	4.1	7.1	5.5	5542
	Percent of household members renouncing to health care at last episode of illness due to lack of health insurance	General population	*	*	*	*	0.9	108
	Percent of household members renouncing to seek care at last episode of illness due to anticipated costs	General population	6.9	14.4	7	8.9	8.1	1921
Out-of-pocket payments	Percent of household members who had OOP expenditures, any level at last episode of illness	General population	87.5	92	86.6	89.3	88.2	1812
	Percent of household members who had OOP expenditures to PHC at last episode of illness	General population	90.3	97.1	91.4	90.4	90.6	365
	Percent of household members who had OOP expenditures to specialist at last episode of illness	General population	96.7	97.9	95.5	97.8	96.9	197
	Percent of household members who had OOP expenditures at the last hospitalization	General population	74.7	88.7	70.4	80.1	76.5	367
Acceptability coverage								
Perceived low quality of services	Percent of household members not seeking care at last episode of illness due to perceived low quality of services	General population	…	…	…	…	0.9	108
Not trusting service providers	Percent of household members not seeking care at last episode of illness due to not trusting physicians	General population	…	…	…	…	5.6	108
Contact coverage								
General use of health services	Use of health services by those with chronic diseases (%)	Population with a chronic disease	…	…	…	…	95.2	1202
	Use of health services at last episode of illness, regardless of level (%)	General population	95.2	91.2	94.8	94.0	94.5	1982

Dimension	Indicator	Population group	Insured	Uninsured	Urban	Rural	Total	Total number of households
	Use of health services at last episode of illness at PHC facility (%)	General population	19.1	21.3	17.5	22.5	19.5	365
	Use of health services at last episode of illness at specialist (%)	General population	9.5	8.7	8.5	10.8	9.4	176
	Seeking health services at last episode of illness at hospital level (%)	General population	20.6	12.3	17.4	22.0	19.2	360
Use of specific health services	Care seeking for suspected pneumonia (%)	Children	…	…	…	…	79.2	1869
	HIV testing at least once during last pregnancy (%)	Pregnant women	…	…	67.1	66.2	66.5	750
Effective coverage								
Preventive services	Annual health check coverage (%)	General population	69.3	54.1	68.8	64.1	65.9	11256
	Thyroid physical exam (%)	General population	32.1	22.1	31.9	28.7	29.9	11256
	Measuring visual acuity (%)	General population	58.5	38	57.8	51.5	53.9	11256
	Measuring blood pressure (%)	General population	83.1	63.1	79.4	78.1	78.6	11256
	Microradiography (%)	General population	72.6	51.5	74	64	67.8	11256
	Ocular tonometry (%)	General population	38	16.7	36.8	31	33.2	11256
Vaccination	Tuberculosis immunization coverage (at birth, %)	Children 15–26 months	…	…	…	…	97.8	
	Polio immunization coverage (3 doses, %)	Children 15–26 months	…	…	87.6	97.5	93.6	383
	Immunization coverage for diphteria, pertussis and tetanus (3 doses, %)	Children 15–26 months	…	…	87	96	92.8	383
	Hepatitis B immunization coverage (3 doses, %)	Children	…	…	89.8	96.3	93.7	383
Effective coverage for childhood illnesses	Oral rehydration therapy with continued feeding (%)	Children	…	…	54.9	54.3	54.7	125
	Antibiotic treatment for suspected pneumonia (%)	Children	…	…			81.9	63
Effective use of contraception	Met need for contraception (%)	Women of reproductive age	…	…	58.3	60.4	59.6	2814

Dimension	Indicator	Population group	Insured	Uninsured	Urban	Rural	Total	Total number of households
Coverage with antenatal services	Antenatal care coverage at least 4 visits (%)	Pregnant women	…	…	94.7	95.8	95.4	750
Antenatal anemia mgmt	Percent of women who have taken iron supplement to prevent anemia	Pregnant women	…	…	89.6	87.1	88.5	723
	Average number of days receiving iron supplements	Pregnant women	…	…	180	145	165	641
Antenatal use of folic acid	Percent of women who have taken folic acid to prevent spina bifida in children during first 3 months of pregnancy	Pregnant women	…	…	50	59.1	66.2	723
	Percent of women who taken folic acid to prevent spina bifida in children for at least 45 days	Pregnant women	…	…	44.7	52.4	58.5	723
Delivery in medical setting	Institutional deliveries (%)	Pregnant women	…	…	99.5	98.4	98.9	750
Postnatal health check	Post-partum stay in health facility (%)	Pregnant women	…	…	100	100	100	742
	Post-natal check for newborn (%)	Children	…	…	99.3	97.7	98.3	750
	Post-natal check for mother (%)	Pregnant women	…	…	94.2	93.3	93.7	750

EXECUTIVE SUMMARY

The AHSS 2012 report describes the access of Moldovan population to health services and health expenditures at last episode of illness and provides a comparison of these to the baseline data collected in 2000 before the introduction of health insurance. In addition, it provides a cross-sectional picture of health coverage dimensions based on Tanahashi framework based on the data collected in both Access to Health Module and MICS 2012.

Socio-demographics of households

The sample included 11,354 households, of which 36.0 percent of males and 64.0 of females, 38.3 percent urban and 61.7 rural population, 40.2 percent of household heads having secondary education, 35.6 professional education and 16.8 percent higher education (6.0 having primary or less and 1.5 no response). By ethnicity, 79.5 percent were Moldovan or Romanian, 5.3 percent Russian, 8.6 Ukrainian, 3.6 percent Gagauz, 0.6 Roma and 2.4 other ethnic group. Of the households, 36.3 percent had at least one child below 18 years.

Chronic disease profile of households

Almost a half of interviewed households (49.9 percent) had at least one non-communicable chronic disease (NCD), more among women (53.0 percent) than men (42.0 percent) and increasing with age (16.5 percent in 15–29 year respondents and 73.6 percent in those over 60 years). There were differences by economic status as well, higher prevalence of NCD in the lowest quintile (57.6 percent) compared to highest quintile (41.4 percent). The top three NCDs were hypertension, at 41.7 percent of the total NCDs, second gastrointestinal (24.6 percent) and osteo-articular (20.8 percent).

Geographic accessibility, measured by distance and time needed to get to the nearest health facility is high in the Republic of Moldova: 97.1 percent of households need less than 5 km away from the nearest health facility and 96.4 percent need less than an hour to get to it, without major differences between urban and rural households.

Health insurance coverage is still an important health system challenge: 77.5 percent mentioned having health insurance coverage. Health insurance coverage is in direct relationship to wealth quintile and level of education of the household head and is higher in urban population, in households headed by a woman and in households without children.

A total 2,500 respondents (22.2 percent) have stated to be uninsured and are likely to be the "have-nots", since the main reason for not having health insurance were unemployment (56.7 percent) and not having sufficient money for it (15.6 percent). Of them:

- 92.2 percent of household heads have secondary or professional education or lower level;
- 90.3 percent were evenly distributed in the three regions of the country and 9.7 percent of households were in Chisinau;
- 76.1 percent live in rural areas;
- 72.3 percent are from the lower three socio-economic quintiles;
- 62.0 percent are with ages comprised between 15 and 49 years;
- 51.4 percent are households with children.

General financial accessibility, measured by cumulative experience of household members to renounce fully or partially to seek health care in the past 12 months has shown that 75.6 percent of household had adequate financial access, 18.9 percent of the population had reduced financial inaccessibility and 5.2 percent had total financial inaccessibility. Health insurance coverage does not ensure fully adequate financial access. The most vulnerable households and household members were:

- Those with advanced age (29.5 percent in those over 60 years with reduced or no access).
- Lowest wealth quintile (29.1 percent had reduced or no access).
- Lower education of household head (29.1 percent households lead by heads with secondary education had reduced or no access).
- Rural households (24.2 percent had reduced or no access).

Direct health expenditures continue to be very high in Moldova. OOP were described based on the last episode of illness in the household occurring in the past four weeks preceding the survey. Despite the introduction of health insurance system, the OOP are almost universal at any level of care:

- 88.7 percent had any out-of-pocket expenditures for self-treatment and home-based treatment;
- 90.6 percent incurred an OOP expenditure when accessing PHC at last episode of illness;
- 96.9 percent had OOP expenditures when accessing specialist care;
- 76.5 percent had an OOP expenditure for any category while hospitalized.

The average out-of-pocket (OOP) expenditures for treatment regardless of treatment type and level of care was 682 MDL. There were important differences by:

- **Region:** lowest in respondents from South at 513 MDL and highest in Chisinau at 726 MDL.
- **Wealth:** 485 MDL in lowest quintile compared to 720 MDL in highest quintile.
- **Health insurance coverage:** 593 MDL in the insured and 832 MDL in the uninsured.

- **Disease severity:** 239 MDL in mild diseases, 500 MDL in moderate forms and 906 MDL in severe forms.
- **Disease type:** highest in those with oncological diseases 2440 MDL and OB/GYN conditions 1164 and lowest in respiratory conditions at 341 MDL.
- **Having children:** 688 MDL in households without children and 392 MDL in households with children.

Direct health expenditures increase with level of care accessed:

- 490 MDL for home-based and self-treatment;
- 451 MDL at primary care level;
- 856 MDL at outpatient specialist level;
- 981 MDL at hospital level1.

The OOP expenditures for medicines dominate at all levels and are by far the most frequent in over 85 percent of cases for home-base, PHC and specialist provided treatment and are one of the more expensive expenditures at any level. The average amount ranged from 395 MDL for self- and home-based treatment to 611 MDL at outpatient specialist level. Other recommended medical procedures for treatment are also an expensive category, at 560 MDL at specialist level and 692 MDL at hospital level. The expenditures on lab tests and diagnostic increase by level of accessed care, at 108 MDL at PHC level, 261 MDL at specialist level and 410 MDL at hospital level.

The lowest category of OOP expenditure in both frequency and size is payment for physician consultation, ranging from 5.5 percent and an average 125 MDL at PHC level to 39.5 percent and 119 MDL at specialist level and 16.3 percent and 1,253 MDL at hospital level.

Moreover, health insurance did not provide significant financial protection for buying prescribed medicines at any level:

- At home-based level, health insurance covered the cost of drugs fully for only 6.6 percent partially for 18.7 percent and did not cover costs of medicines at all for 74.2 percent of those treated at home (with formal medical follow-up). Health insurance coverage did not provide significant financial protection for prescribed medicines. The mean cost of OOP for medicines was 374.8 MDL for insured household members and 504.4 MDL for the uninsured.
- At primary care level, health insurance has covered fully the cost for only 5.8 percent, partially for 31.1 percent and did not cover costs of prescribed medicines at all for 62.6 percent. The mean cost of OOP for medicines was 413 MDL for insured household members and 386 MDL for the uninsured at primary care.
- At specialist level, the mean cost of OOP for medicines was 644 MDL for insured household members and 490 MDL for the uninsured.

1 The questionnaire missed the question asking the amount of expenditures for pharmaceuticals at hospital level, therefore total hospitla expenditure might be underreported.

Key trends between 2000 AHSS and 2012 AHSS

- Geographic access in 2012 is as good as in 2000, with most households needing less than an hour to get to the closest health facility.
- The patterns of seeking care have not changed after the introduction of health insurance: about the same shares of population access health services.
- A significant improvement in general and specific financial accessibility of health services and that it has significantly increased across all quintiles is noted, with a larger increase for lower quintiles compared to wealthier quintiles.
- At the same time, the frequency of OOP expenditures has not decreased and the financial protection is mostly related to the overall economic improvement.
- Health insurance coverage does not provide sufficient financial protection when it comes to pharmaceutical expenditure at primary and specialist level.
- The patterns of seeking health care have not changed over time in terms of the level of care accessed, despite the expectation that with the introduction of PHC and financial incentives to decrease use of specialist and hospital services, the structure of accessing different levels of care should have changed.
- Health insurance system seems to provide the highest financial contribution to hospital level, as this was the level where the lowest proportion of patients paid anything out-of-pocket and the average total seems to have increased less dramatically compared to 2000 AHSS. This creates perverse incentives in the health system, as it makes hospital services more sought and valued and does not provide incentives to population to seek primary care.
- The users of health services continue to value specialist care and disapprove of primary health care's gatekeeping function for referrals to specialist care and hospital care: primary care does has not been as effective as anticipated as a gatekeeper for access to hospital services, as people bypass it by using self-referral and emergency hospital admission in large proportions. At the same time, people who have the ability to pay directly to access hospital care and specialist care perceive as higher quality while those insured are using the formal referral patterns and have a higher dissatisfaction with waiting time and quality of care at PHC level.

INTRODUCTION

This report presents the findings and results of the 2012 Access to Health Services Survey, a module collected during the Multiple Indicator Cluster Survey, which was carried out in Moldova in 2012 by the National Centre of Public Health of the Ministry of Health with support from UNICEF and in collaboration with the National Bureau of Statistics, the Scientific Research Institute of Mother and Child Health Care, the Ministry of Labour, Social Protection and Family, the Ministry of Education, the National Centre for Health Management, and the National Centre for Reproductive Health and Medical Genetics. Financial and technical support was provided by the United Nations Children's Fund (UNICEF), with additional financial support from the Swiss Agency for Development and Cooperation. MICS is designed to collect statistically sound, internationally comparable estimates of key indicators that are used to assess the situation of children and women in the areas of health, education, child protection and HIV/AIDS. The sample for MICS IV Survey is 12,000 households throughout Republic of Moldova.

The baseline survey on Access to Health Services 2000 has been performed as part of the MICS Round II Survey, 2000. The results of the baseline survey on Access to Health Services have been used by policy makers in improving access to health services, including implementation of the mandatory health insurance. In order to assess the progress on accessing health care services, including for mother and child health, the Access to Health Care Services Module was added to MICS Round IV Survey.

The results of Access to Health Services Module will be used by Government to assess the access and effectiveness of health care services with equity focus, having data disaggregated by geographical area and social aspects and will serve as a base to develop strategies of reducing disparities in accessing health care services.

The overall goal was to assess the access to health care services, including, self-medication, access to primary health care, access to specialized health services and hospital services with focus on equity.

The 2012 AHSS has three objectives:

- To quantify financial and non-financial access to health services and the financial protection of the population of the Republic of Moldova based on the key variables: rural/urban, region, socio-economic status, education level, number of household members, gender and age of the household head.
- To quantify household expenditures for health based on household characteristics and type of treatment: self-medication, primary health care level, outpatient specialist level and hospital level).
- To provide comparative data on main indicators with the baseline 2000 AHSS.

TANAHASHI FRAMEWORK FOR ACCESS TO HEALTH SERVICES

The domains of the Tanahashi framework for effective coverage underpin the analysis of findings of 2012 AHSS. Tanahashi proposed five domains of coverage measurement, based on the conceptual framework: availability, accessibility, acceptability, contact and effective coverage (Tanahashi 1978). Where possible, given the comparative nature of a module designed back in 2000, results of 2012 AHSS looked at some dimensions of Tanahashi framework applied and are presented in results in a separate section. The following text highlights some aspects associated with these domains and the dimensions collected under 2012 AHSS and 2012 MICS.

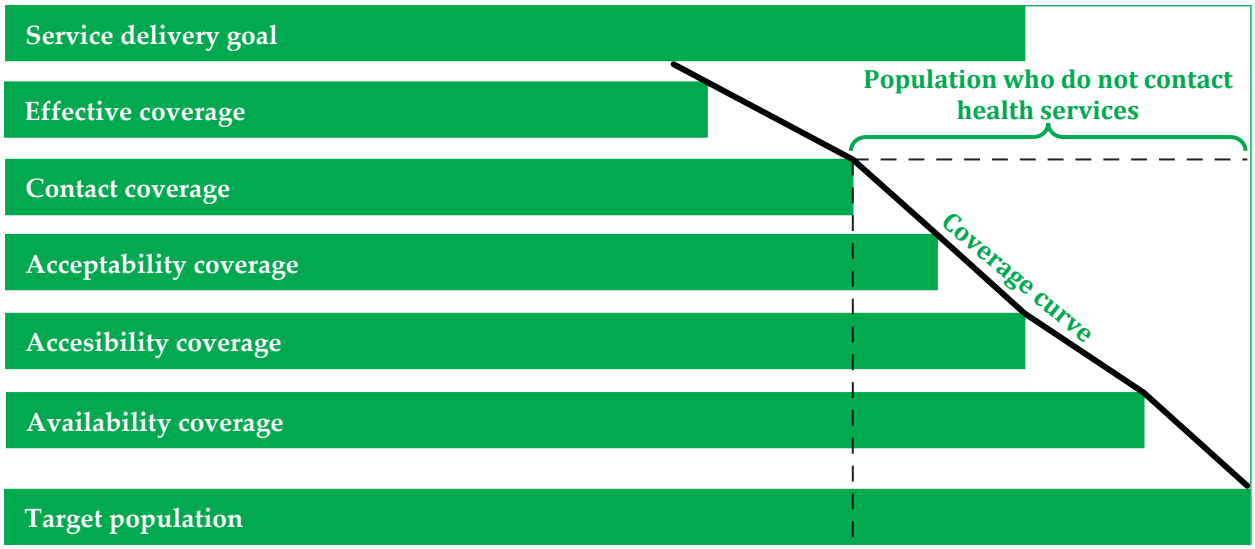

Figure 1: **Tanahashi framework for effective coverage with health services**
Source: adapted from published figure in Barriers and Facilitating factors in access to health services in the Republic of Moldova, *WHO Regional Office for Europe, 2012 (p. 5), based on original figure from Tanahashi, 1978, adapted by authors, including PAS Center staff.*

1. Availability coverage: The ratio between the availability of resources – human power, facilities, drugs – and the size of the target population gives the measurement of availability coverage (Tanahashi, 1978). This considers the resources available for delivering an intervention and their sufficiency. Availability coverage measures a health system's capacity in relation to the size of the target population or, ideally, the population in need.

2. Accessibility coverage: According to Tanahashi's definition, even when a service is available it must be located within reasonable reach of those who should benefit from it. (Tanahashi, 1978) There are two main dimensions of accessibility: physical access and affordability. On the physical dimension, access may be hindered if the resources are

available but located inconveniently, i.e., the distance from a health service provider is a strong accessibility factor and travel time to a health facility to access services and the waiting time to see a health professional. The second main dimension is the financial barrier to access or financial accessibility (affordability). User fees and transport costs have been shown to impact negatively on access to health services, rendering health services inaccessible to poor and vulnerable households. Out-of-pocket (OOP) health expenditure as a percentage of total health expenditure and the percentage of the population suffering from catastrophic health expenditures can be used as indicators to measure the financial barriers to accessibility.

3. Acceptability coverage: Tanahashi defines acceptability coverage as the capacity of the health services to be appealing and sought by the people (Tanahashi, 1978). Even if resources are available and accessible, they may not be used if the population does not accept them. Acceptability includes non-financial factors such as culture, beliefs, religion, gender, age-appropriate services and confidentiality; as well as aspects of affordability that relate to people's perceptions of the value of health services. Acceptability coverage is influenced by people's perceptions; expectations of health services such as expected costs, effectiveness and quality of care; religious views and personal beliefs. Often, these are based on previous experiences and interactions with health personnel. Health personnel's discriminatory attitudes towards some population groups (e.g. socially excluded groups) can create systemic barriers towards acceptable health care for these groups.

4. Contact coverage: This is defined as the actual contact between the service provider and the user. The number of people who have contacted a service is a measurement of service output (Tanahashi, 1978). It is similar to 'use of services'.

5. Effective coverage: The contact between service provider and the user does not always lead to successful intervention by health programmes or effective service. The Tanahashi framework defines effective coverage as the proportion of the population in need of an intervention who have received an effective intervention (Tanahashi, 1978). For health interventions that require a one-time action, contact coverage may be almost equivalent to effective coverage. For other interventions (e.g. chronic disease treatment) effectiveness can require diagnostic accuracy, provider compliance with evidence-based treatment, 'continuity' of access by the patient, effective referrals and adherence to prescribed treatment and rehabilitation.

The table below summarizes the indicators collected in 2012 AHSS according to Tanahashi dimensions of coverage and the population groups for which it is relevant.

Table 1: **Indicators collected in 2012 AHSS and 2012 MICS as relevant for Tanahashi measures of coverage with health services**

Dimension / aspect	Indicator	Population group
Availability coverage		
	Knowledge of a place for HIV testing	Men
	Knowledge of a place for HIV testing	Women
Accessibility coverage		
Geographic accessibilty		
Distance	Distance to nearest health facility	General population
	Traveled distance to PHC facility at last episode of illness	General population
	Traveled distance to medical specialist at last episode of illness	General population
	Traveled distance to hospital at last episode of illness	General population
Travel time	Time needed to get to nearest health facility	General population
	Travel time to PHC facility at last episode of illness	General population
	Travel time to medical specialist at last episode of illness	General population
	Travel time to hospital at last episode of illness	General population
Waiting time	Waiting time in the PHC facility to see a doctor at last episode of illness	General population
	Waiting time between referral and hospital admission at last episode of illness	General population
	Waiting time in the hospital to be admitted to ward at last episode of illness	General population
Financial accessibility		
Health insurance coverage	Percent of HH members who had health insurance	General population
Not seeking care due to anticipated costs	Percent of HH members renouncing to seek health care in past 12 months due to anticipated costs	General population
	Percent of HH members not seeking care for chronic disease in the past year due to insufficient money	General population with a chronic condition
	Percent of HH members refusing to seek care at last episode of illness due to lack of health insurance	General population
	Percent of people refusing to seek care at last episode of illness due to anticipated costs	General population
Out-of-pocket payments	Percent of people who made out-of-pocket payments to PHC at last episode of illness	General population
	Percent of people who made out-of-pocket payments to specialist at last episode of illness	General population
	Percent of people who made out-of-pocket payments at the last hospital admission	General population
Acceptability coverage		
Perceived low quality of services	Percent of HH members not seeking care at last episode of illness due to perceived low quality of services	General population
Not trusting service providers	Percent of HH members not seeking care at last episode of illness due to not trusting physicians	General population

Dimension / aspect	Indicator	Population group
Contact coverage		
General use of services	Use of health services by those with chronic diseases	General population with a chronic disease
	Use of health services at last episode of illness, regardless of level	General population
	Use of health services at last episode of illness at PHC facility	General population
	Seeking health services at last episode of illness at specialist	General population
	Seeking health services at last episode of illness at hospital level	General population
Use of specific health services	Care seeking for suspected pneumonia	Children
	HIV testing at least once during last pregnancy	Pregnant women
Effective coverage		
Preventive services	Annual health check coverage	General population
	Thyroid physical exam	General population
	Measuring visual acuity	General population
	Measuring blood pressure	General population
	Microradiography	General population
	Ocular tonometry	General population
	TB immunization (at birth)	Children 15–26 months
	Polio immunization coverage	Children 15–26 months
	Immunization coverage for diphtheria, pertussis and tetanus	Children 15–26 months
	Hepatitis B immunization coverage	Children 15–26 months
Effective coverage for of childhood illnesses	Oral rehydration therapy with continued feeding	Children
	Antibiotic treatment for suspected pneumonia	Children
Effective use of contraception	Unmet need for contraception	Women of reproductive age
Coverage with antenatal services	Antenatal care coverage at least 4 visits	Pregnant women
Effective coverage for anemia management	Percent of women who have taken iron supplement to prevent anemia	Pregnant women
	Average number of days receiving iron supplements	Pregnant women
Folic Acid	Percent of women who have taken folic acid to prevent spina bifida in children during first 3 months of pregnancy	Pregnant women
	Percent of women who taken folic acid to prevent spina bifida in children for at least 45 days	Pregnant women
Delivery in medical setting	Institutional deliveries	Pregnant women
Postnatal health check	Post-partum stay in health facility	Pregnant women
	Post-natal check for newborn	Children
	Post-natal check for mother	Pregnant women

I. METHODOLOGY

Sample and Survey Methodology

Sample Design

The Survey Sample for 2012 AHSS is based on the 2012 Moldova MICS. It was designed to provide estimates for over 200 indicators on the situation of children, women and men at the national level, for urban and rural areas, and for different regions: North, Center, South, and Chisinau (capital city).

The urban and rural areas within each region were identified as the main sampling strata and the sample was selected in two stages. Taking into account that all cartographical material from the last census in 2004 was destroyed, the first stage has involved working with the same probabilistic sample used for the 2005 Demographic and Health Survey (2005 Moldova DHS), while the second stage selected a probabilistic sample of households within each Primary Sampling Unit (PSU).

The reference population were household population that inhabits Moldova's territorial-administrative units on the right bank of the Dniester river, providing coverage of the whole national territory, with the exception of left-bank territories (Transnistria) not making the subject of this survey. The survey is representative both at national level and – similar to the 2005 Moldova DHS – for both urban and rural residence areas (strata), also including four geographic regions (domains): North, Central, South, and Chisinau.

The PSU used was identical to that used for the 2005 Moldova DHS, divided into a total of 400 census sectors. Note that the sampling frame for the first sampling stage of the 2005 DHS was developed encompassing all census sectors and included an electronically-generated list thereof, with attached variables related to their identification in the 2004 Population Census, their corresponding residence area and region, as well as their size, expressed in number of persons.

The final sample size of 12,000 households was obtained by selecting 30 households in each of the 400 PSUs (167 in the rural stratum + 233 in the urban stratum) selected in the first sampling stage.

The second stage of sampling has encompassed the updated lists of existing households within each of the 400 PSUs (or clusters) from the sample selected in the first stage. Given the rather long time period that extends from the 2004 Population Census, the household lists were updated during the listing and mapping stage, which took place between July 19 and September 25, 2011, thus excluding currently uninhabited households to avoid over coverage, while including new households to avoid undercover age. A set of

updated detailed maps were consequently drawn to help locate all census sectors selected in the sample and to delineate their exact boundaries, thus ensuring inclusion of all households in the sample frame. Households identified based on the listing served as the final sampling units for the reference population defined as "households".

In the first sampling stage, clusters were systematically selected within each stratum with probability proportional to size (the country's population according to the 2004 Population Census). Prior to selection, census sectors within each stratum were geographically ordered from North to South to induce additional implicit geographical stratification. In the second sampling stage conducted October 2011, a sample of 30 households was selected from each PSU (cluster). The selection was made based on the household lists compiled during the update (listing) process within each PSU (cluster), using simple systematic selection.

The PSU sample distribution was inversely correlated to the number of population in each stratum, taking into account that both the response rate and the average household size are usually lower in urban areas compared to rural areas. Thus, in the 2005 Moldova DHS and consequently the 2012 Moldova MICS, the sample of households is not self-weighting. In view of the fact that the first sampling stage had used a method of census sector selection with probability proportional to size within each stratum, the probabilities had to be subsequently calculated.

A full sample description may be found in the report of 2012 Moldova MICS Report (NCPH, UNICEF 2014).

General Questionnaire Characteristics

In consultation with national and international experts on a wide range of subjects, the questionnaire for MICS module was adjusted to the country's needs, to preserve comparability with baseline 2000 AHSS and to update it based on best practices of designing questions for measuring access. Following content approval by Coordination Committee members, the questionnaires were translated from English and Russian into Romanian and were subsequently pre-tested (in Romanian and Russian). Following integration of additional modules in the questionnaires, two rounds of questionnaire and measurement pre-testing took place between 14–25 November 2011 and between 12–19 March 2012.

The pre-test period has allowed evaluating all aspects of data collection. Questionnaires and measurements were tested/practiced in Romanian and Russian both during training sessions (in classrooms and at local Health Centres) and in the field among 208 urban and rural households, as well as the Chisinau and the Central region. For this end, during the listing period and as per standard listing requirements, seven additional clusters in a non-MICS sample were selected. A total of 33 participants attended the pre-tests, of which 10 had previous 2005 Moldova DHS and 2000 Moldova MICS experience. Participant training included presentations, group work, demonstrative interviews, classroom trainings on taking anthropometric and haemoglobin measurements, and familiarization

with documents used to record immunization data. The pre-test results have been used to evaluate interview durations for each questionnaire, adjust and modify the questionnaires' content and translation, and finalize logistical arrangements. The questionnaire was part of the Household Questionnaire. A copy of the 2012 AHSS module of questionnaire is provided in Annex 1.

Training and Fieldwork

Training for the fieldwork was conducted for 23 days (of which 16 were used for providing the theoretical framework and classroom practice, and 4 were used for field practice/piloting), between March 21 to April 12, 2012. The training included lectures on interviewing techniques and the contents of the questionnaires as well as working groups to gain practice in asking questions. Training included classroom presentations, staged interviews and written tests. Training of field staff for both pre-test and data collection was mainly carried out in Romanian by UNICEF's National Consultant with technical support from field coordinators and in collaboration with UNICEF's MICS Regional Consultant. Towards the end of the training period, trainees have spent 4 days in fieldwork (i.e. piloting), conducting interviews in Romanian and Russian as well as measurements and tests prescribed in the survey design, while also engaging in other fieldwork-related activities. Piloting was conducted on 525 households in urban and rural areas of Chişinău and of Străşeni and Ialoveni districts additionally selected on the basis of a non-MICS sample. A total of 107 workshop participants were trained as field staff supervisors, field/office editors, interviewers and measurers. Participants who had medical training were made responsible for testing haemoglobin levels. Participants selected as supervisors and field editors were given two additional days of training on aspects of fieldwork supervision and editing of questionnaires.

The data were collected by fifteen teams; each team was comprised of 8 members: four interviewers (three female and one male), one editor, one measurer, one driver, and a supervisor.

UNICEF's National Consultant coordinated and supervised all fieldwork activities with the support of two field coordinators and in collaboration with the Implementing Agency's MICS team of directors. Fieldwork progress was closely watched and supervised by UNICEF Moldova's MICS Coordinator and MICS experts of the UNICEF Regional Office, who assisted with field activities and regularly (approx. every three weeks) assessed the quality control tables developed based on latest data from the field.

Fieldwork was carried out between 17 April and 30 June 2012.

Data Processing

Data were entered using the CSPro software on 12 computers by 12 previously trained data-entry clerks. A supervisor and an expert in data processing and analysis were responsible for data entry quality. Completed questionnaires were returned each week

from the field to the NCPH office in Chisinau for additional editing by two office editors. In order to ensure quality control, all questionnaires were double-entered and internal consistency checks were performed. Standard procedures and programs developed under the global MICS4 programme and adapted to the Moldova questionnaires were used throughout. Data processing began shortly after fieldwork initiation on April 25 and was completed on July 10, 2012; however, due to inconsistencies between the data entered and the actual data in the questionnaires, the data processing period had to be extended until September 14, 2012.

A preliminary version of the database was transmitted to PAS Center in 2013 that has started data analysis based on it. A final version of database was available in 2014 and was used to redo data analysis and report writing. Data were analysed using the Statistical Package for Social Sciences (SPSS) software program, Version 18. For consistency purposes in the way data is presented and table layout, the final version of the report of 2012 AHSS was produced after the final version of 2012 MICS was available.

How to read the tables

- An asterix in a table indicates that a percentage or proportion has been suppressed because it is based on fewer than 25 unweighted cases.
- Values in parenthesis (number) indicate that the percentage or proportion is based on only 25 to 49 unweighted cases and should be treated with caution.
- Age groups presented in this report include those persons that have reached the full age indicated by the upper limit for an age group, for instance, respondents aged 15–49 years include persons who have reached a full 49 years.

Desk review

A desk review of the available information on access to issues was performed. The desk review looked at extracting the main trends in the past decade since 2000 to add temporal relevance to trends observed in 2012 AHSS and look for data convergence, consistence or differences observed (i.e Health module of National Household Budget Surveys 2008, 2010, 2012, Access to and Quality of Hospital Services in the opinion of Moldovan population 2011 and 2013 and others). The synthesis is presented in the Discussion section.

Qualitative Research

The qualitative component of the study included focus group discussion with users of health services. The qualitative component on attitudes and perceptions of population on accessibility and affordability of health services were conducted after data analysis, to complement findings of AHSS 2012. The objectives of qualitative research were to:

- Identify barriers in accessing health care being experiences and perceived by socially excluded populations and characterize these in relation to availability, accessibility, acceptability, contact and effective coverage
- Identify perceptions of socially excluded populations regarding the access to primary health care, specialised care and hospital care
- Highlight opportunities to improve equity in access to quality health services.

Six focus groups were organized with the following groups: urban insured, rural insured, uninsured migrants, agricultural workers (self-insured and uninsured), informal workers (self-insured and uninsured), Roma (insured and uninsured). Each focus group has on average 6–8 participants. Focus groups were audio-recorded and transcribed verbatim, coded for emerging descriptive content and used to provide additional understanding and depth to trends observed in survey.

II. SAMPLE COVERAGE AND THE CHARACTERISTICS OF HOUSEHOLDS AND RESPONDENTS

Sample Coverage

Of the 12,528 households selected for the sample, 11,657 were found to be dwelled. Of these, 11,354 were successfully interviewed for a household response rate of 97 percent. In the interviewed households, 6,718 women (age 15–49 years) were identified. The household response rate was similar by regions, reaching about 99 percent except for Chisinau (93 percent). The urban population is less open to participate in interviewing. Differences in response rates for the Women's and Men's Questionnaires were insignificant between regions (North, Central, South), but are lower for both women and men in the Chisinau by five and six percentage points respectively. Response rates in under 5 children are also three percentage points lower in Chisinau, as compared to the country average. It should also be noted that rates lower than 85 percent have only been found in men. This result is directly related to the migration of male population (i.e. absence of men), of which a vast majority is gone abroad.

Characteristics of Households

The age and sex distribution of survey population is provided in Table 2. The distribution is also used to produce the population pyramid in Figure 2. A total of 28,789 household members were listed in the 11,354 interviewed households. Of these, as per weighted data, 13,515 were males, and 15,274 were females.

Table 2: **Household age distribution by sex.**
Percent distribution of the household population by five-year age groups, children (0–17 years) and adult population (aged 18 or older), by sex, 2012

Variables		Men		Women		Total	
		Number	Percent	Number	Percent	Number of household members	Percentage of household members
Age	0–4	997	7.4	952	62	1948	6.8
	5–9	876	6.5	851	5.6	1727	6.0
	10–14	873	6.5	795	5.2	1668	5.8
	15–19	992	7.3	997	6.5	1989	6.9

Variables		Men		Women		Total	
		Number	Percent	Number	Percent	Number of household members	Percentage of household members
	20–24	981	7.3	978	6.4	1959	6.8
	25–29	1 011	7.5	993	6.5	2004	7.0
	30–34	815	6.0	906	5.9	1721	6.0
	35–39	808	6.0	854	5.6	1663	5.8
	40–44	818	6.1	833	5.5	1651	5.7
	45–49	859	6.4	932	6.1	1792	6.2
	50–54	1 102	8.2	1315	8.6	2417	8.4
	55–59	1 069	7.9	1285	8.4	2354	8.2
	60–64	952	7.0	1240	8.1	2192	7.6
	65–69	425	3.1	613	4.0	1038	3.6
	70–74	420	3.1	730	4.8	1150	4.0
	75–79	289	2.1	475	3.1	765	2.7
	80–84	160	1.2	333	2.2	493	1.7
	85+	58	(0.4)	183	1.2	241	.8
	Missing/DK	7	(*)	10	(*)	17	(*)
Age group	0–14	2 746	20.3	2598	17.0	5344	18.6
	15–64	9 409	69.6	10333	67.6	19741	68.6
	65+	1 353	10.0	2333	15.3	3687	12.8
	Missing/DK	7	(*)	(*)	.1	17	(*)
Children and adult population	Children age 0–17 years	3 360	24.9	3153	20.6	6513	22.6
	Adults age 18+ years	10 147	75.1	12111	79.3	22258	77.3
	Missing/DK	7	(*)	10	(*)	17	(*)
Total		**13515**	**100.0**	**15274**	**100.0**	**28789**	**100.0**

Note: (*) – figures based on less than 25 unweighted cases

Thus, the percentage of male respondents (47 percent) in the survey was less than the percentage of females (53 percent). The percentage of children aged 0–17 years was 23 percent, while that of adults age 18+ years did not exceed 77 percent. Children aged 0–14 years made up 19 percent in the survey, while those aged 15–64 years accounted for 69 percent. The population group aged 65+ years comprised 13 percent.

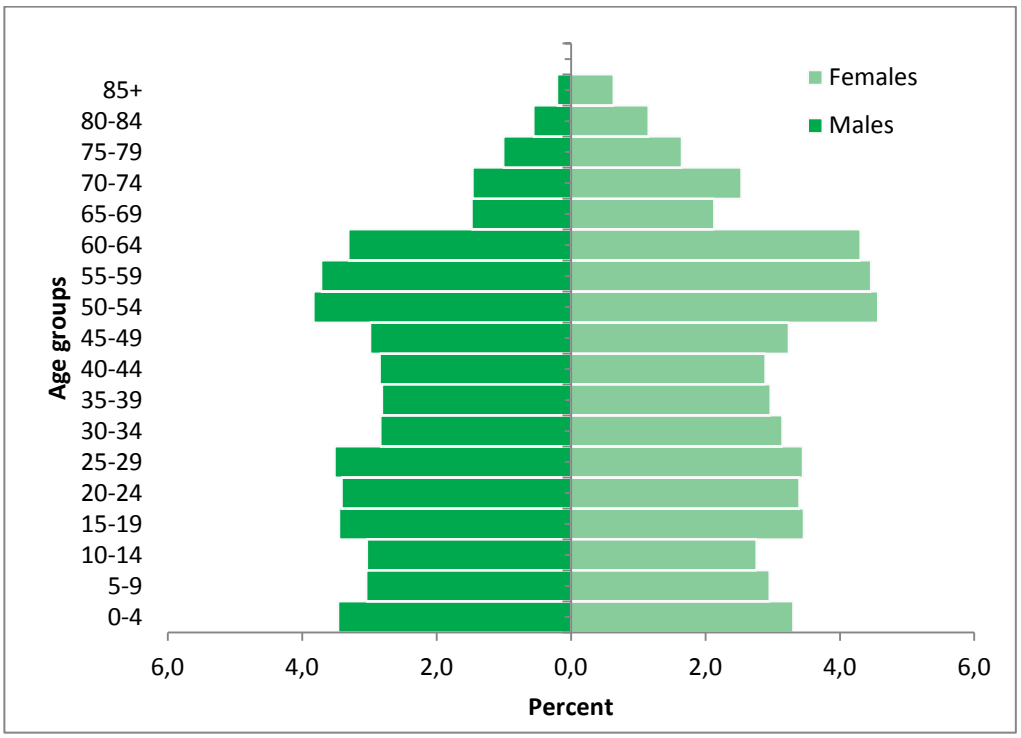

Figure 2: **Percent distribution of the household population by five-year age groups and sex, Moldova, 2012**

Table 3: **Household characteristics**
Percent distribution of households by selected characteristics, Moldova, 2012

		Weighted percent	Number of households	
			Weighted	Unweighted
Sex of household head	Male	36.0	4089	4187
	Female	64.0	7265	7167
Region	North	32.7	3715	3439
	Central	29.6	3359	2694
	South	18.4	2090	2093
	Chisinau	19.3	2190	3128
Area	Urban	38.3	4350	6415
	Rural	61.7	7004	4939
Number of household members	1	25.1	2850	2799
	2	31.6	3587	3558
	3	19.8	2252	2348
	4	15.5	1756	1772
	5	5.4	614	598
	6	1.7	196	188
	7	.7	74	64
	8	(*)	14	15
	9	(*)	5	6
	10+	(*)	6	6
Education of household head	None/Primary	6.0	677	563
	Secondary	40.2	4563	4193
	Professional education	35.6	4038	4058

		Weighted percent	Number of households	
			Weighted	Unweighted
	Higher	16.8	1911	2381
	Missing/DK	1.5	165	159
Ethnicity of household head	Moldovan/Romanian	79.5	9029	8548
	Russian	5.3	597	833
	Ukrainian	8.6	982	1079
	Roma (Gypsy)	.6	67	75
	Gagauz	3.6	410	477
	Other ethnic group	2.4	269	342
Total		**100.0**	**11354**	**11354**

Note: (*) – figures based on less than 25 unweighted cases

Table 4 provides basic background information on the household composition. Within households, the sex of the household head, region, area, number of household members, education of household head and ethnicity of the household head are shown in the table. These background characteristics are used in subsequent tables in this report. Thus 15 percent of households have at least one child aged 0–4 years, 36 percent have at least one child aged 0–17 years, 48 percent have at least one woman aged 15–49 years, and 43 percent have at least one man aged 15–59 years. The mean household size at the national level is 2.5 persons.

Table 4: **Household composition**
Percent distribution and number of households by eligible children, women and men, Moldova, 2012

	Weighted percent	Number of households	
		Weighted	Unweighted
Households with at least one child aged 0–4 years	14.8	11354	11354
Households with at least one child aged 0–17 years	36.3	11354	11354
Households with at least one woman aged 15–49 years	47.6	11354	11354
Households with at least one man aged 15–49 years	43.4	3699	3701
Mean household size (average number of persons per household)	2.5	11354	11354

Prevalence of chronic illnesses and health seeking behavior in households

A half of interviewed household members (49.9 percent) stated they had a chronic illness at the time of interview, with higher shares among women than men (53.0 percent versus 42.0 percent), lower socio-economic status (57.6 percent in poorest versus 41.4 percent in wealthiest quintile). As expected, prevalence of chronic illness is in direct relationship with age, as 73.6 percent among those over 60 years and 61.5 percent among 50–59 year old age groups, have at least one chronic condition compared to 16.5 percent in the 15–29-year-old category and 26.4 percent of those with age between 30 and 39 year. The prevalence of chronic diseases, type of chronic diseases and percent who sought health care for their chronic illness are presented in Table 5.

This is a significantly higher share of prevalence of chronic illnesses than the one reported by NHBS 2012 at 33.1 percent.

Table 5: **Prevalence of chronic diseases, type of chronic diseases and percent who sought health care for their chronic illness**

Percent distribution of household members who have a chronic disease, type of chronic disease (multiple choice from those who have stated they had a chronic disease) and seeking health care in the past 12 months prior to survey, Moldova 2012

		Had chronic illness	Diabetes	Hypertension	Other CV	Respiratory	Digestive	Oncology	Kidney	Neurological	Osteoarticular	Other	Sought health care	Number
Sex	Male	42.0	8.4	33.5	14.4	12.3	20.2	(2.2)	5.7	8.3	21.9	11.4	74.7	3170
	Female	53.0	7.9	44.3	15.3	10.3	25.9	3.9	12.7	8.0	20.5	11.2	79.6	7998
Age	15–24	16.5	*	*	*	*	*	*	(23.9)	*	*	(12.9)	73.8	1048
	15–19	20.0	*	*	*	*	8	*	*	*	*	*	86.1	345
	20–24	14.8	*	*	*	*	(20.4)	*	(27.1)	*	*	*	65.7	703
	25–29	17.6	*	*	*	*	(27.9)	*	(22.6)	*	*	(16.6)	66.8	828
	30–39	26.4	*	13.8	(6.5)	(9.4)	25.9	*	15.1	(10.4)	14.7	16.5	69.1	1565
	40–49	41.9	(4.9)	24.1	8.6	10.4	30.8	(5.6)	13.2	9.3	15.0	17.7	74.6	1708
	50–59	61.5	8.9	42.1	12.0	11.0	26.8	4.0	10.0	8.6	19.3	11.3	80.9	2524
	60+	73.6	9.7	54.0	20.9	11.1	21.4	2.9	9.0	6.8	26.0	8.1	80.5	3493
Region	North	54.9	7.4	43.9	16.9	9.6	23.3	2.9	10.5	9.1	23.7	10.4	78.8	3708
	Center	48.9	7.3	43.6	13.0	10.9	25.2	(3.4)	10.2	7.8	18.8	12.5	81.4	3343
	South	49.4	10.2	39.3	13.0	10.7	22.7	(3.9)	10.4	7.1	20.7	11.1	75.3	2080
	Chisinau	43.1	8.5	36.2	17.5	13.6	28.4	4.4	14.9	7.6	18.1	11.1	75.1	2125
Area	Urban	48.2	10.1	39.2	15.5	13.0	26.3	3.8	12.0	7.3	19.0	11.4	76.1	4272
	Rural	50.9	6.9	43.1	14.9	9.6	23.6	3.2	10.6	8.6	21.9	11.2	79.6	6984
Education	None/primary	70.7	*	58.4	23.6	(9.9)	17.8	*	*	*	32.1	7.9	78.0	579
	Secondary	49.5	8.6	44.2	15.0	9.8	22.1	3.4	9.4	9.6	21.1	(10.1)	79.4	4754
	Professional education	50.0	8.1	37.7	13.8	11.5	27.0	4.0	12.0	6.9	20.5	12.7	79.2	3596

		Had chronic illness	Dia-be-tes	Hyper-tension	Other CV	Respi-ratory	Diges-tive	On-col-ogy	Kidney	Neuro-logical	Osteo-articular	Other	Sought health care	Num-ber
	Higher	44.0	7.3	35.1	13.5	12.3	28.6	3.2	15.6	6.9	15.8	12.9	75.2	2125
	Missing/DK	(65.2)	*	(48.2)	*	*	(28.9)	*	*	*	(24.3)	*	72.3	115
Ethnicity of household head	Moldovan/ Romanian	48.7	7.6	41.7	14.3	10.0	24.5	3.3	10.3	8.5	21.6	11.2	79.7	8964
	Russian	53.8	(9.8)	42.1	20.6	17.5	22.7	4.8	14.1	(6.4)	19.1	(11.1)	72.0	577
	Ukrainian	55.8	8.9	43.8	21.3	11.0	26.0	*	12.1	(7.1)	17.6	12.3	75.3	974
	Roma	(56.9)	*	*	*	*	*	*	*	*	*	*	(89.7)	66
	Gagauz	51.1	*	36.4	(9.7)	(13.2)	22.5	*	(18.2)	*	(17.6)	*	68.6	409
	Other ethnic group	55.9	11.1	38.3	(15.6)	(14.7)	25.8	*	(14.8)	*	(16.0)	*	72.5	265
Children in household	Without children	54.2	8.2	42.8	15.4	10.9	24.4	3.5	10.7	8.0	21.4	11.2	78.8	9599
	With children	24.6	*	27.0	(11.3)	(9.7)	27.6	*	16.9	(9.8)	13.4	(11.4)	72.3	1656
Wealth index quintiles	Poorest	57.6	7.0	50.4	18.0	9.6	21.0	(2.5)	7.7	10.0	27.5	8.4	77.0	2812
	Second	54.4	8.5	42.6	15.3	12.1	22.3	(3.1)	10.6	8.2	20.3	12.6	80.8	2211
	Middle	46.2	7.7	37.6	12.5	9.2	26.7	(4.8)	11.6	6.8	17.4	12.1	80.5	2114
	Fourth	46.5	10.0	40.2	15.2	10.9	26.2	(3.4)	14.3	6.8	16.7	11.9	77.7	2120
	Richest	41.4	7.5	30.0	12.2	13.3	30.5	(4.3)	14.3	7.2	17.4	13.1	75.5	1998
Health insur-ance coverage	Yes	55.8	8.7	44.4	16.3	11.1	23.9	3.5	11.2	8.0	21.4	10.8	81.0	8728
	No	29.5	*	23.8	(7.5)	8.9	28.8	3.0	10.8	(8.6)	16.8	14.1	61.0	2500
	DK	*	*	*	0	0	*	0	0	0	*	0	*	28
Total		**49.9**	**8.1**	**41.7**	**15.1**	**10.8**	**24.6**	**3.5**	**11.1**	**8.1**	**20.8**	**11.3**	**78.3**	**11256**

By far, among those that have reported to have a chronic non-communicable disease (NCD) (n = 5,542), the most prevalent mentioned condition was hypertension (41.7 percent), followed by gastrointestinal conditions (24.6 percent), osteo-articular (20.8 percent), other cardiovascular conditions (15.1 percent), kidney (11.1 percent), respiratory (10.8 percent), neurological (8.1 percent) and other conditions (11.3 percent). Diabetes has been mentioned by 8.1 percent and 3.5 percent of respondents mentioned oncological conditions.

Among those who have reported an NCD, significantly higher shares of women have mentioned to have the following NCDs:

- Hypertension: 44.3 percent of women compared to 33.5 percent of men
- Kidney chronic disease: 12.7 percent of women compared to 5.7 percent of men
- Gastro-intestinal chronic disease: 25.9 percent of women compared to 20.2 percent of men
- Cancer: 3.9 percent of women compared to 2.2 percent of men
- For the following conditions, a higher share of men was observed:
- Respiratory chronic conditions: 13.3 percent of men compared to 10.3 percent of women
- Diabetes: 8.4 percent of men compared to 7.9 percent of women
- For the rest of conditions, the differences in prevalence were less stark: other cardio-vascular conditions, neurological and osteo-articular diseases.

A difference by socio-economic status is observed in case of hypertension and other cardio-vascular conditions, where prevalence decreases with increasing wealth quintile (50.4 percent of the poorest quintile compared to 30.0 percent of the richest quintile for hypertension and 18.0 percent in poorest versus 12.2 percent in the wealthiest quintile for other cardio-vascular conditions). Smaller differences are noted between rural and urban residents.

The majority of respondents (78.3 percent) have sought health care for their chronic condition in the past 12 months. By age, the young adults have the lowest health seeking behavior (66.8 percent in those of age 25–29 years, and 69.1 percent in those 30–39 years) and the highest in the oldest age groups: 80.9 percent in 50–59 year olds and 80.5 in those over 60 years and the highest in those of age 15 to 19 years – 86.1 percent. A higher percentage of women (79.6 percent) compared to men (74.7 percent) sought health services for their NCD. By region, the highest health seeking behavior was registered in Center (81.4 percent) and the lowest in Chisinau (75.3 percent). Finally, differences were noted by health insurance status: 81.0 percent of those who had health insurance compared to 61 percent of those who did not have health insurance coverage have accessed health services in the past 12 months.

Geographic access to health services

Geographic access was measured by asking the respondents how far the closest health facility from their home was (in km) and the time it took them to get to their family doctor (in hours).

The majority of households in the Republic of Moldova live at a distance less than 5 km to the closest health facility (97.1 percent), with some differences between urban and rural areas (94.6 percent and 98.6 percent respectively), due to larger distances in cities. No significant differences were noted by geographic regions, with exception of the city of Chisinau, where 92.4 percent mentioned living within 5 km from the closest health facility.

Geographic access measured as time needed to get to the family doctor/general practitioner is also high, as for 96.4 percent of respondents it takes less than an hour to get to the closest health facility, with no important differences between regions and urban and rural residence. The geographic access is presented in the Table 6.

Table 6: **Geographic access**
Percent distribution of households by geographic access, measured in kilometers and time needed to get to the nearest primary care facility, Moldova 2012

		Distance to the nearest PHC facility			Number of households (distance)	Average time needed to get to family doctor			Number of households (time)
		Less than 5 km	More than 5 km	DK	Total	Up to 1 hour	1–2 hours	More than 2 hours	Total
Region	North	98.0	1.6	*	3708	96.1	3.2	*	3708
	Center	98.6	1.2	*	3343	96.9	2.7	*	3343
	South	97.8	(1.8)	*	2080	95.8	3.8	*	2080
	Chisinau	92.4	6.2	1.4	2125	96.7	2.7	*	2124
Area	Urban	94.6	4.4	1.0	4272	96.7	2.9	(0.4)	4270
	Rural	98.6	1.2	*	6984	96.2	3.2	(0.6)	6984
Total		**97.1**	**2.4**	**0.5**	**11256**	**96.4**	**3.1**	**(0.6)**	**11254**

Health insurance coverage

A total 77.5 percent of respondents have mentioned having health insurance coverage at the time of interview, compared to 75.0 percent of health insurance coverage reported in the National Household Budget Survey conducted in 2012 (NHBS 2012). (Table 7) Health insurance coverage was influenced by the following factors:

- Age (72.0 percent in age group 15–24 years, 65.8 percent in the age group 25–30 years and the lowest coverage at 60.7 percent in the age group 30–39 years compared to 96.7 percent in the age group 60 years or more).
- Sex (71.9 percent among men and 79.8 percent among women).
- Residence (72.5 percent rural versus 85.9 percent urban).

- Region (lowest in Central region (71.8 percent) and highest in Chisinau (88.3 percent).
- Education of household head (90.4 percent among those with university education compared to 70.6 percent among those with secondary and lower education).
- Ethnicity (lowest in Roma households (57.6 percent) and highest in Russian households (87.0 percent)).
- Having children (80.0 percent in households without children compared to 63.6 percent in households with children).

Table 7: **Health insurance coverage**
Percent distribution of households by health insurance coverage, Moldova 2012

		Health insurance coverage			Number
		Yes	No	DK	Total
Sex	Male	71.9	27.7	*	3170
	Female	79.8	20.0	*	7998
Age	15–24	72.0	27.1	*	1048
	15–19	74.5	23.5	*	345
	20–24	70.8	28.8	*	703
	25–29	65.8	34.2	*	828
	30–39	60.7	39.3	*	1565
	40–49	65.0	35.0	*	1708
	50–59	76.3	23.6	*	2524
	60+	96.7	2.9	*	3493
Region	North	78.4	21.3	*	3708
	Center	71.8	28.1	*	3343
	South	74.3	25.5	*	2080
	Chisinau	88.3	11.4	*	2125
Area	Urban	85.9	14.0	*	4272
	Rural	72.5	27.3	*	6984
Education	None/primary	94.9	*	*	579
	Secondary	70.6	29.1	*	4754
	Professional education	76.1	23.8	*	3596
	Higher	90.4	9.5	*	2125
	Missing/DK	89.3	*	*	115
Ethnicity	Moldovan/Romanian	76.5	23.3	*	8964
	Russian	87.0	12.8	*	577
	Ukrainian	82.6	16.9	*	974
	Roma	(58.1)	(41.9)	*	66
	Gagauz	76.4	23.1	*	409

		Health insurance coverage			Number
		Yes	No	DK	Total
	Other ethnic group	80.6	18.9	*	265
Children in household	Without children	80.0	19.8	*	9599
	With children	63.6	36.3	*	1656
Wealth index quintiles	Poorest	75.2	24.4	*	2812
	Second	72.7	27.1	*	2211
	Middle	74.5	25.2	*	2114
	Fourth	80.7	19.1	*	2120
	Richest	86.1	13.8	*	1998
Total		**77.5**	**22.2**	*	**11256**

Health insurance coverage continues to be in direct relationship with socio-economic status and the difference between poorest and richest quintile in health insurance coverage was 10.9 percentage points (Figure 3).

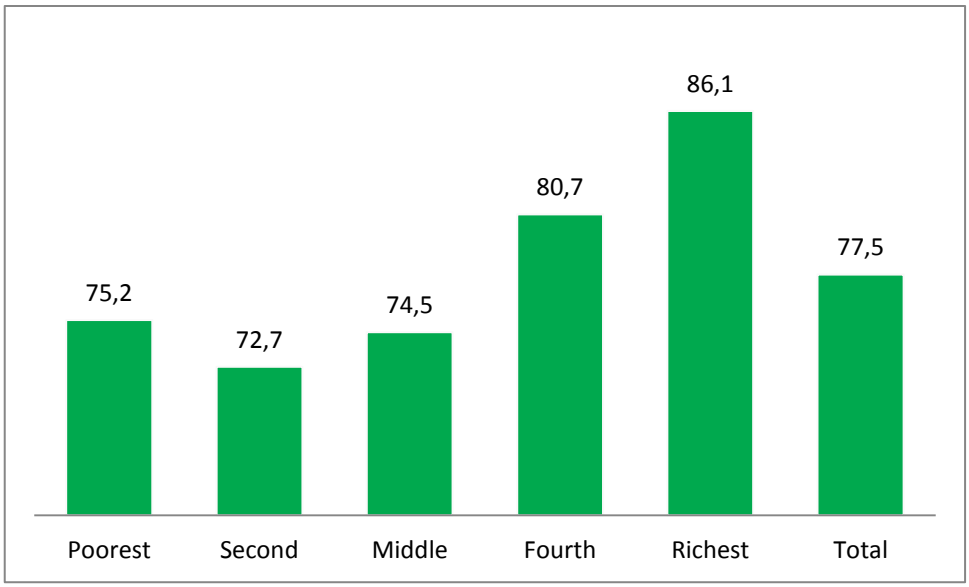

Figure 3: **Health insurance coverage, by wealth quintiles**
Percent distribution of household population by health insurance coverage in socio-economic quintiles, Moldova 2012

Socio-demographic characteristics of uninsured respondents

A total 2,500 respondents have stated they did not have health insurance. Of them:

- 92.2 percent have secondary or professional education or lower level
- 90.3 percent were evenly distributed in the three regions of the country and 9.7 percent of households were in Chisinau
- 76.1 percent live in rural areas
- 74.6 percent live in a household led by a man

- 72.3 percent are from the lower three socio-economic quintiles
- 62.0 percent are with ages comprised between 15 and 49 years
- 51.4 percent are households with children

Reasons to not have health insurance coverage

Respondents were asked to define the main reason why they were not insured, by choosing from a list of reasons. By far, the most important reasons for people to not be covered by health insurance is that they were either unemployed (56.7 percent) or they were informally or self-employed (informal workers 10.1 percent, agricultural workers 2.0 percent and labor migrants 3.0 percent), thus are required to buy their own health insurance on an annual basis. In addition, some 15.3 percent of households thought it was too expensive to buy on their own health insurance premium.

Important differences were noted by residence, as rural residents have mentioned in higher proportions unemployment as the main reason to not have health insurance (58.4 percent rural versus 51.1 percent urban). Higher proportions of urban respondents thought health insurance was not useful, as they would need to pay additionally directly out-of-pocket (6.4 percent urban versus 1.7 percent rural).

By socio-economic status, unemployment was mentioned by a higher share of the poorest quintile (59.1 percent), yet unemployment was mentioned by a high proportion among wealthiest quintile as well (45.4 percent). At the same time, while some 19.6 percent of poorest quintile mentioned that the annual premium was too expensive, only 7.8 percent from wealthiest quintile thought so. The reasons to not have mandatory health insurance coverage are presented in Table 8.

Table 8: **Reasons to not have mandatory health insurance coverage**

Percent distribution of household population by reason to not have health insurance coverage, Moldova 2012

		Unemployed	Informal worker	Labor migrant	Agricultural worker	Self-employed	I am healthy	Too expensive	Useless / Will need to pay extra	Another type of health insurance	Other	Do not know	Number
Sex	Male	52.9	11.8	4.8	*	*	7.5	11.8	(3.1)	*	*	*	880
	Female	59.0	8.9	2.2	*	*	4.2	17.2	2.7	*	(2.7)	*	1598
Age	15–24	58.4	(11.9)	2.0	*	*	*	*	*	*	*	*	284
	15–19	(58.0)	*	1.7	*	*	*	*	*	*	*	*	81
	20–24	58.6	*	2.2	*	*	*	*	*	*	*	*	203
	25–29	63.6	*	3.6	*	*	*	(11.3)	*	*	*	*	283
	30–39	54.4	11.5	5.4	*	*	(5.7)	15.9	(3.6)	*	*	*	615
	40–49	58.2	10.3	3.2	*	*	(5.0)	16.2	2.8	*	*	0	597
	50–59	57.3	(8.8)	*	*	*	(3.5)	17.7	*	*	*	*	595
	60+	(36.8)	*	*	*	*	*	*	3.9	2.5	16.9	3.2	102
Region	North	54.8	9.7	(4.9)	*	*	(5.1)	16.7	(3.0)	.8	2.2	.9	788
	Center	60.6	9.0	*	*	*	(4.8)	15.6	*	.3	1.8	.3	940
	South	57.2	9.3	*	*	*	*	16.5	*	.8	4.2	1.4	530
	Chisinau	46.3	17.0	*	*	*	(10.5)	(6.7)	8.7	.9	5.8	.8	243
Area	Urban	51.1	15.2	*	*	*	7.0	9.4	6.4	1.3	3.7	.8	597
	Rural	58.4	8.4	*	(2.5)	*	4.9	17.1	1.7	.4	2.6	.8	1903
Education	None/primary	*	*	*	*	*	*	*	0	0	*	0	24
	Secondary	58.7	9.6	2.6	*	*	5.1	15.7	(2.2)	*	(2.2)	*	1385

		Unemployed	Informal worker	Labor migrant	Agricultural worker	Self-employed	I am healthy	Too expensive	Useless / Will need to pay extra	Another type of health insurance	Other	Do not know	Number
	Professional education	54.4	10.4	4.6	*	*	4.6	16.4	(3.4)	*	*	*	856
	Higher	53.5	11.7	(0.4)	*	*	(11.4)	*	*	*	*	*	202
	Missing/DK	*	0	0	*	*	0	*	0	0	*	0	10
Ethnicity	Moldovan/ Romanian	57.4	9.3	3.1	(2.2)	*	5.2	15.7	2.5	*	2.7	*	2089
	Russian	(42.9)	*	*	*	*	*	*	*	*	*	*	74
	Ukrainian	52.4	*	*	*	*	*	(17.3)	*	*	*	*	165
	Roma	*	*	*	*	*	*	*	*	0	0	0	28
	Gagauz	55.7	*	*	*	*	*	12.1	*	*	*	*	95
	Other ethnic group	(56.2)	*	*	*	*	*	8.4	*	0	*	*	50
Children in household	Without children	55.4	10.3	3.4	(2.5)	*	5.6	14.8	3.1	*	3.1	*	1900
	With children	60.8	9.3	2.1	*	*	(5.0)	16.8	*	*	*	*	601
Wealth index quintiles	Poorest	59.1	(8.7)	*	*	*	*	19.6	*	*	*	*	687
	Second	59.9	(7.0)	*	*	*	*	19.2	*	*	*	*	600
	Middle	54.5	11.3	*	*	*	(7.7)	16.7	*	*	*	*	533
	Fourth	58.2	11.8	*	*	*	(6.8)	5.5	*	*	*	*	405
	Richest	45.4	15.2	*	*	*	(8.3)	7.8	(8.6)	*	*	*	275
Total		**56.7**	**10.1**	**3.1**	**2.0**	*	**5.4**	**15.3**	**2.8**	**0.6**	**2.9**	**0.8**	**2500**

Compared to 2012 NHBS, the percent of those who mentioned unemployment as the main reason to not have health insurance coverage was much higher in 2012 AHSS (56.7 percent in 2012 AHSS versus 14.1 percent in 2012 NHBS), while the share of those mentioning being informally informed or migrants was higher in 2012 NHBS (29.7 percent in 2012 NHBS versus 15.5 percent in 2012 AHSS). The percent of those that thought that health insurance was too expensive was also higher in 2012 NHBS (18.3 percent in 2012 NHBS and 2.8 percent in 2012 AHSS), as did the share of those that thought health insurance was not useful because they would have to pay extra in informal payments (18.3 percent in 2012 NHBS versus 2.8 percent in 2012 AHSS). (Table 9) The reasons for such variation between the two surveys are not clear.

Table 9: **Reasons to not have health insurance coverage, 2012 AHSS and 2012 NHBS, in percent**

Reasons	NHBS 2012	AHSS 2012
Unemployed	14.1	56.7
Informally employed (labor migrant, agriculture, informal sector)	29.7	15.5
Too expensive	22.9	15.3
Will have to pay extra out-of-pocket	18.3	2.8
Not necessary/healthy	12.5	5.4
Other	2.5	2.8
Do not know	0	1.5
Total	**100**	**100**

Knowledge of health insurance benefit package

Information on the benefit package under health insurance continues to be limited, even as the mandatory health insurance system has already been implemented for over a decade. A third of households (32.3 percent) did not know what health insurance premium covered, about a half of households (48.4 percent) had only partial information and only every fifth household (19.3 percent) was fully informed about the benefit package under health insurance. Not knowing about the benefit package of health insurance coverage was in direct relationship with economic status, as 44.1 percent of households in the lowest quintile compared to 25.3 percent in the wealthiest quintile were not informed about benefit package. Residence played a moderate role, as 34.5 percent of rural versus 28.7 percent of urban households did not know what benefit package covered.

During 2009 and 2010, the government made several legislative amendments that aimed to extend benefits to the most vulnerable. The law on health insurance for year 2010 extended full primary health care and emergency care services to all citizens irrespective of their insurance status, revised in 2011 to limit the universal primary health care benefit to only universal access to PHC visit and not the access to compensated medicines. Additionally, all those registered as poor under the Law on Social Support automatically were entitled to receive fully subsidized health insurance. The 2012 AHSS included questions to assess the population's awareness about these changes.

Unfortunately, these efforts remained largely unknown to the population, as only a third (32.4 percent) of households knew about universal coverage with basic primary and emergency care. Access to information was also dependent on socio-economic status and the most vulnerable were not aware about this entitlement aimed to cover primarily them. Some 17.5 percent in the poorest quintile compared to 44.1 percent in the wealthiest quintile were familiar with legal provisions that ensured universal coverage with basic PHC and emergency care.

Some 43.2 percent were familiar with the provision of health insurance coverage to socially vulnerable categories of population, and by socio-economic quintiles, only 26.7 percent in the poorest quintile compared to 55.4 percent in the wealthiest quintile knew that people below poverty level were eligible for state subsidized health insurance premium (Figure 4).

By residence, 29.7 percent of rural compared to 36.9 percent of urban residents were familiar with provisions of universal PHC and emergency care coverage and 39.9 percent of rural versus 48.6 percent of urban population knew about eligibility for health insurance coverage based on poverty level.

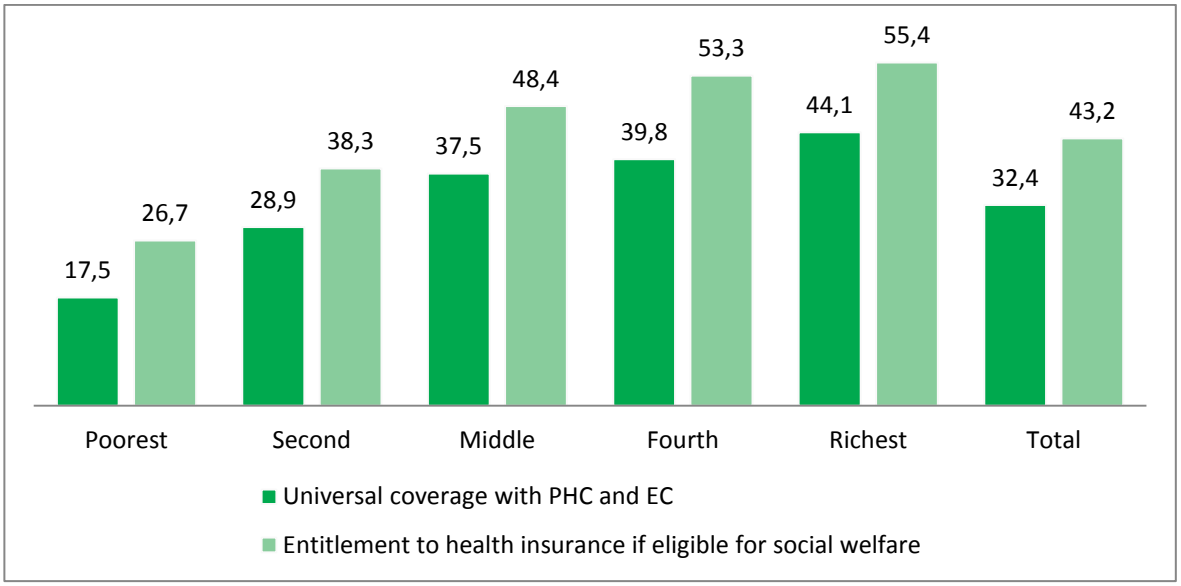

Figure 4: **Knowledge of universal coverage provisions**
Percent of household population who is familiar with legislative changes aiming at increasing health coverage for the most vulnerable categories of population, by socio-economic status

I am registered with the unemployment agency and I have asked about getting health insurance and they told me they cannot provide it. And I really need it, I have all these health issues, I cannot afford buying the medicines I need from the welfare. I do not go to see a doctor, I use traditional remedies. I went once and they told me to pay 50 lei, I did not have them so I went outside and started crying.

Rural female, 54 years, uninsured, uninsured informal worker, former teacher

General financial accessibility of health services

The financial accessibility to health services was estimated based on the cumulative experience of household members in accessing health services in the 12 months preceding the survey. Total financial inaccessibility was defined as not seeking health care due to anticipated costs of transportation, drugs, consultations, and other associated costs for all episodes of illness registered in a household, while partial financial access was defined as at least one episode of not seeking care.

A total 75.6 percent of household population stated that anticipated costs did not prevent them from accessing health services in the 12 months preceding the survey, a total 18.9 percent of the population had reduced financial inaccessibility and 5.2 percent had total financial inaccessibility. Significant differences in financial inaccessibility were observed by socio-economic status: 10.2 percent in the poorest quintile compared to 2.5 percent in the wealthiest quintile had total financial inaccessibility and 26.5 percent in the poorest quintile compared to 15.6 percent in the wealthiest quintile had partial financial inaccessibility. Financial accessibility was in direct relationship with the level of education; those with secondary education at 70.9 percent and 84.9 percent among those with higher education level had adequate financial accessibility. By age, the relationship was inverse: the highest share of adequate financial accessibility was stated by the age group 15–24 years (85.7 percent), the lowest in the age group 60+ years (70.5 percent). By residence, rural residents had lower level of adequate financial accessibility compared to urban population (73.8 percent and 78.5 percent) (Table 10).

Having health insurance coverage does not ensure fully adequate financial access, as lower differences than expected were observed: 6.8 percent among households who did not have health insurance coverage compared to 4.8 percent among those who had health insurance coverage had absolute financial inaccessibility.

Table 10: **General financial accessibility in the past 12 months**
Percent distribution of household population by financial accessibility, Moldova 2012

Variables		Adequate accessibility	Partial inaccessibility	Absolute inaccessibility	Number of households
Sex	Male	76.3	18.9	4.4	3170
	Female	75.3	18.9	5.6	7998
Age	15–24	85.7	12.2	(2.1)	1048
	15–19	88.9	(8.9)	*	345
	20–24	84.1	13.8	*	703
	25–29	83.6	14.0	*	828
	30–39	79.9	16.7	(3.2)	1565
	40–49	76.2	18.3	5.4	1708
	50–59	72.6	19.7	7.5	2524
	60+	70.5	22.8	6.3	3493

Variables		Adequate accessibility	Partial inaccessibility	Absolute inaccessibility	Number of households
Region	North	74.3	20.3	5.2	3708
	Center	72.8	20.6	6.4	3343
	South	78.2	16.9	4.7	2080
	Chisinau	79.7	15.9	4.1	2125
Area	Urban	78.5	17.2	4.0	4272
	Rural	73.8	19.9	6.0	6984
Education	None/primary	65.0	24.1	10.2	579
	Secondary	70.9	22.5	6.3	4754
	Professional education	78.3	17.2	4.3	3596
	Higher	84.9	12.0	3.0	2125
	Missing/DK	61.6	*	*	115
Ethnicity of household head	Moldovan/ Romanian	75.2	19.1	5.4	8964
	Russian	77.1	17.9	(4.9)	577
	Ukrainian	76.4	18.0	5.6	974
	Roma	(52.8)	*	*	66
	Gagauz	81.9	15.0	*	409
	Other ethnic group	77.5	19.5	*	265
Children in household	Without children	74.3	19.7	5.7	9599
	With children	83.0	14.1	(2.6)	1656
Wealth index quintiles	Poorest	62.7	26.5	10.2	2812
	Second	72.9	21.4	5.6	2211
	Middle	80.7	16.2	2.9	2114
	Fourth	81.0	15.6	3.3	2120
	Richest	85.5	11.8	2.5	1998
Health insurance	Yes	76.2	18.7	4.8	8728
	No	73.3	19.6	6.8	2500
Total		**75.6**	**18.9**	**5.3**	**11256**

Note: the "do not know" answers were excluded from the table given their low numbers below 29 cases

Financial accessibility to treatment at last episode of illness

This chapter overviews access tohealth services based on the last episode of illness in the household in the four weeks preceding the survey (1929 cases sought health care). The general description of illness case is followed by access to treatment at the following levels:

1. Self-medication (262 cases).
2. At-home treatment (766 cases).
3. Outpatient treatment at the primary health care level, including family doctor or emergency services (365 cases).
4. Outpatient specialist treatment (176 cases).

5. Inpatient treatment at the public hospital (360 cases).

Geographic and financial access is presented for each level of care described above. The analysis of the specific financial access includes analysis of looks at main components of costs, expenditure structure and average value of expenditures. Geographic and financial access is presented in relationship to household characteristics, such as region, urban/rural residence, number of household members, having children, household head's education level and health insurance status, age, sex and education.

Overview of last episode of illness

A total of 17.1 percent of household population have reported an episode of illness in the four weeks preceding the interview. Reporting the last episode of illness showed differences by most socio-economic factors including residence, wealth index and health insurance coverage. More urban residents compared to rural residents (18.9 percent and 16.0 percent respectively), a higher proportion of wealthiest quintile compared to lowest quintile (19.7 percent and 13.7 percent respectively) and those that had health insurance coverage compared to those not having health insurance coverage (17.8 percent and 14.9 percent respectively) reported an episode of illness. General prevalence of illness in the household in the four weeks preceding interview is presented in Figure 5. This finding is an indication of the subjective nature of reporting a last episode of illness rather than a true difference in occurrence of diseases, and those that anticipate to have lower access to health services might underreport their episodes of illnesses because of not perceiving light forms of illnesses worth reporting. In addition, given the high level of health seeking behavior for the last episode of illness presented further below, it is likely that respondents tended to underreport the diseases for which they had not sought health care.

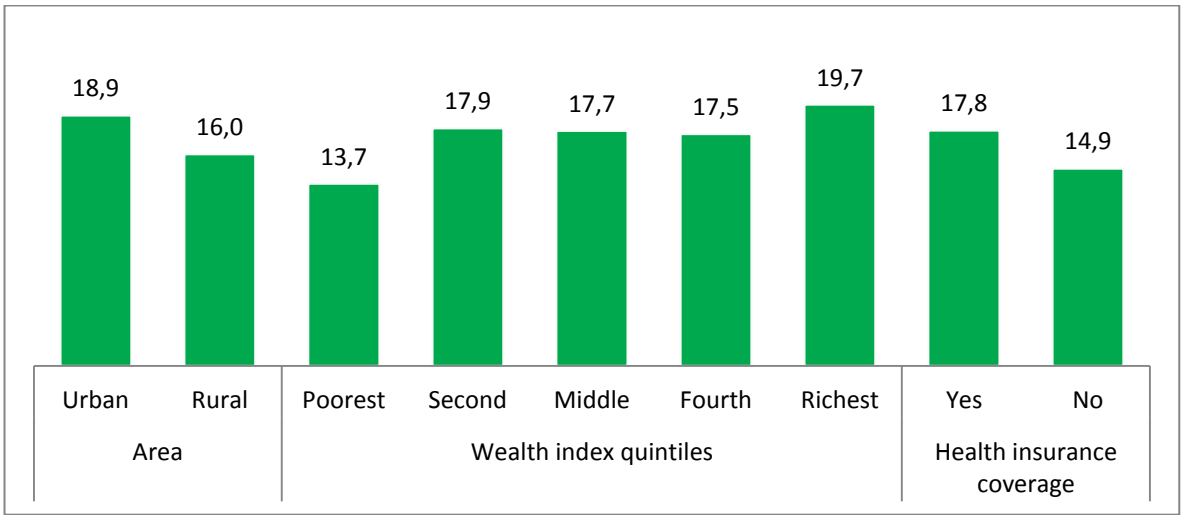

Figure 5: **General prevalence of illness in the household in the four weeks preceding interview**
Percent of household population that have reported an episode of illness in the four weeks preceding the interview, based on residence, wealth index and health insurance coverage, Moldova 2012

By the person who was last sick in the household, in 50.1 percent of cases it was the household head him/herself, in 42.2 percent of cases it was the spouse, in 5.8 percent of cases it was the child, in 1.4 percent of cases it was the son-in-law/daughter-in-law and in 0.4 percent of cases it was the grandchild of the household head. Somewhat higher proportions of rural population compared to urban households reported medium or severe disease (84.5 percent versus 78.5 percent), and higher proportions of poorest compared to wealthiest households (89.9 percent versus 74.0 percent) reported medium or severe disease supporting the above statement that rural and poorer households probably underreported mild forms of illnesses.

Households with children have reported somewhat higher proportions of episodes of illness compared to households without children (20.6 percent versus 15.1 percent) and higher shares among households with children under five years (23.6 percent) compared to households without children under five years (15.9 percent). Households with children under five years have reported lower proportions of medium or severe forms of illness compared to households without children under five years (68.0 percent versus 85.8 percent). These two indicators point to the fact that households with children under 5 years tend to pay more attention and report all forms of illness in children under five years compared to households without children under five.

By far, the most frequently mentioned type of illness was respiratory illnesses (38.2 percent) followed by cardio-vascular (13.8 percent), gastrointestinal (9.3 percent), osteo-articular (8.5 percent) and kidney illnesses (5.1 percent), while trauma, OB/GYN, and oncological accounted for less than 5 percent each and other conditions accounted for 16.4 percent. Respiratory diseases were mentioned more frequently by urban, wealthier households and households with children, while cardio-vascular conditions were mentioned more often by poorer households and households without children. The highest share of respiratory diseases was mentioned in households with children under 5 years (65.7 percent) (Table 11).

Table 11: **Type of illness at last episode**
Percent of household population distribution by type of illness at last episode in the four weeks preceding the interview and who sought health care for it, Moldova 2012

		Heart	Respiratory	Gastro intestinal	OB/GYN	Oncological	Renal	Osteo-articular	Trauma	Other	Do not know	Sought health care
Sex	Male	15.3	34.6	(7.9)	N/A	.5	*	9.0	*	20.9	*	95.9
	Female	13.4	39.2	9.7	(2.0)	2.0	5.8	8.4	(3.4)	15.1	*	94.2
Age	0–5	0	*	0	0	0	0	0	0	0	*	100.0
	6–14	0	*	0	0	.0	0	0	0	0	*	100.0
	15–24	*	62.9	*	*	.0	*	*	*	*	*	93.7
	15–19	*	(58.1)	*	*	.0	*	*	*	*	*	95.3
	20–24	*	64.9	*	*	.0	*	*	*	*	*	93.0
	25–29	*	54.2	*	*	.6	*	*	*	*	*	96.9

		Heart	Respiratory	Gastro intestinal	OB/GYN	Oncological	Renal	Osteoarticular	Trauma	Other	Do not know	Sought health care
	30–39	*	57.1	*	*	.0	*	*	*	(17.6)	*	94.1
	40–49	*	36.8	*	*	*	*	*	*	20.7	*	95.5
	50–59	19.8	24.3	14.9	*	*	*	12.8	*	15.5	*	94.1
	60+	24.6	26.5	8.7	*	*	(5.2)	11.3	*	17.2	*	94.2
Region	North	13.5	33.8	9.8	*	*	(6.0)	(9.1)	*	18.3	*	94.5
	Center	16.1	31.2	(10.2)	*	*	*	(10.5)	*	18.1	*	95.9
	South	15.8	31.8	(9.5)	*	*	*	(9.9)	*	17.3	*	92.5
	Chisinau	9.7	57.6	(7.6)	*	*	(4.4)	(4.2)	*	11.1	*	94.8
Area	Urban	12.1	48.1	9.5	*	*	(4.2)	4.9	(3.0)	14.7	*	94.7
	Rural	15.0	31.0	9.2	*	*	5.7	11.1	*	17.6	*	94.5
Wealth index quintiles	Poorest	17.7	30.8	(9.9)	*	*	(4.1)	(12.5)	*	(16.4)	*	92.7
	Second	17.2	25.7	(11.0)	*	*	(6.8)	(9.9)	*	18.6	*	93.4
	Middle	15.2	33.7	(7.8)	*	*	(7.1)	*	*	16.9	*	94.3
	Fourth	11.2	46.1	(8.6)	*	*	*	(5.5)	*	16.3	*	97.0
	Richest	7.5	54.7	9.2	*	*	(3.7)	(5.0)	2.8	13.8	*	95.5
Health insurance coverage	Yes	14.8	38.2	9.9	*	(1.6)	4.5	8.0	3.5	17.0	*	95.4
	No	*	38.8	(6.0)	*	*	*	(11.8)	*	(13.5)	*	89.7
Total percent		**13.8**	**38.2**	**9.3**	**1.6**	**1.6**	**5.1**	**8.5**	**4.2**	**16.4**	*	**94.6**
Total cases		**267**	**803**	**188**	**32**	**31**	**95**	**153**	**77**	**314**	**22**	**1873**

Inadequate financial access at last episode of illness was defined as the sum of partial and absolute financial inaccessibility, when households had to renounce to treatment fully or partially because of any costs related to transportation, exam, consultation, drugs and investigations. A total 82.7 percent of households stated to have had adequate access to health services, 9.2 percent of them had partial financial inaccessibility and 8.1 percent did not have financial access to health services at their last episode of illness. Financial accessibility at last episode of illness is presented in Table 12. Adequate financial access at last episode of illness has shown variations by the following characteristics:

- Household socio-economic status (74.3 percent in poorest quintile compared to 91.8 percent of wealthiest quintile and).
- Residence (79.9 percent rural compared to 86.7 percent urban).
- Health insurance coverage (73.5 percent of the uninsured compared to 84.4 percent of the insured).
- Children in the household (81.2 percent of households without children and 88.8 percent of households with children).
- Sex (81.8 percent of women and 86.0 percent of men).

- Age (79.0 percent in the eldest age group 60+ years compared to 91.8 percent in the age group 25–29 years).

Table 12: **Financial accessibility at last episode of illness**
Percent of household population distribution by financial access at last episode in the four weeks preceding the interview, Moldova 2012

		Adequate accessibility	Partial inaccessibility	Absolute inaccessibility	DK
Sex	Male	86.0	*	*	421
	Female	81.8	9.6	8.6	1497
Age	0–5	*	0	0	2
	6–14	*	0	0	2
	15–24	90.4	*	*	190
	15–19	93.3	*	*	55
	20–24	89.2	*	*	135
	25–29	91.8	*	*	180
	30–39	87.6	*	*	275
	40–49	81.5	(10.8)	*	267
	50–59	78.0	(10.5)	(11.4)	425
	60+	79.0	12.7	(8.3)	578
Area	Urban	86.7	6.2	7.0	808
	Rural	79.9	11.3	8.9	1113
Children in household	Without children	81.2	9.9	8.9	1529
	With children	88.8	*	*	392
Wealth index quintiles	Poorest	74.3	16.6	(9.2)	386
	Second	78.5	(8.8)	(12.7)	395
	Middle	82.7	(8.4)	(8.9)	375
	Fourth	86.6	(6.9)	(6.6)	371
	Richest	91.8	(5.1)	*	394
Health insurance coverage	Yes	84.4	8.7	6.9	1616
	No	73.5	(12.1)	(14.4)	295
Total		**82.7**	**9.2**	**8.1**	**1921**

Treatment of the last episode of illness

The vast majority of households (94.6 percent) have sought and received treatment for their last episode of illness, without major differences by residence, socio-economic status, health insurance status or severity of disease.

For those who have not received treatment for their last episode (n = 108), the main reasons were: anticipated costs (42.6 percent of those who did not receive treatment); disease was not severe (34.3 percent), mistrust in health providers (5.6 percent), treatment ineffectiveness (5.6 percent), limited geographic access (2.8 percent), perceived low quality of health services (0.9 percent) and having no health insurance coverage (0.9 percent) and other reasons (15.7 percent) (multiple response set, sum more than 100 percent).

Access to health services by level of care at last episode of illness

Of those who stated that they have sought and received treatment for their last episode of illness, a half have self-treated (12.6 percent) or stayed at home for treatment with a consultation from a health worker (37 percent), 18.9 percent went to see their primary care physician, 9.3 percent went to an outpatient specialist and 19.3 percent went to a public hospital (multiple response, summed and presented as 100%). Only 1.1 percent or 29 respondents have sought health service in the private sector. Some differences were noted by residence, where higher shares of urban residents have used self-medication or home-based treatment options and rural residents were more likely to seek care in a health facility: 20.8 percent of rural compared to 16.3 percent urban residents went to PHC, 10.5 percent of rural compared to 7.7 percent of urban residents went to see an outpatient-based specialist and 21.0 percent of rural compared to 17.0 percent of urban residents have been hospitalized at last episode of illness (Figure 6).

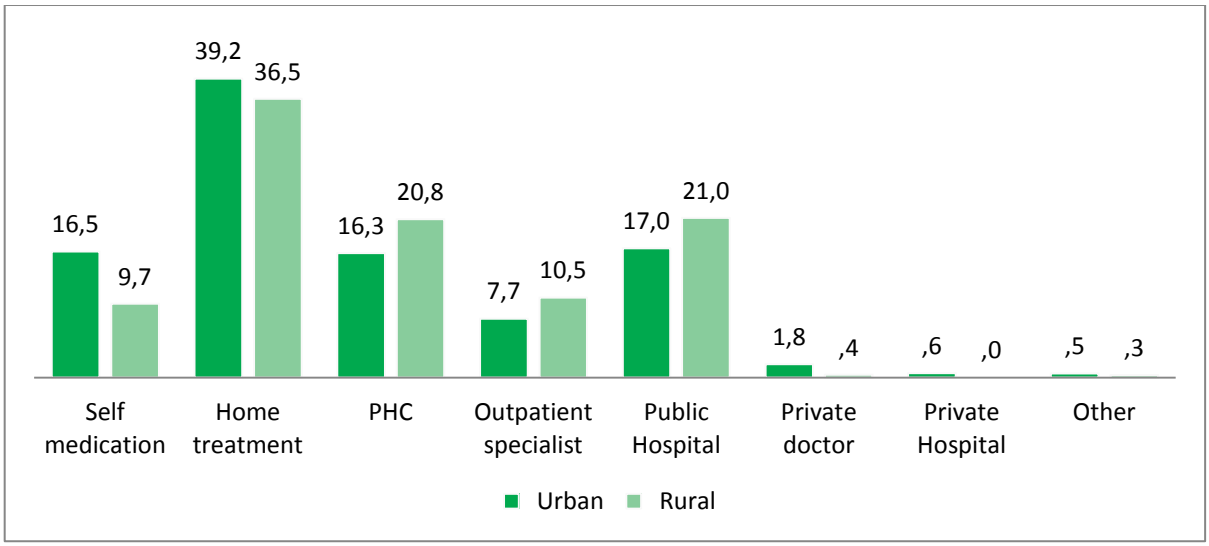

Figure 6: **Level of care sought at last episode of illness**
Percent of household population that has sought different levels of care at last episode of illness, based on residence, Moldova 2012

Some differences were noted by disease severity, health insurance coverage and wealth index, but number of cases is not sufficient to make strong interpretations. The level of sought care at last episode of illness is presented in Table 13.

Table 13: **Level of sought care at last episode of illness**
Percent of household population distribution by level of care at last episode in the four weeks preceding the interview, Moldova 2012

		Self-treatment	Home-based treatment	PHC	Medical Specialist	Public Hospital	Other	Total	Number
Sex	Male	12.2	34.0	17.2	(11.7)	25.8	*	99.9	421
	Female	12.7	38.6	19.4	8.7	17.5	(1.9)	100.0	1497

		Self-treatment	Home-based treatment	PHC	Medical Specialist	Public Hospital	Other	Total	Number
Age	0–5	0	*	*	0	0	*	100.0	2
	6–14	0	*	0	0	0	*	100.0	2
	15–24	21.7	42.5	(11.6)	*	*	*	99.8	190
	15–19	*	*	*	*	*	*	100.0	55
	20–24	(22.8)	42.9	*	*	*	*	99.7	135
	25–29	(15.7)	38.4	(18.4)	*	(16.4)	*	100.0	180
	30–39	(13.9)	39.6	(16.7)	(11.7)	(14.1)	*	100.0	275
	40–49	12.6	42.7	(14.7)	(9.4)	(17.2)	*	100.0	267
	50–59	10.1	33.4	22.1	(11.4)	22.1	*	100.0	425
	60+	9.9	35.4	22.0	8.2	24.4	*	100.0	578
Region	North	11.5	36.6	19.5	10.4	19.4	*	100.0	599
	Center	(9.6)	36.2	24.0	(9.8)	21.1	*	100.0	526
	South	(8.4)	36.2	17.1	(10.4)	21.8	*	100.0	354
	Chisinau	20.9	41.9	13.5	(6.6)	14.9	(4.7)	99.9	442
Area	Urban	16.5	39.2	16.3	7.7	17.0	*	99.9	808
	Rural	9.7	36.5	20.8	10.5	21.0	*	100.0	1113
Wealth index quintiles	Poorest	(9.0)	36.7	23.6	*	18.3	*	100.0	386
	Second	(10.5)	37.5	20.6	(8.5)	21.5	*	100.0	395
	Middle	(9.8)	34.4	16.7	(13.7)	22.1	*	100.0	375
	Fourth	15.5	35.9	18.6	(9.3)	20.1	*	100.0	371
	Richest	18.0	43.5	15.1	(8.0)	14.6	*	99.9	394
Health insurance coverage	Yes	11.9	38.0	20.1	9.2	20.1	1.6	100.0	1616
	No	(15.9)	36.4	(13.0)	(10.3)	(14.5)	*	100.0	295
	DK	*	*	0	*	*	*	94.9	9
Children in household	Without children	12.7	35.5	19.2	9.8	20.8	*	100.0	1529
	With children	12.2	46.2	17.9	(7.6)	13.2	*	100.0	392
Disease severity	Slight	24.3	41.4	17.3	*	*	*	100.0	331
	Moderate	14.5	40.5	18.8	8.7	15.6	*	100.0	805
	Severe	(5.7)	33.2	19.7	12.9	29.8	*	100.0	772
	Do not know	0	*	14.9	*	*	*	96.3	12
Chronic illness	Yes	10.9	38.5	19.9	9.9	20.2	*	100.0	1225
	No	15.4	36.9	17.3	(8.1)	17.7	*	99.9	681
Total		**12.6**	**37.7**	**18.9**	**9.3**	**19.3**	**(1.7)**	**100.0**	**1921**

Self-treatment and home-based treatment

Self-treatment is defined as treatment by the respondent him/herself or other household member, without consultation of qualified medical personnel. Home-based treatment is defined as treatment applied with consultation from a non-household member, including undocumented consultation of medical personnel. A total 272 cases of self-treatment (12.6 percent) and 766 cases of home-based treatment (37 percent) were analyzed

together, given the ambiguity of defining the difference between self-treatment and that with undocumented consultation of medical or non-medical person.

In both cases, most often a physician (74.3 percent) has prescribed treatment, followed by a non-medical person (12.7 percent), by self and household members (10.1 percent), by a nurse (2.6 percent) and a traditional healer (0.2 percent). Compared to urban areas, respondents from rural areas mentioned more often that a doctor prescribed the treatment (77.1 percent rural versus 70.9 percent urban). Almost a third of cases (29.9 percent) treated at home were cases of severe illness, yet, patients remained at home rather than go to a health facility.

> *I get my own treatment at home, I have four children and I cannot leave them alone.*
>
> Female, 33 years, rural, stay-at-home mother, beneficiary of social welfare.
>
> *If you have health insurance you do not pay those 30–50 lei, you only pay for transportation. If you do not have health insurance you just stay at home.*
>
> Female, 28 years, rural, stay-at-home mother, three children.

Frequency and structure of out-of-pocket expenditures for self-treatment and home-based treatment

Structure of OOP expenditures self-treatment and home-based treatment

Of household members who stayed at home for their last episode of illness:

- 88.7 percent had any out-of-pocket expenditures
- 87.1 percent had to buy medicines
- 12.7 percent had other expenditures, such as lab tests and investigations and other treatment interventions
- 9.9 percent paid for the medical worker who came to provide consultation at home.

An insignificant share (1.9 percent) has provided pay in-kind with goods to coming health workers. Of those who did not buy drugs at last episode of illness, the main reason was that they already had them at home from previous episodes of illness (57.3 percent) and that they could not afford their cost (28.3 percent), with the rest 14.4 percent of respondent mentioning other reasons.

For those who paid out-of-pocket for any category of expenditures (n = 840), the average expenditure for the last case of illness treated at home was 490.9 MDL (range between 1 and 11,000 MDL, st. dev 863.3 MDL). By far, the most frequent expenditure was for medicines (mean 395.4 MDL, st. dev. 617.4 MDL), while other expenses were incurred by a small proportion of 13.1 percent of respondents but high (mean 527.8 MDL, st. dev. 729.1 MDL). The average fee for consultation was 236.9 MDL (st. dev. 433.4 MDL) (Table 14).

Table 14: **Out-of-pocket expenditures at last episode of illness self-treated and treated at home**
Percent of household population distribution by frequency and value of OOP expenditures at last episode in the four weeks preceding the interview, Moldova 2012

Type	percent who paid, %	Moldovan Lei					
		Minimum	Maximum	Mean	Std. Deviation	Median	Number who paid
Consultation	9.9	10	2,300	236.9	433.4	60	94
Medicines	87.1	1	6,000	395.4	617.4	200	826
Other	12.7	4	4,000	527.8	729.1	280	126
Total average	**88.7**	**1**	**11,000**	**490.2**	**862.7**	**200**	**841**

The average total cost for home-based consultations was higher in urban areas (498.7 MDL) compared to rural areas (484.3 MDL), the highest in Central region (556.0 MDL), and lowest in the Southern region (373.8 MDL) and higher expenditure increasing with quintiles (325 MDL in the lowest quintile, 528.4 MDL in the fourth quintile and 495.3 MDL in the wealthiest quintile).

Health insurance covered fully the costs of home visit only for 31.8 percent of households who self-treated or treated at home, partially for 16.8 percent and did not cover any costs for 49.7 percent.

Health insurance coverage did not provide significant financial protection to cover costs of medicines, as the mean cost of OOP for medicines was 374.8 MDL for insured household members and 504.4 MDL in the uninsured. Health insurance covered the cost of drugs fully for only 6.6 percent and partially for 18.7 percent of respondents and did not cover costs of medicines at all for 74.2 percent. Disease severity affected significantly the costs of medicines, as the mean costs was 183 MDL of those with mild forms of disease, 340.4 MDL in moderate forms and 628.2 MDL in those with severe forms (Table 15).

Table 15: **Frequency and amount of OOP expenditures at last episode of illness treated at home**
Frequency and value of OOP expenditures of household population distribution by region, residence, wealth, health insurance coverage, having children disease type and severity at last episode of illness treated at home, Moldova 2012

		Paid for consultation, %	Average cost consultation MDL	Paid for medicines, %	Average cost medicines, MDL	Had other expenses, %	Average cost of other expenses MDL	Number
Region	North	*	*	92.0	375.7	(13.4)	(582.1)	286
	Center	(12.4)	(223.2)	87.1	445.8	(15.8)	(506.9)	240
	South	*	*	86.0	334.5	*	*	156
	Chisinau	(17.0)	(262.9)	90.8	407.7	(10.3)	(608.7)	266
Area	Urban	13.1	(266.9)	89.6	397.8	(11.0)	(633.6)	444
	Rural	10.2	(210.6)	89.3	393.3	15.0	462.1	505

		Paid for consultation, %	Average cost consultation MDL	Paid for medicines, %	Average cost medicines, MDL	Had other expenses, %	Average cost of other expenses MDL	Number
Wealth index quintiles	Poorest	*	*	85.1	306.7	*	*	175
	Second	*	*	90.8	469.7	(16.1)	(475.3)	187
	Middle	*	*	89.2	410.7	*	*	166
	Fourth	(15.7)	(300.1)	91.3	358.0	*	*	187
	Richest	(14.0)	(196.7)	90.3	415.7	(12.0)	(601.8)	234
Health insurance coverage	Yes	9.9	219.7	88.8	374.8	10.7	506.5	792
	No	(19.6)	(274.0)	93.0	504.4	(25.8)	(577.1)	152
Children in household	Without children	12.1	271.6	90.1	427.3	14.6	567.9	721
	With children	*	*	87.3	292.8	*	*	228
Disease severity	Mild	*	*	88.1	183.0	*	*	216
	Moderate	(10.6)	(192.2)	90.8	340.4	(11.0)	(361.7)	433
	Severe	(15.3)	(307.2)	88.2	628.2	22.7	681.0	295
Type of illness	Heart	*	*	86.5	527.1	*	*	118
	Respiratory	(7.4)	(140.1)	90.2	271.5	(7.6)	(345.5)	475
	Gastrointestinal	*	*	88.8	619.2	*	*	78
	OB/GYN	*	*	*	*	*	*	12
	Oncological	*	*	*	*	*	*	7
	Renal	*	*	(94.6)	(471.7)	*	*	36
	Osteo-articular	*	*	96.0	609.9	*	*	81
	Trauma	*	*	*	*	*	*	24
	Other	*	*	83.1	396.3	*	*	112
Total		**9.9**	**236.9**	**87.1**	**395.4**	**12.7**	**527.8**	**948**

Affordability of care for self-treatment and home-based treatment

Affordability of care at last episode of illness by level was measured by asking if household income has covered fully, partially or did not cover the treatment costs (without recurring to savings, selling goods or borrowing). Some 49.1 percent of households stated that their income has fully covered treatment costs, some 20.4 percent stated partially and 29.8 percent stated that their income did not cover treatment costs at their last episode of illness treated at home.

Breakdown shows significant differences and better affordability for residents of Chisinau (61.1 percent) compared to the rest of the country (less than 50 percent in all three regions). Affordability of care is in direct relationship with wealth, as for 39.8 percent of those in the poorest quintile income was did not cover the costs of the home-based treatment compared to 16.1 percent in the wealthiest quintile and a doubling affordability is observed for home-based treatment by quintiles (33.5 full affordability in poorest quintile compared to 70.9 percent in the richest quintile). A worrisome finding is the high

level of catastrophic costs related to disease severity, as of those household members with severe cases of disease, 50.3 percent stated their income did not cover treatment costs, compared 11.3 percent in those with mild diseases (Table 16).

Health insurance coverage appears to provide moderate financial protection, as of those insured, 26.9 percent stated their income did not cover cost of treatment at all compared to 45.7 percent of the uninsured.

> *I went to the doctor, he gave me something but it does not help. I better use herbs, as our ancestors, I feel better now. The medicines are for money and not cheap, so I prefer plants that I choose and not pills.*
>
> Urban male, 59 years, insured

Table 16: **Affordability of treatment at last episode of illness treated at home**
Percent of household population distribution by affordability of care at last episode in the four weeks preceding the interview, self-treated or treated at home, Moldova 2012

		Full	Partial	No
Region	North	44.8	22.5	32.4
	Center	42.5	19.6	37.9
	South	47.0	28.6	22.9
	Chisinau	61.1	14.1	23.6
Area	Urban	56.8	16.8	25.7
	Rural	42.4	23.6	33.3
Wealth index quintiles	Poorest	(33.5)	25.2	39.8
	Second	35.1	29.5	35.4
	Middle	47.6	20.9	30.9
	Fourth	51.9	17.4	30.7
	Richest	70.9	11.6	16.1
Health insurance coverage	Yes	51.2	21.5	26.9
	No	39.3	13.5	45.7
Children in household	Without children	42.4	22.6	34.2
	With children	70.4	(13.6)	(15.7)
Disease severity	Slight	75.0	(12.8)	(11.3)
	Moderate	51.7	22.7	24.9
	Severe	26.9	22.4	50.3
Chronic illness	Yes	37.7	24.6	37.2
	No	68.3	(13.6)	17.3
Total		**49.1**	**20.4**	**29.8**

Treatment at primary health care level

A total 365 cases have accessed the PHC facility for outpatient treatment, which constitutes 18.9 percent of those who have sought treatment for their last episode of illness.

Geographic access to PHC facility

The average distance to the PHC facility for the subset of households with a last episode of illness was reported to be 2.9 km (st. dev. 5.4 km), the longer distance being reported by respondents from Chisinau (3.3 km, st. dev. 6.8 km), followed by Southern region (2.6 km, st. dev. 6.3 km), Northern region (2.8 km, st. dev. 5.3 km) and Central region (2.6 km, st. dev. 4.4 km) and small differences between urban and rural regions (2.82 km for urban and 2.9 km for rural households).

The average time to get to the PHC facility was 25.4 minutes (st. dev. 32.6 min) without major differences between urban and rural areas (24.9 urban and 26.1 rural). The waiting time in the PHC facility was on average 39.9 minutes (range 0–360 min, st. dev. 56.1 minutes).

As to transportation means, the majority got to PHC facility on foot (65.4 percent), followed by public bus/minibus (15.4 percent), a taxi (6.0 percent) or the ambulance (5.5 percent), the rest of options being mentioned by less than 3 percent each. Some differences were noted between rural and urban households, as some 75.8 percent of rural residents compared to 47.4 percent of urban residents go on foot and vice versa, higher share of urban residents use public transportation (28.6 percent) compared to rural residents (7.8 percent).

Structure of OOP expenditures at PHC level

Of household members who went to see a family doctor for their last episode of illness:

- 90.6 percent incurred an OOP expenditure when accessing PHC at last episode of illness
- 90.0 percent had to buy medicines
- 21.7 percent paid for transportation
- 14.3 percent paid for lab tests and imaging
- 6.7 percent paid for other medical procedures
- 5.5 percent paid for physician consultation
- 1.9 percent (7 respondents) has mentioned to have paid in-kind for treatment.

Meaningful but small differences by different characteristics were noted only in frequency of household members paying for medicines. Given the small sample size, no significant differences were noted in frequency of different types of payments for other expenditure categories between rural and urban areas, geographic region or wealth quintile. Frequency and amounts of OOPs at last episode of illness treated at PHC level are presented in Table 17.

Table 17: **Frequency and amounts of OOPs at last episode of illness treated at PHC level**
Frequency and value of OOP expenditures of household population distribution by region, residence, wealth, health insurance coverage, having children disease type at last episode of illness treated at PHC level, Moldova 2012

		Paid for transportation, %	Mean cost of transportation, MDL	Paid for medicine, %	Mean cost of medicines, MDL	Paid for lab and imaging, %	Average of all costs
Region	North	(21.6)	(22.9)	85.9	405.1	(18.8)	427.8
	Center	*	*	91.0	380.7	*	399.3
	South	*	*	92.6	384.1	*	478.5
	Chisinau	(36.4)	(98.9)	93.2	500.7	*	577.4
Area	Urban	38.4	55.6	91.9	441.6	(14.8)	505.8
	Rural	*	*	88.9	391.0	(14.0)	419.5
Wealth index quintiles	Poorest	*	*	86.2	399.4	*	414.4
	Second	*	*	89.1	324.4	*	347.8
	Middle	*	*	97.0	401.0	*	438.5
	Fourth	(36.1)	(129.7)	89.8	473.8	*	570.5
	Richest	(31.5)	88.3	90.0	477.6	*	523.7
Health insurance coverage	Yes	21.8	76.8	89.6	412.8	(12.4)	452.5
	No	(20.7)	(40.4)	(93.3)	(386.2)	*	(442.3)
Children in household	Without children	21.0	83.3	90.6	455.7	(15.9)	501.9
	With children	(24.4)	(36.4)	87.6	219.6	*	243.1
Disease severity	Slight	*	*	90.2	213.4	*	241.8
	Moderate	(22.9)	(25.2)	87.2	378.5	(12.0)	396.3
	Severe	(21.9)	(139.6)	92.6	511.1	*	581.2
Chronic illness	Yes	21.7	94.8	91.6	424.6	(17.6)	477.6
	No	(21.8)	28.6	86.6	376.4	*	393.9
Total		**21.7**	**73.1**	**90.0**	**409.8**	**14.3**	**451.4**

For those who paid out-of-pocket for any category of expenditures (n = 329 or 90.6 percent), the average expenditure for the last case of illness treated at the level of primary health care was 451.4 MDL (range 2 – 4,010 MDL, st. dev. 582.3 MDL.) The distribution of expenditures is provided below. By far, the highest expenditure is for medicines (mean 409.8 MDL, SD 502.8 MDL), followed by other treatment procedures (285.1 MDL). At outpatient PHC level, drug expenditure was the single most prevalent expenditure and one with highest financial burden. The family doctor prescribed medicines in 95.5 percent of cases. The majority of respondents (90.0 percent) had to buy prescribed medicines out-of-pocket. Asked if health insurance covered the costs of drugs, only 5.8 percent have mentioned that health insurance has covered fully the costs of prescribed medicines, 31.1 percent partially and 62.6 percent mentioning that health insurance did not cover costs of prescribed medicines at all (0.5 percent did not know).

Only 5.5 or 19 household members stated they have paid for consultation of the physician, with an average 124.5 MDL and a median 50 MDL, which needs to be interpreted with caution given small sample. Of those who said they did not pay anything formally or

informally for physician consultation, almost two thirds (63.8 percent) stated that it was because health insurance covered the cost of consultation, 16.4 percent of respondents mentioned they were not asked to pay, some 9.2 percent mentioned that everyone is entitled to PHC regardless of health insurance status, 4.9 percent mentioned they had no money, other reasons covering the remaining 4.9 percent of answers (Table 17).

Table 18: **Out-of-pocket expenditures at last episode of illness treated at PHC level**
Percent of household population distribution by frequency and amount of OOP expenditures at last episode treated in PHC (formal and informal), Moldova 2012

Type	percent who paid, %	Moldovan Lei					
		Minimum	Maximum	Mean	Std. Deviation	Median	Number who paid
Transportation	21.7	2	2,000	73.1	280	16	79
Medicines	90.0	7	4,000	409.8	502.8	240	317
Consultation	5.5	19	500	*124.5	*150.0	50	19
Medical analyses	14.3	10	570	(108.4)	(94.3)	(90)	43
Other medical procedures	6.7	20	1,800	*285.1	*340.1	*150	21
Total average	**90.6**	**2**	**4,010**	**451.4**	**582.3**	**250**	**329**

The services at primary care level should be free: lab tests, medicines, but he prescribes these only to those who pay him something. You have to go early in the morning to your family doctor, stay there in line, he only sees patients for three hours per day, so even if you have an appointment you wait anyway. Then the primary doctor refers you to a specialist anyway then you need to get back to him to get the prescription, it is ridiculous.

Female, 31 years, rural, 3 children, unemployed, uninsured

They have asked me if I had health insurance, I gave it to them. After going through registering the health insurance number, I paid money everywhere, because they were telling me, this is not covered, the health insurance will not help you.

Female, 29 years, insured, rural Roma.

Affordability of treatment provided at PHC level

Some 36.4 percent of households stated that their income has fully covered treatment costs, some 24.9 percent stated partially and 38.4 percent stated that their income did not cover treatment costs at their last episode of illness treated at PHC. There were significant difference by wealth quintiles, as only 13.1 percent of respondent in the poorest quintile compared to 55.4 percent in the wealthiest quintile said that personal income has fully covered costs of seeking PHC services and 47.8 percent of the poorest quintiles compared to 38.8 percent of the wealthiest quintile have stated their personal income did not cover the costs of treatment at PHC level.

Referral to specialist or hospital level

In 38.7 percent of cases, the family doctor has referred the sick person to a specialist consultation or to hospital treatment, with no differences between urban and rural residents, but with the lowest level of referral being registered among households from the Central region (33.1 percent) compared to Chisinau (40.7 percent), South (41.0 percent) and North (41.9 percent).

Of those referred, only 37.7 percent got to specialist or hospital, with significant differences:

- 32.9 percent of rural compared to 46.2 percent urban
- 33.7 percent of the poorest quintile compared to 47.7 percent of the wealthiest quintile.

The most frequent mentioned reasons to not follow up on the referral to higher level of care by respondents were that they thought it was not necessary (37.4 percent) and that illness was not severe (29.0 percent), some 8.1 percent mentioning geographic inconvenience (being too far or having limited transportation) and only 6.5 percent mentioned not having enough money, (other reasons were: still waiting for the date of the appointment (6.9 percent), mentioned other reasons (7.9 percent), because of bad quality of services (1.9 percent) and 2.2 percent could not name a specific reason).

Treatment at outpatient specialist level

A total 197 cases have accessed outpatient treatment at specialist level, which constitutes 9.4 percent of those who have sought treatment for their last episode of illness.

Geographic access

In the subsample of households who went to see an outpatient-based specialist for their last episode of illness, the average distance was reported to be 36.7 km (SD 54.1 km), a longer average distance being reported by respondents from Northern region (50.5 km, SD 71.2 km), followed by Southern region (49.1 km, SD 60.0), Central region (33.1 km, SD 36.5 km) and Chisinau (10.1 km, SD 15.1 km). Significant differences were observed between urban and rural regions (19.2 km, SD 43.3 km for urban households and 36.7 km, SD 54.1 km for rural households).

The average time to get to the outpatient specialist facility was 69.9 minutes (min) (st. dev. 62.9 min) with significant differences between urban (52.2 min, SD 57.0 min) and rural areas (77.8 min, st. dev. 68.0 min).

As to transportation means, given the significant distance to specialist, very few households have got on foot (17.2 percent), the majority got to specialist on public transportation such as bus/minibus (57.6 percent), personal car (13.1 percent), a passing car (5.1 percent) or ambulance (5.1 percent).

Referral from PHC level to outpatient specialist

In 57.1 percent of cases, the sick person who has accessed specialist care had a referral from a family doctor, with higher proportion of rural residents being referred to the specialist (62.7 percent) versus urban residents (53.0 percent), and no significant differences by other socio-demographics.

> *Every family has their private specialist they can call at 2 AM. To PHC I only for some lab work, weighting the child, but in case of a more serious I do not trust him, I do not take a risk.*
>
> Female, 31 years, rural, 3 children, agricultural worker, self-insured
>
> *I had a concussion. I did not have the money, but I borrowed some. I went to see the doctor, and he saw me first, although there were people with appointment and health insurance, but he saw me first, because I have the money.*
>
> Male, 22 years, rural, Roma, uninsured

Structure of OOP expenditures at outpatient specialist level

Of household members who went to see a specialist for their last episode of illness:

- 96.9 percent had OOP expenditures for any category of expenditures
- 92.8 percent had to buy medicines
- 75.2 percent paid for transportation
- 39.5 percent paid for physician consultation
- 34.3 percent paid for lab tests and imaging
- 16.1 percent paid for other medical procedures
- 2.5 percent (5 respondents) paid in-kind for some part of treatment

Table 19: **Out-of-pocket expenditures at last episode of illness treated at outpatient-based specialist**
Percent of household population distribution by frequency and amount of OOP expenditures at last episode treated by outpatient specialist (formal and informal), Moldova 2012

Type	percent who paid, %	Moldovan Lei					
		Minimum	Maximum	Mean	Std. Deviation	Median	Number who paid
Medicines	92.8	14	5,000	611	636.0	410	164
Transportation	75.2	2	5,000	119	292.0	34	149
Consultation	39.5	15	2,000	119.1	184.5	70	75
Lab tests and imaging	34.3	10	5,000	260.9	559.3	100	65
Medical procedures	16.1	10	6,500	560.3	1145.0	150	32
Total average	**96.9**	**2**	**10,000**	**855.6**	**1146.7**	**520**	**189**

Few significant differences in frequency of OOP by different background characteristics were noted given the small sample size (Table 19).

Table 20: **Frequency and amounts of OOPs at last episode of illness treated at outpatient specialist level**

Frequency and amounts of OOP expenditures of household population distribution by region, residence, wealth, health insurance coverage, having children and disease profile at last episode of illness treated at outpatient specialist level, Moldova 2012

		Paid for transportation, %	Mean cost for transportation, MDL	Bought medicines, %	Mean cost of medicines, MDL	Percent who paid anything	Average total OOP expense
Region	North	(76.4)	93.2	91.8	629.2	100.0	810.5
	Center	(74.6)	127.8	(96.3)	(586.0)	(100.0)	(738.9)
	South	*	77.9	(93.7)	(476.5)	(91.9)	(677.5)
	Chisinau	(72.1)	190.7	89.0	(749.4)	93.1	1248.3
Area	Urban	63.7	201.3	89.7	746.8	95.5	1091.3
	Rural	82.6	79.3	94.8	531.1	97.8	709.8
Wealth index quintiles	Poorest	*	*	*	*	*	*
	Second	*	*	*	*	*	*
	Middle	(87.0)	92.5	(93.7)	(653.1)	*	*
	Fourth	*	*	(87.7)	(671.2)	(96.9)	(945.9)
	Richest	(70.9)	(200.9)	93.3	(758.1)	95.9	1188.8
Health insurance coverage	Yes	74.2	123.2	91.2	643.5	96.7	868.0
	No	*	*	(100.0)	(488.8)	(97.9)	(803.7)
Children in household	Without children	73.6	128.5	92.7	574.7	96.9	869.0
	With children	*	*	*	*	*	*
Disease severity	Light	*	*	*	*	*	*
	Moderate	80.7	88.8	92.8	623.8	96.2	755.3
	Severe	72.2	116.0	92.6	598.4	97.4	908.8
Chronic illness	Yes	74.5	139.4	92.1	608.2	96.6	899.1
	No	(76.8)	(84.0)	93.9	617.7	98.7	769.2
Total		**75.2**	**119.4**	**92.8**	**610.9**	**96.9**	**855.6**

Affordability of treatment provided by specialist

Some 35.7 percent of households stated that their income has fully covered treatment costs, some 21.4 percent stated their income covered costs partially and 42.7 percent stated that their income did not cover treatment costs at their last episode of illness treated at specialist. There were few meaningful differences by different socio-demographics given the small sample size.

Treatment at hospital level

A total 375 cases have accessed hospital level treatment, which constitutes 19.4 percent of those who have sought treatment for their last episode of illness. The highest share of household population who has been hospitalized in a district-level hospital (42.0 percent), followed by a Republican level hospital (24.0 percent), and municipal hospital (28.6

percent), with 2.5 percent hospitalized in a private hospital and 2.42 percent in other type of inpatient facility.

Geographic access to hospital

The average distance to the get to the hospital was reported to be 32.8 km (st. dev. 55.8 km), the longer distance being reported by respondents from Southern region (49.8 km, st. dev. 63.6 km), followed by Northern region (45.3 km, st. dev. 73.0 km), and Central region (23.9 km, st. dev. 22.0 km) and Chisinau (9.4 km, st. dev. 7.7 km). Significant differences were observed between urban and rural regions (22.7 km for urban and 45.1 km for rural household population).

As to transportation means, less than a third got to hospital using public transportation (30.5 percent), significant share called the ambulance (30.5 percent), while the rest resorted to personal car (17.4 percent) and passing car (11.7 percent), and low shares used other forms (4.9 percent) or got on foot (4.6 percent).

Waiting time to get to and within inpatient facility

The waiting time between referral and hospital admission at last episode of illness was on average 2 weeks – 15.1 days (range 0 to 912 days, equal to 30 months, st. dev. 82.2 days). Differences were noted by those covered by health insurance (16.3 days) and no waiting time for the few uninsured that have been hospitalized (0.88 days, n = 17 cases) and by residence (16.7 days for urban residents and 13.2 days for rural residents), but not statistically significant.

The average time to get to the hospital was 66.6 min (st. dev. 58.5 min, range 2–360 min), with significant differences between urban (43.2 min, st. dev. 54.9 min) and rural areas (62.6 min, st. dev. 61.1 min).

The waiting time in the hospital to be admitted to ward at last episode of illness was on average 47.8 min (range 0–1440 min (or 24 hours), st. dev. 119.8 min), with no significant differences by residence or health insurance status.

Referral for hospital admission

In 42.0 percent of cases, the hospitalized person had a referral from a family doctor in 21.0 percent the patient was brought by the ambulance, every sixth was referred by a specialist (15.0 percent) and very few were hospitalized based on outpatient hospital clinic referral (0.5 percent). At the same time almost every fourth person has self-referred to hospital (21.0 percent self-referred and 3.5 percent referred by relatives). There were significant differences by residence, as higher shares of rural residents had a referral from a family physician (45.4 percent rural compared to 39.2 percent urban) and fewer rural residents were brought by ambulance (14.1 percent rural and 26.5 urban) (Figure 7).

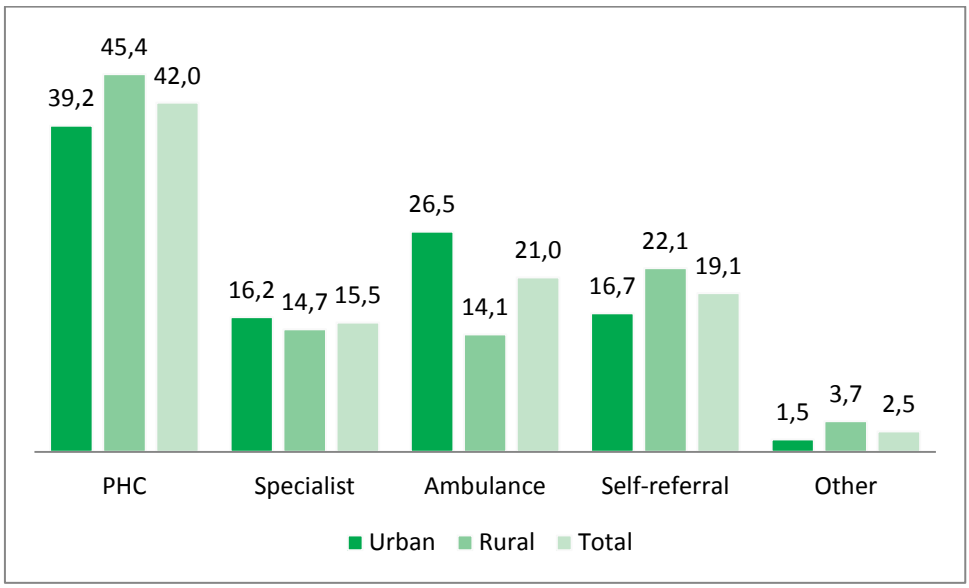

Figure 7: **Distribution of types of referral to hospital level, by residence**
Percent of household population distribution by the type of referral to hospital admission and residence, Moldova 2012

My husband had eczema, he thought it was not important so he stayed at home, and thought it will go away since we did not have money. But then it got really bad, so we have called an ambulance and they took him to the hospital, there was no other way.

Female, 54 years, 5 children, unemployed, uninsured.

I go with my child directly to the Mother and Child Center without going through the health center in the village or the center for family doctors in the district. I do not have confidence in them. I did the same with both deliveries, I paid 3000 MDL for each delivery to the OB/GYN that I chose.

Male, 35 years, self-employed agricultural worker, self-insured, rural

Structure of OOP expenditures at hospital level

- 76.5 percent had an OOP expenditure for any category while hospitalized
- 61.9 percent paid for transportation
- 52.0 percent had to buy additional medicines to those provided in the hospital
- 35.1 percent has other expenditures while in hospital
- 16.9 percent paid for lab tests and imaging
- 16.3 percent paid for physician consultation
- 15.1 percent paid for medical procedures
- 10.6 percent paid for surgery
- 1.4 percent (5 respondents) paid in-kind for some part of treatment

For those who paid out-of-pocket for any category of expenditures (n = 287 or 76.5 percent), the average expenditure for the last case of illness treated in hospital was 980.7 MDL (range 2–25,800 MDL, st. dev. 2,136.5 MDL, median 300 MDL). The distribution of frequency and average amounts of OOP expenditures by categories provided in the table below.2

In terms of size of OOP expenditures, largest expenditure was related to surgery at 2,635 MDL, but should be interpreted with caution given the small sample. The second largest value of expenditure was related to treatment procedures, at 692.3 MDL, with the same caveat of small sample size. Third category, "other expenses", were on average 646.3 MDL, of which 51.6 percent were expenses related to medical supplies, and 29.4 percent was food (other goods 26.2 percent and linen 6.3 percent). The fee for physician consultation was highest at hospital level, at 460.6 MDL (st. dev. 1,252 MDL, median 100 MDL). Expenditures related to lab tests and imaging amounted to an average 418.9 MDL (caution given small sample size) and transportation was on average 136.4 MDL.

Table 21: **Out-of-pocket expenditures at last episode of illness treated in hospital**
Percent of household population distribution by frequency and amount of OOP expenditures at last episode treated in hospital (formal and informal), Moldova 2012

Type	percent who paid, %	Moldovan Lei					
		Minimum	Maximum	Mean	Std. Deviation	Median	Number
Transportation	61.9	2	2,000	134.4	258.7	50	232
Consultation	13.6	11	9,000	460.6	1,252.8	100	51
Lab tests and imaging	12.8	10	2,500	(418.9)	(551.4)	215	48
Treatment procedures	11.3	20	5,000	(692.3)	(1,015.2)	300	42
Surgery	9.7	85	15,000	(2,635.0)	(3,073.6)	2,000	36
Other (linen, food etc)	33.6	10	4,300	646.3	648.3	500	126
Average total	**76.5**	**2**	**25,800**	**980.7**	**2,136.0**	**300**	**287**

The breakdown by region, area, wealth, health insurance status, children in household and disease profile have shown very few meaningful differences by the occurrence and size of the following categories OOP expenditures: consultation, lab tests and imaging, surgery and treatment procedures, and were excluded from presentation of results in the table below. The few categories that had meaningful results: OOP for transportation, medicines and other expenditures, are still limited in comparison given the small sample size but are included in the table.

Only the overall costs have sufficient sample size to be look into differences by background characteristics. One finding is that health insurance provides some protection in case of hospitalization, as the size of OOP was lower compared to those without health insurance coverage (892.3 MDL in insured compared to 1,604.4 MDL in the uninsured). Also, the amount of OOP for households with children is less than that of households

2 The question asking how much was paid for medicines was excluded from the final version of the questionnaire.

without children (549.3 MDL in households with children compared to 1,050 MDL in households without children).

Table 22: **Frequency and amounts of OOPs at last episode of illness treated at hospital level**
Frequency and value of OOP expenditures of household population distribution by region, residence, wealth, health insurance coverage, having children and disease profile at last episode of illness treated at hospital level, Moldova 2012

		Paid for transport, %	Avge cost transport, MDL	Paid for medicines, %	Paid for other expenses, %	Avge cost other expenses, MDL	Paid anything, %	Average total	Number
Region	North	65.7	188.4	49.5	(25.4)	*	76.7	968.6	117
	Center	71.0	107.0	(59.9)	(48.8)	(836.6)	84.8	1009.0	80
	South	(57.4)	155.6	(49.3)	*	*	73.5	649.4	78
	Chisinau	(46.1)	43.0	(46.7)	*	*	66.1	1360.6	92
Area	Urban	53.4	77.1	53.5	32.1	627.0	70.4	1040.8	204
	Rural	67.1	162.1	51.2	36.8	656.5	80.1	948.7	163
Wealth index quintiles	Poorest	*	*	*	*	*	71.2	889.4	52
	Second	*	*	(55.9)	(43.3)	*	85.4	796.7	72
	Middle	(64.2)	(136.9)	(47.5)	*	*	78.0	867.1	77
	Fourth	61.1	201.7	(52.8)	*	*	75.1	1179.6	92
	Richest	(56.5)	(97.5)	(47.0)	*	*	69.5	1315.9	74
Health insurance coverage	Yes	61.6	133.5	51.9	34.1	541.9	74.7	892.3	329
	No	*	*	*	*	*	(88.7)	(1604.4)	36
Children in household	Without children	62.0	138.9	54.6	34.2	673.0	76.4	1050.6	315
	With children	*	*	*	*	*	77.0	549.3	52
Disease severity	Slight	*	*	*	*	*	*	*	15
	Moderate	64.9	144.2	50.2	(27.9)	(535.5)	73.4	827.7	122
	Severe	61.5	132.4	52.5	39.5	707.1	79.1	1090.5	229
Chronic illness	Yes	62.9	138.6	54.4	36.3	638.0	77.1	903.6	250
	No	59.4	127.8	47.8	33.0	664.5	74.9	1162.4	122
Total		**61.9**	**134.4**	**52.0**	**35.1**	**646.3**	**76.5**	**980.7**	**367**

Affordability of treatment provided in hospital

Some 32.5 percent of households stated that their income has fully covered treatment costs, 24.9 percent stated partial coverage and 39.6 percent stated that their income did not cover treatment costs at their last episode of illness treated at hospital. Significant differences were noted only be disease severity: 47.0 percent in those with severe forms compared to 29.1 percent of those with moderate forms of disease have mentioned their income did not cover the hospital treatment expenditures.

I have several illnesses. I used once health insurance to stay at the hospital and it only covered food, bed and a lot of crying.

Man, 42 years, unemployed, uninsured, 2 children, rural

My husband was very sick, we did not receive anything for free, I needed to buy very expensive antibiotics, he stayed for 7 years on and off in hospital. They did not even provide for a single injection for free.

Female, 45 years, insured, urban

The surgery costed us 300 euros. I noticed a change in attitude immediately. We borrowed the money, they were sent from abroad.

Male, 38 years, self-insured agricultural worker, rural, 4 children

My sister gave birth through a C-section, the attitude was fine, but at the end the doctor has written on a piece of paper 4000 MDL.

Male, 34 years Agricultural worker uninsured, rural

It is not worth it [buying health insurance coverage], if you have health insurance, noone will approach you, as the fly will not approach this glass.

Roma, uninsured, male, 19 years, rural

Average out of pocket treatment costs at any level of care at last episode of illness

A total 88.2 have incurred OOP expenditures while accessing health services, without major differences by region, area, wealth, disease type and severity and health insurance status. Detailed frequency and amounts of OOPs at any level of accessed care are presented in Table 23.

The average amount for OOP expenditures was 628 MDL, with significant differences by:

- Region: lowest in respondents from South at 513 MDL and highest in Chisinau at 726 MDL.
- Wealth: 485 MDL in lowest quintile compared to 720 MDL in highest quintile
- Health insurance coverage: 593 MDL in the insured and 832 MDL in the uninsured.
- Disease severity: 239 MDL in mild diseases, 500 in moderate forms and 906 in severe forms).
- Disease type: highest in those with oncological diseases 2440 MDL and OB/GYN conditions 1164 and lowest in respiratory conditions at 341 MDL.
- Having children: 688 MDL in households without children and 392 MDL in households with children

Table 23: **Frequency and amounts of OOPs at last episode of illness treated, any level**
Frequency and amount of OOP expenditures of household population distribution by region, residence, wealth, health insurance coverage, having children and disease profile at last episode of illness treated at hospital level, Moldova 2012

		Paid OOP, %	Average size of OOP, MDL	Number
Region	North	89.3	601	566
	Center	90.4	651	505
	South	85.2	513	324
	Chisinau	86.3	726	418
Area	Urban	86.6	662	764
	Rural	89.3	604	1048
Wealth index quintiles	Poorest	84.4	485	356
	Second	91.0	593	369
	Middle	90.3	645	353
	Fourth	86.7	690	358
	Richest	88.4	720	376
Health insurance	Yes	87.5	593	1540
	No	92.0	832	265
Children in household	Without children	88.4	688	1440
	With children	87.2	392	372
Disease severity	Slight	86.0	239	298
	Moderate	89.1	500	765
	Severe	88.4	906	738
Disease type	Heart disease	85.8	723	257
	Respiratory disease	88.7	341	681
	Gastrointestinal disease	88.3	913	168
	Gynecological/obstetrical disease	(90.5)	(1164)	30
	Oncological disease	(98.1)	(2440)	31
	Nephrological disease	86.5	517	90
	Osteo-articular disease	93.2	905	151
	Trauma	87.1	589	77
	Other	87.2	667	306
Chronic illness	Yes	89.1	660	1169
	No	86.7	569	634
Total		**88.2**	**628**	**1812**

A clear progressive trend was observed in the average amount of OOP expenditures by wealth index especially when people access specialist level of care (a 229% difference between poorest and wealthiest quintiles) and hospital care (148% difference between poorest and wealthiest quintiles), and insignificant differences for home-based treatment and PHC level of care. (Figure 8) This finding points to the fact that the size of specialist and hospital related OOP expenditures is dependent on the ability to pay.

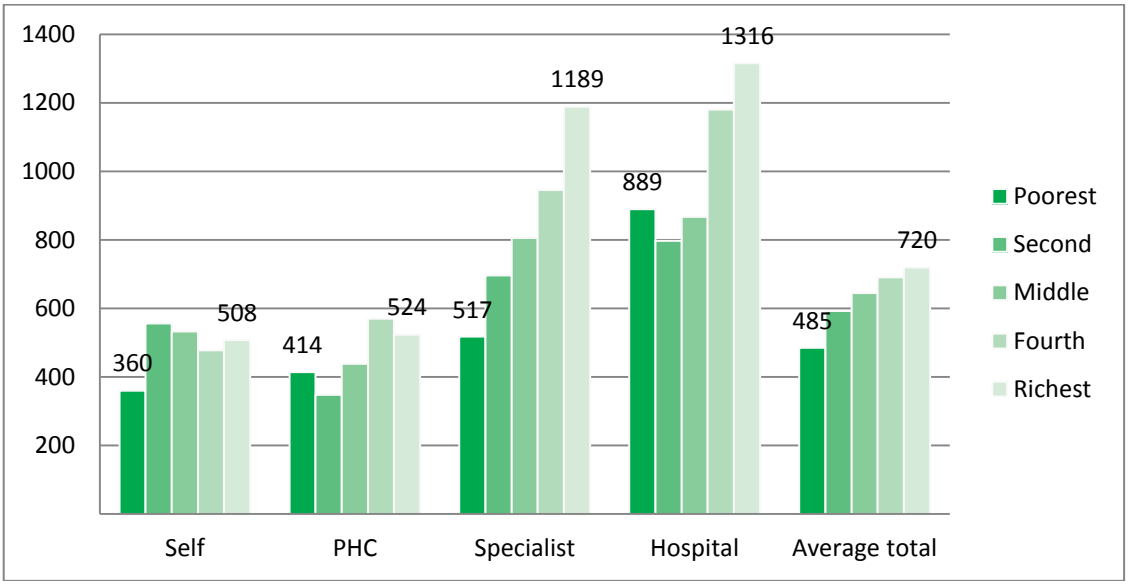

Figure 8: **Average amount of OOP by level of care and wealth index quintiles**
Percent of household population distribution by average amount of OOP when accessing every level of care and wealth index quintiles, Moldova 2012

Effective coverage with prevention services

2012 AHSS has assessed for the first time the cumulative coverage with preventive services in the 12 months preceding the interview. The first and the main point of entry for preventive services is the family doctor (93.5 percent) and only in a few cases this was a specialist (2.3 percent), a private provider (2.2 percent) or a hospital level provider (2.0 percent).

The majority of households has stated that they or eligible household members have been screened for blood pressure (78.6 percent), received a chest X-ray (67.8 percent), had a preventive physical checkup (65.9 percent), women and household members had eyesight screening (53.9 percent) in the past 12 months, with no major differences between urban and rural households. Less than half of respondents had the following preventive exams: ocular pressure check (33.2 percent), thyroid exam (29.9 percent) and immunizations (18.4 percent). No significant differences were observed between urban and rural residents (Table 24).

A higher share of women compared to men underwent yearly preventive examinations, with highest differences for physical exam (68.4 percent of women and 59.7 percent of men), thyroid exam (32.6 percent of women and 23.0 of men) and lower differences for blood pressure (80.2 percent of women and 75.0 percent of men).

By age, higher shares in the older age groups measured blood pressure (82.5 percent in 50–59 years age group and 80.5 percent in those 60 years or older), but still a high proportion had blood pressure checked in the young age groups as well: 72.0 percent in 15–24 years to 77.1 percent in the 40–49 years. Another observation across all preven-

tive checkups was that the age group over 60 year had a lower coverage with preventive checks compared to the age group 50–59 years.

Coverage with preventive services is in direct relationship to the socio-economic status, as 52.5 percent of households in the poorest quintile compared to 72.6 percent in the wealthiest quintile have had physical checkup, 72.2 percent of households in the poorest quintile versus 81.9 percent in the wealthiest quintile had blood pressure measured and 53.6 percent of poorest quintile versus 76.5 percent of households in wealthiest quintile had a chest X-ray in the 12 months preceding the survey. The same trend is observed for other types of preventive services. Health insurance coverage had a positive effect on prevention annual checks for nearly all preventive services with a difference of 10–20 percentage points.

Table 24: **Prevalence of accessed preventive services accessed**

Household population distribution by region, residence, wealth, health insurance coverage, having children and disease profile that has accessed preventive services in the past 12 months, Moldova 2012

		Prophylactic physical exam	Thyroid physical exam	Measure of visual acuity	Measuring blood pressure	Microradiography	Ocular tonometry	Other	Number
Sex	Male	59.7	23.0	51.0	75.0	66.1	30.3	9.2	3170
	Female	68.4	32.6	55.1	80.2	68.6	34.4	13.5	7998
Age	15–24	65.7	28.3	53.2	72.0	61.6	13.0	14.5	1048
	15–19	66.7	22.5	57.4	70.9	59.5	(12.0)	15.7	345
	20–24	65.3	31.2	51.1	72.5	62.6	13.5	13.9	703
	25–29	73.0	27.9	49.1	75.3	65.2	14.7	11.3	828
	30–39	69.6	31.2	48.4	76.6	68.3	18.5	12.2	1565
	40–49	68.7	33.2	52.2	77.1	71.5	32.8	13.0	1708
	50–59	69.9	33.3	61.0	82.5	75.0	45.2	12.7	2524
	60+	58.5	26.1	53.6	80.5	63.4	41.8	11.3	3493
Region	North	65.8	30.8	52.8	79.4	66.0	31.1	13.0	3708
	Center	67.1	29.8	54.2	79.0	66.9	32.9	11.5	3343
	South	62.6	26.3	52.4	76.4	65.7	33.2	11.9	2080
	Chisinau	67.4	31.8	57.0	78.8	74.4	37.2	12.2	2125
Area	Urban	68.8	31.9	57.8	79.4	74.0	36.8	12.7	4272
	Rural	64.1	28.7	51.5	78.1	64.0	31.0	11.9	6984
Education	None/primary	44.1	18.0	43.8	75.2	45.3	30.3	(6.4)	579
	Secondary	62.8	26.3	51.5	75.5	64.0	29.9	10.8	4754
	Professional education	70.6	33.5	56.1	81.7	73.8	37.9	13.7	3596
	Higher	72.3	35.9	59.8	82.6	74.9	34.6	15.0	2125
	Missing/DK	(38.0)	*	(30.9)	61.5	(27.6)	(13.5)	*	115
Ethnicity	Moldovan/ Romanian	66.3	30.4	53.9	78.5	67.4	32.2	12.3	8964
	Russian	66.9	30.1	55.0	79.2	69.6	40.3	10.7	577

		Prophy-lactic physical exam	Thyroid physi-cal exam	Mea-sure of visual acuity	Mea-suring blood pressure	Mi-crora-diog-raphy	Ocu-lar to-nom-etry	Oth-er	Num-ber
	Ukrainian	64.9	28.0	53.7	80.5	69.5	35.7	11.3	974
	Roma	69.7	*	(42.7)	75.4	67.3	*	*	66
	Gagauz	57.7	24.5	52.4	75.0	64.2	34.2	15.5	409
	Other ethnic group	66.7	30.8	59.3	79.3	75.3	45.4	(10.4)	265
Children in household	Without children	64.6	29.6	53.9	78.8	68.3	35.3	12.2	9599
	With children	73.4	31.4	54.1	77.3	64.9	21.3	12.2	1656
Wealth index quintiles	Poorest	52.5	20.4	44.2	72.2	53.6	27.0	8.3	2812
	Second	65.4	29.6	51.8	79.5	67.5	33.2	12.5	2211
	Middle	71.9	32.8	57.8	79.7	72.1	33.6	14.2	2114
	Fourth	71.8	32.9	59.3	81.9	74.5	38.1	14.0	2120
	Richest	72.6	37.2	60.1	81.9	76.5	36.3	13.4	1998
Health insurance coverage	Yes	69.3	32.1	58.5	83.1	72.6	38.0	13.0	8728
	No	54.1	22.2	38.0	63.1	51.5	16.7	9.7	2500
Total		**65.9**	**29.9**	**53.9**	**78.6**	**67.8**	**33.2**	**12.2**	**11256**

One has the right to get an annual checkup for free to any doctor at any health center. Also cars with equipment came to village to screen everyone for free.

Female, 32 years, insured, rural, unemployed, three children

Effective coverage: treatment outcome at last episode of illness

Although subjective by nature, the survey sought to measure treatment outcomes as perceived by those household members who have reported a recent episode of illness. Two positive outcomes were full and partial recovery after received treatment, negative outcomes were that the condition became chronic, a worsening of health status and disability as a result of the last episode of illness, and unknown outcome as those who were continuing treatment at the time of interview. A bit over half of household members have reported positive outcomes: a quarter (27.6 percent) has completely recovered from the disease, less than a third (31.1 percent) reported partial recovery. Negative outcomes were reported by 11 percent: 6.6 percent reported that the last illness became chronic, 4.4 percent reported disability or worsening of health status as the outcome of treatment of last episode of illness. About a third of patients (30.0 percent) had an unknown outcome of last illness, as they were continuing treatment at the time of interview.

Treatment outcome had a direct relationship with severity of illness at the time of seeking care ($p < 0.001$):

- Full recovery in 56.6 percent of those with slight forms of disease, 29.0 in those with moderate forms and 12.9 percent in household population with severe forms of disease

- Negative treatment outcomes (chronic, disability or worsening) in 1.4 percent of households with slight forms, 6.4 percent in those with moderate forms and 18.4 in those with severe forms of disease.

Socio-economic status was in inverse correlation with treatment outcome, as the following statistically significant differences ($p < 0.001$) were observed:

- Full recovery in 16.4 percent in the lowest quintile compared to 38.7 percent in highest quintiles
- Negative treatment outcomes (chronic, disability or worsening) in 18.5 percent of households in the lowest quintile compared to 4.4 percent in the highest quintile

Residence was in inverse correlation with treatment outcome, as the following statistically significant differences ($p < 0.001$) were observed:

- Full recovery in 21.1 percent of rural households compared to 31.8 percent of urban households
- Negative treatment outcomes (chronic, disability or worsening) in 12.1 percent of rural households compared to 8.9 percent of urban households.

Table 25: **Treatment outcome at last episode of illness**

Percent of household population distribution by treatment outcome at last episode of illness, Moldova 2012

		Complete recovery	Partial recovery	Got chronic	Worsening, disability, other	Continuing treatment	Number
Sex	Male	28.6	30.3	6.1	(3.8)	30.9	1220
	Female	26.0	32.3	7.2	(5.5)	28.6	762
Area	Urban	31.8	31.1	5.9	(3.9)	27.1	1194
	Rural	21.2	31.1	7.5	(5.3)	34.5	788
Wealth index quintiles	Poorest	(16.4)	34.3	*	*	30.1	286
	Second	15.6	34.3	*	*	36.8	321
	Middle	21.9	34.8	(8.5)	*	30.2	351
	Fourth	33.6	29.0	(7.0)	*	27.3	455
	Richest	38.7	27.1	*	*	28.3	569
Health insurance coverage	Yes	25.9	31.3	7.0	4.7	30.9	1642
	No	35.6	30.0	*	*	25.9	340
Disease severity	Slight	56.6	21.4	*	*	19.4	355
	Moderate	29.0	35.7	(5.2)	*	27.7	840
	Severe	12.9	30.5	10.5	8.8	37.1	773
Chronic illness	Yes	19.0	33.2	9.0	5.9	32.6	1262
	No	43.3	27.0	(2.4)	*	25.2	707
Total		**27.6**	**31.1**	**6.6**	**4.4**	**30.0**	**1982**

Comparative results 2000 AHSS and 2012 AHSS

Socio-demographics background comparison and disease profile is presented in Table 26 below.

Table 26: **Socio-demographic characteristics, AHSS 2000 and AHS 2012**
Percent of household population distribution by socio-demographic characteristics, Moldova 2000 and 2012

Background characteristics		2000	2012
Sex	Male	30.0	36.0
	Female	70.0	64.0
Age	0–29 years	14.1	39.3
	30–39 years	18.9	11.8
	40–49 years	23.1	11.9
	50–59 years	16.6	16.6
	60 or more years	27.1	20.4
Residency	Urban	42.1	38.3
	Rural	57.9	61.7
Education of the household head	None/other	8.3	6.0
	Secondary or less	31.9	40.2
	Lyceum or college	59.7	35.6
	University or more	N/A	16.8
	Missing	0.1	1.5
Household size	1–2 members	17.0	25.1
	3–4 members	43.5	52.4
	5–6 members	32.8	20.9
	>6 members	6.6	1.6
Children in the household	With children		24.9
	Without children		75.1
Type of last episode of illness	Cardio-vascular	16.2	13.8
	Respiratory	17.8	38.2
	Gastrointestinal	13.3	9.3
	OB/GYN	4.3	1.6
	Oncologic	3.3	1.6
	Professional	0.2	NA
	Trauma	9.6	4.2
	Osteo-articular	NA	8.5
	Other	32.7	21.6
	Do not know	2.6	1.2

Last episode of illness

The same proportion of households have reported an episode of illness in the four weeks preceding the interview in 2012 compared to 2000: 17.8 percent in 2000 and 17.1 percent

in 2012. The trends of lower levels of reporting of an episode of illness mirrored the trends observed in 2000 AHSS, that rural households and those from poorer quintiles reported lower levels of a case of illness than wealthier and urban households, having a connection to anticipated experience of health seeking rather than a true occurrence of disease.

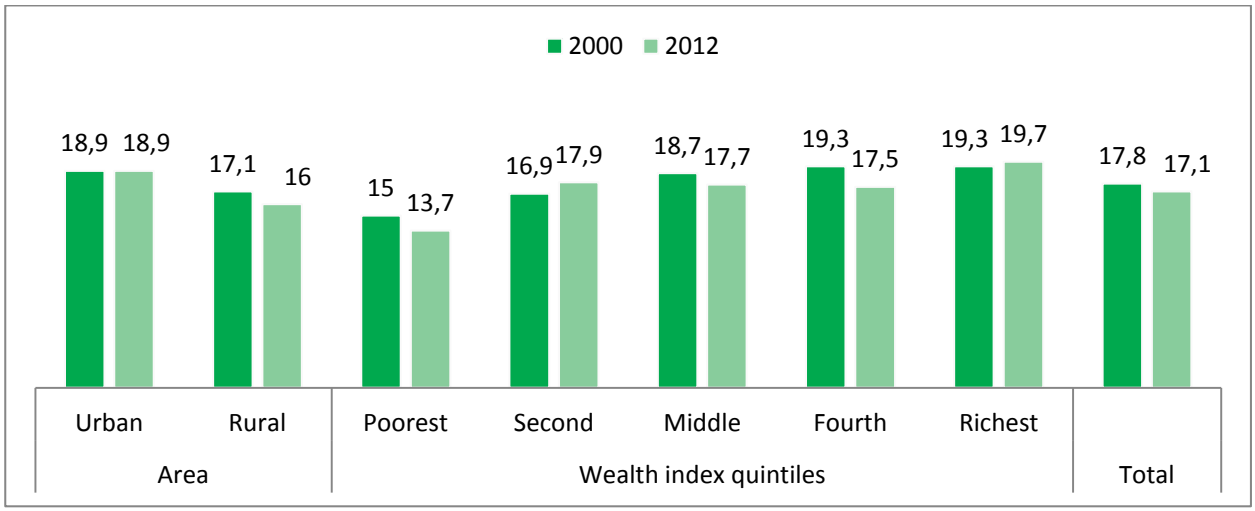

Figure 9: **Frequency of illness in the four months preceding interview, comparison years 2000 and 2012**

Distribution of household population by reporting an episode of illness of household members by area and wealth index, Moldova comparison 2000 and 2012

Geographic access

The general geographic access to health services has remained unchanged, as 97.1 percent of households lived within 5 km from the closest health facility in 2012 compared to 97.1 percent in 2000 and 96.4 percent in 2012 needing less than an hour to get to the closest facility compared to 93.5 percent in 2000.

At the same time, the breakdown by level of care showed a decrease in the share of households living within 5 km away from a health facility for all levels, including primary care, specialized outpatient and hospital care. Yet, the share of those who needed less than an hour to get to a health facility depending on the level has in general has increased, due to better access to faster and more affordable means of transportation compared to year 2000. Some 94.5 of households in 2012 compared to 85.0 percent needed less than an hour to get to the closest PHC facility, 74.2 percent of households in 2012 compared to 69.1 percent in 2000 needed less than an hour to get to a specialist and 80.1 percent of households in 2012 compared to 62.2 percent in 2000 needed less than an hour to get to a hospital, despite largest distances needed for specialist and hospital care (Table 27).

Table 27: **Geographic accessibility to health services, comparison years 2000 and 2012**
Distribution of household population by area who are at less than 5 km away from a health facility and need less than an hour to get to it, Moldova comparison 2000 and 2012

		PHC		Specialist		Hospital	
		2000	2012	2000	2012	2000	2012
<5 km	Urban	93.2	86.4	80.1	64.2	58.2	53.8
	Rural	82.3	86.2	26.2	15.4	16.3	7.5
	Total	87.0	86.3	59.6	43.9	34. 0	33.1
<1 hour	Urban	92.8	96.0	84.7	78.3	78.6	84.5
	Rural	79.2	92.8	43.7	68.7	50.2	74.5
	Total	85.0	94.5	69.1	74.2	62.2	80.1

Financial accessibility of health services

Compared to year 2000, general financial accessibility of health services has significantly improved, as 75.6 percent of respondents in 2012 compared to 44.1 percent of households in 2000 thought they had an adequate financial access to health services, 18.9 percent of households in 2012 compared to 40.0 percent in 2000 had partial financial access and some 5.3 percent of households had no financial accessibility in 2012 compared to 15.5 percent in 2000 (Figure 10).

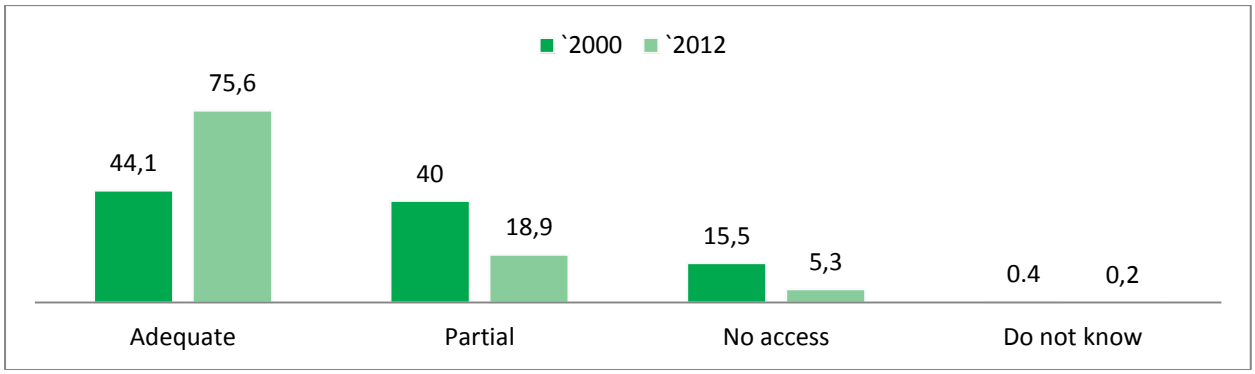

Figure 10: **General financial accessibility to health services, comparison years 2000 and 2012**
Distribution of household population by level of cumulative experiences of household members of financial accessibility of health services in 12 months preceding the interview, Moldova comparison 2000 and 2012

The same trend was observed in financial accessibility at last episode of illness, a significant increase in adequate financial access from 50.6 percent in 2000 to 82.7 percent in 2012 and a significant decrease in those not able to access health care at last episode due to anticipated costs: partial inaccessibility from 30.4 percent in 2000 to 9.2 percent in 2012 and absolute inaccessibility from 18.5 percent in 2000 to 8.1 percent in 2012 (Figure 11).

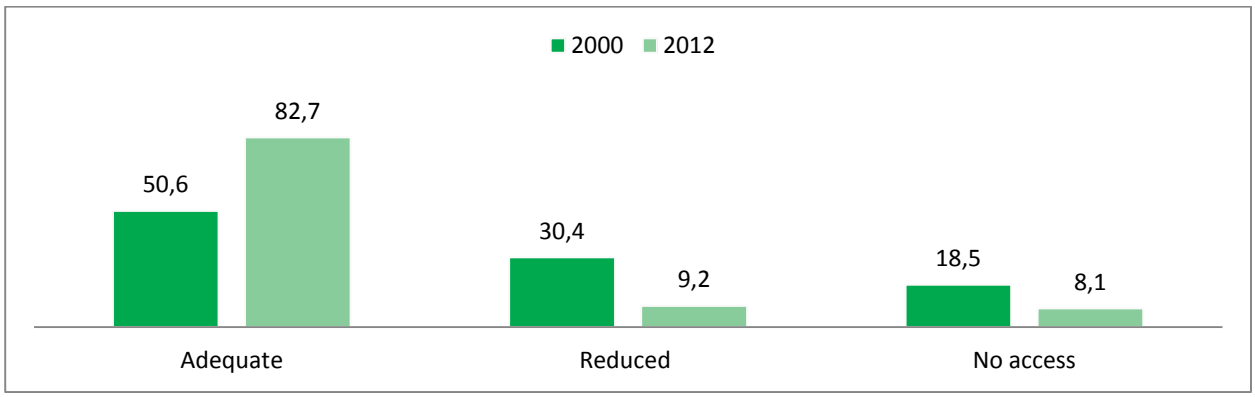

Figure 11: **Specific financial accessibility to health services at last episode of illness, comparison years 2000 and 2012**

Distribution of household population by level of cumulative experiences of household members if they had to renounce accessing health services due to anticipated costs, Moldova comparison 2000 and 2012

The comparison by wealth index has shown that financial accessibility has significantly increased for poorer quintiles: if in 2000 around a third of households had adequate financial access (27.9 percent in 12 months and 36.2 percent at last episode), it has more than doubled in 2012 (62.7 percent in 12 months and 74.3 percent at last episode). The wealthiest quintile has seen a similar increase in financial access from 53.4 percent in 2000 to 85.5 percent in 2012 for general financial access and from 55.1 percent in 2000 to 91.8 percent in 2012 at last episode. By residence, improvement in financial accessibility have benefitted both urban and rural residents, but the difference is still maintained and lower percentage of rural households have adequate financial accessibility compared to urban households. A positive trend was also observed in the share of respondents who have sought care at last episode from 88.0 percent in 2000 to 94.6 percent in 2012. General and specific financial accessibility to health services by years is presented in Table 28.

Table 28: **General and specific adequate financial accessibility to health services, comparison years 2000 and 2012**

Distribution of household population by area and wealth index quintiles who have adequate general and specific financial access, Moldova comparison 2000 and 2012

		12 months		Last episode of illness	
		2000	2012	2000	2012
Area	Urban	48.1	78.5	53.4	86.7
	Rural	41.1	73.8	48.4	77.9
Wealth index quintiles	Poorest	27.9	62.7	36.2	74.3
	Second	38.5	72.9	47.6	78.5
	Middle	51.2	80.7	53.4	82.7
	Fourth	49.4	81	57.3	86.6
	Richest	53.4	85.5	55.1	91.8
Total		**44.1**	**75.6**	**50.6**	**82.7**

Level of care accessed at last episode of illness

No significant differences were observed as to the level of care accessed at last episode of illness between the two surveys. In fact, there was a surprising stability in the level of accessed primary, specialist and hospital care, despite the significant focus of health insurance on incentivizing use of primary care and enforcing its gate-keeping function and discouraging use of specialist and hospital-based care: 18.9 percent of household population in 2012 compared to 17.1 percent in 2000 went to PHC level, 9.3 percent in 2012 compared to 11.6 in 2000 went to specialist and the same proportion of 19.6 in 2000 and 19.3 in 2012 treated their illness in hospital. In addition, in 2012 a larger proportion of patients treated their last illness at home (37.7 percent in 2012 compared to 25.5 percent in 2000) and an unchanged percent of household members used self-medication (12.6 percent in 2012 compared to 11.6 percent in year 2000) (Figure 12).

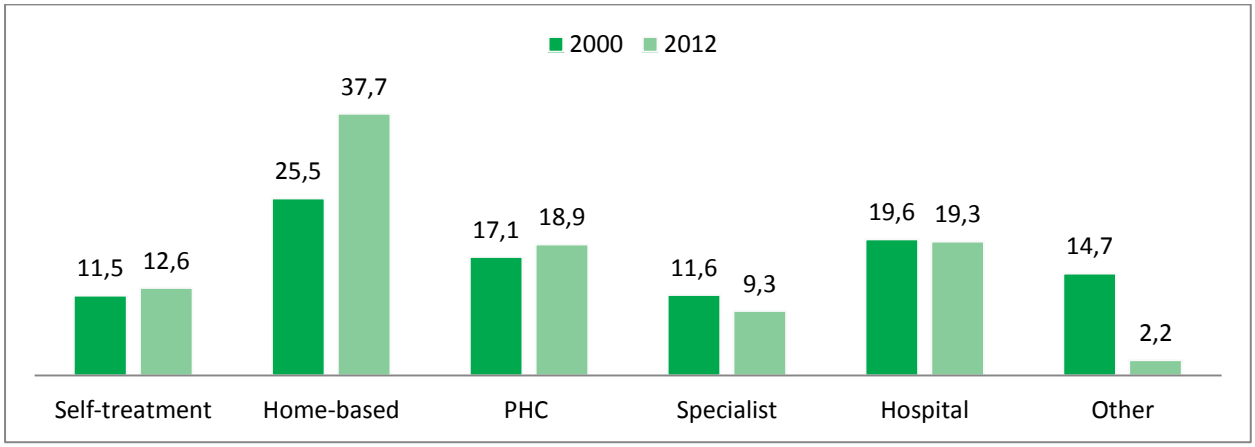

Figure 12: **Level of care accessed at last episode of illness, comparison years 2000 and 2012**
Distribution of household population by level of care accessed at last episode of illness in the four weeks preceding the interview, Moldova comparison data 2000 and 2012

OOP expenditures at last episode of illness

At PHC level, important differences were observed in frequency of OOP payments made, with frequency of paying for consultation having decreased from 32.8 percent in 2000 to 5.5 percent in 2012 and the percent paying for laboratory tests having decreased from 33.4 percent to 14.3 percent. The amount of OOP expenditures for medicines have remained almost unchanged at 90.6 percent in 2012 compared to 96.3 percent, being the single most important OOP expenditure at PHC level and where access to medicines reimbursed by CNAM did not bring a significant effect on OOP. The total amount of OOP has also increased, an average 451 MDL in 2012 compared to 171 MDL in 2000, driven by the increased amount of OOP expenditure for prescribed medicines, an average 410 MDL in 2012 compared to 128 MDL in 20003. The average amount of OOP payments for lab examinations increased from 29 MDL in 2000 to 108 MDL in 2012, for consultation it

3 The exchange rate for 1 USD was on average 12.5 MDL in 2000 and 12.0 MDL in 2012.

increased from 10 MDL in 2000 to 125 MDL in 2012 and for transportation has increased from 4 MDL to 73 MDL.4

Table 29: **Frequency and amounts of OOP expenditures at last episode of illness treated at PHC level, comparison between 2000 and 2012**
Household population distribution by frequency and average amount of OOP expenditures by category, Moldova 2012 compared to 2000

	Paid, %		Amount, MDL	
	2000	2012	2000	2012
Transportation	29.1	21.7	4	73
Consultation	32.8	5.5	10	125
Medicines	96.3	90.0	128	410
Lab examinations	33.4	14.3	29	108
Medical procedures	NA	6.7	NA	285
Average total	**NA**	**90.6**	**171**	**451**

At outpatient specialist level, important differences were noted in frequency of OOP payments made, the percent of households paying for laboratory tests having increased from 23.8 percent to 34.3 percent, frequency of paying for consultation having decreased from 51.3 percent in 2000 to 39.5 percent in 2012, frequency for other expenditures including medical procedures decreasing from 23.8 percent to 16.1 percent, while the frequency of OOP expenditures for medicines remained unchanged, 92.8 percent in 2012 compared to 93.6 percent in 2000. At the same time, the total amount of OOP expenditures has significantly increased, being on average 856 MDL in 2012 compared to 212 MDL in 2000, driven by the increased OOP expenditure for prescribed medicines, an average 611 MDL in 2012 compared to 150 MDL in 2000. The average amount for lab examinations increased from 21 MDL in 2000 to 261 MDL in 2012, expenditures for consultation increased from 13 MDL in 2000 to 119 MDL in 2012 and for transportation from 12 MDL to 119 MDL.

Table 30: **Frequency and amounts of OOPs at last episode of illness treated at outpatient specialist level, comparison between 2000 and 2012**
Household population distribution by frequency and average amount of OOP expenditures by category, Moldova 2012 compared to 2000

	Paid, %		Amount, MDL	
	2000	2012	2000	2012
Transportation	62.0	75.2	12	119
Consultation	51.3	39.5	13	119
Medicines	93.6	92.8	150	611
Lab tests	42.8	34.3	21	261
Medical procedures, other	23.8	16.1	16	560
Total	**NA**	**96.9**	**212**	**856**

4 It was not possible to compare data for self-treatment and home-based treatment due to differences in formulation of questions between AHSS 2000 and AHSS 2012.

At inpatient level, the frequency of OOP payments have seen the most changes compared to other levels of care, and the introduction of health insurance is likely to have produced most of the financial protection effects at hospital level. The frequency of making payment has decreased for the following categories:

- Medicines: form 94.6 percent in 2000 to 52 percent in 2012.
- Consultation from 42.0 percent in 2000 to 16.3 percent in 2012.
- Lab tests from 56.4 percent n 2000 to 16.9 percent in 2012.

As to the total amount of OOP expenditures, it has not significantly changed, at 981 MDL in 2012 compared to 846 MDL in 2000, with the caveat that in 2012 question on the size of OOP for medicines has been taken out from the questionnaire. For the following categories of OOP a significant increase was observed5:

- Lab examinations from 88 MDL in 2000 to 419 MDL in 2012.
- Consultation from 119 MDL in 2000 to 461 MDL in 2012.
- Transportation from 12 MDL in 2000 to 119 MDL in 2012.
- Other costs from 101 MDL to 648 MDL (driven by other medical supplies).

Table 31: **Frequency and amounts of OOPs at last episode of illness treated at inpatient level, comparison between 2000 and 2012**

Household population distribution by frequency and average amount of OOP expenditures by category, 2012 AHSS compared to 2000 AHSS

	Paid, %		Amount, MDL	
	2000	2012	2000	2012
Transportation	69.9	61.9	39	134
Medicines	94.6	52	397	N/A
Consultation	42	16.3	119	461
Lab examinations	56.4	16.9	88	419
Surgery	NA	10.6	NA	2635
Procedures	NA	11.3	NA	692
Other	NA	35.1	101	648
Average total	**NA**	**76.5**	**846**	**981**

5 New categories of expenditures that were not asked in 2000 with limited comparability are OOP expenditures for surgery and procedures, therefore with limited comparability.

DISCUSSION

Since the introduction of health insurance there has been growing concern that increased government funding has not translated into greater population coverage under the national health insurance. A study on access to health services has conducted a desk review on financial accessibility and has concluded that access to services has increased for insured population, but access to health services is still directly related to socioeconomic status. (WHO, 2012) The 2012 AHSS and its comparison to AHSS 2000 provided for a great opportunity to analyze if health insurance coverage has influenced access to health services and financial protection against catastrophic costs, as it provides comparable data a few years before introduction of mandatory health insurance and eight years after its introduction.

This section provides a discussion of findings from 2012 AHSS in the context of some of the similar surveys measuring access to health services, such as Health Module of the National Household Budget Survey (NHBS) and Access and Quality of Hospital Services in the Opinion of the Moldovan Population (AQHS).

Starting with 2008, data on use of health services has been collected every two years as part of the National Household Budget Survey conducted by the National Bureau of Statistics. So far, three rounds have been conducted in 2008, 2010 and 2012, and some of the information collected under this survey complements the information collected in AHSS, although with limited comparability given different formulation of questions. For example, the NHBS measures the frequency of OOP expenditures at different levels of care, but it does not capture measurement of amounts of OOP payments for services and medicines. Therefore, conducting the 2012 AHSS has the added value of providing more comprehensive information on financial access to care by any level. It would be useful to extend the NHBS Health module to track the amount of private household expenditures for at all levels of health services, in order to understand how affordability of health services evolves.

Starting with 2011, the PAS Center conducted AQHS on a biannual basis by PAS Center under its Health Monitor Initiative. While AQHS goes into details of both financial accessibility, acceptability, quality of care and outcomes of hospital stays in great detail based on a national sample of people hospitalized in the last 12 months, the 2012 AHSS brings the value of having captured a few dimensions not measured by AQHS, such as variables of average travel time and waiting time between referral and hospital admission and data on OOP expenditures comparable to other levels of care. The different methods are complimentary, as the AHSS gives a good cross-sectional summary every decade, while the more detailed and hospital-focused AQHS provides a better and more sensitive measuring of trends in the hospital on a biannual basis.

Renouncing to health services because of anticipated costs

As described in the section on comparative data between the AHSS conducted in 2000 and 2012 both general financial accessibility of health services and specific accessibility at last episode has significantly improved. The comparison by wealth index has shown that financial accessibility has significantly increased across all quintiles, with a larger increase for lower quintiles compared to wealthier quintiles. Although general financial accessibility have benefitted both urban and rural residents, still lower percentage of rural households have adequate financial accessibility compared to urban households.

The NHBS data support these findings about increase in financial accessibility between the three rounds of household surveys conducted in 2008, 2010, 2012, measured by a the question of renouncing to health care for PHC/specialist and hospital services separately in the past 12 months. According to the results, 25.4 percent of respondents in 2008, 19.2 percent in 2010 and 28.5 percent in 2012 did not access primary or specialized outpatient health care when needed. Of those who did not seek health care when needed, 29.2 percent in 2008 and 20.9 percent in 2010 and 14.8 percent in 2012 did not do so because of anticipated costs related to visiting a health institution, the main reason to renouncing to a visit being to use the medicines prescribed (64.0 percent in 2012). The urban rural difference is maintained, as only 6.2 percent of urban household members compared to 22.3 percent of rural respondents have renounced seeking care because of anticipated costs. Renouncing to a visit to PHC or specialist also is in direct relationship with quintiles, the number of people renouncing to a visit increasing from 21.1 percent in lowest quintile to 34.8 percent in highest quintile, pointing again to the fact that the reasons to renounce to care are not necessarily linked to financial access and actual need in health services. As to hospital level, only 3.8 percent in 2012 compared to 5.6 percent in 2008 have renounced to a hospital admission. At the same time, the main reason to not seek hospital admission when needed is the financial reason in 62.7 percent of cases in 2012 (NBS, 2009, 2011, 2013).

Table 32: **Renouncing to seek health services in AHSS and NHBS**
Percent of household members who renounced to health services by residence and health insurance coverage, AHSS 2000, 2012 and NHBS 2012 (recall period 12 months)6

	AHSS 2000	AHSS 2012		NHBS 2012	NHBS 2012
	Any health service			PHC	Hospital
Urban	51.5	21.2		31.2	2.7
Rural	58.6	25.9		26.6	4.5
Insured	NA	23.5		27.8	4.1
Uninsured	NA	26.4		30.8	2.9
Total	**55.5**	**24.2**		**28.5**	**3.8**

6 Data presented in the table is not directly comparable, because the question was applied to any level of care in AHSS and for PHC/specialist and hospital care in NHBS.

Out of pocket expenditures for health services

While there is evidence that overall financial accessibility and financial protection improved, the data from different sources demonstrate that the frequency of OOP expenditures have not decreased and the financial protection is mostly related to the overall economic improvement than health reforms. Moreover, the amounts of OOP have significantly increased over time, driven by the increasing expenditures on medicines and diagnostic tests, as evidenced by cross comparison of AHSS 2000 and 2012 data in the section above.

This data is supported by a cross country comparative survey conducted in 2001 and repeatedly 2010 showed that in Moldova, some 36.6 percent made OOP payments for outpatient services, 29.0 percent made OOP payments for inpatient services, 91.2 percent had to pay for drugs costs and 93.4 percent paid for transportation costs. Thus, an overall 96.3 percent had to make OOP payments in various forms (Balabanova et al., 2012). The size of OOP expenditures placed the Republic of Moldova second highest after Georgia.

NHBS collected data on direct OOP using a different method, estimating the total monthly health expenditure then attributing to different levels of care, but the trend is similar: an increase in the total health expenditure from 94.1 MDL/person/month in 2008 to 107.7 MDL/person/month in 2012, of which 64.4 percent in 2008 and 62.0 percent in 2012 were expenditures on pharmaceuticals.

The 2012 AHSS has shown that health insurance coverage does not provide sufficient financial protection when it comes to PHC, specialist and most importantly coverage of pharmaceutical expenditure, but that health insurance coverage has had the most effect on improving access to hospital services. The most recent 2012 NHBS concludes that those with health insurance have on average higher expenditures for health than those without health insurance, driven by higher need in health services of the insured population, but also by the pharmaceutical expenditures that are not covered by health insurance (65 percent of all expenditures in those insured were for pharmaceuticals compared to 49 percent in the uninsured). NHBS has also evidenced the best financial protection provided by health insurance coverage at hospital level, as the total expenditure for the last hospital admission was 769 MDL in the insured and 1263 MDL in the uninsured, which is consistent with the findings of 2012 AHSS.

The percent of those reporting to have incurred OOP expenditures in hospital was 76.5 percent in 2012 AHSS compared to a similar 72.0 percent in 2012 NHBS. 2013 AQHS has reported a different percentage, some 17.8 percent of respondents having paid formal OOP payments to the hospital, and another 37.1 percent of respondents having made informal OOP payments. Of note is that the results are not directly comparable given different structure of questions: AHSS 2000 and 2012 has asked for the total amount of OOP by category and then asked for breakdown between formal and informal payments, whereas 2013 AQHS asked separate questions about formal payment and informal payments. There was also a difference in listed expenditure categories, with a more detailed list in 2013 AQHS and finally there was a difference in recall period: 12 months for 2013 AQHS and 4 weeks for 2012 AHSS.

The most frequent in-hospital expenditure category was for medicines, and 52.0 percent of hospitalized household members according 2012 AHSS had to pay for medicines out of pocket in addition to those provided by the hospital (recall period 4 weeks) compared to 40.5 percent who had to pay out of pocket for medicines based on 2013 AQHS (recall period 12 months) and 40.5 percent who had to buy additional medicines based on 2012 NHBS (recall period 12 months). Results are sufficiently convergent and consistent.

Hospital services are the best documented area for absolute value of direct payments because of consistent comparability. The average value of OOP payments in cases of hospitalization has increased from 400 MDL in 1997 (UNICEF, 1997) to 846 MDL in 2000 (Berdaga, Stefanet & Bivol, 2001) and to 981 MDL in 2012 (with the limitation that OOP for medicines was omitted from questionnaire). The average size of overall OOP expenditures was higher based on 2013 AQHS, at 1571 MDL (formal at an average 1968 MDL and informal at an average 1166 MDL) compared to 980.7 MDL based on 2012 AHSS.

The OOP payments size is related to a household's financial capacity. Households from the highest quintile spent on average 8.3 times more for health than the lowest quintile. Catastrophic expenditures are registered in all income groups. The most vulnerable households are those with retired people (Ursu, 2010). NHBS 2012 also shows this trend in size of OOP expenditure related to financial capacity of the household, as the average OOP expenditure for hospital admission was 588 MDL in poorest quintile compared to 1429 MDL in the wealthiest quintile.

Contact with health services and gate-keeping functions of primary care

The 2012 AHSS has found that patterns of seeking health care have not changed over time in terms of the level of care accessed, despite the expectation that with the introduction of PHC and financial incentives to decrease use of specialist and hospital services, the structure of accessing different levels of care should have changed.

Data of NHBS on level of accessed care is not directly comparable because of a different approach to assess it.7 However there are some consistent trends observed that allow to make the conclusion that Moldovan users of health services continue to value specialist care and disapprove of primary health care's gatekeeping function for referrals to specialist care and hospital care. For instance, the 2012 NHBS data shows that the share of those accessing directly specialist provide in the uninsured is higher compared to the insured (35.5 percent compared to 27.1 percent) and they bypass primary care providers (49.5 percent in the uninsured compared to 64.0 percent of the insured went to their family doctor). The same is observed by quintiles, as the percentage of those accessing specialist-provided care is in direct relationship to wealth.

7 The AHSS has asked the level of health facility who provided the treatment by the following categories: self-treatment, home-based treatment, PHC, outpatient specialist and hospital, while NHBS has asked about the provider accessed (family doctor, specialist, pharmacists, dentist) and the type of facility: home-based treatment, health post/health office, health center and hospital and omitting the specialized outpatient services.

Primary care does has not been as effective as anticipated as a gatekeeper for access to hospital services, as people bypass it by using self-referral and emergency hospital admission in large proportions, as evidenced by both AQHS and AHSS8:

- 42.0 percent of hospitalized person had a referral from a family doctor (2012 AHSS) compared to 35.8 percent (2013 AQHS).
- 21.0 percent of patients were admitted by using an ambulance (2012 AHSS) compared to 56.1 percent (2013 AQHS).
- 0.5 percent by referral from an outpatient-based specialist (2012 AHSS) compared to 13.8 percent (2013 AQHS).
- 24.5 percent have self-referred (2012 AHSS) compared to 13.3 percent (2013 AQHS).

The focus groups discussions have shown that people who have the ability to pay access directly hospital care and specialist care that they perceive as higher quality, by using facilitation fees, while those insured are using the formal referral patterns and have a higher dissatisfaction with waiting time and quality of care at PHC level.

The doctor from the district knows the doctor who performed the surgery. I paid 300 lei to the district doctor to get a referral to the hospital.

Male 34 years, self-insured agricultural worker, uninsured, male, rural, 4 children

If health services are quality services, they are very expensive but we cannot afford all the necessary expenses for good lab tests and good doctors, so we go instead to our primary care doctor.

Female, 25 years, mother of two children and student, rural, on welfare

8 There is a difference in the response distribution by referral mode to hospital admission, probably related to a different recall period (12 months for AQHS and 4 weeks for AHSS).

KEY FINDINGS

1. A half of population have chronic illness with higher shares among women, poorer quintiles and elder.

2. More than two-third of population have sought health care for their chronic condition in the past 12 months; the highest seeking behaviour has been registered among women, from the Center region and insured households.

3. Geographic access is high in Moldova; majority of households live at a distance less than 5 km and it takes less than an hour to get the closest health facility; no significant differences between regions and urban and rural residence.

4. Health insurance coverage is still a challenge in Moldova; most un-insured people are outside the capital city, have low education level, leave in rural area, poor, in age between 15–49 and from households with children; the reasons not to have health insurance are unemployment and self-employment.

5. Information on the benefit package under health insurance continues to be limited; only a third of population know about universal coverage with basic primary and emergency care; the mechanisms to provide health insurance to beneficiaries of the social support based on the Law on Social Support (Ajutorul Social) do not work well.

6. About one fourth of population experienced at least one episode of not seeking health care due to anticipated costs; health insurance coverage does not ensure fully adequate financial access.

7. The absolute majority of population had out-of-pocket expenditures, primarily for medicines, diagnostic and laboratory costs and treatment interventions, and for medical consultations at home; health insurance coverage did not provide significant financial protection to cover costs of medicines.

8. Half of population could not afford to cover full treatment costs out of their income, primarily those from outside Chisinau and poor; there is high level of catastrophic costs related to sever disease cases.

9. There is satisfactory coverage with preventive services, with differences by gender, age and socio-economic status; the first and the main point of entry for preventive services is the family doctor, only in a few cases this was a specialist or a hospital level provider; health insurance coverage had a positive effect on prevention annual check-ups

10. Comparative data between the 2012 AHSS and 200) demonstrate:

a. A significant improvement in general and specific financial accessibility of health services and that it has significantly increased across all quintiles, with a larger increase for lower quintiles compared to wealthier quintiles.

b. At the same time, the frequency of OOP expenditures has not decreased and the financial protection is mostly related to the overall economic improvement.

c. Health insurance coverage does not provide sufficient financial protection when it comes to pharmaceutical expenditure at primary and specialist level, but that health insurance coverage has had the most effect on improving access to hospital services.

d. The patterns of seeking health care have not changed over time in terms of the level of care accessed, despite the expectation that with the introduction of PHC and financial incentives to decrease use of specialist and hospital services, the structure of accessing different levels of care should have changed.

e. The users of health services continue to value specialist care more and disapprove of primary health care's gatekeeping function for referrals to specialist care and hospital care: primary care does has not been as effective as anticipated as a gatekeeper for access to hospital services, as people bypass it by using self-referral and emergency hospital admission in large proportions. At the same time, people who have the ability to pay directly to access hospital care and specialist care perceive as higher quality while those insured are using the formal referral patterns and have a higher dissatisfaction with waiting time and quality of care at PHC level.

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ANNEX 1. QUESTIONNAIRE

QUESTIONNAIRE ON THE ACCESS OF POPULATION TO HEALTH SERVICES
[MOLDOVA]

This questionnaire is to be administered to the head of the household or any other adult (age over 15) member of the household

MODULE I. ACCESSIBILITY OF HEALTH SERVICES AHS		
AHS1. Cluster number: __ __ __	AHS2. Household number: __ __	
AHS3. Respondent name and line number from HHs listing form _____ __ __	AHS4. Interviewer name and number _____ ___ ___	
AHS5. Editor (Name and number) Name ___ ___	AHS6. Supervisor (Name and number): Name ___ ___	
So I want to discuss health services and your and household members' health status. All information will be kept strictly confidential. Again, all the information we obtain will remain strictly confidential and your answers will never be shared with anyone other than our project team.		
AHS7. Interview result	Completed ..... 1 Partly completed ..... 2 Not at home..... 3 Refused..... 4 Other (*specify*) _____..... 6	
AHS8. Record the time.	Hour and minutes __ __:__ __	
AHS9. How far is **the nearest** health facility?	Less than 5 km ..... 1 More than 5 km ..... 2 DK..... 8	
AHS10. How much time do you **usually** spend to get to your General Practitioner / Family Doctor?	Up to 1 hour..... 1 1–2 hours ..... 2 More than 2 hours 3	
AHS11. When somebody from the household fells ill last 12 months, does the price for the treatment (transportation, drugs, consultations, examinations, etc) **keep you** or other HH member **from** applying for treatment?	No..... 1 Partially..... 2 Yes, always ..... 3 DK..... 8	
AHS12. Do you hold a health insurance issued by the National Medical Insurance Company?	Yes ..... 1 No..... 2 DK 8	1=>AHS14 8=>AHS14

AHS13. Why you do not hold a health insurance provided by MHIC? *Encircle only one code for the response*	I am not working ..... 01 I am an informal worker ..... 02 I work outside the country ..... 03 I'm agricultural worker ..... 04 I am self-employed ..... 05 I do not feel it is necessary/I'm healthy ..... 06 I cannot afford/too expensive ..... 07 I will have to pay for health care, so it is useless ..... 08 I have a different type of health insurance .... 09 Other (*specify*)_____ 96 DK 98	
AHS14. Do you know what health services are covered by your health insurance?	Yes, fully ..... 1 Partially ..... 2 No 3	
AHS15. Are you aware that since 2010 you are entitled to a basic package of services at Primary Health Care (Family Medicine) regardless of your health insurance status?	Yes ..... 1 No ..... 2 DK what it is 8	
AHS16. Are you aware that persons eligible for social assistance under the law on social support are also entitled to state-paid health insurance?	Yes ..... 1 No ..... 2 DK what it is 8	

AHS17. Which of preventative exams have you and household members undertaken during last 12 months?

	Y	No	DK
[A] Prophylactic physical exam	1	2	8
[B] Thyroid physical exam	1	2	8
[C] Breast exam (women over 20 years)	1	2	8
[D] Measure of visual acuity	1	2	8
[E] Measuring blood pressure	1	2	8
[F] Microradiography	1	2	8
[G] Gynecologic exam (women over 20 years) ...	1	2	8
[H] Ocular tonometry (over 40 years)	1	2	8
[I] Vaccination	1	2	8
[X] Other (*specify*)_____	1	2	8

AHS18. *Check AHS17:*

☐ *If at least one answer is Yes (AHS17=A-X)=>continue with question AHS19*

☐ *If not => go to question AHS20*

AHS19. Where do you go for preventive services?	Health Centre, Family Doctor's Centre ..... 1 Medical professional, specialist ..... 2 Private health center ..... 3 Hospital 4	
AHS20. Do you have a chronic illness?	Yes ..... 1 No ..... 2 DK 8	2=>AHS24 8=>AHS24
AHS21. Which chronic illness do you have? *(multiple choices)*	Diabetes ..... A Hypertension ..... B Other cardio-vascular disease ..... C Respiratory disease ..... D Gastroenterological disease ..... E Oncological disease ..... F Kidney disease ..... G Neurological disease ..... H Osteo-articular disease ..... I Other (*specify*) _____ . X	
AHS22. Have you seek health care **in the last year** for the chronic illness that you have?	Yes ..... 1 No 2	1=>AHS24
AHS23. What was the reason for not seeking health care? *MULTIPLE RESPONSES POSSIBLE.*	Illness is not severe ..... A Have no pain / do not mind ..... B Not enough money ..... C Health Centre, Family Doctor's Office, hospital, etc., are too far from my locality ..... D It serves no purpose, treatment is ineffective for this disease ..... E Bad quality of services ..... F I do not trust physicians ..... G I do not hold health insurance ..... H Other (*specify*) _____ ... X	
AHS24. Have there been any cases of illness among household's members during **the last 4 weeks**?	Yes ..... 1 No ..... 2 DK 8	2=>TS43 8=>TS43
AHS25. Could you give me the name of the person who was the most recent ill during **the last 4 weeks**? *Note the name and the line number of the person from HH Questionnaire who was the most recently ill.*	Name:_____ Line No. _____ _____ *If the most recently ill person is not present =>TS43*	

MODULE II. TREATMENT OF LAST EPISODE OF ILLNESS TI		
Note: Module 2 is to be administered to a person (adult) who was sick last 4 weeks *or mother/ caregiver (in case of a child under 54) In case when above mentioned person(s) is not available the head of the household or any other adult (age over 18) member of the household will answer the questions. In case when there were several recent cases of illness (e.g. adult and child) the preference will be given to child. In case when there were several recent cases of illness the preference will be given to the most recent case.*		
TI1. Respondent Name _____	TI2. Sick person line number from HHs listing form HL1 __ __	
TI3. Did you/sick person hold a health insurance?	Yes .....1 No.....2 DK.....8	
TI4. What was your/sick person last episode of illness? _____ *Disease* *Encircle only one code for the response corresponding to the basic pathology.*	Heart disease..... 01 Respiratory disease ..... 02 Gastrointestinal disease ..... 03 Gynecological/obstetrical disease..... 04 Oncological disease..... 05 Nephrological disease..... 06 Osteo-articular disease..... 07 Trauma ..... 08 Other (*specify*)_____ ..... 96 Do not know the diagnosis..... 98	
TI5. What is your opinion about severity (seriousness) of the illness?	Slight .....1 Moderate .....2 Severe .....3 Do not know 8	
TI6. Please let me know about the outcome of the illness?	Complete recovery .....1 Partial recovery.....2 Disease became chronic.....3 Disability.....4 Worsening .....5 Other_____ .....6 Continuing treatment.....7 DK.....8	
TI7. Did the cost of transportation, drugs, consultations, analyses, etc. during the last episode of illness prevent you / sick person from seeking treatment?	No.....1 Partially.....2 Yes .....3 DK.....8	

TI8. Did you/sick person receive any treatment for this illness?	Yes .....1 No .....2 DK 8	1=>TI10 8=>TS4I
TI9. What were the reasons for you / sick person to not receive treatment? Name main reasons. *Encircle 3 top reasons for the response.*	Illness was not severe ..... A Not enough money .....B Health Centre, Family Doctor's Office, hospital, etc. are too far from my locality ..... C Serves no purpose, treatment is ineffective for this disease. ..... D Low quality of services .....E I do not trust physicians .....F I do not hold health insurance ..... G Other (*specify*)_____ ..... X DK .....Z	A=>TS43 B=>TS43 C=>TS43 D=> TS43 E=> TS43 F=> TS43 G=> TS43 X=> TS43 Z=> TS43
TI10. More specifically, where did you seek treatment for this illness?	Self-medication ..... A Treatment at home, with consultation .....B Treatment at Health Centre, Family Doctor's, emergency service ..... C Medical specialist ..... D At the hospital. .....E Private doctor .....F Private hospital ..... G Other (*specify*)_____ ..... X DK .....Z	
TI11. *Check TI10:* ☐ *If it is mentioned response A or/and B => continue with SM1* ☐ *If do not => go to SM16*		

MODULE A. SELF-MEDICATION OR TREATMENT AT HOME WITH CONSULTATION SM		
SM1. You said that you / sick person (*the name of the person who was most recently sick*) was treated at home. Who provided that treatment?	A member of the household who is not a medical professional .....1 Doctor .....2 Nurse .....3 Healer .....4 Other (*specify*) _____ . .6 DK 8	1=>SM3 4=>SM3 6=>SM3 8=>SM3

SM2. Did health insurance cover the cost of home visit and treatment?	Yes .....1 Partially .....2 No .....3 DK 8	1=>SM5
SM3. Did you / sick person have to pay anything in cash?	Yes .....1 No .....2 DK 8	2=>SM5 8=>SM5
SM4. How much did you / sick person pay in cash to the person who came to provide care at home? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ __ lei Informally __ __ __ __ __ lei	
SM5. Did you / sick person pay something in kind for the treatment or some part of treatment?	Yes .....1 No .....2 DK 8	2=>SM7 8=>SM7
SM6. What was the price of these goods, or what would they have cost you/sick person if you/or sick person had had to purchase them? *For refuse and choice "don't know" indicate 9998*	__ __ __ __ __ lei	
SM7. Did you took any drugs for this illness?	Yes .....1 No .....2 DK 8	2=>SM12 8=>SM12
SM8. Did your or sick person insurance cover the cost of drugs?	Yes, fully .....1 Partially .....2 No .....3 DK 8	1=>SM12
SM9. Did you or sick person have to purchase drugs for the treatment of discussed illness?	Yes .....1 No .....2 DK 8	1=>SM11 8=>SM12
SM10. What was the main reason to not purchase the drugs needed or not purchase all of them?	Not enough money .....1 We already had them .....2 We could not find them .....3 Other (*specify*) _____ .....6 DK 8	1=>SM12 2=>SM12 3=>SM12 6=>SM12 8=>SM12
SM11. How much did the drugs cost you/or sick person? *For refuse and choice "don't know" indicate 9998*	__ __ __ __ __ lei	

SM12. Did you/or sick person have any expenses other than those for consultation and drugs?	Yes .....1 No.....2 DK.....8	2=>SM15 8=>SM15
SM13. What kind of other expenses did you/ or sick person have/has?	Investigations ..... A Medical procedure..... B Other (*specify*)_____ X DK..... Z	Z=>SM15
SM14. How much did the other expenses cost you/or sick person? *For refuse and choice "don't know" indicate 9998*	__ __ __ __ lei	
SM15. Did your/or sick person income covers treatment costs?	Yes .....1 Partially.....2 No.....3 DK.....8	
SM16. *Check TI10:* ☐ *If it is indicated response C => continue with THC1* ☐ *If NOT => Go to THC24*		

MODULE B. TREATMENT AT THE HEALTH CENTER, FAMILY DOCTOR'S OFFICE THC		
THC1. You said that you or sick person went to the Health Centre, Family Doctor's Office, emergency to be treated for the illness. How far this health facility is? *(if the distance is less than 1 km indicate 000)*	__ __ __ km DK.....998	
THC2. What means of transportation did you or sick person use to get to the named facility? *Indicate only one principal means of transport facility.*	On foot .....01 Cart.....02 Bicycle or motorcycle .....03 Passing car .....04 Bus / route minibus .....05 Personal car .....06 Taxi.....07 Ambulance.....08 Other (*specify*)_____ .....96 DK.....98	01=>THC4 98=>THC4
THC3. How much did you/or sick person pay for transportation (round trip), including escorting expenses as well? *For refuse and choice "don't know" indicate 9998*	__ __ __ __ lei	

THC4. How long did it take you/or sick person to get to the facility?	__ __ hours __ __ min. DK.....9998	
THC5. How long did you or sick person wait **in line before you have been seen** at the Health Centre, Family Doctor's Office, emergency?	__ __ hours __ __ min. DK.....9998	
THC6. Did the doctor prescribes any drugs?	Yes ..... 1 No..... 2 DK..... 8	2=>THC11 8=>THC11
THC7. Did your or sick person insurance cover the cost of drugs?	Yes, fully ..... 1 Partially..... 2 No..... 3 DK..... 8	
THC8. Did you/or sick person have to purchase drugs for the treatment of discussed illness?	Yes ..... 1 No..... 2 DK..... 8	1=>THC10
THC9. For what **basic reason** did you/or sick person not purchase all or some part of the drugs needed? *Encircle only one code for the response.*	Not enough money..... 1 We already had them ..... 2 We could not find them ..... 3 Other (*specify*) _____..... 6 DK..... 8	1=>THC11 2=>THC11 3=>THC11 6=>THC11 8=>THC11
THC10. How much did the drugs cost you/or sick person?	__ __ __ __ lei DK.....9998	
THC11. Did family doctor refer you/or sick person to the specialist/hospital?	Yes ..... 1 No..... 2 DK..... 8	
THC12. Have you/or sick person got the specialist or hospital care?	Yes ..... 1 No..... 2 DK..... 8	1=>THC14 8=>THC14
THC13. What was **the reason** that you/or sick person didn't get specialist or hospital care?	Not enough money..... 01 Limited transportation ..... 02 The specialist is too far ..... 03 Illness was not severe ..... 04 I do not think it was necessary..... 05 Bad quality of services ..... 06 I am awaiting for an appointment..... 07 Other (*specify*) _____ ..... 96 DK..... 98	
THC14. Did you or sick person pay for family doctor consultation?	Yes ..... 1 No..... 2 DK..... 8	2=>THC16 8=>THC17

THC15. How much did you/or sick person pay for family doctor consultation? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ __ lei Informally __ __ __ __ __ lei	=>THC17
THC16. Why you/or sick person did not pay for consultation?	Health insurance covers the cost . . . . . 1 Everyone is entitled to PHC care regardless of health insurance . . . . . 2 I do not have money . . . . . 3 I do not think it is necessary . . . . . 4 Has not been asked . . . . . 5 Other reason (specify) _____ . . . . . 6 DK 8	
THC17. Did you or sick person pay for medical analyses and examinations?	Yes . . . . . 1 No . . . . . 2 DK 8	2=>THC19 8=>THC19
THC18. How much did you/or sick person pay for medical analyses and examinations? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ __ lei Informally __ __ __ __ __ lei	
THC19. Did you or sick person pay for medical procedures?	Yes . . . . . 1 No . . . . . 2 DK 8	2=>THC21 8=>THC21
THC20. How much did you/or sick person pay for medical procedures? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ __ lei Informally __ __ __ __ __ lei	
THC21. Did you/or sick person pay something in kind for treatment of some part of treatment?	Yes . . . . . 1 No . . . . . 2 DK 8	2=>THC23 8=>THC23
THC22. What was the price of these goods, or what would they have cost you/or sick person if you had had to purchase them? *For refuse and choice "don't know" indicate 9998*	__ __ __ __ __ lei	

THC23. Did your/or sick person income covers treatment costs?	Yes . . . . . 1 Partially . . . . . 2 No . . . . . 3 DK 8	
THC24. *Check TI10:* ☐ *If it is indicated response D and/or F => continue with TS1* ☐ *If NOT => Go to TS18*		

Module C. TREATMENT AT THE SPECIALIST AND HOSPITAL TS		
TS1. You said that you/or sick person went to the medical professional specialist to be treated for the illness. How far the specialist is? *(if the distance is less than 1 km indicate 000)*	In Moldova . . . . . __ __ __ km In other country . . . . . 996 DK 998	
TS2. Have you/or sick person been referred to specialist	Yes . . . . . 1 No . . . . . 2 DK 8	
TS3. What means of transportation did you/or sick person use to get to the medical professional specialist? *Indicate only one principal means of transport facility.*	On foot . . . . . 01 Cart . . . . . 02 Bicycle or motorcycle . . . . . 03 Passing car . . . . . 04 Bus / route minibus . . . . . 05 Personal car . . . . . 07 Ambulance . . . . . 08 Other (*specify*) _____ . . . . . 96 DK 98	01=>TS5 98=>TS5
TS4. How much did you/or sick person pay for transportation (round trip) during the course of treatment by a medical specialist? *Do not forget to include the escorting expenses as well.*	__ __ __ __ lei DK 9998	
TS5. How long did it take you/or sick person to get to the specialist?	__ __ hours __ __ min. DK 9998	
TS6. Did you or sick person pay for medical specialist consultation?	Yes . . . . . 1 No . . . . . 2 DK 8	2=>TS8 8=>TS8
TS7. How much did you/or sick person pay for medical specialist consultation? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ lei Informally __ __ __ __ lei	

TS8. Did you or sick person pay for medical analyses and examinations?	Yes ..... 1 No ..... 2 DK 8	2=>TS10 8=>TS10
TS9. How much did you/or sick person pay for medical analyses and examinations? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ lei Informally __ __ __ __ lei	
TS10. Did you or sick person pay for medical procedures?	Yes ..... 1 No ..... 2 DK 8	2=>TS12 8=>TS12
TS11. How much did you/or sick person pay for medical procedures? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ lei Informally __ __ __ __ lei	
TS12. Did you/or sick person pay something in kind for treatment at the medical specialist of some part of treatment?	Yes ..... 1 No ..... 2 DK 8	2=>TS14 8=>TS14
TS13. What was the price of these goods, or what would they have cost you/or sick person if you had had to purchase them? *For refuse and choice "don't know" indicate 9998*	__ __ __ __ __ lei	
TS14. Did you or sick person have to purchase drugs for the treatment of discussed illness prescribed by specialist?	Yes, fully ..... 1 Partially ..... 2 No ..... 3 DK 8	1=>TS16 8=>TS17
TS15. For what basic reason did you/or sick person not purchase all or some part of the drugs needed?	Not enough money ..... 1 We already had them ..... 2 We could not find them ..... 3 Other (*specify*) _____ ..... 6 DK 8	1=>TS17 2=>TS17 3=>TS17 6=>TS17 8=>TS17
TS16. How much did the drugs cost you/or sick person? *For refuse and choice "don't know" indicate 9998*	__ __ __ __ __ lei	

TS17. Did your/or sick person income covers treatment costs?	Yes ..... 1 Partially ..... 2 No ..... 3 DK 8	
TS18. *Check TI10:* ☐ *If it is indicated response E and/or G => continue with TS19* ☐ *If NOT => Go to TS43*		
TS19. You said that you/ or sick person went to hospital to be treated for the illness. How far the hospital is? *(if the distance is less than 1 km indicate 000)*	In Moldova ..... __ __ __ km In other country ..... 996 DK 998	
TS20. What means of transportation did you or sick person use to get to the hospital? *Indicate only one principal means of transport facility.*	On foot ..... 01 Cart ..... 02 Bicycle or motorcycle ..... 03 Passing car ..... 04 Bus / route minibus ..... 05 Personal car ..... 07 Ambulance ..... 08 Other (*specify*)_____ ..... 96 DK 98	01=>TS22 98=>TS22
TS21. How much did you/ or sick person pay for transportation (round trip) to get the hospital? *Do not forget to include the escorting expenses as well.*	__ __ __ __lei DK 9998	
TS22. How long did it take you/or sick person to get to the hospital?	__ __ hours __ __ min. DK 8	
TS23. What level was the hospital where you/or sick person were treated? _____ *indicate the name of the hospital*	Republican ..... 1 Municipal ..... 2 District ..... 3 Private ..... 5 Other (*specify*) _____ ..... 6 DK 8	
TS24. Who referred you/or sick person to the hospital?	Family doctor ..... 01 Specialist physician ..... 02 Outpatient department of the hospital ..... 03 Relative/friends ..... 04 Self-referred ..... 05 Emergency/ambulance ..... 06 Transferred from another hospital ..... 07 Other (*specify*)_____ ..... 96 DK 98	05=>TS26 06=>TS26 07=>TS26

TS25. How long did you/or sick person wait for hospitalization day?	___ ___ days ___ ___ months DK.....9998	
TS26. How long did you/or sick person wait at the triage room?	__ __ hours __ __ min. DK.....9998	
TS27. Did you or sick person pay for doctor consultations in hospital?	Yes ..... 1 No..... 2 DK..... 8	2=>TS29 8=>TS29
TS28. How much did you/or sick person pay for doctor consultation? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ lei Informally __ __ __ __ lei	
TS29. Did you or sick person pay for medical analyses and examinations in hospital?	Yes ..... 1 No..... 2 DK..... 8	2=>TS31 8=>TS31
TS30. How much did you/or sick person pay for medical analyses and examinations? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ lei Informally __ __ __ __ lei	
TS31. Did you or sick person pay for medical procedures?	Yes ..... 1 No..... 2 DK..... 8	2=>TS33 8=>TS33
TS32. How much did you/or sick person pay for medical procedures? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 9998*	Formally __ __ __ __ lei Informally __ __ __ __ lei	
TS33. Did you or sick person pay for surgery?	Yes ..... 1 No..... 2 No operation was performed..... 3 DK..... 8	2=>TS35 3=>TS35 8=>TS35
TS34. How much did you/or sick person pay for surgery? *If the respondent indicates the amount, specify how much he/she paid formally or informally* *For refuse and choice "don't know" indicate 99998*	Formally __ __ __ __ lei Informally __ __ __ __ lei	

TS35. Did you / sick person have/ has other expenses related to treatment during hospitalization?	Yes ..... 1 No ..... 2 DK 8	2=>TS38 8=>TS38
TS36. What kind of other expenses did you/sick person have?	Food products ..... 1 Linen ..... 2 Medical supplies ..... 3 Other goods (*specify*)_____ ..... 6 DK 8	8=>TS38
TS37. How much did you/or sick person pay for other expenses? *Refer to TS36* *For refuse and choice "don't know" indicate 9998*	__ __ __ __ lei	
TS38. Did you/or sick person pay something in kind for treatment of some part of treatment?	Yes ..... 1 No ..... 2 DK 8	2=>TS40 8=>TS40
TS39. What was the price of these goods, or what would they have cost you/or sick person if you/or sick person had had to purchase them? *For refuse and choice "don't know" indicate 9998*	__ __ __ __ lei	
TS40. Did you/or sick person have to purchase drugs for the treatment of discussed illness while in the hospital?	Yes ..... 1 Partially ..... 2 No ..... 3 DK 8	1=>TS42 8=>TS42
TS41. For what basic reason did you/or sick person not purchase all or some part of the drugs needed?	Received in hospital without any payment ..... 1 Not enough money ..... 2 We already had them ..... 3 We could not find them ..... 4 Other (*specify*) _____ ..... 6 DK 8	
TS42. Did your/or sick person income covers treatment costs?	Yes ..... 1 Partially ..... 2 No ..... 3 DK 8	
TS43. *Record the time.*	Hour and minutes __ __:__ __	