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PROJECT APPRAISAL DOCUMENT

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IN THE AMOUNT OF SDR 10.7 MILLION
(US\$15.4 MILLION EQUIVALENT)

TO

ALBANIA

FOR A

HEALTH SYSTEM MODERNIZATION PROJECT

February 17, 2006

Human Development Sector Unit
South East Europe Country Unit
Europe and Central Asia Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective January 31, 2006)

Currency Unit = LEK
1 LEK = US\$0.00978
1 US\$ = SDR 0.6901

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

CAS	Country Assistance Strategy
CME	Continuing Medical Education
DPL	Development Policy Loan
ECA	Europe and Central Asia
EIB	European Investment Bank
GDP	Gross Domestic Product
GP	General Practitioner
HII	Health Insurance Institute
IBRD	International Bank for Reconstruction and Development
ICR	Implementation Completion Report
ICU	Intensive Care Unit
IDA	International Development Association
IFC	International Finance Corporation
IRR	Internal Rate of Return
LSMS	Living Standards Measurement Survey
MOH	Ministry of Health
NSSD	National Strategy for Social and Economic Development
OPEC	Organization of Petroleum Exporting Countries
PAD	Project Appraisal Document
PHC	Primary Health Care
PHRD	Policy and Human Resources Development
SDC	Swiss Development Cooperation
SDR	Special Drawing Rights
SIDA	Swedish International Development Authority
SME	Sector of Monitoring and Evaluation
SPP	Sector of Policy and Planning
SWAp	Sector Wide Approach
TOR	Terms of Reference
TOT	Training of Trainers
TUHC	Tirana University Hospital Center
UNFA	United Nations Food Agency
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Vice President:	Shigeo Katsu
Country Director:	Orsalia Kalantzopoulos
Sector Manager:	Armin H. Fidler
Task Team Leader:	Dominic S. Haazen

ALBANIA
Health System Modernization

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Map: IBRD 33359

ALBANIA
HEALTH SYSTEM MODERNIZATION PROJECT
PROJECT APPRAISAL DOCUMENT
EUROPE AND CENTRAL ASIA
ECSHD

Date: February 17, 2006 Country Director: Orsalia Kalantzopoulos Sector Manager/Director: Charles C. Griffin Project ID: P082814 Lending Instrument: Specific Investment Loan	Team Leader: Dominic S. Haazen Sectors: Health (100%) Themes: Health system performance (P); Public expenditure, financial management and procurement (S); Other human development (S) Environmental screening category: Not Required Safeguard screening category: No impact								
Project Financing Data									
<input type="checkbox"/> Loan <input checked="" type="checkbox"/> Credit <input type="checkbox"/> Grant <input type="checkbox"/> Guarantee <input type="checkbox"/> Other:									
For Loans/Credits/Others: Total Bank financing (US\$m.): 15.4 Proposed terms: Maturity of 20 years, inclusive of a ten year grace period									
Financing Plan (US\$m)									
Source	Local	Foreign	Total						
RECIPIENT/RECIPIENT	2.1	0.0	2.1						
INTERNATIONAL DEVELOPMENT ASSOCIATION	5.7	9.7	15.4						
GOVERNMENT OF JAPAN (PHRD)	0.1	1.5	1.6						
Total:	7.9	11.2	19.1						
Recipient:									
Ministry of Finance Tirana, Albania									
Responsible Agency:									
Ministry of Health Bulv. Bajram Curri Tirana, Albania skadiu@icc-al.org									
FY	2007	2008	2009	2010	2011				
Annual	1.61	4.66	4.59	3.03	1.50				
Cumulative	1.61	6.28	10.87	13.90	15.40				
Project implementation period: Start July 1, 2006 End: March 31, 2010 Expected effectiveness date: July 1, 2006 Expected closing date: September 30, 2010									
Does the project depart from the CAS in content or other significant respects? <i>Ref.</i> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No PAD A.3									

Does the project require any exceptions from Bank policies? <i>Ref. PAD D.7</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Have these been approved by Bank management?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is approval for any policy exception sought from the Board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the project include any critical risks rated “substantial” or “high”? <i>Ref. PAD C.5</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does the project meet the Regional criteria for readiness for implementation? <i>Ref. PAD D.7</i>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Project development objective <i>Ref. PAD B.2, Technical Annex 3</i></p> <p>The development objectives of this project are (i) to improve both physical and financial access to and the actual use of high quality primary health care services, with an emphasis on those in poor and under-serviced areas as well as to diminish the unnecessary use of secondary and tertiary care facilities, (ii) to increase the effectiveness of the MOH and HIF in formulating and implementing reforms in provider payments and health system performance, and (iii) to improve governance and management in the hospital sector.</p>	
<p>Project description [<i>one-sentence summary of each component</i>] <i>Ref. PAD B.3.a, Technical Annex 4</i></p> <p>Component A - Strengthening Sector Stewardship, Financing and Purchasing (total cost US\$ 7.7 million) would help the HII develop its functions and capacity as sole purchaser of health services, and would support capacity building in the MOH, the Institute of Public Health (IPH) and the HII to strengthen their stewardship roles in the health system.</p> <p>Component B – Improving Primary Health Care (PHC) Service Delivery (total cost US\$ 10.1 million) would support institutional reforms and limited investments aimed at improving quality of care among health care providers and in health facilities.</p> <p>Component C – Strengthening Hospital Governance and Management (total cost US\$ 1.3 million) would provide initial steps to improve hospital operations and direction by focusing on (i) the development and introduction of accounting and internal control structures for hospital care providers, (ii) developing the regulatory framework, including by-laws and regulations to support the move of MOH hospitals to the status of autonomous public entities; and, (iii) piloting reforms of hospital management and governance structures in selected hospitals.</p>	
Which safeguard policies are triggered, if any? <i>Ref. PAD D.6, Technical Annex 10</i> None.	
Significant, non-standard conditions, if any , for: <i>Ref. PAD C.7</i>	
<p>Credit effectiveness:</p> <ul style="list-style-type: none"> ▪ The Co-financing Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of the Financing Agreement) have been fulfilled; ▪ The Project Implementation Plan for the Project has been completed, adopted by the Recipient and agreed to by IDA; ▪ The Operations Manual for the Grants Program of the Project has been completed, adopted by the Recipient and agreed to by IDA; ▪ The Recipient has adopted a framework, acceptable to IDA, which facilitates the: <ul style="list-style-type: none"> a) establishment of primary health care practices funded through Capitation-based contracts with the Health Insurance Institute (HII); b) registration of Beneficiaries with the HII; and c) enrollment of Beneficiaries with the Primary Health Care Providers of their choice. ▪ The following departments and organizational units are in place and operational, and the following staff positions have been established and filled, with Terms of Reference approved by IDA: <ul style="list-style-type: none"> a) The General Department for Policy and Planning for Health Services within the MOH; 	

- b) Appropriate staff in charge of Project implementation within the MOH, including at least one staff responsible for day-to-day management of the Project, at least one staff in charge of financial management of the Project, and at least one staff for procurement under the Project;
- c) A Monitoring and Evaluation Unit within the MOH, with at least two staff;
- d) a Project Management and Policy Department within the IPH, with at least five staff; and
- e) A Chair of Family Medicine within the Faculty of Medicine of the University of Tirana, with at least two staff.

Project Implementation Conditions

- Not later than October 31 of each year during the implementation of the Project, starting October 31, 2006, submit to IDA for review and approval an Annual Work Program for the following calendar year, and shall agree with IDA on the steps to be taken in the following calendar year;
- Not later than October 31 of each year during the implementation of the Project, starting October 31, 2006, submit to IDA for review and approval a report on the performance of the health sector in the preceding calendar year, and jointly undertake with IDA the identification of specific actions needed to address problem areas in the health sector.
- The Recipient shall ensure that during the life of the Project, the following departments, Working Groups and the units and staff positions for the management and implementation of the Project are operational, adequately filled and maintained, under Terms of Reference satisfactory to IDA:
 - b) the Deputy Minister of Health within the MOH shall be responsible for overall implementation and management of the Project, including the management of policy issues, resource mobilization, and donor coordination;
 - c) the Director of the Economics Department within the MOH shall be responsible for day-to-day Project management. Staff within the Economics Department of the MOH shall be responsible for financial management and procurement;
 - d) Three Working Groups shall oversee the technical implementation issues relating to: (i) health financing; (ii) health quality improvement; and (iii) hospital governance and management. Each Working Group shall be composed of representatives of the MOH, the HII, the IPH and other stakeholders. The Working Groups shall be responsible for the coordination and technical management of the Project activities.
 - e) During implementation of the Project, the following entities shall become responsible for planning and implementation of the reforms and policies initiated by the Project: (i) the Monitoring and Evaluation Unit within the Ministry of Health; (ii) the General Department for Policy and Planning for Health Services within the Ministry of Health; (iii) the Project Management and Policy Department within the Institute of Public Health; (vi) the Department for Medical and Pharmaceutical Monitoring within the Health Insurance Institute; and (v) the Chair of Family Medicine within the Faculty of Medicine of the University of Tirana.
- The covenant pertaining to the mid-term review includes an assessment on the possibility of restructuring the Project from a SIL to a SWAP.

Disbursement Conditions Specific to Certain Expenditure Categories:

- for Goods procured for the establishment of health information systems and infrastructure, a written agreement has been reached between the MOH and HII on the methods of payment of Primary Health Care Providers, satisfactory to IDA
- for equipment for primary health care provided to Primary Health Care Providers, the Clinical Guidelines have been approved by the MOH and HII and the training programs for health practitioners have been developed;
- for costs related to registration of Beneficiaries with HII and their subsequent enrollment with PHC Providers, the Unit Costs have been determined in a manner satisfactory to IDA.

A. STRATEGIC CONTEXT AND RATIONALE

1. Country and sector issues¹

Albania's health care system prior to transition was characterized by strong central government control over all aspects of the system. Despite a widespread primary care network which had been established with a focus on antenatal care and immunization, the system was largely led by secondary care and was highly centralized, with the Ministry of Health (MOH) providing and regulating all health services in the country and deciding on resource allocation and the nomination of health care staff. The construction of new facilities was favored over the maintenance and operation of existing infrastructure, which led to considerable deterioration in facilities and equipment. Inadequate recurrent expenditures, obsolete drug therapies and outdated medical skills resulted in low quality of care and inefficient use of resources.

Civil unrest and the Kosovo crisis took a heavy toll on the health care system during the 1990s. The violence and civil unrest in the early 1990's and again in 1997 resulted in extensive damage to health care infrastructure and in the disruption of essential services, including immunization, surveillance and environmental health programs. Almost one third of the country's medical staff abandoned their posts during the 1997 unrest. The Kosovo crisis in 1999 put additional strain on the system, as over 4,000 refugees were admitted to hospitals, while others were provided accommodation in hospitals for want of other shelter. The crisis caused further damage, consumed significant resources and brought stopped nascent structural reforms in the sector.

A series of reforms were initiated in the mid-1990s, but limited progress has been made in advancing this agenda. These reforms included some reduction in the overextended provider network capacity, the decentralization of primary care management to district public health directorates and integration of the former with public health functions, the privatization of the pharmaceutical sector and most dental care, and the establishment of the Health Insurance Institute (HII) in view of a gradual aspired change of the health financing system. Plans were also made to substantially upgrade the quality of the primary care system through physical investments and skills upgrading. The Kosovo crisis interrupted many of these initiatives, and limited progress has been made in most of the reform areas since then. Some pilot projects in provider organization and financing were initiated recently and have yielded valuable lessons. More recently, encouraging progress has been made on pharmaceutical policy issues.

Albania's health outcomes compare favorably with those of lower middle income countries outside the Europe and Central Asia Region, but lag behind those of other countries in the South East European Region.

Physical and human resources in the sector are ill aligned with the population's health needs, productivity in the health sector is low and resources are used inefficiently. There are a large number of small hospitals with low utilization and occupancy rates which points to a sub-optimal hospital structure. Finally, the quality of health care is low, particularly at the primary care level.

¹ This section is largely based on Albania Health Sector Note, Report No. 32612-ALB. See Annex 1 for more detail.

Low income groups are not well protected from health shocks and are easily thrown into poverty as a result of out-of-pocket spending on health care. While the six per cent of GDP which Albania spends on health care is in line with the average for lower middle income countries, the public sector contributes a below average share of these expenditures. As a result, out-of-pocket expenditures account for almost 60 percent of health sector funding. Further, although health insurance is mandatory, household survey data suggest that only between 40-45 percent of the population have a health insurance card and thus benefit from coverage. Active contributors account for less than one third of the active labor force, pointing to large contribution evasion.

The high share of out-of-pocket payments outside an overall health finance framework creates serious inequities in access, has a considerable poverty impact and limits effectiveness of Government stewardship. Lower income households are more likely to incur catastrophic health expenditures than those who are better off, with the average out-of-pocket expenditures for one episode of outpatient care amounting to 50 percent of the average monthly per capita expenditure of the lowest consumption quintile. Although the law provides for free inpatient care, survey data suggests that essentially everybody who is hospitalized incurs substantial costs and that informal payments account for at least one quarter of these costs. Average outlays for hospital care amount to four times the monthly per capita expenditure of the lowest consumption quintile. Poverty assessments have shown that those who live in remote areas are less likely to seek care when they are sick, and have a higher incidence of poverty. They also have more limited access to health services. Making essential Primary Health Care (PHC) services more widely available should address some of these issues.

Area	Population	PHC Services	Hospital Beds	% Seek Care **	Poverty percent*
Central	39%	35%	37%	58%	30.2
Coastal	32%	35%	26%	70%	24.2
Mountain	10%	5%	10%	36%	55.3
Tirana	19%	25%	27%	74%	20.1
Albania	100%	100%	100%	58%	30.1

* Percent of population poor or extremely poor

** Percent of people seeking care when sick

The health financing system is fragmented and fails to give providers incentives for efficiency and quality improvements, nor does it establish clear lines of accountability.

Key Challenges: The main challenge for Albania's health sector is to consolidate achievements in health outcomes to date, while establishing capacity to effectively address the growing incidence of non-communicable diseases and affording low income groups better protection from impoverishing effects of health expenditures. This will require fundamental and systemic changes in the way health care is financed, delivered and organized, and can be summarized around three core pillars: (i) more efficient resource mobilization and allocation; (ii) improvements in service delivery quality; (iii) improvements in sectoral management and stewardship. The recent health sector note suggested key changes needed in each of these areas:

- (i) **Enhance Resource Mobilization and Allocation**
- Pool all public sector resources under one funding agency.
 - Rely on general taxation rather than payroll tax as the main source of public funding.
 - Clearly define the benefits which will be covered by public funds and introduce co-payments for a wider range of services, including inpatient care.
 - Combine changes in co-payments with broad action to root out informal payments.
 - Increase resource allocation for public health and health information.
 - In the medium term, shift to a population based regional funding allocation.
 - In the medium term, improve the balance between public and private spending on health care to enhance the population's protection from health shocks.
 - Finalize and use the hospital map to guide investments in the hospital infrastructure.
 - Develop regional primary health care plans.
- (ii) **Improve Quality and Efficiency of Health Services Delivery**
- Consolidate pilot efforts to improve clinical effectiveness and quality of care.
 - Shift from input based financing of health providers to performance based payments.
 - Establish a quality assurance system.
 - Consolidate reforms in the pharmaceutical sector.
- (iii) **Improve Health Sector Management and Stewardship**
- The roles and responsibilities of all core actors in the sector need to be clearly defined and accountability mechanisms established.
 - Review the role of regional health authorities in light of the Tirana experience and make a decision about the future of regional health authorities in Albania.
 - Improve the organization and management of primary care providers.
 - Increase autonomy for hospitals.
 - Increase population feedback and community participation.

These changes will require a gradual introduction, careful preparation and capacity building of health care providers, HII, and MOH to ensure that they are ready to assume their increased responsibilities. Fundamental decisions must be made regarding legal status, organizational arrangements, governance structures and extent of provider autonomy before such changes can be introduced. Provider financial systems will need to be strengthened, performance standards established and adequate provider reporting and information systems introduced to allow for appropriate performance monitoring and transparency. Management capacity must be developed and payment reforms will need to be coordinated with efforts to improve the quality of care to enhance the incentives for payment mechanisms to change both provider and patient behavior. The Government has sought Bank assistance to help operationalize and implement this strategy.

2. Rationale for Bank involvement

Throughout the 1990s, Albania received considerable foreign assistance to the health sector, focused on reconstruction of a severely damaged provider network. As reconstruction advanced, donor support diminished considerably, from roughly 25 percent of total health spending after the Kosovo crisis to below 5 percent in 2003. The Bank has been the key foreign financier in the health sector in Albania over the past decade and remains the most important partner.

To date, the Bank has supported two health projects in Albania. The first was successfully completed in 2001 and focused on reconstruction of the health facilities network in two regions, as well as limited provider and management training for district health department staff. The second project closed in January 2005 and was designed to support the pilot testing of a new organizational set-up in Tirana region, combined with substantial physical upgrading at Tirana University Hospital and other facilities in the capital region. Because the project experienced significant implementation difficulties, the lessons learned – reflected in the Implementation Completion Report (ICR) – played an even greater role than usual in the preparation of this new project. As a result, the proposed project will further shift the emphasis of the Bank's support away from reconstruction and towards support for structural reforms. The Bank has also completed a health sector policy note which provided key analytical input to project preparation and will support the overall policy dialogue in the future. The Government increasingly looks to the Bank for support with policy formulation and implementation, and the Bank is well positioned to offer this, based on its extensive experience across the region. The reform orientation of the project will require support in the next round of development policy lending, following on the experience with the Poverty Reduction Support Credits (PRSCs).

Health is a key priority in the National Strategy for Social and Economic Development (NSSED) – Albania's PRSP equivalent – which is organized around the pillars of public sector governance and strong economic growth. The NSSED emphasizes policy interventions to improve health care, to address the key non-income dimensions of poverty including issues of access, and to provide a sound basis for long-term growth and competitiveness. It also recognizes the need for stronger public accountability and increased public participation in decision making to empower the poor. The 2004 NSSED progress report underscores the need to continue structural reforms aimed at improving service delivery to facilitate healthcare access for lower income groups. Under the NSSED the Government identified three strategic approaches to start addressing the identified health sector problems: (i) improving efficiency of the system through better planning and resource allocation; (ii) investing in a priority health delivery system to improve access to care and quality of services; and (iii) targeting public resources for priority public health programs that have the greatest impact on health outcomes.

In the health area, the third Poverty Reduction Support Credit (PRSC-3), focused on clarifying the responsibilities and accountability mechanisms of local self-governments in the health, and improving resource allocation to priority social services through increasing the share of total public spending going to the health and protecting sector-specific priority areas through real expenditure increases. In this way, it centered on paving the way for broader acceptance of proposed reforms, while ensuring that health expenditures were utilized more effectively to help stem the deterioration in service delivery. Policy measures included:

- Increasing the share of budget in 2004 with a real increase relative to 2003 in funding for targeted public health programs and operations and maintenance for primary care (core);
- Demonstrating progress on the budget tracking survey;
- Adopting a financial sustainability plan for immunization and incorporating the funding needs for MMR and Hepatitis into the 2005 budget proposal and 2005-07 MTEF.
- Adopting an HIV/AIDS strategy and launching the campaign to raise HIV/AIDS awareness.

- Adopting a policy paper on the role of central and local governments in the health sector, consistent with the Reform Strategy (core).
- Completing and adopting the health sector reform strategy.

A new round of Development Policy Lending (DPL) is now being initiated and conditionality will be sought to support project interventions through specific policy actions, focusing on areas where government-wide commitment and/or intervention is needed (e.g., legislation and financing), and the Ministry of Health acting by itself is not able to ensure progress.

3. Higher level objectives to which the project contributes

The second pillar of the current CAS² is focused on human development issues:

Improved service delivery, particularly in the social sectors. Through a focus on service delivery the Bank would seek to: (a) appropriately target the poor; (b) continue to address governance issues, at a level at which they impact everyday citizens directly; (c) address remaining macroeconomic issues such as the fiscal risks of the pensions system, and efficiency issues in big spending sectors such as health and education; (d) build upon the basis that has been laid for comprehensive reform of the civil service by extending reform efforts through the social ministries where public employment is concentrated; and, (e) continue supporting the process of decentralization of service delivery while ensuring appropriate financing levels and controls.

This project is designed to make major contributions in each of these areas.

B. PROJECT DESCRIPTION

1. Lending instrument

The project would be financed through a Specific Investment Loan (SIL), of US\$15.4 million, a PHRD Co-financing Grant of US\$1.6 million for project implementation, and a Government contribution of US\$2.1 million. It would be implemented over a four and a half year period. A SIL is considered to be the most appropriate instrument since the Government is relatively new and not yet able to commit to the specific triggers that would be needed for an Adaptable Program Loan. However, to assist the MOH and HII to move towards Adaptable Program Loan (APL) or Sector Wide Approach (SWAp) type projects in the future, project activities have been organized into “annual work programs”; with specific milestones leading to the following year’s activities (see Annex 3.1). An annual performance review will be conducted to document progress against these milestones. During the mid-term review, an evaluation will be conducted to determine the feasibility of moving immediately to a SWAp type approach, and the project would be restructured at that point if this arrangement is determined to be appropriate. The continued use of development policy lending conditions will be essential in supporting the project activities, especially in the areas of (i) ensuring adequate levels of health system funding; (ii) facilitating the restructuring of health financing methods through the passage of key legislation; and (iii) supporting governance and decentralization reforms.

² Report 34329-AL, approved by the Board on January 10, 2006.

2. Program objective and Phases N/A

3. Project development objective and key indicators

The development objectives of this project are (i) to improve both physical and financial access to and the actual use of high quality primary health care services, with an emphasis on those in poor and under-serviced areas as well as to diminish the unnecessary use of secondary and tertiary care facilities, (ii) to increase the effectiveness of the MOH and HII in formulating and implementing reforms in provider payments and health system performance, and (iii) to improve governance and management in the hospital sector.

Key performance indicators would include the following:

- At least 70 percent of the population is enrolled with a primary health care provider and use him/her as their first source of health care
- Reduced percentage of households who do not seek necessary health care because they cannot afford it and reduced share of household expenditure for primary care services
- Increased patient satisfaction with PHC treatment and improved outcomes for defined health conditions
- HII is able to live within its overall budget, without additional allocations from the MOF
- Based on agreed key performance indicators, hospitals using new governance approaches perform better than those who do not.

Despite the range of issues facing the health system, the project is designed to tackle those which (a) are most critical to the long-term success of the health reform strategy; (b) have the potential for the highest impact on health service access and the health status of the poor and those in rural and remote areas; and (c) begin to address essential governance and management issues. The areas chosen focus on building the capacity of the MOH and HII, making PHC services available to all in Albania and increasing the quality of those services, and starting to develop new governance structures for hospitals. As noted above, there is expected to be a major poverty impact from making essential PHC services more widely available.

4. Project components

Component A - Strengthening Sector Stewardship, Financing and Purchasing (base cost US\$6.9 million, total cost US\$7.7 million) would help the HII develop its capacity as the sole purchaser of health services, and would support capacity building to strengthen the stewardship role of the MOH, the Institute of Public Health (IPH) and the HII. Activities would include (i) capacity building in the HII and its local branches; (ii) strengthening the policy formulation and performance monitoring functions within the MOH and the IPH; (iii) development of health information systems to support payment and management reforms; (iv) development and implementation of a system to monitor provider performance (both clinical and financial); (v) establishing a licensing/re-licensing scheme for physicians and health facilities, and an accreditation program for hospitals; (vi) development of Health Technology Assessment (HTA) capacity; and, (vii) building up MOH capacity in financial management, procurement and project coordination.

Component B – Improving PHC Service Delivery (base cost \$8.9 million, total cost US\$10.1 million) would support institutional reforms and limited investments aimed at improving quality of care among health care providers and in health facilities. The program would (i) facilitate registration of the population with the HII and enrollment with a primary care physician, together with related public information campaigns; (ii) build practice management capacity at the primary care level; (iii) develop and introduce clinical guidelines with an initial focus on primary care and the primary-secondary care interface and the most pressing health issues (e.g., child health, ante-natal care, respiratory infections); (iv) establish a continuing medical education system (CME) and link this to the re-licensing scheme; (v) retrain existing general practitioners and pediatricians in evidence based treatment of common conditions and rational drugs use, based on the clinical guidelines; (vi) provide basic equipment to physicians who complete the retraining program; and (vii) establish a grant facility to fund proposals from primary care providers in support of quality of care and continuum of care improvement initiatives.

To promote a rapid registration and enrollment process, these costs will be reimbursed on an output basis, using the cost of the registration card plus an estimate of the additional staff time needed to register each individual. Staff costs will reflect the incremental HII staff time needed to process each registration/enrollment, using average HII salaries. The amount will be agreed to by the Bank prior to disbursements being allowed, will be subject to spot checks and review as part of the normal supervision process. It would be adjusted as appropriately justified following such a review, and would be audited as part of the annual external audit process. The methodology for determining Unit Costs will be described in more detail in the PIP, and will be used as a basis for the determination of the Unit Costs, which is a condition of disbursement, and for subsequent adjustments of the Unit Costs. Additional details are provided in Annex 4.

Component C – Strengthening Hospital Governance and Management (base cost US\$1.2 million, total cost US\$1.3 million) would provide initial steps to improve hospital operations and direction by focusing on (i) the development and introduction of accounting and internal control structures for hospital care providers and training in hospital management, (ii) developing the regulatory framework, including by-laws and regulations to support the move of MOH hospitals to the status of autonomous public entities; and (iii) piloting reforms of hospital management and governance structures in selected hospitals.

5. Lessons learned and reflected in the project design

The lessons learned from the ICR of the last health project included the following:

1. Contributions from other donors should not be reflected in the project costing and activities schedule unless firm commitments have been obtained. In the absence of this, explicit arrangements should be included in the Credit financing and covenants to ensure that these activities can be continued if the donor financing does not materialize.
2. The inclusion of large infrastructure investments should be carefully considered in projects which support substantial sector restructuring, as the infrastructure investments may divert attention from the reforms and reinforce attention to service delivery, especially where the line agency is still substantially engaged in service delivery and financing of service provision rather than policy formulation and governance.

3. Monitoring and evaluation indicators should include key benchmarks and decision points, especially where activities require substantial implementation time. Time schedules should be carefully constructed, allowing an appropriate length of time for each step of the process, and also reflecting the experience and expertise of the implementation agency.
4. Small punctuated Technical Assistance (TA) interventions achieve little, as they fail to substantially engage counterparts, do not build up a longer term relationship of mutual trust, and do not result in the TA activity becoming an integral part of the implementing agency's work program. A more comprehensive, coherent and longer-term technical assistance program is usually necessary.

The design of the proposed project also draws on the significant success of several neighboring countries in improving access and quality through targeted interventions in primary health care, especially for the poor and those in rural and remote areas. In Bulgaria, the enrollment of the population with PHC physicians, together with initiatives to promote the improved distribution of family doctors, resulted in 1400 vacant practices being filled, mostly in rural and remote areas, and improved access to PHC services for approximately 1.4 million people. In Macedonia, a PHC component which included training, equipment, and supplies, contributed to a reduction of more than 20 percent in perinatal mortality, and an improvement in the quality of primary care offered by Continuous Medical Education (CME) graduates.

These lessons have been incorporated by (i) reflecting only PHRD co-financing which has been approved; (ii) not including any civil works in the project; (iii) agreeing on an M&E strategy with specific targets up front (see section C.3 and Annex 3); (iv) including significant, focused TA and capacity building activities; and, (v) concentrating on improving the quality and coverage of PHC services, using implementation approaches that are already being used by a USAID funded program to reduce the development time requirements.

6. Alternatives considered and reasons for rejection

Expanded Project Scope: The proposed project would begin to address the critical area of hospital reform, with initial steps in the area of governance and management. Clearly much more needs to be done, but it is felt that until the policy and stewardship capacity of the MOH and HII is increased to allow them to cope with the heavy demands of major hospital reform, it is unlikely that additional effort in this area will succeed. The previous project clearly showed the danger in attempting too many disparate reforms within a single operation. Limited initial interventions in the areas of governance and management have been included to initiate progress while the capacity is developed in the MOH and HII. Similarly, pharmaceutical policy reform has been excluded, although there have been some initial actions as part of the general policy dialogue, which will likely lead to specific DPL conditions.

Sector Wide Approach (SWAp) or Adaptable Program Loan (APL): A clear sector strategy is now in place and has been endorsed by the new government, but a consensus needs to be developed among the various stake-holders, including NGO's, and civil society on the long-term vision that is reflected in that strategy. Detailed action plans have also not yet been developed, to the extent that a comprehensive "program of work" can be specified. Further work is needed to enhance donor receptivity to a SWAp, and capacity building is needed to allow the MOH and

HII to effectively take the lead in these areas. Finally, given the shifting focus on structural reform rather than reconstruction, it is considered wise to limit the Bank commitment at this point, with the option to come in with further support later on if progress on reforms is proven satisfactory and there is demonstrated need and commitment to continue with reforms.

Budgetary Support (Development Policy Lending): A DPL approach would tend to separate the Bank team from the operational aspects of health reform implementation. There is a need for Bank financed TA to support reforms and there is a substantial investment need (for example, health management information system) arising from reforms implementation which are better addressed by a SIL than a DPL. Once the policy analysis and implementation capacity of the MOH and HII are enhanced, a DPL approach would become much more feasible.

C. IMPLEMENTATION

1. Partnership arrangements

In addition to the Bank, other agencies involved in the sector include USAID, the Italian Cooperation, the OPEC Fund, the Swiss Development Cooperation, SIDA, UNICEF, UNFPA and WHO. The Bank has been designated to lead donor coordination on the socio-economic development front in close cooperation with the Government, and shares this role with WHO in the health sector, offering the opportunity for general donor agreement on the overall strategy and opening the potential for more sector-wide approaches in the future. The project was prepared in close coordination with other donors, and will to a significant extent build on the efforts of USAID and SDC, which have both expressed a strong desire for ongoing cooperation. USAID is currently implementing a program with key interventions which are related to health care financing and systems strengthening, health information systems, and improved PHC service delivery and access in 5 prefectures. SDC is finalizing a new work program which will focus on establishing a Center of Continuing Education for the health sector (subject to final approval). WHO will address health financing, stewardship, and performance management. Agreements have been reached for active collaboration to achieve the maximum development impact, including a wider roll-out of approaches that have been successfully piloted by these or other donors, and providing specified inputs (e.g., equipment), while other donors provide technical assistance or training services.

2. Institutional and implementation arrangements

The project would be implemented by the MOH, using existing structures and staff. The executive sponsor is the Deputy Minister responsible for international cooperation, while the Director of the Economic Department would handle day-to-day project management. Procurement and financial management would be done by staff in the Economic Department. They will be assisted initially by both foreign and local consultants who would help MOH staff in building capacity to utilize World Bank procedures and requirements. The Director has worked previously on World Bank financed projects, as have the local consultants in procurement and financial management. Staff in the Ministry of Health have some procurement and finance expertise, but are not familiar with World Bank procedures. At the same time, efforts will be made to utilize country systems to the extent possible.

Working groups have been appointed by the Minister of Health in each of three key subject areas – (i) health financing, (ii) quality, and (iii) governance and management – with broad stakeholder representation; responsible for coordination and technical management of the project activities, especially regarding the linkages with stakeholders outside the working group. A chair has been appointed for each working group to coordinate their activities, and overall policy level direction will be provided by the Deputy Minister.

The project is designed to improve planning and implementation capacity within the Albanian health system. Significant capacity building will be needed to provide essential manpower, expertise and experience to support the needed reforms. In the short term, this expertise will be acquired from abroad to supplement local capacity and facilitate the rapid start-up called for in the national strategy. Later, this expertise will be replaced by domestic talent who will take over implementation of the reforms and their deployment. The key recipients of this capacity building will include the Policy and Planning and Monitoring and Evaluation Sectors within the MOH, the Public Health Policy Development Sector within the IPH, and the Service Monitoring and other departments within the HII. In addition, the Chair of Family Medicine will be developed to the point that it can take a leadership role in all aspects of family medicine training, including undergraduate and post-graduate training, retraining of existing PHC staff, and continuing medical educations for family physicians. In order to ensure that this capacity is not lost once it is built, specific loan conditions require ongoing maintenance of these units.

3. Monitoring and evaluation of outcomes/results

A comprehensive monitoring and evaluation strategy has been developed, with baseline data to be obtained through a household survey of the key sector issues, supplemented by the LSMS survey undertaken by INSTAT to provide key inputs in the areas of patient satisfaction, out-of-pocket payment and delays in care-seeking behavior. As part of the project activities, capacity will be built within the MOH Policy and Planning Department and the HII Planning Department to facilitate the mainstreaming of monitoring and evaluation activities, both for the project interventions and for the health system generally. In addition to regularly collecting administrative data on service utilization, costs, and coverage, ongoing monitoring and evaluation activities will include: (i) external evaluations of revised payment methods, CME, licensing and accreditation systems; (ii) surveys of primary health care practices to determine the extent to which guidelines are used appropriately, (iii) surveys of primary health care patients to assess user satisfaction and self-rated health status following PHC encounters; and, (iv) subjective and objective assessments of hospital governance and management effectiveness. Annual performance reviews will be used to monitor progress with respect to project implementation and impact, drawing on the information that has been collected. The same approach will be developed to promote annual sector performance reviews, which will look at the broader policy achievements in relation to the overall health sector strategy.

4. Sustainability

In a large, complex undertaking such as the health reform, sustainability is a major issue. For this reason, the project has concentrated on a limited number of key interventions. A key focus is enhancing the overall level of health system financial sustainability through effective provider

payment methods, pooling of funds and coverage of primary care services. Sustainability of policy, planning and program implementation capacity should be enhanced through extensive TA and training, although strategies are needed to ensure that the people trained are retained within the health system. This will require a supportive work environment as well as competitive salary levels. The latter is already being pursued through the general public administration reform. Adequate provision must also be made for (i) replacement of the medical, training and computer equipment, (ii) software upgrading and eventual replacement, (iii) ongoing training of user personnel, both as a refresher and for new hires; and (iv) continuing training, re-training and upgrading of those running the system, both at the HII and the provider level. Both the implementation approach and the focus on capacity building should ensure that these requirements are sufficiently appreciated and incorporated into the ongoing operations and maintenance of the health system.

5. Critical risks and possible controversial aspects

Albania has an uneven record in implementing reform and limited implementation capacity. Leadership turnover has hampered progress, although the recent elections should provide some stability in the medium term. General mitigation factors or strategies include: (i) the recently adopted Long Term Health Sector Strategy for the first time sets the tone for reform and enjoys support beyond the MOH; (ii) project preparation was done by working groups with participation from implementing departments of MOH and HII, other relevant organizations and representatives of other donor supported projects; (iii) reforms will be back-stopped by relevant conditionality, both within the project and under the next series of DPL's; (iv) the introduction of annual sector performance reviews should regroup other donors behind the program, provide a forum for regular discussions on the progress achieved and impact of reforms and provide a mechanism to ensure and maintain commitment; and (v) strategies to ensure continuity, such as through long term TA, will be pursued. The following table shows the risks related to specific reforms that are most likely to be the subject of opposition and the selected mitigation strategies:

Risk	Risk Rating	Mitigation Strategy
Opposition to changing the payment method for PHC physicians from salary to capitation	S	<ul style="list-style-type: none"> ▪ ensure clear direction from GOA and MOH executive regarding the need for this reform ▪ include Albania Medical Association (AMA) in the planning process ▪ provide opportunity for income enhancement through increasing the number of patients and/or superior performance
Resistance to re-licensing physicians tied to CME	S	<ul style="list-style-type: none"> ▪ include AMA in the planning process ▪ tie PHC equipment to CME completion
Move toward single source purchasing (HII) for all health care services	M	<ul style="list-style-type: none"> ▪ ensure clear direction from GOA and MOH executive regarding the need for this reform ▪ build capacity within the MOH to adapt to their new roles and responsibilities
Moves toward increased independence for hospitals and managerial autonomy and accountability	M	<ul style="list-style-type: none"> ▪ ensure that appropriate legislation is in place to support this approach (through AWP process) ▪ ensure clear direction from GOA and MOH executive regarding the need for this reform ▪ include hospital managers, local government representatives and other stakeholders in the initial stages

Risk rating: H (high risk), S (substantial risk), M (modest risk), N (negligible or low risk)

The move from a PIU structure towards incorporating project implementation into the Ministry of Health also represents a risk at this time. This is being mitigated by (i) having an experienced project director as the Director of the Economic Department of the MOH, responsible for day-to-day implementation; (ii) engaging local consultants with substantial background in World Bank procurement and financial management; and, (iii) bringing in foreign technical assistance.

One final risk is the lack of experience with governance reform, especially in the health sector. This will be mitigated by extensive capacity building at the management, Board (including basic training in board management concepts and techniques) and MOH/HII levels; extensive attention to ensuring that the legal frameworks are well designed and support the desired governance reforms; and the inclusion of key stakeholders in the development of the concepts and implementation strategies.

6. Loan/credit conditions and covenants

Credit effectiveness:

- The Co-financing Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of the Financing Agreement) have been fulfilled;
- The Project Implementation Plan for the Project has been completed, adopted by the Recipient and agreed to by IDA;
- The Operations Manual for the Grants Program of the Project has been completed, adopted by the Recipient and agreed to by IDA;
- The Recipient has adopted a framework, acceptable to IDA, which facilitates the:
 - a) establishment of primary health care practices funded through Capitation-based contracts with the Health Insurance Institute (HII);
 - b) registration of Beneficiaries with the HII; and
 - c) enrollment of Beneficiaries with the Primary Health Care Providers of their choice.
- The following departments and organizational units are in place and operational, and the following staff positions have been established and filled, with Terms of Reference approved by IDA:
 - a) The General Department for Policy and Planning for Health Services within the MOH;
 - b) Appropriate staff in charge of Project implementation within the MOH, including at least one staff responsible for day-to-day management of the Project, at least one staff in charge of financial management of the Project, and at least one staff for procurement under the Project;
 - c) A Monitoring and Evaluation Unit within the MOH, with at least two staff;
 - d) a Project Management and Policy Department within the IPH, with at least five staff;
 - e) A Chair of Family Medicine within the Faculty of Medicine of the University of Tirana, with at least two staff.

Project Implementation Conditions:

- Not later than October 31 of each year, starting October 31, 2006, submit to IDA for review and approval an Annual Work Program for the following calendar year, and shall agree with IDA on the steps to be taken in the following calendar year;
- Not later than October 31 of each year, starting October 31, 2006, submit to IDA for review and approval a report on the performance of the health sector in the preceding calendar year, and jointly undertake with IDA the identification of specific actions needed to address problem areas in the health sector.
- The Recipient shall ensure that the following departments, Working Groups and the units and staff positions for the management and implementation of the Project are operational, adequately filled and maintained, under Terms of Reference satisfactory to IDA:
 - a) the Deputy Minister of Health within the MOH shall be responsible for overall implementation and management of the Project, including the management of policy issues, resource mobilization, and donor coordination;
 - b) the Director of the Economics Department within the MOH shall be responsible for day-to-day Project management. Staff within the Economics Department of the MOH shall be responsible for financial management and procurement;
 - c) Three Working Groups shall oversee the technical implementation issues relating to: (i) health financing; (ii) health quality improvement; and (iii) hospital governance and management. Each Working Group shall be composed of representatives of the MOH, the HII, the IPH and other stakeholders. The Working Groups shall be responsible for the coordination and technical management of the Project activities.
 - d) During implementation, the following entities shall become responsible for planning and implementation of the reforms and policies initiated by the Project: (i) the Monitoring and Evaluation Unit within the Ministry of Health; (ii) the General Department for Policy and Planning for Health Services within the Ministry of Health; (iii) the Project Management and Policy Department within the Institute of Public Health; (iv) the Department for Medical and Pharmaceutical Monitoring within the Health Insurance Institute; and (v) the Chair of Family Medicine within the Faculty of Medicine of the University of Tirana.
- The covenant pertaining to the mid-term review includes an assessment on the possibility of restructuring the Project from a SIL to a SWAP.

Disbursement Conditions Specific to Certain Expenditure Categories:

- for Goods related to health information systems and infrastructure, a written agreement has been reached between the MOH and HII on the methods of payment of Primary Health Care Providers, satisfactory to IDA
- for equipment for primary health care provided to Primary Health Care Providers, the Clinical Guidelines have been approved by the MOH and HII and the training programs for health practitioners have been developed;
- for costs related to registration of Beneficiaries with HII and their subsequent enrollment with PHC Providers, the Unit Costs have been determined in a manner satisfactory to IDA.

D. APPRAISAL SUMMARY

1. Economic and financial analyses

A cost benefit analysis was done to estimate the economic and financial impact of the project. Calculations were based on a ten year time horizon, including recurrent costs and equipment operations and maintenance costs. The following direct and indirect benefits are expected:

Direct Benefits	Indirect Benefits
Reduced unnecessary hospital admissions	Averted productivity loss due to improved access to preventive and basic PH care
	Potential life years saved due to reduced mortality (e.g. from respiratory or endocrinal diseases)
Reduced unnecessary specialist referrals	Reduced travel costs to hospitals and specialists clinics

The combined effect of the three components is estimated, using a 5 percent interest rate over 10 years. Positive values are expected for the project's net present value (NPV) as well as the internal rate of return (IRR). Most of these benefits will occur after about five years and are due to reduced referrals to hospitals. The fiscal impact analysis suggests that there is negligible recurrent cost impact of the health modernization project on the state budget. A complete description of the analysis is presented in Annex 9.

2. Technical

Project interventions in the areas of quality of care are targeted at priority areas of preventable morbidity and mortality, and are expected to contribute to improving the health status for conditions where Albania lags behind neighboring countries. Investments supporting higher quality and improved access to effective primary care have achieved substantial improvements of health outcomes and more efficient use of resources in neighboring countries, and use proven technologies which have been shown to produce good outcomes. The implementation process itself will provide the greatest technical challenge, especially ensuring the proper timing and mix of technical assistance, training and physical investments.

3. Fiduciary

Financial Management – The financial management arrangements are acceptable to the Bank. The Economic Department of the MOH is considered capable of satisfactorily recording all transactions and balances and supporting the preparation of regular and reliable financial statements. The project is subject to auditing arrangements acceptable to the Bank. Initially, a designated account (previously known as special account) and external private sector auditor will be used in line with the arrangements for the previous health project. The Bank, together with the MOH, will assess the reporting and flow of funds arrangements with a view of using the government treasury system for this project when the new computerized treasury system begins operation (currently expected in beginning of January 2007), and will assess the potential of having the annual audit performed by the High State Control when this is appropriate.

The latest Country Financial Accountability Assessment (CFAA – April 2002) confirms that improvement is needed in the management of public expenditures, including cash management in Treasury and better internal control throughout the public sector. Internal audit is being fully developed to improve the government's internal control environment. A Public Internal Financial Control framework is being implemented and a new computerized treasury system is under implementation. The supreme audit institution is also being strengthened. Public financial management has improved significantly during the last few years in areas such as budgeting, internal control, internal and external audit. The project will benefit from the ongoing substantial improvements in the treasury system including improved financial reporting. The project will utilize these improvements by using the treasury system for the payment and reporting functions once it becomes operational, and assessed as acceptable to the Bank. Internal audit should also be utilized to monitor project implementation. Finally, the supreme audit institution could be used to perform project audit at a later date, with support as needed, and when it is considered acceptable to the Bank. A Country Fiduciary Assessment Update (CFAU) is ongoing as well as a Public Expenditure and Institutional Review to be completed before the end of June 2006, which will underpin further improvements in a more efficient use of public resources.

The MOH will further develop project specific policies and procedures to complement the current public expenditure management framework in order to minimize project financial management risks when shifting to the treasury system. The aim of these procedures will be to ensure that the staff involved in the implementation of the project will sign-off on any payment before submission for payment through the treasury system ensuring that the MOH will receive full value for money in terms of quality and quantity of services financed under the project. Further, the project will include capacity building in support of the specific fiduciary issues in the health sector to further develop the fiduciary capacity of the ministry and the sector.

Procurement – The Bank has agreed that the MOH Procurement Section will be responsible for project procurement. The Procurement Section has three staff members. They have little procurement training and capacity and will not be able to implement procurement under the proposed project without additional capacity and training. They have the right skills though and great potential for learning and increasing their knowledge in the area of procurement, both international and national. To facilitate this, the MOH has appointed an experienced project coordinator as the Director of the Economic Department, whose main responsibility will be to provide a liaison between the Bank and the MOH and to coordinate the activities of the different MOH departments, including procurement. Additional local and international TA will also be provided to help improve the capabilities of these staff. A capacity assessment and action plan have been completed and agreed to by the Recipient.

4. Social

A social analysis was conducted to examine care-seeking behavior by socio-economic groups and examine the expected social impact of the project, focusing on four criteria: (1) access to care, (2) utilization of care, (3) out-of-pocket payments, and (4) patient satisfaction; and used Living Standards Measurement Survey (LSMS) data from 2002 and 2004 and findings from other qualitative and quantitative studies. Utilization of both PHC and hospitals is extremely low resulting in low productivity and idle resources. Since chronic illness and health care utilization

are both related to socio-economic background, it is clear that the social impact (and overall impact in terms of improvements in health outcomes) will be maximized if the project focuses on rural and poor localities. Out-of-pocket payments contribute to higher poverty incidence, and survey findings indicate that poor patients are equally as likely to pay for care as the better-off. This may cause the poor to receive incomplete care because they cannot afford paying for full treatment and in particular for the prescribed drugs. This is supported by findings of more extensive insurance coverage in Tirana than in other areas which leads to higher shares of insured drug reimbursement. Affordability and unsatisfactory quality of care are major reasons why sick individuals do not seek care, providing clear support for the proposed project's priorities to focus on the improvement of medical services in rural PHC facilities. The following table summarizes the expected social contribution of each component:

Component	Expected social impact on health system
Strengthening Stewardship: Increased efficiency in purchasing health services, increased financial protection, especially the poor and vulnerable, and improved capacity to make effective health policy and manage the health system effectively.	Financial protection against the consequences of using medical care leads to (a) increased utilization, (b) decreased out-of-pocket payments and (c) income protection against poverty
Improved Primary Health Care: Improved quality of care and access to primary health care services, and increased use of primary care services for the majority of health care needs.	Better quality health care leads to higher satisfaction of both patients and PHC physicians and staff, and more appropriate use of PHC facilities.
Hospital Governance and Management: Improved management of hospitals, increased stakeholder involvement in hospital governance.	Effective hospital management leads to more efficient resource use, resulting in more, higher quality services and higher patient satisfaction.

5. Environment

Category C

There will be no environmental impact as the Bank will finance only consultant services, training and limited low-technology equipment – computers, servers, and basic medical equipment.

6. Safeguard policies

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Natural Habitats (OP/BP 4.04)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pest Management (OP 4.09)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cultural Property (OPN 11.03, being revised as OP 4.11)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Involuntary Resettlement (OP/BP 4.12)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Forests (OP/BP 4.36)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Safety of Dams (OP/BP 4.37)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Projects in Disputed Areas (OP/BP/GP 7.60)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Projects on International Waterways (OP/BP/GP 7.50)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

7. Policy Exceptions and Readiness

There will be no policy exceptions for this project.

Annex 1: Country and Sector or Program Background

ALBANIA: Health System Modernization

Albania's health care system prior to the transition was characterized by strong central government control over all aspects of the system. Despite a widespread primary care network which had been established with a focus on antenatal care and immunization, Albania's pre-transition health care system was largely led by secondary care. The system was highly centralized, with the Ministry of Health providing and regulating all health services in the country and deciding on resource allocation and the nomination of health care staff. The construction of new facilities was favored over the maintenance and operation of existing infrastructure, which led to considerable deterioration in facilities and equipment. Inadequate recurrent expenditures, obsolete drug therapies and outdated medical skills resulted in low quality of care and inefficient use of resources.

Civil unrest and the Kosovo crisis took a heavy toll on the health care system during the 1990s. The violence and civil unrest during the early transition years and again in 1997 resulted in extensive damage to the health care infrastructure and in the disruption of essential services, including immunization, surveillance and environmental health programs, such as water quality and waste removal. Almost one third of the country's medical staff abandoned their posts during the 1997 unrest. The Kosovo crisis in 1999 put additional strains on the system, as over 4,000 refugees were admitted to hospitals, while others were provided accommodation in hospitals for want of other shelter. The crisis caused further damage, consumed a significant amount of resources and brought to a halt the nascent structural reforms in the sector.

A series of sectoral reforms were initiated in the mid-1990s, but limited progress has been made over the past five years in advancing these reforms. While focusing on re-establishing services following the events of the early and mid-1990s, Government also initiated a series of reforms to begin to address some of the sector's weaknesses in the mid-1990s. The reforms included some reduction in the overextended provider network capacity, the decentralization of primary care management to district public health directorates and integration of the former with public health functions, the privatization of the pharmaceutical sector and most dental care, and the establishment of the Health Insurance Institute (HII) in view of a gradual aspired change of the health financing system. Plans were also made to substantially upgrade the quality of the primary care system through physical investments and skills upgrading. The Kosovo crisis interrupted many of these initiatives, and limited progress has been made in most of the reform areas since then. Some pilot projects on the provider organization and financing front were initiated over the past four years which have yielded valuable lessons. More recently, encouraging progress has been made on pharmaceutical policy issues.

Albania's health outcomes compare favorably with those of lower middle income countries outside the Europe and Central Asia Region, but lag behind those of other countries in the South East European Region. Albania's demographic and epidemiological profile is changing. The relative burden of infectious diseases is decreasing while non-communicable diseases have become the leading cause of death among the adult population. Albania's health care system is ill prepared to face the growing incidence of non-communicable diseases and other new health risks.

Physical and human resources in the sector are ill aligned with the population's health needs. A review of the distribution of physical and human resource capacity in the health sector points to large variations in coverage across districts and regions. The significant internal and out-migration in Albania over the past 15 years, combined with the massive destruction of facilities during the 1990s, has left an already imbalanced health care provider network further out of line with the population's health needs. There are marked regional imbalances in medical personnel coverage. Regional variations are highest for specialists and pharmacists and lowest, though still considerable, for primary care physicians. The relatively lower variation in general practitioner coverage appears to reflect concerted Government efforts to rebalance the ratio of general practitioners versus specialists, to substantially upgrade salaries for general practitioners, and, most importantly, to allow for considerably higher salaries for general practitioners serving in the more remote rural areas. There are also imbalances in terms of hospital versus primary care medical staff, and the ratio of doctors to nurses is high by international standards. There is considerable scope for substituting nursing time for physician time and clerical staff for nursing staff in hospitals in the medium to longer term. The skewed geographic distribution of health sector staff will need to be corrected over time as part of an overall planning exercise for health sector human resources.

Productivity in the health sector is low and resources are used inefficiently. Productivity is low, both for primary and hospital care, and it varies substantially across regions and individual facilities. Administrative data suggest that Albanians have significantly less outpatient contacts with health care providers than people from other countries in Eastern Europe and Central Asia, Latin American and the Caribbean or Western Europe. Due to low perceived quality, bypassing of primary care in favor of seeking care at polyclinics or hospital outpatient facilities is widespread even for simple conditions. On average, a primary care doctor sees only about eight patients per day, with marked regional variations resulting in as few as three visits per day in certain regions. Analysis of primary care activity in Tirana region further points to substantial inter-facility variation in productivity. The gatekeeper role that general practitioners (GPs) are expected to play is not functioning, even though the MOH has introduced a fee system which would require payment for care by all those who seek outpatient care directly at a polyclinic or at the hospital. The fee structure, however, is such that it provides the estimated 60 percent of the population without a health insurance card with little incentive to see a primary care physician, particularly if it is felt that the physician will be unable to provide the expected care. Experience in other transition countries and initial evidence from recent pilot activities in Albania suggest that productivity of primary care providers, particularly in rural areas, can substantially improve if they are provided the with skills upgrading to offer a more comprehensive population centered set of services and have access to adequate supplies and equipment.

A large number of small hospitals with low utilization and occupancy rates point to a sub-optimal hospital structure. Over 60 percent of Albania's hospitals are too small to exploit scale economies in the general acute care hospital setting. 30 out of 46 hospitals have less than 200 beds and jointly account for only one quarter of all hospital admissions, while they continue to consume a considerable amount of scarce resources. Low admission and occupancy rates lead to high staff per occupied bed ratios in the smaller hospitals and raise serious concerns about fixed costs, ineffective utilization of limited resources and quality assurance. Several hospitals

exhibit an oversupply of identical departments that could be merged, thus allowing for substantial efficiency gains. Hospital managers have neither incentives nor authority to undertake changes to improve the efficiency and quality of their operation.

The quality of health care is low, particularly at the primary care level. Both the substantial amount of primary care bypassing that takes place and qualitative surveys point to serious deficiencies in the quality of care, particularly at the primary care level. Quality of care standards and standard treatment protocols have not been developed and adopted for outpatient care and providers do not have an established system for continuous quality improvement. Household survey data suggest that bypassing of primary care is more prevalent among the rural population and low income groups, although seeking care at a higher end facility results in higher out-of-pocket payments and longer travel times. This suggests that the quality and scope of service delivery in primary care facilities in rural and peri-urban areas with a high concentration of poor households is of particular concern. A recent survey on reproductive health found that the quality and coverage of prenatal care is of serious concern and ranks among the lowest in the ECA Region.

Quality improvement is a core objective of the Government's long term health sector strategy³. Albania has already undertaken substantial work on the establishment of quality standards for hospitals and strives to establish a hospital accreditation system. A set of quality standards covering the main domains of hospital functioning are currently being pilot tested.

As the provision of private health care is growing, the regulatory framework to ensure that the private sector will contribute to meeting the country's overall health sector goals needs to be strengthened. Although the private sector is still relatively small, its importance in providing outpatient services is growing. Dental care and the pharmaceutical sector are largely privatized. The provision of other health care is still dominated by public providers, but the importance of the private sector is growing in the areas of diagnostics and outpatient services.

Low income groups are ill protected from health shocks and are easily thrown into poverty as a result of out-of-pocket spending on health care. The six per cent of GDP which Albania spends on health care is in line with the average for lower middle income countries, but Albania's public sector contributes a below average share to these expenditures. Because of low public sector spending, out-of-pocket expenditures at the point of service accounts for almost sixty percent of health sector funding. Although health insurance is mandatory, household survey data suggest that only between 40-45 percent of the population have a health insurance card and thus benefit from coverage. Active contributors account for less than one third of the active labor force, pointing to large contribution evasion.

The high share of out-of-pocket payments at the point of service and outside an overall health finance framework creates serious inequities in access, has a considerable poverty impact and limits effectiveness of the Government's sectoral stewardship. Lower income households exhibit a significantly higher likelihood of incurring catastrophic health care expenditures than better off households, with the average out-of-pocket expenditures for one episode of outpatient care amounting to 50 percent of the average monthly per capita expenditure

³ Government of Albania, Long Term Strategy for the Development of the Albanian Health System, July 2004.

of the lowest consumption quintile. Although the law provides for free inpatient care, survey data suggests that essentially everybody who is hospitalized incurs substantial costs and that informal payments account for at least one quarter of these costs. Average outlays for hospital care amount to four times the monthly per capita expenditure of the lowest consumption quintile.

The health financing system is fragmented and fails to give providers incentives for efficiency and quality improvements, nor does it establish clear lines of accountability. The continued fragmentation of the health finance system and at times unclear assignment of financing responsibilities have resulted in a lack of accountability for sectoral performance in general and individual providers' performance in particular. The health finance system is fragmented with the MOH paying for hospital care, non-physician salaries and at times other operating costs for primary care, while HII pays for salaries of primary care physicians, prescription drugs and high end diagnostics. Financing responsibilities have changed repeatedly over the past several years, with local governments at times expected to cover operating costs for primary care. As a result of dispersed funding sources, the lines of accountability are unclear, particularly at primary care level. The introduction of user fees for outpatient care for those not covered by health insurance or those who circumvent primary care has not been applied evenly and tended to create uncertainty among providers and patients, leaving ample room for abuse. While informal payments are relatively modest for outpatient care, they are widespread and substantial for inpatient care. Input based financing gives providers no incentive to improve quality or efficiency and has led to skewed geographic allocation of resources.

The main challenge for Albania's health sector is to consolidate the achievements in health outcomes to date, while establishing capacity to effectively address the growing incidence of non-communicable diseases and affording low income groups better protection from impoverishing effects of health expenditures. To consolidate achievements in health outcomes, establish capacity to effectively address new health needs and better protect low income groups from health risks, fundamental and systemic changes in the way health care is financed, delivered and organized will be required. These can best be summarized around three core pillars: (i) more efficient resource mobilization and allocation; (ii) improvements in service delivery quality; (iii) improvements in sectoral management and stewardship. A recently completed sector note highlighted the key changes needed in each of these areas:

(i) Resource Mobilization and Allocation

- pool all public sector resources under one funding agency.
- rely on general taxation rather than payroll tax contributions as the main source of public funding for health care.
- clearly define the health care benefits which will be made available from public funds and introduce co-payments for a wider range of services, including inpatient care.
- combine the introduction of increased co-payments with broad based action to root out informal payments.
- increase resource allocation for public health and health information.
- in the medium term, shift to a population based regional funding allocation.
- in the medium term, improve the balance between public and private spending on health care to enhance the population's protection from health shocks.

- finalize and use the hospital map as an instrument to guide any future investment in the hospital infrastructure.
- develop regional primary health care plans.

(ii) Improve Quality and Efficiency of Health Services Delivery

- consolidate pilot efforts to improve clinical effectiveness and quality of care.
- shift from input based financing of health care providers to performance based payments.
- establish a quality assurance system.
- consolidate reforms in the pharmaceutical sector.

(iii) Improve Sectoral Management and Stewardship

- the roles and responsibilities of all core actors in the sector need to be clearly defined and accountability mechanisms established.
- review the potential role of regional health authorities in light of the pilot experience gained in Tirana and a decision needs to be made about the future of regional health authorities in Albania.
- improve the organization and management of primary care providers.
- increase autonomy for hospitals.
- increase population feedback and community participation.

The changes in the organization and financing of health care will require a gradual introduction and careful preparation and capacity building of health care providers, HII, and MOH to ensure that they are ready to assume their increased responsibilities. Fundamental decisions on the legal status, organizational arrangements, governance structures and extent of autonomy for health care providers will need to be taken before such changes can be introduced. Provider accounting systems need to be strengthened, performance standards established and adequate provider reporting and information systems introduced to allow for appropriate performance monitoring and transparency. Provider management capacity will need to be developed and payment reforms will need to be coordinated with efforts to improve the quality of care to enhance payment mechanisms' incentives for behavioral change on the provider as well as the patients' side.

Annex 2: Major Related Projects Financed by the Bank and/or other Agencies

ALBANIA: Health System Modernization

To date, the Bank has supported two health sector operations in Albania. The first project was successfully completed in 2001 (rated “S” in all major areas) and focused on reconstruction of the health facilities network in two regions, plus limited provider and management training for district health department staff. The second project closed in January 2005, and was designed to support the pilot testing of a new organizational set-up in Tirana region, combined with substantial physical upgrading at Tirana University Hospital and other facilities in the capital region. The ICR, which was completed in June, 2005, rated many aspects of the project as unsatisfactory and noted that:

The project's overall achievements clearly do not match the expectations set out either at appraisal or the revised expectations developed during the mid-term review. Relatively inconsistent monitoring of key indicators, except towards the end of the project, as well as a number of changes in these indicators during project implementation tended to hamper ongoing efforts to monitor project achievements ... However, the project should make an initial contribution towards strengthening planning and management capacity in the Ministry of Health as well as in the Tirana Region. These include:

- *completion of the Tirana Region Health Master Plan (the first effort in the country to plan health care provision and investments in service delivery in line with population needs),*
- *completion of the TUHC Master Development Plan, including architectural drawings and specifications,*
- *development of a business and management plan for Tirana University and Durrës University Hospital as well as a national strategy to strengthen management capacity in the hospital sector*
- *completion of the national health sector reform strategy*
- *development and adoption of a national health promotion strategy (the IPH is currently in the process of developing implementation plans)*
- *national HIV/AIDS strategy*

In addition to the Bank, other agencies involved in the sector include USAID, the Italian Cooperation, the OPEC Fund, the Swiss Development Cooperation, SIDA, UNICEF, UNFPA and WHO. The German Government, EIB and IFC are also exploring engagement in the sector. The Bank has been designated by the donor coordination secretariat to lead donor coordination on the socio-economic development front in close cooperation with the Government, and shares this role with WHO in the health sector, offering the opportunity for general donor agreement on the overall strategy and opening the potential for more sector-wide approaches in the future. The proposed project is being prepared in close coordination with other donors, and will, to a significant extent, build on work currently supported by USAID and SDC, which have both expressed a strong desire for close coordination.

The current USAID-funded intervention is designed to allow the Albanian health system to (a) manage its health resources more efficiently; (b) improve the quality of its primary healthcare services; and (c) increase use of primary healthcare services. The emphasis will be on the decentralization of health management and increased access to quality care without additional cost. Specific interventions include: (i) promoting policy and health sector reform, where these

relate to the intermediate results; (ii) conducting analyses, including cost and cost effectiveness, of current and proposed policies; (iii) emphasizing meeting the needs of the target population through integration of primary health care services rather than improving separate service delivery systems; (iv) using the continuum of care model to better focus health services to the needs of the client; (v) engaging communities in identifying and responding to their own health needs; (vi) introducing mechanisms for “performance improvement” as opposed to just training; and (vii) building partnerships between providers and communities. There is a clear compatibility between these activities and the proposed Bank-funded project. The USAID-financed integrated PHC program will be rolled out aggressively over a two year period to initiate all key activities and set a firm base for achieving nation-wide impact with as many intervention areas as possible over a four-year period. The team anticipates beginning program activities with major focus in five prefectures: Korce, Berat, Diber, Lenzhe, and Shkoder.

The SDC initiative, which has been submitted for final approval, seeks to establish a Center for Continuing Education for health care professionals, including both clinical and administrative staff. The role of this Center would be to coordinate and organize continuing education initiatives under the direction of the MOH. It would not develop its own content, but would rely on the professional associations or faculties to provide the courses to be delivered and determine the appropriateness for continuing education credit purposes.

Annex 3: Results Framework and Monitoring

ALBANIA: Health System Modernization

Results Framework

PDO	Project Outcome Indicators	Use of Project Outcome Information
<p>The objectives of the project are (i) to improve both physical and financial access to and the actual use of high quality primary health care services, with an emphasis on those in poor and under-serviced areas as well as to diminish the unnecessary use of secondary and tertiary care facilities, (ii) to increase the effectiveness of the MOH and HIF in formulating and implementing reforms in provider payments and health system performance, and (iii) to improve governance and management in the hospital sector.</p>	<ul style="list-style-type: none"> ▪ At least 70 percent of the population is enrolled with a primary health care provider and use him/her as their first source of health care ▪ Reduced percentage of households who do not seek necessary health care because they cannot afford it and reduced share of household expenditure for primary care services ▪ Increased patient satisfaction with PHC treatment and improved outcomes for defined health conditions ▪ HII lives within its budget without additional MOF funding ▪ Based on agreed key performance indicators, hospitals using new governance approaches perform better than those who do not. 	<p>Information used to:</p> <ul style="list-style-type: none"> ▪ provide performance feedback for health care providers, and to set targets and agree on strategies for performance improvement ▪ evaluate the effectiveness of project interventions and identify priorities for future policy and investment interventions ▪ identify issues and actions for changes to project design and approach during project implementation
Intermediate Outcomes	Intermediate Outcome Indicators	Use of Intermediate Outcome Monitoring
<p>Component One: The MOH and HIF are capable of developing and modifying health policies, effectively monitoring health system performance, and effectively purchasing and monitoring health services on behalf of the population of Albania.</p>	<p>Component One:</p> <ul style="list-style-type: none"> ▪ Over 90 percent of total publicly financed health expenditures flow through active purchasing methods ▪ Revised payment methods in primary, specialist and hospital care increase efficiency and effectiveness, measured by 10 percent reduction in admission rate, and 10 percent lower ALOS ▪ An agreed set of monitoring data is available on an ongoing basis, with monthly/quarterly performance reports produced ▪ MOH and HIF policy units provide timely support for policy development 	<p>Component One:</p> <ul style="list-style-type: none"> ▪ Determine if single purchaser model is working and make adjustments as necessary ▪ Indicate effectiveness of contracting and payment methods being used ▪ Determine the effectiveness of investments in information technology ▪ Suggest areas to concentrate further capacity building activity

	<ul style="list-style-type: none"> ▪ New CPG's developed and implemented for xx priority diseases. ▪ Effective CME catering to all GPs and FPs and delivering 40 hours of training per year per physician, ▪ All physicians are licensed and a first cohort of 20 percent of all physicians has gone through the re-validation (re-licensing) procedure, ▪ All hospitals have been surveyed according to the accreditation standards and have written quality improvement plans to achieve the standards. ▪ Health technology assessment function established and used in decision making on the positive list of drugs and investments in hospitals 	<ul style="list-style-type: none"> ▪ Determine whether additional effort is needed in these areas ▪ Determine whether additional effort is needed in these areas ▪ Determine whether additional effort is needed in these areas ▪ Determine whether additional effort is needed in these areas ▪ Determine whether additional effort is needed in these areas
<p>Component Two: The population is registered with primary health care providers, has better access to these service, quality is improved, and PHC providers are being used for the majority of health care needs.</p>	<p>Component Two:</p> <ul style="list-style-type: none"> ▪ 70 percent of the population per district/regions is enrolled with a specific physician (or PHC center) ▪ Training has been completed and primary care physician practice patterns are consistent with this training, confirmed by the 70 percent compliance with disseminated clinical practice guidelines and by referrals to secondary and tertiary care, consistent with these guidelines ▪ Increase of 30 percent in the proportion of identified medical conditions that are cared for within a PHC setting ▪ Average out-of-pocket payment for PHC services is reduced by 50 percent ▪ avoiding care-seeking behavior due to financial factors has reduced by 50 percent ▪ Patient/physician satisfaction with PHC has increased by 30 percent according to two subsequent population surveys with identical questionnaires 	<p>Component Two:</p> <ul style="list-style-type: none"> ▪ Determine what additional effort is needed to improve registration compliance ▪ Determine whether quality improvement approaches are being used in daily service provision, and where changes or improvements are needed ▪ Determine where there needs to be increased emphasis on the use of PHC over specialist or hospital services ▪ Determine barriers to increased use of PHC, and inform on potential areas of intervention ▪ Provide check against objective utilization measures

<p>Component Three: Improved management of hospitals, and piloting efforts for increased involvement by stakeholders in the governance of these facilities</p>	<p>Component Three:</p> <ul style="list-style-type: none"> ▪ Hospital performance using an agreed set of key indicators, and comparisons between hospitals being done. ▪ Number of hospitals where board governance structures are successfully piloted 	<p>Component Three:</p> <ul style="list-style-type: none"> ▪ Determine effectiveness of capacity development initiatives and indicate areas requiring further effort ▪ Determine readiness for larger roll-out of governance reform
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Arrangements for Results Monitoring

Project Outcome Indicators	Baseline	Target Values					Data Collection and Reporting			
		YR1	YR2	YR3	YR4	YR5	Frequency and Reports	Data Collection Instruments	Responsibility for Data Collection	
<ul style="list-style-type: none"> ▪ At least 70 percent of the population is enrolled with a primary health care provider and use him/her as their first source of health care ▪ Reduced percentage of households who do not seek necessary health care because they cannot afford it and reduced share of household expenditure for primary care services ▪ Increased patient satisfaction with PHC treatment and improved outcomes for defined health conditions ▪ HII lives within its budget without additional MOF funding ▪ Based on agreed key performance indicators, hospitals using new governance approaches perform better than those who do not. 	None	0	30	60	70	70	Quarterly FMR	HII information system	HII	
	No care -- 27% of PHC – 30% of per capita consumption (2004 LSMS – all outpatient) TBD-LSMS (satisfaction) TBD-Survey (outcomes) TBD-2005-est. KPI to be defined in 2006	Develop PHC baseline	No change	10% imp.	30% imp.	40% imp.	Annual M&E report	LSMS	INSTAT, with analysis by MOH or IPH	
		No chg. No chg. -20% +/- 5%	10% imp. 5% imp. +/- 4%	30% imp. 10% imp. +/- 3%	40% imp. 15% imp. +/- 2%	50% imp. 20% imp. Bal.	Annual M&E report Biennial M&E report Quarterly FMR Annual M&E report	LSMS M&E Survey HII annual report Hospital KPI reports	INSTAT, MOH or IPH MOH M&E unit HII HII & MOH hospitals department	
Intermediate Outcome Indicators										
Component One: <ul style="list-style-type: none"> ▪ Over 90 percent of total publicly financed health expenditures flow through active purchasing methods 	~25% HII, not active purchasing	~25%	30%	40%	60%	90%	Annual M&E report	HII information system	HII	

* LTHS = Long-term health strategy

<ul style="list-style-type: none"> Revised payment methods in primary, specialist and hospital care increase efficiency and effectiveness, measured by 10 percent reduction in admission rate, and 10 percent lower ALOS An agreed set of monitoring data is available on an ongoing basis, with monthly/quarterly performance reports produced MOH and HIF policy units provide timely support for policy development New CPG's developed and implemented for 32 priority diseases. <ul style="list-style-type: none"> Effective CME catering to all GPs and FPs and delivering 40 hours of training per year per physician All physicians are licensed and a first cohort of 20 percent of all physicians has gone through the re-validation (re-licensing) procedure, <ul style="list-style-type: none"> All hospitals have been surveyed according to the accreditation standards and have written quality improvement plans to achieve the standards. Health technology assessment function established and used in decision making on the positive list of drugs and investments in hospitals 	<p>Admit. Rate=8.7 ALOS= 6.6</p> <p>No progress, agree in 2006</p> <p>Little policy capacity</p> <p>28 CPG's, not implemented.</p> <p>No systems established</p> <p>Licensing in progress no re-licensing</p> <p>No surveys completed</p> <p>No HTA capacity</p>	<p>8.7 6.6</p> <p>Agree on ind.</p> <p>LTHS* action plan</p> <p>Imp. 5 regions (URC)</p> <p>Center set up, first courses</p> <p>30% licensed, 0% re-licensed</p> <p>Agree on approach</p> <p>Capacity building</p>	<p>8.7 6.6</p> <p>First set of ind.</p> <p>1 major Policy</p> <p>Finish 5 reg. (URC)</p> <p>Avg. 10 hrs. per yr.</p> <p>60% lic., 0% re-lic.</p> <p>System is set up</p> <p>Appr. agreed</p>	<p>8.4 6.4</p> <p>Quarterly ind. Prod.</p> <p>2 major policies</p> <p>Imp. 8 regions</p> <p>Avg. 20 hrs. per year</p> <p>100% lic., 0% re-lic.</p> <p>Survey 20% of hosp.</p> <p>HTA unit set up</p>	<p>8.1 6.2</p> <p>Monthly ind. Prod.</p> <p>2 major policies</p> <p>Imp. 12 regions</p> <p>Avg. 30 hrs. per yr.</p> <p>100% lic., 0% re-lic.</p> <p>Survey 55% of hosp.</p> <p>Drug list reviewed</p>	<p>7.8 5.9</p> <p>Monthly ind. Prod.</p> <p>2 major policies</p> <p>Imp. 12 regions</p> <p>Avg. 40 hrs. per yr.</p> <p>100% lic., 20% re-lic.</p> <p>Survey 100% of hosp.</p> <p>Invest. guides dev.</p>	<p>Annual M&E report</p> <p>Monthly & quarterly reports</p> <p>Annual M&E report</p>	<p>MOH information system</p> <p>MOH/HII information systems</p> <p>Direct observation</p> <p>Reports from FM dept.</p> <p>Reports from FM dept.</p> <p>Reports from OPA, FM dept.</p> <p>Accredit'n reports</p> <p>HTA activity reports</p> <p>HII information</p>	<p>MOH M&E unit</p> <p>MOH M&E units and HII</p> <p>MOH and HII</p> <p>MOH and FM department</p> <p>MOH and FM department</p> <p>MOH, OPA and FM department</p> <p>MOH hospitals department</p> <p>MOH and HII</p> <p>HII</p>
<p>Component Two:</p> <ul style="list-style-type: none"> 70 percent of the population per district/regions is enrolled 	<p>No enrollment</p>	<p>0</p>	<p>30</p>	<p>60</p>	<p>70</p>	<p>70</p>	<p>Quarterly FMR</p>	<p>HII information</p>	<p>HII</p>

<p>with a specific physician (or PHC center)</p> <ul style="list-style-type: none"> Training has been completed and primary care physician practice patterns are consistent with this training, confirmed by the 70 percent compliance with disseminated clinical practice guidelines and by referrals to secondary and tertiary care, consistent with these guidelines 	<p>Training in Berat only, no estimate on compliance</p>	<p>Imp. 5 regions (URC)</p> <p>Assess. tool agreed</p>	<p>Finish 5 reg. (URC)</p> <p>Tool tested in 5 regions</p>	<p>Imp. 8 regions</p> <p>30% compliance</p>	<p>Imp. 12 regions</p> <p>50% compliance</p>	<p>Imp. 12 regions</p> <p>70% compliance</p>	<p>Annual M&E report</p>	<p>Annual M&E report</p>	<p>MOH and FM department</p>
<ul style="list-style-type: none"> Increase of 30 percent in the proportion of identified medical conditions that are cared for within a PHC setting Average out-of-pocket payment for PHC services is reduced by 50 percent avoiding care-seeking behavior due to financial factors has reduced by 50 percent Patient/physician satisfaction with PHC has increased by 30 percent according to two subsequent population surveys with identical questionnaires 	<p>Year 1 Identify conditions</p> <p>LSMS=2155 Lek (all O/P)</p> <p>LSMS=27% (all services)</p> <p>LSMS=13.7% not satisfied (all O/P)</p>	<p>Conditions agreed</p> <p>Develop PHC baseline</p> <p>Develop PHC baseline</p> <p>Develop PHC baseline</p>	<p>Tool tested in 5 regions</p> <p>10% reduct.</p> <p>10% reduct.</p> <p>5% incr.</p>	<p>10% incr.</p> <p>20% reduct.</p> <p>20% reduct.</p> <p>15% incr.</p>	<p>20% incr.</p> <p>35% reduct.</p> <p>35% reduct.</p> <p>25% incr.</p>	<p>30% incr.</p> <p>50% reduct.</p> <p>50% reduct.</p> <p>30% incr.</p>	<p>Annual M&E report</p> <p>Annual M&E report</p> <p>Annual M&E report</p> <p>Annual M&E report</p>	<p>Annual M&E report</p> <p>Annual M&E report</p>	<p>HII and MOH</p> <p>INSTAT, with analysis by MOH or IPH</p> <p>INSTAT, with analysis by MOH or IPH</p> <p>INSTAT, with analysis by MOH or IPH, plus M&E unit</p>
<p>Component Three:</p> <ul style="list-style-type: none"> Hospital performance using an agreed set of key indicators, and comparisons between hospitals being done. Number of hospitals where board governance structures are successfully piloted 	<p>KPI to be defined in 2006</p> <p>0</p>	<p>0</p>	<p>No diff.</p> <p>1</p>	<p>No diff.</p> <p>2</p>	<p>10% diff.</p> <p>3</p>	<p>20% diff.</p> <p>3</p>	<p>Annual M&E report</p> <p>Annual M&E report</p>	<p>Hospital KPI reports</p> <p>MOH annual report</p>	<p>HII & MOH hospitals department</p> <p>MOH hospitals department</p>

ANNEX 3.1 – ALBANIA HEALTH SECTOR MODERNIZATION PROJECT – ANNUAL WORK PROGRAMS BY YEAR

2006 Work Program		
Sub-Components	Activities	End of Year Target
A.1 Capacity Building Contracting and Payment Methods	Program preparation and training abroad	Program approved by MOH Management
A.2 Policy Development and Monitoring	Review TOR of Policy and Planning Department and training of staff abroad	Revised TOR approved by MOH Management, study tours for 5 people
A.3 Health Information Systems	Development of technical specifications for hardware and software, MOH LAN, prescription drug system, standards	NOB for approved specifications, MOH LAN installed, standards process started, drug system development started
A.5 Licensing and Accreditation	Preparation of approach for both licensing and hospital accreditation, and training abroad	Approaches approved by MOH Management, study tours for 12 people, licensing hardware/software procured
A.6 Health Technology Assessment	Preparation of approach for HTA, EBM, initial training	Approach approved by MOH, 2 people trained
A.7 Preparation for Project Implementation	FM, procurement, project management capacity building	All training completed, foreign and local TA in place
B.1 Primary Health Care (PHC) Enrollment	Development of technical specifications for information systems	NOB for approved specifications, tendering process started
B.2 PHC Practice Management	Program preparation	Program is approved by MOH Management
B.3 Clinical guidelines	Preparation of guidelines	Guidelines approved by MOH Management
B.4 Continuous Medical Education	Preparation of approach and training abroad	Approach approved by MOH Management
B.6 PHC Equipment	Development of technical specifications for equipment	NOB for approved specifications
2007 Work Program		
Sub-Components	Activities	End of Year Target
A.1 Capacity Building Contracting and Payment Methods	Training in contracting and payment methods	Training completed
A.2 Policy Development and Monitoring	Review TOR – Monitoring/Evaluation Sector and training of staff abroad for M&E Sector and IPH	Revised TOR approved by MOH Management, study tours for 16 people
A.3 Health Information Systems	Develop software and distribute PHC hardware, procure HII hardware and MOH document management system	50% completion on HII software and PHC HW/SW, HII hardware procured, MOH document management system procured
A.4 Monitoring Health Care Services	Prepare approach and technical specifications for monitoring software, staff training	Approach approved by MOH Management, NOB for specifications, 5 staff trained
A.5 Licensing and Accreditation	Finalize standards, begin licensing and accreditation process, training abroad,	Standards approved by MOH Management, 60% of physicians licensed, 15 staff trained

Sub-Components	Activities	End of Year Target
A.6 Health Technology Assessment	Establish HTA infrastructure, including HW & SW	HTA infrastructure is in place
B.1 Primary Health Care (PHC) Enrollment	Software development and begin issuing new cards, PR campaign	Software completed, 30% of cards distributed, PR campaign launched
B.2 PHC Practice Management	Training of trainers and initial training	Trainers trained, 40% of practice managers trained
B.4 Continuous Medical Education	Finalize development of regional infrastructure	Regional centers established and operating
B.5 PHC Quality Improvement	Training of trainers and initial training, PR campaign	Trainers trained, 20% of PHC staff trained, PR campaign launched
B.6 PHC Equipment	Procure and provide equipment for HC, HP, and Polyclinics	17% of health facilities provided with equipment
C.1 Hospital Management/Financial Management	Development of training programs and commencement of training	Training programs approved by MOH, 50% of senior managers and 25% of finance and procurement managers trained
C.2 Provider Autonomy	Develop acts/regulations, train staff	Acts and Regulations approved by MOH
C.3 Implementing hospital governance	Select hospitals, training and implementation support	3 hospitals selected and approved by MOH, 30% of relevant staff/board members trained
2008 Work Program		
Sub-Components	Activities	End of Year Target
A.3 Health Information Systems	Distribute PHC and hospital hardware and software	100% PHC completion, 50% hospitals
A.4 Monitoring health care services	Development of monitoring software	50% completion of software
A.5 Licensing and Accreditation	Finalize licensing and begin hospital accreditation	100% of physicians licensed, 55% hospitals surveyed for accreditation
B.1 Primary Health Care (PHC) Enrollment	Continue issuing new cards, begin GP registration, continue PR campaign	100% cards distributed, 90% registered with GPs, PR campaign finalized
B.2 PHC Practice Management	Ongoing training	100% of practice managers trained
B.5 PHC Quality Improvement	Ongoing training, PR campaign	60% PHC trained, PR campaign completed
B.6 PHC Equipment	Procure/provide equipment for HC, HP, and Polyclinics	55% of health facilities provided equipment
B.7 Quality Improvement Grants	Distribution of grants	50% of grants distributed
C.1 Hospital Management/Financial Management	Training of staff	100% of hospital staff trained

If all end-of-year targets are met, preparation of next project can commence		
2009 Work Program		
Sub-Components	Activities	End of Year Target
A.3 Health Information Systems	Distribute hospital hardware and software	100% hospital completion
B.5 PHC Quality Improvement	Quality training	100% of PHC staff trained
B.6 PHC Equipment	Procure and provide equipment for HC, HP, and Polyclinics	100% of health facilities provided with equipment
B.7 Quality Improvement Grants	Distribution of grants	100% of grants distributed

Annex 4: Detailed Project Description
ALBANIA: Health System Modernization

Component A - Strengthen Sector Stewardship, Financing and Purchasing (base cost US\$ 6.4 million, total cost US\$ 7.2 million) would help the HII develop its functions and capacity as sole purchaser of health services, and would support capacity building in the MOH, the Institute of Public Health (IPH) and the HII to strengthen their stewardship roles in the health system. Activities would include (i) capacity building in the HII and its local branches; (ii) strengthening the policy formulation and performance monitoring functions within the MOH and the IPH; (iii) development of health information system capacity to support payment and management reforms; (iv) development and implementation of a system to monitor provider performance (both clinical and financial); (v) establish a licensing/re-licensing scheme for physicians and health facilities, and an accreditation program for hospitals; (vi) development of Health Technology Assessment (HTA) capacity; and (vii) building up MOH capacity in financial management, procurement and project coordination. It would include the following sub-components:

A.1. Capacity Building – Contracting and Payment Methods

This sub-component would involve the development of payment and contracting methods which are compatible with the needs of a single payer, as well as those of autonomous institutions, and the dissemination of such methods to providers and payer of services. It would include study tours to enhance the knowledge of provider payment methods in different countries, and the influence of difference methods of payment of health services (positive and negative impacts of each and experiences of other countries). Courses would be developed for the dissemination of this knowledge to trainers who would conduct workshops for health service providers throughout the chain of health service, to raise the awareness of health staff about the concepts of the administration of the financial resources. Equipment would be provided to enable the organization and performance of the process of qualification of all participators in the scheme, and continuous advice would be provided regarding administration and capacity building of the staffs during whole transition period.

A.2. Policy Development and Monitoring

This sub-component would begin with a review of the Terms of Reference (ToR) of the Sector of Policy and Planning of Department of Policy and Planning of the MOH (SPP), followed by capacity building in the SPP in conformity with the revised ToR. This capacity building would include assistance in the preparation and formulation of health policies; strategies at national and regional level; and performance of economic analysis (cost-effectiveness analysis, etc.) for different programs in health sector. There would also be a review of ToR of the Sector of Monitoring and Evaluation (SME) of the Policy and Planning Department, followed by capacity building in Monitoring and Evaluation sector in conformity with this ToR, covering areas such as the process of evaluation of projects and programs, the development of monitoring indicators and systems, and the incorporation of monitoring and evaluation into the day-to-day workings of the MOH.

A.3. Health Information Systems

The establishment of the appropriate infrastructure for the management of the health information and preparation of the information systems and its elaboration is a key focus of this sub-component. This would include providing needed hardware and software to enable the establishment of health information systems and infrastructure, including servers to enable the collection and storage of information and files for all health institutions, hardware and software to enable the organization of the system of information in hospitals and HII, and the preparation of the specialized computer programs for the elaborating of health information and its management. Specific activities would include (i) the development of systems for the HII in the area of prescription drug processing, patient registration/enrolment, and service monitoring; (ii) improving document management, internet access, and standards development in the MOH; (iii) creating a public health data warehouse in the IPH; and, (iv) supporting the implementation of new systems in PHC and hospitals.

A.4. Monitoring of Health Care Services

This sub-component would include technical assistance for monitoring provider practice patterns and outcome evaluation, and the preparation and provision of the computer programs to assist in evaluating the appropriateness of the health care services being provided and funded through the HII.

A.5. Licensing and Accreditation

This sub-component includes the preparation of the standards for licensing of health professionals with foreign assistance, technical assistance for the preparation of the standards for licensing hospitals (basic level of standards and for specific hospital services such as neonatal ICU, CT Scanner and MRI), and determining and selecting the most appropriate model considering the specific circumstances in Albania. In addition study tours would be supported to study the different experiences in other countries regarding: (i) preparation of the standards for licensing of the health professionals, (ii) implementing the supervision and inspection of services to comply with the standards, and (iii) the way of reporting of the activities performed by the providers. This sub-component would also include training for capacity building within the framework of accreditation process to further development of the supervisory capacities of accrediting visits, training for capacity building within the framework of accreditation process to training of Accreditation boards, and training for capacity building within the framework of accreditation process to Center of Accreditation and Quality. Necessary office automation support is also included in this sub-component.

A.6. Health Technology Assessment

To support the development of a health technology assessment capability within Albania, this sub-component would include the evaluation and analysis of the situation of medical equipment, an evaluation and analysis of the situation of supportive systems in hospital facilities (power supply system, medical gases supply system, vacuum and compressed air supply etc.), and the preparation of the standards for medical equipment and for supporting hospital systems. The specific activities for this sub-component, as well as A.5, would be reviewed following the completion of the PHRD-funded activities in the area of quality improvement, which is expected shortly.

A.7. Capacity Building for Project Implementation

Since this project would be managed from within the MOH, rather than a separate PIU, capacity building would be needed in the areas of financial administration, procurement service provision, and project administration. Under this subcomponent, a fiduciary capacity building plan will be prepared and implemented. The plan will include the following:

- A brief procurement training needs assessment, covering the whole sector from the Ministry down to the local government units involved in conducting procurement for the health sector;
- Development and implementation of training plan according to the results of the needs assessment study. Training programs will be prepared in consultation and with the support of the Public Procurement Agency, so that their contents comply with the requirements of the existing public procurement law and regulations;
- Training programs will be prepared according to the needs of the agencies at different levels. For example, the agencies at the central level may need more training in procurement of goods while those at the local levels may need training only in procurement of civil works;
- Agencies that will be involved in international procurement will be identified and their staff trained in conducting procurement according to international requirements, including the requirements of the World Bank procurement and consultant guidelines applicable to this project;
- Training programs will also be developed and delivered for the private sector firms to increase their awareness of the requirements of the public procurement law and regulations and those of the procurement and consultant guidelines. This will improve the quality of their bids and proposals resulting in efficient procurement;
- A special technical note will be prepared and/or updated for the procurement of health goods, including pharmaceuticals, and used in training programs.
- Short awareness programs will also be developed and implemented for the users of health services.
- Consultants will also assist in developing an anti-corruption program for the health sector, including a hotline that would be made available to the users of health services to report irregularities, possibly using the existing website of the Ministry of Health.

This subcomponent would finance these activities, as well as technical assistance in procurement and project management.

Component B – Improving PHC Service Delivery (base cost US\$ 9.4 million, total cost US\$ 10.6 million) would support institutional reforms and limited investments aimed at improving the access and quality of primary health care. The program would (i) facilitate the registration of the population with the HII, and subsequent enrollment with a particular primary care physician; (ii) build practice management capacity at the primary care level; (iii) develop and introduce clinical guidelines with an initial focus on primary care and the primary-secondary care interface and the most pressing health issues (e.g., child health, ante-natal care, respiratory infections); (iv) establish a continuing medical education system (CME) and link this to the re-licensing scheme; (v) retrain existing general practitioners and pediatricians in evidence based treatment of

common conditions and rational drugs use, based on the clinical guidelines; (vi) provide basic equipment to physicians who complete the retraining program; and (vii) establish a grant facility to fund proposals from primary care providers in support of quality of care and continuum of care improvement initiatives. It would include the following sub-components:

B.1. Primary Health Care (PHC) Enrollment

This sub-component will involve co-operation with the institutions responsible for the collection of the health insurance contributions and other institutions dealing with and responsible for the non-active population to enable the nominal identification, registration, and management of the all eligible beneficiaries, with out regard to whether they are making contributions.

It will include measures for the identification of each contributor through establishing an insurance number and provision of some form of identification, and other measures to encourage those who are not making contributions – and are not exempt – to do so. A process will be developed for the enrollment of all eligible beneficiaries with primary health care physicians in the whole country, engaging the existing personnel and extra staff as needed, preparing the forms to be filled with the required information, and the preparation of software for collecting and managing all of this information.

To promote a rapid registration and enrollment process, these costs will be reimbursed on an output basis, using the cost of the registration card plus an estimate of the additional staff time needed to register each individual.

Staffing costs will reflect the incremental HII staff time needed to process each registration and enrollment, using average HII salaries. Based on discussions with the HII, it is estimated that it will take about 12.75 minutes of additional staff time to process each registration (about 38 registrations per day), resulting in additional staffing needs of 339.5 Full-Time Equivalents. According to the latest HII financial statements, clerical staff salaries and benefits amount to approximately 32,000 Lek per month (\$314 equivalent). An estimated 3.2 million people are expected to be registered and enrolled. Based on these figures, an incremental staff cost figure of 40.74 LEK per person registered and enrolled has been agreed, although this will be refined before effectiveness and the final cost estimate will be put in the PIP.

In addition to the staff cost, the only additional cost will be the card which will identify the beneficiary and indicate his or her selection of primary care practitioner. It has been agreed that a magnetic stripe type card would be used. Although a detailed cost estimate will be prepared for the PIP, and will depend on the specific technology selected, a standard industry estimate of \$0.50 per card produced has been used for estimation purposes (including blank cards, equipment and other supplies required for producing these cards).

The amount will be agreed to by the Bank prior to disbursements being allowed, will be subject to spot checks and review as part of the normal supervision process. It would be adjusted as appropriately justified following such a review, and would be audited as part of the annual external audit process. The methodology for determining Unit Costs will be described in more detail in the PIP, and will be used as a basis for the determination of the Unit Costs, which is a condition of disbursement, and for subsequent adjustments of the Unit Costs. As specified in the

agreed Minutes of Negotiations, the following format will be used to track the costs associated with this component.

Line		Current Period			Cumulative			Revised PAD
		Planned	Actual	Variance	Planned	Actual	Variance	
1	Base HII Staffing (January 1, 2006 FTEs)							
2	HII Staffing Cost (LEK – January 1, 2006)							
3	HII Average cost per FTE (LEK - January 1, 2006)							
4	HII Staff Current Period (FTEs)							
5	HII Staffing Cost Current Period (LEK)							
6	HII Average cost per FTE (LEK - current period)							40.74
7	Change in FTEs (line 6 – line 4)							
8	Change in staffing cost (LEK) (line 2 – line 5)							
9	Change in Average cost per FTE (line 3 – line 6)							
10	Additional FTEs at Standard Cost (line 6 x line 7)							130,354,900
11	Total value of contract for ID cards (LEK)							162,280,000
12	Number of ID cards included in contract							3,200,000
13	Unit cost for ID cards (line 11 / line 12)							50.90
14	Total number of subscribers enrolled							3,200,000
UNIT COST CALCULATION								
15	Total staffing cost (line 10)							130,354,900
16	Total cost of cards (line 13 x line 14)							162,280,000
17	Total cost for enrollment (line 15 + line 16)							292,634,900
18	Unit cost to be reimbursed (line 17 / line 14)							91.64

B.2. Strengthening PHC Practice Management

This sub-component will begin with the preparation of a program of training for the heads of the health centers regarding the management of services provided by their units. The curriculum will include issues such as administration, management, preparation of business plans, financing mechanisms etc. The program will be extended in four weeks and the 600 heads of health centers will be trained nationwide. A train-the-trainer approach will be used, with 15 trainers who will organize and perform training programs in 12 regions of the country. The component will provide training equipment and materials – photocopier; video projector; laptop; flipcharts – and provide transport and accommodation for the participants in trainings and a fee and per diem for the trainers.

B.3. Preparation of Clinical Guidelines

This sub-component would select the most common diseases in the practice of the GP and identification of the group of diseases lacking the protocols of treatment, and prepare protocols for the diseases lacking the protocols with foreign consultant's advice. The work done to date by other donors in this area will be used where it is available, to ensure the maximum value of the available resources. Local consultants will assist the foreign consultants for the preparation of the guidelines for treatment protocols.

B.4. Continuous Medical Education

The focus of this sub-component will be the development of an approach for making functional the Center for Continuous Education at regional level; including preparation of the schedule for training of different health professionals and support for the implementation of such schedule. It would include capacity building and study tours. A key element will be the linkage between the training on the clinical practice guidelines and CME credit.

B.5. Quality Improvement in PHC

This sub-component would result in the development of training programs for General Practitioners regarding: treatment of the acute morbidity; treatment of the chronic morbidity; existing protocols of treatment and those where protocols are lacking (the newly developed/introduced ones); and commitment to prevent and health education of the population. The process would use a "training-of-trainers" (TOT) approach, with the organization of a group of trainers for each, and the number of courses of training/ number of trainers per each region based on the number of GP's per each region. Training costs for GP's are also covered.

B.6. Equipment for PHC

Consistent with the content of the clinical guidelines and training programs, this sub-component would include basic equipment for health posts, health centers, and polyclinics. Equipment would be selected to ensure that the activities of each of these units can be performed in a satisfactory manner, and would be contingent upon satisfactory completion of the quality improvement courses.

B.7. Quality Improvement Grants

To focus local level attention on quality improvement issues, a grants program is envisioned which would include financing initiatives in PHC such as: (i) establishing feed-back

mechanisms for health centers; (ii) training nurses for the education of patients in using health services; (iii) improving access to health services for handicapped people; and, (iv) the development of training materials, publications and medical newspapers to support quality improvement initiatives. An operating manual for this program will be developed prior to effectiveness, with a view to beginning the program in late 2007 or early 2008.

B.8 Public Information

This sub-component will include information campaigns will for the public related to the registration and enrollment process – including obligations to contribute, exemptions and outlining the benefits from the scheme – as well as campaigns related to the improvements in quality of care resulting from the GP training programs.

Component C – Health Sector Governance and Management (base cost US\$ 1.2 million, total cost US\$ 1.3 million) would provide initial steps to improve hospital operations and direction by focusing on (i) the development and introduction of accounting and internal control structures for hospital care providers; (ii) developing the regulatory framework, including by-laws and regulations to support the move of MOH hospitals to the status of autonomous public entities; and (iii) piloting reforms of hospital management and governance structures in selected hospitals. It would include the following sub-components:

C.1. Hospital Management / Financial Management

This sub-component will include the training of hospital managers and financial staff to improve management abilities and awareness of modern management concepts. The sub-component would involve the preparation of training courses with adequate curricula for building-up and operationalizing improved administration and finances of providers. This would include the preparation of the method/s to define the costs per service at hospitals, ways of cost-calculation, and training of staff to such methods and practices.

C.2. Framework for Provider Autonomy

This sub-component would provide both foreign and local technical assistance to select the adequate model of autonomy in the areas of filling the legal gap and experience from other countries, covering both governance and financial aspects. It will also fund evaluations of the Durres Hospital and TRHA pilots, and the development of a hospital rationalization plan.

C.3. Implementation of Hospital Governance

The MOH in co-operation with HII would pre-select the hospitals where the model that has been developed for hospital autonomy will be applied and tested. This will be followed by capacity building of technical staff of the MOH and the management staff of hospitals. Foreign assistance will be obtained to support the selected hospitals to implement the autonomy model (1 person for 2 years), and local assistance will also be provided (4 persons for 2 years).

Annex 5: Project Costs
ALBANIA: Health System Modernization

Project Cost By Component and Sub-Component	Local US \$'000	Foreign US \$'000	Total US \$'000
A. Strengthening Sector Stewardship, Financing and Purchasing			
A.1 Capacity building - contracting and payment methods	68.3	1,008.7	1,077.0
A.2 Policy Development and Monitoring	200.5	270.5	471.0
A.3 Health Information Systems	914.6	2,621.4	3,536.0
A.4 Monitoring Health Care Services	55.5	312.5	368.0
A.5 Licensing and Accreditation	244.2	478.8	723.0
A.6 Health Technology Assessment	29.2	375.6	404.8
A.7 Capacity building for project implementation	99.4	268.2	367.6
Component Total	1,611.7	5,335.7	6,947.4
B. Improving PHC Service Delivery			
B.1 Primary Health Care (PHC) Enrollment	2,880.0	0.0	2,880.0
B.2 Strengthening PHC practice management	283.7	66.0	349.6
B.3 Preparation of clinical guidelines	35.5	434.5	470.0
B.4 Continuous medical education	136.9	279.7	416.6
B.5 Quality Improvement in PHC	418.5	351.5	770.0
B.6 Equipment for PHC	824.2	2,145.9	2,970.2
B.7 Quality improvement grants	250.0	250.0	500.0
B.8 Public Information	500.0	0.0	500.0
Component Total	5,328.8	3,527.5	8,856.4
C. Strengthening Hospital Governance and Management			
C.1 Hospital Management/ Financial Management	150.0	315.0	465.0
C.2 Framework for Provider Autonomy	0.0	294.0	294.0
C.3 Implementation of hospital governance	232.4	252.0	484.4
Component Total	382.4	861.0	1,243.4
Total Baseline Costs	7,323.0	9,724.2	17,047.2
Physical Contingencies	194.3	527.2	721.6
Price Contingencies	658.3	727.2	1,385.5
Total Project Costs	8,175.6	10,978.7	19,154.3

Annex 6: Implementation Arrangements

ALBANIA: Health System Modernization

There is an agreement between the Bank and the Ministry of Health on the elimination of the PIU which has been used in the first two projects, and the integration of these functions into the Ministry.

The project will be implemented by the MOH, using existing structures and staff. The executive sponsor is the Deputy Minister responsible for international cooperation, who will exercise overall policy direction for the project. Day-to-day management will be done by the Director of the Economic Department who has extensive project management experience in World Bank financed projects. Procurement and financial management functions will be carried out by staff in the Economic Department. They would be assisted initially by both foreign and local consultants who would help MOH staff in building capacity to utilize World Bank procedures and requirements. At the same time, efforts will be made to utilize country systems to the extent possible, including the Treasury system (once it is in operation and has been assessed), and the High State Control for audit purposes (once capacity building and an assessment have been completed). Capacity assessments have been completed in both the procurement and financial management areas, and action plans have been agreed with the Recipient.

Working groups have been appointed by the Minister of Health in each of three key subject areas – (i) health financing, (ii) quality, and (iii) governance and management – with broad stakeholder representation; responsible for coordination and technical management of the project activities, especially regarding the linkages with stakeholders outside the working group. The working groups include representatives of the line departments of the MOH and HII, as well as representatives from the Organization of Physicians of Albania, the Faculty of Medicine, the Family Medicine department, the Institute of Public Health, and the Center for Health Care Quality. A chair has been appointed for each working group to coordinate their activities, and overall policy level direction will be provided by the Deputy Minister.

The project is designed to improve planning and implementation capacity within the Albanian health system. Significant capacity building will be needed to provide essential manpower, expertise and experience to support the needed reforms. In the short term, this expertise will be acquired from abroad to supplement local capacity and facilitate the rapid start-up called for in the national strategy. Later, this expertise will be replaced by domestic talent who will take over implementation of the reforms and their deployment.

The key recipients of this capacity building will include the Policy and Planning and Monitoring and Evaluation Sectors within the MOH, the Public Health Policy Development Sector within the IPH, and the Service Monitoring and other departments within the HII. In addition, the Chair of Family Medicine will be developed to the point that it can take a leadership role in all aspects of family medicine training, including undergraduate and post-graduate training, retraining of existing PHC staff, and continuing medical educations for family physicians. In order to ensure that this capacity is not lost once it is built, specific loan conditions require ongoing maintenance of these units.

During project implementation, extensive capacity building and “technology transfer” will be pursued in the areas of monitoring and evaluation and project planning and execution, so that by the end of the project a strong internal capacity will exist within the MOH to independently perform these functions.

The same arrangements will also be used for the PHRD co-financing grant for project implementation.

Annex 7: Financial Management and Disbursement Arrangements
ALBANIA: Health System Modernization

1. Country Issues.

The latest Country Financial Accountability Assessment (CFAA – April 2002) confirms that improvement is required in the management of public expenditures, including cash management in Treasury and better internal control throughout the public sector. - Internal audit is currently being fully developed to improve the government’s internal control environment. A Public Internal Financial Control framework is being implemented and a new computerized treasury system is under implementation. The supreme audit institution is also being strengthened. Public financial management has improved significantly during the last few years in areas such as budgeting, internal control, internal and external audit. The project will also benefit from the ongoing substantial improvements in the treasury system including improved financial reporting. The project will utilize these improvements by using the treasury system for the payment and reporting functions once it becomes operational, and assessed as acceptable to the Bank. Internal audit should also be utilized to monitor project implementation. Finally, the supreme audit institution could be used to perform project audit at a later date, with support as needed, and when it is considered acceptable to the Bank. A Country Fiduciary Assessment Update (CFAU) is ongoing as well as a Public Expenditure and Institutional Review to be completed before the end of June 2006, which will underpin further improvements in a more efficient use of public resources.

2. Risk Analysis.

The risk analysis from the Financial Management Questionnaire is as presented below.

<i>Risk</i>	<i>Risk Rating</i>	<i>Risk Mitigation Measures</i>
1. INHERENT RISK		
Country Financial Management Risk	S	Project funds are ring-fenced.
Project Financial Management Risk	M	Supervision throughout implementation and a number of actions to be taken before effectiveness, see below
Banking sector	M	Bank of Albania is well regarded
Perceived corruption	H	Procurement for the project will be substantially monitored
<i>Overall Inherent Risk</i>	S	
2. CONTROL RISK		
1. Implementing Entity	S	MOH has assigned project specific staff to implement and monitor the project implementation
2. Funds Flow	M	Standard special account to be used. Assessment of the finalized treasury system

		will be conducted when system is operational
3. Staffing	S	Specific staff assigned and capacity building included in the project based on agreed plan
4. Accounting Policies and Procedures	M	Will be described in the PIP – normal MOH procedures complemented by project specific control measures
5. Internal Audit	M	Regular reporting is institutionalized, but will be strengthened through general support by CARDS and specific support to IA in MOH through the project
6. External Audit	M	Initially private sector, but possibility of using HSC to be explored when appropriate
7. Reporting and Monitoring	S	Reporting will initially be through MOH system using agreed FMR's; move to the new treasury system when/if appropriate
8. Information Systems	S	MOH system to be used, supplemented by system to produce FMR's
<i>OVERALL CONTROL RISK</i>	M	

Risk rating: H (high risk), S (substantial risk), M (modest risk), N (negligible or low risk)

3. *Strengths and Weaknesses.*

The significant strengths that provide a basis of reliance on the project financial management system include: (i) the experience of MOH through its former PIU staff (to be hired as a consultant in the two first years of the new project), in implementing Bank-financed projects and satisfying Bank financial management requirements; (ii) recent improvements in the overall control framework in the public financial management, and (iii) the unqualified audit reports and positive management letters issued by project auditors in previous projects managed by the PIU in the MOH.

Perceived weaknesses in the financial management of MOH will be dealt through a capacity building component that would precede the expected shift to using the treasury system and other normal MOH internal control systems. An assessment of these systems and procedures will be undertaken before these systems will be utilized by the project.

4. *Implementing Entity.*

The project will be implemented by the Ministry of Health, using existing structures and staff. The executive sponsor of the project would be the Deputy Minister of Health responsible for international cooperation, and day-to-day management would be provided by the Director of the Economic Department. Procurement and financial management functions would be carried out by staff in the Economic Department with these specific responsibilities. They would be assisted initially by both foreign and local consultants who would assist the MOH staff in building capacity to utilize World Bank procedures and requirements. At the same time, efforts will be made to utilize country systems to the extent possible. Capacity assessments have been

completed in both the procurement and financial management areas, and action plans have been agreed with the Recipient.

5. *Funds Flow.*

Project funds will flow as an advance from the IDA via a designated account (previously known as Special Account) held in the Bank of Albania which will be replenished supported by interim un-audited financial reports (report based procedures using FMRs). During the first period of the project an account will be opened in a commercial Bank acceptable to the Association where funding will be transferred to. Counterpart funding from GOA will be provided through the treasury system directly to the suppliers.

6. *Staffing.*

The MOH has ensured that the financial management specialist and the procurement specialist from the previous Bank financed health project will be hired for two years for the new project. Terms of Reference for the staff were included in the financial management manual for the previous project. Staff within the Economic Department will be involved in the project once the treasury system will be used after conducting an assessment of these arrangements. The PIP will be revised to describe any complementary procedures on project specific control measures, including terms of reference for staff when the project will eventually shift to using the treasury system.

7. *Accounting Policies and Procedures.*

The accounting books and records are maintained by the Economic Department of the MOH (and later by the treasury, as appropriate) on a cash basis with additional information on commitments related to signed contracts. Project financial statements are presented in local currency. Specific written policies and procedures for the internal financial control in MOH are not fully documented, but the project will initially use the procedures utilized for the previous project. MOH has instituted a set of appropriate accounting procedures and internal controls including authorization and segregation of duties as far as possible. .

The policies and procedures when shifting to the treasury system will be further elaborated in the PIP describing any complementary procedures on project specific control measures

8. *Internal Control and Audit.*

Initially the project will follow the control procedures and audit arrangements utilized in the previous project.

Ex-ante controls in the MOH are assessed to be quite robust. But as mentioned above the financial management arrangements will be assessed before shifting the initial arrangements. Treasury controls are elaborate, and cash allocation combined with strict procurement planning schedules is probably not flexible enough in the medium-term to support an efficient use of the budgets allocated. Before such flexibility can be introduced improvements are needed for the

ex-post controls, the financial reporting, and in the budgetary framework introducing measures of performance based allocations and outcome based monitoring. MOH's internal audit unit will audit the activities as a normal part of their work. The unit has a staff of 5 auditors, but currently no Director of the unit is appointed. As the capacity of the unit is still low, the project will support the further development of the internal audit complementing the general twinning support provided through the EU's CARDS program.

9. *External Audit.*

No significant issues have arisen in the audits of previous Bank-financed projects implemented by the MOH. These audits were conducted by private sector auditors. The MOH will initially use private auditors, but will explore the possibility of getting the project's annual financial statements certified/audited by the Albanian Supreme Audit Institution, the High State Control (HSC). Considering the HSC's inexperience with this kind of audit, a plan for a twinning arrangement with experienced auditors will be developed and agreed between the HSC and the MOH.

The MOH is responsible for delivering to the Bank, within six months of the closing of each fiscal year, the audited financial statements. The annual cost of the audit twinning will be covered by the project while the private sector auditing will be paid by the government under the portfolio-wide audit arrangements used in Albania. In addition the country's supreme audit institution performs ad hoc external audits of the project.

10. *Reporting and Monitoring.*

The accounting for the project is cash basis with additional information provided on contractual commitments. The project accounting will initially be based on a system of excel spreadsheets. The quarterly financial reports were satisfactorily produced by the previous project and it is expected that the initial reporting system agreed with MOH is satisfactory. The project will, probably from 2007, be using the reporting from the treasury system. Any agreed reporting that will not routinely be produced by the MOH or treasury system will either be developed by the Treasury or will need to be produced by the project team in MOH. Interim un-audited financial reports or Financial Monitoring Reports (FMRs) will be used for project monitoring and supervision and the indicative formats of these reports will be agreed during the negotiation and are included in the PIP. MOH will produce a full set of FMRs every three months throughout the life of the project.

11. *Information Systems.*

The MOH will utilize the reporting generated by the new computerized treasury system currently being implemented in all treasury offices when it is available, and the MOH system in the interim. It is expected that this system will contain adequate user access controls and will be capable of generating FMRs. Additional reports may need to be produced by the MOH.

The Financial Management Manual included in the PIP will set out the financial management and internal controls policies and procedures and is intended to guide staff and minimize the risk of errors and omissions, as well as delays in recording and reporting. These written standards

also clarify responsibilities, including level of authority, clear control over assets, cash, and bank accounts, and it ensures timely and accurate financial reporting.

12. Impact of Procurement Arrangements.

See Annex 8.

13. Disbursement Arrangements.

Bank funds will be disbursed as an advance with documentation for replenishment provided in the interim un-audited financial reports (report based procedures using FMRs), i.e. the MOH will use the quarterly Financial Monitoring Reports to support applications for withdrawal, and the MOH will not provide the Bank with a detailed list of expenditures. Should the IDA determine at any time that the FMRs are not adequate to support the disbursement process, it reserves the right to revert to the traditional disbursement methodology (SOEs, summary sheets etc.). Supporting documentation for all payments, including completion reports and certificates, will be retained by the Recipient and made available to the Bank during project supervision. It is assessed that the MOH has adequate capacity to use report-based disbursement.

The use of output based disbursement will be closely reported through the progress reporting of the project as well as through the financial reporting. The comparison of the actual and forecasted unit costs will specifically be included audited through the annual external audits.

As soon as the project becomes effective the MOF will open and manage a designated/Special Account in the Bank of Albania to which the IDA funds will be transferred. During the first period of the project an account will be opened in a commercial Bank acceptable to the Association where funding will be transferred to. After satisfactory assessment of the use of the treasury system, treasury will perform the payments based on payment requests by the MOH. Counterpart funds are transferred through the treasury system directly to the suppliers. Withdrawal applications for the replenishments of the designated account will be sent to the Bank every three months attaching the FMR. Upon receipt of each application for withdrawal of an amount of the Credit, the Bank shall, on behalf of the Recipient, withdraw from the Credit Account and deposit into the designated account an amount based on the Financial Monitoring Reports and changes to the initial deposit as agreed with the Bank enabling the financing of eligible expenditures during the three-months period following the date of such reports. The allocation of credit proceeds will be as follows:

Category	Amount of the Credit Allocated (million USD)	Percentage of Expenditures to be Financed
(1) Goods, other than under Parts A.3 and B.6	1.61	85%
(2) Goods under Part A.3 of the Project	2.81	85%
(3) Goods under Part B.6 of the Project	3.15	85%
(4) Consultants' services	2.45	100%
(5) Training	0.96	100%

(6) Unit Costs under Part B.1 of the Project	2.43	75%
(7) Small Grants under Part B.7 of the Project	0.49	100%
(8) Incremental Operating Costs	0.64	100%
(9) Unallocated	0.86	
TOTAL AMOUNT	15.40	

14. Action Plan.

The following action will be agreed with the MOH:

Action	Responsible entity	Timing
Agree on the FMR formats and audit TOR	MOF, MOH and WB	At negotiations
Describe the internal control procedures, include in PIP	MOH	Before effectiveness
Develop a fiduciary capacity building plan	MOH and consultant	Before effectiveness
Agree on the conduct of the audit of the project by the High State Control	MOH to agree with HSC	Once assessment of HSC has been completed
Assess reporting and flow of funds arrangements when the new treasury system will be in place	WB in cooperation with MOF and MOH	Once treasury system is in operation

15. Financial Covenants.

MOH will maintain a financial management system acceptable to the Bank. The project financial statements and Special Account will be audited by independent auditors acceptable to the Bank and on terms of reference acceptable to the Bank. The annual audited statements and audit report will be provided to the Bank within six months of the end of each fiscal year.

16. Supervision Plan.

During project implementation, the Bank will supervise the project's financial management arrangements in two main ways: (i) review the project's quarterly financial management reports as well as the project's annual audited financial statements and auditor's management letter; and (ii) during the Bank's supervision missions, review the project's financial management and disbursement arrangements (including a review of FMRs and movements on the Special Account) to ensure compliance with the Bank's minimum requirements. As required, a Bank-accredited Financial Management Specialist will assist in the supervision process.

Annex 8: Procurement Arrangements
ALBANIA: Health System Modernization

A. General

Procurement for the proposed project would be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated May 2004; and "Guidelines: Selection and Employment of Consultants by World Bank Recipients" dated May 2004, and the provisions stipulated in the Grant Agreement. The various items under different expenditure categories are described in general below. For each contract to be financed by the Grant, the different procurement methods or consultant selection methods, the need for pre-qualification, estimated costs, prior review requirements, and time frame are agreed between the Recipient and the Bank in the Procurement Plan. The Procurement Plan will be updated at least annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Procurement of Works: None

Procurement of Goods: Goods procured under this project would include information technology (hardware and software), training equipment, and medical equipment for primary care practices. For procurement of goods under the project, the following methods will be used: ICB, Shopping and Direct Contracting. The Bank's Standard Bidding Documents (SBD) for all ICB contracts will be used.

Selection of Consultants: Consulting services from firms and individuals will be required for, among others, the development of new approaches to health financing, quality improvement and governance, and capacity building in these areas for the MOH, HII, service providers and other key players in the health system in Albania. The following methods will be used for selecting firms and individuals whose services will be required for the project: Quality and Cost Based Selection (QCBS); Least Cost Selection for Project Audit (LCS); Selection Based on Consultants' Qualifications (CQ), Individual Consultants (IC), and, where justified, Single Source Selection (SSS). Shortlist of consulting firms for services estimated to cost less than US\$100,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7.

Training: Training will include Project related study tours, training courses, seminars, workshops and other training activities not included under goods or service providers' contracts, including costs of training materials, space and equipment rental, travel and per diem costs of trainees and trainers.

Operating Costs: Operating costs will include equipment operation and maintenance, including vehicles, communications, such as email, telephone and fax, utilities, and office space rental costs. Operating costs will be incurred according to an annual budget satisfactory to the Bank and using procedures to be described in the Project Implementation Plan.

B. Assessment of the agency's capacity to implement procurement

An assessment of the capacity of the MOH to implement procurement actions for the project has been carried out in November, 2005. The assessment reviewed the organizational structure for implementing the project and the interaction between the project's staff responsible for procurement and the MOH's relevant central unit for administration and finance.

The MOH would be responsible for the overall project management and coordination. With a view to helping the MOH build its overall capacity to implement projects, the Bank has agreed that its relevant departments will be responsible for the implementation of the components relevant to them. Similarly, in order to build the MOH capacity in conducting procurement, the Bank has agreed that its Procurement Section will be responsible for project procurement. The MOH has appointed an experienced project coordinator whose main responsibility will be to provide a liaison between the Bank and the MOH and to coordinate the activities of the different MOH departments, including procurement, and other agencies at different levels of government who will be involved in project implementation. The Procurement Section has three staff members. The staff of the Procurement Section have little procurement training and capacity and will not be able to implement procurement under the proposed project without additional capacity and training. However, they have adequate skills and great potential for learning and increasing their knowledge in the area of procurement, both international and national.

The Bank finalized the Country Procurement Assessment Review (CPAR) for the Albania in January 2001. As a result of the findings of this assessment, from the public procurement point of view the Albania has been ranked as a high risk category country. Given the current lack of proper implementation of the public procurement law, lack of transparency in the public procurement environment and the little experience of the Procurement Section, procurement under this project is also rated high risk. The following risks have been identified:

- The Procurement Section staff lack capacity to undertake additional procurement work. They also lack experience in international procurement.
- High officials involved in project implementation may not have a good understanding of the procurement processes which may result in implementation delays. Lack of good understanding of the procurement procedures and requirements on the part of the business community may lead to poor bids and complaints and may also delay implementation.
- There may not be sufficient number of suppliers and consulting firms of the goods and services (respectively) required for the project. This may lead to inadequate competition and higher prices for the project.
- Weak contract management procedures may create high risks for effective use of resources and delayed or no benefits to the intended beneficiaries of the project.

C. Procurement Considerations

The following strategy has been devised to mitigate the above-mentioned risks to project implementation:

- In order to ensure that procurement under the proposed project is carried out in a timely and effective manner, it would be necessary to add a local staff to the procurement team (to be financed with the Ministry's budget); a local consultant with experience in international procurement, and an international consultant (both to be financed with the credit funds). The international consultant will pay short visits to Albania according to an agreed program to help the team with large procurement packages and to provide them on-the-job training.
- The local consultants should be appointed to the Procurement Section as soon as possible but no later than the signature date of the credit agreement. They should be made responsible for procurement under the project. The timing of the selection and deployment of the international consultant should be determined carefully to optimize the use of his/her services. The international consultant should not only support the local consultant in all aspects of the procurement process but he/she should also be made responsible to provide on-the-job training to the local consultant, the additional MOH staff to be appointed to the Procurement Section, and the existing team so that by the time the international consultant completes his assignment, which should not last more than a year, the team is fully prepared to conduct all procurement itself.
- The Ministry will prepare a detailed procurement training program for the procurement team which will include on-the-job training, seminars and workshops both in Albania and abroad. The international consultant will also prepare the procurement team in the Ministry as trainers. The main objective of this training would be to ensure that the procurement team in the Ministry takes over completely the function of procurement under the project one year after the Credit becomes effective and an assessment of the developed capacity of the procurement team has been made and found satisfactory by the Bank. The international and local consultant (to be financed by the Credit) will have their assignments limited to one year, although there will be possibility of a further extension of the national consultant's assignment.
- The procurement team staff that would be trained as trainers would train procurement staff at local levels as the ongoing decentralization may result in decentralization of resources and authority to local levels.
- A simple but detailed Project Implementation Plan should be prepared. The Plan should include procurement methods to be used in the project along with their step by step explanation as well as the standard and sample documents to be used for each method.

- The Bank staff should also organize a short project and procurement information seminars for the concerned high officials as well as for the business community to improve their understanding of the importance of procurement procedures.
- The Procurement Section team should prepare a database of suppliers of the required goods, construction contractors and consultants (firms and individuals, as well as an inventory of the available goods in the country). It should also prepare a database of historical prices so as to be able to prepare more precise and up-to-date contract estimates to use meaningfully use them as reference prices.
- Procurement Section of the MOH should prepare detailed contract management procedures satisfactory to the Bank.

The Bank staff will review the efficiency of procurement under the project and the improvement in the procurement capacity of the Procurement Section team after one year of the credit effectiveness, and will make recommendations for further improvements as necessary.

D. Procurement Plan

The Recipient has developed a procurement plan (PP) for project implementation which provides the basis for the procurement methods to be used during project implementation. This plan has been agreed between the Recipient and the Bank Project Team. The plan will be available in the project's database and on the Bank's external website. The Procurement Plan will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity. The procurement plan shall indicate the contracts subject to Bank's prior review.

E. Frequency of Procurement Supervision

In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended one supervision mission per year to visit the field to carry out post review of procurement actions.

F. Details of the Procurement Arrangements Involving International Competition

Prior Review Threshold: Procurement Decisions subject to Prior Review by Bank as stated in Appendix 1 to the Guidelines for Procurement:

	Procurement Method	Procurement Method threshold	Prior Review Threshold	Aggregate US \$ '000)
1.	ICB for goods	> US\$ 500,000	All prior review	1,061
2.	NCB for goods	> US\$ 100,000, < US\$500,000	Only the first NCB package	756
2.	Shopping	<US\$ 100,000	All post review	175

1	2	3	4	5	6	7	8	9	10
No	Contract (Description)	Total Estimated Cost (\$,000)	Number of Contracts	Procurement Method	Domestic Preference (yes/no)	Review by Bank (Prior / Post)	Expected Bid-Opening Date	Expected Contract Signing	Expected Contract Completion
A.2 Policy Development and Monitoring									
1	Data warehouse for IPH	200	1	NCB	n/a	Post review	May 2007	July 2007	October 2007
A.3 Health Information System									
1	Personal computers /software and other computers programme for PHC, HII and hospitals	300	1	NCB	n/a	Prior review	April 2007	June 2007	October 2007
2	Personal Computers/software and other computer programs for HII and hospitals	120	1	NCB		Post review	April 2007	June 2007	October 2007
3	Improved LAN, internet and support services for MoH;	236	1	NCB	n/a	Post review	June 2007	August 2007	October 2007
B.1 PHC Enrollment									
1	Registration, identification and management of the insurance contributors to HII	530	1	ICB	n/a	Prior review	June 2006	September 2006	November 2006
B.6 Equipment for PHC									
1	Basic medical equipment for PHC	531	1	ICB	n/a	Prior review	March 2007	May 2007	October 2007
TOTAL		1,917							

2. Consulting Services

Prior Review Threshold: Selection Decisions subject to Prior Review by Bank as stated in Appendix 1 to the Guidelines Selection and Employment of Consultants:

	Selection Method	Procurement method threshold	Prior Review Threshold	Aggregate (US \$'000)
1.	QCBS	> \$200,000 (International shortlist)	All contracts	1,014
2.	Consultant qualification	< \$200, 000	> 100, 000	1,479
3	Individual Consultant	< 50,000	> 20,000	833

1	2	3	4	5	6	7	8	9
No	Description of Assignment	Total Estimated Cost (\$.000)	Number of Contracts	Selection Method	Review by Bank (Prior / Post)	Expected Proposals Submission Date	Expected Contract Signing	Expected Contract Completion
A.3	Health Information System							
1	Preparation of the specialized computer programs for prescription drug processing system	300	1	QCBS	Prior review	June 2006	September 2006	September 2007
2	Training , standards and capacity building for MoH	210	1	QCBS	Prior review	September 2007	December 2007	2007-2009
B.3	<i>Preparation of clinical guidelines</i>							
1	Preparation of guidelines for treatment protocols	252	1	QCBS	Prior review	August 2006	November 2006	2006- 2008
B.4	<i>Continuous Medical Education</i>							
	Development of an approach for making functional the Center for CME at the regional level.	252	1	QCBS	Prior review	October 2006	January 2007	2007- 2008
	TOTAL	US \$ 1,014						

Thresholds for Procurement Methods

11. The following thresholds will be applied to select procurement methods under this project:

Procurement Method	Threshold
ICB: Goods	>US\$100,000
Shopping: Goods	<US\$100,000
Quality and Cost Based Selection (QCBS) for Consultant Services	>US\$200,000 (International shortlist) <US\$100,000 (National shortlist)*
Selection Based on Consultants' Qualifications	<US\$200,000 per contract
Selection of individual Consultants	<50.000

* The short list may be comprised entirely of national consultants.

Suggested Thresholds for Prior Review

12. The project procurement plan has been prepared for the first 18 months of the project by the MOH in close collaboration with the Bank team and will be negotiated and signed by both

parties at the end of the credit negotiations. It indicates which contracts will be subject to prior or ex-post review. For this purpose, the following thresholds will be used:

- a. All contracts awarded through ICB (estimated to cost more than US\$100,000)
- b. All TORs for consulting services, irrespective of the contract value;
- c. Contracts with consulting firms (\geq US\$100,000) and first two contracts with individual consultants (US\$20,000) or more; and any individual consultant contract of US \$50,000 or more.
- d. Single source or direct contracting is also subject to justification.

The above thresholds can be subject to revision as the project implementation progresses and the Procurement Section has acquired higher procurement capacity.

Annex 9: Economic and Financial Analysis
ALBANIA: Health System Modernization

Macro- and Socio-Economic Context

Until 1990, Albania was almost completely isolated both from the Western world and from other Communist countries. The transition out of communism, while sometimes chaotic leading to destruction of infrastructure, has been relatively peaceful compared to the civil wars in neighboring countries. Albania has enjoyed strong economic performance in the last five years, growing at an average of above 7 percent annually for most of the period leading to a per capita GDP of USD 1,740 (Atlas method) or PPP adjusted of USD 4,583 by 2002⁴. Inflation remained at levels of 4 percent or less, exports and imports grew steadily, and both the current account and the domestically financed fiscal deficit improved significantly. Several structural reforms have been carried out including banking, land reforms and privatization. However, Albania remains one of the poorest countries in Europe, with a quarter of Albania's population living in poverty and about 5 percent in extreme poverty. Per capita income, at around US\$1,230 in 2002, is one of the lowest among transition economies. Economic growth had little impact on the labor force participation which remained on a similar level during the past ten year (53.9 percent or 1.6 million in absolute numbers)⁵.

In 2002, Albania spent totally about 6 percent of nominal GDP on health, or in absolute terms USD 94 per capita per year. According to National Health Accounts (NHA), only 34 percent of total health expenditure is financed by the government, leaving the remaining 61 percent to be paid by private sources and 4 percent by donors. These total and public health expenditures are the lowest values reported in Europe, while the share paid by private sources is extremely high even compared to other low-income countries.

Health Context

Utilization of Health Services

According to LSMS data from 2002 and 2004, seeking outpatient care is significantly influenced by gender and insurance status (Table 1). During the year 2002 seeking outpatient care is significantly more common with increasing socio-economic quintile ($p < 0.05$); whereas in 2004 outpatient visits seem to be equally common across socio-economic groups.

Table 1: Frequency of Outpatient Visits, by Socio-demographic Characteristics

<i>Year</i>	<i>Female</i>	<i>Male</i>	<i>Urban</i>	<i>Rural</i>	<i>Insured</i>	<i>Uninsured</i>	<i>All</i>
2002	16.96**	13.09	13.95	15.58	20.26**	13.28	15.02
2004	15.88**	9.24	13.46	12.32	18.82**	6.83	12.78

Source: LSMS 2002/04. Level of significance between socio-demographic variables: ** p -value < 0.01 .

⁴ WDI. Per capita GDP, PPP in current international dollars. http://www-int.worldbank.org/jsp/data_view.jsp?tab=7&gwitem=82664&gwIndex=461584

⁵ Albania Poverty Assessment. 2003; and World Development Indicators. Albania at a Glance.

LSMS findings suggest that public ambulatory clinics are the preferred outpatient care location, with about 10 percent of all individuals having had a public ambulatory visit during the four weeks prior to the interview. The second choice is hospital outpatient departments (4 percent). Nurse care and private care is considerably less common. A significantly higher proportion of women than men, insured than uninsured individuals, and sick individuals compared to the non-sick go to public ambulatories. Although private sector care is not covered by health insurance, a significant proportion of the population uses private providers, including low income groups suggesting that the private sector is either offering more services, shorter waits, or better quality than the public sector. LSMS findings show insured individuals and women are significantly more likely to visit a private provider than the uninsured and men.

The average annual visit rate to a PHC health facility decreased from 1.78 in 2000 to 1.6 visits per capita in 2003. Albania's per capita visit rate is considerably below the average visit rates reported in the ECA and European region, and below values reported in the region including Macedonia and Turkey. Based on MOH annual statistics, there are impressive differences in the annual PHC visit rates per capita across regions, ranging from totally 3 visits per capita in Durres to less than one visit per capita per year in Diber and Elbasan. These very low utilization rates in PHC facilities indicate that patients shortcut PHC facilities to seek care directly in hospitals.

In 2003, PHC providers delivered totally 5,099,000 consultations in outpatient settings. In the absence of administrative data on the number of patients who contact first a GP and are then referred to specialist care, it is estimated that about half of the patients seen in primary care settings are referred to specialists or hospital care (DFID, 2003).

Out-of-pocket Payments

Paying for health care can be a major drain on household income. LSMS 2002 findings show that almost all patients (95 percent) had to pay for care received, and almost everybody pays for the medicines prescribed (88 percent). Table 2 shows the relevance of out-of-pocket payment in outpatient care settings. Overall about 95 percent of patients had to pay and they paid on average about 2,466 Leks per month. Medicines constitute the major expenditure for people seeking outpatient care in all regions of the country and represents close to 55 percent of total expenditure for outpatient care visits. Informal payments (gifts) are common. Studies from other transition economies suggest substantial under the table payments⁶.

Table 2: Out-of-pocket Payments for Outpatient Care in 2002 per Month per Patient, by Area and Service

	<i>Treatment</i>	<i>Gifts</i>	<i>Medicines</i>	<i>Lab Tests</i>	<i>Transportation</i>	<i>Total</i>
Average Monthly Payment per Patient, in Leks						
Albania	360.9	163.2	1,368.9	294.0	278.6	2,465.8

Source: LSMS 2002.

Average expenditure for hospital care among individuals reporting a hospital stay in the year before the interview amount to 20,786 Leks per year (about US\$ 200). Poor people on average spend about 30 percent less on hospital care than the non-poor in rural and urban areas⁷. Having

⁶ Ensor, Tim: Informal payments for health care in transition economies. *Social Science and Medicine* 58 (2004) 237-246.

⁷ Albania Poverty Assessment Report, 2003.

insurance coverage does not shield the insured from paying for care. Based on LSMS 2002 results, there are no significant differences in outpatient care expenditure between insured and uninsured groups adjusted by place of residence, suggesting that the HII is not fulfilling its insurance function of improving access to care by lowering the out-of-pocket amount paid at the time of service use.

Health financing is regressive in Albania. Overall, total health expenditure reflects 6.7 percent of household total expenditures. This share is considerably higher for the poorest households (9.1) compared to the better-off (4.9). About 3.5 percent of total household expenditure goes to the purchase of drugs; this share is considerably higher for poor households (4.9 percent) compared to the better-off (2.5 percent) pointing to inequity in financing of pharmaceuticals⁸.

The Albanian health system has been criticized for the lack the capacity to deliver the scope and quality of services to serve the health of the population, to be under-utilized and under-funded and to have tremendous inefficiencies in the production of care and inequity in financing. To some extent this is caused by: (i) high costs of provision owing to failure to achieve economies of scale created by an over-supply of hospitals, beds and staff compared to service use; (ii) inequalities in the health care provision and extremely low utilization rates leading to a large percentage of the population being excluded from care; (iii) informal payments; (iv) lack of information on insurance coverage; and (v) the absence of efficiency-enhancing financial incentives and management capacity in the health sector. In addition, inefficient treatment protocols and management, and a neglect of primary health care in favor of specialist and hospital care have contributed to the inadequate provision of services across facilities levels. Not surprising, as the public's confidence in the state sector diminishes the use of private practice is growing.

Implications for Health Project

The third WB health project contains three components that aim to address the above weaknesses:

- A) **Strengthening Sector Stewardship, Financing and Purchasing Component:** Increased efficiency in the pooling and purchasing of health services on behalf of the population, and increased financial protection to citizens, especially the poor and vulnerable.
- B) **Strengthening Primary Health Care (PHC) Services Component:** Improved quality of care and access to primary health care services, and increased use of primary care services for the majority of health care needs.
- C) **Strengthening Hospital Governance and Management Component:** Improved management of health care facilities, increased involvement by stakeholders in the governance of these facilities.

These components are expected to contribute to four health policy goals: (1) financial protection against the consequences of using medial care and thereby protecting the poor to slip deeper into poverty and the non-poor to slip into poverty, (2) increased utilization of quality health care, (3) strengthened primary health care management, and (4) more efficient use of scarce resources.

⁸ See Albania Poverty Assessment, 2003.

Efficiency gains are expected to be reinvested and passed on to patients in form of improved quality of care.

Accordingly, it is expected that the combined effect of the three components will lead to improved quality of care and increased access to PHC care, lower treatment cost and OOP payments, and less severe case-mix among patients due to better case-management of patients who seek care at the onset of illness and contact first the GP as a gatekeeper in accessing specialized care. Improved access to quality care, patient case-management and the use of preventive care may have a positive impact on lost productivity due to preventable illness and related premature deaths, particularly for diseases that can be managed through better quality care at the PHC level, such as respiratory, circulatory and digestive system illness. As a result it is anticipated that people will report fewer inadequate hospital referrals, faster recovery, better health and fewer days lost through inactivity. It is likely that low-income groups and the uninsured will be the major beneficiaries of an expanded family medicine network.

Cost Benefit Analysis⁹:

A cost benefit analysis was carried out to estimate the economic and financial impact of the project. The calculations were based on a ten year time horizon, including recurrent costs, operations and maintenance costs for purchased equipment. Total project costs amount to US \$19.4 million including all sources (IDA, PHRD grant, recipient country) and is assumed to be disbursed over four years. It includes payments made for recurrent costs, and accounts for operational and maintenance costs for eventual equipment purchased. The project amount is accounted for financing for the three components. The analysis excludes taxes. For the base year (2005), local costs are converted to US\$ at an exchange rate of 1 US\$ = 104.80 Lek.

The expected direct and indirect benefits are summarized in Table 3. Due to difficulties in estimating benefits of Components A and C, for the purpose of this analysis, only benefits of the PHC Service Component B will be estimated. However, it is assumed that Component A and C support the effectiveness of the PHC Service Component.

⁹ This analysis will be updated based on revised cost figures during appraisal.

Table 3: Expected Direct and Indirect Benefits

Component	Direct Benefits	Indirect Benefits
Strengthening of Primary Health Care (PHC) Services	Reduction in unnecessary hospital admissions due to improved quality of care and patient case-management in PHC facilities, and improved adherence to standard referral protocols	Averted productivity loss due to improved access to preventive and basic PHC, improved case-management
		Potential life years saved due to reduced mortality (e.g. from respiratory, circulatory and endocrine diseases)
	Reduction in unnecessary specialist referrals due to improved quality of care and patient case-management in PHC facilities, and improved adherence to standard referral protocols	Reduction in travel costs to hospitals and specialists clinics

The cost benefit analysis uses several key assumptions. Table 4 provides an overview.

1) Decrease in unnecessary hospital bed days due to improved quality of primary health care:

It is expected that better trained GPs will provide better quality care and case-management and be able to treat patients instead of referring them unnecessarily to hospitals and specialists. Following other evaluations (Armenia: Health system modernization project) it is expected that:

- (a) Hospital admissions drop annually by about 2.4 percent, ranging between 1 and 3 percent over ten years due in part to the decline of unnecessary self-referrals as patients will more likely use well-trained providers in PHC clinics that provide quality care; and
- (b) Savings of total bed days from unnecessary hospital admissions is estimated at 30 percent of total hospital recurrent costs is used to finance increased costs of outpatient care and drugs.

In the absence of cost data on inpatient care for this analysis, the cost of *inpatient care* per hospital day is estimated by dividing the total inpatient care expenditures (NHA 2003) by the total number of number of hospital days (1.8 million), resulting in total cost per inpatient day of US\$42.80, including salaries, drugs and maintenance. For the purpose of this analysis, hospital recurrent costs are estimated at a conservative level of 20 percent of the above total inpatient estimate (US\$8.6).

2) Reduction in unnecessary referrals to specialist care:

The evaluation of the family medicine project in Bosnia estimated a decrease of 35 percent in referrals by trained GPs. A similar evaluation of the primary health care project in Armenia showed a more conservative reduction of 30 percent. More conservative assumptions are made in this analysis, and unnecessary specialist referrals are expected to drop over ten years at an annual average of about 2.4 percent, which includes unnecessary self-referrals, as patients will more likely use well-trained GPs who provide quality care in PHC clinics and better patient case-management. Although unit costs in specialist practices are most likely higher than in PHC

facilities, following a conservative assumption, they are expected to be similar, resulting in no treatment cost savings in a shift from specialist to primary care.

3) Reduction in OOP expenditures for travel costs:

LSMS findings suggest that patients spend about US \$1.9 for travel per outpatient visit. Travel related costs for hospital stays are assumed to be slightly higher (US \$2) due to distance, eventual OOP payments made for ambulance and additional trips by family members. With fewer referrals, total travel cost OOP expenditures for patients are expected to decrease, as will patients' total OOP payments for specialist and hospital care. The impact on total OOP is not approximated for the purpose of this analysis; however, from a poverty reduction point of view this is a relevant aspect, as suggested by LSMS 2002 results.

4) Averted productivity losses:

Productivity is valued based on an average daily wage of US \$11.65 per person at a labor participation rate of 54 percent. Two assumptions are made to estimate averted productivity losses associated with fewer specialist and hospital referrals. First, and following the Armenia analysis, fewer specialist visits are assumed to result in reduced productivity losses of 0.5 days per referral. Second, fewer bed days due to fewer hospital admissions leads to productivity gains; based on comparable project experience¹⁰ 30 percent of bed days are assumed to be saved.

5) Benefits of reduced mortality:

It is expected that better trained GPs will provide better quality treatment, case-management and preventive measures to avert chronic diseases and death associated with the lifestyle maladies that currently dominate the burden of disease in Albania. Particularly, improved monitoring of respiratory and circulatory system diseases, as well as early detection of diseases of the digestive system, may lead to reduced mortality rates of conditions associated with these diseases¹¹. Accordingly, and following the assumptions made by other studies, it is conservatively assumed that due to better quality of care and higher utilization of PHC services, the health of the population will improve and mortality related to respiratory and circulatory problems and diabetes will decline by an annual average of 2.8 percent over ten years. The analysis uses mortality rates from 2002. It is anticipated that on average each averted death results in 9 life years saved. The monetary value per life year saved is determined conservatively by using the discounted (5 percent) annual per capita income over ten years. Benefits are expected to start materializing as of year 2 of the project implementation.

¹⁰ Armenia: Health System Modernization Project

¹¹ WHO: Atlas of health in Europe 2003. <http://www.euro.who.int/Document/E79876.pdf>

Table 4: Summary of Assumptions and Parameters Used in Analysis

Parameters and Assumptions	Value	Source
Annual GDP growth over 10 years	5.9%	Ave 2000-2003
Annual growth in public spending on health, in % of previous year	0.2%	NHA 2003
Ave wage per person per month	\$233	Poverty unit
Daily wage per person	\$11.65	Poverty unit
Labor participation rate	54%	Poverty reduction report
Reduction in hospital referral, annual average estimates	2.4%	Armenia and Bosnia
Increased costs of outpatient care, in % of hospital savings	30%	Armenia and Bosnia
Cost bed day \$ (excl utilities/maint) 20% of total bed day	\$8.60	MOH Albania and NHA'03
Reduction in specialist referral, annual average estimates	2.4%	Armenia and Bosnia
Travel OOP per trip to specialist, estimated	\$1.91	LSMS 2002
% of patients paying for transport	31%	LSMS 2002
Productivity gain for one less specialist referral	0.5 day	Armenia and Bosnia
Productivity gain, hospitalization, in % of total bed days	30%	Armenia and Bosnia
Life years saved due less mortality	9 y	WHO
Number of deaths saved, in % of total deaths due to respiratory, circulatory and endocrine system diseases, annual average	3%	WHO, Armenia, Bosnia

Results

The cost benefit analysis presents four scenarios. Each scenario is estimated based on total project costs of \$19.04 million including Bank, PHRD and counterpart funding, and assuming benefits due to reduced mortality, reduced hospital bed-days, lower travel costs, and savings in forgone earnings to the society. It is assumed that all three project components contribute to these benefits with component A and C mainly enhancing the effects of the PHC component. The sensitivity of each scenario is tested by changing the assumed discount rate and time frame.

Base Scenario 1

Table 5 presents results of scenario 1. The effect of the project components is estimated, using a 5 percent discount rate over 10 years. Based on total project costs, a negative net benefit value (NPV) of \$ 2.6 million is expected over ten years, at an internal rate of return (IRR) of 0.8 percent. The sensitivity analysis assumes a 10 percent discount rate over 20 years, resulting in a NPV of \$2.8 million over twenty years yielding an IRR of 12.9 percent. Most of these net benefits will occur after about five years and are due to reduced referrals to hospitals and life years saved due to improved case-management at the PHC level of patients who suffer from respiratory, circulatory and digestive diseases.

Table 5: Scenario 1: Base Scenario Cost Benefit Analysis

Net Present Value	10 years (i=5%)	20 years (i=10%)
Based on Total Project Cost		
Net present value (NPV)	(\$2,634,997)	\$2,884,369
Internal rate of return (IRR)	0.8%	12.9%

These results should be interpreted with caution. The additional gains from hospital savings due to reduced bed days will only materialize if hospitals address their inefficient productivity for example by adjusting their bed and staff capacity over time to the lower demand for hospital care, which would eventually require closing empty hospital wards and restructuring small under-utilized hospitals into health centers to gain economies of scale. Net benefits are most likely not to occur if scarce resources are used to finance empty hospital capacity and staff. Furthermore, in the absence of information on informal OOP payments, this analysis does not include eventual savings from decreases in informal payments paid by patients to specialist and hospital providers. It may be that better trained and qualified providers, professional facility management, and financial controls through the PHC management reform component of the Project will positively affect worker motivation and their financial situation, which will eventually lead to a decrease in informal payments.

Other long-term benefits that are not accounted for in the analysis include the following two possible efficiency gains. First, economies of scale in PHC facilities caused by higher productivity of better trained personnel and an increased demand for their services, and second, less severely ill patients who have faster access to care, in an expanded PHC network, will require less intense and thus less-costly treatment.

From a health facility point of view, the most tangible benefits may include better trained and motivated staff providing better quality of care to a larger number of better satisfied patients. As patients pay user fees in PHC facilities, a larger number of patients will positively affect the financial situation in PHC facilities.

The analysis includes additional sensitivity tests presented in three scenarios. Scenario 2, assumes the impact of delayed effects by two years; Scenario 3 reduced PHC benefits by 10 percent, and Scenario 4 both a two-year delay and 10 percent benefit reduction.

Scenario 2

In this scenario, benefits start materializing only in year 4. Results in Table 6 show that the two-year delays in benefits, cause negative NPV and IRR are reached over ten years and a 5 percent discount rate. Using total project cost as a base and a 10 percent discount rate, a negative NPV will be reached over 20 years in this delayed scenario yielding an IRR of 9 percent.

Table 6: Scenario 2: Two-Years Delay in Benefits

Net Present Value	10 years (i=5%)	20 years (i=10%)
Based on Total Project Cost		
NPV	(\$7,459,604)	(\$973,013)
IRR	-6%	9%

Scenario 3

Results from Scenario 3 presented in Table 7 show that when assuming a 10 percent decrease in benefits compared to the baseline Scenario 1, with benefits occurring in year 2 the NPV and IRR are negative based on total project costs over 10 years and assuming a 5 percent discount rate. The sensitivity of this result is tested assuming 20 years and 10 percent discount rates, which yields positive results; though, at a lower level than in Scenario 1.

Table 7: Scenario 3: 10 Percent Reduction in Benefits

Net Present Value	10 years (i=5%)	20 years (i=10%)
Based on Total Project Cost		
NPV	(\$4,041,738)	\$1,119,719
IRR	-1.7%	11.1%

Scenario 4

Finally, Scenario 4 in Table 8 assumes both: a two-year delay and 10 percent reduction in benefits compared to the baseline Scenario 1. If benefits start materializing in year 5 and on a lower level, the NPV and IRR are negative over ten years. Over twenty years and assuming a 10 percent discount rates yields in a negative NPV but positive IRR of 7.9 percent.

Table 8: Sensitivity Analysis: 10 Percent Reduction in Benefits + 2 Years Delay

Net Present Value	10 years (i=5%)	20 years (i=10%)
Based on Total Project Cost		
NPV	(\$8,383,884)	(\$2,351,925)
IRR	-8.2%	7.9%

Benefits created by the three components of this project are likely to materialize some time after project start and gradually over time. Therefore and most likely, Scenario 2 presented in Table 6, yielding a 9 percent IRR over 20 years, might be most realistic.

Fiscal Impact Analysis

The following Table describes the expected fiscal impact and the financial sustainability of the Project. The following scenario is assumed. Annual GDP growth is constant at an average rate of 5.97%, reflecting the average from 2000 to 2003. Public health spending increases annually by 0.1 percentage point of GDP to reach higher levels, compatible with anticipated public health spending in neighboring countries reflecting 3 percent of GDP. Project disbursement ranges from 1 percent to 5.2 percent of anticipated public health spending. Counterpart funds requirements, disbursed over three years, range from 0.1% to 0.7% of expected public health expenditures. Recurrent costs, including replacement costs for medical equipment, operation and maintenance of IT equipment are estimated to range from 0.2% to 0.4% of total public health spending, and expected to be financed from public funds. Based on these assumptions, the recurrent cost impact of the health modernization project on the state budget can be considered as negligible.

Table 9: Expected Fiscal Impact of the Project

(in '000 US\$)	Base Year	Projections						
	2003	2006	2007	2008	2009	2010	2011	2012
Gross domestic product	\$6,124,225	\$7,287,859	\$7,722,944	\$8,184,004	\$8,672,589	\$9,190,342	\$9,739,006	\$10,320,424
Public Health spending) (NHA 2003)	\$125,407	\$ 171,099	\$ 189,036	\$ 208,506	\$ 229,626	\$ 252,525	\$ 277,340	\$ 304,217
Public health spending as % of GDP	2.0%	2.3%	2.4%	2.5%	2.6%	2.7%	2.8%	2.9%
Project disbursement		\$ 1,366	\$ 7,484	\$ 8,884	\$ 2,916			
Project disbursements as % of health spending		1.0%	4.8%	5.2%	1.5%			
Counterpart funds		\$ -	\$ 555	\$ 1,137	\$ 286			
Counterpart funds as % of health budget		0.0%	0.4%	0.7%	0.2%			
Recurrent expenditures		\$ 550	\$ 550	\$ 550	\$ 550	\$ 550	\$ 550	\$ 550
Recurrent expenditures as % of health budget		0.4%	0.4%	0.3%	0.3%	0.3%	0.2%	0.2%

Note: all \$ US amounts are in thousands. Base Year values are from WB and NHA 2003.

Annex 10: Safeguard Policy Issues
ALBANIA: Health System Modernization

No civil works or no new structures of works are planned; hence, no environmental impacts are anticipated under the proposed program given the projects' focus on human capacity building in health financing, quality of care and management in the health sector. The equipment to be purchased includes computer equipment and low technology primary health care equipment.

Annex 11: Project Preparation and Supervision
ALBANIA: Health System Modernization

	Planned	Actual
PCN review	02/24/2005	02/24/2005
Initial PID to PIC	02/25/2005	03/01/2005
Initial ISDS to PIC	02/25/2005	03/01/2005
Appraisal	12/05/2005	12/05/2005
Negotiations	01/31/2006	02/06/2006
Board/RVP approval	03/07/2006	
Planned date of effectiveness	07/01/2006	
Planned date of mid-term review	03/31/2008	
Planned closing date	09/30/2010	

Key institutions responsible for preparation of the project:

Ministry of Health of Albania, Health Insurance Institute, Institute of Public Health

Bank staff and consultants who worked on the project included:

Name	Title	Unit
Dominic Haazen	Team Leader/Sr. Health Specialist	ECSHD
Jan Bultman	Lead Health Specialist	ECSHD
Monika Huppi	Lead HD Economist	ECSHD
Pia Helene Schneider	Economist (Health)	ECSHD
Francois Decaillet	Lead Public Health Specialist	ECSHD
Lorena Kostallari	Operations Officer	ECSHD
Imelda Mueller	Operations Analyst	ECSHD
Carmen Laurente	Sr. Program Assistant	ECSHD
Yingwei Wu	Sr. Procurement Specialist	ECSPS
Olav Christensen	Sr. Financial Management Specialist	ECSPS
Nicholay Chistyakov	Sr. Finance Officer	LOAG1
Kirsten Burghardt Propst	Counsel	LEGEC

Bank funds expended to date on project preparation:

1. Bank resources: \$294,405
2. Trust funds: \$499,500
3. Total: \$793,905

Estimated Approval and Supervision costs:

1. Remaining costs to approval: \$ 5,000
2. Estimated annual supervision cost: \$80,000

Annex 12: Documents in the Project File
ALBANIA: Health System Modernization

Project Concept Note

Quality Enhancement Review

Health Sector Modernisation Project: Preparation for Health Finance Reform – Strengths & Weaknesses Of Health Insurance Institute (HII), Providers & Issues Of Governance

Health Sector Modernisation Project: Preparation for Health Finance Reform – Abstracts from: Strengths & Weaknesses Survey Findings Draft Final Report

Health Sector Modernisation Project: Preparation for Health Finance Reform – Health Sector Stakeholder Survey for Health Financing

Health Sector Modernization Project – Health Financing, a Discussion on Reform (workshop presentations, December 15, 2005)

Health Care Quality Improvement Strategy for the Government of Albania – Inception report

Health Care Quality Improvement Strategy for the Government of Albania – Revised Project Report and Detailed Terms of Reference

Health Care Quality Improvement Strategy for the Government of Albania – Report 3: Indicators to Monitor Successful Implementation of the Health Care Quality Improvement Strategy Components

A High Level Strategy for Health Management Information Systems [HMIS] in the Republic of Albania: Proposed Next Steps and Plans for the Next Five (5) Years

Report on Assessment of Implementation Agency to Conduct Procurement

Annex 13: Statement of Loans and Credits

ALBANIA: Health System Modernization

Project ID	FY	Purpose	Original Amount in US\$ Millions				Cancel.	Undisb.	Difference between expected and actual disbursements	
			IBRD	IDA	SF	GEF			Orig.	Frm. Rev'd
P090656	2005	ECSEE APL#2	0.00	27.00	0.00	0.00	0.00	25.61	0.00	0.00
P086807	2005	COASTAL ZONE MGMT (APL)	0.00	17.50	0.00	0.00	0.00	17.08	0.00	0.00
P082375	2005	NATURAL RES DEVT	0.00	7.00	0.00	0.00	0.00	6.71	0.00	0.00
P082128	2004	WATER RES MGMT	0.00	15.00	0.00	0.00	0.00	14.24	-0.07	0.00
P077526	2004	POWER SECTOR GENER & RESTRCT'G	0.00	25.00	0.00	0.00	0.00	24.34	3.94	0.00
P075156	2004	INTGD WATER/ECOSYS MGMT (GEF)	0.00	0.00	0.00	4.87	0.00	4.77	2.82	0.00
P077297	2003	COM WRKS 2	0.00	15.00	0.00	0.00	0.00	10.94	1.46	-1.19
P041442	2003	MUN WATER/WW	0.00	15.00	0.00	0.00	0.00	13.27	3.02	0.00
P074905	2002	PWR SECT REHAB/RESTRCT'G	0.00	29.90	0.00	0.00	0.00	27.08	18.72	0.00
P069479	2002	FISHERY DEVT	0.00	5.60	0.00	0.00	0.00	2.75	0.35	0.00
P066260	2002	ROAD MAINT	0.00	30.00	0.00	0.00	0.00	10.36	-10.26	-2.45
P055383	2001	SOC SERV DEVT	0.00	10.00	0.00	0.00	0.00	10.17	3.13	0.00
P054736	2001	AG SERVICES	0.00	9.90	0.00	0.00	0.00	4.87	1.47	0.00
P069939	2000	PUB ADM REF	0.00	8.50	0.00	0.00	0.00	5.43	7.74	4.81
P057182	2000	LEG/JUD REF	0.00	9.00	0.00	0.00	0.00	2.27	1.79	1.79
Total:			0.00	224.40	0.00	4.87	0.00	179.92	34.11	2.96

ALBANIA
STATEMENT OF IFC's
Held and Disbursed Portfolio
In Millions of US Dollars

FY Approval	Company	Committed				Disbursed			
		IFC				IFC			
		Loan	Equity	Quasi	Partic.	Loan	Equity	Quasi	Partic.
2005	Fushe Kruje	30.00	0.00	0.00	0.00	15.00	0.00	0.00	0.00
2002	INSIG	0.00	0.00	6.23	0.00	0.00	0.00	6.22	0.00
2000	NCBank	0.00	2.00	0.00	0.00	0.00	2.00	0.00	0.00
1999	ProCredit ALB	0.00	0.98	0.00	0.00	0.00	0.98	0.00	0.00
1999	SEF Eurotech	0.20	0.00	0.00	0.00	0.20	0.00	0.00	0.00
2003	Vodafone Albania	29.92	0.00	0.00	6.41	29.92	0.00	0.00	6.41
Total portfolio:		60.12	2.98	6.23	6.41	45.12	2.98	6.22	6.41

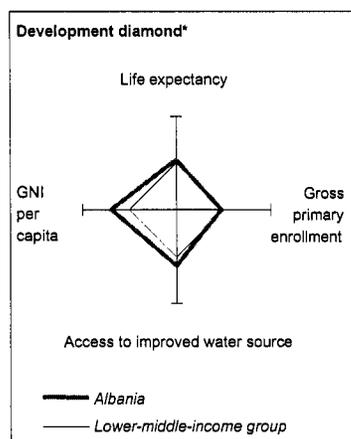
FY Approval	Company	Approvals Pending Commitment			
		Loan	Equity	Quasi	Partic.
2002	Savings Bank	0.00	0.15	0.00	0.00
Total pending commitment:		0.00	0.15	0.00	0.00

Annex 14: Country at a Glance

ALBANIA: Health System Modernization

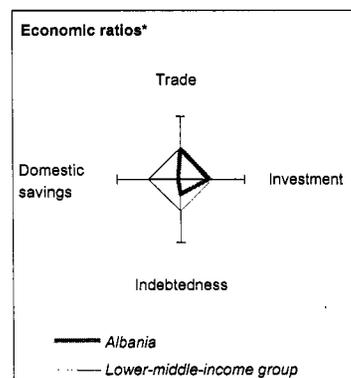
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	Albania	Europe & Central Asia	Lower-middle-income
POVERTY and SOCIAL			
2004			
Population, mid-year (millions)	3.2	473	2,655
GNI per capita (Atlas method, US\$)	2,060	2,570	1,480
GNI (Atlas method, US\$ billions)	6.6	1,217	3,934
Average annual growth, 1998-04			
Population (%)	0.5	0.0	0.9
Labor force (%)	1.0	0.2	1.2
Most recent estimate (latest year available, 1998-04)			
Poverty (% of population below national poverty line)	25	..	..
Urban population (% of total population)	44	63	50
Life expectancy at birth (years)	74	69	69
Infant mortality (per 1,000 live births)	22	31	32
Child malnutrition (% of children under 5)	14	..	11
Access to an improved water source (% of population)	97	91	81
Illiteracy (% of population age 15+)	1	3	10
Gross primary enrollment (% of school-age population)	107	103	112
Male	107	104	113
Female	107	102	111



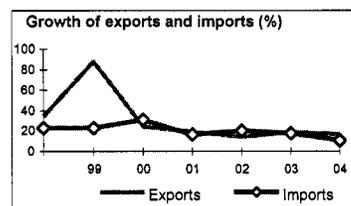
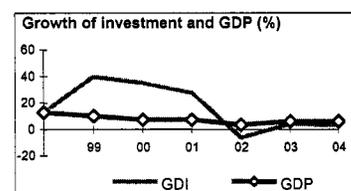
KEY ECONOMIC RATIOS and LONG-TERM TRENDS

	1984	1994	2003	2004	
GDP (US\$ billions)	..	2.0	5.7	7.51	
Gross domestic investment/GDP	31.8	17.9	25.0	23.7	
Exports of goods and services/GDP	17.4	11.4	20.4	21.4	
Gross domestic savings/GDP	29.8	-9.7	0.1	2.0	
Gross national savings/GDP	30.0	3.9	16.7	17.6	
Current account balance/GDP	..	..	-8.2	-6.1
Interest payments/GDP	..	0.5	0.3	0.3	
Total debt/GDP	..	44.5	23.6	21.5	
Total debt service/exports	..	6.6	2.6	2.4	
Present value of debt/GDP	..	..	..	..
Present value of debt/exports	..	..	..	..
(average annual growth)					
GDP	-3.9	6.1	6.0	5.9	6.0
GDP per capita	-5.2	6.1	5.4	5.3	5.4
Exports of goods and services	..	20.5	18.8	16.5	13.5



STRUCTURE of the ECONOMY

	1984	1994	2003	2004
(% of GDP)				
Agriculture	33.1	53.6	25.3	24.7
Industry	44.0	21.7	18.4	19.2
Manufacturing	..	..	..	..
Services	22.9	24.6	56.3	56.1
Private consumption	60.8	95.8	90.2	88.7
General government consumption	9.4	13.9	9.7	9.4
Imports of goods and services	19.4	39.0	45.2	43.1
(average annual growth)				
Agriculture	2.1	2.7	3.0	3.5
Industry	-10.5	7.4	6.4	10.2
Manufacturing	..	5.8	0.0	0.0
Services	-3.5	8.9	7.3	5.6
Private consumption	..	4.2	10.0	7.0
General government consumption	..	18.5	10.5	6.2
Gross domestic investment	8.4	12.8	3.9	3.0
Imports of goods and services	..	16.7	17.7	10.7

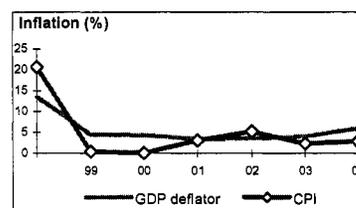


Note: 2004 data are preliminary estimates. Group data are for 2003.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

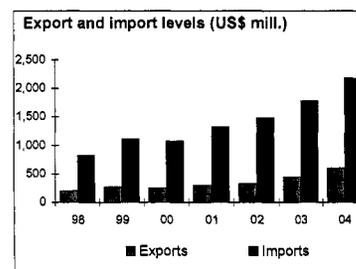
PRICES and GOVERNMENT FINANCE

	1984	1994	2003	2004
Domestic prices				
(% change)				
Consumer prices	..	..	2.4	2.9
Implicit GDP deflator	0.0	38.4	4.1	6.0
Government finance				
(% of GDP, includes current grants)				
Current revenue	50.9	25.6	24.0	23.7
Current budget balance	25.6	-0.4	-0.1	-2.0
Overall surplus/deficit	..	-7.8	-4.4	-5.0



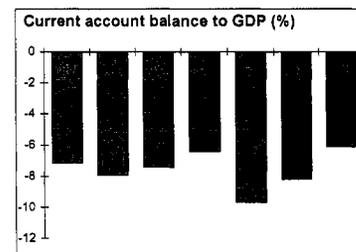
TRADE

	1984	1994	2003	2004
(US\$ millions)				
Total exports (fob)	319	141	447	603
Agriculture and food	..	27	37	50
Energy, minerals and electricity	..	23	79	135
Manufactures	..	1	331	419
Total imports (cif)	353	601	1,783	2,182
Food	..	68	369	447
Fuel and energy	..	77	220	245
Capital goods	..	231	644	837
Export price index (1995=100)	..	..	..	..
Import price index (1995=100)	..	..	..	..
Terms of trade (1995=100)	..	..	..	..



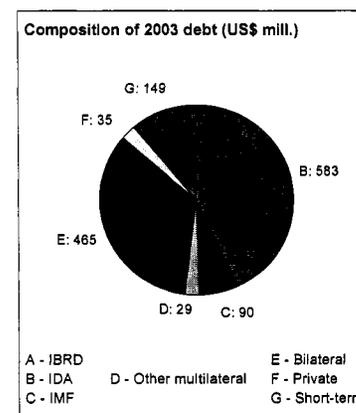
BALANCE of PAYMENTS

	1984	1994	2003	2004
(US\$ millions)				
Exports of goods and services	335	220	1,167	1,607
Imports of goods and services	372	734	2,586	3,237
Resource balance	-38	-513	-1,419	-1,630
Net income	3	14	167	144
Net current transfers	..	..	782	1,028
Current account balance	..	..	-469	-458
Financing items (net)	..	..	587	743
Changes in net reserves	12	-7	-118	-284
Memo:				
Reserves including gold (US\$ millions)	..	226	1,026	1,374
Conversion rate (DEC, local/US\$)	..	94.6	121.5	103.8



EXTERNAL DEBT and RESOURCE FLOWS

	1984	1994	2003	2004
(US\$ millions)				
Total debt outstanding and disbursed	..	883	1,351	1,614
IBRD	..	0	0	0
IDA	..	65	583	743
Total debt service	..	18	55	68
IBRD	..	0	0	0
IDA	..	0	5	7
Composition of net resource flows				
Official grants	..	68	146	125
Official creditors	..	72	121	112
Private creditors	..	-8	-3	-1
Foreign direct investment	..	53	178	343
Portfolio equity	..	0	0	..
World Bank program				
Commitments	..	63	61	66
Disbursements	..	35	61	66
Principal repayments	..	0	1	3
Net flows	..	35	60	63
Interest payments	..	0	4	5
Net transfers	..	35	56	59



MAP SECTION

