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Health Sector Review

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SECTION I: INTRODUCTION

This paper is intended to serve as an update of an earlier (2008) assessment[1] that examined the key challenges in the Albanian health sector; and identified a number of prospective USAID interventions that might effectively address those challenges. The list of interventions proposed therein was constrained, of course, by resource limits and by the drafters' efforts to ensure that the cited activities were consistent with USAID's priorities and comparative advantages in relation to other donors' plans and programs in the country. The discussion below identifies some of the more important changes that have taken place in the health sector since that last overview.

Further to the Scope of Work (Annex B) for this exercise, and in view of the changes that have occurred in the health sector over the past few years, the consultant team also prepared a scope of work for a new activity that would address continuing challenges in the Albanian health system. That scope of work is attached to this document as Annex A.

Given the procurement-related aspects of the assessment and the above-noted attachment, this paper is not intended for distribution beyond USAID.

A. METHODOLOGY

The consultant team reviewed numerous reports and studies produced by USAID and other donors on the health sector in Albania, consulted with host country and international implementers and other donors, and made visits to selected field sites.

As the "flagship" USAID project ("*PRO Shëndetit*", managed by University Research Corp—URC) had ended by the time of the team's arrival, the team solicited the views of former partners and stakeholders regarding their assessment of the project's impact. The team also sought the recommendations of GOA leaders, GOA technical personnel, and the staff and leadership of other donors regarding the elements and objectives of future USAID support in the sector. The team's discussions emphasized that future USAID assistance would reflect the guiding principles laid out in the Global Health Initiative, including an emphasis on host country ownership, with investment in country-led plans; reliance on a multilateral approach to problem-solving; and efforts to build sustainability through health systems strengthening.

Finally, the team reviewed the assistance portfolios of other major donors in the Albanian health sector to ensure that 1) the proposed elements of a future USAID program did not duplicate or conflict with any of those efforts; 2) prospective USAID activities would either reinforce, or would be reinforced by, other donors' programs; and 3) other areas of long-standing importance to the USG in the region (environmental health, food quality, non-communicable diseases and various infectious diseases such as HIV/AIDS, TB, avian influenza and hepatitis) were being addressed by other donors, or would call for

[1] USAID/ALBANIA Health Strategy Review, Paul Holmes, Jessica Forrest, Gerard Bowers. 2008.

investments that would produce comparatively less sustainable impact than would investments in efforts that addressed broader, more systematic vulnerabilities in the Albanian health sector.

B. RATIONALE FOR USAID ASSISTANCE IN THE HEALTH SECTOR

The 2008 paper summarized several reasons, most of which were also reported in other assessments, for continuing USAID engagement in the Albanian health sector. These included:

- Poor health status indicators, compared to other countries in Europe
- Weak public health services
- Frequent turnover of senior leadership in the Ministry of Health
- Inadequate levels of public funding for health, again compared to neighboring countries; and
- Corruption

These factors were determined to be negatively impacting the health of Albanians—and especially of low-income families—on several levels. First, the Government of Albania's (GOA) inadequate investment in its citizens was directly reflected in the less-than favorable measures of well-being of the Albanian population. Second, pervasive corruption in the health sector was having a corrosive effect on public perceptions of the government generally, and the health delivery system specifically; and thirdly, Albania's poor record of progress in the health sector was becoming a constraining factor to efforts to facilitate the freer movement of Albanian citizens in Europe.

The 2008 paper concluded that that USAID could play a singularly important role in addressing these vulnerabilities, with specific emphasis on health reform activities that encouraged increased GOA commitment to the sector, and efforts to combat corruption.

The relatively brief assessment conducted over two weeks in January and February of 2010 found that the earlier rationale for USAID assistance is still mostly valid, albeit with some modifications: With regard to the inadequacy of GOA support for the health sector, the earlier assessment reported that Albania's public health expenditure on health was approximately 2.7% of Gross Domestic Product (GDP) in 2007, or less than half the European average. Anecdotal evidence[2] suggests that expenditures in the health sector are currently estimated to be 3-4% of GDP. Moreover, a large portion of those health expenditures (approximately 60%)[3] are provided by out-of-pocket payments by patients, especially for health services in secondary and tertiary facilities. The financial burden of this much-remarked upon system of "informal payments" disproportionately affects low-income elements of the population who do not participate in the formal workforce, and thus are not enrolled in the country's national health insurance program.

[2] Informal communication with GTZ.

[3] Albania National Health Accounts 2003. Osmat Azzam, Sotiraq Dhamo, and Tonin Kola, Ministry of Health, December, 2004.

As the two major vulnerabilities in the health sector (inadequate funding for the sector/inequitable burden of health care costs on the poor) reported in the 2008 review continue essentially unabated, they should continue to be a focus of USAID's assistance efforts in Albania. The review conducted this year, however, found that changes in the country's political, legal and administrative environment, as well as modest but important improvements in health conditions in Albania, called for refinements in the orientation of USAID's health assistance program. These changes are noted below.

C. CHANGES IN THE ALBANIAN HEALTH SECTOR SINCE 2008

Several important developments that bear on prospective USAID assistance in the health sector have taken place since the last (2008) assessment. These include:

1. Passage of the **Law on Health Care** (March 30, 2009), and the **Law on Public Health** (May, 2009)**:** The new laws are essentially descriptive, and lack implementing regulations. Moreover, the GOA has not yet adopted the National Health Sector Strategy of March, 2007 (currently being updated). That said, some of the Health Care Law's provisions have the potential to improve health care across the system. These include:

- Legal Formalization of mandatory **Continuing Medical Education:** Among its other provisions, the 2009 Law on Public Health Care mandated, for the first time, compulsory re-certification/re-licensing of some 10,000 physicians, dentists and pharmacists. That re-certification and re-licensing is to be provided every five years upon the professionals' completion of at least 150 continuing education (CE) credits obtained over that five-year period, with the first cycle (Phase I) beginning in January, 2010. According to the Director of the newly-created National Center of Continuing Education (NCCE)[4], the second phase of the activity will be expanded to include nurses if "all goes well" with Phase I. The obvious value of the new program is that it may bring Albania's adherence to CME requirements into theoretical consistency with European practice. Less clear, however, is the rigor with which claims of CME credits will be monitored. The law allows medical practitioners to claim CE credits for conferences, courses, workshops, study visits, as well as job-related articles read in journals or websites. Self-reporting can account for up to 20% of credits awarded.

- Compulsory **Accreditation of Hospitals:** The Law states that all hospitals must obtain MOH accreditation; and requires that such accreditation will be granted upon the hospitals' adoption and compliance with a minimum package of service provision standards and protocols to enhance quality and ensure patient safety. The law does not, however, set any deadline by which institutions must obtain accreditation, nor does it identify the standards and protocols with which the institutions will be expected to comply. A newly-established National Centre of Quality, Safety and Accreditation (NCQSA) is charged with the development of these standards and protocols, drawing especially on European models. The

[4] The CME program, and the NCCE, are funded by the Swiss Government.

director of the center advises the consulting team, however, that he is encountering significant resistance from hospital directors, and from the Faculty of Medicine in Tirana, and does not expect timely implementation of the Law's requirements.

2. Completion of the ***PRO Shëndetit* project:** USAID/Albania's flagship project in the health sector came to a close in September, 2009. The project can claim several accomplishments. These include:

- *PRO Shëndetit* project reforms provided a foundation for a major assistance program launched by the World Bank (see below). Indeed, the World Bank insisted upon GOA adoption of several tools and interventions developed under the *PRO Shëndetit* project as pre-conditions for Bank assistance.

- Development of a Basic Package of Medical Services at primary health care centers (PHC). The basic package has been adopted nationwide, and serves as a basis for funding of PHC by the Health Insurance Institute (HII—see below). Moreover, the approach taken to establish the package serves as a model for ongoing efforts by the MOH and HII to establish a comparable (i.e., HII-reimbursable) "basic services package" of care at secondary and tertiary levels of the health care system.

- Conversion of GOA Health Centers (HCs) into autonomous facilities responsible, further to contracts executed between the Center and the HII, for the delivery of primary health care services to the population.

- Creation of a functioning Health Information System (HIS). The HIS developed and installed by the project on a pilot basis in five prefectures is now in use nationwide, and serves as the primary basis for HII reimbursement to Health Centers and pharmacies for services and drugs, respectively.

- Other achievements of the project were more noteworthy for their potential than for their continuing impact. These included the development of a system of Supportive Supervision; completion of a Training Needs Assessment; creation of Manuals for Family Medicine for use by general practitioners (GPs) and nurses; and development of a Health Promotion Manual and the associated training of health promotion personnel in 16 districts. The adoption of any or all of these measures would significantly advance primary health care in the country; none, however, has received adequate funding to make them operational.

3. Implementation of the **World Bank "Albania Health Sector Modernization" Project:** While the five-year (2006-2010) $15.4 million project[5] nominally started in September, 2006, it experienced a number of delays getting under way. Key among these

[5] Major elements of the project include technical assistance in health financing, health sector stewardship, and the purchase of information technology (IT) equipment.

delays were—and continue to be—inaction by the GOA in adopting a Health Financing Law that would, *inter alia*, establish and regulate a compulsory national health insurance program managed by HII; and delays in the tendering process for IT equipment. As of February, 2010, only 30% of project funds had been disbursed (although 50% has been contracted). The Bank has requested an 18-month extension which, if approved, would extend the project into early 2012. The Bank has also reduced the amount of funds originally allocated to technical assistance, and shifted those funds to equipment procurement.

4. Expansion of the **HII Single-Payer System** to include Secondary and Tertiary Facilities: By far the most noteworthy development since the 2008 assessment has been the GOA decision to expand the HII contracting mechanism to include virtually all of the country's (non-private) health care system. As of February, 2010, HII had executed contracts (based on the HII-HC model for primary health care) with all 39 of the country's secondary and tertiary hospitals.[6] HII's long-term goal is to reimburse these facilities on the basis of their performance in providing a yet-to-be-identified package of health services. In practice, and pending that development, HII is serving as a pass-through mechanism for essentially the same hospital costs that were provided historically by the MOH.

5. Completion of the **Albania Demographic and Health Survey (DHS) 2008-2009:** The Albania DHS indicates that the country has made significant progress in addressing basic public health deficiencies over the past several years. Some summary findings from the preliminary report[7] include the following:

- **Fertility:** The Total Fertility Rate (TFR) is 1.6 children per woman—a rate that is generally consistent with surrounding countries.
- **Family Planning:** While the overall contraceptive prevalence rate (CPR) is 69 percent, only 11 percent of currently married women use modern methods (condom, female sterilization, the pill), while most women continue to rely on traditional methods such as periodic abstinence or rhythm and withdrawal.
- **Maternity Care:** Compared with estimates from recent Demographic and Health Surveys conducted in other countries in Eastern Europe and Caucasus, Albania is among those with the highest coverage (>98 percent) of antenatal and delivery care by a trained provider.
- **Child Health:** Overall, 95 percent of children age 18-29 months are fully vaccinated. Among children with ARI symptoms, about seven in ten were taken for treatment to a health facility or provider; and a similar percentage (71 percent) of children with fever were taken for treatment to a health facility or health provider. Six in ten children with diarrhea in the previous two weeks were taken

[6] The sole holdout, Mother Teresa Hospital in Tirana, has objected to the terms of their contract, and is contracted on a month-to-month basis until the parties can negotiate a mutually-acceptable agreement.
[7] *Albania Demographic and Health Survey 2008-09, Preliminary Report*. Institute of Statistics, Institute of Public Health, Tirana, Albania and MEASURE DHS, ICF Macro, Calverton, Maryland, USA. October, 2009.

for treatment; more than half (54 percent) were given oral rehydration salt (ORS); and about seven in ten (68 percent) were treated with oral rehydration therapy.

- **Nutrition:** The nutritional status of Albanian children has been improving gradually over the past decade. Stunting among children under five has decreased from 34 percent in 2000 to 22 percent in 2005 to 16 percent in 2008-09. The proportion of children who are wasted has dropped from 11 percent in 2000 to 7 percent in 2005 and 7 percent in 2008-09. Finally, the percentage of underweight children has decreased from 14 percent in 2000 to 8 percent in 2005 to 6 percent in 2008-09.
- **Anemia:** Anemia among both children (17 percent) and women (19 percent) in Albania is about half the levels in Azerbaijan, Moldova and Armenia.
- **Infant and child mortality:** The IMR in Albania (18 per 1,000) and U5MR (22 per 1,000) are slightly higher than in Moldova (13 per 1,000 and 14 per thousand, respectively; and Ukraine (14 per 1,000 and 17 per thousand, respectively; but lower than in Armenia (26 per 1,000 and 30 per 1,000, respectively); and Azerbaijan (43 per 1,000 and 50 per 1,000, respectively).
- **HIV/AIDS:** Awareness of AIDS is nearly universal among women (93 percent) and men (94 percent) age 15-49 in Albania. Education, marital status and place of residence (urban/rural) were associated with varying degrees of knowledge and practices to avoid exposure to HIV.

The DHS findings lend support to observations documented elsewhere[8] [9] that the health status of Albanians is relatively good compared to other countries with similar per capita revenue profiles. Life expectancy is 73.3 years for men and 78.4 years women (2003)—an example, perhaps, of the "Mediterranean paradox". Data published by INSTAT in 2004 indicate that the leading causes of mortality are cardio-vascular diseases (286/100,000), cancer (93/100,000), and accidents and injuries (39/100,000).[10] In sum, the health profile of the Albanian population is becoming increasingly consistent with the rest of Europe.

6. Heightened Political Support for Health Sector Reform: The GOA has launched a number of initiatives that signal a change-for-the-better in the government's attention to the needs of the health sector. These include:

- Expansion of the Single-Payer system (discussed above) to the entire (public) health sector
- Vigorous debate among the MOH, HII and the Ministry of Finance (MOF) regarding ways to ensure adequate funding of the health sector (see below)
- MOH/World Bank agreement to undertake a "Health Facility Rationalization" Study that would facilitate a reorganization of regional and district hospitals

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[8] *Review of the Ministry of Health in Albania. Focus on Stewardship Function*. K. Leppo, V. Lazarevik, H. Stein and B. Nuri. WHO European Office, December, 2008.
[9] Country of Return Information Project: *Country Sheet Albania*. EU. May, 2009
[10] WHO, *Country Cooperation Strategy: Albania*. (periodical update), http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_alb_en.pdf.

- The creation, by the Prime Minister, of a Health Sector Reform Working Group, comprised of leading figures in health sector (from government, academia, major hospital centers, HII, etc.). Meeting under the chairmanship of the Prime Minister, the Group has been charged by the chief minister with the task of determining "not only the goals of the reform, but also the action plan for its implementation."

Taken separately, none of these initiatives turns a new page on the GOA's record to date with regard to the needs of the health sector. Together, however, they suggest a new readiness on the part of the country's political and technical leadership to address some of the core problems bearing on the health sector.[11]

SECTION II: STRENGTHENING THE HEALTH REFORM PROCESS

A. PROBLEM ANALYSIS

The 2008 sector assessment noted that USAID has implemented a primary health care (PHC) strategy in Albania [since 2000] because critical health indices such as infant and maternal mortality, abortion rates, contraceptive use, TB incidence, etc. were among the worst in Europe – and because these health indices were particularly bad among the 25 percent of Albania's population that lived below the poverty line, and which depended on the government's primary health care system for essential services. Drawing on past USAID evaluations and donor reports on the Albanian heath care system and conversations with implementing partners and other donors, the 2008 team recommended that USAID "[maximize] the effectiveness of scarce USAID resources by building on accomplishments in PHC and leveraging other donor commitments in health finance reform."

The 2010 sector review reported herein concluded that recent data, including the DHS, suggest the need for a more targeted assistance strategy. Overall health indices appear to have improved; but the earlier assessment's observation that Albania's poor population suffers unfairly and disproportionately at the hands of a health system that is non-responsive to their needs is still painfully accurate. More specifically, a system that demands informal payment for necessary services creates a tiered system of health care that serves those who can pay, while creating barriers to service to those who cannot. To the extent that lower income patients pay these costs, major illness can be financially ruinous. In brief, the fundamental rationale for continued USAID assistance in the health sector is evolving from a focus on primary health care, to a strategy that addresses the

[11] Albania's young democracy is still sorting out its procedures for resolution of political differences. While that process has often involved parliamentary deal-making, the country's main political parties are increasingly realizing that longer-term stability is based on electoral mandates. These parties are aware of the deep popular discontent with the country's health system—including most notably the blight of informal payments—and may be recognizing, if belatedly, the political utility of measures that address this discontent. The current prime minister, moreover, is a physician who has had his own personal experience with that health system.

systematic obstacles that impede fair and equitable access to health care for all citizens.[12]

The 2008 assessment also pointed out that improvements in the Albanian health system would serve broader USG strategic efforts to promote closer integration of Albania and the rest of Europe. That objective has been somewhat muted in previous health assistance strategies; it warrants closer attention, however, especially if actions that narrow the gap between Albanian and European health care systems also help resolve the access and equity constraints noted above.[13]

Some of the key systems-level factors that limit the capacity of the Albanian PHC system to provide quality care to low-income citizens include:

A.1: A Disconnect between the *de jure* and *de facto* legal frameworks for the Health Care System: The GOA has published an extensive body of strategic, regulatory and legislative provisions that comprise a guiding framework for the health care system—and for the health reform process. In practice, however, very few parts of this framework are enforced—or even acknowledged at operational levels of the system. GOA directives in the health sector lack clarity, are not widely disseminated, and lack provisions for their implementation or enforcement: Neither the Law on Public Health nor the Law on Public Health Care, both passed in 2009, include any implementing regulations.[14] The GOA Health Systems Strategy 2007-2013 (March, 2007) includes affirmations of the government's intentions to improve health system financing and governance; reduce financial, geographic and financial barriers to health services; reduce informal payments; improve MOH capacity to develop policy, strategies and plans, etc. The Strategy, however, was turned aside by the Council of Ministers[15] and is being re-worked three years later. A directive requiring accreditation of all public and private hospitals is silent on any dates by which such accreditation would be necessary; with very few exceptions (e.g., some drug use protocols prepared by pharmaceutical companies), there are virtually no protocols, standards or guidelines in place to assure quality of care, infection control, patient (or provider) safety, waste management, etc.[16] Parties familiar with the contents of the draft Health Financing Law have suggested that it too lacks any enabling provisions, so that its eventual passage will set the stage for a long and not assuredly

[12] The Roma population in particular have very limited access to the health system due to their low income and low levels of registration in the national health insurance program. (Glaros and others, *Health care in Albania: What is the future*?, in: The Lancet , Volume 357, Issue 9261, Pages 1047 – 1047).

[13] Article 152 of the 1997 Amsterdam Treaty obliges the EU to take measures towards improving public health, and ensuring a high level of protection for EU citizens.

[14] Examples: Article 29 of the Law on Public Health notes that "Minister of Health shall propose necessary laws and bylaws to prevent and control infectious diseases." Article 34 states that "Responsible structures and preventive measures for the spread of HIV/AIDS shall be regulated by a special law." Article 46 notes the "Minister of Health shall frame necessary policies pursuant to health nourishment and nutritional advancements."

[15] Largely because the Strategy called for several "unfunded mandates" the costs of which were (and remain) unknown.

[16] A noteworthy exception: The ACCESS project supported by USAID/Albania has developed and put in place a national set of protocols and performance standards for the provision of post-partum and post-abortion care.

successful period of further negotiations before it can impose any clarity on the functioning of the national health insurance program. In brief, the adherence to the "rule of law"—the essential steps needed to transform strategies and policies into reality, to implement them, to monitor and control their enforcement—is lacking in the health sector.

A.2: Unresolved Funding Issues for the Health Sector: Notwithstanding an improved political climate vis-à-vis the health sector (see above), the GOA has not been able to chart a clear course toward the development of a long-term financing plan for the health system. One area of emerging consensus between HII and the MOH is an acknowledgment that major components of the system are indeed under-funded. Both bodies further agree, however, that the system may in fact be adequately funded in gross terms, but that a substantial portion of the system's funds are being squandered or lost as a result of bloat, poor accountability, mal-distribution of resources, and failure to capture patient fees (including informal payments). What is needed more than additional funding, they maintain, are steps to ensure more responsible use of resources already devoted to the system. Among these steps would be 1) the generation of financial savings by reorganizing regional and district hospitals to squeeze out excess capacity—and costs; 2) "capturing" informal payments by replacing them with posted fees for services and patient co-payments; and 3) expanding the national health insurance program to cover (i.e., collect premiums from) most of the population.

The GOA has taken some initial steps to implement these measures. In September, 2009, a World Bank team delivered to the MOH an Inception Report for "Technical Assistance for Health Facility Rationalization" which recognizes the ministry's intention to reconfigure its regional and district hospitals, with the explicit aim of eliminating redundancies in the secondary and tertiary hospital system.[17]

Adding impetus to these rationalization-and-cost-recovery efforts are Ministry of Finance (MOF) warnings to both HII and the MOH to the effect that neither of the two bodies should expect the MOF to remain complacent (or generous) in the face of HII/MOH inaction re their financing challenges. All parties agree that passage of the Health Finance Law cited earlier will be key to addressing those challenges. None of the parties, however, has been able to determine with any clarity what final elements should be included in that law. Various iterations of the law have been circulating for over three years—despite significant technical assistance from the World Bank and the German Development agency, GTZ.[18] Absent that legislation, HII outlays to both primary and secondary/tertiary health care facilities are essentially unchanged from historic budgetary outlays.[19]

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[17]This would involve the strengthening of selected Regional hospitals, and the downsizing of several under-utilized district hospitals to local polyclinics that would provide outpatient services only.

[18] The World Bank had cited enactment of the Health Finance Law as a condition precedent to its health assistance program, but subsequently conceded that requirement as unrealistic.

[19] HII insists that it reimburses Health Centers on the basis of performance criteria set forth in the HCs' contracts with HII. Actual payments, however, are essentially unchanged from the period prior to HII's assumption of responsibility as the Single Payer for PHC services.

A.3 Questionable Financial Sustainability: The revenue measures noted in A.2 above (capturing informal payments; expanding health insurance coverage) are reasonable, indeed necessary steps to putting the health system on a more sound financial footing. However, the centerpiece of the plan—expanding enrollment in national health insurance—rests on some dubious assumptions, namely, that 1) most of the country's citizens will opt to purchase HII coverage (at a cost of approx. $7.00/month); and 2) those additional revenues (supplemented by fees and patient copayments) will be adequate to fully fund the entire health care system[20] without reliance on other tax revenues. The likelihood that the 65 percent of the population not currently enrolled in the HII system will choose to do so is perhaps more of a sociological question than a financial one.[21] Under any optic, however, it is an optimistic projection evidently driven by the government's weak fiscal situation, and may be yet another manifestation of the government's chronic reluctance to adequately fund the health sector.

A.4 Weak Management Structure: The leadership of the Ministry of Health has traditionally been awarded to small, usually weak political parties that have little leverage within the GOA counsels that set national priorities.[22] The ministerial portfolio, moreover, changes hands with considerable frequency—four times, for example, in the last five years. Each new minister arrives with new staff,[23] new priorities, virtually no access to an institutional memory that departed with the previous staff, and a willingness, in the words of the country representative of a major donor in the sector, to "reinvent the same wheel" yet another time.[24] These frequent staff turnovers at the health ministry's leadership and management levels, exacerbated by a lack of depth in technical departments, leaves the ministry ill-equipped to manage the burden imposed by the health sector reform process. [25]

The Faculty of Medicine, which trains virtually all of the country's physicians, has no curriculum in facilities management, and no in-service training program is in place to prepare managers at operational levels of the system, e.g., directors of Health Centers and hospitals, for their management responsibilities. In consequence, physicians trained in

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[20] That is, a system made less costly as a result of efforts to redress bloat and inefficiencies in the secondary/tertiary network

[21] The national health insurance program has been characterized by widespread evasion of contribution requirements. (World Bank, Health System Modernization Project 2006-2010, (Project ID: PO82814). Long time observers suggest that the basic premise of health insurance—making payments, in the absence of a problem, to minimize costs should a problem arise—is incompatible with Albanian culture.

[22] The health ministry portfolio is currently held by the Socialist Movement for Integration (SMI)—a small breakaway party from the main opposition Socialist Party (SP). The Democratic Party (DP) allied with the SMI to create a parliamentary majority, and thus the right to form a ruling coalition government.

[23] A ministerial change is generally followed by replacement of the secretary general, directors general, chief of cabinet, and frequently the heads of other directorates and offices, even at regional and district levels (*Review of the Ministry of Health in Albania*. K. Leppo, H. Stein, V. Lazarevik, and B. Nuri. WHO/European Regional Office. December 2008)

[24] Even under the best of circumstances, the health ministry has little technical depth, and concentrates virtually all substantive decision-making in the person of the health minister.

[25] The health ministry's relative weakness in addressing the sectoral reform agenda may have contributed to the Prime Minister's unusual step of personally convoking/chairing the Health Sector Working Group cited earlier.

clinical services and procedures are frequently promoted into management positions that demand a different and unfamiliar set of skills. An indicator of these management weaknesses is the extensive disregard, at the PHC level, of reporting requirements contained in HII-Health Center contracts: A donor representative familiar with the clinic reporting system advises that "a large percentage" of the health care system is not providing health care or financial data to HII, even though clinic staff salaries and performance bonuses are theoretically determined on the basis of those reports.[26] Similarly, hospitals do not report accurate cost and expenditure data, accurate tallies of patients treated, or accurate rosters of staff on board—leaving both HII and the MOH unable to estimate the actual "carrying cost" of either individual facilities, or the secondary/tertiary system as a whole.

A.5 Corruption: As pointed out in the 2008 assessment, corruption undercuts popular confidence in the system, serves as a barrier to treatment, particularly for the poor, and distorts government efforts to improve equity and efficiency in the health care system. It is repeatedly cited by observers as an impediment to reform and a drain on resources in the health system. The GOA Health System Strategy, 2007-2013 (being updated by the MOH) explicitly cites corruption—it limits its discussion to informal payments—as "the greatest barrier to access health care services for the poorer segments of the population in Albania." The strategy calls for efforts to transform out-of-pocket payments into clear and transparent financial flows, "which will require both strong monitoring schemes and incentives for both health professionals and patients." When asked to describe those schemes in practice, informants identified several elements that would be necessary. These include 1) creation, at the secondary/tertiary levels, of a Basic Services Package (on the model of the Basic Services package at the PHC level), which would specify those services that would be reimbursable by HII; 2) the posting of a fee schedule for all other services; 3) establishment of clear and consistent copayment requirements; and 4) a public education campaign that would increase popular awareness of the pricing regime; educate users regarding their rights vis-à-vis health care providers; and empower the public to demand change (including the disciplining of recalcitrant health care providers) if the health care system failed to deliver on its promises.

B. ACTIVITIES TO DATE

B.1. **Primary Health Care:** As discussed above, the *PRO Shëndetit* project, which ended in September, 2009, left a mixed legacy of achievements. Several of its accomplishments, such as a functioning Health Information System (HIS) and the Basic Health Care Package at primary health care facilities, provide important underpinnings to a larger PHC reform process. More broadly, the project's work at the PHC level--facilitating a transition to a Single-Payer System--laid the groundwork for a profound shift in institutional responsibilities in the health sector. That shift—whereby the MOH

[26] Some observers have suggested that these reporting lapses are an indication of the discomfort/lack of confidence of personnel who dutifully filed reports, met deadlines and observed formal directives under the "old" vertical system of the communist era. These personnel are now on unfamiliar ground—engaged, yet disoriented, in the midst of a reform process that is still lacking in direction, or even in specificity regarding their new reporting channels.

moves from its erstwhile role as service provider to a more limited, but critically important role in setting/monitoring health policies, standards and practices—will shape the character of the Albanian health system for years to come.

Other "products" of the project were, as noted earlier, potentially valuable, but their use was not scaled up and funded by the health ministry. Several of these products are available "on the shelf" (training manuals, health promotion materials, supervision guides, etc.), and are accessible to the ministry should it choose to employ them.

B.2. Family Planning: USAID is supporting two initiatives in family planning. These include:

- Behavior Change Communication (BCC) through the USAID/W-managed C-Change project; and
- Improvement of Post-partum and post-abortion care through the ACCESS-FP project, also managed by USAID/W

The C-Change project is utilizing mass media and interpersonal communications techniques (with university students) to provide information regarding modern contraceptive methods, and to counter pervasive myths and misperceptions regarding their side-effects. The project also works with pharmacists to improve their knowledge regarding contraceptive products, and to encourage increased use of point-of-sale promotional materials.

ACCESS-FP started activities in Albania in February, 2008. Its objectives are to work with the Ministry of Health of Albania and other partners to:

1. Expand family planning services for postpartum and post abortion women through public sector facilities in three districts.
2. Expand method choice to increase use of long acting methods, specifically focusing on the IUD.
3. Increase the demand for modern contraceptives, especially in postpartum and post abortion periods.

The project has shown considerable success in its three district-sites (Tirana, Korce and Shkodra): 90% of clinical personnel in the three Maternity Hospitals have been trained in post-abortion and postpartum counseling; and approximately 40% of PP and PA women counseled by the staff accept a modern method of contraception. The project also developed a set of patient treatment protocols that have been accepted by the MOH as national standards of care, and have been distributed to the entire country. Over the next year ACCESS-FP staff plan to conduct 45 two-day workshops (for 25-30 people each) in PP and PA care.

Staff of both projects were asked to comment on the unexpectedly low CPR (modern methods) reported in the preliminary findings of the 2008-2009 DHS. The consensus was that the CPR reported by the survey may not reflect actual use, primarily because the DHS failed to capture contraceptive sales through commercial pharmacies—where anecdotal information and project staff observations suggest that purchases of emergency

contraception is both significant and under-reported. EC use, they maintain, is under-reported by users because of its association with unplanned/casual sexual encounters, and under-reported by pharmaceutical companies because sales data are proprietary information.

USAID advises that it intends to support secondary analyses of DHS data, and that the analysis will attempt to shed more light on the CPR anomaly.

C. TOWARD A REVISED STRATEGY

The foregoing assessment suggests that USAID has arrived at an important juncture in the way it should best assist the GOA in the health sector. One option is to continue support for improvements in the government's PHC system. Recent data indicate, however, that returns on that investment are starting to decline. Another approach, proposed herein—and endorsed by the leadership of the MOH and HII, as well as donors engaged in the Albanian health sector—is to target USAID assistance in the area having the highest potential to effect lasting change in the sector, namely on efforts to assist the GOA implement its own health reform agenda.

That ambitious agenda includes a wide array of strategies, policies, laws and regulations which, *if enacted and implemented*, would effect significant and lasting improvement in the quality and responsiveness of the Albanian health care delivery system. Yet, despite years of discussion, debate and donor exhortation, virtually none of those nominal reforms have been finalized and implemented.[27] Reasons for this inaction have included frequent staff turnovers with consequent lack of continuity, weak managerial capacity, inter-agency rivalries, and perhaps most fundamentally, weak GOA commitment to the health sector.

Regarding this last point, the GOA is taking steps that suggest a more positive stance vis-à-vis the health sector (universal insurance coverage, rationalization of service delivery, collection of copayments/elimination of "informal" payments, etc.) that are intended to generate significant increases in resource flows into the health care system. GOA partners have acknowledged, however, that many of the procedural and management constraints identified herein threaten its ability to fully implement this reform agenda.

No donor in Albania has attempted to work continuously, and for an extended period of time, on efforts that directly support the execution of GOA functions needed to implement the policy reform process: preparing work schedules; enumerating the tasks and responsibilities of designated action officers in the MOH, HII, etc.; drafting implementation plans; and preparing draft enabling laws, regulations and service delivery protocols. These are the tasks that are chronically left undone—and in being left undone, effectively halt forward movement on sectoral reform. The USAID assistance strategy proposed in this paper would take on those tasks.

[27] Specific examples include the MOH Health System Strategy, 2007-2013; the Health Finance Law (in draft for the past three years); and the two health laws passed in 2009.

Key to the success of the activity would be two measures intended to increase the likelihood that specific implementation measures developed by the activity 1) have practical feasibility in the health system, and 2) serve to improve the long-term planning and program implementation capacity of GOA partners. These two measures include:

- Testing the adoption, feasibility and operational utility of project-developed enabling measures at the Regional level prior to their nationwide application; and
- Working with Albanian counterparts closely on the development and execution of the enabling measures to strengthen counterparts' comfort, familiarity and confidence as they increasing move into forward positions as the "owners" of the process.

As the major health activity for USAID/Albania, this activity would contribute indirectly to all parts of the Mission's strategic framework. In addition, the activity will contribute directly to USAID/Albania's cross-cutting anti-corruption goals and to its objectives in democracy and governance (SO 2.1, "Increased involvement of civil society in economic and political decision-making").

SECTION III: DONOR COORDINATION

There are at present only three donors—USAID, the World Bank and WHO--providing substantive assistance to the Albanian health sector.[28] USAID assistance will be more effective if is designed to work in partnership with both agencies.

- *World Bank*: In terms of financial resources, the World Bank and USAID are—in that order--the two primary donors in the health sector. Bank personnel have noted their strong interest in securing passage of the Health Finance Law, and have encouraged USAID to support that process. The Bank and the GOA are in very preliminary discussions about an 18-month extension (to early 2012) of the Bank's $15.4 million assistance program, and about the possibility of a follow-on loan. Bank officials suggest that prospects for the latter would be enhanced by progress in a reform initiative supported by USAID (and GOA readiness to pay higher interest rates for an IBRD loan).

- *WHO*: Most WHO technical assistance is targeted on specific public health issues, such as control of communicable diseases, prevention and control of TB and HIV/AIDS, improvements in MCH and adolescent health, etc. A portion of the agency's health assistance portfolio is directed, however, at efforts to strengthen health financing policy and the Health Ministry's stewardship role—defined as the production of key policies and strategies.[29] The WHO country representative strongly endorses the USAID assistance initiative proposed herein—noting that USAID's role as an impartial support mechanism for both HII and the MOH

[28] Some donors that were active in the health sector are terminating their health assistance programs in Albania. These include the Swiss Development Corporation (supported Continuing Medical Education); and the German Development Agency-GTZ (policy reform, with a focus on the Health Finance Law).
[29] Biennial Collaborative Agreement between the Ministry of Health of Albania and WHO/Regional Office for Europe, 2010/2011.

would afford it considerable flexibility in seeking common solutions (WHO's counterpart agency is the MOH).

SECTION IV. RESOURCE ESTIMATES

The table below shows the USAID funding estimated to be available for investment in Albania's health sector, by source and use. Briefly, it is expected that funding levels, and the soft earmarks within those levels, will continue relatively unchanged for the next three years. If those estimates are accurate, funding available for programming in FP and PHC during the period FY11-13 would amount to approximately $1.5 million and $6.0 million respectively.

Projected USG resources available for obligation in the health sector ($000):

Program Element	FY 10	FY 11	FY 12	FY 13
FP	530	500	500	500
PHC (AEECA/MCH)	1.270	1.300	1,300	1,300
PHC (AEECA/OPHT)	700	700	700	700
TOTAL	2.500	2.500	2.500	2.500