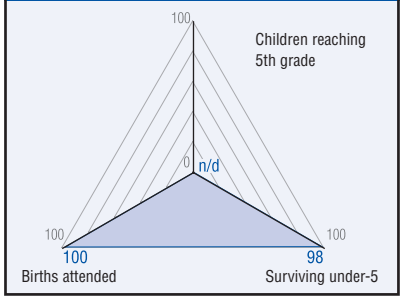
MOLDOVA

Old age pensions near the poverty line

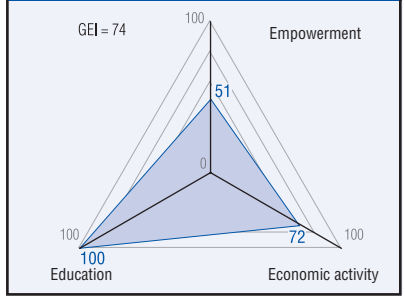
Despite comprehensive World Bank-supported reform of the public pension system, old age pensions remain very close to the poverty line. While current public expenditure on health care is significant compared to other former republics of the Soviet Union, the public health care system faces major challenges, including the loss of trained professionals to neighbouring countries. Meanwhile, community-based social services are being developed in partnership with civil society as an alternative to institutional services, especially for children and the elderly.

National Women´s Studies and Information Centre "Partnership for Development"
Diana Mocanu

Basic Capabilities Index (BCI)



Gender Equity Index (GEI)



The reform of the pension system was supported in large part by the World Bank's Social Protection Management Project. The social insurance system from the pre-transition period could not ensure protection for the people of Moldova, and the elderly and poor were among the most vulnerable. Among other things, the system suffered from a poor political framework, a weak administrative capacity, and a lack of understanding by society. The country's overarching economic challenges further undermined the system's sustainability.

In 1998, things began to change. That year, with the assistance of the World Bank and European Union, Moldova's long-term pension strategy was finalized and a new law on state social insurance pensions was adopted, establishing a correlation between social contributions and pension size.

In 1999, Moldova asked the World Bank for support in implementing comprehensive reforms of the public pension system and designing a new organizational structure for social insurance. The project included analysis, monitoring and evaluation of social policies; strengthening of social protection management by creating and implementing an integrated information system; and better public information.

As a result of the project, the capacity of staff in the Ministry of Labour and Social Protection has been increased considerably through training. Social protection policies are evaluated regularly, social reports are published yearly, and the Moldovan people are well informed about reforms through public information campaigns that utilize brochures, radio and television programmes, public service announcements, and newspaper articles to spread the word.

The organizational structure of the National Social Insurance House (CNAS) was improved, taking into account international best practice examples, and staff members have been trained accordingly. Both the CNAS central office and local offices have been furnished with the equipment needed to ensure that individual records of social insurance contributions are kept, and many offices have been renovated. Communications and internet networks have also been installed.

The results of the project are clear. The number of contributions to the state social insurance budget has increased and the budget income has also risen. Pension arrears have been settled, and pensions are now indexed yearly. Employees can more efficiently monitor the payment of contributions by employers. Public communication regarding social protection policies has also greatly improved, and as a consequence, the population is better informed about the connection between the sums of social contributions transferred and pension size.

However, in 2006 retirement pensions averaged MDL 457.51 (USD 38), reflecting a 15% increase compared to 2005 (MDL 397.18 – USD 33). This level is very close to the poverty line. In addition, the replacement rate (payment size as a percentage of last income) continued to decrease, falling to 27% in late 2006 from 30% in 2005.

Public health system faced with serious challenges

Access to quality health services is a key problem for Moldova. According to a national household survey, only 44.1% of the country's population has full access to health services, 40% has limited access, while 15% has no access to health services at all. This situation is largely explained by economic factors. For example, direct payments for health care services significantly exceed the 15% share of the health care budget recommended by the World Health Organization (WHO). The low wages of medical staff also affect the accessibility and quality of health services. The Public Opinion Barometer Surveys carried out during 2000-2003 indicated that as much as half of the population in the Republic of Moldova who benefited from hospital care had to pay additional unofficial fees for health care services.[1]

During the implementation of the 2004-2006 Economic Growth and Poverty Reduction Strategy Paper (EGPRSP), the development of the health care sector was marked by the extension of the primary health care network, the introduction of mandatory health care insurance, and an increase in state budget contributions, which amounted to 3.5% of GDP in 2006. Current public expenditure on health care is significant compared to other CIS[2] countries, but is 1.9 times less than in the EU countries. Currently, about 75% of the population of the country is covered by health care insurance and over 80% of the population has access to family doctors.

The strengthening of primary health care is still one of the priority strategic areas in the health sector. In 2006, the average number of visits to the family doctor stayed the same as in 2005, and was 3.3 visits for insured persons and 2.7 visits for uninsured ones. The share of doctors' visits corresponding to preventive health care was 21% for adults and 49.7% for children. As compared to 2005, requests for emergency health care services had increased by 3.8%, while in comparison with 2004 they had grown by 22.3%.

Over recent years, specific actions have been undertaken to strengthen primary health care institutions in rural communities. However, there are still many challenges facing the health care system. With the exception of facilities renovated through the Investment Fund for Health Care project, the infrastructure of primary health care institutions tends to fall considerably short of expectations. Only 91 of the country's 979 primary health care institutions

1 <ec.europa.eu/health-eu/doc/lgbt.pdf>

2 Commonwealth of Independent States, a loose federation of 11 former Soviet Republics.

have new health care vehicles, and numerous institutions are operating in deteriorated premises and urgently need capital repairs or relocation. For the most part, health care equipment is old and outdated, which results in insufficient use of high-performance technologies for diagnosis and treatment. The poor working conditions for health care staff and lack of opportunities to use modern diagnosis and treatment technologies spur young medical specialists to migrate abroad. This problem has become even more acute as a result of substantial increases in salaries for health care staff in neighbouring countries. The number of family doctors in Moldova in 2006 was 2,031, which represented a 1.7% decrease as compared to 2005.[3]

The country also faces significant gaps in health care access between the poor and non-poor, and between rural and urban populations. About 25% of the socially vulnerable population of working age, mainly concentrated in rural areas, has no adequate access to health care services due to financial difficulties and lack of transportation infrastructure, among other factors. These sectors of the population are not covered by the mandatory health care insurance system. For example, in rural areas, a poor household spends 28 times less on health care services than a prosperous one. Uninsured persons may benefit from minimal health care provided free of charge by the state, which includes services offered as part of national programmes, family doctor consultations, and emergency health care for major emergency cases at the pre-hospital stage.

Unemployment insurance

Unemployed persons can receive unemployment benefits if they are registered at a district employment agency, have worked for more than six of the previous 24 months, and have no income of any kind.

Unemployment benefits are tax free and are allocated from the state social insurance budget. Depending on the reason for termination of employment, benefits represent either 30%, 40% or 50% of the national average wage during the previous year. The length of time during which unemployment benefits can be received varies in accordance with the amount of time the individual had been employed. It ranges from six months (for those who have worked at least six months), to nine months (five to 10 years) to 12 months (for those who have worked more than 10 years).

Growing number of children and adolescents in institutions

The limited access to specialized community-based services for children in difficult situations has fostered an increase in the rate of institutionalization. There are various reasons for which children are institutionalized: 36% of children in institutions were placed there as a result of diseases and disabilities; 16% after their parents' death; 27% because of their parents' poverty; 8% because of family problems; and 4% because their parents were unemployed. It is worth mentioning that some children are institutionalized because of the lack of primary education institutions in the localities were they live (0.2%). Often institutionalization is used as a means of resolving the problem of children who are left without permanent supervision when their parents leave to work abroad.

Support for immigrants and asylum-seekers

Asylum-seekers are provided with free legal aid and representation, and those considered as vulnerable refugees and asylum-seekers receive basic humanitarian assistance. Training activities specifically geared to the judiciary, police, lawyers and ministry-level officials have contributed to enhancing government expertise in the field of asylum. At the end of 2006, according to government figures, there were more than 160 recognized refugees along with more than 1,700 stateless persons living in the country.[4]

Social assistance for vulnerable groups

Expenditure on social assistance programmes has increased over the past few years, rising from 8.8% of GDP in 2004 to 11.7% of GDP in 2006. The system of 'nominative targeted compensation' – through which benefits are provided to households based on membership in one of 11 'socially vulnerable' categories, as opposed to financial need – continues to be the most expensive social programme, accounting for roughly 47% of social assistance expenditure from the state budget.

In the context of reforming the social assistance system, a pilot testing of a new mechanism for nominative compensation benefits was undertaken in 2006. Information was collected about the income of 25,099 families that are beneficiaries of nominative compensation grants. The analyzed data revealed that 56.6% of these households came from rural localities, whereas 43.4% were from urban localities. Two categories accounted for almost one half of all beneficiaries: 'second-degree' work disabled persons, who made up 34.3% of beneficiaries, and pensioners living alone, who made up 13.8%. Women represent over 80% of all pensioners who live alone.

The distribution of targeted compensation beneficiaries by revenue categories reveals that the disabled, participants in the Second World War, and victims of the Chernobyl nuclear disaster tend to fall into higher income categories. Individuals in these categories typically receive social assistance from other programmes as well. Meanwhile, the beneficiaries in the poorest categories come from rural localities and consist of 'third-degree' disabled persons, families with four or more children, 'second-degree' work disabled persons, and persons who have been disabled since childhood.

The lack of a single database of all social assistance beneficiaries makes it impossible to identify both the number of beneficiaries of social assistance and the number of social benefits rendered to them. Another problem is related to the lack of a recording mechanism focused on a 'family' approach, because within one family there may be two or even more persons entitled to separate benefits, which makes it impossible to evaluate the total amount of the assistance delivered by the state to vulnerable groups.

Promoting community-based services

Currently, the demand for community-based social services far exceeds the local public administration capacity. The need to develop cost-efficient services with a community accent, as an alternative to institutional services, is more than obvious. As a result, in some districts of the country, the local public authorities have entered into partnership with civil society groups and donors to develop such services. In 2006, the community-based services registered included 21 community-based senior citizens' homes, where 481 elderly people are provided with housing and access to different services, and 64 community-based social service centres that cater to 2,964 vulnerable persons, such as elderly people with disabilities, children and young people in difficult situations.

However, the most widespread social service at the local level is that of home-based services. A total of 2,329 social workers offer home-based services to 24,446 senior citizens living on their own and individuals unable to work.

There have also been new social service programmes established with the goal of decreasing school dropout and the institutionalization of children. In 2006, a total of 193 children who had been living in residential institutions were able to return to living with their families.

Alternative services are developed and delivered mainly with the support of civil society. At the same time, however, there is no state mechanism to certify social assistance services and control their quality. As a result, there is no way for the government to effectively monitor the situation of social services development, assess the costs of services, and create a competitive market for all social service suppliers. ■

3 <ec.europa.eu/europeaid/projects/tacis/pdf/moldova_ap_2005_pf_health_reform.pdf>

4 <www.unhcr.org/publ/PUBL/4666d24e11.pdf>