STUDIA UNIVERSITATIS MOLDAVIAE, 2019, nr.8(128)
Seria "Științe sociale" ISSN 1814-3199, ISSN online 2345-1017, p.3-12

CZU: 364.046.24(478)

HOME-BASED CARE PROVIDERS FROM THE REPUBLIC OF MOLDOVA: CHARACTERISTICS AND MODELS

Diana CHEIANU-ANDREI
Moldova State University

This article presents the data of the home care mapping survey. The research was conducted in the Republic of Moldova and was based on a methodological approach centered on the knowledge of the situation in the field of home care services, based on the opinions of the service providers (public and private). Assessment results reveal the shortcomings and achievements in the field of home-based care in the Republic of Moldova and are for the governmental and local authorities, public and private providers in order to develop home care services policies, advocacy activities.
Keywords: *home care services, social home-based care services, medical home-based care services, provider*

SERVICIILE DE ÎNGRIJIRE LA DOMICILIU ÎN REPUBLICA MOLDOVA: CARACTERISTICI ŞI MODELE
În articol sunt prezentate datele unei cercetări de cartografiere a serviciilor de îngrijire la domiciliu. Cercetarea s-a realizat în Republica Moldova şi a avut la bază o abordare metodologică axată pe cunoaşterea situaţiei în domeniul serviciilor de îngrijire la domiciliu, bazată pe opiniile prestatorilor de servicii (publici şi privaţi). Rezultatele evaluării relevă deficienţele şi realizările din domeniul îngrijirii la domiciliu în Republica Moldova şi sunt destinate autorităţilor guvernamentale şi locale, prestatorilor publici şi privaţi pentru dezvoltarea serviciilor şi politicilor în domeniul serviciilor de îngrijire la domiciliu, organizarea activităţilor de advocacy.
Cuvinte-cheie: *servicii de îngrijire la domiciliu, servicii sociale de îngrijire la domiciliu, servicii medicale de îngrijire la domiciliu, prestator.*

The **social home-based care** is one of the oldest social services in the Republic of Moldova. Social workers were the first specialists to be employed in the social assistance sphere to provide social home-based care services. Within the first years of the Republic of Moldova's independence, social workers providing social home-based care services were employed by the National Social Insurance House and with the creation of Territorial Units of Social Assistance (TUSA) in 1998, they were subordinated to the last. Gradually, social home-based care service has been developed and private providers have emerged alongside with public providers.

The bedrock of **medical home-based care** services, in the Republic of Moldova was put in December 1999 by the Catholic Religious Mission "Caritas-Moldova", Interconfessional Society of Christian Doctors "Emanuil" and the Civil Society Organization (CSO) "Nursing Association from Republic of Moldova", with the support of "CORDAID" organization, Holland, that implemented the first pilot project on home-based care. An essential step in the development of the medical home-based care services was the approval in 2007 of the Unique Compulsory Health Insurance Program and the inclusion of medical home-based care services as a form of medical assistance, alongside with pre-hospital emergency, primary, ambulatory and hospital care [1]. The section 6 of this Program stipulates that insured bedridden patients are entitled to medical home-based care services. These services are provided individually by service providers contracted by the National Health Insurance Company (NHIC) according to the law. The first service providers were contracted in 2008.

The article is based on comprehensive assessment of home-based care service and providers (private and public). The assessment relied on primary and secondary data sources. Thus, a desk review was conducted on legal framework and analysis of provision home-based care characteristics and models. Additional to these data, field information was collected from home-based care service providers, service beneficiaries and local public authorities (LPA) at I and II levels. The assessment is mixing quantitative and qualitative research methods. The survey sample comprised 84 home-based care service providers from 23 of 35 administrative territorial units.

The assessment reveal 3 types of home-based care services: social home-based care services, medical home-based care services and integrated home-based care services[1] (see Fig.1).

[1] Are not regulated by normative acts.

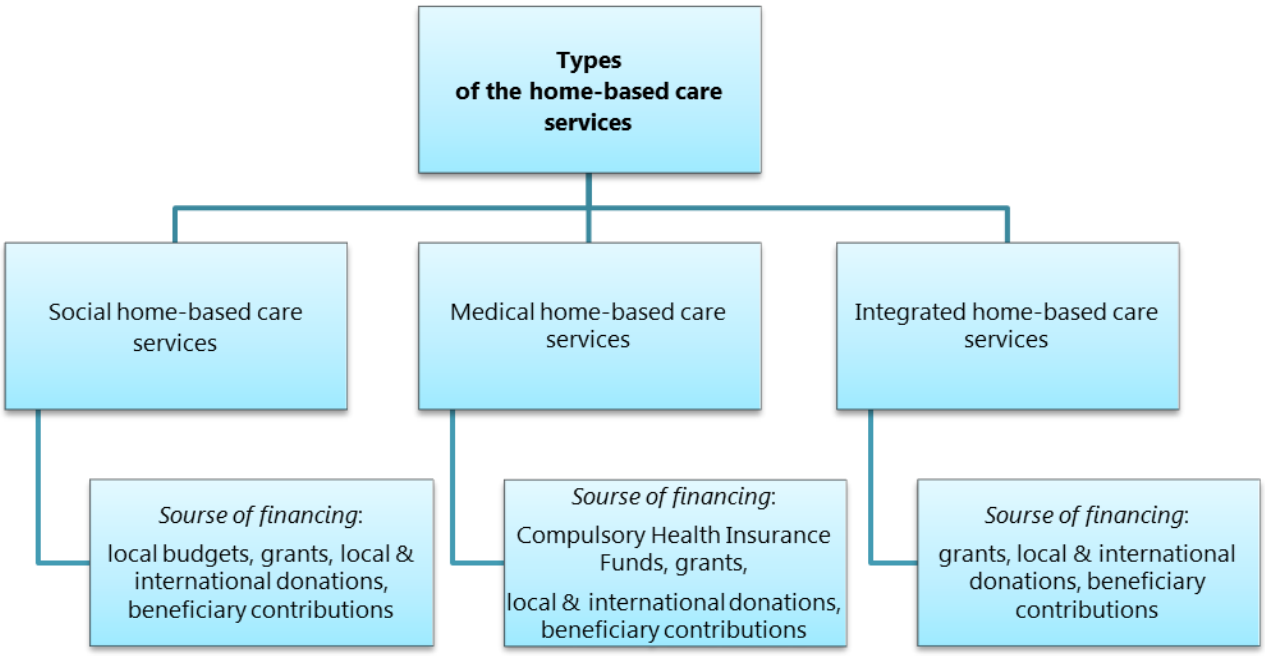

Fig.1. Home-based care services types and sources of funding.

Source: Author' analysis

The social home-based care service [2], represents a public (established within territorial structures of social assistance) or private service (created by foundations, private non-profit organizations, registered according to the law, dealing with social sector). The purpose of the service is to provide quality social home-based care services as to ensure better quality of the beneficiaries' life. The providers of social home-based care services are presented in the Figure 2.

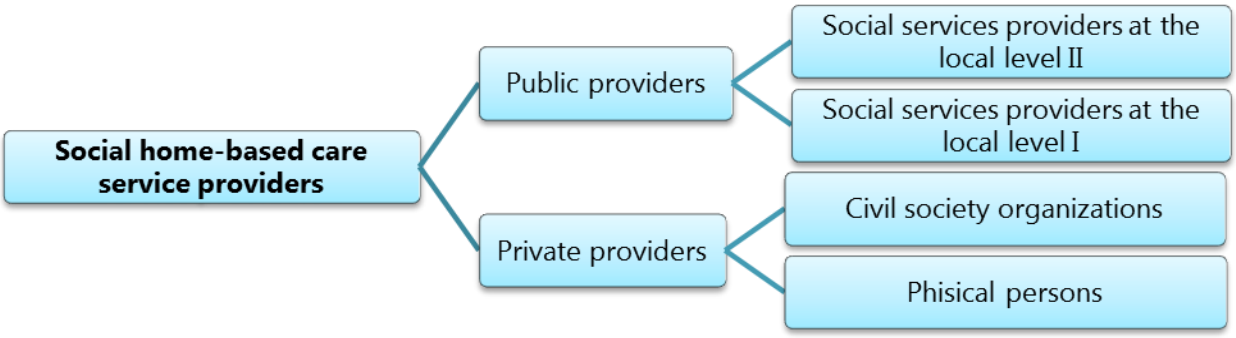

Fig.2. Home-based care social service providers.

Source: Author' analysis

Medical home-based care service represents a public or private service provided, in accordance with the law in force, by a healthcare institution, irrespective of its type of ownership and legal form of organization, usually CSOs (the model in which the "medical" component stays a part of the health care system and the "social" component of the social system exist in the Czech Republic, Slovak Republic, Romania). The providers of medical home-based care service are presented in Figure 3. The purpose of medical home-based care services is to provide the patient with qualified, dignified and appropriate care according to his individual needs, in order to stimulate the rehabilitation, maintenance and/or rehabilitation of the health condition and reduce the negative effects of the disease. The public medical home-based care service providers are mainly medical public institutions and a few private institutions. In 2017 NHIC contracted, for the provision of medical home-based care services, 131 state medical institutions and other 9 private institutions.

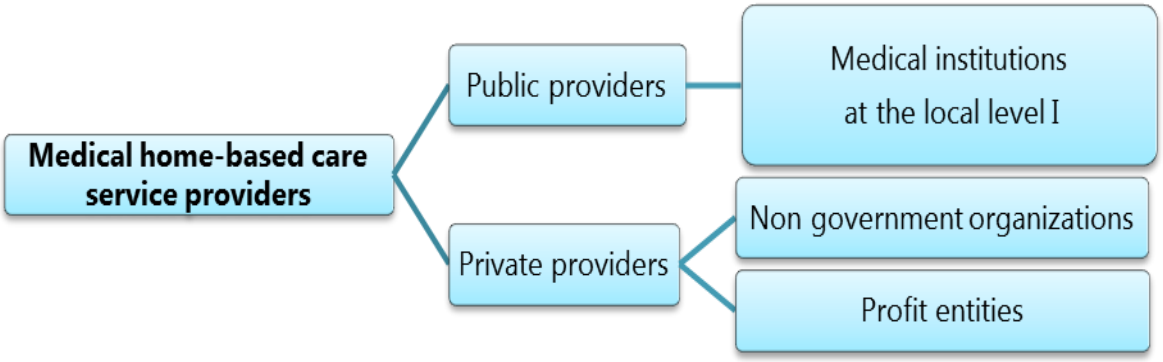

Fig.3. Medical home-based care service.

Source: Author' analysis

There are no legal provisions regarding the **integrated home-based care services**, neither standards (the model in which social and medical are almost fully integrated is the "Scandinavian model" – Sweden, Finland, Norway). However, certain service providers, especially the CSOs, but also some public institutions, operate within this notion. Integrated services provide, as per particular needs, both social and medical home-based care services or in other words, the same beneficiary receives support from a social worker and from a medical assistant, but not always with common coordination of their efforts.

Characteristics of home-based care service providers

The mapping study reveals a wide range of home-based care service providers **according the organization and legal status**: medical institutions, TUSA, CSOs, providers appointed by LPA[2], including profit entities. Most of the service providers are public institutions (medical institution, TUSA), followed by CSOs.

From the perspective of the geographical coverage, most of the home-based care service are provided at the community/first level (50), followed by those operating at the district/second level (29), regional (2) and national providers (3). Thus, public medical institutions usually provide home-based care at community level, TUSA - at the district level (except Administrative Territorial Unit Gagauzia, where TUSA does not provide social home-based care services, but the mayoralties), providers appointed by LPA at both, community level and district, profit entity at the district level. The CSOs are diverse and operate in different geographical areas – starting with the community, district, regional and finishing with national coverage (Table 1).

Table 1

Home-based care providers according to the geographical coverage, number

		Medical institutions	TUSA	CSO	Provider appointed by LPA	Profit entity
Geographical area	National	-	-	3	-	-
	Regional	-	-	2	-	-
	District	3	22	4	1	1
	Local	39	-	8	1	-
Total		**42**	**22**	**17**	**2**	**1**

According the types of provided home-based care, it was established that most of providers offer medical services, followed by those providing social services and only a few provide integrated services (Table 2). The CSOs, most often, provide integrated home-based care services. However, some medical institutions and TUSA follow their example. The home-based care services depend on the beneficiaries need and possibility of provider to respond to these needs.

[2] There are 2 situations in this case: home-based care service provider appointed by the LPA of the II level and the provider appointed by the LPA of the I level. Social workers from Administrative Territorial Unit Gagauzia are employed within the municipality, not the TUSA. The representative of LPA of the II level believes it is more correct that social home-based care services is within TUSA ensuring in this way a methodological control and increasing social home-based care quality.

Table 2

Types of home-based care providers, number

Type of home-based care services	Medical institutions	TUSA	CSO	Provider appointed by LPA	Profit entity
Social	-	20	9	1	-
Medical	39	-	1	-	1
Integrated	3	2	7	1	-
Total	**42**	**22**	**17**	**2**	**1**

According to home-based care service for free or for a fee, out of the 84 service providers, 74 render free home-based care services, 3 from 74 providers render home-based care services for free and for a fee, while 10 providers offer only co-paid services[3] (Table 3).

Table 3

Home-based care service providers ensuring services for free or for a fee, number

	Free services	Co-paid services	Paid services
Medical institutions	42	-	-
TUSA	22	-	3
CSO	7	10	-
Provider appointed by LPA	2	-	-
Profit entities	1	-	-
Total	**74**	**10**	**3**

The number of service beneficiaries differs from one provider to another, including from one type of service to another. Thus, the research data reveal that medical institutions provide services to a minimum of 2 persons (Health Centers from rural areas) to maximum - 107 persons (20 beneficiaries on average). The number of CSOs' beneficiaries is much higher, from at least 8 persons to maximum 2100 (472 beneficiaries on average). TUSA registered the highest number of beneficiaries, from a minimum of 298 persons to 2171 persons (636 beneficiaries on average) (see Table 4).

Table 4

The number of beneficiaries per home-based care providers, number[4]

	Medical institutions	TUSA	CSO
Mean	20	636	472
Median[5]	10	522	142
Mode[6]	5	412	44
Minimum	2	298	8
Maximum	107	2171	2100

Almost every 4th institution[7] of those 84 participating in assessment, asserted that they have restrictions in providing home-based care services.[8] Most restrictions were mentioned by medical institutions, followed by

[3] An amount is paid by the beneficiary, a part by – LPA and the rest by – CSO "CASMED" or an amount is paid by the beneficiary and the rest by different CSOs.
[4] Service providers appointed by LPAs and businesses will not be assessed, due to their small number. The profit entity provided services in 2016 to 101 persons. The service provider appointed by LPA that operates in the district, provided services to 110 in 2016, while that working in the community – to 58 persons.
[5] The **median** is the value separating the higher half of a data simple, from the lower half. For a data set, it may be thought of as the "middle" value.
[6] The **mode** of a set of data values is the value that appears most often.

TUSA and CSOs. Medical institutions have contracted an exact number of visits – 36 visits per beneficiary (72 visits in special cases), visits exceeding this number are not paid. Some CSOs also have to provide services to beneficiaries in rotation (once every 3 or 6 months) at the donor's request or according to their own regulations. Maintaining a fixed period for home-based care service provision is targeted to serve much more beneficiaries requiring home-based care services. The number of those in need is high and still growing, triggered by the ageing of the population (the national ageing index in 1980 was 10.7%, while in 2017 it reached 17.7%) [3].

Home-based care service models

The assessment revealed **various models of home-based care service provision**. Within each type of home-based care service (medical, social, integrated), several models were identified based on 9 main criteria: (i) type of provided service, (ii) legal form of organization of the provider, (iii) human resources involved in the provision of services, (iv) working mode of the provision of home-based care services, (v) type of beneficiaries, (vi) criteria for admission to service, (vii) duration of service provision, (viii) area of service delivery (ix) cost of the service paid by the beneficiary.

The models of social home-based care services have in common only the development of partnerships and, with few exceptions, the working hours. Social models are designed to complement each other (see Table 5) which is a major advantage. Thus, local private providers, or even the public ones, target vulnerable beneficiaries that do not meet the criteria of the Government Decision no.1034 of 31.12.2014.

Table 5

Models of social home-based care services delivery

Criteria for differentiation	Model A	Model B	Model C	Model D
Type of provided service	Social home-based care services			
Form of organization	Public	Private (CSOs)	Public	Public
Human resources	Head of the service, Social workers	Head of the service, Social assistant, Social workers	Social workers	Head of the service, social workers
Working mode	8 hours per day, on Saturdays and Sundays at request	8 hours per day 5 days a week	8 hours per day 5 days a week	8 hours per day 5 days a week
Type of beneficiaries	Categories enlisted in the pt. 11 and 12 of the Regulatory Framework on Home based Social Care Services, Government Decision no.1034	Categories enlisted in the pt. 11 and 12 of the Regulatory Framework on Home based Social Care Services, Government Decision no.1034, vulnerable people that have not reached the retirement age	Vulnerable people that have reached the retirement age	Categories enlisted in the pt. 11 of the Regulatory Framework on Home based Social Care Services, Government Decision no.1034
Criteria for admission to service	Based on the eligibility criteria for care services and the results of	Based on the eligibility criteria for care services and the results of the	Request from LPA	Request from LPA

[7] 22 institutions.
[8] There are restrictions regarding free services.

Criteria for differentiation	Model A	Model B	Model C	Model D
	the assessment of applicant's care needs	assessment of applicant's care needs. Referral mechanism applied by TUSA, LPA, other relevant institutions. Beneficiary's own request or request from his/her representative		
The duration of service provision	Till the decease, improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	3-6 months, till the improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	Till the decease, improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	Till the decease, improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible
Area of service delivery	District	Local	District	Local
Cost of the service paid by the beneficiary	Free of charge For a fee	Free of charge Symbolic co-payment of the cost of the service	Free of charge	Free of charge

The strong points of the **model A-social** consist provision of funding from the LPA budget and the presence of social workers in almost all localities from the Republic of Moldova. The weak points of the model lie in the fact that vulnerable people requiring home-based care are not admitted to services if they do not meet the provisions of the Government Decision no. 1034. The opportunity of this model is the development of services provided for a fee that could be delivered to beneficiaries with a better financial situation but still requiring such services. **Model B-social and C-social** are designed to complement the gaps of the model A, through undertaking certain responsibilities by LPA (model C) or by assigning responsibilities to both, LPA and beneficiaries (model B). **Model D-social** exists only in the Gagauzia and is the archaic model from the Soviet Union period. The gaps of this model lie in the fact that social workers employed by LPA of the 1st level are not part of a service evaluation and monitoring system.

Medical home based-care models have much in common (see Table 6).

Table 6

Models of medical home-based care services delivery

Criteria for differentiation	Model A	Model B	Model C	Model D	Model E
Type of provided service	Medical home-based care services				
Form of organization	Public	Private (business entity)	Private (CSO)	Private (CSO)	Private (CSO)
Human resources	Doctors, medical	Doctor, medical	Doctor, medical	Doctor, medical	Doctor, medical

Criteria for differentiation	Model A	Model B	Model C	Model D	Model E
	assistants	assistants	assistants	assistants	assistants
Working mode	Differ from 2/4 hours to 7 hours per day or a few hours 2-3 days a week	7 hours per day, on Saturdays and Sundays at request	7 hours per day, at request	7 hours per day, at request	7 hours per day, at request
Type of beneficiaries	Insured people	Insured people	Insured people, uninsured people, without identity documents inclusively	Insured people, uninsured people, without identity documents inclusively	Insured people
Criteria for admission to service	Family doctor's recommendation written in the patient's medical record	Referral form (form no. 027/e) from the family doctor or specialist	Referral form (form no. 027/e) from the family doctor, specialist, doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request	Referral form (form no. 027/e) from the family doctor, specialist, doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request	Referral form (form no. 027/e) from the family doctor, specialist, LPA
The duration of service provision	36 visits, sometimes 72 visits	36 visits, sometimes 72 visits	36 visits, sometimes 72 visits contracted from the NHIC. Up to 365 visits per year, depending on the current financial resources of the provider (donations, sponsorship, co-financing)	36 visits, sometimes 72 visits contracted from the NHIC. Up to 365 visits per year, depending on the current financial resources of the provider (donations, sponsorship)	36 visits, sometimes 72 visits
Area of service delivery	Local	District	Regional (more Districts)	Regional (more Districts)	Local
Cost of the service paid by the beneficiary	Free of charge	Free of charge	Free of charge, a symbolic co-payment of the cost of the service	Free of charge	Free of charge

Model A-medical addresses the insured people, but does not allow all insured people to benefit from such services (the evaluation study outcomes show that not all medical institutions contract medical home-based care services from NHIC). It can be explained by the small number of visits offered to medical institutions from rural areas and the low cost of a visit reimbursed by the NHIC. **Model B-medical** is a successful one, both, from the perspective of the working schedule – 7 hours per day but also from the perspective it meets the beneficiaries' needs. This model aims to provide services to the large majority of insured beneficiaries from the district. **Model C-medical** has as advantage the opportunity to access the service – 7 hours per day, admission to services of uninsured people, people without identity documents, multiple funding (NHIC, donors, LPA), including the empowerment of beneficiaries to come up with a symbolic co-payment, possibility to provide services for a period of time up to one year. **Model D-medical** differs from **model C-medical** in the absence of the symbolic co-payment from the beneficiaries' side. **Model E-medical** differs from **models C-medical** and **D-medical** in the existence of funding exclusively from the NHIC, provision of services for 36/72 visits, limited collaboration with authorities.

The integrated models meet a wider variety of needs (social, medical) through the presence of a diverse team of professionals. They provide services 8/24 hours per day, 5/7 days a weeks and focus on the establishment of partnerships in the community, district, region or national (see Table 7). The development of these models has been possible due to funding from international donor agencies. All models address the vulnerable categories of beneficiaries, besides the referral from the family doctor and/or the specialist; they also have referral from the LPA, churches, and religious missions. It is important that 3 of the 4 models of the integrated home-based care services are accredited to provide medical services and contract medical visits from NHIC. Not less important is the fact that the 3 models render services for a period of 3 months (with the possibility to extend it up to 6 months or 1 year), which enables a rotation of the beneficiaries and delivery of services to a larger number of people requiring these services. In the favor of the integrated models are also the ways of fund allocation as well as the cost of the provision of services, which is lower, compared to the delivery of two separate components.

Table 7

Models of integrated home-base care service delivery

Criteria for differentiation	Model A	Model B	Model C	Model D
Type of provided service		Integrated home-based care services		
Form of organization	Private (CSOs)	Private (CSOs)	Private (CSOs)	Private (CSOs)
Human resources	Doctor, medical assistants	Social workers, medical assistants	Doctor, medical assistants, social workers	Medical assistants, social workers, psychologist, jurist
Working mode	7 hours per day 5 days a week	7-8 hours per day 5 days a week	7-8 hours per day 5 days a week	7-8 hours per day 5 days a week
Type of beneficiaries	Insured people, uninsured people	Uninsured people, including without identity documents, vulnerable people that have not reached the retirement age	Insured people, uninsured people, including without identity documents, vulnerable people that have not reached the retirement age	Insured people, uninsured people, including without identity documents, vulnerable people that have reached the retirement age
Criteria for admission to service	Referral form (form no. 027/e) from the family doctor, specialist,	Based on the eligibility criteria for care services and the results of the	Referral form (form no. 027/e) from the family doctor, specialist, doctor	Referral form (form no. 027/e) from the family doctor, specialist,

Criteria for differentiation	Model A	Model B	Model C	Model D
	doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request	assessment of applicant's care needs. Referral mechanism applied by TUSA, LPA, other relevant institutions. Beneficiary's own request or request from his/her representative	employed by the provider, case referral from TUSA or LPA, including patient's individual request. Based on the eligibility criteria for care services and the results of the assessment of applicant's care needs. Referral mechanism applied by TUSA, LPA, other relevant institutions. Beneficiary's own request or request from his/her representative	doctor employed by the provider, case referral from TUSA or LPA, including patient's individual request. Based on the eligibility criteria for care services and the results of the assessment of applicant's care needs. Referral mechanism applied by TUSA, LPA, other relevant institutions. Beneficiary's own request or request from his/her representative
The duration of service provision	3-12 months till the improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	Unlimited	3-6 months till the improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible	3-6 months, till the improvement of the beneficiary's condition or the occurrence of circumstances that makes the person ineligible
Area of service delivery	Local / district	District	Regional (more districts)	Regional (more districts)
Cost of the service paid by the beneficiary	Free of charge	Free of charge	Free of charge, symbolic co-payment of the cost of the service	Free of charge

Peculiarities of the **model A-integrated** – consists in the team of medical experts providing a limited range of social services. The services are delivered most often at the community level, sometimes in several villages from the district. **Model B-integrated** implies a team of social workers and medical assistants, providing services in district, but has no accreditation for the medical services rendered, respectively has no financing from NHIC, relying exclusively on the non-reimbursable external funds. This model stands out by offering the widest range of social services. We also point out that services are provided for an unlimited period of time. **Model C-integrated** implies a larger team of experts if compared to **models A and B-integrated**, based on the financial participation of LPA for the provision of services, including on a contribution from the beneficiary and renders regionally-based services. **Model D-integrated** implies the largest team of specialists (medical assistant, jurist, psychologist) providing services regionally.

The assessment data allow as to come with the some **recommendations:** (i) to develop integrated home-based care services and a regulatory basis for this purpose, including a mechanism for cooperation between healthcare institutions, social services and CSOs to provide integrated services; (ii) to develop standard job

descriptions that would outline the responsibilities of medical assistant and social worker in providing home-based care services; (iii) to continue partnerships with LPA and home-based care service providers.

References:

1. Government Decision no.1387 from 10.12.2007 on the approval of the Unique Program of Compulsory Health Insurance.
2. Government Decision no.1034 from 31.12.2014 on the approval of the Framework Regulation of the Social home-based care and Minimum Quality Standards.
3. Data of the National Bureau of Statistics. [Accessed: 29.03.2019] Available: http://statbank.statistica.md/pxweb/pxweb/ro/20%20Populatia%20si%20procesele%20demografice/20%20Populatia%20si%20procesele%20demografice__POP010/POP011600.px/table/tableViewLayout1/?rxid=2345d98a-890b-4459-bb1f-9b565f99b3b9

Date despre autor:
Diana CHEIANU-ANDREI, doctor în sociologie, conferențiar universitar, Departamentul Sociologie și Asistență Socială, Universitatea de Stat din Moldova.
ORCID: 0000-0001-5637-8211
E-mail: dcheianu@yahoo.com

Prezentat la 25.04.2019