STUDY OF POLICY ON THE DEGREE OF ADMINISTRATIVE DECENTRALISATION IN THE PUBLIC HEALTH DOMAIN

FINAL REPORT

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I THE CURRENT CONCEPT ON DECENTRALISATION ADN TERMINOLOGY

Today, the term „decentralization" is widely used in all spheres of the social, economic, and cultural life. The transition from a centralized state to a democratic and decentralized one has become one of the basic priorities and conditions for the process of adherence to the European Union and the general European values. In this respect, the principle of decentralization is present in the Constitution and in almost all the laws and normative acts, as well as in many strategies and programs regarding the modernizing and reforming the health system(1).

At the same time, the study found that the usage of the term "decentralization" by the legislative and judicial practice of the Republic of Moldova did not always correspond to the meaning and goal implied. In some cases decentralization was considered as a simple delegation of duties (powers) from one administration level to another one, "forgetting" about the financial and human resources, necessary to make these powers functional.

Currently, there are a lot of legislative acts providing for various duties the local public authorities (LPA) in the health system domain. However, the current version does not provide with a clear explanation regarding the kind of duties: specific, deconcentrated, or split (mixed). As a result, these regulatory provisions cannot be currently applied, because it is not clear delegation of duties to the LPA.

In other cases, decentralization is understood as only as certain technical operations, which have little in common with the decentralization concept.(2) Also, the study found that in many cases there was a limiting approach to decentralization. The concept was reduced to a simple distribution of authority (services) among different administrative levels. At the same time, there were not taken into account such important concept elements as the economic decentralization (privatisation and/or the enlargement of the private sector access to the process of public services provision).

All these, together with other subjective and objective causes, became an important impediment to the right understanding of the public services decentralization process. That is why, in the context of the current study, the term "decentralization", as well as other relevant terms, are defined and made clear just from the beginning.

Centralization

Centralization in public administration means a system based on hierarchic subordination of the local public authorities to the central ones. Within this system the appointment of civil servants for local government is made exclusively by the central authorities. The central government issue precepts and the local one just implement them.

Any state has a certain group of public services (interests, competences) which are of a special general importance and whose management may be effective and carried out exclusively by the central government. The number of these public services varies from state to state; however, according to the current concept about a democratic state and decentralization, the number of services provided by the central government should decrease and reduce basically to: armed forces, security, foreign policy, justice, etc. Therefore, centralization is not a negative phenomenon, but, in some cases, a necessary

and a useful one. However, it becomes a negative phenomenon when it is excessive or economically, financially, and socially groundless; thus, becoming a break in the country's development.

Advantages and Disadvantages of the Administrative Centralisation

Table 1

Centralisation Advantages	Centralisation Disadvantages
- a coordinated, prompt, and efficient functioning; - removal of overlaps and alignment; - a more efficient administrative control, providing the administrated ones with additional guarantees; - some short-term success.	- disregard of local interests; - the central government does not know the real local problems; - overconcentration and bureaucratisation of the central government; - citizens are excluded from the decision-making process and are deprived of their initiative; - long-term inefficiency and ineffectiveness.

Decentralization

The decentralization is very complex and multilateral. Each decentralization element is important and indispensable. The disregard of any element makes the process of decentralization function in an inappropriate way and may, even, bring to its blockage.

Thus, currently, decentralization is treated under the following interacting and essential aspects: *political, administrative, fiscal, and economic.*

Decentralization Forms and their Characteristics

Table 1

1. Political Decentralization	2. Administrative Decentralization
- political pluralism of the self-governed LPA (local government); - direct elections of the decision-making LPA and the direct elections of the local executive authorities; - the transfer to the LPA of the decisional power in all the matters of local interest; - better information and knowledge of the local community needs by the local decision makers; - higher degree of responsibility of the local decision makers towards the citizens who know and vote them.	- distribution among different levels of the public administration of the powers, responsibilities, and resources to provide citizens with public services; - transfer of responsibilities from the Central Public Authorities (CPA) to the LPA or some semi-autonomous agencies regarding the planning, financing, and management of certain public functions ; - combining several forms of managing public services of national and local interest in the field: deconcentration, delegation, and devolution; - developed legal framework with clear regulations regarding the powers, their nature and mechanisms of achievement.
3. Fiscal Decentralization	**4. Economic Decentralization**
- delegation and provision with adequate financial resources and capacities to the subjects who were transmitted certain public responsibilities (powers) and services; - the local government right to decide and influence the process of establishing and collecting local taxes; - providing with sufficient powers, as well as functional and human capacities the LPA subdivisions responsible for the collection and pursuance of local taxes; - the elements of fiscal decentralization are: (1) self-financing through the complete payment of services by the users; (2) co-financing: public-private partnership; (3) establishing and rising the number of local taxes for	- delegation from the public to the private sectors of responsibilities to provide public services ; - current basic forms: privatisation and liberalisation of the institutional framework; - within privatisation: (1) the private sector overtakes certain public functions and services which were under the state monopole; (2) certain services of public interest are contracted from the private entrepreneurs; (3) financing of public programs out of capital market loans (private financial institutions); (4) delegation of responsibilities to provide public services through the surrender (selling) or concession of state or municipal companies ; - the liberalization of institutional framework is carried

the provision of certain services; (4) transfer from the state budget; (5) breakdown of state revenues; (6) local heritage administration; (7) loans from national and foreign financial institutions.	out through: (1) limitation of legal restrictions regarding the private sector participation in the domain of public services provision; (2) provision of free competition and contest among the subjects of the private sector to provide public services.

The administrative decentralization knows three major principles: *deconcentration, delegation, and devolution.*

Deconcentration

Deconcentration is the delegation of powers, responsibilities, and resources in the public services domain to the local structures of the Central Public Authorities specially created to provide certain public services of national interest. It is considered a light form of decentralization. Within the framework of the deconcentration process certain services are territorially dispersed and relocated for a better function. The relationships between the deconcentrated public authorities and the central government are based on total and strict hierarchic subordination. Territorially deconcentrated authorities (services) are an integral part in the central hierarchy system. In this sense, the representatives of the territorially deconcentrated authorities are not elected by the local communities, are not subjects of their control, and are responsible only to the hierarchic superior bodies, but not to the local authorities.

Currently, according to the Government Decision Nr. 735/16.06.2003, there are 26 territorially deconcentrated services in the Republic of Moldova[3].

Delegation

Delegation is a form with a higher degree of decentralization. It represents the transfer of certain powers and responsibilities of national interest of the central government to local public authorities and other structures (companies and agencies) which have a decisional and functional autonomy. Within the delegation process the transfer of powers and responsibilities must be accompanied by the transfer of adequate and sufficient material, financial, and human resources.

In comparison with deconcentration, within the delegation framework the subjects who were transferred the powers and resources have a high level of decisional freedom and autonomy regarding the way the transferred powers are carried out and are not totally controlled by the central public authorities. The only form of control, which may be applied by the central public authorities within the delegation framework, is the opportunity control of the way the responsibilities are carried out and the way the transferred financial means used.

In the Republic of Moldova the concept of delegated powers mentioned above may be mainly deduced from the art. 6 of the Law Nr. 435 from 28.12.2006[4] regarding the administrative decentralization. It stipulates that the powers of the central public authorities may be delegated to the local public authorities of the I-st and II-nd level, observing the criteria of efficiency and economic rationalisation. The delegation of powers is to be accompanied by the provision of financial resources necessary and sufficient for their realisation.

Devolution

Devolution or decentralisation represents the total delegation of certain decisional powers, responsibilities and resources to structures having a large autonomy (regularly, the deliberative or executive local public authorities). Usually, services of local interest (municipal, regional) are delegated. Devolution is the most advanced form of

decentralization within whose framework local public authorities are independent while taking some decisions on the public services management and are not hierarchic subordinated to the central government, which may not issue compulsory orders for the LPA. The central public authorities may only request and recommend certain behaviour to the LPA or, mostly, contest in the court (administrative legal department) certain LPA acts within the framework of the administrative control and according to the procedures and regulations established by law.

In conclusion, the current judicial theory and practice of the decentralization domain offers a large scale of concepts, forms and tools, which, having been adequately studied and applied, allow us to find the best and most efficient decisions within the process of decentralization and improvement of the various public services functioning, including health care. At the same time, to carry out the decentralization process, several conditions should be observed:

a. A coherent and transparent legal framework, which would clearly establish the decisional powers and responsibilities among different levels of public administration, the mechanisms to carry them out, as well as the financial resources necessary to provide their effective exercise;
b. Central public authorities' political will and interest to fully implement the process of decentralization as a rule of law symbol;
c. To set several real and coherent goals and objectives in the key domains which would contribute to the implementation of the decentralization policies;
d. To prepare skilled and motivated staff according to its responsibilities within the decentralization process;
e. The presence of a favourable and facilitating environment to provide the creation of some partnerships between different actors involved in the decentralization process.

II THE ANALYSIS OF THE REPUBLIC OF MOLDOVA LEGISLATION ON THE ADMINISTRATIVE DECENTRALIZATION AND THE HEALTH CARE SYSTEM

At present, the precepts which refer directly to the administrative decentralization may be found in the Constitution of the Republic of Moldova, art. 109 "Major principles of the local public administration", in the European Charter on Local Self-Government (signed at Strasbourg on October 15, 1985), approved by the Parliament of the Republic of Moldova on 16.07.97, Decision Nr. 1253-XIII[5] and the following organic laws:

- The Law on Administrative Decentralization[4];
- The Law on Local Public Administration[6];
- The Law on Local Public Finances[7];
- The Law on Public Property of the Territorial Administrative Units[8].

These laws define the whole set of regulations applied to processes happening during the administrative decentralization and are the object of this study, especially, the Law on Administrative Decentralization. Other precepts, laws and acts subordinated to laws have an optional incidence on the domain and have been examined properly.

Decentralization in the context of the law on administrative decentralization

The Law on Administrative Decentralization[4] provide us with several important characteristics of decentralization. Art. 9 "Rules of administrative decentralization process" mentions that "Administrative decentralization is a continual and progressive process, which evolves along with the expansion of administrative capacity of the territorial administrative units in order to manage efficiently the public services under their responsibility". These three characteristics leave enough space for subjective interpretation, that is, the subjective assessment of a given situation. The attempt to establish whether it is a continual and progressive process inevitably defines several opinions.

The decentralization principles stipulated in the art. 3 of the Law, together with the three characteristics offered by the art. 9, actually, form the legal dimension of the administrative decentralization concept. The other articles of this Law treat mostly the technical aspect of the decentralization process, stipulation certain procedures or indicators. Therefore, the administrative decentralization is a process being characterized by several qualities (art. 9) and is carried out several hardships (principles) being taken into account (art. 3).

These principles set the way which should be taken in the decentralization process. All the actions necessary to carry out the provisions of the Law 435 from 28.12.2006 must be in accordance with the decentralization principles. Thus, we may assert that the art. 3 of the Law on Administrative Decentralization provides the foundation pillar of the decentralization philosophy.

The Law on Administrative Decentralization does not explain the concept significance, does not determine the set goal, and does not stipulate expressly the process technology. At the same time, the law presents the technical details on the preceding procedures to decentralization, as well as some conditions which are to be followed within the decentralization process.

Chapter IV "Financial and material resources of the local communities" contains provisions which, in one way or another, are already in the legal circuit due to the Law on Local Public Administration[6], the Law on Local Public Finances[7], and the Law on public Property of the Territorial Administrative Units[8].
The Law on Administrative Decentralization makes some vague landmarks, overlooking the basic questions: what is administrative decentralization and why is it drawn upon. Nevertheless, the Law on Administrative Decentralization contains several norms having univocal, precise, and explicit nature, which refer directly to the the heart of the matter.

First of all, the law determines in an exhaustive way the local public administration fields of activity, as well as the concentrated presentation of the decentralization principles. Though, the majority of principles are already stipulated in the European Charter on Local Self-Government, it is important that they are explicitly treated in the national legislation. Secondly, clear legal delimitation between the decontrated and decentralized public services and the establishment of the authority who will provide with the general coordination of the decontrated public services activities is a step ahead. Art. 7 par. 3 of the Law 435 from 28.12.2006[4] determines that it will be done through regional structures of the Ministry for Local Public Administration. Another positive innovation is the introduction of the administrative capacity concept (art.11), which is a lever and adjustment tool of the administrative-territorial structure to their resources. Although, the functioning of this concept requires detailed legal explanations and mechanisms, it is already an advancement that there exist ways of optimising the territorial structures. Another positive element is the express stipulation of the principle which considers the resources and powers as integral (art. 3 let. e) and art. 6 par. 4 – delegation of powers together with finances.

Finally, it is important that the law expressly stipulates the interdiction to decentralize and delegate from the state's responsibility to the local public authorities the constitutionally regulated public services (art. 9 al. 5).

The right to property and the administrative decentralization

The decisions of any power are mainly determined by two parameters – property and financing resources. A clear delimitation of property within the decentralization process is the major condition in the success achievement of this process. There many precepts which regulate the status of the territorial-administrative units, the Law on Public Property of the Territorial Administrative Units[8] being the major one.

The Law on Public Property of the Territorial Administrative Units stipulates in art. 1 par. 5 that "property of the territorial-administrative units may be considered any personal or real estate which was on their territory before the Law on territorial-administrative organisation of the Republic of Moldova entered into force, *except the goods which were the state's or private property.*" One would say that this precept is very clear and explains which is the state's and territorial-administrative units property; however, the statement regarding the exclusion from this list of the goods which were the state's and private property, being really a criterion which may not be easily delimited, change the clarity into uncertainty.

Essentially, the real identification of the territorial-administrative units property is done only after the state's property has been established; there is no any difficulty in identifying the private property. Though the rule is a very specific one, due to the fact

that, from the Declaration of Independence until that moment, there has not been identified and registered the whole state's property, the day the law entered into force there was not a complete data base comprising information about this property. This situation provides premises for discrepancy of opinions and conflict of interests.

The process of delimitating the territorial-administrative units' property has not been finished yet, despite the deadline prescribed by that very law (art. 15 stipulates the process accomplishment by January 01, 2000). At the same time, it is important that the legislation expressly established, though unjustified, that the estate of health care institutions is the public property of the territorial-administrative units.

The Law on Administrative Decentralization[4] enriches, to a certain extent, the technology of delimiting the state's and territorial-administrative units' property, establishing in the art.13 par. 4 certain delimiting criteria. These could be used to reaffirm the state's property over the health care field property; however, this may happen only along with the amendment of the art. 3 of the Law on Public Property of the Territorial Administrative Units.

The matter of disposed assets is still an important one in the decentralization process, including the health care field. The Law on Public Property of the Territorial Administrative Units[8] expressly stipulates the right of the territorial-administrative units to the property of the health care institutions, thus making them, de jure, owners of these institutions. Actually, before this Law entered into force (11.11.1999), the majority of health care institutions were acknowledged as owners of the territorial-administrative units and were subordinated to the local public authorities (articles 4,5,6 of the Law on Health Care[9]). Some of the local public authorities understood that this right may be exercised through the disposal of estate, part of the medical institutions heritage.

It should be mentioned that the law on Privatization nr. 627 – XII from 04.07.1991[10]in its original variant did not contain a stipulation regarding the disposal of goods, part of the territorial-administrative units property; thus, one interpreted that it did not cover the local public authorities: only on 07.03.2003, by the Law nr. 100-XV on the Amendment of the Law on Privatisation was established that it also covered the mechanism of the territorial-administrative units' property disposal (art. I, 1, 2 of the Law nr. 100-XV from 07.03.2003).

As a consequence, though neither of the laws referring which approved the privatisation programs contained a list of objects of the public medical institutions which were privatised, the local public authorities, using the uncertain statement from the Law on Privatisation, have disposed many of the public medical institutions goods. Certain legal provisions, which regulated the local public authorities at that time, served as ground for these actions.

The study found that the legislation contained many unclear and ambiguous statements which provided with possibilities to carry out such intentions. It is a hard task, often impossible to be carried out, to reset the state's right over this property. Each case is to be examined separately, whereas the solution should be established for each circumstance.

ANALYSIS OF THE LEGISLATION IN THE DOMAIN OF THE HEALTH CARE SYSTEM

Health protection is a direct and unconditional obligation of the state.

Legislation governing health protection is based on the norm of the Constitution of the Republic of Moldova which in art. 36 „The Right to Health Security" paragraph 1 stipulates the following: (1)*„The right to health security is guaranteed".* This is the stipulation which serves as the cornerstone for the whole bulk which regulates the domain in question and which according to paragraph 3 of the same article shall be established by the organic law.

Unequivocally the state, directly and unconditionally under the constitutional norm assumes the responsibility regarding health protection of its citizens. This norm is definitive for the establishing of the whole system of medical assistance, and its spirit shall be reflected and specified in all subsequent normative acts. Therefore, the state is obliged to offer unconditionally and the citizens can require from the state execution of this right.

Art. 36 „Right to Health Security" is incorporated in Title III, Chapter II of the Constitution under the heading „Fundamental Rights and Freedoms", alongside with other rights recognised by the international community as inalienable rights of modern civilization. Thus, we can affirm that the state ascertains health protection, attributing special treatment to it and assuming unconditioned responsibilities for the execution of this right.

While referring to the state obligations, we should understand this concept in the narrowest sense, that is central public authority. In conformity with the Constitution, the Government is the central public authority, therefore the supreme executive body of the country. It, in conformity with the Law regarding the Government nr. 64-XII of 31.05.90[(11)], has the obligation to execute laws and manage state affairs. The Government represents the state in civil and administrative relations. Thus, the Government and sectoral ministry are state exponents as regards the obligation to execute the right to health security.

Granting of the right denotes ensuring of the conditions when such a right can be exercised in any case, notwithstanding the circumstances. No local public authority can excess its powers and satisfy general and unconditional right to health protection, as this right should be exercised anywhere within the jurisdiction of the Moldovan state powers, but the power of the public authority extends up to the border of the administrative and territorial unit which it reprezents, in other words each local public authority has a limited territorial jurisdiction. Moreover, local public authority also has limited jurisdiction as regards the instruments of attributed power realization due to narrow financial capacities.

Analisys of the Law on health protection

As it is stipulated by the Constitution of the country, health protection is regulated by an organic law, Law on health protection nr. 411-XIII of 28.03.1995[(9)]. Being approved in 1995, and modified several times, this legislative act has not undergone essential changes, thus preserving until nowadays the spirit which dominated in the society at the beginning of the 90's. The gaps of this document are revealed not only by the noncompliance to the requirements of modern life but also to the tendencies of technological and coherent regulation. The act is in disharmony with the constitutional provisions and legislation which regulates legal regime of the local public authorities.

First of all, the Constitution (art.36) stipulates that the organic law shall decode from the legal point of view the following components: national health protection system structure, means of physical and mental health protection of the person. As regards the system structure we can state that the Law on health protection does not provide explicit regulations. Under the text of the Law in question we can not deduce how the system is structured, which elements it contains and how does the whole mechanism function.

It is the Law in question which stipulates, inter alia, as the principles of the health protection system the following: decentralized management, responsibility of the local public authorities (alongside with central ones) for the promotion of the state policy in the domain. In case when under the Constitution the state garantees a right, it (the state) shall build, support financially and maintain the functioning of an adequate mechanism for exercising of the granted right. The norms, which should specify this mechanism, shall be formulated so that they develop constitutional provisions, whereas what is stipulated in art. 2 of the Law on health protection contradicts the constitutional norm, as it transfers a part of the state responsibility to the local public authorities.

The norms of the Law on health protection were not harmonised with the provisions of the public authorities legislation in force at that time. Thus, the Law on local public administration Nr.310-XIII of 07.12.94[12], in force since 14.01.1995 until 12.02.99 did not contain any provision which would directly refer to the obligation of the public authorities to finance, organize or govern medical and sanitary institutions in another way.

It is true that the Law in question stipulates in art. 17 par. 2 lit. j) that organization of public services, appointment and destitution of executives is within the terms of reference of the (village, district, municipality) council. Even so, the provision in question can not be extensively interpreted and cover also the domain of health protection as it prevails the constitutional norm which proclaims the state guarantee for the right to health protection.

Analisys of normative acts regarding health service structure

It was mentioned above that the Law on health protection does not contain provisions regarding the regulations, mechanisms and principles of structuring of services, which provide medical assistance, even at the general level. In such a situation it is obvious that the solutions were stipulated by the subordinate acts. The Ministry of Health by means of its orders tried to cover the domain which under Constitution shall be regulated by the law.

Paragraph 2 of art. 4 „Medical and Sanitary Institution"of the Law on health protection stipulates that „public medical and sanitary institution is established by the decision of the Ministry of Health or local public authority". First of all the Law does not give any explanation what is a medical and sanitary institution and what is the legal regime of it, this is a gap which create uncertainty in terms of the system structuring. Secondly, the Law does not stipulate any delimitation of the terms of reference: what is the case when the founder is a local public authority and when it is the Ministry of Health. This provokes even more confusion, especially as par. 1 of art. 5 „Subordonation of Units of the Health Protection System", in the same confusing manner stipulates that medical and sanitary institutions (with some exceptions described in the Law) are subordinate to the Ministry of Health and local public authorities.

In addition there is one more norm which directly covers local public authorities, art. 6 - „Terms of Reference of the Local Public Authorities in the Domain of Public Health

Assuarance", where the right of local public authorities to establish medical and sanitary institutions is not mentioned at all. Consequently there is complete ambiguity about what is a medical and sanitary institution, how is it established and whom it is subordinate to.

The Ministry of Health clarifies the situation regarding the health protection system organization by its own acts. The structure of the domain is configured by two documents issued by the Ministry of Health: Regulations nr. 03/20-99 of 06.04.2006 regarding public medical and sanitary institutions involved in the system of the obligatory medical assistance insurance, approved by the Ministry of Health and the abovementioned Order of the Ministry of Health nr. 404 of 30.10.2007, Regarding legal delimitation of the primary medical assistance at district level.

The first document explains the legal regime of the public medical and sanitary institution, and the second traces the configuration of the system which includes medical and sanitary institutions at the district level. It is worth mentioning that the notion of „medical assistance" is not covered by the Law on health protection, being put in the normativ circuit by Law Nr.1585-XIII of 27.02.98 regarding obligatory medical assistance, still being undefined, and its understanding and interpretation remains at the level of use and tradition. The deciphering of this term would not be of applicative importance, if it did not have derivatives like, for example, the notion of „primary medical assistance", which is not present in the legislative acts vocabulary.

The regulations on public medical and sanitary institutions involved in the system of the obligatory medical assistance insurance from the very beginning declares that it „stipulates the procedure of establishment, property formation, operational activity, principles of financial sources and property management, accounting, reasons and procedure of reorganization and liquidation of the public medical and sanitary institutions involved in the system of the obligatory medical assistance insurance". While reading the text of the act, we can see that the procedure of establishment, which is the key element of the legal status, in fact is not given in the text of the act. Neither is it found in Order nr. 404 of 30.10.2007, Regarding legal delimitation of the primary medical assistance at district level. But it is quite obvious as the procedure of public institutions establishment is a general one stipulated by the civil legislation.

Article 183 of the Civil Code[13] states that an institution as a legal entity is a non-commercial organisation established by the founder with the purpose of carrying out administrative, social, cultural, educational functions, as well as other functions of non-commercial nature. Art. 184 par. 1 of the Civil Code specifies that: „A public institution is established on the basis of an act issued by the public authority and is fully or partially financed from its buget". In case of public medical and sanitary institutions general rule is applicable, i.e. the competent public authority takes such a decision, forms the administrative board, grants property to the institution, offers financial support and monitors its activity. But due to the fact that the Law on health protection contains vague and ambiguious norms these terms of reference were infringed. Normative acts of the Ministry of Health also do not clearly stipulate the legal status of public institutions.

Obligatory medical assistance insurance

The system of obligatory medical insurance was implemented in 2004, based on the Law on obligatory medical assistance insurance nr. 1585-XIII of 27.02.1998[14], which has rebuild the main mechanism of financial flow establishment. The system of medical insurance completely changed the interrelations between medical and sanitary institutions and their „founders", no matter who they were, or other administrative bodies (other than founders), as the relation of dependency between the institution and

the body whose terms of reference could influence its activity was placed in another perspective, or, in terms of the Law on health protection (art. 5) - subordination relations. Detailed analisys of the legislative framework is attached to the present report.

In conclusion, as the norms of the Constitution refer both to the autonomy of the local public authorities (art. 109) which, in conformity with the European Charter on local self-government, denotes „the right and the ability of local authorities, within the limits of the law, to regulate and manage a substantial share of public affairs under their own responsibility and in the interests of the local population" (art. 3 Concept of local self-government), and to the guarantee regarding the right to health protection (art.36), which denotes direct obligation of the state to assure this right, the legislation should be formulated in such manner that it clearly states the correlation between these two dimensions of the society life.

The Law on health protection does not contain regulations regarding the rules, mechanisms and principles of structuring of the services which offer medical assistance. It is in dissonance with constitutional provisions and legislation which regulates the legal regime of the local public authorities. The Ministry of Health by means of its orders has amended the current legal framework. The system of medical insurance completely changes the relations between medical and sanitary institutions and their founders or other administrative bodies as subordination relations are placed in another perspective.

III DECENTRALIZATION OF PUBLIC SERVICES OF THE REPUBLIC OF MOLDOVA

Evolution and general characteristics of the current situation

Analysing the evolution of the decentralization process in different domains which took place during the last 17 years in the Republic of Moldova, we can state that this process was and continues to be a very complicated, contradictory and troublesome.

Until 1991 the Republic of Moldova was a part of the state with the most centralized form of public government - USSR. The process of decision making was an exclusive prerogative of the state and central authorities. Decentralization and local autonomy as the principles of organization and operation of the local public administration were completely excluded from practice of law, and correlations between different levels of public administration were based on hierarchy and direct subordonation („vertical chain of command", „democratic centralism"). As a result, this hypercentralized, extremely ineffective and expensive system collapsed. Among the latest features of this system there can be mentioned such as limited number of public services, their low quality, high expenditure for their maintenance, inefficiency of economic and financial management, high level of corruption and burocracy.

After 1991 alongside with democratic transformations, which took place in the Republic of Moldova, local public administration was designated to exercise new terms of reference and assume new obligations regarding management of different public domains of local interest. In particular this was done based on the provisions of the Constitution of the Republic of Moldova under which for the first time the principle of local self-government and decentralization of public services were legalised as fundamental principles of organization and operation of the local public administration. Later these principles were developed within the framework of multiple reforms of the local public administration system which took place in the course of the recent 17 years (6 laws regarding local public administration and 3 laws regarding administrative and territorial reorganization).

Likewise there also should be mentioned „European Charter of Local Self-Government" an international normative act which the Republic of Moldova acceded in 1998. This international act alongside with other important regulations stipulates that „ local public authorities are one of the main foundations of any democratic regime" by means of which „ the right of citizens to participate in the conduct of public affairs" „ can be most directly exercised". And this assumes the existence of the local public administration authorities having decision-making bodies, being established on democratic basis and enjoying wide autonomy regarding terms of reference, procedures to exercise them and necessary means to accomplish their mission.

Therefore, the European Charter defines local autonomy as „the right and the ability of local authorities, within the limits of the law, to regulate and manage a substantial share of public affairs under their own responsibility and in the interests of the local population" considering that „ Public responsibilities shall generally be exercised, in preference, by those authorities which are closest to the citizen".

Following these principles in the Republic of Moldova there were drawn up a series of regulations with regard to decentralization and transfer of some duties, tasks, property assets, etc., to the local public administration. Gradually the local public administration became responsible for public facilities services, heat and water supply, maintenance of

local roads, local transport, property management of the institutions from the domain of education and health, etc. At the same time local public authorities based on various normative acts were to assume numerous obligations and duties of national interest which as a rule are within the terms of reference of the central authorities. In addition to it within the process of decentralization some public tasks and services became the subject of the privatization process or their implementation was transferred to the representatives of the private sector (electric power and gas, water supply and sewerage, notary service, stomatology service etc.).

Notwithstanding such measures and even some quite positive results in certain domains, it should be mentioned that at present the general situation within the process of decentralization in the Republic of Moldova can be assessed as quite complicated and uncertain. At present, we can state that the process of decentralization has started in many domains but is not finished in any of them. Thus, for example, in the domains of education, health and social protection we are in the situation of partial decentralization, where a great number of duties are attributed to local public administration, the legal nature of which until nowadays is not clearly defined: proper, delegated or shared terms of reference. This leads to authority overlapping, conflicts regarding terms of reference and also gaps when it is a question of financing.

Therefore, it can be stated that many reforms and measures which concerned decentralization of certain domains were implemented without good preparation and well defined conceptual foundation based on scientific, legal, economic, financial, social etc arguments. As a result the majority of reforms and measures which are being implemented in the field of decentralization have an inapplicable and formal nature, thus they do not reach their objective and do not lead to the improvement of the situation in the domains in question, more than that in some cases the situation became worse (for example: decentralization of heat supply services).

Decentralization of some public services

On Analysing the decentralization process which took place in the Republic of Moldova during the last 10 years, the study results showed that within this process there were used many forms of decentralization mentioned above, but the degree of success was different.

The adoption of the Law on property[15] (1991), the Land Code[16] (1991), the Law on privatization[10] (1991) and the Law regarding housing resources privatization (1993) initiated the process of economic decentralization of special importance, in which local public authorities played an important role, as they were for the first time recognised as subjects of municipial property right being attributed many decision-making powers in the process of privatization of different categories of assets. Alongside with the fact that as a result of the privatization process there took place wide economic decentralization, the major part of land and housing resources was privatized, local public authorities on behalf of the corresponding administrative and territorial units became owners of some assets (land lots, edifices, constructions, housing and non-residential premises etc.) which later constituted the property foundation of the local autonomy and local public services.

Another case of successful economic decentralization of some public services is the privatization in 2000 of the electric power supply network by the Spanish company „Union Fenosa in Moldova" which bought 100% of shares of three supplying enterprises – Joint-stock company „RE Chisinau", Joint-stock company „RED Centru" and Joint-stock company „RED Sud". As a result for the first time a public service of special importance

was completely transferred to a private economic agent, which managed to solve the problems existing in that domain at the corresponding moment and ensure continuous and qualitative supply of electric power to the majority of the population of the Republic of Moldova.

The creation since 1997 of the private notarial system by means of transfer of the right to execute the service of public interest – defense of legal rights and interests of persons and state by execution of notarial acts on behalf of the Republic of Moldova to the private notaries can also be mentioned as a successful form of economic decentralization.

In the context of present study it should be mentioned that in the domain of health there are also cases of successful implementation of economic decentralization. It is worth mentioning that since 1999 by the Decision of Government 672/21.07.1999[17] there started the process of liberalization in the field of stomatology services by means of establishment of state stomatological enterprises on the basis of public institutions and their transfer to self-supporting basis. At present the situation has significantly developed and the major part of stomatological services is offered by private clinics and stomatologists. This ensures quite big competition and therefore has a positive influence on the quality of services rendered.

The transfer of some public assets and services from the state property to the property of administrative and territorial units constituted one of the main forms of administrative decentralization which took place in the Republic of Moldova starting mainly in 1999 after the Law on public property of the administrative and teritorial units[8] was adopted. The Law stipulated certain rules regarding the procedure of assets and services transfer. As a result of implementation of this form of decentralization within the period of 2000-2002 the main public services of vital importance for the population, such as: water supply and sewerage; heat supply; housing and communal services; social services were tranfered into property and management of the administrative and teritorial units [18-20].

Analysing the current situation with the corresponding services and problems of local public authorities regarding their normal operation we can conclude that this form of decentralization has not yet showed expected efficacy and expedience. At present we can observe serious problems in supplying population with water, heat and housing and communal services. Moreover, in some domains we can state regression in comparison with the situation until decentralization. For example, in the majority of towns the systems of centralised heating do not exist. Also there is a difficult situation with water supply and sewerage.

In conclusion, though at present there are different opinions and discussions about the form, mechanisms and effects of decentralization in some of the domains mentioned above (especially regarding privatization), mistakes which were made in that period, we still have to recognise that in general this process was necessary, important and effective one which influenced greatly the economic relations of ownership and way of functioning of the corresponding services.

IV INTERNATIONAL EXPERIENCE IN THE DOMAIN OF HEALTH SYSTEM DECENTRALIZATION

All countries of the former socialist camp and those which became or aspire to become members of the European Union have undergone the process of reformation in health system. Each of the corresponding countries has acquired rich experience both positive and negative, which has to be studied carefully and taken into account in the process of reformation of the health system of the Republic of Moldova. Efficient and adequate use of the corresponding positive experience, its adaptation to the conditions of the Republic of Moldova can contribute to the acceleration and efficiency of the reform.

Premises and general principles

The following are the rules and general principles resulting from the experience of some countrie which have to be taken into account within the process of reformation (decentralization) of the health system[21]:

1. With the aim to achieve the objectives and goals set forth, the reform in health care shall be based on the explicit and developed legal framework, which clearly defines the role and duties of the state (central public authorities), local communities (LPA) and private sector, as well as the procedure of rendering, financing and regulating of services in the given domain.
2. Health care reform is a complicated multidimensional process. That is why partial or incomplete reforms generate incomplete results and lead to the system distortion when they are not correlated with reforms and changes in other domains such as: the state of law, public administration, transparency, organisational and institutional development etc.
3. The role of the state in ensuring of services in health care domain is and will continue to be highly important as these services are of national public interest. In particular the role of the state consists in drawing up and implementation of public policies, financing and taking many aspects into account, such as: economic and that related to the social solidarity, property and provision of citizens with medical services, contracting of services based on public and private law, adoption of the corresponding legal framework.
4. Without adequate and stable financial ground poor citizens will get unsatisfactory treatment at public institutions supported from public budget.
5. For the majority of population their needs in medical services are better ensured by medical institutions (systems) financed by the public budgets, but with certain share of involvement (participation) of the private sector – mixed system.
6. Primary health care shall be of constant priority and adequately structured, financially supported and integrated into the framework of a mixed system of health care: with participation of public and private sectors.
7. The participation of private sector in financing and rendering of medical services shall be well defined, structured and strictly regulated. As a rule, private sector is designed for rendering services for those belonging to the social stratum with average and high income.
8. Practically in all health care systems there exist and will exist possibilities to involve private sector into the process of medical services rendering, participation in

financing of various activities within the framework of health system as well as its involvement into the process of self-regulation.

9. Reforms in health care shall aspire to the creation of a mixed system based on public/private partnership in financing and rendering of medical services.
10. As a result of decentralization processes in some countries medical institutions and obligations to finance them were transferred from the centre to the territories, but in many cases this transfer was realised without transfer of resources, decision-making terms of reference, property and other associated elements. Therefore, it was confirmed that decentralization can be successful only if all institutional, organizational, financial, administrative and political structures are transferred and concentrated at the local level. Alongside with it low level of management capacities, lack of financial resources and limited rights to decide on the transferred assets considerably diminishes the importance of descentralization and involvement of local authorities. Thus, decentralization as a public policy shall be based on real assessment of local capacities, and redistribution of the terms of reference within the framework of health system shall be grounded on certain institutional, organizational, operational, economic, financial, social and other criteria.

The Czech Republic: experience

The Czech Republic is one of the states which quickly abandoned the old system of health care of the Soviet type and successfully replaced it with a European system based on pluralism, obligatory medical insurance and cooperation of the public and private sector in the process of providing medical services for population [22]. As opposed to other countries, Cehia did not hesitate much in finding of a new better formula and initiated the reform in health care by means of liberalization of many sectors. Among the basic lessons learned from the experience of the Czech Republic there can be mentioned the following:

1. If the state „guarantees" the right to health security and minimum medical assurance, it means that it also assumes final responsibility for the system solvency and fulfilment of contractual obligations;
2. Accordance of the administrative (managerial) independence (autonomy) imposes high degree of transparency and responsibility within the framework of decision-making process;
3. The state has to preserve a certain supervisory role regarding quality of services and activity of providers in the domain of health care;
4. Public/private partnership in the domain of health care means that financing and rendering of medical services is carried out by both public and private sectors;
5. The activity of independent doctors has a private nature even in cases when their activity is financed from public funds. Their activity is equivalent to that of private doctors who order services at public hospitals (laboratories, operating rooms);
6. Irrespective of the sources of financing (private, public, mixed), hospitals remain public (public property).
7. With the aim to ensure the efficiency of the reformation process of the health care system there shall be provided the framework of effective communication and cooperation between all interested actors: those who draw up and implement public policies, those who render medical services, representatives of professional associations of doctors and patients, general public.

Republic of Estonia: experience

In Estonia, as in other countries of the region, the primary objective at the first stage was to switch from the hypercentralised and subsidized system of health care to a decentralized one, based on the modern and effective system of social insurance. At the second stage there were analized the results of the first stage and made necessary corrections with the aim to make the new system more efficient, transparent and correlated with the European Union standards.

The system of health care of Estonia underwent 2 esential stages of reformation. The first stage took place at the beginning of the 90s, when the health system structure was essentially modified and drawn up the principles of the present system. There was adopted legal framework on the implementation of social health insurance, as well as on the principles of medical services rendering organization. Alongside with it at this stage the departmental medicine was integrated into the national system of health care, with the exception of medical assistance rendered to the persons enrolled for military service and those from the penitentiaries, thus preserving some separate medical services rendered to detainees, including some hospitals. The second stage of reform started in 1999. The measures undertaken during the second stage were mainly directed at service providers. There were changed legal and organisational forms, improved and updated management principles, concretely defined functions and responsibilities of the parties, as well as increased the purchasing capacity of the Medical Insurance Company (Estonian Fund of Medical Insurance) for services in the domain of health care. Thus, nowadays Estonia is considered to be one of the countries with the highest progress in the domain of health system reform and many things can be learned from its experience.

Since 2002 the hospitals in Estonia are defined as "economic unit created with the purpose of rendering out-patient and in-patient medical services". Such an approach offers to hospitals the statute of an economic and entrepreneurial complex, making innovative institutional forms as well as legal, financial and management instruments more accesible and effective. There are 2 main legal forms of activity stipulated by the law for hospitals: joint-stock company and foundation, where shares are held by municipalities, but more and more hospitals start working in conformity with the private-law.

The degree of the hospitals autonomy permanently increases, many of them acquire the right to decide on capital investments (renovations), staff employment and dismissal and salary negotiation. The main problem which was present at the beginning of the hospital sector reform was surplus of beds. At present the number of beds for active treatment constitutes cca. 6000 beds, in comparison with 18.000 beds in 1991. The number of hospitals was reduced approximately thrice. At present stage there are contracted 2 regional hospitals, 4 central hospitals, 9 general hospitals and 3 local hospitals for the total number of ~1.3 mln residents of the country. The reduction of the number of hospitals became possible due to the Master Plan of hospitals reform drawn up with the support of international experts in the period of 2000–2003. On merging of some hospitals into one legal person there still is a problem of unused premises. These premises in case they are available (hospital property) can be sold by the hospital and resources redirected or invested into the development of a newly created regional hospital.

An analysis of the hospital expenditure structure shows that 30% of financial sources are used for consumables and drugs, 50% - for medical staff and 15% - for infrastructure maintenance. The average monthly salary of a doctor in 2007 constituted ~30.000 MDL.

Hospitals differentiation is done depending on the range of services which can be legally offered by a district or regional hospital. All services which are allowed to be offered are stipulated in the license for activity. The criteria are approved by the Order of the Minister, which stipulates the requirements towards premises for service rendering as well as equipment. The Order stipulates the list of obligatory services which are required to be rendered, services which can be rendered, out-patient services which can be rendered.

Since 1993 there was initiated the reform in the sector of primary medical assistance (PMA). At present, each person has the right to choose the family doctor. On average each doctor supervises approximately 2000 persons. Family doctors are legal persons and have contracts with the insurance fund. Notwithstanding the fact that there are undertaken measures to motivate medical staff and create better working conditions there is a shortage of family doctors, including in Tallin city. The quality of services rendered is supervised by the Health Department which is authorised to issue licenses for activity. The main lessons learned from the experience of Estonia are the following:

1. Since the very beginning the authors of the reform focused on the problems related to health care system financing and quickly introduced a system of medical insurance.
2. Insufficient attention was paid to the administrative and institutional problems, which in the majority of the countries are considered to be key ones for success.
3. The planning process in health care is quite complicated task, which requires qualified management and considerable resources. At the same time within the process of decentralization of these terms of reference to the administrative and territorial units of the I and II level this aspect was not taken into account.
4. As a great problem can be considered the absence of a national plan (strategy) in the domain of health care reform, as well as absence of any estimation regarding the number of beds or staff which should be reduced. This problem is relevant to many countries and is explained by the necessity to speed up the process of demolition of a centralized system and transfer of the terms of reference to the regions (districts, rayons) and municipalities.
5. Excessive decentralization (up to the I level of the local public administration) was recognised as the major mistake of the system.
6. Re-centralization of the planning and administration process shall take place not only within health care system but also should be correlated with other similar measures at other administrative levels such as, for example, reduction of the number of districts and rationalization of the number of municipalities.
7. Since the moment of introduction of a licensing system for hospitals (1994), the common efforts directed at the reduction of the number of beds and study of different forms of hospitals autonomy are considered a success. This experience is considered a good example worth following both by the neighbour countries and other countries where the process of health care system reformation takes place.

Republic of Latvia: experience

Latvia as the other republics of the ex-USSR had to undergo the difficult process of the Soviet health care system demolition. In the course of this process, Latvia faced a series of problems such as: arduous reformation of the old social insurance system, utopian decentralization, reformation of primary medicine, limited insurance funds, absence of adequate legal and institutional framework[22]. Latvian experience presents a special

interest as one of the main foundations of the health system reform was descentralization. In Latvia the success of the health care reform was strictly linked with the establishment of good relations between central and local public administration. In addition the role of the local public administration was considered fundamental in the process of primary medical asistence development, as it is considered the basis of the health care system reformation process in Latvia.

At the same time Latvian experience in the domain of decentralization by devolution (complete transfer to LPA of the terms of reference) of the medical institutions and responsabilities to the local authorities reveals certain difficulties in implementation of such a strategy when local authorities are weak and do not possess financial resources and management capacities. In the context of the study in question of special interest are the following lessons learned from Latvian experience:

1. The property rights regarding primary and secondary medical assistance institutions were transferred to the municipial (local) level.
2. Due to the problems which appeared in relation to insufficient financing, limited managerial capacities and limited local resourses (financial basis) decentralized medical institutions became heavy, ineffective, costly and unbearable burden for the local authorities.
3. Financial resources provided by the central budget as a rule are meant for service purchasing and do not cover or insufficiently cover the expenditure related to the maintenance of the corresponding institutions and capital investments.
4. Strengthening of the family doctors status and making them equal with the other categories of doctors requires clear definition of their status and establishment of a lisencing system for their activity. The same procedure of licensing and status definition is required for nurses.
5. The legal and institutional system shall stipulate (allow) rendering of primary medical services by private doctors (based on permissive licensing system) individually or in groups, both within medical institutions and outside them (for example at home).
6. It is necessary to draw up a flexible mechanism of payment for private doctors in such a way that the given activity becomes attractive and financially secure. Also it is recommended to provide for tax concessions on income tax for private doctors.
7. Clear rules which make the system of payment transparent, attractive and formal can contribute to overcome the problem of unofficial payments. If the experience regarding payment establishment in primary medicine can be considered positive, then as regards secondary and tertiary medicine the given experience is not considered quite successful. According to the opinion of some experts it was even negative and pernicious. Among recommendations there was a proposal to evaluate alternatives and elaborate better mechanisms.

Republic of Macedonia: experience

Macedonian experience is of interest as opposed to the countries mentioned above, this country since the very beginning (socialist period) had a health care system with high degree of autonomy and decentralization. Within the transiton period there were applied many concepts and approaches towards the process of health care system reform. Thus, within the period of 1991-2001, there took place a kind of centralization with preservation of the decentralized structures, and since 2001 Macedonia again

returned to the decentralization principle in health care within the framework of the general national policy of state democratization and decentralization. The main objective of this process is to bring services as close to the citizens as possible by devolution of services in the domain of education, social protection and health care to the administrative and teritorial units (municipalities, LPA).

Until 1991 local public authorities (30 municipalities) had exclusive terms of reference in ensuring medical services for population, administration, financing and supervison of them. The state (central Government) was mainly responsible for planning and implementation of big projects on capital investment. Initially health care system financing was carried out at the municipial level. At the central level there was a solidarity fund managed by the Government by means of which municipalities with insufficient income were subsidized to ensure minimum financing of the public health care services. As a result of such hyperdecentralization the health care system within the period until 1991, each municipality has created its own system (structures) providing medical services for population. This led to the fragmentation of the system of medical services rendering, oversaturation and duplication of institutions and medical services. Also it was revealed that many medical units combine elements of primary, secondary and tertiary medicine. In addition to it, due to the extended autonomy of municipalities (LPA) in the domain of decision-making and financing, the influence of the central government on the process of development and reformation of the health care system at the local level was quite insignificant.

On obtaining independence there appeared the necessity of the centralized planning in the domain of health care. Therefore in 1991 there was adopted the Law on health care by means of which there was initiated the process of centralization of financing and administration of public medical institutions. Thus, the Government through its structures became responsible for the health care system administration at the regional level. Also the establishment of the Health care Insurance Fund strengthened the terms of reference of the governmental structures regarding strategic planning and administration.

At the same time there was preserved a certain degree of autonomy of the medical services providers at the local level. Alongside with it through amendments to the Law on health care of 1995 there was recognised the importance of local actors involvement into the decision-making process and proposed the establishment of administrative boards at medical institutions and involvement of LPA representatives and other local actors into these decision-making structures. Later the representatives (employees) of medical institutions and representatives designated by the Parliament of Macedonia became members of the administrative boards of the national medical institutions (2005).

Many reforms in Macedonia were implemented based on some models and theoretical evaluation. Anyway without real and objective analisys of the situation in the field, there is a risc of building the system of health care cut off from reality which does not meet the current needs of the citizens.

Nowadays in Macedonia the interest of citizens towards public primary medicine is reduced, but at the same time the number of citizens who apply for primary medicine services offered by private sector increases, as they are more accesible and better equipped. Among the main lessons learned from Macedonia experience we can mention:

1. Macedonian experience shows that there are no ideal solutions applicable for the health care system in the process of reform and very often this process can be

arduous, with possible succesive alternations from one form of administration to another.

2. The main objective followed in the process of re-decentralization was to bring services as close to the citizens as possible.
3. Excessive decentralization in some cases can lead to the fragmentation of the system of medical services rendering, and sometimes to the duplication of institutions and services offered.
4. In case of the extended autonomy the role of the central Government in health care system reformation and regulation decreases considerably.
5. Positive practice of involvement of the local public authorities into the administrative boards of the medical and sanitary institutions at the local level.
6. To obtain good results in the process of health care system reformation alongside the theoretical analisys it is necessary to have real practical awareness of the situation in the field.
7. The key factors which increase the frequency of patients' visits to the private sector institutions providing primary medical assistance in comparison with public ones is the increase of competition, greater possibilities regarding equipment and consequently higher attractiveness.

In conclusion, the process of decentralization is a necessary and complicated one. There is no golden rule on how and to what extend shall the health care system be decentralized. The degree of decentralization applied by a certain country depends on the context and reforms implemented within a certain period of time.

V ANALISYS OF KNOWLEDGE, ATTITUDES AND PRACTICES

Following the interests of this study there was evaluated the level of knowledge of medical staff and representatives of local public authorities regarding the process of decentralization in the domain of health care, described the attitude of medical staff and representatives of LPA towards the existent degree of decentralization and necessity in decentralization or centralization of the health care system, as well as the attitude of the respondents towards the process of autonomisation or privatization in the field of primary medical assistance and other levels of health care administration.

All in all within the period of October 21 – 27, 2008 there were interviewed 86 persons from all 5 districts and municipalities: Edinet district - 15 persons, Balti municipality - 18; Floresti district - 17, Straseni district - 17, and Comrat municipality - 19 persons.

The research team assumed the initial hypothesis that the target group composed mostly of health care domain workers is not fully aware of the process of decentralization in general and within the health care system in particular. This may be due to the fact that the knowledge acquired during the years of study could not provide information about these concepts, since the majority of the respondents have done studies in Soviet times, when there was a highly centralized system of health care. This is the reason why we assume the possible risk that the answers to some questions can be distorted if the respondent understood them wrong.

The results of questioning show that the majority of interviewed persons qualify the health care system in the Republic of Moldova as partially or moderately decentralized.

The respondents from the regions where there are departments of health care very often express the opinion that health care system is a centralized one, compared with regions where such administrative structures do not exist. For example, 44% of respondents from municipalities noted that the system is centralized compared to 18% of respondents from district centers. It is also interesting to mention that only doctors noted in their answers that the health care system is completely decentralized. Thus 31% of doctors have chosen this answer.

In conformity with the given answers, the central Government and the Ministry of Health were identified as the most important actors of the domain.

According to the opinion of the interviewed persons, the National Health Insurance Company plays the most important role in the system financing, followed by the local authorities of the 1st and 2nd levels. The role of donors and private sector was less appreciated.

Almost half of those surveyed considers that there should be a territorial authority subordinate to the Ministry of Health, which would take part in the elaboration of health care domain policies.

Another question included in the questionnaire reveals what is the respondents opinion regarding the role of local public authorities in the health care sector. The majority of the given answers show that the respondents think that local authorities have both a decision-making role and an advisory one.

According to the majority of the respondents the local public authorities of the 1st and 2nd level must be responsible for the participation in the financing of medical institutions of local public interest and development of programs of the district and local interest.

The process of decentralization, or the current level of decentralization of the health care domain are new and not quite known concepts for the medical staff, as it was mentioned above. However, the research team attempted to find out the opinions of the interviewed persons with reference to the current degree of decentralization in the Republic of Moldova and recommended decentralization models for medical assistance services.

Having analyzed the obtained results, we can see that in the opinion of the medical staff and representatives of the regional LPA under study the most decentralized sector is that of primary medicine, followed by the emergency medicine and hospital care.

Respondents have experienced difficulties when trying to recommend the most optimal decentralization form for different types of medical assistance. The results show that for all health care domain services listed in the questionnaire the most recommended model of decentralization is administrative decentralization. Economic and fiscal decentralization have been less cited as the optimal model.

To find the opinion of persons from the group under study about the level of autonomy of medical institutions in the primary sector, they were asked if they consider appropriate direct contracting of family doctors offices by the National Health Insurance Company. The responses show that PMSI managers are the biggest opponents of direct contracting (59.3% answered negatively), while doctors would accept this change much easier (72% affirmative responses). There was not a big gap between the responses of primary sector staff and hospital one. If we compare the received responses by region, then we see a lower rate of positive responses in Straseni and Comrat compared with the northern regions of the republic.

Less than a half of all respondents who participated in the study consider that there are can be offices of family doctors or private doctors. There is a big difference between the responses depending on the function the person helds, but this difference was not statistically significant. Thus 70% of the LPA representatives support the existence of OMF and private doctors opposed to 23.8% of employees with secondary education.

Most respondents (77.6%) believe that in the Republic of Moldova there may exist private hospitals, the question being referred to municipal and district or regional hospitals. Depending on the position held by respondents LPA officials answered affirmatively most often. 90% of representatives of this group believe that private hospitals may exist as opposed to 71% of employees with secondary education. It is interesting to note that the interviewed from primary medical assistance sector were more frequently for private hospitals (85%) compared with those of the hospital sector (69%).

Detailed analysis of knowledge, attitudes and practices are attached to this report.

In conclusion, health care employees are not fully aware of the concept and process of decentralization within health care system and most often can not properly assess currently existing degree of decentralization. In general, LPA representatives and medical staff from regions where there are departments of health believe that the health system is highly centralized and are less optimistic about the opportunity of decentralization compared to the same categories of persons from other regions. Almost half of those who answered the questionnaire believe that there should be a territorial authority subordinate to the Ministry of Health, which would participate in the elaboration of policies for health care domain. According to the opinion of the survey participants, the basic functions of LPA are: "Participation in the financing of public medical institutions of local interest" and "Development of programs of district and local

interest". According to the respondents' opinion, administrative decentralization model is the most preferable for all types of medical assistance in the country. PMSI managers are the biggest opponents of direct contracting of OMF by NHIC, while doctors would accept this change more easily. Less than a half of all respondents and 70% of the LPA consider that there can exist offices of family doctors or private doctors. Most respondents think that in the Republic of Moldova there can exist private hospitals. LPA representatives seemed more positive towards the liberalization or privatization process in both primary and hospital sector of medicine.

VI CONSIDERATIONS AND DISCUSSIONS

The term "decentralization" is widely used in all spheres of the social, economic, and cultural life. The transition from a centralized state to a democratic and decentralized one has become one of the basic priorities and conditions for the process of adherence to the European Union and the general European values. As it is stated "public services decentralization", it is stipulated by the Constitution of the Republic of Moldova, art.109 "Major Principles of the Local Public Administration" as one of the basic principles which lies at the background of the public administration in the territorial administrative units. The notion of "administrative decentralization" as a law institute is expressly stipulated in our country's legislation quite late, in the Law on Administrative Decentralization(4).

The need to synchronize the central and local governments' reforms. When speaking of the administrative decentralization, one cannot, generally, avoid the discussion regarding the government reform. The administration of public affairs is performed in two directions – at the whole country level and at the local community level. The definition of the relationship between the central and local government cannot be separated from the process of rearranging the central public authorities' powers and functions. It would be better to say that both processes are to be performed in a synchronised and correlated way.

In some cases centralization should replace decentralization. The administrative decentralization should not be treated as a compulsory procedure which would delegate some of the central authorities' powers to the local ones. This is a superficial and mechanic understanding, which cannot develop the potential of this mechanism. The administrative decentralization is not only a delegation of powers, but also a mechanism of structuring their best in all their projections, both horizontally and vertically. In this sense, we ascertain that, following the best adjustment of the public services structure to the public needs, in some cases centralisation, not decentralization ought to be applied to some services.

Local self-government is a fundamental principle. There are several reflection points which took shape while analysing: (1) correlation between the administrative decentralization and the public administration reform; (2) the impact of the administrative decentralization on the local public self-government, and (3) the public benefit resulting out of the administrative decentralization. Local self-government is the fundamental principle which governs local public administration and represents the territorial administrative units' right to satisfy their own interests, without central authorities' interference, certainly within the legal prescription.

Decentralization should be treated from the public benefit perspective. The principle of local self-government results in administrative decentralization; self-government being e right, whereas decentralization – a system through which the powers are distributed in such a way that they lead to self-government.

In this connection, we mention that public services decentralization, as it is prescribed by law, should be treated from the public benefit perspective and may exist only if two objectives are satisfied: the first is that the decentralization is carried out to the benefit of the territorial-administrative units' population; the second – decentralization does not affect the society at national level.

The legal framework should be directed to solve the social situation. The above mentioned statements lead us to the conclusion that, both the legislation on administrative decentralization and that which will interfere to adjust the legal

framework, ought to project mechanisms and formulae to solve the social situations, taking into consideration certain guide marks, whose finality is the individual's interests.

The classical relationship supposes finances. Financing is a determining element, as the public institution is created with a certain goal – to carry out the activities meant to exercise the powers of the public authorities which have founded them – and the financing from the founder's budget is the connection which links directly the institution with its founder. The periodical or systematic financing done by the founder is the main existence source of the institution, thus creating a direct dependency.

This financing justifies the control of the activity and the exercise of a special influence on the institution. In the case when the institution is supported by other means, it gains a certain autonomy, which, though it is not reflected in the legal regime, influences the interest and the obligation to control and manage, which is usually the founder's priority.

Along with the development of the capacities and the welfare increase there would be the situation when the financing sources in the health care domain would be formed almost out of the medical insurance means. It is obvious that in this context, the role of the central public authorities' administrator (the Ministry of Health) would considerably diminish and any interference of the local public authorities would disappear. This is another argument to exclude from the local public authorities' powers the health care domain. And, the sooner this tendency would be understood, the better the processes dynamics would be managed, adjusting the formal conditions of the medical institutions activities to the forces which determine these processes.

To consider the legal issues of the reform. At present, the authors of the public administration reform in the health care domain are confronted with several legal issues: (1) the legislation regarding the administrative decentralization and medical assistance services; (2) the legal solutions for the reform of the health care services administration in the context of the central public administration reform; and (3) the adjustment of regulations in the health care domain to the general legal framework and the medicine's objectives.

The *administrative decentralization has no incidence over the health care domain.* The study proved that, in fact, the situation is quite transparent and all the gathered arguments speak univocally that the decentralization, as a procedure of power delegation from the centre to the periphery, has no incidence over the health care domain. First of all, the Constitution establishes the state's guarantee to provide the right to health protection, which excludes any delegation of responsibilities for the domain management and the medical services provision from the stat's central authorities to the local ones. Then, the Law on Administrative Decentralization expressly stipulates the prohibition of decentralization and delegation of the local public authorities services, constitutionally regulated, these being directly and exclusively guaranteed and provided by the state.

Health protection is not contained in the list of the LPA activities domains. In addition, the legislation does not provide for the health protection as an activity of the local public authorities, which means that the power to manage the medical services is to be excluded from their jurisdiction. From the operational point of view, the management of the medical services by the local public authorities is inefficient, because the financial flows are mainly composed out of medical insurance means, and the state is, currently, the major provider. . In addition, the legislation does not provide any norms which could be interpreted as the local public authorities should have the power to manage the medical services.

More than that, we cannot find statements of any other nature (social, economic, managerial) which would lead to the conclusion that, for the common good, the LPA are to overtake completely or partially the task to provide the population with medical services. Since the Constitution adoption, one should have placed on pending the regulations set that would have clearly structured the medical services scheme, excluding the local public authorities interference. Unfortunately, inaction and lack of clear understanding of the situation provided with a confusing approach, manifested through current policies, legal particular and controversial adjustments.

The legislation stipulates another way to organise the medical public services. When we ascertain that the medical services are not subject of the administrative decentralization, we only explain an aspect of the equation. At present, the medical services (the public medical institutions) are formed in such a way that the local public authorities could participate to their management, as we have already proven in the study; they do it in an implicit way. Because the legislation stipulates another way to organise the medical public services, the situation should be rectified.

In this sense, the first action to be done is the amendment of the legislative framework, so that it is in accordance to the constitutional requirements. The functioning acts of the medical institutions should be adjusted based on these amendments. Of course, it may be done only in the context of general reorganisation of the power relationships between the central and local public authorities.

Paradox: centralization as a process of administrative decentralization. In a way, analysing the current situation, we may speak of a centralisation action as a particular case of the administrative decentralization process. The answer to the question what is the relationship between the regulations on the administrative decentralization and the health care domain leads to a conclusion which is apparently contrary to the decentralization concept. This is, however, a superficial conclusion resulting from a same superficial and rigid approach of the reality. Yes, indeed, the administrative decentralization as a fundamental principle which governs the local public authorities' activity implies the separation of certain powers of the central government and their delegation to the public authorities, so that they have the capacity to manage the local communities' affairs in order to satisfy everybody's interests. But this is not a mechanical unilateral procedure drawn out of a complex reform.

The administrative decentralization treated strictly in this way is only an element of a complex process which aims at reorganising widely the public administration. It is obvious that each organisation, institution, and structure involved in this process has a limited interest, which is only a part or a projection of the general goal. One of the government's tasks, in this context, is not to exaggerate in showing a particular interest in the detriment of the basic purpose.

As there may not be a true decentralization out of the central public authorities reform, which would include the reorganisation of the managed (subordinated) services, all the actions related to decentralization and redefinition of the local public authorities powers, particularly, regarding the public services which they are in charge of, are to be carried out in a correlation between them and according to the principle of the best functional arrangement of all the public authorities powers.

Health care is one of the most sensible subjects of the public interest aspect. The reform and reorganisation of the health care services have a special significance. Being one of the few domains, which is constitutionally regulated, health care is one of the most sensible subjects from the point of view of the public interest. The changes performed by the state in the structure and the medical services functioning are immediately felt buy

the population. In such a situation, it is important that there is transparency and exactness in the scheme of changing the competences of the medical services management.

In this context, we may ascertain that the legal solutions required by the public administration reform ought to have at their background the commutation concept of all management powers of the public medical services under the central public authorities' management (the Ministry of Health). This supposes adequate amendment of the legislative acts which regulate the medical assistance. Having an explicit legislation, the Ministry of Health could come with some regulations which would specify the peculiarities of the organisation and functioning of the public medical services.

We emphasise that the Law on Administrative Decentralisation places to the forefront the inconsistency between the mechanism of medical services management and the country's fundamental law, this observation forcing the amendment of the main Law on Health care, so that it corresponds to the principle of the domain single administration: adopting a law which would correspond to the constitutional principles and the reform purposes, it is possible to draw out the background regulations which would provide a coherent and adequate functioning of the medical services.

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