

# TECHNICAL ASSISTANCE FOR HEALTH FACILITY RATIONALIZATION PLAN IN ALBANIA

Project ID: P082814

Grant No. TF 055804

## INCEPTION REPORT

### Revised version 1

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## **Purpose of the Inception Report (IR)**

The Inception Report presents the view of the Consultant's team, taking into account their first hand experience of the local context and the priorities of the client, following on from the team's initial mission.

The IR is presented for approval to the MOH and, once approved by the Ministry, this approach will form a key part of the project's strategy and delivery.

The purpose of the IR is to highlight the essential findings on the actual circumstances currently affecting the project, a task that has been conducted by the Project Team during its Inception Phase field-based mission in Albania.

The essential - and unchallenged - elements of the Project are set out both by Terms of Reference (TOR) and the Consultant's Technical Proposal Methodology.

It must be emphasised that the IR is not intended to review the programme's fundamental approach and components. It is an opportunity for the Client, the Project Team and other stakeholders to contribute to the further planning of the projects' activities, improving its effectiveness and delivery.

The Project Team have made their best effort to discuss, share and take into account all relevant ideas, views and inputs originating in institutional and technical counterparts, Albanian experts and consultants and major Project stakeholders.

The Project Team is submitting this document to the MOH, as part of its proactive approach, and would welcome any further input and suggestions.

## 1.- Background

Albania has had a significantly more turbulent progress along the path of economic and structural transition than most of its Central European neighbours. This has been due to both internal and external disruption, most notably the civil unrest following the pyramid selling scandal, and then the Kosovo crisis, with its wide ranging consequences, human as well as economic, both immediate – during the war – and in the longer term aftermath.

Because of this, there has been major disruption to both the effective working of the existing health infrastructure, particularly a loss of qualified staff to emigration for example, and also the disruption of a number of early initiatives in the field of broad economic reform as well as, specifically, initiatives in the field of healthcare reform and development.

Despite these difficulties the Ministry of Health has continuously strived to develop programmes and policies to redevelop and realign the healthcare system into a more effective structure – both cost effective, and more responsive to population needs.

In more recent times, with more economic stability and the formalisation of the Stabilisation and Association Agreement with the EU together with the development of strategic planning across economic and Health fields, the impetus towards change and improvement across the healthcare system has been renewed.

The Healthcare system is in the process of a complete systemic change, and as can readily be appreciated this has been – and still is – a very major undertaking. The initial and key change at a delivery level has been a wider implementation of family medicine/Primary Health care, and with it the essential structural elements of defining a basic package of services, including key essential equipment for PHC<sup>1</sup>. In parallel organisational changes such as the development of the Tirana regional health authority, and the beginning of devolution of some financial and management authority to the PHC level is under way.

Key developments such as the setting up of the HII which has now – as of 2009 – taken over as the single funding source for both PHC and Secondary care, and the Basic Package of Services, as mentioned, have been the initial major steps in the reconfiguration of Albania's Healthcare system, and in this project the team will be delivering TA which will assist in the delivery of the Health Facility Rationalization Plan which will address the delivery of care in the secondary care sector, essentially the Hospitals and polyclinics.

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<sup>1</sup> See for instance: Paketa Bazë e Shërbimeve në kujdesin shëndetësor parësor (MoH/USAID, January 2009)

## 2.- Activities of Initial Project Mission

The initial project mission – September 7<sup>th</sup>- 19<sup>th</sup> 2009 – was the opportunity for the team to meet key personnel within the Ministry of Health, the Health Insurance Institute, and other stakeholders, to allow the international part of the team to get an overview of the current Albanian context, the pace of change, and the challenges faced by both the Ministry and its partners in healthcare, as well as the team, in its aim of delivering this project. (the list of those met on this mission is included as Annex 1)

The team leader arrived on September 6<sup>th</sup> and spent the first week making initial contacts and having meetings across the range of counterparts and arranging further meetings for the rest of the team who joined him and were present during the second week.

During the second week, as well as meetings in Tirana, two team members visited the regional hospital at Vlora for a day in order to get a first hand impression of the reality of a regional hospital in terms of its overall structure – physical as well as organisational - and its range of services, including trying to identify gaps and opportunities for improvements in the range of services being delivered.

The overall activities and aims of the project clearly stated in the TOR, but the initial visit was the key opportunity for clarification with the Ministry of the Ministry's own priorities and an opportunity for an exchange of views on modes of approaching a range of issues.

It was clarified by the Ministry of Health that although the TOR specified a “Master Plan for restructuring of health facilities at all levels of care to allow a continuum of care”, that PHC was not to be included in the work of the project, as decisions on PHC had already been taken and implemented.

In addition, the Mother Teresa hospital in Tirana, which functions both as a secondary care centre for Tirana as well as a tertiary centre for the country, was not to be included as part of the work of the project because of its unique context.

The Ministry clarified that the key focus of project activity was to be on rationalization of the District and Regional hospitals, which it was agreed would involve the strengthening of the Regional hospitals and the reconfiguration of the district hospitals to deliver local polyclinic – outpatient specialist care – services as well as local ambulatory services, but to no longer function as district hospitals per se.

A further important clarification by the Ministry related to the question of infrastructure. Here the TOR call for “Assessing the current general status of healthcare facility infrastructure” with what was seen to be detailed work to be done to specify what was necessary to upgrade/redevelop the core infrastructure – the buildings. The Ministry has made it clear to the team that all infrastructure work and upgrading/redevelopment work will be the direct responsibility of the Ministry and should not be a key element of the work of the project.

In addition to the discussion on refining and progressing the deliverables within the TOR, the Ministry also requested that the team prepare an equipment list for the hospitals, not - as initially planned - as part of the final Master Plan report which will outline the equipment needs of each regional hospital, based on its overall context and competences, both current and projected, but as a separate exercise, to be

delivered in time for the development - by the Ministry - of an equipment tender. The indicative timescale for this being end November.

As well as policy clarification and guidance within the Ministry, the team also gained significant background information from both Hospital and the Primary Health Care (PHC) directorates' visions of the Ministry, as well as the Equipment Procurement Division.

The equipment division arranged a visit to the Biomedical Institute of Albania (BIA), which allowed the team access to the national database for hospital equipment, which was an excellent example of its type, and would clearly be an excellent resource in assisting in the delivery of the project.

Meetings were held with the Health Insurance Institute (HII), the first when the team leader presented the project and explained its aims, and the second which, as well as exploring the details of the project, allowed a wider discussion on the stage of evolution of the HII as a payer/purchaser, and how it saw its response to the challenges of "purchasing" in the future the "new" range of services which the team envisaged being delivered in the future by the "rationalized" and (hopefully) upgraded regional hospitals.

Meetings also took place with Prof. Kalo, Director of the National Centre for Quality, Safety and Accreditation of Health Institutions in Albania, to assist in clarification of a number of issues related to levels of competence and experience across the different hospital levels in Albania, and discussion of a variety of options for quality improvement issues and markers which the team will be exploring. Members of the team also met staff from the Institute of Statistics and civil servants in the MoH to clarify the amount of empirical and routine data that were available.

Other activities on this initial visit included liaison with local GIS provider companies to discuss co-operation in the delivery of the GIS segment of the project, and also meetings with potential local staff, who would be responsible for local activities whilst the International experts were not in Albania, and would be responsible for continuing liaison throughout the project.

Regarding the Project Team joint internal activities in Tirana, the Consortium had a keen interest in bringing all the expatriate team members to Tirana during the Inception Phase in order to know personally their respective counterparts, approach some stakeholders and be confronted directly with all relevant issues relating to their knowledge areas. Consequently, in addition to Dr. McNally and Dr. Ramis, the two specialising key consultants joined the Inception mission: Mr. Francisco Jiménez (GIS) and Mr. Félix Varela (Equipment). Personnel from Eptisa's Headquarters in charge of the overall project management on behalf of the Consortium also visited Tirana: Mr. Gonzalo Peña (Healthcare Programmes Director) and Ms. Ruza Radovic (Project Manager). Permanent support and assistance to our professional team was granted, and will be during the missions implementation, by Mrs. D. Koci, the Consultant's representative in Albania.

Close collaboration with the Albanian experts started during those days. Expatriate consultants had several in-depth working sessions with the Albanian consultants in Tirana and exchanged key ideas, and valuable views and information with Dr. Preza. Dr. Subashi, Arch. Iliariana Bozo, and Eng. Blerina Kurti. Actual planning on all projects' subcomponents started (i.e. Healthcare Systems reconfiguration overall

strategies, GIS, equipment, general information/data gathering, and architect/engineering for infrastructures).

Regarding project implementation organizational aspects, suitable solutions and logistic support have been arranged for in all relevant fronts.

### **3.- Analysis of the Current Situation**

#### **3.1. Overview**

As laid down in the TOR, the project has a clear goal, which is to deliver a comprehensive network of outpatient and Inpatient Care Facilities in Albania, and to achieve this by developing a Master Plan for the restructuring of health facilities to ensure a continuum of care.

It is clear from discussions and local input that the focus of this planning will be on the secondary hospital sector, since the revised – 2009 - BPS for PHC has defined equipment needs, organization and other issues for the PHC sector which have been, or are being put in place, and also excluding, as instructed, Tirana's hospital, with its unique context.

Whilst this, as agreed with the Ministry, will be the main focus of the team's work, as this is an overall Master Plan, the team will be taking into account the effectiveness of the new PHC developments including both the equipment delivered under the new Basic Package plans, and also the pattern of referrals from PHC to secondary care, and, also the referral pattern to the Mother Teresa hospital tertiary care level.

The Master plan will seek to deliver across the country, a secondary sector, which will give a more efficient use of all healthcare resources, the hospitals themselves, the staff and the equipment and other relevant resources.

Albania has a legacy of health facilities, which date from the communist era where the fulfilling of targets rather than effectiveness of service delivery was the priority. This has resulted in hospitals that are limited in what they can deliver due to a variety of reasons.

This can be due to an overall lack of staff numbers, or indeed a lack of key staff, e.g., surgical services which cannot function effectively due to lack of anaesthetists. Lack of support facilities such as laboratory and diagnostic equipment, as well as surgical and other equipment also play a major role, the precise mix of factors varying from hospital to hospital.

In addition, there is a recurring theme from all sources that the bed occupancy rates (approx. 40% for the district hospitals and not much greater than 60 % for the regional hospitals) reflects a perception by the public – the potential patients - that these hospitals do not provide the same level of quality and safety (meaning also appropriate skills, skill-mix and training in their staff) that the level Tirana can offer, with the result that there is major pressure on the Mother Theresa tertiary level hospital to deliver, as well as its tertiary services which of course it delivers for the entire country, a range of more routine services for patients from outwith Tirana which should more appropriately, and more cost effectively be delivered by hospitals closer to the patients' home.

A systemic approach may also help to understand how the Albanian health system currently operates (and therefore why the district & regional hospitals are shaped in

their present status). Overall public funding allocation for health care, existing public and private payment mechanisms and other financial arrangements, unavoidable conflicts of legitimate interests and other forces all play a role in the present and the future shape and sustainability of current health care institutions beyond the technical considerations of staff availability and technological change. During the inception report the team double checked the relevance of such considerations with the HII. Although assistance in these issues lies beyond the ToR of the present project, inputs from HII and the MoH will be needed to ensure the Master Plan and the Implementation Plan are feasible and useful.

Healthcare is an expensive issue for any society, and if resources are not being effectively and appropriately used, then public money is being wasted. The purpose of this project is to rationalise the current secondary care structure into a more effective model and prepare a plan to allow the services delivered by the new structure to be of a clearly defined and higher quality than is perceived at present, to the benefit of the healthcare professionals and the public as a whole.

This will not simply be a case of closing district hospitals and consolidation in the regional centres, although of course the latter will form the basis of the new rationalized framework, as access for patients to an improved and hopefully more uniform level of care (in this context we are essentially concerned with secondary care) will be a paramount concern.

### **3.2. District Hospitals**

The geography of Albania, in common with a number of other countries, dictates that “simple” organizational solutions such as simply closing and transferring facilities are not an option, if patient access to specialist care is to be maintained within a reasonable geographical framework, and for this reason, the basis of the team’s approach at the district hospital level will be **reconfiguration of the existing facilities**.

This reconfiguration will take the form – as appropriate to each individual case – of transforming the District hospital into, as examples, a day hospital, a polyclinic, or an ambulatory centre, or combination of these, and each geographical case will be individually examined in detail and proposals brought forward, bearing in mind population served, geographical factors, the network of PHC facilities in the catchment area which will need support etc.

The team are aware of the current legislation which requires every district hospital to have a specialist physician, surgeon and gynaecologist, but they are also aware that in many places there is either a lack of such staff, or no anaesthetic staff to support any surgical intervention, or there is a low level of training/clinical expertise in the staff on site.

These factors - of which the local population are usually well aware - contribute to the tendency of patients to bypass the district and go direct to the centre.

The team’s proposals will allow the concentration and further development of expertise to take place at the regional hospital level, but the local needs of the local population will not be ignored.

Transforming a district hospital to an ambulatory facility will allow the definition of a range of procedures to be carried out at this district level in the reconfigured unit.

Some countries – e.g., UK have a list of minor surgical cases which can safely be done at an outlying ambulatory capacity – the list is based on ICD 10 codes so it immediately comprehensible in any country – and using this, and other international indicators, the project team will develop a profile of clinical services including minor surgery which could appropriately be delivered at the district level (see Annex 3).

In addition – again associated with the often limited experience of the current specialists at the district level - the outpatient “specialist” care currently delivered at a local district polyclinic level is often less than ideal. In the spirit of accessibility which will be a theme of the team’s work, proposals will be developed to ensure that the polyclinic element of the reconfigured district hospital will be delivered on a planned visit basis by specialists from the regional hospital on timetabled visits, delivering a quality of service which, reflecting the greater expertise and experience of the regional hospital staff, will enhance the health services to the local population.

In addition, the reconfiguration of the district hospitals will point the way to their revised staffing, since the new configuration will reflect the range and type of services, which will be offered. It will allow a truly “rational” staffing plan, as opposed to the existing legacy staffing, and with the definition of range of services offered will come the corollary of the definition of required training level of the “new” staff.

This definition of the services to be offered – as outlined above - will also allow the definition of what supporting technical equipment should be available in the reconfigured unit.

This will be done in co-ordination with the local PHC infrastructures, organisational, – i.e., numbers and skill mix - and also technical/equipment resources in order, as much as possible, to most effectively ensure a continuum of care locally.

This is a complicated task, and its delivery will be facilitated by the GIS element of the project. Using baseline geographic and demographic data and building on this with data from the MoH, the HII, and other sources the GIS will allow the development of a comprehensive overview of all the healthcare assets across Albania.

As well as assisting the team in planning the rationalization project, this will serve in the longer term as a planning tool for longer term issues, and also will assist in developing the milestones which it will be necessary to identify to both develop the plan and also the evaluation and delivery of the process of implementation of the programme for rationalization.

It is worth highlighting that with the reconfiguration of the district hospitals, it is likely that there will be “surplus” accommodation available at these sites, after the reconfiguration has been defined & agreed – and then of course after implementation.

The team will suggest that the MoH might wish to consider using this surplus capacity – if not for healthcare activities, then transferring it to a “social” or “community” use.

These general terms – deliberately chosen so as NOT to be prescriptive - reflect the often very successful uses to which other countries which have similarly rationalised healthcare accommodation, have put such accommodation, and in addition, the transfer to another use has created local employment opportunities which staff who

might be displaced by the reconfiguration and do not wish to move, may wish to take up.

### **3.3.- Regional Hospitals**

With the reconfiguration of the district hospitals will come a shift in workload to the regional hospitals.

Benchmarking with existing European data bases would help the team to estimate the approximate activity of each Regional hospital based in their hypothetical catchments areas and therefore to reassess the appropriateness of its current size and definition of functions.

This will also entail revising their staffing, but here the team propose rather than a simple review of staffing, a more in-depth look at the overall role of the regional hospitals, and their relationship with the tertiary level Mother Teresa hospital, defining what services *they* should be providing, what should the specialist staffing norms be for regional hospitals in Albania, and not simply looking at “shuffling” staff e.g., who may have been “displaced” from the district hospitals.

In parallel with this examination of their simple numbers, must come an examination of the training levels and competences of the staff, to ensure that they are appropriate to allow them to safely and effectively deliver the defined level of services.

This is an opportunity to allow important decisions to be made about the key issues of norms for specialists and appropriate training levels across specialities, and the team will work with the MoH, and other relevant actors to help develop such norms – and once more, with the GIS system developed and in place - a long term planning and implementation tool will have been delivered.

There is a truism that states that form always follows function, and this also applies to Hospitals. In this context, the team will be laying out options for moving significantly to a more widespread use of ambulatory surgery in the regional hospitals, and as such, this will mean consequences both for their configuration, and also in their equipment requirements.

A key challenge – and a risk for the project implementation – is that there will be a clear need for further training of specialists to allow this shift in emphasis to more ambulatory care to be implemented, and there will need to be support from the relevant specialists in this development. Here the team see a role for the Order of Physicians and the National Centre for Quality as partners in the implementation process to hopefully support the process.

As will be emphasised in the discussion on equipment, the move to more ambulatory surgery in more “major” procedures (gall bladder surgery being a good example) will require the appropriate laparoscopic instruments, and with them – when tenders are being issued – a key requirement will be for the equipment supplier to ensure effective training in its use.

### 3.4.- The Master Plan for Restructuring Health Facilities

It is clear that this project will not **implement** the rationalization plan for Albania's secondary care health facilities within the one-year timescale.

What it will do is to deliver a Master Plan for an effective and hopefully cost effective rationalized structure which will benefit all, healthcare professionals, the public – who as the potential (& real) patients are key in this entire process, and the resultant increase in efficiency of use of resources will benefit the overall Economy.

This plan will identify the new, rationalised secondary care structure, and will have within it a clearly set out pathway which will show the way to deliver that new structure, including a set of steps, goals and milestones to be achieved, which will allow the effectiveness of the implementation process to be accurately measured.

This plan will be developed and presented to the MoH by the project team but it will have to be implemented and the reconfiguration and changes put in place by the MoH itself, and as such it would be wholly inappropriate for the team to simply deliver such a plan to the MoH and leave.

### 3.5.- Reconfiguration of Secondary care – Competences and Consequences

In the process of rationalizing the hospital sector, and improving its efficiency, the team will have as one of their aims, the encouragement of specialists in Albania to move to increased use of day surgery – ambulatory surgery.

The range of procedures which can safely and effectively be carried out on an ambulatory basis has significantly increased across European medical practice, and the team would plan in their equipment planning component to include the necessary equipment to allow this increased range of interventions to be implemented.

This investment in equipment would however be wasted if the necessary skills and competences were not in place to allow the equipment to be used – and more than just occasionally. This decision – whether to supply this equipment and how much and to where, will be intermingled with the decision – a policy one – on skill levels and what services should be delivered from where.

Irrespective of this, it is the team's view that any tender prepared which covers this category of surgical equipment must include a requirement for the supplier to deliver appropriate training to the relevant specialist – and from previous projects the team are aware that this is not a difficulty for most surgical equipment suppliers.

A recurrent theme for the project team has been low bed occupancy in the hospital sector, and this has led to the question of why try to increase ambulatory surgery when there is significant empty bed capacity?

The answer is first, that ambulatory is – and has been widely confirmed to be – better for the patient, and also that the team do not regard the current structure of the regional hospitals as sacrosanct.

Yes, they will be the key building blocks of the rationalized structure, but they need not retain unchanged their existing form.

The team will be reconfiguring them to give the most cost effective, and locally appropriate combination of an on-site (or close nearby) polyclinic, an ambulatory surgery facility and a rationalized hospital. Many may change significantly to allow

the necessary changes to deliver a more rational and cost effective secondary healthcare delivery service, but all will of course be examined on an individual basis and reconfigured to best – both clinically and cost effectively - deliver the services needed within their own context.

In looking at this the team will examine parameters such as not only bed occupancy, but also, using the best data available, average length of stay per condition, and key indicators such as operating theatre utilisation – an operating theatre if appropriately equipped is an expensive asset/resource, and needs to be used on a regular basis to appropriately justify its investment.

### **3.6.- Planning the Rationalization Process and its Progress**

As has been already stated, this process will take time to be implemented, but what is essential for its implementation is a structured Implementation Plan which, while having the final outcomes already defined – the proposed rationalization of facilities which will have been delivered by the project – will have a clear pathway, including a timeline, for delivery of the rationalized units.

Since this will very much NOT be a “one size fits all” approach by the project team, but a specific proposal for each district and regional context, since this will vary for each region based on demography, local epidemiological factors, and also – a significant element in Albania – the local geography. The timescale for implementation of all the changes in each facility is likely to vary, but in all cases there should be an identified timeline, with clear milestones to ensure effective monitoring of the implementation process.

Key to this aspect of planning the rationalization is effective information on the district and regional hospitals, including such basics as staff numbers, range of services provided, bed occupancy, throughput, and any outcome measures which are currently available – although the team are aware that these are limited.

In addition the project team will wish to know the level of qualification/experience of the staff, both clinical, and technical – e.g., laboratory staff, to enable a quality improvement programme to be put in place in the longer term.

An inventory of diagnostic/technical equipment will be carried out to allow as complete a picture as possible of the resources currently in place to fully inform the rationalization process decisions.

This will be done using a combination of information which will be supplied by the MoH and other relevant agencies including the HII, and also by the use of a questionnaire which the team will design and develop, together with validation of this data by on-site visits.

This process will also aim to assess, as well as possible (and the team are well aware of this challenge) the level of competences/services currently offered in each regional hospital and also within each specialist service, the better to assess both where to target resources, and where to highlight significant service gaps which would need to be addressed.

These Questionnaires and the validation visits will be delivered by the project’s local staff.

In addition to this assessment of human and technical resources, the team's architect will also visit a representative sample of the hospitals, both district and regional to give an opinion on their suitability for reconfiguration, looking at such issues a infrastructure needs, medical gases, appropriateness of operating theatre structure and layout, appropriate shielding in place, or able to be installed to allow new x-ray equipment to be safely installed etc.

This wide ranging data will inform the decision pathway in developing the rationalization plan.

Throughout the process, it will be essential to keep the local PHC doctors and staff informed of changes, and of the development of new resources, and in every local area they should be regularly informed of progress, and what will be available in terms of improved local resources for their patients who require secondary care.

This is essential since without local PHC partnership, and an understanding of what is to be delivered, and with a belief in it, the rationalization process will not be fully effective, and, in addition, if the local PHC doctors do not "believe in" the new rationalized and improved hospitals and ambulatory centres, then the clinically correct, and cost -effective appropriate referral pattern which should result from this rationalization process will not develop effectively.

When the project team has completed the rationalization plan, and outline agreement has been reached on its proposals, the development of the time line, together with the milestones for measuring progress will take place as a co-operative process between the project team, and the Implementation team, again as part of the continuing commitment to knowledge transfer as identified in the TOR, a process which will give the Implementation team a sense of "ownership" of both the plan and the process.

The identification of milestones is a key factor in the effective monitoring of the implementation/delivery process, as mentioned above, and to facilitate communication, outlining the progress on milestones, the team propose that the Implementation Group produce a quarterly report outlining progress towards the identified milestones, and that this report be presented to the Minister, or a designated Vice-Minister who would have the overall responsibility for the Implementation of this important policy item.

### **3.7.- Training**

As stated in the TOR, and in the project proposal, an agreed fundamental aspect of the delivery of this project will be a **continuing process of knowledge and skill transfer** from the international experts to all the relevant local counterparts. In addition to this however, the team believe that there is a requirement for some more formal training, which should include as well as the Implementation team and other relevant counterparts from central bodies, key personnel from especially the regional hospitals, whose directors, for example, will need to be part of the process for it to be effective.

Although the team will of course **train the Implementation Team by the "knowledge transfer"** as envisaged in the TOR, having seen the local context, and wishing to ensure that the project is effectively followed through to its full

implementation in the longer term, the team feel that a formal and structured training should be added to the project plan to allow the appropriate dissemination of not only the project aims and goals, but an awareness of the context and framework within which these goals can, and hopefully will be achieved.

Not to take this additional step carries with it, in our view the **likelihood of increased resistance to the implementation of the changes**. Delivering an appropriate training will however inform the local personnel and give them an ownership of the implementation of the process, eliminating (at least an element of) opposition and/or inertia and hopefully facilitating a speedier and more effective progress towards the agreed goals.

The team will be preparing a proposal for an addendum to the contract to allow this – we consider – important additional element to be separately funded.

## 4.- Delivery and implementation

### 4.1. The *Implementation Group* and the *Stakeholder Committee*

The implementation process will involve delivering across a wide range of issues, as outlined below, and the Project team would propose to work with the MoH's Implementation team to jointly develop the final version of the plan, since in developing it in parallel with the Implementation team and the Project team, the Implementation team will be more fully aware of the ideas and international experience which influence the proposals which the project team will be preparing, and the process will allow for both training "on the job" but also an element of knowledge transfer, as set out in the TOR.



**The team therefore makes two - key - important proposals:**

#### ***a.- The Implementation Group***

The first, which is essential, and the more pressing, is that the MoH identify those personnel who will be responsible for implementing the plan in the longer term<sup>2</sup>. The project team will assess the background management experience/training of the new ***Implementation Group*** and to identify any training needs.<sup>3</sup>

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<sup>2</sup>. As per correspondence with Mr. Kadiu on September 17<sup>th</sup> following the inception visit, the implementation group will include: Fedor KALLAJXHI, Vjollca DURRO and Silva NOVI

<sup>3</sup> It would be the project team's aim to identify any such management training needs, to identify where any appropriate training could and should be delivered, and to draw up – in co-operation with any such training

## **b.- The Stakeholder Committee**

The project team's second proposal has to do with both the long term challenges which can be foreseen for the implementation process, and the options which exist to facilitate the broader changes proposed – such as quality and qualification issues.

What is proposed is a **Stakeholder Committee**. This will not be a supervisory body – the implementation process will – and should - continue to be the responsibility of the Implementation Group within the MoH, but this process has ramifications for a number of key actors beyond the MoH both within and outside the healthcare sector.

As proposed, there will be significant changes in hospital staffing both numbers and the pattern of staffing. This will impinge on the **Health Insurance Institute HII** which has, as of this year, 2009, have become the paymaster for the Secondary Health sector.

Also, with the issues of training and quality assurance/definition of competences, then both the **University/Medical School** and the **National Centre for Quality and Accreditation of Health Institutions** would have an interest in the project, and in the implementation process.

In addition, the **Order of Physicians** should also be present, since a significant factor in the project team's approach is to try to help drive up clinical standards and training for specialists to facilitate the delivery of an improved level of quality of care.

Out with the broader healthcare sector, there is one other group which will without a doubt have an interest, and that is the **Municipalities/Local government entities**.

Any attempt to change health institutions, such as closing hospitals, and even major reconfiguration rather than outright closure invariably attracts protest from local people, and also, on occasion, from elements of local government.

One way to defuse this – it can never be completely eliminated – is to keep the local government element fully informed of the process, its aims, the benefits envisaged, and the steps and progress being achieved.

It will not of course be possible to include every local government entity, but in the envisaged "Stakeholder Committee" there would be a member from the HII, a member from the University/Medical School, a member from the National Centre for Quality, and a member from the association of local government entities, and a member from the order of physicians..

The linkage between the Stakeholder Committee and the Implementation Group would be that the Implementation Group would keep the Stakeholder

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institution – a draft training curriculum, including costings, and to arrange for the delivery of such training.(Training will be discussed further below).

Committee informed of progress, by joint meetings, but also by producing e.g., quarterly reports on progress which they would deliver to them.

In turn, the Implementation Group would treat the Stakeholder Committee as a resource, calling, as required, on its expertise on training and quality issues, and if there was a local problem with any specific local government entity, seeking the help of the association representative to smooth progress.

This structure – or model – would in the team’s view – deliver the best of all possible worlds, co-operation without interference, a sense of “ownership” of the process across a wider range of relevant actors, and the ability to easily access any appropriate input and as such, an effective way of delivering an additional element of efficiency and effectiveness to the implementation process.

This should ensure an active interest in and effective participation in the process by the key relevant actors – to the benefit of all.

#### **4.2. Other implementation arrangements.**

As described in the plan of activities the implementation logic of the project team beyond the Inception Phase is as follows (a graphic representation can be seen in attached charts):

1. To finalise data collection from routine sources (although most collection was already done during the inception phase)
2. To start analysing the existing data making use of benchmarking. Simultaneously an instrument for qualitative data collection and validation will be designed. Consequently data will be collected through phone interviews and validated/completed through site visits.
3. Simultaneously, the equipment expert will initiate the preparation of the equipment list in cooperation with the rest of the team and the identified counterparts. The list should be ready by November.
4. Also, simultaneously the GIS team will prepare the required maps.
5. The analysis of all that work will produce a Master Plan draft and a multi-stakeholder conference will be organised for late March where the master plan will be discussed.
6. The implementation plan and monitoring and evaluation mechanisms will be prepared after the conference together with a monitoring and evaluation mechanism.
7. The project will close in July 2009

The Stakeholder Committee will be convened regularly and it will have a key role in the March conference.

## 5.- Summary of relevant changes

These are the modifications on the contractual documents establishing the Scope of Work (i.e. TOR and Technical Proposal) as agreed during the inception mission<sup>4</sup>.

- The **purpose of the project remains unchanged** as stated in the ToR although its detailed objectives (see below) have been adjusted to the reality of the existing present needs. The original ToR purpose refers “to support the government with the elaboration of an appropriate Health Facility Rationalization Plan”. We clarified that the “Health Facility rationalization Plan” plan and the “Master Plan” used in other parts of the ToR refer to the same document.
- The objectives of the present project remain those described in the ToR with the **adjustments discussed** and agreed during the mission:
  - i. *To develop, in collaboration with the MoH, a **Master Plan for restructuring health facilities** through Albania. It should provide a long term vision with targets for an efficient, sustainable and equitable network; encompassing development plans to guide investment and restructuring of the health sector.* Note it was agreed that: (1) the Master Plan will deal only with hospital care (i.e. the current district and regional hospitals) outside Tirana as primary health care and other health care premises are being dealt by other projects as is the situation in Tirana. and (2) guidance is not required for detailed plans for building and civil works. It is mainly required to advise on functions and roles of the different institutions: specially to identify services to be offered at referral (from PHC) hospitals except, as said, in Tirana.
  - ii. The team will be identifying for each type of hospital a recommendation for medical equipment based on the local context, demography, epidemiology and geographical factors, and the institution’s place in the continuum of care. This is clearly set out in the TOR and the methodology. Equipment procurement is an essential part of the rationalization process as envisaged, since without appropriate equipment, new, improved, and more cost effective technologies may not be able to be implemented appropriately across Albania, and is an essential underpinning part of the rationalization plan.
  - iii. *To develop **an implementation plan** in accordance with the overall rationalization strategy identifying: annual action plans, responsibilities, and timetables.* Note it was agreed that, given its nature and time constraints, the project cannot ensure the delivery of the implementation of any change but will make sure training is

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<sup>4</sup> The Inception Report will be a part of the contractual documents defining the Final Scope of Work.

delivered to the implementation group as well as there is permanent contact between the group and the project team to deliver an implementation plan that will be instrumental in the actions to deliver change.

- iv. To prepare an **inventory of equipment needs** for a “notional” hospital to be handed in by November 2009. Note that is an additional element to the work of the project, which the team, as detailed below, are happy to deliver, and is in addition to the equipment needs definition work – as referred to in ii) above which will be delivered as part of the final completed plan at the end of the project.
- v. To develop a **practical monitoring and evaluation mechanism** to assess the impact of the Master Plan on sector performance (unchanged)
- vi. To train staff at the MoH and in health facilities on the development and implementation of the master Plan and promotion of the plan and the steps of its implementation (...) with all relevant stakeholders. Note the **project will be offering a separate proposal to enhance the training function**. Otherwise training will be limited to in-house training and development to the implementation group and to the staff from health facilities working with them. The consultant is proposing, as suggested in the Technical Proposal, an extension of that function (see also 3.7).

## 6.- Activity plan

See enclosed chart in Annex 1.

## 7.- Geographical Information System

### 7.1.- General view

The objective of these section is to describe the data requirements and the deliverables of the GIS Mapping subcomponent.

#### Reference Documents

- Request for Proposal
- Technical Proposal

## Data requirements

**1.- Geographic information:** The basic geographic information required for the project is the following:

- Administrative boundaries: Prefectures, Districts, Communes/Municipalities
- Cities and villages
- Location of care facilities (primary, secondary, tertiary)
- Location of Specialty facilities
- MOH offices
- Location of specific services such as Computed tomography (CT) and Magnetic Resonance Imaging (MRI)
- Street and road network

**2.- Alphanumeric information** related to **cities and villages**

- Total population
- Total population by gender
- Total population by age
- Total population by employment status
- Total population by socioeconomic status

 This information will be provided by **Institute of Statistics (INSTAT)**. In the event the information provided is not referenced to cities and villages, and is grouped by municipalities or districts instead, the accuracy of the delivered maps will be directly affected. **Externally provided data for basic calculations could vary considerably.** Precision of isochrones and other parameters for decision making will be a result of the provided basic data.

**3.- Alphanumeric information** related to **healthcare and specialty facilities**

- Bed number by care facilities
- Bed number by care facilities by specialty
- Professional staff by care facilities
- Doctors, nurses and pharmacists by care facilities
- Doctors, nurses and pharmacists by care facilities by specialty
- Specialties by care facilities
- Department by care facilities
- Equipment by care facilities
- Patients by care facilities
- Admissions rate by care facilities

- ❑ Occupancy rate by care facilities
- ❑ Patient/staff ratios by care facilities
- ❑ Staff/occupied bed ratios by care facilities

 This information will be provided for the Ministry of Health. Accuracy and quality of the externally provided data for basic calculations could vary considerably. The accuracy of the delivered maps might be consequently affected.

## 7.2.- Deliverables

### 2.1.- Initial data presentation

- Mapping of the total population by cities or village
- Mapping of population by gender by cities or village
- Mapping of population by age range by cities or village
- Mapping of population by employment status by cities or village
- Mapping of population by wealth by cities or village
- Mapping of the street infrastructure

 It is important to consider that if the data provided by **INSTAT** is not referenced to cities and villages it will be not possible to achieve the **pursued mapping quality**.

### 2.1.- Data collection and presentation

- Mapping of primary care facilities
- Mapping of secondary care facilities
- Mapping of tertiary care facilities
- Mapping of specific services such as MRI and CT
- Mapping of MOH offices

In order to build up these maps, location of primary, secondary and tertiary care facilities, specific services, MOH offices is required.  **MOH is the main and most reliable source** of the necessary information.

### 1.3.- Calculations based on existing and gathered data

- Average travel time from each cities or village to the closest primary care facility
- Average travel time from each cities or village to the closest secondary care facility
- Average travel time from each cities or village to the closest tertiary care facility
- Average travel time from each cities or village to the closest specialty facility
- Average travel time from each cities or village to closest specific service such as MRI or CT

- Specialties by care facilities
- Beds by specialty by care facilities
- Beds per population per specialty by care facilities
- Equipment by care facilities
- Number and skill levels of professional staff by care facilities
- Doctors/nurses/pharmacists per specialty by care facilities
- Doctors/nurses/pharmacists per bed by specialty by care facilities
- Doctors/nurses/pharmacists per population by specialty by care facilities
- Doctors/nurses/pharmacists per patient by specialty by care facilities
- Admission rate by care facilities
- Occupancy rate by care facilities
- Patient/staff ratios by care facilities
- Staff/occupied bed ratios by care facilities

➡ On of our field-based mission findings on GIS was that a **referenced network of the Albanian roads** (with turns, times, speed restrictions, circulation directions and intersections) is not currently available. **Street network** is only available for main cities and it does not include key data such as turns, times, speed restrictions, circulation directions and intersections.

One of the GIS subcomponent's essential tasks will be to cope with this fact and try to **build up a road and street network categorized by types of road**. This critical basic layer will permit visualizing the length of each segment of the network. With this network and based on the assumption that each road type has an "average travel speed", it will be possible to build a network with segments average travel speeds. ➡ Accuracy and quality of the externally provided data for basic calculations could vary considerably. The accuracy of the delivered maps might be consequently affected.

### 7.3.- Alternative strategic options

**Six different "scenarios" with alternative options** will be developed. Each of these visual tools will facilitate assessment, discussions and decision making on the best strategic, tactical and logistics alternatives for healthcare policy.

### 7.4.- Map delivery formats

Two hard copies and a disk of all reports will be submitted in English language to the MoH.

## Printed maps

- All generated maps will be presented in a **printed edition for planning reports** including fully integrated images. In addition, a folder containing all maps will be presented in **A3 format prints**. Maps include a fringe containing the following **information**: date, project title, displayed information, applied data layers, map scale, author.
- All maps will include a **legend** explaining the meaning of used symbols, icons and the different colours for highlighting relevant information and quick visual interpretation.

## Electronic format maps

- All maps will be presented to the client **in IT format (CD, DVD, Pen Drive), in jpg. images format**.
- All maps will be submitted within **.mxd** file by **ArcGIS Desktop 9.3**. **Layout** map will be defined belong to MoH.
- In addition, all layer information will include **Shape format GIS files**. Deliverables include the **layer model, structured data, and all geo-referenced information used for map generation**.
- This will permit regenerating news maps using desired specific parameters, patrons and updated data. Each shape format layer will be composed of **seven files** with the following extensions: **.shx, .shp, .xml, .shp, .sbx, .sbn, .prj, and .dbf**.

 TA team must have **timely access to all complete and updated requested data in digital format as an essential requirement with out which GIS for this program could not be possibly developed**. This info will **provided by the Government of Albania** (MOH, HII, INSTAT, etc.) as discussed and agreed during our meetings in Tirana, and complemented by local subcontractors.

## 8.- Overview of medical equipment issues

### 8.1. General view

The rationalization of the secondary/hospital services in Albania will only be effective if the planned reconfiguration is accompanied by the delivery of a consistent and improved level of services to the population. This will need as already outlined above, training, as well as the re-allocation and re-alignment of resources and services, but it will also need a major investment in medical equipment.

Mention has already been made of surgical equipment such as that necessary for the increased use of ambulatory surgery, but what will also be needed is an assessment of the current state of “routine” surgical equipment, and the preparation of an inventory, and a list of requirements for replacements to allow an appropriate level of equipment to deliver the level of surgical services which will have been decided on – as referred to above – as appropriate.

Other key categories of equipment will also be inventoried and the needs identified, such as:-Laboratory/diagnostic technical equipment, e.g., auto analysers for all

laboratory disciplines, as well as microscopes, bench equipment etc.. In reference to the imaging/diagnostic equipment, the question of CT/MRI imaging has to be explored. This will be a policy decision for the MoH to take, since this is a major investment, but given geographical and transport difficulties for some areas of Albania, the question of a number of geographically appropriate Regional hospitals having such a facility will be examined.

Ward/polyclinic equipment, such as ECG machines and monitors, Blood Pressure measuring equipment, and the question – again a policy issue to be examined – of whether the reconfigured hospitals will have any “High Dependency” or Intensive Care units, and if so they will require their own dedicated range of equipment.

As will be clear from the above, the decision on some elements of equipment will need policy input from the MoH and the team will be working closely with the MoH to examine in detail these issues since although some equipment will be clearly essential whatever level of service the reconfigured units deliver, other items, including some major items will only be relevant if they are necessary to facilitate the service delivery. This project has at its heart cost effectiveness; to seek equipment which will not be used would vitiate that aim.

In simple terms, not every hospital will be equipped with the same range of updated equipment – this will be proposed on a hospital by hospital basis.

## **8.2.- The November 2009 Equipment Tender**

As mentioned before, the MoH has made the team aware that an equipment tender is due to be prepared for late November, and has asked the team for input for this.

This creates a challenge, since it is clear that not all the data will be fully available by that date, and the team’s stated aim is NOT a one size fits all approach, but a balanced and targeted rationalization plan. The team would therefore suggest the following course of action:

The definition of a “*Notional Hospital*’ equipment list:

This would involve the team producing an equipment list which would appropriately update a “Notional” Regional hospital across all its specialities, including diagnostic and therapeutic equipment, together with the necessary equipment for an appropriately sized ICU/High Dependency units and the purchase of equipment for the development of endoscopic/ambulatory surgery.

The team feel that this would deliver an appropriate and effective equipment list, the contents of which could easily be effectively used and dispersed across the regional hospitals, and in addition, this “notional” list could have a role as a template, both as a “shopping list” for the November 2009 tender, but also for future use.

In discussing the broad issue of equipment with the Technical Procurement Department of the MOH Hospital Division, the team outlined some new approaches to the issue of warranty and maintenance which are now current in EU and other countries. These approaches could assist to avoid the clearly identified and often reiterated problems related to failures of maintenance and consequently expensive equipment lying in hospitals, unused – and unusable - which were highlighted to the team, both in discussions within the Ministry, but also very clearly demonstrated to the team members who visited the hospital at Vlora.

An explanation of this new/current EU approach, with its key aims and benefits will be supplied, and more fully explained, by the team when they provide the “notional” hospital equipment list. Some general issues are already presented below.

### 8.3.- General issues on medical equipment investment

 ***The following special considerations regarding “equipment” have been included in this section of the IR, considering that the tasks to be completed for the November ‘09 tender must be underway immediately if we are to meet the MOH timeline. These ideas should assist counterparts to prepare for implementing equipment related activities starting in mid October 09.***

Medical equipment is an important component of modern health services. As said above, while adapting to the time constraints set by the client, the main purpose of this component will be to provide a list of essential medical equipment for regional hospitals, and to describe methodologies for selection of technologies, procurement, and management of the equipment and for training of the clinical staff and the maintenance technicians. All should be considered during the modernization/rationalization of equipments / medical technology for any effective hospital.

International trends show that major medical equipment is increasingly being deployed to enhance diagnostic and treatment capabilities in primary health care settings. At the same time major equipment such as x-ray, ultrasound units, surgical equipments, surgical instruments and laboratory auto-analyzers are reaching most regional hospital and the rate of deployment is accelerating.

On the other hand, the capabilities to manage and to maintain medical equipment in Albania remains weak as confirmed during our site visits and interviews, those capabilities being particularly serious in district and regional facilities. As in many other countries, the growth in capabilities to manage or maintain medical equipment falls behind the rate of deployment of equipment. The situation may easily run out of control and investment could become wasted while quality of care would suffer.

One of the main aims of the team is avoid this situation through a careful consideration of all the relevant parameters in any equipments / medical technology investment cycle (see figure1). A key aspect is to ensure health care equipment interventions are linked to health care delivery processes. At present, health care technologies are often seen as peripheral to health care delivery and subsequently receive little attention from health care planners. The recommendations for equipment management should be part of the plans.

This marginalization of health care equipment issues is likely to change over the next decade both because ongoing health care reform processes and also because of changes in the environments where medical equipment is operating such as: (a) increased litigation by the public due to the incorrect application or non-availability of medical equipment, and (b) an increasing trend towards diagnostic and therapeutic interventions using sophisticated equipment. This change means higher equipment content is included in health care delivery processes at all levels. In addition, health education, better access to information, improved communications are factors acting upon the community to act as a “demand vector” that is also pushing for the adaptation and improvement in health care equipment.

These considerations apply to investment both using national recourses or through donor's aid or international credits. To ensure that aid is optimized, the need should be clearly identified and mechanisms to ensure effective use of the investment should be implemented. Common findings in middle and low income economies still are both limited population coverage and limited quality of care due to poor techniques and sub-standard equipments and services. Despite the very limited resources available -or perhaps because of this- it is imperative health care is provided with full adherence to the principles of adequate quality and sound technology.

Our methodology makes sure that the planning and investment in equipment and medical technology takes into consideration that:

- ☞ Health care equipment should improve the quality of the delivered health care services to the maximum extent possible. All investment should be based on validated needs and implementation capacity.
  
- ☞ There should not be double standard in quality. If the quality of an item of equipment is not acceptable in the donor/provider country it's also unacceptable for Albania<sup>5</sup>.
  
- ☞ An appropriate selection of the technology must take into account (among other factors): specific health needs local characteristics and international good practices and guidelines.
  
- ☞ In order to guaranty the sustainability and the highest rate of effectiveness of medical technology through all its lifespan, the following general criteria should apply:
  - ⊕ Simplicity of operation.
  - ⊕ Minimal number of accessories required.
  - ⊕ Availability of operating supplies, at an affordable cost.
  - ⊕ Standardization.
  - ⊕ Low energy consumption.
  - ⊕ Not environmentally hazardous substances used.
  - ⊕ Easy maintenance.
  - ⊕ Existence of official/certificated maintenance network.
  - ⊕ Tolerance to hostile electrical and physical environment.
  
- ☞ The investment in equipments / medical technology requires to be part of an integral plan in order to guarantee:
  - ⊕ Readiness to absorb the technology.

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<sup>5</sup> Albania has established the National Centre for Quality Safety and Accreditation of Health Institutions (NCQSAHI) which has come to force on March 2006. HEALTH CARE AND LONG TERM CARE IN ALBANIA, Prof. Isuf Kalo & Prof Asc, V. Gusmari, Tirana 2007.

- ⊕ Availability of Human Resources to operate the new equipments /technology.
  - ⊕ A proper environment in the facilities (physical space, stable and good power supply (provided by the network or by UPS units), water supply, air conditioning, etc)
  - ⊕ Availability of consumables and spare parts.
  - ⊕ Availability of maintenance capabilities during all lifespan.
- ☞ Investment in equipments requires effective communication between all actors involved in the process (government, recipient authority, donors, and end-users).

## 8.4.- Definitions and general guidelines and criteria used in this component

### Essential medical equipments

Essential medical equipment means **basic equipment** needed for a specified health service delivery. The team will provide a general list of essential medical equipment. Users of the list should keep in mind before any decision regarding allocation that equipment is a tool for a particular service.

- ☞ One must first identify what services are delivered in a particular health facility before equipping that facility with appropriate equipment.
- ☞ One must first compare the inventory of functional equipments in a particular health facility with the list of essential equipments in order to avoid equipping redundancies.

### Selection of medical equipment:

The following factors must be included in the selection process:

- ☞ Specific **health services needs** are met by acquiring equipment.
- ☞ All **equipment needs** should be **identified and costed**, including **training** of end users and servicing staff, physical facilities renovation (if needed) and auxiliary supplies, such as water, electricity, air- conditioning, maintenance, protection and safety precautions for staff and patients.
- ☞ **Existence of spare parts** supply and **technical support** from the local agent or representative must be ensured in any way.
- ☞ With independence of the origin of the equipments the suppliers must provide both **operation and service manuals** in Albanian language.
- ☞ In evaluating tenders, quotations must be compared and evaluated, not only in terms of price and delivery time, but also in terms of availability and quality of back-up support, spare parts, technical staff and performance.
- ☞ The need to standardize must be considered so as to facilitate the ease of use and maintenance.

## Procurement of medical equipments

Planning and acquisition of medical equipment are initial phases of the **Life Cycle Management of Medical Equipment**. These phases must be carefully considered because they can greatly affect later use and maintenance of equipment.

### Technical specifications:

- ☞ Technical specifications have to be written in general, non-proprietary terms specifying the characteristics and performance expected from equipment.
- ☞ Generic specifications provide all manufacturers an equal chance to bid in a call for tender making possible free competition and transparency.
- ☞ Where a poor procurement practice simply uses specifications describing brands available in the market, equipment procured may not correspond precisely to local health care needs. In addition, equipment may cost more than it should due to lack of competition. This poor practice is strictly forbidden by all international donors and development agencies as well as for EC countries.
- ☞ Procurement of equipment using funds from multilateral organizations normally requires Intentional Open Tenders (IOT) or Local Open Tenders (LOT). The decision regarding which procedure to apply is made base on the ceiling stated in such different procedures.
- ☞ Objective performance indicators, monitoring and reporting procedures are highly recommended to be part of the Technical Specification and contracts in order to link payments with performances.

## Management of medical equipments

Medical equipment brings along with its benefits, associated problems. In several low-mid income economies such as Albania, the most common and relevant problems are:

- ☞ Maintenance: **lack of maintenance and spare parts** renders non-functional an enormous amount of medical equipment.
- ☞ Training; Lack of training for end users and maintenance technician.
- ☞ Contracting and payments: In many countries these tools are not yet properly used to enforce effectiveness. The team also found that this is the current situation in Albania; this situation has been also described in some reports by local experts. "...*Current systems of paying providers, and especially hospitals, do not encourage cost containment nor provide incentives for better performance. It is these systems that are, in part, responsible for the efficiency problems.*"<sup>6</sup>

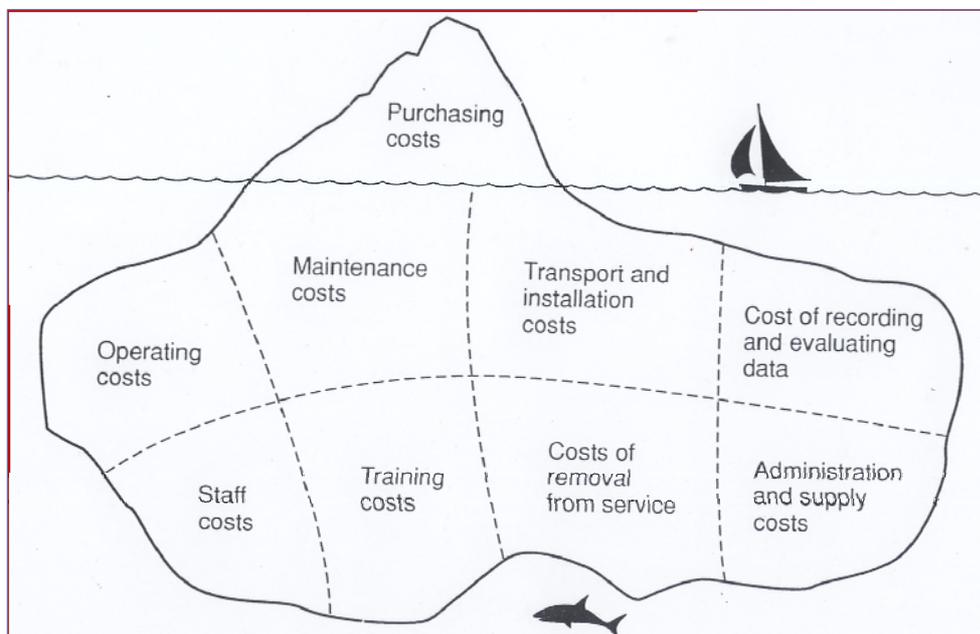
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<sup>6</sup> HEALTH CARE AND LONG TERM CARE IN ALBANIA, By Prof. Isuf Kalo & Prof Asc, V. Gusmari

Training of engineers/technicians and the supply of spare parts are often cited as solutions to the problem. However, shortcomings at different stages of the equipment life cycle can greatly complicate the maintenance problem.

- ✓ If maintenance and training capabilities are considered during the initial stage of making a decision to acquire equipment, maintenance problems can be minimized.
- ✓ There are different tendering, contracting, supervision, reporting and payments methodologies of proved value in minimizing the above underlined problems.

For a comprehensive and more effective system in managing medical equipment, the life –cycle approach should be used. It is strongly recommended to look at the different stages (phases) of the equipment life cycle, and how to manage each stage for better results:



It's a common planning mistake to look only at the tip. This is a **recipe for disaster**

Iceberg syndrome of Life-cycle cost for healthcare technology.

### 8.5.- Essential medical equipments for regional hospitals

As said above, the MoH has made the team aware that an equipment tender is due to be prepared soon, its estimate for late November, and has asked the team for its general and generic input.

We already discussed the challenge the demand creates since it is clear that not all the data will be fully available by that date, and the team's stated aim is **NOT a one size fits all approach**, but a balanced and targeted rationalization plan. As a consequence, the team's proposal described so far can be summarised in the following graph and table:

**Table 1 Options to considered**

OPTIONS	DESCRIPTION	COMMENTS
<b>OPTION 1</b> Priorities set up base on services.	Based on the general list, organized by clinical services, the MoH could equip as many <b>hospitals services</b> as possible for upgrading <b>top priority services</b> , all across the hospital network. There could be several hospitals which will receive updated equipments for those services on top of the <b>services priority list</b> .	<ul style="list-style-type: none"> <li>✓ Many hospitals will benefit at the same time of improvement for <b>highly prioritized services</b>.</li> <li>☞ Full equipment of the hospital network will require as many "rounds" as dictated by the resources available.</li> </ul>
<b>OPTION 2</b> Priorities set up base on hospitals.	Based on the general list, organized by clinical services, the MoH could <b>fully equip</b> as many hospitals as possible with the equipment needed for top priority hospital. First upgrade hospital will be the one on top of the hospital priority list.	<ul style="list-style-type: none"> <li>✓ One or a few hospitals will benefice, step by step, of improvement for <b>highly prioritized hospitals</b>.</li> <li>☞ Full equipment of the hospital network will require as many "rounds" as dictated by the resources available.</li> </ul>
<b>OPTION 3</b>	A combination of OPTIONS 1 &2.	A combination of OPTIONS 1 &2.



**For final suggestions about the more convenient strategies additional data, information and discussion with the MoH and the others stakeholders will be needed. This is only a picture of possible options scenario.**

**OPTION 1**



**OPTION 2**



The team feels OPTION 1 would deliver equipment which could easily be effectively used and dispersed across the hospitals, and OPTION 2, would allow a “notional” list to have a role as a template, both as a “shopping list” for the next tender, but also for future use.

Either of these options would assist the MoH in developing its tender, and at the same time not compromise the team’s firm wish to avoid a “one size fits all” approach. The second option would in fact also allow the team to use this “Notional hospital” equipment list as a template against which to check current assets/resources and identified needs across the hospital system.

In discussing the broad issue of equipment with the technical procurement department of the hospital division of the MoH, the team outlined some new approaches to the **issues of warranty, maintenance and contracting**<sup>7</sup> which are now current in EU and other countries which could assist with the clearly identified and often reiterated problems which were highlighted to the team, and an explanation of this new/current EU approach, with its key aims and benefits will be supplied by the team when they provide the “notional” hospital equipment list<sup>8</sup>.

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<sup>7</sup> Also, while the contracts between healthcare institutions and health insurance funds may require reports on performance, there are typically no penalties associated with poor performance, and hence no accountability. HEALTH CARE AND LONG TERM CARE IN ALBANIA, By Prof. Isuf Kalo & Prof Asc, V. Gusmari.

<sup>8</sup> The provision of a piece of equipment represents the introduction of technology into the existing health care environment. To make the introduction of the technology successful, a number of activities must be conducted in addition to the purchase of hardware. Such activities include: staff training, consumables supply, contracting and payment (including penalties or bonus directly linked to performance) maintenance and development of safety procedures. All of them are of major importance and must be taken into consideration. Recommendations regarding all these issues will be provided.