Public Disclosure Authorized

Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 16-Mar-2023 | Report No: PIDC35169

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Moldova	P180306		Modernization and Improvement of Rehabilitation Services Project (P180306)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
EUROPE AND CENTRAL ASIA	Jun 19, 2023	Nov 09, 2023	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Republic of Moldova	Ministry of Health	

Proposed Development Objective(s)

The PDO is to improve the quality and accessibility of rehabilitation services and strengthen primary care services for preventing and managing cardiovascular diseases.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	40.00
Total Financing	40.00
of which IBRD/IDA	40.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Bank for Reconstruction and Development (IBRD)	40.00

Environmental and Social Risk Classification	Concept Review Decision
Moderate	Track I-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Moldova is a small lower-middle-income country (GNI per capita of USD 4,676 in 2020) with a ranking of 80 out of 198 countries in the Human Development Index (HDI 0.77 in 2021).**[1] In 2019, 14.7 percent of its 2.57 million population lived below the poverty line of USD 6.85 per day at purchasing power parity (PPP).[2] Despite solid economic performance over the past two decades, with GDP per capita growing with an average rate of 5.14 percent per year, Moldova remains among the poorest countries in Europe.[3] Economic opportunities are particularly limited in rural areas, where absolute poverty is almost five times greater than in urban areas.[4] Moldova's economic growth model, which relies heavily on remittance-induced consumption, was successful in generating high growth but began showing signs of unsustainability, even before the COVID-19 pandemic.[5] The country's low endowment of institutional, human, and natural capitals prevents it from taking full advantage of wealthier regional markets.

2. **The COVID-19 pandemic revealed vulnerabilities in the Moldova's economic model.** With a decline in GDP of more than 7 percent in 2020, the impact of the COVID-19 pandemic, combined with the economic consequences of a drought, has been one of the most severe in Europe (World Bank 2021). The shock has had a large and heterogenous impact across households, firms, sectors, and geographical areas (World Bank 2021). Poverty (using the national poverty line) increased by 1.6 percentage points, rising from 25.2 percent in 2019 to 26.8 percent in 2020, as households faced the impact of the crisis, including loss of employment and earnings, a reduction in remittance receipts, and the return of vulnerable migrants from abroad who might struggle to find employment (World Bank 2021). As a result of the economic rebound in 2021, poverty fell to 24.5 percent in 2021, below precrisis levels.

3. **The full-scale invasion of Ukraine by Russia in February 2022 has further amplified these vulnerabilities.** While the impacts of the war are still unfolding, high levels of food and energy inflation have sharpened preexisting concerns. Many more Moldovans are at risk of falling, and being pushed deeper, into poverty. Rising inflation is limiting the purchasing power of pensions, social assistance, and wages. Lower external demand, lower investment, and restrained consumer spending could weaken the labor market. Moldova is acutely reliant on natural gas from Russia. Import disruptions are expected to increase price pressures, eroding the competitiveness of firms and household incomes, especially for the poor. In addition, Moldova is currently supporting 80,000 Ukrainian refugees, 90 percent of whom are women and children, concentrated in urban areas.

4. **Moldova is now at a critical juncture, having gained EU candidate status, and the Government of Moldova's (GoM) approach towards EU accession recognizes the importance of human development.** In June 2022, Moldova gained EU candidate status and the GoM National Development Strategy "European Moldova 2030" (NDS),[6] has an ambitious, forward-looking reform agenda. The NDS calls for a shift from the current consumption-based growth model toward a model based on raising investment, increasing productivity

[1] World Bank, "World Development Indicators" (WDI); United Nations Development Program (UNDP); Republic of Moldova.
[2] World Bank, WDI.
[3] World Bank, WDI.
[4] Lupusor et al., "Mid-Term Evaluation of National Development Strategy 'Moldova 2020': Key Findings."
[5] World Bank Group, "Moldova."
[6] https://gov.md/ro/content/strategia-nationala-de-dezvoltare-moldova-europeana-2030-fost-aprobata-de-guvern.

and competitiveness, developing export industries, and promoting a knowledge-based society. The NDS has prioritized sustainable and inclusive economic development, long-term human and social capital, and honest and efficient institutions.

5. **Improving service delivery goes hand in hand with realizing the NDS, given that health outcomes lag behind other countries and are not on par with the size of the GoM's expenditures.** With the population aging, the incidence of noncommunicable diseases (NCDs) on the rise, the advent of new technologies, and Moldova's dilapidated hospital infrastructure, the cost of healthcare is likely to grow if preventive and low-cost technologies are not expanded. Out-of-pocket (OOP) expenditures on health are high, disproportionally affecting low-income households. Hospitals need to become more efficient and deliver greater value for money, while primary healthcare services need to be supported to reduce the burden of disease and support a broader set of patient needs.

Sectoral and Institutional Context

6. **Moldova's health outcomes are slightly better than expected for its level of economic development.** The country's life expectancy at birth (74.3 years) and healthy life expectancy (65.1 years) are higher than middle-income countries in ECA on average. Since 2010, Moldova's premature mortality rate, defined as deaths occurring before age 70, has declined by 15 percent, outpacing the average decline in ECA over the same period—6 percent. But despite this encouraging trend, premature mortality rates in Moldova (456 per 100,000 population in 2019) remain nearly 50 percent higher than in ECA (307 per 100,000 population in 2019).[7]

7. **While public expenditure on health in Moldova (60 percent of total health expenditure) is slightly above the upper middle-income country average (56 percent), so too is the proportion of total health expenditure paid for by households OOP, hindering the financial risk protection of Moldova's health system.** Moldovan households contributed nearly 36 percent of total health expenditure through OOP payments (USD 170 per capita), with 19 percent of households paying more than 10 percent of their annual income on OOP health payments. High OOP payments negatively impact healthcare utilization rates and medication adherence (OOP payments are largely used to finance drugs), particularly for the poorest Moldovan households.

8. **The Moldovan health system is centralized, with the National Health Insurance Company (Compania Nationala de Asigurari in Medicina, CNAM) serving as the single purchaser of publicly financed health services since 2004.** The Ministry of Health (MoH) is primarily responsible for health policy, development of legislation and regulations, organization and provision of services, and oversight of the National Agency for Public Health. The Agency for Medicines and Medical Devices regulates and supervises medicines and medical devices, and the Center for Centralized Public Procurement in Health plans and conducts public procurement of medical and protective equipment.

9. **CNAM covers 86 percent of the population with a package of emergency, primary, and inpatient services without payment at the point of access.** The system provides universal access to primary health care for uninsured and insured patients, and this enables access to key public health services such as mental health, oncology, HIV/AIDS, and tuberculosis (TB). Inpatient care is provided at the municipal and district (secondary care) and republican (tertiary care) levels. Highly specialized tertiary services are concentrated in Chisinau, the capital city. Within this financing and service delivery structure, family doctors for insured patients are expected to act as gatekeepers for specialist care and inpatient services. However, patients tend to bypass

[7] Global Burden of Disease Collaborative Network. *Global Burden of Disease Study 2019*. Seattle: Institute for Health Metrics and Evaluation (IHME), 2021. http://ghdx.healthdata.org/gbd-2019.

primary care and seek secondary care.

10. **Strengthening PHC has been a priority since 1998 and there has been some progress in recent years.** The number of publicly financed PHC providers has grown steadily from 67 in 2008 to 293 in 2021. In 1998, family medicine was introduced as a specialty, with support from international donors to develop standardized clinical protocols for primary care and criteria for family doctor referrals to specialists, laboratory tests, and further investigations. Financing reforms to incentivize gatekeeping for specialist care and improve coverage of PHC consultations for the uninsured have also strengthened PHC.

11. **Nevertheless, the unfinished agenda remains significant across financial protection and service delivery.** High OOP costs reflect that financial protection is underdeveloped and catastrophic spending is among the highest in region and concentrated amongst the poor. In 2019, 19 percent of households experienced catastrophic OOP spending (OOP spending greater than 10 percent of annual income) and nearly 7 percent were impoverished as a result. Catastrophic expenditure, driven by outpatient medication, is highest among people living in rural areas, those with incomplete secondary education, and pensioners. Health insurance coverage for outpatient medication was extended between 2017 and 2021, and it is hoped that this will alleviate the burden on households.

12. **Weaknesses in service delivery for people with NCDs, particularly cardiovascular diseases, are apparent across three areas: primary care services for those at risk; post-acute services immediately following an acute event, such as a stroke or heart attack; and primary care services for post-acute follow-up and prevention of recurrent events.** Hypertension is a leading risk factor for CVD and has been identified by the WHO as the leading risk factor affecting Moldovans' health status. The Moldovan primary care system has been unable to sufficiently manage hypertension in the population, with 87 percent of the patients with hypertension having uncontrolled blood pressure (BBP > 140 mmHg, DBP > 90 mmHg). When patients experience an acute cardiovascular event, like stroke or heart attack, many are unable to quickly access appropriate, specialized treatment. As a result, patient outcomes are poor; the mortality rates from stroke and ischemic heart disease (152 and 417 per 100,000 population, respectively) are among the highest in Europe.[8] Post-acute cardiac and neurological rehabilitation services, which are essential for limiting long-term disability following an acute event, are currently provided in four overburdened hospitals with patient waiting times of up to three months.

13. **The Ministry of Health estimates that the unmet need for rehabilitation services is 70 percent. Lack of service provision is driven by a previous lack of prioritization in recent decades, and as a result quality of care is significantly compromised.** Over the last 10 years, the demand for rehabilitation services has steadily increased, particularly for patients recovering from strokes, traumatic brain injuries, spinal cord injuries, severe trauma, and heart and lung diseases. However, due to the lack of service provision and long waiting times, patients are often discharged immediately after being stabilized. As a result, approximately 90 percent of these patients do not return to the workforce. Based on information from the Ministry of Health, as of January 2021, 174,500 people with disabilities had been formally registered in the Republic of Moldova. Some 27,922 patients with disabilities from childhood require rehabilitation services and 6.7 percent of the population are living with disabilities. Between 2019 and 2020, there was a 7.8 percent increase in the rate of strokes, and in 2020, there were 218 stroke cases per 100,000 people.

14. **Adult rehabilitation services are challenged by poor infrastructure and the lack of appropriate facilities and equipment, defined clinical protocols and pathways, and an adequately trained workforce.** Despite rehabilitation services being part of the health benefit package funded by CNAM, years of

[8] Global Burden of Disease Study 2019.

underinvestment mean that facilities are limited, and existing facilities are ill-equipped to respond to the needs of patients living with disabilities. The MoH estimates that at the Institute for Neurology, the primary tertiary center for rehabilitation services, the annual unmet demand is approximately 88 percent.

15. **The limited and low-quality rehabilitation services provided through the public sector have given rise to private sector rehabilitation services.** While private sector service provision relieves some of the population's unmet needs, it also increases patients' financial risk when seeking rehabilitation services. In the last decade, the MoH has registered 30 new private rehabilitation practices, which charge between MDL 5,000 (USD 250) and MDL 15,000 (USD 750) for a 10–30-day rehabilitation course. For an average household in Moldova, these prices represent 5–16 percent of annual income, meaning that private rehabilitation services would be impoverishing for many Moldovans and entirely inaccessible for the poorest. Moreover, rehabilitation services provided through the private sector are not fully regulated by the government, leaving the quality of these services largely unknown.

Relationship to CPF

16. **The Project seeks to address the binding constraints identified in the 2021 Systematic Country Diagnostic (SCD) Update and is aligned with the upcoming Country Partnership Framework (CPF) for FY23–27.** The Project contributes to Pillar 5 (Improving resilience, efficiency and equity in service delivery) of the SCD and the upcoming CPF's Higher-level Objective 2 on Improved Human Capital. By improving the provision of services for: patients at risk of cardiac and stroke events, post-acute, and follow-up care, the proposed project contributes to CPF Objective 2.2. – improving the efficiency of health service delivery.

17. **The Project is also aligned with the NHS being developed by the GoM, and Goal 3 of the 2030 Agenda of the Sustainable Development Goals – ensuring healthy lives and promoting well-being**. The proposed project would support the NHS, which has the following vision: "By 2030, the health of the population will improve significantly, supported by a modern and efficient health system, organized based on the principles of universal coverage with quality health services, which contribute to achieving the Sustainable Development Goals." The selection of project activities is also informed by the fundamental values of the NHS regarding providing person-centered care that is fair, non-discriminatory, offers respect and dignity, and is accessible and high quality. By strengthening the continuum of care for the improved management of NCDs, the proposed project directly supports indicator 3.4.1 **–** the mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease **–** and the goal of reducing premature mortality from NCDs. It also supports progress towards indicator 3.8.1 (coverage of essential health services) by improving access to quality essential health-care services, and indicator 3.C.1 (health worker density and distribution), by financing the development, training, and retention of the health workforce.

18. **The proposed project builds on a foundation of previous operations and analytical programming to support the achievement of Universal Health Coverage.** Since 2014, the World Bank has financed the Health Transformation Operation (HTO) (US$ 30.8 million), and the Emergency COVID-19 Response Operation and its Additional Financing to support COVID-19 vaccine delivery (US$ $90.78 million). The HTO supported the 2007-2021 National Health Policy (NHP), which was operationalized by the 2008-2017 National Health System Development Strategy for 2008-2017. It sought to improve population health, increase financial risk protection, reduce inequalities to health care services, enhance user satisfaction, and facilitate improvements in health systems performance and population health. The Project also leverages the platform provided by the World Bank's collaboration with the Swiss Development Corporation, through which the World Bank has led and supported a range of analytical studies, with development partners, on health system reform priorities in Moldova. For example, the recent analytical activities on primary health care highlighted the importance of improving the accessibility of facilities and strengthening health sector governance to enable the provision of

integrated care, two areas that the Project will help to address.

19. **The Project is also aligned with Pillar 4 of the World Bank's Global Crisis Response Framework (GCRF), which focuses on strengthening policies and institutions, and investments for rebuilding better.** Recognizing that Moldova is facing unprecedented crises on multiple fronts, the proposed project aims to support Moldova's health sector in developing a resilience and inclusive foundation for its long-term recovery. Through a focus on health system strengthening for people with NCDs, who are particularly vulnerable to pandemics, and upgrading of facilities to improve accessibility for differently-abled patients, the Project will strengthen institutional capacity. By supporting the development of emergency response protocols for patients suffering from an acute episode, such as a heart attack of stroke, the Project will also directly strengthen operational policies and procedures within the health sector.

C. Proposed Development Objective(s)

The PDO is to improve the quality and accessibility of rehabilitation services and strengthen primary care services for addressing non-communicable diseases (NCDs).

Key Results (From PCN)

PDO Elements	PDO Indicators
Quality	• Percentage of stroke and cardiac patients who received physical rehabilitation care following updated integrated care pathways.
Accessibility	• Percentage of health care facilities in target regions with accessibility modifications enabling access for differently-abled patients.
Primary care capacity for noncommunicable diseases	• Number of primary care facilities providing early screening for at least two NCDs. • Percentage of patients with post-acute stroke and cardiac conditions that receive follow-up care from PHC staff who received relevant training. • Proportion of hypertension patients with controlled blood pressure

D. Concept Description

20. The proposed Project seeks to improve the provision of rehabilitation services through three areas, presented in Figure 4: (1) improving support for patients at risk of an acute episode; (2) improving services for patients immediately following an acute episode, such as a stroke or cardiac arrest; and (3) improving services following an acute episode. Area 2 entails strengthening hospital-based services, which provides equipment-intensive care in settings that need to be accessible for patients with limited mobility and functional ability. Areas 1 and 3 are lower-intensity primary care interventions, which can be delivered in community settings. In addition, these two areas are important for the sustainability of the health system. Interventions in these two categories are cost-effective and important for positioning the health system on a path away from hospital-centric care for services that are amenable to outpatient, ambulatory, or community provision. Figure 5 provides an example of the types of activities, by area.

21. **Component 1: Modernizing and improving rehabilitation services.** This component would support improvements in the quality, efficiency, and accessibility of rehabilitation services, with a focus on patients

following an acute episode requiring intensive rehabilitation services. The component would finance equipment, infrastructure improvements, and transportation. It would support current reforms, which aim to develop seven centers of excellence. Additionally, it would support the development of specialized rehabilitation departments, guidelines and protocols, discharge practices and training, and digital tools for improved treatment and emergency services. The primary focus would be on patients recovering from stroke or cardiac events, and selected rehabilitation needs, where limited support would be of benefit to strengthening the overall system.

22. **Subcomponent 1.1. Developing and upgrading post-acute facilities, equipment, and services.** This component would support the upgrading of facilities at the Clinical Hospital of the Ministry of Health and the Institute of Neurology and Neurosurgery so that they can support differently abled patients in need of post-acute care. This will include modifications of rooms and facilities such as the introduction of railings and non-slip flooring. This component will finance equipment and service improvements for selected other service lines, such as pediatric trauma recovery, where doing so would constitute a cost-effective investment alongside stroke and cardiac care rehabilitation improvements.

23. **Subcomponent 1.2. Strengthening emergency response capabilities for stroke, heart attack, and trauma.** This component will finance the development and uptake of protocols to triage, assess, and manage the care of patients immediately following a substantial trauma, such as a stroke or heart attack; training to support health care workers in rapidly identifying strokes and heart attacks; diagnostic equipment; and emergency transport to safely transfer patients in need of complex care in a timely manner to an appropriate level of the health system.

24. **Component 2: Strengthening integrated care for patients with NCDs.** This component will support cost-effective primary care interventions with a focus on patients at risk of a stroke or cardiac arrest, and the provision of step-down rehabilitation services to support patients following a stroke or cardiac arrest or acute event. The purpose of these interventions would be to limit the likelihood of patients experiencing an initial acute episode and then experiencing recurrent events. The component would finance telemedicine and digital health programs, disease management programs, workforce training, public awareness campaigns, and improved links between interdisciplinary providers to better enable integrated care.

25. **Subcomponent 2.1. Primary care interventions for patients at risk of stroke and heart attacks.** This subcomponent would finance the introduction of disease management programs for NCD screening, prevention and management; training for healthcare workers to better manage chronic disease conditions and to detect the early signs of strokes and cardiac episodes; public awareness campaigns to address the major risk factors for stroke and heart attacks, including hypertension, salt consumption, physical inactivity and diet; and scale up existing telemedicine and digital health programs to improve access to counseling to address risk factors for vulnerable populations.

26. **Subcomponent 2.2. Primary care follow-up for patients recovering from stroke and heart attacks.** This subcomponent would finance the development and training to support the utilization of protocols for the integration of multidisciplinary care for cardiac and stroke patients; strengthening of digital infrastructure between facilities to support the integration of rehabilitation services, and equipment such as ramps, rails and other modifications for differently-abled patients at the PHC level; discharge planning and protocols from secondary to primary care; rehabilitation support materials; and, the development of home-based care models to minimize unnecessary and prolonged hospital-based treatment. Financing from this component will also be used to incentivize improvements in the quality of care to strengthen the integration of post-rehabilitation services.

27. **Component 3: Project management.** This component will provide support for the execution of project management, coordination, and monitoring and evaluation (M&E) activities, including third party monitoring. The component will finance the Project Implementation Unit (PIU), consulting services, office equipment, training,

audits, filing systems, and operating costs.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

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APPROVAL

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