Author's response to reviews

Title: Barriers to universal coverage in Republic of Moldova: a policy analysis of formal and informal out of pocket payments

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Author's response to reviews:

Dear Editors,

Thank you for the opportunity to resubmit our paper "Barriers to universal coverage in Republic of Moldova: a policy analysis of formal and informal out of pocket payments." We appreciate the reviewers' thoughtful and helpful comments. We have revised the manuscript to address the comments and describe these revisions in detail below. Hopefully, with these changes, you will find our manuscript acceptable for publication. We would be happy to respond to any further queries regarding this response letter and the revised manuscript.

Below are our responses to the editor's and reviewers' comments point by point:

Editor Comments:

1. We recommend that you copyedit the paper to improve the style of written English.

Thank you for this suggestion. We have carefully copyedited the article. We hope that this meets the expectations of the editor.

2. In accordance with BioMed Central editorial policies, could you please ensure your manuscript reporting adheres to STROBE guidelines for reporting observational data. Can you please include a completed STROBE checklist as an additional file when submitting your revised manuscript?

We have completed the STROBE checklist as mentioned in text (p. 7, line 15-16) and attach it as a separate file. We have reviewed the manuscript and believe that it adheres to STROBE guidelines.

3. Please remove author suffixes from title page.

We have removed the author suffixes.

Reviewer Comments:
Reviewer #1:

Minor Essential Revisions:

1. When authors present the OOP amounts in the Result section, they should mention in the text whether these are yearly or monthly amounts.

On page 14, we have edited to make clearer the recall period. For the Household Budget Survey data, we mention on line 7-8 that the recall period was 4 weeks for outpatient payment estimates and 12 months for inpatient estimates. For the PAS data, we have added a sentence on line 14 to say that the recall period was one year.

2. For the Figures and Tables, the source of data should be indicated as authors used different datasets for the study.

Thank you for this suggestion. We have added sources to the tables and figures, as follows:

• Table 2: National Bureau of Statistics, Household Budget Survey ad hoc module on health, collected every other year
• Table 3: National Bureau of Statistics, Household Budget Survey (annual)
• Table 4: Stakeholder feedback (focus groups and in-depth interviews) collected in October 2013; qualitative data from previous research (WHO, 2012)
• Figure 1: Authors, based on stakeholder feedback
• Figure 2: National Bureau of Statistics, Household Budget Survey (annual)
• Figure 3: National Bureau of Statistics, Household Budget Survey (annual)

3. P. 8 line 29. “Informal payments are sometimes referred to locally in three categories: conditioned payments (perceived by patients as necessary in order to receive services), facilitation payments (offered voluntarily by patients to obtain something outside the basic service package entitlement), and gifts (given freely to express gratitude).” The authors should provide reference for this classification or framework (the same stands for Figure 1).

We have changed this section to explain that the typology was developed based on data collected during stakeholder interviews and focus groups (p. 10, line 26-30). We have noted the source of data for Figure 1 (see answer to Q2 above).

“During stakeholder feedback interviews and focus groups, we found that IPs are sometimes referred to locally in three categories: conditioned payments (perceived by patients as necessary in order to receive services), facilitation payments (offered voluntarily by patients to obtain something outside the basic service package entitlement), and gifts (given freely to express gratitude).”

Discretionary revisions:

1. It would be beneficial if the authors could provide a little bit more detailed description of the changes in the health care system during the past decade
We have expanded text on p. 5-6 of the introduction to address this suggestion.

On p. 5, line 1-7: “The mandatory health insurance system was created by law in 1998 and became operational in 2004 [26]. Administered by the National Health Insurance Company (CNAM), the program provides access to an essential package of emergency, primary, and inpatient services without charge [18]. The package of services includes drugs in inpatient settings and a limited list of reimbursable medicines for outpatient care [19, 26]. For a majority of conditions, family doctors serve a gatekeeping function, and referral is required to access secondary and tertiary services.”

On p. 5, line 9-21: “An amendment to the Law on Mandatory Health Insurance in 2009 ensured that families living below the poverty line, even if formally self-employed, would automatically receive fully subsidized health insurance [26, 27]. Additional amendments in 2010 provided all citizens, regardless of income level, with access to free primary health care services provided by family doctors [24] and pre-hospital emergency care services [19]. To implement this reform, the health insurance system allocated additional funding with a focus on improving rural access. About 30% of the insurance program’s budget was spent on primary care including prescription medicines in 2012 [28]. Funding has strengthened the family medicine model and enhanced autonomous management of primary care centers, independent of hospitals, so they are able to separately contract with CNAM [29]. Coverage under the mandatory health insurance system was 79.7% in 2011; however, patients still often pay in the private sector for uncovered services such as some high technology diagnostic tests, medicines not on the Reimbursed Drugs List, and for secondary/tertiary services if they are not referred [18].”

On p. 5, line 28 to p. 6, line 12: “CNAM plans to achieve these targets through the expansion of health insurance coverage and benefits (as mentioned above), and other strategies in the early stages of implementation, including assuring protection of the rights of insured people through better customer service, complaint management, and a beneficiary protection system, and further increasing access and quality of care by reducing waiting time to obtain services, conducting medical audits, and using innovative performance-based financing mechanisms for contracting with hospitals [23].

“At a broader level, health sector reforms since 2012 have tried to reduce OOP payments by gradually increasing salaries of health workers [30], increasing budget for covered prescription medicines, introducing mandatory use of international non-proprietary names (INN) in prescribing, and implementing a medicines pricing policy reform whereby the manufacturer’s price is set at the time of product registration using external reference price information [31]. Debates in recent years have also recognized corruption as a key development challenge, and the need to increase transparency as a cross-sectoral issue [32].”
2. It would be helpful to see what is the burden of OOPs for the households as a percent of their income (or expenditure) or as a percentage of the average income in the country. (Not a Table, just an estimation, probably in the discussion section).

On p. 14, line 9-11 we have added text to compare OOP average amounts to the estimated monthly wage in Moldova. The text is as follows: “Compared to the average salary in Moldova (3,550 MDL or €231 Euro per month [30]), this means that people who pay for care are spending 7-8% of monthly income on outpatient episodes, and up to 35% of monthly income on inpatient care.”

3. P. 9, line 22 “non-governmental organizations (NGOs) serving households (15.8%)” It is not clear for me what types of payments are these? The authors should probably clarify.

We have included a more specific description of the meaning of this phrase, taken from definitions included in the Glossary of terms from the WHO Global Health Expenditure Database. The paragraph on p. 11, line 19-23 now reads as follows:

“OOP payments by private households account for 83.2% of private spending; other sources of private expenditure on health include 15.8% by non-profit institutions serving households, e.g. NGOs (defined by WHO as institutions which are not predominantly financed and controlled by government, that provide goods or services to households free or at prices that are not economically significant) and 1% spending on private health insurance/other [17].”

4. The authors provide an extensive description of different methods that were used in the study in the Method section. However, it would be useful for the readers, if these were shortly listed in the Introduction section too to be clear for the reader what to expect from the study.

We have modified the last paragraph of the introduction (starting on p. 6, line 22) as follows:

“The objective of this study is to document trends in OOP payments and IP in Moldova, looking especially at how the rate of OOP payments may vary by insurance status and socio-economic status. We use multiple sources of data, including desk review of policies and documents, stakeholder feedback, analysis of annual Household Budget Survey data and the ad hoc module on health administered every two years, secondary analysis of an inpatient survey of OOP payments and IPs, legal review, and the findings from a policy workshop. The study discusses differences in perceptions about the factors driving formal payments and the largely hidden practice of IPs, and makes recommendations to reduce OOP payments and IP taking into account values, institutions, and capacities of Moldova’s health sector.”

5. Comment: I do not understand why is it a reasonably policy objective to decrease the share of pharmaceutical expenditure as a share of OOP payments?
It can be achieved by increasing payments for health care services too. In the CEE countries the high share pharmaceutical expenditure is common (in Hungary over 80% as well). So isn’t it a better objective to decrease OOP for pharmaceuticals?

The reviewer is referring to the institutional strategy of CNAM which includes a goal “to decrease the share of expenditures for medicines as a proportion of OOP payments to 65%.” The reviewer may be right, that reducing actual OOP payments on pharmaceuticals (rather than the proportion) would be a better goal. But if other OOP payments remain the same, then if CNAM is able to reduce OOP payments on pharmaceuticals, they would reduce it as a share of the total. CNAM recognizes that OOP payment for pharmaceuticals is the biggest burden on the average Moldovan, and that is where they are hoping to effect change. Our purpose here was not to critique CNAM’s goals, so we have not edited the section. The measure may be a proxy indicator of complex reforms which also included extending the benefit package, pricing reforms, and changes in prescribing to try to rationalize use of medicines. These additional reforms are now explained in more detail on p. 5-6. See also the answer to Discretionary revision #1 above.

Reviewer #2:

1. Re: Introduction: - It is unclear form the introduction whether there are at the moment formal charges for services in the basic package. This should be clarified.

We have altered the sentence starting on page 5, line 3-4, to add the phrase “without charge.” This should make it clear that the basic package is meant to be without charge. The sentence now reads as follows:

“Administered by the National Health Insurance Company (CNAM), the program provides access to an essential package of emergency, primary, and inpatient services without charge [18].”

2. On p.5 line 10-15, the authors state the policy targets related to out-of-pocket payments. But it is unclear how the government plans to achieve these targets. Information on intended or already implemented reforms related to these targets should be added.

We have edited p. 5 to make it clearer that the government has already implemented reforms to expand insurance coverage and increase the benefit package. We also added a description of the intended reforms. The section starting on p. 5 line 28 and ending on p. 6 line 12 now reads as follows:

“CNAM plans to achieve these targets through the expansion of health insurance coverage and benefits (as mentioned above), and other strategies in the early stages of implementation, including assuring protection of the rights of insured people through better customer service, complaint management, and a beneficiary protection system, and further increasing access and quality of care by reducing waiting time to obtain services, conducting medical audits, and using
innovative performance-based financing mechanisms for contracting with hospitals [23].

“At a broader level, health sector reforms since 2012 have tried to reduce OOP payments by gradually increasing salaries of health workers [30], increasing budget for covered prescription medicines, introducing mandatory use of international non-proprietary names (INN) in prescribing, and implementing a medicines pricing policy reform whereby the manufacturer’s price is set at the time of product registration using external reference price information [31]. Debates in recent years have also recognized corruption as a key development challenge, and the need to increase transparency as a cross-sectoral issue [32].”

3. On p.5 line 17, authors write ‘Evidence suggests that these reforms have already resulted in increased use of services’. It is not clear what reforms they refer to. Information on the reforms that led to the favorable visit rates cited below this statement, is necessary.

See answer to Q2, above.

4. Re: Methods: - I suspect that the sentence on p.6 line 19 ‘The policy framework was then reviewed based on the framework.’ contains a misprint. Or otherwise, what is the difference between ‘policy framework’ and ‘framework’ in this sentence?

Indeed, this was a misprint. The sentence on p. 7 line 24 now reads: “The analytical framework was then revised based on the results.”

5. And also what is meant by ‘analytical framework’ on p.6 line 22 - ‘policy framework’ or ‘framework’ or another framework? The use of this terminology should be consistent.

Thank you for this suggestion. We have changed language to use only “analytical framework” throughout the document.

6. How were the participants in the qualitative part of the study chosen? What type of sampling method?

Convenience sampling was used to gather participants. We have added a sentence stating this on p. 8, line 2.

7. What is the justification behind the selection of the legal documents? Why (only) this documents? I would expect that important non-English legal documents were not included which is a potentially major drawback.

Our selection of these legal documents was based on our desk review, consultation with stakeholders, and a previous review of health insurance law and informal payments conducted by one of the authors (FF) in Albania. We have added a statement to this effect on p. 8, line 14-15. We determined that the Law on Mandatory Health Insurance, related amendments, and the Decision on the Type Contract (i.e. model contract) for Health Care Provision provided the data we were seeking related to insurance reimbursement and patient payment
processes and how these processes are controlled. Although it is possible that non-English language documents could have contained additional control procedures, we think the major provisions were captured. We have added a statement in the limitation section to acknowledge that other documents might have existed in Romanian language, about which we were not aware (see p. 21, line 1-4).

8. Details on the design (incl. sampling, response rate, etc.) of the two quantitative studies should be provided.

We have added information on design for the HBS survey on p. 8, line 27 to p. 9 line 2 and for the ad hoc module on health on p. 9, lines 16-21.

9. It not clear why the HBS data on reasons for not seeking care have a different time dimension (2008, 2010, and 2012) compared to the data on out-of-pocket payments (2009-2012). This should be clarified.

The HBS data from the ad hoc module is only collected every other year. This is why we do not have annual data for this question. We have tried to revise the text to clarify (p. 9, line 16-19):

“The second data source was an ad hoc module on health which is collected as part of the HBS. This specific ad hoc module is implemented every other year, rather than annually. This module provides data on reasons for not seeking care when ill. Data were analyzed for 2008, 2010, and 2012.”

10. On p. 8 line 10, the authors state ‘longer recall period’ but it is not clear why longer recall period. The recall period for inpatient care in the HBS is also 12 months.

This is a good point. The text has been changed to say “This study provides a larger sample of hospitalized patients than the NBS HBS.” (p. 9, line 27-28)

11. Overall it is completely unclear why so many different data sources have been used and to what extent are these sources comparable. Justification on this should be provided at the beginning of the Methods section. Also a framework that provides a base for combining these sources can be provided. For example, the method of framework analysis can be a useful umbrella for the entire analysis. However, the application of this analysis and it justification should be made clear.

We have tried to make our use of multiple data sources clearer (see response to #12 below). Our goal in using multiple sources of data was to triangulate. We have explained this in the methods section on p. 7, lines 4-6.

12. A paragraph explaining the method(s) of data analysis applied in the paper should be added. The choice of the method should be explained in terms of the paper aim stated in the introduction.

We have added a paragraph to explain our methods for analyzing the data. On
page 10, lines 8-17 we now describe this as follows:

“Analysis. Using the various data sources, we analyzed trends in total health expenditure, and OOP payments as a proportion of total health expenditures, for Moldova compared to other countries; trends in proportion of people who experienced a health problem but did not seek care due to financial reasons; trends in the percentage of people who made an OOP payment for services received at outpatient facilities or as an inpatient; and trends in the percentage of people who paid informally (of those who paid anything at all). We analyzed how the rate of OOP payment varied by insurance status (insured versus uninsured) and by socio-economic status (consumption quintile). For qualitative data we used inductive thematic analysis to examine collated data from in-depth interviews and focus group discussions to identify patterns of meaning and to define and name themes [38].”

13. Re: Findings and Discussion - Findings should be separated from the discussion. The authors should first present an objective picture of the findings per type of data source, and then in a subsequent section, the interpretation and discussion of the findings should be presented. This will allow to better judge the quality of the findings and the adequacy of the interpretations. The first part in this section that supposedly presents the findings, contains a mixture of data and authors’ interpretation, and cannot be considered an objective presentation of evidence.

We have created separate sections for the Findings (p. 11) and the Discussion (p. 16). We made several edits to remove author interpretation in the Findings, especially in the early sub-sections. Interpretation was moved to the Discussion section where we emphasize broader themes and patterns shown in the data.

14. Also this section provides no clear evidence on the second part of the aim of the paper as stated in the introduction ‘looking especially at how the practice of making payments may be related to insurance and socio-economic status’. A relation cannot be studied based on simple descriptive analysis. I would expect some quantitative analysis, especially given the rich databases that the authors have.

We have analyzed financial access to care (Table 2) and OOP payments (Table 3) by insurance status and socio-economic status. These are quantitative analyses. Further information on informal payments (separate from formal payments) by socio-economic variables was not available from the quantitative surveys used. We have noted this as a limitation of the study (see p. 20, line 24-26). We have edited the introduction to state that our objective is to look at “how the rate of OOP payments may vary by insurance status and socio-economic status.” (see p. 6, line 22-24).

15. The discussion of the limitations focus only on HBS. Limitations to other sources as well as limitations related to the entire study design are absent.

We have expanded the limitations section of the paper, adding a new paragraph
as shown below and found on page 20 line 24 to page 21 line 4.

“A second limitation of the study is that we had limited data sources for monitoring IP practice and could not measure how these payments may vary with socio-economic status and with insurance status. Future studies should try to measure changes in the practice of making IPs of various types (e.g. facilitation payments, gifts, compulsory payments) and correlate IPs with other demographic factors. Our qualitative interviews and focus groups also were limited in geographic scope due to budget constraints; however, the analysis raised themes which were similar to those documented previously in Moldova, suggesting that the issues we identified are persistent concerns. Finally, our legal analysis was limited to laws which were translated into English. Although the most important laws and amendments were available in English, it is possible that our legal review omitted documents which describe payment control procedures and exist only in the Romanian language.”

16. Re: Conclusions: - I do not see a direct link between the aim of the paper and the conclusions. Also some conclusions seem overreaching in the absence of an objective presentation of the findings. Perhaps if the presentation of the findings is improved as suggested above, this comment might be of less importance.

We have tried to make the link between the objective of the article and the conclusions clearer. If after reading the conclusion in light of other changes, the reviewer feels we still are over-reaching on particular points, we are happy to review this section again.

17. Minor essential comments: - ‘OOP’ is not a correct abbreviation of ‘out-of-pocket payments’. The correct abbreviation is ‘OPP’ or ‘OOP payments’. This should be corrected. - Also ‘out of pocket payments’ should be written as ‘out-of-pocket payments’.

Thank you for this observation. We have edited the manuscript to use OOP payments. The first time it is used, we have changed spelling to “out-of-pocket” payments.

18. Abbreviations should be used consistently, e.g. on line 29, ‘out of pocket payments’ is written instead of the abbreviation. The entire text should be carefully checked. For example the same problem can be observed for the abbreviation HBS.

We have checked the text and edited for consistency in use of abbreviations including OOP and HBS.