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WORLD BANK

**TECHNICAL ASSISTANCE FOR CAPACITY
BUILDING ON CONTRACTING AND PAYMENT
METHODS**

Project ID No P082814

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FINAL REPORT



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ABBREVIATIONS

ABC-studies	Activity-Based Costing studies
BBP	Basic Benefit Package
DRGs	Diagnosis Related Groups
FFS	Fee for service
GoA	Government of Albania
GP	General Practitioner
HII	(National) Health Insurance Institute
IPH	Institute of Public Health
ICD	International Classification of Diseases
IPH	Institute of Public Health
IR	Inception Report
JWG	Joint Working Group
LSMS	Living Standards Measurement Study
LTSHSD	Long-Term Strategy for Health System Development
MoH	Ministry of Health
MoF	Ministry of Finance
OECD	Organization of Economic Cooperation and Development
PHC	Primary Health Care
PPP	Public-Private Partnership
SHC	Secondary Health Care
TA	Technical Assistance
TNA	Training Needs Assessment
ToR	Terms of Reference
TRHA	Tirana Regional Health Authority
WB	World Bank
WHO	World Health Organization

1. EXECUTIVE SUMMARY

The preparation of the current final report (FR) had been proposed in the technical offer of the Consultant with the aim to summarize the results achieved during project implementation in carrying out the tasks as these were specified in the Terms of References (ToR). The Technical Assistance (TA) project can look back to very fruitful and intensive operations with all parties involved in the health financing reform. The FR includes a project synopsis with the main objectives and tasks of the consultancy followed by the presentation of the key elements of the outputs 1-5 delivered by the project according to the plan. It should be emphasized that the Joint Working Group (JWG) with participants of the HII proved to be the main driving force of the project implementation and has clearly demonstrated the enthusiasm and commitment of all members to make maximum use of the TA project and advance the measures already taken by the HII in the area of health care financing and control. Great emphasis has been put throughout the project implementation in documenting the results of the JWG meetings.

The Output 1 of the project the 'Strategy on Financing and Contracting of Health Care Providers & Implementation Plan' was submitted during the Inception phase (December 2007) while Output 2 & 3 'Development of qualification programs and Preliminary assessment of existing staff capabilities' was submitted in a revised version in April 2008. They were followed by Output 4 'Training Manuals' and Output 5 'Case studies and analysis of international experience' (June 2008).

The FR also includes a draft programme for a study tour (Romania) as requested in the ToR (Task 7). A final performance plan is attached as Appendix to the FR.

It is expected that the FR will be used by the beneficiaries and in particular by the HII as a reference document to the detailed material developed under each outputs where recommendations for all administrative levels of the Albanian health care system related to contracting and payment systems have also been included. Moreover, high emphasis was put by the project team to detail as much as possible the relations between the strategy for contracting and payments (output 1) and the training material developed under the project (output 4) based on the assessment of existing staff capabilities (output 2&3).

Implementation of the recommendations made by the TA project depend on specific assumptions, that include the following: (1) the commitment to changing care provider payment methods being more important than accuracy of the data entry; (2) staff of MoH and the HII will be actively involved in the planning and execution of the new provider payment methods and (3) emphasis on improvement of incentives for existing health care providers than on changes of their ownership, despite the fact that other forms of organization (including privatization) may also be considered as complementary procedures. Another crucial assumption is the approval of the Draft Mandatory Health Insurance Law in the version of February 2008 as this includes the introduction of key elements such as the pooling of resources, the introduction of co-payments, the introduction of performance-based-payment systems, etc.

The project team of Conseil Sante would like to express its gratitude to all parties that have contributed to the successful preparation and implementation of the project and in particular the realization of training courses in which approx. 400 participants from all main levels of administration and delivery on health care services in Albania received a 2 days training in topics related to contracting, payment systems and

costing for PHC and SHC. It is envisaged that the approach and the material used for this course will serve as a model for the preparation of further training activities mostly by the HR Department of HII, which is playing a leading role in the field of capacity building.

2. PROJECT SYNOPSIS

2.1 OBJECTIVES AND TASKS OF THE CONSULTANCY

The World Bank project “Technical Assistance for Capacity Building on Contracting and Payment Methods” officially started on 4th July 2008. The overall objective of the project is to:

1. To improve both the physical and financial access to and the actual use of high quality primary health care services, with an emphasis on those in poor and underserved areas as well as to diminish the unnecessary use of secondary and tertiary care facilities
2. To increase the effectiveness of the MoH and HII in formulating and implementing reforms in provider payments and health system performance, and
3. To improve governance and management in the hospital sector.

Objectives of the Consultancy

Within this framework, the objectives of the Consultant (as per ToR) are:

To work in the development of payment and contracting methods, which are compatible with the needs of a single payer and autonomous institutions, and the dissemination of such methods to providers and payers of healthcare services. The consultant will also assess the Client in the definition of study tours abroad and other relevant training programs in selected countries.

Tasks of the Consultancy

The tasks of the consultancy (as per ToR) are:

1. “Development of methods of payment and contracting considering a single payer model and the Albanian context, including the development and/or refinement of appropriate approaches for primary health care, hospitals (including in-patient, out-patient and emergency care) and prehospital emergency services.
2. Development of implementation strategies and plans to facilitate the smooth implementation of such revised payment and contracting methods, including estimated resource and time requirements and phasing to begin utilizing the revised methods in the shortest possible time.
3. Preparation of the study program for the use and further refinement of such provider payment approaches, including a preliminary assessment of existing capabilities among both MoH and HII staff.
4. Implementation of training courses and workshops for trainers and health providers on payment mechanisms, contracting, administration, finances, costing of hospital services and related issues. This would include the development of workshops for the qualification of the health services providers and implementation of courses for trainers dealing with the qualification of the staff, the preparation of training courses for building-up, making functional, administration and finances of the providers. This activity would need to be coordinated with the broader hospital and PHC management training activities under this project.
5. Elaboration of case studies based on best-practices and international experiences.
6. Preparation of the training calendar and training location;
7. Preparation of training program abroad.

2.2 PROJECT MILESTONES

The project milestones / deliverables are summarized below:

INCEPTION PHASE

Updated project work-plan 1

IMPLEMENTATION PHASE

Report on Payment and Contracting methodologies, including recommendations for implementation (**Output A1**)

Report on Qualifications Program (**Output A2**)

Report on Assessment of Staff Capabilities (**Output A3**)

Training Manuals (**Output A4**)

Case studies and analysis of international experience (**Output A5**)

Final Report

2.3 ACHIEVEMENTS

Since the start of the project, national and international experts were very much involved in different activities. They have closely collaborated with the local counterparts, in particular with the members of the Joint Working Group (JWG) at the Health Insurance Institute. The JWG discussed all project proposals, mostly those included in the project outputs and has also operated as a link between the project, the regional offices of HII and the Health Centres (HCs). Its members have demonstrated enthusiasm and commitment to make maximum use of the TA project and advance the measures already taken by the HII in the area of health care financing and control. Great emphasis has been put throughout the project implementation in documenting the results of the JWG meetings.

Please, refer to Appendix 2 for the members of the JWG.

Thanks to this collaboration, the technical assistance team delivered the 5 required outputs:

Development of a strategy and recommendations:

At the project start, a strategy paper on Payment and Contracting methodologies (output 1) has been developed, and has underlined 24 visions and recommendations for the Albanian Context.

Assessment of the Albanian needs:

The output 2 “Qualification program”, defined the institutional capacity and staff competencies needed to implement the provider payment methods, based on the first output.

Moreover, the team assessed the existing capabilities in order to identify the gaps and define a relevant training program (output 3).

Capacity building

Based on this assessment, 5 training manuals on key aspects of Social Health Insurance, Payment systems, Contracting arrangements, Costing methods and Monitoring and Evaluation were developed. The Training manuals (output 4) were distributed in English and Albanian version to the participants. Moreover, several case-studies (output 5) were submitted to the trainees for a more concrete approach.

Four levels of training sessions have been organised, in Tirana and in the regions with 410 participants:

- 18 persons for a two-days workshop 4-5 March 2008 in Tirana with participants from HII, MoH and IPH.
- 12 persons for a two-days training 15-16 April 2008 (ToT) in Tirana with participants from HII, MoH and IPH.
- 85 persons for two-days training 6-7 May 2008 in Tirana with participants from the regions of Tirana, Kukes and Tropoja.
- 71 persons for two-days training 9-10 May 2008 in Durres with participants from the regions of Durres, and Fier.
- 63 persons for two-days training 13-14 May 2008 in Vlora with participants from the regions of Vlora, Gjirokastra, and Berat.
- 75 persons for two-days training 15-16 May 2008 in Durres with participants from the regions of Shkodra, Dibra, and Lezha.
- 72 persons for two-days training 20-21 May 2008 in Elbasan with participants from the regions of Elbasan and Korca.
- 16 persons for one day workshop 1 August 2008 in Tirana with participants from HII and MoH.

During training sessions, modern training methodologies were also introduced. Evaluation forms were reviewed and analysed. In general, the results have been very positive (see point 3.2.8 “Interview through structured questionnaires” and point 3.3.2 “Highlights of the training evaluation”).

Recommendations

Throughout the project, the experts have tried to identify relevant options in order to improve Albanian capacities in the area of contracting and payment methods. The final report includes a proposal of study tour in Romania.

3. ACTIVITIES AND OUTPUTS DELIVERED DURING THE PROJECT

This chapter gives an overview of the activities undertaken during the project. It is organized following the 5 main outputs delivered.

3.1 OUTPUT 1 'PROVIDER PAYMENT AND CONTRACTING STRATEGY IN ALBANIA - A LONG TERM VISION AND IMPLEMENTATION PLAN'

3.1.1 Key Issues in relation to output 1

The thorough revision of the provider payment system in Albania is the highest priority and in order to demonstrate progress the following key issues were used by the project as a basis for the development of the strategy for contracting and payment mechanisms.

1. Pooling of all public sector resources under one funding agency;
2. General taxation (and complementary on payroll tax contributions) as basic source of public funding for health care;
3. Clear definition of health care benefits and introduction of co-payments (also with the aim to eliminate informal payments) for a wider range of services, including in-patient care;
4. Gradual introduction of a population-based regional funding allocation;
5. Balanced public and private spending on health care overtime;
6. Input-based financing of healthcare providers based on performance based payments;
7. Clear roles and responsibilities of all core actors in the sector and establish accountability mechanisms;

This Chapter summarizes the recommendations developed under Output 1 in the form of 24 visions.

3.1.2 24 VISIONS & RECOMMENDATIONS

Vision 1: A universal health financing system that addresses the health needs of the Albanian population and that is based on equity

To ensure universality and financial accessibility, all citizens should contribute to and be included in the health care system based on their ability to pay. This means that the individual contribution is higher for people with higher personal income, and that access to a minimum level of health services should be guaranteed for those who have limited or no ability to financially contribute to the system: the poor and some socially vulnerable groups.

The main obstacle for the establishment of a universal and equitable health financing system in Albania is the low level of population participation to the health financing system through pre-paid channels, be it general or income taxation, insurance premiums etc. This causes an absolute lack of funds, unmet health needs and a dependence on direct or informal payments, which are detrimental to equity.

Therefore, the main policy aims of the Government should be to increase public sector funding for the health sector and to increase the participation rate to pre-paid insurance mechanisms.

Vision 2: Increased public sector financing for the health sector through strengthening of the pre-paid social health insurance scheme funded mainly by taxation sources

In countries with a relatively low per capita income and substantial poverty incidence, such as Albania, even expenditures for relatively low cost interventions can result in catastrophic expenditures for low-income households. This is clearly the case in Albania, as the total costs of an out-patient visit amounts to approximately 0.5 times, and the average hospital episode even to approximately 4 times the average monthly income of the lowest quintile ¹.

Therefore, financial protection from impoverishment through health shocks and the desire of most societies to ensure equity in access to health care make pre-payment for health care and pooling of these prepaid funds an essential instrument of protection against health shocks. Typically, these pre-paid funds are pooled by a third party which then purchases a set bundle of health services on behalf of the population which has made pre-payments. Insurance against the risk of health shocks does not necessarily require that individuals pay direct contributions to a health insurance organization. Pre-payment for health care and the pooling of funds can also occur through taxation mechanisms. The concept of insurance simply implies that the population is provided with financial protection from health shocks with pre-paid and pooled funds.

In health care systems where the funding comes from general taxation or income taxation, pre-payment occurs at the time of payment of (non-) earmarked tax revenues to the government. In Albania it does not make sense to develop a new and separate financial flow solely for the health sector away from current tax and social insurance collection mechanisms, e.g. by making the health insurance institute responsible for the collection of the ear-marked payroll taxes. It would only raise transaction and administration costs and divert the attention of the health insurance institute's limited capacities away from its most important functions of pooling funds, designing the benefit package and paying & contracting of providers.

Vision 3: Pooling of public sector resources: general taxation and payroll taxes, under one funding agency: the Health Insurance Institute

Albania should strive to put all public sector funding for health care in a single pool, with the exception of financing for certain public health interventions provided by the Institute of Public Health and its local affiliates. The main purpose of pooling health care funds is to increase the redistributive potential of the health financing system to enhance equity in financing and equity in access to services irrespective of the geographical location or socioeconomic status of the individuals in need. The broader the pools are, the easier it will be to rearrange the flow of funds to meet these objectives.

Therefore, it is important that financing from all sources and for all services would be pooled and would flow to the provider through the same purchaser. The current

¹ See World Bank, Albania Poverty Assessment, 2003.

system of fragmented payments, particularly for primary care, creates inequities in access as well as in quality of care.

It is recommended that Albania maintains a health financing system which on the public funding side relies largely on general taxation rather than an increase in payroll taxes and a concomitant decrease in general revenue financing. To date, over 90% of public sector spending comes from general taxation, with the remainder coming from non-budgetary payroll tax contributions to HII. Only one-third of the active labor force participates in what is by law a mandatory health insurance scheme, suggesting large contribution evasion. In this context, continued reliance on general taxation (but with an increase in current rates of payroll taxes as proposed by the Draft Law on Health Insurance Fund), is advisable as it:

- promotes equity
- avoids creation of incentives for individual non-participation in the scheme and adverse selection
- avoids creation of incentives for population groups to seek exemptions for participating in the scheme

In addition, countries, which have relied more on general taxation rather than payroll tax contributions have tended to face less steep increases in health care expenditures than those that have relied on contribution, based insurance schemes.²

Vision 4: A universal Basic Benefit Package to cover for a positive list of essential and high-value-for money health services

No country can afford to cover all types of services through compulsory and universal insurance. It is therefore necessary to ration – to restrict coverage under insurance in one way or another. The best approach involves formal and transparent rationing on the basis of value for money. In other words, services available to members of the insurance scheme should be selected according to the ratio of cost to health benefit.

A few countries choose to cover only services that are low-cost. They argue that it is too expensive to cover services like cardiac surgery or organ transplants even if they are effective forms of care. This is a weak approach, since some high-cost services are life saving or otherwise provide large health gains.

In contrast, some countries have insurance that only covers services that are high-cost, on the grounds that people can pay for low-cost services themselves. This is a dangerous idea, because many low-cost services (such as childhood immunisations) are of high value. If people had to pay for immunisations themselves, many poor people might decide not to incur the cost – and this would do harm to many children. It follows that cost is hardly relevant by itself. The only logical approach is selection of services on the basis of the ratio of service costs to health benefits.

In Albania, there is no formal process for assessing value for money, and there is not yet a form of formal rationing of services as, by law, health care is still largely free of charge with co-payments allowed in a number of defined areas. As a consequence, service availability is not always correlated with value for money: some services of high cost and relatively low value are covered (e.g. dialysis), whereas there are

² See, for example, OECD, Health Care Systems – Lessons from the Reform Experience, OECD Health Working Paper 3, 2003

shortfalls in the coverage of some high-value services, such as ante-natal care and child dental care.

It is widely accepted that value must be estimated in a scientific and publicly visible way. In general, it is necessary to use a global measure of health gains, like the quality-adjusted life-year or the disability-adjusted life-year. In this case, it becomes possible to ensure that services like childhood immunisations, first visits to GPs and ante-natal care are covered 100% by the insurance scheme because they are high value-for-money, and that low value-for-money services are offered with a high co-payment rate.

Albania needs to have goals in this regard. For example, it would be sensible to decide that, in the next decade, cost per QALY (or a similar measure) has been estimated for all the major types of health care services (and other services where there are differences of opinion about whether they should be covered). The community at large should be routinely informed of the estimates (and consequent decisions to include or exclude services) and invited to make comments.

Furthermore, we suggest that in Albania decisions are largely made by the government, and that there is a formal and transparent way of rationing on the basis of value for money. Therefore, we recommend the Ministry of Health to establish a kind of statutory Benefit Package or Health Insurance Committee, which exists in many countries. The task of this Committee would be to review service provision in Albania on the basis of value for money and – within the current legal framework - define the levels of co-payment (0-100%) for each service).

Vision 5: A co-payment scheme for people who do not take health insurance, and for people who seek non-emergency secondary/tertiary health care services without referral from a general practitioner / family practitioner.

The World Bank (2005) advises that, to ensure greater transparency in the provider system, formal co-payments should be introduced for a wider range of health care services, including in-patient care. The introduction of a wider range of co-payments, however, would need to be coupled with efforts to address the issue of informal payments. The objective should not be to increase the overall volume of out-of-pocket payments, which is already high, but to replace, as much as possible, informal payments with formal payments. The development of the co-payment system should be linked to the definition of the benefits package that will be made available to the population with public funding.

The main advantages of co-payments are that the burden on the insurance scheme is reduced, and some of the demand is diverted: some patients will decide not to ask for a drug, diagnostic or treatment, because they cannot afford the co-payment. There are also some disadvantages, when for example the patients chose not to ask for the drug. Perhaps the drug was needed, but the patient chose not to ask for it because of the cost. Co-payments are no problem for wealthy people, and consequently they will get more and better health care than the poor. Moreover, the co-payments add up, when a person has a chronic illness. Another disadvantage is that the poor patient who chooses not to have the drug might become even more ill as a consequence of not getting early treatment. Therefore the overall efficiency of the health care system is reduced: there is more ill health and more costly treatment in the long run. Finally, co-payments add to the administrative cost of health care. The payments have to be made and accounted for, and there will have to be auditing processes.

As noted above, co-payments should apply only to services that are of low value for money. No single formula for co-payments will be suitable for all types of patients and all types of services. Different kinds of methods need to be applied, depending on the circumstances.³ In determining the type of co-payment it is necessary to take account of value for money, what kind of people (rich or poor, young or old, etc) need the service, and what kind of health problem exists (acute or chronic, life-threatening or not, etc). The best-designed system will use a carefully selected mix of co-payment models.

We recommend that Albanian citizens who pay the statutory health insurance contribution as part of the payroll tax should have the right to a benefit package offered largely free of charge (without co-payments or co-payments only for low-value-for-money services). To discourage the free-rider behaviour of people, we recommend that, with the exception of some vulnerable groups who are unable to pay, people who do not pay their health insurance contribution should be subject to a larger co-payments scheme. However, this should not lead to the underutilization of essential and cost-effective care, particularly preventive and primary health care, even if people are not insured. This would mean that preventive health care would largely be excluded from co-payments.

The co-payment strategy should also encourage people to seek health care at the adequate provider level. This means that the co-payment strategy should encourage people to go to the general practitioner / family practitioner for a non-emergency first contact visit, while discouraging the behaviour to seek care at the highest possible level (hospital) for first contact and/or non-emergency purposes. This means that first contact visits of a general practitioner / family practitioner should be excluded from co-payments, while hefty co-payments should be introduced for non-emergency first contact visits at higher levels of care.

It is crucial that mechanisms would need to be put in place to mitigate the impact of the out-of-pocket payments for low-income groups. One possibility might be to exempt the lowest income groups from co-payments for a given package of services by giving them a health card which entitles them to co-payment exemptions. The high poverty impact of out-of-pocket expenditures for outpatient care suggests that the lowest income groups should be exempt from co-payments at the primary care level and also accorded with limited drugs benefits. Furthermore, while the poverty impact from hospital expenditures is lower due to the rare occurrence of hospitalization, hospital expenditures have highly catastrophic proportions for low-income households. Therefore, the benefits package for low-income households should also include limits on co-payments for a defined bundle of hospital care for lower income groups. Another option might be to regionally target co-payment exemptions for core services (e.g., primary care and limited drugs benefits, maternal and child health services in mountainous regions).

Co-payment strategy should be linked to measures to stop informal payments

The introduction of formal co-payments would need to be linked to efforts to address the issue of informal payments, as proposed under vision 9.

³ See also recommendations in chapter 6 under output 5 regarding the case studies, in particular the details on introduction of a fee for service.

A decision would need to be taken on whether co-payments will remain the property of the provider or whether they will be returned to the HII. In either case, the provider should be required to account for all revenues and report to the HII on all revenues raised. In general and from a public health point of view, in the long run it is always better to pool resources at the highest level, meaning at the HII. However, in the short term there may be transitional benefits in allowing at least part of the 'ownership' of co-payment resources at the provider level, for example in an attempt to raise salaries in combination with other measures to stop informal payments.

Vision 6: Co-payments should be decided centrally on the basis of a uniform service and price list developed and updated under the auspices of the Government

One element of concern in the current Albanian setting is the fact that there is no national co-payment strategy and, as a consequence, discussions and decisions in the public system on introduction of co-payments and their price levels are being done at the level of individual health facilities, most notably in some hospitals. In a well-managed health system this is not the level where such discussions should take place, as it promotes in-transparency and possible inequities for Albanian citizens. For example, in this scenario it is possible that person A who lives in Durres would pay for a certain laboratory or diagnostic procedure while person B living in Shkodra would receive this service free of charge, while both would pay the same taxes and have the same legal rights to health care.

Therefore, we recommend to establish the Committee for Benefits Package or Health Insurance Committee under the auspices of the Government (see vision 4) who would have the task to either advise the Government on all issues concerning benefits package and co-payments (Government decides) or as a (semi-) autonomous decision-making body within the health (insurance) system.

Vision 7: Optional additional or private insurance for health care services outside the benefits package, for increased consumer choice, and/or for coverage of health care services supplied by health care providers that do not have a contract with the Health Insurance Institute, is allowed under tight Government control

There are several options with regard to services covered by optional additional insurance. In Albania, we recommend that optional additional insurance could be allowed in the future in 2 market segments:

1. For people who pay their health compulsory insurance contributions: to cover co-payments for services and/or amenities (e.g. better hospital accommodation etc.) that are included in the compulsory basic benefit package scheme. This scheme could be offered by the HII as additional insurance.
2. For people who pay their compulsory insurance contributions: to cover for low-value-for money services outside the benefits package and/or for insurance coverage for health services offered by private providers or providers outside Albania. This scheme should be left to the market as private insurance.

However, measures must be taken to ensure that optional additional insurance does not create inequities within the compulsory scheme, e.g. by allowing more choice of doctor within the public scheme, or more rapid access to services covered by the compulsory scheme. By this, we mean optional insurance should be available only to the extent that the government considers useful. It is restricted to services not

covered by the compulsory insurance and does not compete with the compulsory insurance. It should apply only to a small proportion of health care services. Governments that adopt this strategy are motivated by the view that its main goal is the well-being of the entire population. Optional additional insurance is justified only if it contributes to society as a whole. It is not justified if it only provides benefits to the people who can afford and choose to pay more.

Vision 8: Informal payments are illegal and will be routed-out

According to the World Bank Health Sector Note (2005) and surveys in the country, informal payments account for a relatively modest share (6-7 percent) of out-of-pocket expenditures for outpatient care, but for at least one-quarter to 40 percent of in-patient care payments⁴. Overall, about 30 percent of those seeking outpatient care report making informal payments, but almost 60 percent of those seeking in-patient care state that they made a “gift.” It is likely that the share of those paying informally for hospital care is even higher, as at least a part of reported treatment costs may also be informal payments (LSMS 2002). Informal payments for hospital care create a significant burden on low-income groups seeking care, amounting to over 100 percent of the monthly per capita consumption of households in the lowest income groups. Because they are not known in advance, the uncertainty surrounding informal payments creates a significant additional burden on those seeking care in hospitals. Furthermore, as these payments do not go to the providing institution, they are not subject to the policy and managerial controls of the health system and are a major source of lack of transparency.

The system of informal payments is certainly encouraged by an unclear co-payments policy, which often blurs the distinction between formal and informal payments. Without tackling the problem of informal payments, it will be very difficult to attain the Government’s goals to change the provider payment system by inducing providers to attain higher efficiency and improved performance.

We recommend that the introduction of formal co-payments would need to be linked to efforts to address the issue of informal payments, particularly in the hospital sector, so as to ensure that co-payments would not result in an additional burden on those seeking care. Such efforts might include aggressive information campaigns that would inform the population about the changes, their entitlements and their obligations and the rationale for those measures, introduction of grievance mechanisms for patients and distinct efforts by the provider managers and the HII as their main purchaser to take action upon the receipt of complaints. Collection of co-payments should be linked to improved remuneration of health workers, and this linkage and the new expectations be clearly explained to them.

Vision 9: Health spending is capped by the Government, in close consultation with the community

It is essential that the amount of money spent on health is an informed decision involving the community, rather than determined by the ability of care providers to find

⁴ Reported informal payments based on the LSMS amount to 26 percent of in-patient care. However, it is quite likely that a share of the 41 percent reported as treatment costs also constitutes informal payments, when one considers that hospital treatment is in principle free of charge. A PHR+ survey in Berat, Fier, Kucova found similar results for primary care (informal payments = 7 percent of the total out-of-pocket expenditures) but showed that patients reported paying almost 40 percent in informal payments for in-patient care (Hotchkiss et.al., 2004).

additional opportunities to deliver services. There is no obviously correct answer (such as 6 or 8% of GDP). There is only an informed answer, which means that the level reflects what the community at large has judged best for them.

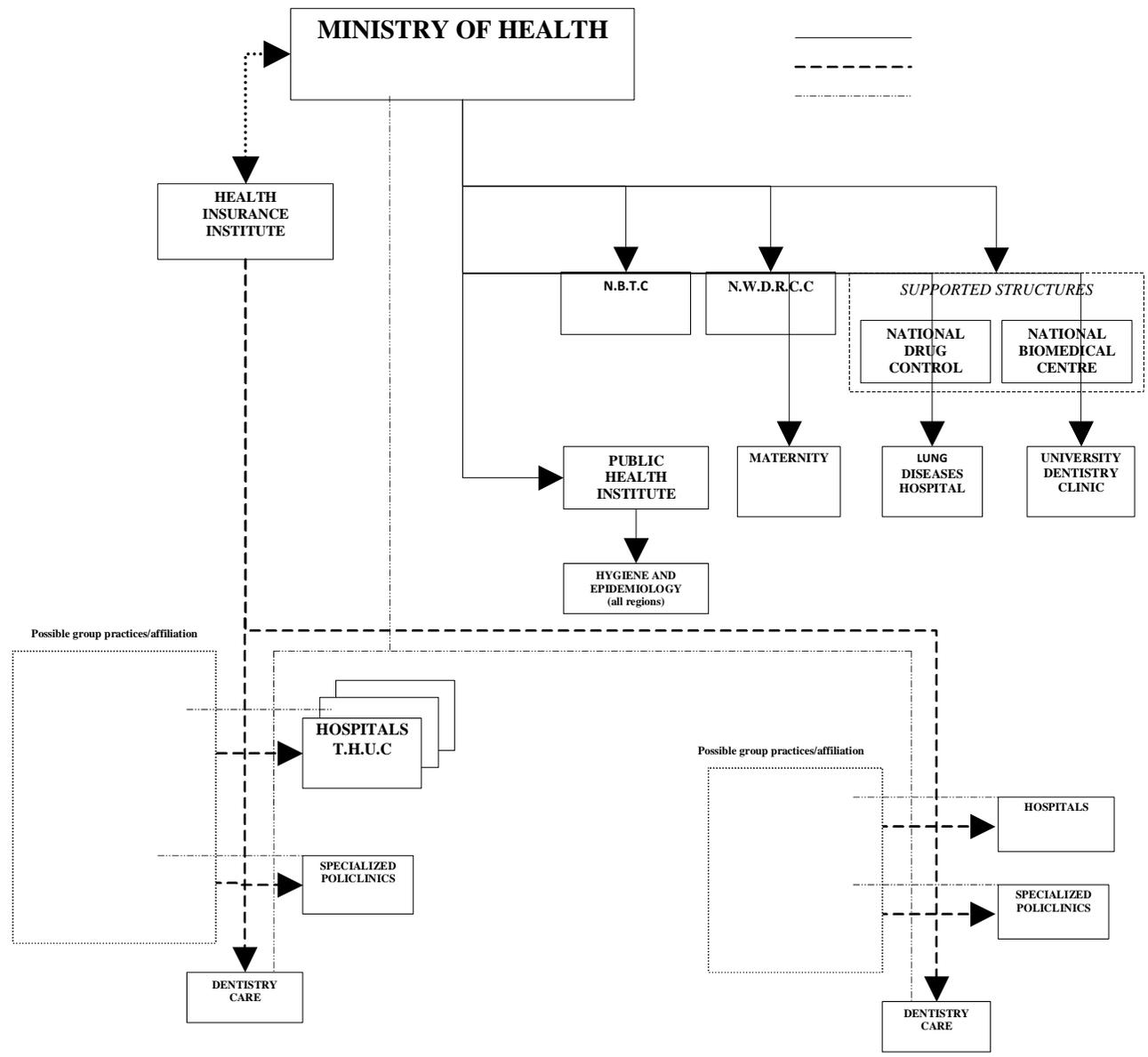
Capping may be achieved in several ways. At one extreme, only total payments are specified. At the other, many caps are specified on the volumes of specific types of health care. It is usually better to define caps on components of the health care system. We believe it is clearly better to rely on the government to take note of the community's views, than to depend on the individual interests of major employers. With the growing of the Albanian economy, on the basis of international scientific evidence one may expect significant increases in health spending in absolute terms and as a percentage of GDP in the coming decade. It is important that the Government is able to steer this process, and can take informed decisions and effective measures to ensure sound investments in infrastructure and therapies, balanced growth of the public and private sector, justifiable increases in salary levels, and increased accessibility and coverage of essential health services in a financially sustainable manner. This cannot be done without National Health Accounts, which we recommend the Government to produce on an annual basis.

Vision 10: Further strengthening of the social health insurance mechanism with the decentralized purchaser-provider split as main contractual model

The World Bank's Health Sector Note (2005) has extensively described several types of contractual models and analysed the merits and shortcomings. The main models are:

- Decentralized Purchaser-Provider Model
- Regional Health Authority Structure
- A Hybrid between both models

The regional health authority structure – as was piloted in the Tirana region - is associated with a number of system problems, such as the lack of proper managers and planners, the extra bureaucracy and administrative costs, and the increased complexity and lack of transparency. In combination with the Government policy of strengthening social health insurance and in line with some recent developments in Albania, for example the introduction of contracts between the HII and the Health Centers as well as the Durres hospital in 2007, we recommend to further strengthen the social health insurance mechanisms with a decentralized purchaser-provider split as the main contractual model in the country (see below).



Decentralized Purchaser - Provider Model (source: World Bank, 2005)

Vision 11: The Health Insurance Institute of Albania assumes full responsibility for payment of healthcare providers for a defined set of services at an established price

The Government's long-term health sector strategy entails substantial changes in the roles and responsibilities of various actors in the sector. The MoH would assume a policymaking and stewardship role and increasingly withdraw from service provision and financing of health care. The HII would assume full responsibility for financing of health care, channelling the Government's health budget to health care providers (all levels) by contracting them to offer a defined set of services to the population against an established price.

This means that the role of the HII will overtime change from being de facto now a payment office of healthcare providers on the basis of input standards and norms to becoming a strategic purchaser that pays on the basis of outputs and that contracts on the basis of needs and cost-effectiveness standards. This strategic vision immediately requires the need to:

- Define outputs in terms of episodes of patient care
- Get more information on health and healthcare needs
- Develop standards of care
- Get insight into costs

Albania's health sector strategy also describes that this would mean „including selected private providers in a mixed market under clear regulatory conditions“, thus promoting some degree of competition among public and private providers in a mixed market scheme.

As the major task in Albania is to upgrade the quality and performance of public sector providers, we recommend indeed to be cautious with this approach, and only allow and/or stimulate this type of arrangements in some market segments at the primary care level, such as general practice/family medicine, dentistry, ophthalmology, pharmacies. We recommend against the development of direct HII contracting of private for-profit hospitals or other secondary care facilities and services, incl. diagnostics, in the current environment as this would certainly lead to cream-skimming of profitable services and patients by private providers: this is uneven competition and it would actually decrease the financial sustainability and performance of public hospitals.

Vision 12: An effective classification system is gradually developed that covers all health services

Classification is essential, and clinicians recognise this because they cannot communicate effectively without it. It is important to ensure that there are common ways of classifying, and that the classification system has been scientifically designed to meet precise objectives. A classification system is also crucially important to define and refine a provider payment system that is based on outputs and performance. Therefore, over time all services need to be covered by a well-designed classification system, even if some parts are (temporarily) less refined than others.

Classifications of health care products must make sense to clinicians. If not, there will be no possibility of using the classifications to expand knowledge and to support clinical practice improvements. In addition, it will risk non-compliance of clinicians and errors in classification. Everyone must understand why the classification exists – what problems it is intended to resolve, how successful it has been, and so on. Too often,

the implementation of new classifications becomes an end in itself. For example, some countries have decided to implement the DRG classification along US lines, without realising that the US introduced DRGs for quite different reasons. The main goal for the US Federal government was to control total health care expenditure. In contrast, countries in Europe already have better ways of controlling total spending. DRGs might be useful in European countries, but the reasons for their introduction will be different.

There are some obvious advantages in using international standard classifications. For example, it increases the opportunities for comparison with other countries, and reduces the cost of development and maintenance. However, classifications developed for use in countries with quite different methods of care financing and delivery are unlikely to be ideal totally suited for Albania. Albania should strive to adopt and develop a set of classifications, some of which are internationally comparable and others that are local. Even where eventually an international standard like DRGs may be used over time, it will need to be adjusted to meet Albania's particular needs. The most important idea is to use the same underlying logic if it makes sense. Albania should be making decisions after careful evaluation of the options, rather than making rash judgments about the automatic superiority of national or international solutions.

To start enabling the definition of outputs and measuring of costs it is important to enable proper classification of patients and activities particularly in the hospital sector. Therefore, it is probably wise to start using ICD-10 for diagnoses (now a 3-digit code of ICD-9 is used) in the hospital sector (both out-an in-patient) as this also enables possible future introduction of refined output-based payment system in the hospital sector, such as DRGs. It is also recommendable to introduce a single nation-wide system for classification of medical procedures in the hospital sector, again this system should be acquired or developed also with a view to enable future refined payment systems.

Vision 13: Care providers are paid in ways that encourage equity, cost-effective care and performance

No payment system is inherently good or bad. The main concern is whether it promotes improvements in the health care system. One fundamentally important objective is to use the payment system to encourage and reward improvements in methods of care. As a minimum, weaknesses that lead to perverse incentives must be eliminated. In some health care systems, the dominant objective is to ensure that the care providers are treated fairly – that they receive a fair share of the available funding. While this is important, it should not be the only concern. Moreover, fairness to care providers is not as important a goal as fairness to patients (and to all citizens who need health care).

In Albania, debate about the shares for care providers has been prevailing. This is usual in a system where financial resource allocation takes place on the basis of input indicators and where politics plays a dominant role in management. It is important to give much greater emphasis on fair shares for the population, and on incentives to improve clinical practice.

Most health care insurers have reimbursed care providers' expenditures in the past, and this is still common in many countries, incl. Albania's HII approach in payment of the Durres hospital. The expenditures have usually been categorised by type of input (such as building costs or nursing salaries). It is much better to pay care providers for

what they produce, rather than to reimburse their spending. This approach, usually called output-based payment, encourages care providers to focus on what they are producing, and gives them incentives to control their costs. In contrast, reimbursement of inputs (such as spending on clinicians' salaries or use of equipment) encourages the over-use or other forms of careless use of resources. If outputs are effectively defined, output-based payment provides a better basis for comparing the performance of care providers – and hence a better basis for encouraging improvements in efficiency and quality of care.

Bundled payment systems involve incorporating payments for the many different kinds of services a patient might receive during an episode of care into a single amount that is agreed in advance. For example, there could be an agreed total payment of 100.000 Lek for every patient who has an appendicectomy. This payment would be the same for all appendicectomy patients, even though in practice they will receive different bundles of services. Patient with complications would tend to cost the hospital more, but the payment would still be the same.

The same idea is often applied to general practice / family medicine services. Rather than the GP being paid each time a patient visits, there could be a single payment to cover an entire year of care. The payment for the care-year would be the same, regardless of the number of patient-visits or the types of care given by the GP. This is the basis of the capitation system, which would also be applied in Albania's near future.

Bundled payment changes the incentives. The total payment for each case type is fixed in advance, and remains the same no matter whether only a few or many services are given to the patient. This has the effect of changing the 'profit zone'. Now hospitals make the most profit if they discharge the patient quickly and avoid giving them unnecessary services. This idea of bundled payment in hospital care is not used yet in Albania. We recommend starting using it through a carefully designed and gradual process, which is proposed in vision 16.

Payments should relate to specific types of health care products

In many countries, it is still common for government-owned care providers to be given global budgets each year by the government. In some countries, a global budget is simply a single amount to cover all activities during the coming year. The amount is mainly based on the previous year's actual total expenditures. This method is relatively simple as very little needs to be measured or estimated. Little more is needed than a record of what was actually spent last year. It has some obvious disadvantages. One is that the hospital is rewarded for spending. If it saves money this year by becoming more efficient, it will lose money when next year's global budget is set. Another obvious weakness is that there is no basis for identifying differences in cost-effectiveness between care providers, or over time. Nor can care providers easily identify their own production problems.

In other countries, the global budget system is more refined: as budgets can also be given for specified services at a specified price, first also as a cap on ever rising hospital costs - based on previous years' expenditures. Therefore, we recommend that, if Albania intends to start using the global budget system, which is indicated in many papers, these global budgets are as soon as possible linked to specific output measures. This may be difficult in the first year of so, as very little information is available on outputs and associated costs, but there should be a strategy in place

and implemented to get the information and use it in the negotiations (and the to be established contracting system) with the hospitals. As mentioned earlier, the introduction of minimum classification systems, activity and costs data gathering and analysis and the development of model contracts between the HII and the hospitals are crucial steps to allow refining the global budget system. On the other hand, the lack of information should not be an argument against the introduction of a budget system. This is always a good idea as it promotes cost consciousness and as it is a useful tool to stimulate more decentralized management of the health care sector, which is also a policy goal.

Vision 14: Public health and preventive health care services are funded by earmarked budgets and incentives are in place that reward specific output targets

The World Bank Health Sector Note (2005) concludes that „the Albanian health care system remains skewed towards clinical care, while public health initiatives remain underdeveloped and under-funded. The increasing burden of non-communicable diseases and the new health risk factors call for increased emphasis on health promotion and public health initiatives. Furthermore, the analysis of epidemiological trends in Albania is severely compromised by the availability and reliability of data, which therefore cannot form the basis of effective policy. It poses the risk of distorted emphasis and attention. This is an area which has not received sufficient attention over the past. The Institute of Public Health (IPH) has a good basis and would be a natural body to assume responsibility for the collection and analysis of routine health information as well as increased focused research efforts. Similarly, IPH has a good basis and would be the natural locus for increased efforts in health promotion and public health initiatives. However, IPH can only effectively carry out these tasks if more resources are allocated towards health promotion, new public health initiatives and health information and its capacity is further strengthened.“

To ensure long-term resources for further development of effective public health and prevention programs, we suggest that a decision is made at the highest political level that arranges for an earmarked budget – suggested at around 2-3% of total health expenditures (public and private) for financial coverage of public health and prevention activities and programs. A similar approach is taken in a number of countries, notably in countries with a national health system (e.g. some Scandinavian countries), but also in countries with insurance-based systems. For example, the Netherlands annually earmarks and budgets funds prospectively for coverage of public health and national prevention programs (e.g. screening programs).

The Institute of Public Health receives an earmarked budget through the Ministry of Health with specific activity & coverage targets for public health and prevention: To guarantee the medium- and long-term development and implementation of nationwide health promotion, public health and health information goals, it is essential to have sufficient resources allocated and earmarked to develop the capacity of the Institute of Public Health to continue, initiate and/or coordinate cost-effective programs. We suggest that resources for the IPH are allocated within the Ministry of Health funds by means of an earmarked budget with specific targets and activities related to:

- Epidemiological data and trends reporting and analysis
- Healthcare activities (diagnosis and procedures) classification, coding and reporting and mechanisms
- Public health laboratory functions and programs

- National public health and prevention programs (e.g. health education and health promotion programs, screening programs etc.)

In the optimum scenario, budgets are based on a Government approved short- and medium term strategy and activity plan that - though budgets are set annually - include sufficient financial safe-guards to allow for multi-year programming for certain programs with a longer time-horizon than one year.

The Health Insurance Institute includes earmarked budgets for prevention activities in the contracts with care providers

We recommend that the HII includes provision of prevention activities (e.g. health education, measuring of height, weight, blood and urine values, vaccination programs, contribution to screening programs etc.) as a specific chapter with an earmarked budget amount of, say 5-10%, in the contracts with PHC and private GPs/FPs. Funds can be spent on the basis of annual specific targets and activity/coverage reports, to be defined within the contract. In principle, the same is possible with the hospital contracting mechanism. Instigation of measures to prevent hospital infections, which is a serious though under-reported problem, can be included as a condition of contract with a specific global budget and targets set – and funds allocated – for preventive measures and proper epidemiological and case reporting.

Vision 15: Payment of primary health care providers and out-patient emergency services is mainly based on capitation

The most important aspect of effective community-oriented primary care and out-patient emergency services systems is its ability to provide freely accessible services to patients within the geographic area it covers. Therefore these services render themselves very well for a payment system based on capitation fees. A variant of this payment system, based on a geographic catchment area, is already functioning in Albania, albeit only in relation to the payment of salaries of general practitioners in health centers through the HII. With the future role of the HII as single payer, this system should be the basis also for other (public or private) PHC and out-patient emergency services to be contracted by the HII, and be gradually developed into a real capitation-based system. Even if out-patient emergency services are part of the hospital, payment to the hospital for these services can still be done by means of capitation to reflect the geographical coverage.

The capitation fee should be an integral average price for the cost of care for one year for one person.

At the moment, the payment of PHC facilities is fragmented, with GP salaries, drugs and consumables paid by the HII and costs of investment and equipment paid by the MoH. In the future, it is critical that capitation payments for primary care include the full cost of providing care (including operating costs and allowance for facility/equipment depreciation) so as to stimulate quality of care and investments in technology. Adjustment of the standard fee can be made to ensure coverage in rural areas – which is already done - or to allow for variations depending on the age and sex of patients, which is not (yet) done.

In the future, we recommend that payment of health centers– with salaried physicians employed – or payment of private GPs/family doctors would be done largely through an integral capitation fee including the full operating costs and allowance for

facility/equipment depreciation, to be paid by the Health Insurance Institute. For this purpose, MoH funds should be transferred to the HII. Health centers and private GPs would then be given more autonomy and responsibility for the management of their budget, for the purchase of equipment and for the maintenance of facilities.

Capitation payments should also be based on actual enrolment of patients with a particular doctor or facility. The latter, however, is a big problem in Albania given the large population movements and out-dated reporting systems. This does not only affect the health system but other public (registration) systems and services as well. In the healthcare system, the problem can be gradually resolved by full implementation (with universal coverage) of a real health insurance system based on an individual contract between the HII and the patient/citizen: in such a system each citizen would receive a specific health insurance number and/or card and the citizen would need to indicate the new GP or PHC facility of choice within the geographic area. There should not be high barriers to change to a new GP/PHC facility. If the patient/citizen moves, s/he would need to report this to the HII and select a new GP/PHC service within the new area. The HII can give the patient/citizen an incentive to change his registration, for example by making non-emergency PHC/GP services only be freely accessible with his/her own GP/PHC, while introducing a co-payment if the patient visits a different GP/PHC facility.

We recommend to link the introduction of the health insurance card, which is currently developed through the Health System Modernization Project, with mandatory registration of patients with one GP and the introduction of the capitation fee as one „policy package“.

Implementation and further development of the contracting tool is achieved jointly by the HII and PHC providers

In 2007, the HII has developed and is implementing a new contract for PHC services based on international recommendations. Very important in this new contract is the contribution of PHC providers to effective and efficient reporting and health information systems, with the mandatory form of a patient activity report attached to the contract. It is important for the HII and the primary care providers to get acquainted with the new contracting methodology. They should make concerted efforts during the year 2008 to analyse the reports and reporting system, as well as the payment system on the basis of the goals the payment system is aimed at achieving or contributing to:

- Geographical accessibility
- Financial accessibility and equity
- Stimulating quality of care
- Stimulating prevention
- Transparency and fairness of payment methodology
- Effectiveness and efficiency of coding, reporting and feed-back systems

Outcomes of these discussions should result in amendments and targets for performance (e.g. for prevention), reporting and fees to be included in the contract for the year 2008 and 2009, while this type of discussions and negotiations should be a continuous process to be institutionalized through a standard annual procedure.

An important amendment to the 2009 contract should also be linked to the need to develop and implement clinical pathways in primary health care for major disease

types encountered at this level. It is recommended that a proportion of funds for the health center, e.g. 5-10% be reserved for this purpose.

Vision 16: Payment of hospital-specialist care services is mainly based on a global budget with case-mix adjusters

Under the current input based financing system hospitals have no incentives to increase efficiency and improve quality and quantity of care. It is therefore suggested that the payments for hospitals be changed to a performance based system by means of having HII contract with providers for a defined bundle of services. Experience in other transition economies as well as OECD countries suggests that global budgets with case mix adjusters may present a good basis for such changes in Albania.

Gradual development and implementation of case-mix adjusted global budgets based on major diagnosis types

The development of global budgets for hospital providers would need to occur gradually. In the first stage (e.g. in 2009), we recommend to introduce a simple contract between the HII and the hospitals which defines the hospitals' global budget based on last year's expenditures and based on last year's performance in terms of out-patient visits and in-patient admissions. In 2009, still the hospitals would be based mainly on inputs but the contract would define also a proportion of funds, say 10%, to be paid upon delivery of timely and accurate diagnosis, activities and cost data. In addition, hospitals would be contracted for a proportion of funds, say 5%, to prepare and implement clinical pathways in a number of high volume areas. In the next year (2010) and on the basis of information gained about diagnoses, activities and costs, the contract will also specify a proportion of payments to be made on output targets in terms of patient episodes and case-mix. This output-based proportion of the hospital budget would then be gradually increased until it has fully replaced the input-based system.

Patients would preferably be classified in accordance with the main diagnosis categories (chapters) in ICD-9/10 and a standard average fee given per patient as outpatient case and in-patient admission would be the basis of the output-based payment system to be applied in the next 3-5 years. This payment system is possible as some hospitals already use ICD-9 for diagnosis reporting. Other output-based payment systems (e.g. DRGs or itemised) are either very complex to be achieved in the short- and medium-term as the information basis is too small (e.g. there is not yet any procedure reporting system), or are scientifically not sound, e.g. payment based on a standard fee per patient in the clinic where the patient is admitted. The initiation of payment based on ICD-9/10 classification has the advantages of being a major step into the right direction (payment based on patient case-mix), encouraging hospitals and departments/clinics to collect and analyse information and data about patient management and costs, encouraging hospitals to be interested in cost-effective clinical pathways for main case-types, and allowing for easy future refinement into e.g. a DRG system. In the following years, the payment system can be further refined on the basis of more case-mix adjusters for high-volume patient types on the basis of costed clinical pathways.

The contracting mechanism is an important tool to gradually implement the output-based payment system and to achieve higher performance over-time

This payment system also has a major advantage for the MoH and HII as it immediately would give information already in the first year about differences in performance and costs per patient in the Albanian hospitals, which would allow for further study and negotiation for the next year's contract and price levels. International evidence shows that higher costs per patient in academic and tertiary referral hospitals are normal and can also be expected in Albania, as teaching and more complex cases are an extra financial burden. However, large cost differences between 2 regional hospitals for the same diagnosis are more difficult to explain and are likely to point to differences in performance.

The introduction of further case mix adjusters would be conditional upon provider information systems becoming more developed so that they can provide the necessary data on the financial and clinical performance of facilities and, ultimately, of facility departments. Work in this respect could build on the achievements to date at Durres hospital, and the further development of provider information system and development of clinical pathways should become a condition to contract. However, the World Bank (2005) points out that: „such changes can only be expected to lead to desired provider behavioural changes if they are complemented by organizational changes which give providers increased managerial autonomy and by efforts to strengthen the quality of care“.

Vision 17: Prices for health care are mainly based on standard costs

By standard costing, we mean estimating the cost of providing good quality care in an efficient way. Prices should be based mainly on this value, rather than on (say) last year's actual costs or on market forces. Albania should strive to start using standard costing as the main basis for setting prices for all kinds of care that consume a significant amount of funding. A reasonable target in the next decade would be coverage of 20% of product types that account for at least 50% of total health care costs. At the moment, costing in Albania takes mainly place in the form of establishing actual average costs, which is a very good way of checking standard costs and assessing prices for low volume services. However, actual average costs can be a dangerous basis for pricing : It is very common to base prices on the actual average costs of care last year. For example, if the average cost of an appendectomy was 50,000 Lek last year, then the price for this year could be (say) 53,000 Lek to take account of cost inflation or to allow the care provider a margin of profit.

This approach is relatively easy to use. However, we are assuming that the method of care used last year was a good method of care. In fact, it might be bad care – such as of poor quality or excessively wasteful of resources. Indeed, it is often the case that average patterns of care are sub-optimal. Moreover, if next year's prices are based on last year's costs, innovation is discouraged and wasteful practices prolonged. Another common way of setting prices is to allow them to be decided by competition in the marketplace. If hospital A charges higher prices than hospital B, it could lose business: customers will go to hospital B instead, if they think that the quality of care is about the same at A and B. This approach makes sense in a few circumstances, but it has serious weaknesses for most kinds of health care services. One problem is that there might not be any competition. For example, patients living in rural areas of Albania usually have little choice while, in general, most patients cannot judge whether the quality of care is the same at hospitals A and B.

It is practical and beneficial to base prices on standard costs:

The most sensible approach involves standard costing. In the health care context, this can be viewed as the cost of the best affordable clinical practice – where knowledge about the way to produce the best outcomes is combined with appreciation of the unavoidable scarcity of resources. To illustrate the way in which this approach could be applied, consider price setting for appendicectomy. A clinical pathway can be designed for appendicectomy by an expert team, and then costed. In other words, we calculate how many resources are used on the average, when the recommended method of care is used. Then this value is the main determinant of the payment rate.

In the broader context, expert teams could be established for each major specialty (paediatrics, general medicine, cardiology, etc) and asked to select high-volume case types. Then they could be asked to design a clinical pathway for each selected case type. The development of Clinical Guidelines and Clinical Pathways is subject of a specific Ministry of Health Project also funded by the World Bank. We suggest that this project be focussing on developing a few clinical pathways that are high cost-high volume. Other case types could be added each year. The costing of a pathway involves expert clinical teams making estimates of how many resources would be needed on average (such as doctor and nurse time, number of tests, and drugs). Then accountants of the hospital and HII can estimate the unit costs (such as the average cost per nursing minute).

When the standard costing had been completed, prices can be negotiated between the insurer and the care providers. Contracts can then be signed in which the prices are guaranteed, subject to the care providers agreeing that their methods of care can be audited on a sample basis. The main method of audit should be checking whether the pathways are being correctly used. In this way there is an optimal relation between costs, prices, clinical quality and innovation.

Vision 18: There are national (annual) product cost surveys that mainly use by-product data

Data on actual average and standard costs are important, as noted above, but care is needed to avoid excessive work. Experience in many countries shows there is a danger of believing that all data related to costs need to be collected, just in case they are needed. Sellers of computer systems can play a major role in encouraging this belief. Moreover, they can encourage individual care provider agencies to believe they can get a competitive advantage by developing their own, more expensive approaches.

It would be more sensible for the government to take the lead in setting rules and standards for product costing. This could include the establishment of a national annual survey of actual average costs, which is probably sufficient to meet most needs for product cost data. The government could also reduce total costs by making available low-cost analytical tools (such as cost allocation software). This approach has been taken in quite some transition countries, usually supported by international projects. For example, in Serbia the Ministry of Health and the European Agency for Reconstruction have developed and distributed a standard Activity-Based-Costing (ABC) tool and supported the 44 general hospitals to gather and analyse data about average actual cost per patient in several departments, costs per bed day, costs per operation etc. These data were then compared at the national level and workshops were held to explain and discuss results. The hospitals and the Health Insurance

Institute have used these cost data as basis for contractual negotiations about volumes and prices of service.

What is important is that the data for this kind of survey should largely be by-products of the data that care providers need for their own management purposes. By this, we mean that care providers should not be asked to provide data that are only useful for the survey. Rather, they should provide data that they wanted to collect anyway, for other purposes. Finally, the national costing program should include the routine production of relevant standard costs. These might include updating the standard costs for important products, as well as progressively expanded coverage relating to less important products not previously costed in this way.

Vision 19: There are effective cost containment methods for drug reimbursement

Albania has made good progress in improving the public expenditure management of pharmaceuticals through the introduction of a basic reimbursement list, reference pricing and centralized tenders for hospital supplies. However, health finance reforms aimed at improving the insurance coverage of a wider population group, together with stricter registration requirements for generic drugs, are likely to put additional pressure on drug expenditures. Steps will therefore need to be taken to ensure cost containment. This will require keeping a close watch on prescription patterns, reviewing the co-payment structure and the co-payment exemption policy, and conceivably also tightening the positive list of reimbursable drugs. Many of the recommendations are derived from the analysis presented in the World Bank Sector Note (2005), which is still very valid.

Although prescriptions are made on generic names, clinicians are still allowed to write the brand name of drugs prescribed under the name of the „active substance“. For example, for cholesterol-lowering treatment the doctor would write under the „Atorvastatin 20 mg“ e.g. „Lipitor 20“ or „Sortis 20“. This limits the possibility of the pharmacist to provide –face-to-face with the patient, a lower-cost alternative. Therefore, we recommend to enforce a system where the clinician prescribes only the active substance and dosis and the pharmacist must provide the lowest-cost option. The latter can be reinforced by implementing a system of indication-based reference prices and reimbursement.

Drug price negotiations with importers on the basis of reference prices

In the past years, Albania has introduced the system of reference pricing where the price of the drug to be introduced in Albania is based on the mean price of the drug in a basket of reference countries. This is a very positive development. In the near future, it may be worth considering alternative approaches such as negotiating a rebate for HII reimbursed drugs while maintaining a set price on the official list.

Review of prescription behaviour of clinicians

The World Bank Note showed that in the top 10 of prescribed drugs, 6 drugs were (formerly) innovative drugs for which already a cheaper generic variant is on the market. The HII and providers' management should make concerted efforts to improve information about generic drugs and review prescription behaviour in PHC and hospitals. This could be done by e.g. making a top-10 or top-20 of drugs prescribed in each individual facility, analysing the room for cost containment and

then changing behaviour by providing information to clinicians and development of pharmaceutical guidelines.

Review of the positive drug list and co-payment policies

Last but not least, we recommend reviewing the positive drug list and co-payment policies (structure and exemption of co-payments) as an integral part of the definition of the publicly financed benefits package. This would take place in the short-term. The drug list and co-payment policies should be reviewed bearing in mind the above-mentioned strategies of reference pricing and reimbursement on the basis lowest cost option where this is possible.

Vision 20: Care providers are selectively contracted on the basis of population needs and performance

To allow for competition among providers in those segments of the Albanian healthcare market where this is feasible and desirable (e.g. PHC in large urban areas, pharmaceuticals, etc.), the HII as main purchaser should develop skills to make sure that care providers can be ranked according to performance. There should be a general policy of inviting and accepting bids from any agency (public and/or private) as long as it is performing well. The dominant concerns should be whether a care provider is cost-effective, and whether reasonable access will be available for all members of the insurance scheme.

Several strategies are used around the world. They include formal evaluation by an independent body, such as an accreditation agency. Some insurers use a competitive contracting process, where the onus is on the care providers to demonstrate their abilities. In some countries, the numbers and sizes of government and privately owned healthcare services and clinics are determined largely by the market. For example, patients make their own choices: if government facilities are competitive, they grow in size and numbers, and if not they die.

It is often noted that fair competition between government and non-government care providers is difficult to achieve. In some countries, government care providers complain that they lack the freedom to make changes (for example, as a consequence of excessive protection of employees' job security). In other countries, non-government care providers complain that, say, government care providers do not pay in full for capital infrastructure. These kinds of problems, where they exist, need to be alleviated. However, the existence of unfair competition is not sufficient reason to avoid competitive pressures altogether.

Care providers should compete for business where there are clear community benefits:

In some countries, government-owned facilities and clinics are automatically given annual contracts to provide services under the government-owned health insurance scheme. Similarly, government-owned agencies in many countries are given annual budgets so they may continue to be operated. This may be a good arrangement, if the government clinics and hospitals are the only source of health care services in a particular area. If they were not given contracts, the local community would lose its only access to services. However, it makes sense to increase the degree of competition in some circumstances. Its benefits include providing more opportunity for initiative and imagination on the part of the care providers. It also allows them to make use of any under-used capacity (and where they bid to reflect their marginal

costs, this benefits the purchaser). In Albania, there is the potential to use more competition, and thus selective contracting, in a few geographical-urban areas and segments of the market, because distances between care providers in those areas (notably the Tirana-Durres regions) are never very great and transport facilities are reasonable.

In our view, it will be very difficult to achieve increased performance by competition in the hospital segment and the large rural areas of the country, as distances here are large and the infrastructure in poor condition. Selective contracting of care providers here is mostly not feasible and desirable, and the emphasis should be to ensure accessibility and stimulate performance of the existing care providers, regardless if they are public or private.

A balance must be struck between insurer choice and patient choice

There are two main ways of having competition between care providers. One is patient choice: patients have the right to choose their own care provider. Then a care provider will only maintain its revenue if it is both efficient and able to provide good quality care. This is the approach being used in primary care (and especially GP) services in many social democracies including several of the transitional economies. Patients make their choices, and if they do not like the services GPs will go out of business.

The second main way of having competition between care providers is through insurer choice. In other words, the insurance company (whether government or private) can decide only to contract with a subset of hospitals and clinics for a particular set of services.

An insurance company is more likely to make better choices than many of the patients themselves. There are also some disadvantages. One is that not all patients will agree with the choices made by their insurer. For example, the patient might have a favourite hospital, but his or her insurance company might decide not to have a contract with that hospital, and the patient will therefore have to go to a different hospital. Equally important, the way that individuals exercise their right of choice provides valuable information that insurers might overlook. It is unwise to assume that the insurer will always listen carefully to its members.

There is a compromise approach, often called the preferred provider method. As before, the insurance company decides to contract only a subset of care providers, after inviting bids and carefully evaluating them in terms of value for money. Then the members of the insurance scheme can obtain care free of charge if he or she uses one of the contracted care providers. However, the patient can still use one of the non-contracted care providers if willing to make a co-payment. For example, it may cost the patient nothing to go to care provider A (which has been contracted by the insurer). However, there might be a co-payment of, say, 1000 Lek if the patient uses provider B (non-contracted).

It should be understood that any approach that involves making choices between care providers has a significant administrative overhead. Therefore each idea for increasing choice must be carefully evaluated on its merits. Increased choice is not always an improvement.

Vision 21: Care providers' methods of work are intelligently controlled

By this, we mean there must be a well-designed system of planning, regulating, monitoring, and evaluating the processes of care provision. Several approaches including licensing and accreditation need to be employed. However, the best strategy is to require care methods to be specified in the form of clinical pathways, and to conduct periodic audits of the ways that pathways are being used.

Licensing and accreditation are necessary but not sufficient:

Experience from around the world shows that clinicians (doctors, nurses, etc) do not always use the best methods of giving care. For example, they may make mistakes (like giving the wrong drug, or failing to control infections). They often are not aware of the latest evidence on treatment methods. On occasions, they give the wrong care because of personal financial gain.

Licensing and accreditation are ways of trying to ensure that clinicians have the right facilities, skills and knowledge before they start to provide treatments to patients. It is necessary to ensure that these processes are integrated (mainly to avoid duplication), that they are operated without undue influence from care providers, and that they focus on prospective encouragement of good practice rather than retrospective censure and punishment.

However, no system of licensing and accreditation can guarantee that care providers always perform satisfactorily. They might behave well at the time they are being examined for licensing or accreditation purposes and perform worse once they have passed the tests. Moreover, they can never be designed in such a way that they can effectively measure performance at the level of care of individual patients.

Periodic sample auditing is essential

Routine auditing means there is an independent group of people who check on the clinicians' work. The independent group should be well trained and have the power to criticise (and even penalise clinicians whose work is poor). This process is ongoing. Moreover, it involves sampling of the details of care provision, and therefore overcomes the dangers noted above with respect to licensing or accreditation.

Routine auditing can, however, be very expensive. It is therefore important to use scientific methods. In particular, it is necessary to use a sampling approach and to measure only those features of clinicians' work that are worth observing. The design and supervision of any auditing process must involve the care providers themselves, and other concerned bodies such as the professional associations of clinical groups.

Vision 22: Clinical pathways are used for all important case types

Clinical pathways are crucially important. They encourage teamwork, inform the patient, reduce errors of omission and synchronisation, improve quality of care and reduce waste. They also provide a good basis for standard costing – and consequently for annual price setting. Moreover, in the future they could be serving as the main basis for comparison of clinical practice between care providers within and outside Albania. Albania should aim to support most high-volume case types and other case types of concern by the routine use of clinical pathways. The HII should be encouraging their use. However, care providers will be playing the major

role, in terms of using and continually improving pathways, and stimulating the insurer to purchase on the basis of costed pathways that have been jointly reviewed.

Correct use of clinical pathways is a condition of contract:

Insurers always interfere in clinical practice. This is inevitable, unless they are willing and able to pay as much as the care provider wants without question. The issue is whether the insurer will interfere intelligently and openly, or carelessly and in private. One of the best ways for insurers to interfere is by way of encouraging and supporting the use of clinical pathways. Therefore, in the future the HII should aim care providers' use of appropriately designed pathways as a condition of contract: care providers could be required to show they are using pathways correctly. If not, the insurer may make use of a wide variety of penalties, such as reduction of payment levels or denial of contracts for certain kinds of services.

The insurer could concentrate on requiring the use of pathways for high-volume case types in the short- and medium-term. It might also encourage or require the use of pathways for case types where there are particular risks of poor health outcomes, and where there is an unusually high level of clinical practice variation.

Clinical teams are supported in the development, use, and continual refinement of their pathways

A clinical pathway can cover any kind of episode of care that needs to be managed in an integral way. For example, it can cover only a part of an inpatient episode, or it could even cover care that spans multiple settings (both hospital and non-hospital) over a prolonged period of time. The pathway is used by all kinds of clinical staff (doctors, nurses, anaesthetists, etc). When an activity is done, a tick is entered or perhaps a measurement to show that the task was done correctly. This kind of approach reduces duplication and omission, and improves synchronisation. As a consequence, quality of care and efficiency will improve. Where patients require unusual care, this is noted as a variance. Analyses of variances can lead to improved pathways and better clinical practice in general.

The idea of the clinical pathway is simple and obviously sensible to most people. However, it addresses the core of clinical work, and therefore tends to raise a wide variety of cultural, social, and psychological responses. It is therefore seldom easy in practice to establish and maintain the process of clinical practice control. A variety of supporting activities is therefore required including:

- introduction of the core ideas to formal education programs of all clinical professionals, thereby increasing both their technical knowledge and their attitudes towards this approach
- creation of opportunities for clinicians to understand, respect, and manage differences in culture that exist across the various health care professions
- provision of administrative and technical support such as online access to evidence, or to each patient's details.

Many clinicians accept and apply the idea of the pathway without external encouragement and support. However, other clinicians need considerable assistance if they are to make the significant changes that are implied by the pathway approach.

Vision 23: An effective referral system is maintained and improved through sensible payment rules

Well-designed referral systems are essential if health care is to be provided in a cost-effective way. It is necessary to ensure that changes in health care financing and resource allocation support and encourage continual improvements in the referral system. This includes ensuring that care providers are motivated to refer patients at the right times and to the appropriate destinations, and that providers who are expected to treat referred patients are appropriately compensated for treating more complicated cases.

Well-designed referral systems are crucial to cost-effective care

Care provision needs to have some degree of specialisation if it is to be cost-effective. Moreover, points of entry and routes that should be taken to access other forms of care need to be carefully designed. These ideas have led to the development of the kind of referral system that exists, at least in theory, in Albania and other similar countries. The problem is certainly in Albania in the implementation and enforcement of such a referral system.

It is crucial that the methods of financing and resource allocation support and strengthen the referral system, as there are numerous signs that elements of the Albanian referral system are not working well, or have even been prejudiced by perverse financial incentives, such as a direct out-of-pocket payment for first contact with a GP.

Essential elements of an effective referral system are rules regarding referral. These not only provide advice to the source agencies, but also control the care provision of the destination agencies. For example, hospitals must be advised of their roles including when it is appropriate to provide inpatient care.

There must be financial incentives to refer in the best ways

In many health care systems, care providers are simply not given the knowledge or the incentives to make appropriate referral decisions. For example, they may refer simply because it saves them money. Another potential problem is that clinicians do not have easy access to relevant data, such as the waiting times for different kinds of services. Payment systems must be designed so they give financial rewards for correct referral. These must include penalties for inappropriate referral (such as the GP sending a patient to a hospital for care that could have been provided by the GP), as well as failures to refer when it was necessary.

There must be fair payment for recipients of more complicated in-patients

When progressively changing to an output-based payment system in the hospital sector, it is important to measure case-mix differences and acknowledge these in fair and transparent price settings. For example, it is very likely that most of the complicated cases for the same diagnosis (e.g. for colorectal cancer and other cancers, renal failure, heart disease etc.) will be referred to and treated in only one or a few hospitals, such as the Mother Theresa in Albania. As a result, these „tertiary“ facilities will be making higher costs per patient than other facilities. To maintain an effective referral chain, the HII could be paying additional amounts per patient to these hospitals higher in the referral chain. As far as possible, this should be done on the basis of objective measures of clinical need, rather than on the basis of a belief that higher-level hospitals deserve higher payments.

Vision 24: Health care information systems are cost-effective

Health care provision is one of the most information-intensive industries. It would be too expensive to record, store, process, and report all kinds of data. Moreover, clinicians will not fully comply with reporting requirements that have no obvious value. Albania should strive to have cost-effective information systems that have been designed to take account of both the uses and the costs of information. They should be supported by long-term information plans, national data definitions and other relevant tools. Inter alia, there should be no redundancy of data collection or analysis. It is therefore essential clearly to define the roles of the insurers, the Ministry of Health, and the care providers themselves.

Minimal external reporting requirements for clearly defined purposes:

It is costly to collect, store, process, and transmit information. Moreover, clinicians will not fully comply with reporting requirements that have no obvious value to them. Therefore, only data that represent value for money should be required to be collected and transmitted to external agencies such as the health insurers and other private and government agencies.

It should be a requirement that existing reporting requirements be regularly reviewed, and that they should be abandoned if there is no strong logical reasons for their continuation. It should also be required that no data elements are added or modified without thorough research, and that care providers must be given sufficiently long lead times to allow collection and processing systems to be changed in an efficient way.

Management information as a by-product of patient care:

In most countries, there is far too much information that must be collected and processed simply to meet an external requirement – that is, to serve the management purposes of non-clinicians within the care provider agency, or of bodies outside the care provider agency itself. There is often poor understanding of the consequent burden on care providers, or of the potential weaknesses in the data that are provided.

As far as possible, information for management purposes at any level in the health care system should be produced by analysis of the data that clinical teams require in order to manage the care of individual patients. The focus should be on improving the information that clinical teams collect for their own purposes, and how they subsequently store, analyse, and transmit it.

Other agencies may generate additional information that is potentially useful. For example, health insurers can generate information about socio-economic attributes of their members. However, the general argument still applies: insurers themselves should rely primarily on data that are by-products of patient care.

Low-cost and accurate clinical coding by clinical teams:

Computerised records of patients' clinical characteristics are an essential part of good clinical practice. They are not only important for each patient's well-being. They are also one of the most important sources of data for ongoing research and evaluation. Albania should encourage and facilitate clinical professionals to take over responsibilities for design, redesign, operation, and evaluation of computerised clinical records. Only clinicians can do this task well.

There should be national rules for coding, and nationally developed and maintained tools (such as software and manuals) to support the process. Payments systems could then make use of data that are by-products of good clinical practice.

Effective use of payment claims data by insurers:

Insurers have a responsibility to their members to conduct checks on cost and quality. Moreover, they are in a position to do so at marginal cost because they need to receive claims for payment for other reasons. However, checks that are intrusive, which place an unnecessary burden on care providers, or which are prone to errors of interpretation need to be avoided.

Therefore, the HII and care providers should be jointly operating checking and feedback processes that are recognised to be in everyone's interest – excepting those who are performing poorly. The processes could include pattern analysis, sample auditing against clinical pathways, and surveys of patients and their families.

The purpose of the checking should be clear to all: to identify opportunities for improvement, and to give care providers incentives to improve. Censure or criticism should not be goals. Rather, the aim should be continuous learning, and insurers and care providers should have equal input to the checking processes.

A 3-year Implementation Strategy for 2008-2010

The changes in the 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. The following implementation components are identified:

- A. **Development of an effective and efficient purchaser function:** Pooling of resources under the HII, with the HII responsible for payment of health care providers for a defined set of services (PHC, hospitals and drugs) at an established price
- B. **Increasing health insurance coverage and transparent benefits:** Increasing health insurance coverage, development of a benefit-package with sensible co-payment rules and rooting out informal payments
- C. **Increasing performance in primary health care and strengthening the referral chain:** Further development of the contractual mechanisms, strengthening prevention and incentives for good practice and effective referral
- D. **Increasing performance in the hospital sector:** Development of classification, coding and reporting systems, shift from input-based payment to performance-based payments, and development of the contracting mechanism between HII and hospitals

Component A can be seen as the cornerstone of the health finance reforms, as it involves the most relevant regulation to be developed and implemented upon which other components can build. **Component A is proposed as a one-year phase to develop and implement the regulation and build the minimum capacity at HII.**

Components B-D are dependent on Component A and are mutually interlinked. If implemented in a coherent and consistent way, they can mutually reinforce each other (1+1 = 3). However, improvements in each individual component (B, C, D) are needed also as 'independent entities'. Therefore, possible future problems or delays in the implementation in one component should not become an argument to stop or delay developments in other areas.

It is recommended that the Ministry of Health develops a **coordination & monitoring mechanism** to stimulate developments in accordance with the strategy and implementation path, and to measure the progress of implementation of each project individually and in combination. We recommend monitoring on a quarterly and annual basis. The quarterly report should state the progress of the implementation vis-à-vis the proposed implementation table: sequence and timing. The annual report should, next to measuring progress of the implementation, describe possible effects of interventions, identify bottlenecks and propose adjustments or new targets for implementation steps, timing and/or tools/mechanisms to be deployed.

As a first step, we recommend that the Ministry of Health assigned a responsible department and person(s) as soon as possible. The **milestones, sequence and timing of the implementation activities are provided in summarizing tables and charts below.**

Chart of Implementation Activities

Chart of Implementation Activities 2008 – 2010 (I)

Implementation Activities	Quarters / Year 2008-2010											
	Q1/ 2008	Q2/ 2008	Q3/ 2008	Q4/ 2008	Q1/ 2009	Q2/ 2009	Q3/ 2009	Q4/ 2009	Q1/ 2010	Q2/ 2010	Q3/ 2010	Q4/ 2010
Component A: Health Financing Model												
A1: Development and adoption of health financing regulation	☑	☑	☑	☑								
A2: Development of the HII internal organisation	☑	☑	☑	☑								
A3: Developments of budgets / accounts at the HII			☑	☑								
A4: Effectuation of health financing regulations					☑							
A5: Implementation of MoH coordination/monitoring function					☑	☑	☑	☑	☑	☑	☑	☑
Component B: Health Insurance Coverage, BBP & Co-Payments												
<i>Preparatory Phase</i>												
B1: Studies to determine the 2009 BBP and co-payment list	☑	☑	☑									
B2: Establishment of national BBP advisory committee		☑										
B3: Decision Minister of Health on 2009 BBP/co-payment list				☑								
B4: Development sustainable procedures for BBP/co-payment			☑	☑								
B5: Development health insurance information campaign			☑	☑								
B6: Capacity-building of the HII and health care providers			☑	☑								
<i>Implementation Phase</i>												
B7: Publication and effectuation of the 2009 BBP/co-payment list					☑							
B8: Implementation of the health insurance information campaign					☑	☑						
B9: Auditing and monitoring activities					☑	☑	☑	☑	☑	☑	☑	☑
B10: Institutionalisation procedure developed and adopted						☑	☑					
B11: Development of a health insurance card					☑	☑	☑	☑	☑	☑	☑	☑

Chart of Implementation Activities 2008-2010 (II)

Implementation Activities	Quarters / Year 2008-2010											
	Q1/ 2008	Q2/ 2008	Q3/ 2008	Q4/ 2008	Q1/ 2009	Q2/ 2009	Q3/ 2009	Q4/ 2009	Q1/ 2010	Q2/ 2010	Q3/ 2010	Q4/ 2010
Component C: PHC Model and referral chain												
<i>Preparatory Phase</i>												
C1: Monitoring 2007 contracts and preparing for 2008 contract	☐	☐	☐	☐								
C2: Preparing 2009 contracts: integrated fees/payments			☐	☐								
C3: Institutionalisation of contract review and negotiation model			☐	☐								
<i>Implementation Phase</i>												
C4: Effectuation of 2009 contract with integrated fees					☐							
C5: Studies on the introduction of the capitation fee					☐	☐	☐	☐	☐	☐	☐	☐
C6: Introduction of the capitation fee												2011
C7: Capacity-building at the HII and PHC providers										☐	☐	
C8: Information to the public to register with 1 GP / health center										☐	☐	
Component D: Hospital Payment and Contracting Model												
<i>Preparatory Phase</i>												
D1: Design of global budget formula and model contract	☐	☐	☐									
D2: Careful design of a transition path		☐	☐	☐								
D3: Enforcement of uniform diagnosis reporting on ICD 9/10	☐											
D4: Capacity-building at HII and hospitals			☐	☐								
D5: Negotiation and contracting for 2009				☐	☐							
<i>Implementation Phase</i>												
D6: Effectuation of global budget model and hospital contracts 2009				☐								
D7: Costing studies and price setting for output parameters				☐	☐	☐	☐	☐	☐	☐	☐	☐
D8: Gradual implementation of output-based payment									☐	☐	☐	☐
D9: Institutionalisation of negotiation and contracting procedure										☐	☐	☐
D10: Implementing a uniform medical procedures recording system									☐	☐	☐	☐

3.2 OUTPUT 2 & 3 'DEVELOPMENT OF QUALIFICATION PROGRAMS AND PRELIMINARY ASSESSMENT OF EXISTING STAFF CAPABILITIES'

3.2.1 Preparation of Qualification Programs

The preparation of a qualification program is meant to specify the institutional capacity and staff competencies needed to implement the provider payment methods. The preparation of the qualification programs was based on the options for provider payment methods and contracting presented under output 1. The qualification program was essential input to further steps of the project. Work done by the project included the definition of the institutional requirements in relation to the new provider payment mechanisms, such as the planning and implementation of the new provider payment mechanisms at national and institutional levels, monitoring and evaluation, establishing the minimum data set, collection, analysis and reporting of data, setting appropriate payment rates and prices, inter-institutional arrangements, developing contracts and procedures for negotiations, etc.

Output 2 includes the institutional requirements to implement the provider payment and contracting strategy and the organisational model for the Ministry of Health and the Health Insurance Institute describing positions and mandates of the staff for achieving the successful implementation and tools for adapting the current organisation. Output 2 also takes into account the Draft Mandatory Health Insurance Law in the version of February 2008.

Output 3 refers to the results of a survey carried out to define the knowledge of the HII-staff and healthcare providers on key components of contracting and payment contracting methods, providers, methods in order to adapt the content of the training curricula to be developed under the TA project and the logistics concerning the implementation of training.

3.2.2 Institutional requirements to implement the provider payment and contracting strategy

Pooling of resources

Pooling of resources under the Health Care Insurance Fund (HCIF)⁵, responsible for payment of health care providers for a defined set of services (PHC, hospitals and drugs) at an established price, is a condition sine qua non for the success of its mission. This evidence is confirmed by the draft Mandatory Health Care Insurance Law and will be implemented as soon as its approval.

Reinforcement of the HCIF- responsibilities actually shared between the MoH and the HII

The HCIF statute, its responsibility and accountability as a single payer and as care purchaser need to be specified in the Charter of the Fund⁶, including the means of functioning, actions to be implemented and annual monitoring procedures.

Functional links between MoH and HCIF

⁵ This is the name used for the HII in the Draft Mandatory Public Health Insurance Law, (26th February 2008)

⁶ Article 4 of the Mandatory Public Health Insurance law, revised version of 26th February 2008.

The new organisation of the mandatory public health insurance system foresees relationship between MoH and HCIF. The establishment of regular links between MoH and HCIF will allow the MoH to develop its proper policy role, to follow the progress in the health coverage of the population and to focus on the most advantageous financial options.

Define content of a set of health services to be covered by the HCIF

A list of essential health services with 100% health coverage by the healthcare system must be an integrated part of health care. This Basic Benefit Package shall include preventive health service, primary health care, child dental care, emergency care and specialized medical services including diagnostics, treatment, rehabilitation and pharmaceutical therapy, upon referral from a general practitioner/ family practitioner. The BBP shall be defined at the proposal of the General Director of the Fund⁷.

Co-payments system

Formal co-payments should be introduced for a wide range of health care services, including in hospital. The objective should not be to increase the overall volume of informal payments but to replace informal payments with formal payments. The implementation of a co-payment system should be linked to the definition of the benefit package that will be available for the population with public funding. The new organisation under the Draft Health Care Insurance Law mentions in Article 39 the co-payments will be decided by the Council of Ministers but does not specify who will be in charge of the preparation of the list of co-payments.

Health care services performance

Since early 2007, an important part of PHC services delivery is regulated by contracts between HII and healthcare providers linking the payment of funds with the results of services activities. This new approach utilising incentives for funding healthcare providers will be extended to all healthcare providers in PHC and the hospital sector⁸.

Incentives for quality of care

The aim of the performance-based contracting method is to stimulate providers to reform inefficient practices and improve performance, yielding measurable gains in public health. Additional requirements regarding the quality of care and the means to encourage health providers to use them in a referral system will be implemented⁹.

Management of relations with the care providers

The contracting and payment relations with the HCIF and healthcare providers will be improved by the negotiation for the price of health services, performance quality indicators and incentives with their representatives. The HCIF represents the interests of the insured people, employers and other contributors to the health insurance sector in the partners' negotiations.

HCIF- Organisation in accordance to principles and mission of a Health Care

⁷ Article 38 of the same law

⁸ Article 19 of the same law

⁹ Article 18.3 and 19 of the same law

Insurance Fund

The basic principles on which the system is based are universality, equity and the evolving nature of coverage for health care services. The mission of the healthcare system is to ensure that all citizens have access to the care and services required by their state of health in accordance to these principles.

HCIF- skills

The implementation requires essential functions that the employees must accomplish such as proper accounting of revenues and expenditures, information system on insured, uninsured and exempted persons, and healthcare providers, development and pricing of the Benefit package health services and co-payments, budgeting, contracting with PHC providers, hospital care and pharmacies, performance monitoring. These functions require skilled staff to run the HCIF and to regulate and supervise its activity.

MoH- Organisation

Public Health Insurance systems worldwide have a unit into the MoH in charge of the follow-up and the coordination of the HCIF. At the present, the MoH flow chart does not include such a unit. Its role will be to supervise the policy led by the HCIF, to ensure that the HCIF has the correct information about the strategies and policies of the MoH and to report the progress made in the implementation of the provider payment and contracting system reform.

3.2.3 MoH - Requirements

The draft Mandatory Health Care Insurance Law, when approved, will define the MoH and HCIF requirements for implementing the new health insurance system: the HCIF- autonomy of management, the functions and attributions of the Administrative Council and the General Director and the role of supervisor of the MoH. A co-ordination between the MoH and the HCIF will support the implementation of the above Draft Law. The links between MOH and HCIF are to be developed in two ways: through links established on a regular basis with a MOH-Unit in charge of the co-ordination with the HCIF and through the implementation of working groups on topics presenting a major interest for the Ministry of Health.

MOH-Unit in charge of the co-ordination with the HCIF

This unit composed of two persons at the beginning of the reform and possibly of more persons after proper evaluation, will have a mandate for supervising the health financing reform, for measuring on a regular basis the progress of the implementation in accordance to the strategy and implementation path proposed under output 1.

Its mandates will be to:

- Supervise the health financing reforms on the basis of a quarterly and annual HCIF-report,
- Measure on a regular basis the progress of the implementation in accordance to the strategy and implementation path.

Its responsibilities for achieving the mandates will be to:

- Prepare the transfer of public sector resources (general taxation and payroll

taxes) under the HCIF in 2008,

- Prepare advice of the National Advisory Committee and prepare MoH-resulting decisions on BBP and co-payments list,
- Prepare the text of law against the informal payments,
- Prepare procedures to monitor and audit the implementation of the reform on contracting and payment methods,
- Prepare the MOH-decisions concerning tariffs of the hospital care,

National Advisory Committee for the Basic Benefit Package and the Co-payment List

The Ministry of Health will establish working groups on topics presenting a major interest. Based on the high priority given in the draft law to the BBP and co-payments, the first kind of working group can be a National Advisory Committee for the Basic Benefit Package and the Co-payment List.

This committee will be chaired by the MoH and will be composed by the HII, representatives of healthcare providers, pharmaceutical committee and patients/citizens groups. Its direct supervisor is the Minister of Health.

It will have as mandate to review health service provision, to define levels of co-payment for each health service, and to advise the Government on all issues concerning benefits package and co-payments.

The content of advice, frequency of meetings on a quarterly basis for the first year, means of working (reports, documents of work and their origins) and monitoring reports, will be decided during the first meeting. They will be preferably formalized in a simple partnership agreement prepared by the MoH, between the MoH and its partners of the BBP Committee.

3.2.4 HCIF- Activities and Internal Organisation

Creating the conditions for a change is mainly a matter of organisation. Organisation is the most difficult task to do because it is an on-going process and needs clear objectives to follow during the whole period.

The integration of the reform into the HCIF will need a modification of the internal organisation in order to adapt mandates and duties of the whole staff. The analysis of the HII-capabilities shows that no personnel reduction or increase are to be envisaged as it is more a re-organization of the tasks carried out. It is not possible to obtain a change in an organization without the direct implication of the staff.

Several standard tools exist to help this phase which can be adapt to the context of the administration or firm to re-organise as a consensus shared between the administrative council, the DG and the staff on the objectives of the organisation. The Charter of the HIF as mentioned in Article 4 of the Draft Law is an important instrument to support a consensus. Another tool is a job-description which details for each employee the elements which create the consensus. The HII has at present a description of the tasks by directorate and by departments, in other words 'job-titles'. They show already a functional structure of the HII-organisation, at central level and regional level. Based on the discussions with professional staff of the HII, the

Consultant has observed that the job-titles are not consistent with the daily job carried out as tasks are not individualized.

However, job titles can be used as a basis for the formulation of job descriptions. They should be improved in order to support the HCIF-mission and further reflect the dynamics of the development. The positions already existing at the HII will have to be completed with elements presented in this chapter and attention should be given to eliminate less useful mandates and duties in the re-organisation. The ultimate aim should be to prepare individual job descriptions for all staff of the HII.

In order to simplify this phase, the adapted positions are detailed in accordance with the content of job description (job summary, job duties, qualifications) and there is a link with the objectives of the strategy for contracting and payment mechanisms developed under the output1. Key components and tools for this implementation will be presented further.

Organization of the HCIF-network

HII is at the present organised in a decentralised way, with a national level and 12 regional directorates. In 2007, the HII employs 425 persons (approx. 100 on the national level and 325 on the regional level). The approval of the Draft Mandatory Health Care Insurance Law will change the name of the HII to Health Care Insurance Fund (HCIF) but no change in the HCIF network is to envisage as it will be a classical decentralized organisation with a national level in the capital city and a regional directorate in each region.

Methods

The proposed re-organisation uses a management approach by applying a methodology of creation of priority functions arising in performing those functions and decision-making:

- The activities of the HCIF-network staff are coordinated at the central level by a Board of Directors, composed by the staff in charge of the whole directorates of the institution; these persons also act as advisors to the general Director.
- The key function of the HCIF is the risk management, on which the efforts of the staff of the organisation are concentrated.
- The advisory role of the central level of the HCIF towards the HCIF- regional directorates will be introduced in order to harmonise the HCIF practices and to improve the corporate image of the HCIF.
- The responsibilities of the HII-regional directorates are to ensure close relations with the regional population and healthcare providers. Daily relations with the healthcare providers must be managed by the network of HII-regional directorates.
- The tasks of the staff will be planned by an annual plan prepared by Directors and discussed during the Board of Directors meeting,
- Coordination between Departments will be developed by the use of working groups indicated on the annual plans.

3.2.5 HCIF Current Organization / new organization

Board of Directors

In the current organisation, the General Director manages 9 Directors and 12 regional Directors.

It is proposed that the new organisation will have a Board of Directors composed of 6 Directors in charge of the HII-Directorates of the institution. The coordination of the Directors will be ensured by weekly meetings chaired by the GD, where the Directors present the works carried out by their teams, and discuss these works with the other Directors regarding subsequent steps to be taken.

The Board of Directors will be composed by the Vice-general Director, the Medical Director, the Legal Advisor, the Risk management Director, the Accountant, and the Human Resources and Administration Director.

The adaptations in each directorate needed for the implementation of the new organisation are as follows:

Medical Directorate

In the current organisation, the physician Directorate is composed of 10 persons distributed into 3 sectors, PHC, hospitals and monitoring sectors.

The new organisation proposed to change the content of sectors. Each of the 4 new departments manage cross-cutting functions between PHC and hospitals: BBP, Contracting Methods, Quality of Care and Medical Information departments.

It could be reinforced to deal with the tasks related to the strategy implementation by the grouping of the medical and para-medical staff (31% of the staff). A procedure is proposed where the physician or the pharmacist would be asked to join a weekly working group. This will allow to reinforce the Medical Directorate while the above staff will be still dealing with their sectors' requirements.

The Vice- General Directorate

In the new organisation, it is proposed that the Vice-General Director combines the duties of Vice-Director and Director of the regional HCIF-network. His role will be to co-ordinate the actions of the HCIF-regional directorates, and to ensure that the network follows up the healthcare politics decided by the GD.

The Legal Directorate

In the current organisation, the Juridical and International Relations Director is in charge of 3 sectors: the Juridical Sector, the International Affairs and Publication Sector and the Project Coordination and Integration Sector.

In the new organisation, this directorate becomes the Legal Directorate, managed by the Legal Advisor in charge of the International Relations, the Juridical Department and the Foreign Affairs and Publication Department.

Note: It is proposed that the current Project Coordination and Integration sector is integrated into the Risk Management Directorate in order to strengthen its operational functions.

The Risk Management Directorate

This directorate does not exist in the current organisation. Its introduction is the key element of the re-organisation. The role of the RMD will consist of developing activities together with the medical Directorate concerning the following topics:

- Prevention development in order to contain healthcare expenditures which means acting on behaviours before the development of a disease,
- Information and support regarding all those involved in the system (insured persons and healthcare providers),
- Limitation of expenditures through the control of reimbursed care, tariff fixing and medical justification to receive care.

This directorate will be composed of 5 departments:

- The Risk Management Department,
- The Statistics Department,
- The Communication Department,
- The IT Department,
- The External Audit.

In order to form the Risk Management Directorate (RMD):

- Two directorates have to be merged: the current Information and Statistics Directorate and the current Technical Audit Directorate under the new Risk management Directorate
- Three directorates have to be divided:
 - the current Juridical and International Relations Directorate: one of its sector, the Project Coordination and Integration Sector, will go under the new RMD.
 - the current Economical Directorate and the current Prices and Drugs Reimbursement Directorate: the tasks regarding the Accounting and Financing will merge into the Accountant Directorate, while those related to the analysis of the expenses will be included into the new Risk management Directorate.

The Accountant directorate

The Accountant Directorate is not available in the current organisation. Some of the mandates are ensured by the Economical Directorate, the Prices and Drugs Reimbursement Directorate or the Internal Auditing Directorate and the Internal Finance Sector, under the Human Resources and Services Directorate.

The Accountant Directorate will be in charge of the HII-expenses. The creation of this Directorate replies to a standard practice in EU countries in accordance to the regulations against corruption and fraud risks. Particularly in public institutions in charge to manage public funds, a separation is made between the function of organizer of the expenditures assured by the General Director and the function of payer held by the Accountant. Both have their own audit, the external audit is supervised by the Director General and the Internal Audit is supervised by the Accountant.¹⁰

The Accountant will be responsible of the Budgeting and Accounting Department linked to three sectors (Accounting, Reimbursement and Internal finances sectors) and the Internal Audit Department.

¹⁰ It is recommended to the MOH to modify the Albanian Law on auditing in line with the EU regulations.

The Human Resources and Administrative Services Directorate

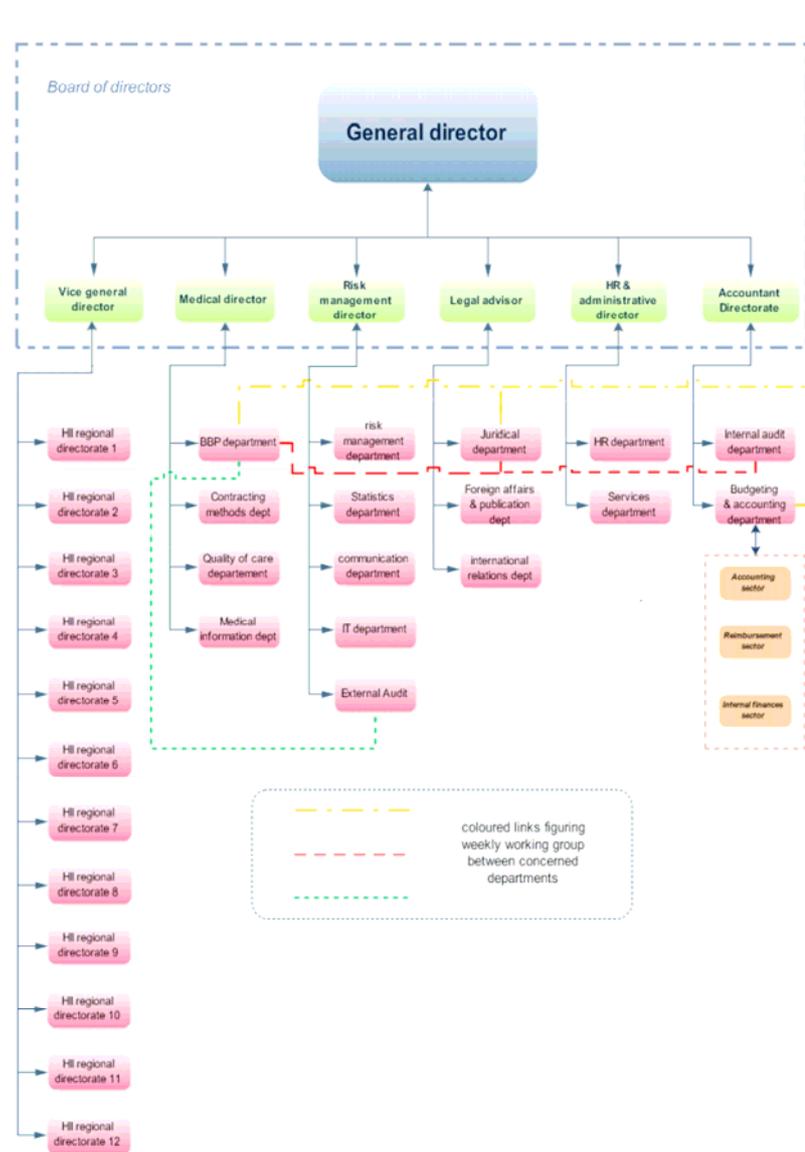
In the current organisation, the Human Resources and Services Directorate is in charge of the Human Resources and the Internal Finance Sector.

In the new organisation, it is proposed that the Internal Finance Sector is related to the Accountant Directorate and the current Services Directorate becomes a department and relates to the Human Resources and Administrative Services Directorate. This directorate will be then composed of:

- The Human Resources Department
- The Services Department

The Human Resources Department is a key department for the implementation of the reorganisation. Its role will be to develop, implement, monitor and support the reorganisation. It will have to find means to motivate the staff, to incite them to participate in the reform.

The proposed structure of the HCIF is visualized below:



3.2.6 Revised functions of Regional Offices of HCIF upon introduction of a capitation payment system

The introduction of a capitation payment system requires a profound restructuring of the organization of the regional offices of the HCIF as well as of the HCs in order to prepare adequately for carrying out their new functions be capable to play their new role in accordance to the requirements stipulated in the new contracts. Among the future staff positions to be included under the new managerial structure of the Regional Offices of HII following tasks for 5 key positions are briefly presented below:

1. Head of Regional Office of HCIF (RO-HCIF)

- to conclude contracts on health care services purchase at the expense of the Regional HCIF budget;
- to provide implementation of health state policy;
- to ensure planning and control process according to requirements of MoH at Central and Regional level and other regional and municipal authorities and to focus on its organizational targets;
- to prepare proposals for draft programs of territory social-economic development and local budget drafts, submit them for consideration by the Regional Administration and guarantee their fulfillment;
- to set up a business plan for the PHC service delivery in the frame of income and expenditure budget in order to maintain the office operative as needed;
- to forecast the development of a network of PHC and SHC facilities to provide population with health care services;
- to organize, delegate and control the work of the RO and take care of for efficient usage of human resources in the RO;
- to insure that RO acts as an independent purchaser without influence by hospital or other health care providers;
- to organize work on labour protection, safe traffic and fire protection of health care facilities;
- to develop together with his deputy a strategy for the negotiations with the health care providers;
- to be responsible for the fulfilment of the tasks assigned to the RO by the Director General of the HII and to provide advice to the Regional Administrative Council to issues related to medical needs assessment;
- to ensure data protection and patients' rights;
- to define the responsibility level of his/her deputies, heads of the department units;
- to issue orders within his/her competence, organize and control their fulfilment;
- to approve provisions on department units and functional responsibilities of its workers;
- to appoint and dismiss the RO staff;
- to have a right to take part in meetings of local self-government bodies and speak on the issues related to his/her competence;
- to inform population on the state of liabilities assigned to the department through mass-media.

2. Legal specialist of Regional Office - HCIF

- to give advice for improvement of current used contracts;
- to cover all legal aspects of contracting in terms of fulfilment of health care legislative acts, state standards, criteria and requirements;

- to apply changes on the legal level to the contract;
- to work out new forms of contracts and statutes and provides options for decision making if necessary;
- to provide legal advice to economist and physician, local council and by request to citizens of the region.

3. Accountant of Regional Office - HCIF

- to support the command of finance within adopted income and expenditure budget to maintain the Regional HCIF office;
- to transfer funds from Central HCIF office to health care providers (pooling of resources) according to legal requirements and regulations;
- to pay invoices on time to health care providers according to legal requirements and regulations of the contract;
- to ensure correct accounting and book keeping according to legal requirements;
- to coordinate his work with the economist;
- to support the economist by his daily work;
- to make reports and documentation;
- to fulfill special tasks given by the Head of regional HCIF office.

4. Physician (Medical Controller) of Regional Office - HCIF

- to be responsible for outcomes (quality of health care);
- to issue medical monitoring by analyzing of official state and other statistics as well as epidemiological trends;
- to make assessment of medical needs for the rayon & district population by analyzing patient flows and clinical pathways;
- to monitor the implementation of (national) medical standards;
- to implement performance and case management (insure that the right patient is treated at the right time on the right place):
 - to avoid that patients, which belong to outpatient care, are treated inpatient (incorrect assignment of hospital bed days)
 - to reduce the length of an individual inpatient stay, if it's from the medical point of view not necessary
 - to ensure that primary care treatment is actually being done at the primary care level
 - to ensure that secondary care treatment is performed at the secondary level
- to provide medical advice for the economist and legal specialist to the rayon council and by request to citizens;
- to inform patients about health services and provide medical assistance to population;
- to focus on prevention of infectious diseases, epidemics and their liquidation;
- to provide environmental preservation and maintenance of public sanitary-epidemiological welfare as well as adherence to standards of health care activity, standards of healthcare service, medical materials and technologies;
- to coordinate his work with the economist and legal specialist;
- to make reports and documentation;
- to fulfill special tasks given by the Head of RO.

5. Economist of Regional Office (HCIF)

- to set up a budgetary reallocation plan for regional & district health care facilities according to the medical needs of the population;
- to issue adequate types of payment for health care providers;
- to increase the efficiency of resources on regional level;
- to be responsible for the outputs (number of patents treated) of health services;
- to analyze data (for example state statistics) by usage of IT- technology;
- to create indicators in order to evaluate efficiency (number of visits, number of beds, average bed occupancy, ALOS, use of diagnostic center, use of operational rooms, structure of cured patients);
- to conduct volume and cost comparison between regional and national level;
- to analyze cost of services;
- to conduct financial analysis;
- to support competitive environment of health care providers;
- to make reports and documentation;
- to fulfill special tasks given by the Head of RO.

3.2.7 Additional arrangements

In addition to the development of the above mentioned positions, continuous quality improvement should be one of the aims of the PHC reform and therefore it is proposed to set-up a formalized quality improvement procedure organized by the HCIF- Central Office. The procedure is based on regular evaluation of activity of PHC providers. Following three type of sources shall be prioritized:

- The evaluation consists in assessment of treatment patterns of randomly or purposely (with focus on specific diagnosis) selected patients based on expert analysis of medical documentation. Quality and completeness of documentation is evaluated as well.
- The quality evaluation of statistical data on activity of the PHC provider is assessed based on number of visits, number of referrals, prescription patterns, number of preventive services rendered etc.
- The quality assessment shall include regular patient's satisfaction surveys. The purpose of such complex evaluation procedure is to help the PHC providers to improve steadily quality of their work.

The evaluation procedure shall be summarized in a “**Quarterly evaluation report**” that can be done by a regional committee composed of representatives of the Regional office of HCIF, regional department of the MoH and also of representatives of regional medical professional associations acting in PHC field.

With regard to **Key Performance Indicators** to be used for monitoring purposes by the Regional Office - HCIF, in particular, these must reflect the organisation's goals, they must be key to its success, and they must be quantifiable (measurable). Key Performance Indicators usually are long-term considerations. The definition of what they are and how they are measured do not change often. The goals for a particular Key Performance Indicator may change as the organisations goals change, or as it get closer to achieving a goal. All duties and activities of the management will be undertaken in a context of performance targets. The success of the Family Medicine

practice can be measured by such performance indicators as access, utilization, quality and continuity, satisfaction/acceptability and efficiency. The major indicator of initial success of PHC reform will be the improvement in the utilization of PHC services.

HCs (or Family Medicine practices in the future) need to set targets for each performance indicator. This includes both clinical and management data but the more important of the two (at least initially) will be the clinical data, which will be drawn from patient medical records. Record-keeping procedures should be established. A comprehensive planning document should be developed for all monitoring and evaluation activities within programs: which documents the key M&E questions should address, which indicators must be collected, how often, from where and why they will be collected; baselines, targets and assumptions; how they are going to be analyzed/interpreted and how/how often reports will be developed and distributed on the evolution of these indicators.

Regular reporting forms should be used to facilitate compilation of a form “**Minimum Performance Indicators for PHC**” (MPI-PHC), a new form that is proposed by the project to be included in the contract to be signed between the HCIF and the HC (tentatively in 2010).

The Minimum Performance Indicators correspond to the following measurement criteria used for Monitoring the performance of delivery of health care services: Accessibility, Utilization, Quality, Acceptability, Efficiency and Cash Flow Assessment.

In addition to the MPI-PHC Form presented above it is also strongly recommended to include as part of the contract between HC and HCIF the **Cash-flow form** to be filled in each month by the HC. This form will provide the most accurate status of income & expenses and comparisons among various HCs centres for the same period will be facilitated.

3.2.8 In-depth interview through structured questionnaires

Based on the discussions with professional staff of the MoH, HCIF and healthcare providers (health centres and hospitals) one of the priorities for the successful implementation of the compulsory health insurance is that professional staff, at the central, regional and local levels will develop their responsibilities and new social roles in line with the requirements of the new health insurance principles, the required skills in contracting and the new attitudes in public relations and information.

A TNA was carried out with the staff of HII, HCs and Hospitals through a structured questionnaire directed to the senior staff at central and regional level. It was introduced with the aim to assess the knowledge regarding contracting and identify the level of understanding of the relations among the various health actors.

Composition of the group of interviewed persons

62 persons were interviewed (including 31 from HII):

- HII central office - 3 people representing Law Directorate, Primary Health Care, Physician Directorate (out of 100 staff) – 3%.
- HII (regional) (RDHII) 12 Directors of Kukës, Gjirokastra, Dibër, Lezhë, Korçë, Shkodër, Durrës, Berat, Fier, Elbasan, Tirana, Vlorë as well as 16 other professionals from Regional offices (out of 260 staff of these 12 regional offices) – 10%.

- The providers, 20 interviewed persons were from Durres hospital (administrative staff and physicians - out of 702 – 3%.
- 11 from Tirana University Hospital Centre, only administrative staff (out of 2 433) – 0.5%.

The composition of the interviewed persons reflects the content of the training, which was on contracting and payment methods, functions relevant for the HII. The regional offices of HII sign contracts with public HCs and private pharmacies as well as with the Durres hospital, which was considered as a pilot project.

Working experience

The staff of HII at central level is mostly aware of their functions and the 8 Regional Directors of Tirana, Berat, Durrësi, Kukësi, Shkodra, Korça, Gjirokastra and Dibra, who joined the interview are mostly aware of their responsibilities. Their answers on activities are in accordance with the job description specified by the HII, as following:

- Management of the regional office
- Contracting, financing and monitoring HCs
- Reimbursement of drugs
- Monitoring the implementation of the legislation

47 interviewed people (or **76% of the total**) are aware of their functions, 9 persons - 14% are not so much aware and 6 persons – 10% have not answered the question.

This is related with their work experience. Only 12% – 20% of them have less than 6 months in their position and only 3 of them belong to the staff of HII while the others are from the Tirana Hospital administration. 37 out of 62, or **60% have more than 1 year in their position and** only 9 people – 14% have 1 year. Most of the regional directors of HII have more than one year in this position, and all of them answered “YES” to the question “*if they understand clearly the new functions they are performing*”. Although three directors have less then 6 months in these positions, they are fully aware of the new functions.

From Tirana hospital administration 5 persons are less than 6 months in their position but they are fully aware of their functions as they have been working previously in other institutions in similar functions.

Qualification

In the period 2006-2007 **27** persons or **45% received training** (7 out of 12 regional directors of HII were trained and 15 persons from the HII staff at central level). The training that they received referred mainly to the following areas:

- **Medicine 15 persons - 25% of all the interviewed:** from which 11 from Durres hospital and 4 people from HII staff, (including the regional directors of Gjirokastra, Lezha, short 1-2 days courses, 2 others have more than 1 month training).
- **Management 11 persons – 16% of all the interviewed,** all from HII, from which 4 of regional directors in short 1-2 days courses, 1 in a training course 1 month, 3 others more than 1-month course.

- **Finances 6 persons – 10% of all the interviewed**, from which 3 people from HII.
- **Partnership 5 persons – 8 % of all the interviewed**, from hospitals.
- **Foreign language – 1 person** from HII.

The fact that one person could receive more than one training is related with the situation of **short term courses (1-2 days)** predominating (13 cases out of 36 or **37%** of the trainings. There was one week training in 8 cases and 8 persons have participated in more than 1 month training: 3 in management and may be 5 others in medicine (physicians). Only 5 persons have participated in trainings of 1 month and 2 persons joined a training of two weeks.

Request for training

A question referred to their needs on the four main orientations of the strategy where the training can improve the managers' skills: Financial Management, Social Health Insurance, Contracting & Negotiations, and Monitoring & Evaluation. All staff need training in all four fields, giving their interest from the lowest point 1 to the highest point 4, as the table below shows:

Needs for training
(From 1 = not really a need To 4 = really a need)

Priorities	1	2	3	4	TOTAL
Social Health Insurance	4	5	6	33	48 – 75%
Contracting & Negotiations	3	2	3	18	26 – 41%
Monitoring & Evaluation	12	10	8	21	51 – 80%
Financial & Management	8	7	9	22	46 – 70%

Contracting & Negotiations show the lowest interest, only 26 people or 41% of the total, even this is the main activity developed from HII. Maybe because most of HII staff had training in management, they actually have some knowledge on contracting. **80%** of the interviewed persons asked for training in Monitoring and Evaluation, which is a new function, not well organized from the structural point of view, there are not appropriate structures even in the central level of HII.

Most (10) of the regional directors of HII are interested in the training in the four above-mentioned areas, prioritizing the Financing and Management and Social Health Insurance. **33 persons or 53% of the total have the highest interest in training in the field of Social Health Insurance**, as a new field in Albania, not developed on the curricula of the university education.

Through this questionnaire, the participants express their availability for training in the first half of 2008. For most of them, the best period for training is the spring (April – 11 people, 2 of them from central HII; **May – 31 persons, or 50% of the total**, 2 of them from central HII and **June 17 persons – 30% of the total**, who should be from providers - hospitals). 7 people wanted to be trained in March, and only 2 in July. One person is available more than one month.

Identification of the cost of health services

The most difficult question was the “*identification of the main cost for health services*”. **Only 23 persons (37%) provided a positive answer.** From this group, 11 persons are from the staff of HII and 10 of them identified as the main cost of the health services the salary of the family doctor. The other answers from the providers are related to the cost of visit (Durrës hospital – physician staff) or the cost of hotel. So, all of them are referring to special costs, related with their jobs, without identification of the main cost for health services which is salaries of the staff. This is considered difficult even for the very experienced staff (e.g. a financial expert of the Durrës hospital, with more than 30 years experience in this field, and has been concentrated on the cost identification for Durrës hospital, in the frame of the pilot, for approx. 5 years).

17 persons answered “no” on cost identification, among them 6 people from Tirana Hospital who stated that costing was not in their field of interest. The main reasons for not being in a position to identify the costs relate to administrative constraints (9 persons), 2 physicians are not concerned about this topic and 1 director of a regional hospital expressed no time availability. 22 others do not give any response, 5 of which are from HII.

Another group of questions relate to the new ways of communication and cooperation between actors involved in the health sector. Regional managers who shall know the local priorities have to find and use new forms of decision-making. In this context, it should be mentioned the order of the MoH to create a new decision making body in the regional level, with representatives from MoH, HII, and regional government which have to appoint the directors of HC and to take decisions on health issues on regional level.

The group who gave a positive answer to this question was asked if they discuss about it with: their staff – 14 (out of 23), answered ‘yes’ and 5 persons replied ‘no’. The same is the situation when they were asked, if they are discussing with their supervisors, 14 positive answers and 5 negative. Only 3 of them are discussing with the staff of other units while 2 of them are regional directors of HII who argue that such a topic is not considered to be relevant as long as the budget and cost related issues are defined by the HII.

Regional directors of HII do get in touch on a regular basis with health providers to discuss their results as each month they organize regular meetings with HC directors, discuss health providers' activities with the local authorities and the HII at central level. 42 persons in total (20 staff members of HII) replied being in contact with the health care providers.

27 persons (**45% of the interviewed persons**) **discuss the health providers' activity with their staff**, 12 persons do not discuss it and 23 persons do not give an answer. From all the interviewed persons 36 discuss with other institutions/health providers.

60% of the interviewed persons have identified the ways for increasing the number of visits to the HCs, **16% of the interviewed persons provided a negative answer**, and **24%** did not provide any answer. For the people with positive answers, the further question is to define the concrete ways to increase the number of visits and they describe as the most important way the communication with people on the advantages of the HC (12 people – 30% of the positive answers); improving the quality of service (14 answers – 39% of the positive answers); 15% or 6 persons are

asking for improving the confidence of the families and increasing the number of insured people. The table below demonstrates the answers received by the HII staff and the total of positive answers.

	HII – staff	Total
Public awareness	2	0
Communicate on the advantages of the HC	3	12
Improve the quality of care	3	14
Propose + services	1	4
Better wages for the GP	2	5
Better following of the families	1	2
Better following of the chronic deceases	2	5
Improve the confidence of the families	2	6
Increase the number of insured persons	2	6
Improve the discipline at work	1	1
Make health promotion	1	5
Better wages for the GP (capitation)	1	1
Use the referral system	0	4
Bad reimbursement	0	1

Factors to improve the job performance

To improve their job all the following factors are considered important. Most of them, 37 persons – 60% give the highest priority (4) to the staff qualification, 45% - technology, 51% - improving the structures and management. The regional directors of HII mainly are asking for introducing in the regional level units on Monitoring and Evaluation.

What do you think should change for you to improve your job? (From 1= not really to 4= really)

	1	2	3	4
More staff	14	8	10	12
Better quality of staff	5	2	4	37
Higher wages	5	5	8	34
More technology	9	5	9	27
Improve management	6	1	12	32
Improve procedures	14	14	6	14
Improve the type of healthcare services	13	5	11	21
Improve the staff motivation				1

The increase in wages is one of the dominant elements considered as very important on improving job performance (34 answers or 55% of the total). 21 persons (30%) mentioned as the highest priority to improve the type of services. The latter relates to the fact that currently services offered under the health care insurance include only the PHC and the reimbursement of the drugs as defined by the Council of Ministers.

Please, refer to project report on Output 4 for full results of the TNA.

3.3 OUTPUT 4 ‘TRAINING MANUALS WITH CONTENT OF THE COURSES’

3.3.1 In-Country Training Program

In accordance with the ToR this task included the planning, development and implementation of various types of training based on the particular requirements of each target group and the training methodology to be used. Moreover, the

qualification programs as well as the TNA results obtained at the early stage of the project were used to formulate a general training strategy and program and to develop training manuals.

Each training manual includes a detailed description of (1) Target group and Participants; (2) Training / Workshop Program; (3) General Learning Objectives; (4) Training sessions, expected outcomes and training methodologies used; (5) Trainers and facilitators for each session; (6) Training materials (documents); (7) Training requirements in terms of Infrastructure, equipment and organization, and (8) Evaluation methods.

Output 4 'Training Manuals with content of the courses' was structured as follows:

Part 1 includes 5 Modules of training material that have been submitted to the main beneficiaries for comments and approval. Part 2 includes the presentations delivered in the training courses (workshop 4-5 March 2008 & Regional trainings 7-21 May 2008) while Part 3 includes main Annexes related to the training courses and workshops for trainers and trainees (Agenda, List of participants, Evaluation of training courses).

All training material was delivered to the participants in hardcopy (reduced version) and the e version in a CD (full version) in Albanian version. The participants of the ToT course (workshop 15-16 April) received also a full version in English for comments. A certificate of attendance was awarded to all participants at all levels.

The 5 Modules of the training covered the following topics:

Module 1: *Social Health Insurance – Definitions & Payment methods; Countries Experience*

Module 2: *Contracting of Health Care Services – Types & Procedures; Purchaser-Provider relations; What should a contract contain; A model Contract*

Module 3: *Payment Systems for Health Care Services – Overview of provider payment systems: Types, assessment, procedures; Capitation & PHC services; Guidelines for introducing a global budget*

Module 4: *Costing of Health Care Services – Concepts & Methods of costing; Cost Centre Accounting; Use of Accounting Information*

Module 5: *Monitoring and Evaluation as a management tool*

The final workshop (4th level) of the project took place on August 1, 2008 and 15 staff members of the HII and the MoH participated. The agenda included a presentation of an overview of the project results, detailed comments of the HII staff on the case studies elaborated by the project team¹¹ and a briefing on the evaluation of the regional trainings. The session scheduled for working groups was - upon request of the participants - dedicated to an open and fruitful discussion of the project recommendations. The issues prepared to be dealt with in the frame of the working groups were covered through the comments made by the HII staff, mostly regarding capitation. The workshop concluded with very positive comments mostly from the side

¹¹ For a summary of the case studies see chapter 5 below.

of the beneficiaries regarding the project achievements. The workshop agenda is presented below:

**CONTRACTING AND PAYMENT MECHANISMS
- OVERVIEW OF PROJECT RESULTS -**

FINAL AGENDA

Session	Topic	Speakers
Session 1 9.30-10.00	Capacity building on Contracting and Payment systems: Overview of project results	Dr. Antonis Malagardis, Conseil Sante
Session 2 10.00-10.30	Evaluation of Training in the Regions - Recommendations	Dr. Merita Xhumari, Conseil Sante
Session 3 10.30-11.00	Comments on the Case Studies	Representatives of HII
Session 4 11.00-12.00	Working Groups (Contracting, Capitation)	Dr. Merita Xhumari/ Dr. Antonis Malagardis
Session 5 12.00-12.30	Presentation of the Working Groups Results	Rapporteurs
Session 6 12.30-12.45	Closing Remarks	
12.45-14.00	Lunch	

3.3.2 Highlights of the training evaluation

Regarding the evaluation of the regional training courses following aspects are summarized below:

It should firstly be underlined the high participation in the 5 courses from all institutions (MoH, HII, managers and economists of HCs and the regional Hospitals in Albania). From 375 participants invited, 366 persons joined the trainings, which represents a **97 % participation rate** as follows:

- 85 persons for two-days training 6-7 May 2008 in Tirana with participants from the regions of Tirana, Kukes and Tropoja.
- 71 persons for two-days training 9-10 May 2008 in Durres with participants from the regions of Durres, and Fier.
- 63 persons for two-days training 13-14 May 2008 in Vlora with participants from the regions of Vlora, Gjirokastra, and Berat.
- 75 persons for two-days training 15-16 May 2008 in Durres with participants from the regions of Shkodra, Dibra, and Lezha.
- 72 persons for two-days training 20-21 May 2008 in Elbasan with participants from the regions of Elbasan and Korca.

Out of 366 participants, **297 persons or 80 %** filled in and handed over the evaluation form, which demonstrates the high interest of the participants. The fact that approx. 20% of the participants did not fill in the form is due to the fact that these persons had to leave from the training location earlier as they had to travel more than 3 hours to reach their home addresses. The evaluation forms were completed as follows:

Location	Date	Nr. of Participants	Nr. of Evaluation forms	% of completed Evaluation forms

Tirana	6-7 May	85	72	84,7%
Durres	9-10 May	71	50	70,4%
Vlora	13-14 May	63	55	87,3%
Durres	15-16 May	75	55	73,3%
Elbasan	20-21 May	72	65	90,3%
TOTAL		366	297	100,0%

Institution where the participants are employed (based on completed evaluation forms)

Institution	Tirana 6-7 May	Durres 9-10 May	Durres 15-16 May	Vlora 13-14 May	Elbasan 20-21 May	TOTAL	%
ISKSH	19	16	16	18	17	86	29,0
Health Center	39	29	29	31	42	170	57,2
Hospital	7		5	3	4	19	6,4
MoH	4	5	5	3	2	3	6,4
IPH	3					3	1,0
TOTAL	72	50	55	55	65	297	100,0

The first

Question 1: To what extent do you feel that the content of the training will be useful?

Rate	Nr of Answers	%
1: Not useful at all	4	1,4
2	18	6,1
3	69	23,5
4	96	32,8
5: Very useful	106	36,2
TOTAL	293	100,0

Out of 297 participants who filled in the evaluation form, **293 participants (or 99 %)**. Out of them **70 %** said the training **will be very useful**. This is in line with the high interest ratio obtained by the persons in the frame of the TNA carried out in December 2007 with the aim to determine the topics for training. In other words, the project followed the basic principle of preparing **'Training tailored according to the needs of the main stakeholders in the field of health: MoH, HII and health care providers'**.

We consider that the evaluation results demonstrate that the content of the courses met the needs of staff of MoH, HII at the central and regional offices and of the health care providers. This is shown in the answers below:

Question 2: Which parts of the content do you feel will be most useful for the regional training?

Topics	Nr of Answers
Hospital costs	38
Monitoring and evaluation	48

Contracting methods	64
Cost calculation of health care services	56
Health Centre tasks	17
Payment system	50
The discussions with trainers	10
All parts	24

The participants confirmed that most the useful parts of the training will be the contracting methods, and the cost calculation of the health services. HII as a new public organization is performing new functions related to the contracting and payment of the primary health care providers, and with one pilot hospital in Durres. The trainers put therefore great emphasis to analyze the existing contracts (with HCs and with the Hospital of Durres) and discuss options to introduce new contractual relationships between HII and providers and instruct the participants to implement the new methods and approaches presented during the training course on these topics.

The analysis of the evaluation forms has shown that mostly the staff of central office of HII as well as the regional directors expressed a low interest on the topic of contracting. However, the overall results demonstrate that contracting is the highest priority of the trainees. The low interest of the HII staff at central and regional level on contracting needs to be analyzed in detail, mostly by the HR Department of HII; in our opinion the HII staff has demonstrated a ‘power position’ due to the fact that currently it is only the HII that prepares the contract to be signed by the HCs with no detailed negotiations taking place between the parties. On the other hand, it was emphasized during the training that there are still a lot of issues to be solved as part of the contracting negotiations that should be understood as a ‘negotiation between equal partners’. The latter, is even more important as the process of designing the new contract between HII and the HCs for 2009 is already well advanced.

To the ‘Question 3: Which parts of the content do you feel will be least useful or not at all useful?’ the following feedback was received by the participants:

Topic	Nr. of Answers
Hospital costs	63
Issues related to the HC	13
Contracting methods	17
Registration of population	12
None	45

It is clear that all the topics are considered very relevant to their job except for the calculation of the hospital cost. Comparing with the results of the TNA survey carried out in December 2007, the most difficult question to get an answer was related to the *identification of the main cost for health services*. Most of them had no knowledge about the cost identification as only some of them mentioned as the main cost item the salary of the family doctor. The explanation of this attitude is that the cost item is not considered important, as long as the budget is defined by the MoH/HII. The hospital services have not been yet been contracted by the HII, with the exception of the Durres Hospital.

More than 90 % of the participants said their understanding of Contracting increased as a result of the WGs based on the answers obtained under the following question:

Question 9: To what extent has your understanding of Contracting increased

as a result of the working groups?

Rate	Nr of Answers	%
1: Not at all	3	1,0
2	21	7,1
3	102	34,5
4	111	37,5
5: Fully	59	19,9
TOTAL	296	100,0

Despite the fact that costing issues are considered a rather complicated topic, the participants of the WGs were very proactive and showed great interest in exercises of cost calculation for hospital services as it was demonstrated through their replies to the following question:

Question 10: To what extent has your understanding of costing increased as a result of the working groups?

Rate	Nr. of Answers	%
1: Not at all	6	2,1
2	16	5,6
3	78	27,1
4	126	43,8
5: Fully	62	21,5
TOTAL	288	100,0

72 % of the participants replied that their understanding of costing increased considerably as result of the WGs. We believe that **2% of the participants**, whose knowledge was not increased at all as a result of the WGs discussions, belong to the Durrës Hospital as they are already aware and practice on daily basis on costing related issues. It should be underlined here that other Directors of regional hospitals confirmed explicitly their readiness to go through the process of contracting of hospital services with the HII despite the difficulties they may face at the beginning in dealing with costing issues.

Furthermore, issues related to the **payment system** drew a considerable attention of the participants. This was clearly demonstrated from their answers to question below:

Question 11: To what extent has your understanding of payment systems increased as a result of the working groups?

Rate	Nr of Answers	%
1: Not at all	3	1,0
2	25	8,5
3	87	29,6
4	117	39,8
5: Fully	62	21,1
TOTAL	294	100,0

Over 90% of the participants replied that their understanding of payment systems increased as a result of the WGs.

Question 12: To what extent has your understanding of monitoring increased as a result of the working groups?

Rate	Nr. of Answers	%
1: Not at all	2	0,9
2	11	5,2
3	69	32,4
4	81	38,0
5: Fully	50	23,5
TOTAL	213	100,0

More than 90% of the participants said their understanding of monitoring increased as a result of the working groups. They are trying to understand the new function, prepare concrete proposals for reorganization of their work with the aim to establish 'monitoring & evaluation' as the main function of the regional agencies of the HII.

The evaluation of the regional training included the following additional overall results:

Question 4: Were the concepts presented on the course easy or difficult to understand in the time allowed?

Rate	Nr of Answers	%
1: entirely too easy	35	11,6
2	37	12,3
3: just right	129	42,9
4	73	24,3
5: entirely too difficult	27	9,0
TOTAL	301	100,0

Almost **50% of the participants** replied that the concepts were just right to understand in the time allowed. The different methods used during the training, as well as the manuals in Albanian language (including all presentations) created opportunities for a good understanding of the topics and allowed to make reference to the Albanian context to exemplify the basic concepts, terms or/and procedures.

The project staff is aware of the fact that even if the duration of the course would be 5 days (instead of 2 days), it would not have been sufficient to analyze in depth all topics raised in the trainings. However, this training was planned to be a 'training model' and a first experience which will guide the preparation of similar capacity building measures in the future under the responsibility of the HII trainers selected under the current project. The trainers from HII have been part of the project expert's team with the main objective to develop further their approach, knowledge and skills on these topics.

Question 5: To what extent was the programme of the course well structured?

Rate	Nr of Answers	%
1: Not at all	0	0,0
2	13	4,3
3	78	25,9
4	105	34,9
5: fully	105	34,9
TOTAL	301	100,0

More than 70% of the participants replied that the program was well structured, which means that it was helpful for them to follow the presentations on the first part of the day and in the afternoon to go in the exercises on how they perceived the new ideas, and how they will implement these concepts in their respective institutions.

Question 6: Provide your evaluation of the training location (training room, services available to trainees, etc) where the course was delivered?

Rate	Nr of Answers	%
1: Poor	30	10,7
2	30	10,7
3	107	38,2
4	59	21,1
5: Excellent	54	19,3
TOTAL	280	100,0

Approx. **21 %** of the participants rated 1-2 the training location for the following reasons: not enough space (10 replies), inappropriate for training (6 replies), no microphone (7 replies). There is no doubt that the best locations require also more resources. In a situation that no adequate premises were offered by the MoH, (except for the Tirana regional authority) after the first course in Tirana, the project team decided to organize the training in spaces offered by Hotels (e.g. Durres – Hotel Majestic, twice; Vlora – Hotel Bologna and Elbasan).

Question 7: How do you rate the course presentations and training manual presented in the training?

Rate	Nr of Answers	%
1: Poor	2	0,7
2	9	3,0
3	74	25,0
4	137	46,3
5: Excellent	74	25,0
TOTAL	296	100,0

71, 3% of the participants replied that the course presentations and training manual were excellent (rate 4 and 5).

Question 8: How do you rate the training organization and logistics?

Rate	Nr of Answers	(%)
1: Poor	2	1,0
2	15	5,1
3	92	31,1
4	112	37,7
5: Excellent	75	25,3
TOTAL	297	100,0

Approx. **90%** of the participants replied that the training organisation and logistics were good-excellent.

Question 14: Opinion about the training

Rate	Nr of Answers	(%)
1: Poor	0	1,0
2	3	2,4
3	7	24,0
4	69	46,7
5: Excellent	134	25,8
TOTAL	287	100,0

About 95% of the participants expressed a very good opinion about the training.

Question 15: Would you recommend this training ?

Rate	Nr of Answers	(%)
1: No	13	4,3
2: Maybe	47	15,7
3: Yes	239	79,9
TOTAL	299	100,0

About 95% of the participants said they would recommend this kind of training.

Question 16: Are you able to deliver the regional training?

Rate	Nr of answers	(%)
1: Yes	166	56,7
2: Maybe	113	38,6
3: Yes and I don't need more training for 6-12 months	14	4,8
TOTAL	293	100,0

A big success: Out of 296, almost all of them give a positive answer to their abilities of acting as a trainer in the future on these topics. The project has developed the capacities in the field of contracting, payment, costing and monitoring & evaluation issues. The replies to question 16 demonstrated clearly that the project achieved the aim of the training: To develop the capacities not only on the central level, MoH and HII, but mainly on the regional level, where the main functions of HII are delegated in the process of decentralization of the administration of the health insurance system.

On the other side, the providers, who are expected to function as autonomous bodies need to be aware of their new functions and contracting issues are crucial. One of the objectives of the cascade training approach is to increase the knowledge and skills of the regional managers to successfully fulfill their new roles as well as to develop regional capacities based on similar trainings in the future. We consider that the best way is that trainings are initiated and funded by the HII but the organization and the responsibility for their development to be at the regional level. The fact that staff of the HII has undertaken the role of moderators has had a very positive impact on the participants as they are looking to their colleagues also as trainers. It is known the impact of the method of 'role player' and in this case we can say that the moderators

from HII have played with success their role and they can be now a strong pressure group inside HII to continue this process of trainings in the future.

3.4 OUTPUT 5 'CASE STUDIES AND ANALYSIS OF INTERNATIONAL EXPERIENCE'

This chapter includes a summary of the results of three case studies developed in line with the ToR of the project and presented in detail under output 5. It should be underlined that the case studies were discussed and agreed with the members of the JWG. In our opinion a case study should be the subject of capacity building measures and therefore it is crucial that it is prepared, presented, analyzed and evaluated in a systematic way as it has been explained in the full report on output 5, Appendix 1.

3.4.1 INTRODUCTION OF A FEE FOR SERVICE AND CO-PAYMENT IN ALBANIA

Albania moves towards the development of a mechanism of sharing the costs of services between patients and health insurance. What lessons can be drawn for Albania from the experience of other countries in the field of FFS?

Assessment of the situation

In order to make a decision for charging for health services concrete situation should be assessed on the basis of the following questions:

What is the objective in introducing user fees and co-payments? Determining what services to charge for and how much to charge will depend on the objectives for introducing the fee. Is it to expand access to basic services? Is it to increase the public health participation for vulnerable people?

The objectives for charging a fee should be clearly stated and discussed as they will form the basis for the decision about what to charge for and how much to charge. Charging for certain medical services may be the only way to provide the service. For other services charging fees may increase the access to and the use of these services.

Can the users afford to pay for the services offered? Fees should be not so high that users cannot afford to pay and co-payments should be proportional. If users cannot afford to pay, the introduction of fees and co-payments might lead to a large reduction in users.

Therefore, it is necessary to consider some way of helping people who cannot afford to pay so that co-payments do not prevent them from obtaining health services. The users' ability to pay will help determine how much of the costs can be recovered by fees and how much must be covered by other means like exemption programs.

What is the users' perception of the quality of services offered? If users believe that the services are of good quality, they will be more willing to pay for these services. Improvements can be made in the standard of services by: providing sensitive and clear counseling to users; maintaining an uninterrupted supply of health services; increasing the range of services; improving the condition of the building; reducing waiting lines; offering more convenient clinic hours.

Will the health care providers be able to keep and use some or all of the fees it collects? Fees generated by the health care provider should remain with him. This income can be used at the provider's discretion to support its own activities, such as improving the services or the facility (HC or hospital). To determine if charging fees will benefit the users, it shall be estimated how much of the total projected revenue will be retained for use by the facility.

What does it cost to the health care provider to provide services? Although it is possible to set fees without knowing the actual cost of each service, it is important to try to accurately estimate what this cost is. Knowing the cost of each service will help to determine how much of the costs can be reasonably recovered and enable to justify the level of the fee.

Once the above questions have been considered, decisions can be made: which services to charge for, what portion of the health expenses should be collected from users, how much to charge for different types of services and how the funds can be used to increase the quality and accessibility of the health services.

Current system in Albania

For Eduard, who lives in Albania we have the following situation: Eduard, 42, is insured with the HII. He visits this morning the HC in order to see his GP because he has had a pain in his leg for several days. When he arrives at the HC he registers like each patient and he sees his GP. After the visit, normally, he does not pay the GP because he is insured and the health services are covered for insured persons. Meanwhile, Eduard may give a direct payment (out of his pocket and informally) which will not be reimbursed by the HII. Fortunately, Eduard can afford to make an out of pocket payment.

His wife Albana, pregnant with her second son, has just had the first echography for the following of the pregnancy. She is insured with the HII and she is exempted from the fees for the specialist- 600 Leke for a gynecologist- and for the echography, because she benefits from the exemption program for pregnant women. At the beginning of her pregnancy, she wanted to choose a gynecologist close to her house. But he charges a high direct payment for the visit and she could not afford it because she needs several visits before the childbirth. Her gynecologist is far but his direct payment is lower than the first one. Sometimes, she goes directly to the emergency unit of the hospital. She knows that she must wait a lot before seeing a doctor; as she is exempted of the tariff of the visit in hospital, she prefers to go directly because the result is the same: she will pay a direct payment (out-of-pocket informally, kind of gift) for the doctor or the nurse in hospital.

His brother is not insured with the HII, because his employer is not paying contributions. When he needs to visit the GP, he goes to the HC and he pays 400 Leke for using public health services – authorized tariff of the visit for uninsured people. He pays also a direct payment which varies according to the GP. He is not reimbursed for 400 Leke or/and for the direct payments (out-of-pocket). Sometimes, he prefers to go directly to the private doctor, because the tariff of the visit is almost the same. He knows that if he needs more frequent care, he will not afford an expensive medical treatment and he will be obliged to ask his family for support for paying the expenses.

Determining the level of fees and co-payments

There are various ways of deciding how much to charge for a service. The easiest way to set a fee is to base it on what the users are able and willing to pay. This can be approached in various ways. For instance, a fee can be based on what users pay for services at other private facilities that already charge fees. The fees range between the charges at private, for-profit clinics (which usually charge the highest fee), and the charges at public health services (which are often free). Many countries had used this approach, mainly in primary health care, in order to set an amount for the fee. The level of the co-payment was set to a percentage of the fee (30-35% of the fee).

Another approach is to establish fees according to the cost of the health services. For example, a hospital might wish to recover 20% of operating costs by charging user fees. To do this, it needs to estimate the cost of each type of service using the actual costs of: personnel time (based on salaries), and other items used in delivering that service (materials, drugs, maintenance, etc). This approach (DRGs) is used for costing in the hospital sector.

An alternative approach, which could be used in Albania, is to establish fees at the level of the health service's tariff for uninsured people, for example, 400 Leke for a GP visit. In this context, Eduard - insured person, his wife Albana, who benefits of the exemption program, and his brother - uninsured person, pay 400 Leke for the GP visit. One part will be the part reimbursed by the ISKSH for Eduard and his wife and another part will be the financial participation of the patient at the visit, that is to say the co-payment. The draft mandatory health care insurance law specifies in Article 39, the "rate of co-payment may be fixed, or based on a percentage depending on the medical procedure". For example, 30% of the tariff may be the co-payment and remains at the GP. In this case, it is necessary to establish exemptions for people which can afford to pay, for example, 30% of the tariff.

Example of co-payment for a visit

Health service	Proposed level for FFS Tariff for uninsured people	Proposed amount of co-payment	Exemption	Process
Visit for GP	400 Leke	120 Leke (30% of the amount)	Exempted people according to the article 32 of the "Draft Mandatory Health Care Insurance Law"	Eduard, insured patient, pays 120 Leke to the GP. It is his financial participation to the visit. The contract between the GP and the ISKSH specifies the amount of the co-payment remains with the GP. For Eduard's wife, exempted patient, the amount of the co-payment is reimbursed to the GP by the ISKSH. His brother pays the total fee-for services (400 leks) without reimbursement by the ISKSH.
Visit for the specialist	600 Leke	180 Leke (30% of the amount)	Exempted people according to the article 32 of the "Draft Mandatory Health Care Insurance Law"	Eduard, insured patient, pays 180 Leke to the specialist. The contract between the specialist and the ISKSH specifies the amount of the co-payment stays to the specialist. For Eduard's wife, exempted patient, the amount of the co-payment is reimbursed to the specialist by the ISKSH. His brother pays the total fee (600 Leke) without reimbursement by the ISKSH.

Incentives for the GP or the specialist: One of the problems for its implementation can be the lack of accountability of the visits for not insured people. In order to encourage GP and specialist for registering the visit number of a not insured patient, one solution can be to link the visit number to the indicators for obtaining the bonus. For example, the bonus is allocated according to the total number of visits, not only to the number of visit for insured patients.

Developing a System of Exemptions for vulnerable people

In order to make health services more widely available to everybody, whatever the income level, it is important to establish a system to completely exempt certain categories of users from having to pay a fee such as non active persons. For example, users earning below the minimum wage or users suffering chronic diseases are exempt from program co-payments. A system for reducing co-payments needs to be simple so that it doesn't take up staff time. Such a system must also include controls to make sure that it is not abused. In Eduard's case, his wife will benefit of co-payment exemption: the tariff of the visit will be totally paid by Albana during her visit to the HC and totally reimbursed by the ISKSH to her.

3.4.2 Introduction of costing procedures for hospitals in Albania

The second case study analyzed the process of payment of a 'typical' French hospital based on a contract between the hospital and the Regional Agency of Hospitalization (ARH). The financing method is based on the model of "Diagnosis Related Groups (DRGs)" developed in Australia and in the United States in the 80s and 90s and introduced in Europe after 2000 (e.g. Portugal, Britain, Sweden, Switzerland, Italy, Belgium, Germany, etc). A comparison was made with the modalities of costing of health care services introduced in the regional hospital of Durres in Albania. The case study concluded with the future steps to be taken for having a functional costing and payment system for hospital services in Albania.

The case study also analyzed briefly the costing and payment systems in selected countries in Western and Eastern Europe. The most popular approaches in the early years of transition in Central and Eastern Europe were based on payment per day and per case, which can be viewed as linked. These systems were implemented in some countries in four or five successive stages:

- A specific rate per day based on the historical budget divided by the average number of hospital days, the denominator being based on the hospital, the category of hospital (for example, rural or urban) or a geographical region.
- A specific rate per discharge, regardless of case severity or hospital, which (predictably) encouraged admissions of easy cases relative to severe ones.
- A specific rate per discharge, adjusted by type of facility, so that, for example, a specialty hospital was differentiated from a small rural hospital, to proxy both differences in case mix and differences in input costs such as labour costs.
- A specific rate per discharge, adjusted by clinical department across hospitals, with some facility-based adjustments.
- Real average case costs were calculated for each hospital by each clinical department and averaged across all hospitals, resulting in a unified weighting scale against the average cost of the treated case in the defined region.

Countries started at different levels and progressed differently, and typically included only recurrent costs not capital costs or depreciation. Nevertheless, these steps serve as a developmental framework for examining these countries in terms of alternative

hospital payment models. The table below summarizes hospital payment systems in selected countries in Central and Eastern Europe ¹².

Country	Line item	Per diem	Per case	Global budget
Albania	X			Developing
Bosnia & Herzegovina			Developing	Developing
Bulgaria			Developing	X
Croatia		X		X
Czech Republic			X	X
Estonia		X	X	
Moldova	X			
Poland			X	X
Romania			X	X
Slovakia		X	Developing	Developing
Slovenia		X	Developing	X
Ukraine	X			

Experience shows that all countries implement a combination of payment systems that depends on the local particularities in terms of health policy, the weight of local lobbies of medical professionals and the level of data computerization in their system, in particular the human and technical capacities to support more complex costing systems. ¹³

The case of Durres Hospital

The Durres Hospital has a contract with the HII on the identification of the patient costs by diagnosis. These data are provided on a monthly and annual report on the base of the patient medical cards which details precisely the consumption of hospital resources for each patient. The results give an information system based on the main activities of the hospital – surgery, obstetrics, pediatrics and medicine.

The information system provides elements for a case-mix adjusted global budget based on major diagnosis types. The HII collects monthly data in order to calculate the costs for the main diagnosis categories. The 3 digit classification system ICD-9 is used for the classification of the diagnosis. The medical information system details:

- total expenses by diagnosis
- number of cases by diagnosis
- average length of stay (ALOS) by diagnosis
- average cost by diagnosis
- % of drugs in the total cost by diagnosis
- % of staff expenses by diagnosis
- % of administrative costs by diagnosis

508 diagnosis have been itemized in 2007 for 12885 cases and 4.69 days in average.

¹² For more details on payment systems applied in South-Eastern Europe please refer to: *World Bank (2007) Sustainability of Health Care Financing in the Western Balkans: An Overview of Progress and Challenges* (by Caryn Bredenkamp and Michele Gragnolati), Policy Research Working Paper 4374

¹³ Please, refer to Module 4 of the Training Manual for details on the most common costing methodologies.

The European experience and particularly the case of a French hospital analyzed in the frame of the case study shows that it is a long process to introduce a payment system according to the kind and volume of activity carried out by the hospital. An implementation of an appropriate health information system (HIS) in other hospitals will allow to compare the information system data between hospitals, for example the use of medical resources, the length of stay, or the cost per diagnosis. This is the basis of the output-based payment system. It brings the mayor advantage of encouraging hospitals and departments/clinics to collect and analyze information and data about patient management and costs, and to be interested in cost-effective clinical pathways for main case-types allowing for and easier future introduction of a DRG system.

Contracting arrangements

In a first stage, a contract between the HII and the hospitals is to be introduced, which will define the hospitals' global budget based, for example, on last year's expenditures and on last year's performance according to the information system developed in the Durres Hospital ¹⁴. If these contracting arrangements are introduced by various hospitals in Albania at the same time, they will allow the collection of data by hospital related to different performance results and costs per patient; this would allow further analysis and negotiations for the next year contract details.

Moreover, intensive training is to be organized by the HII for staff of hospitals in order to explain the costing procedures and the data collection. The training material developed under the current World Bank project, in particular the module 4 on Costing of health care services, provides a good basis for further capacity building measures.

Please, refer to Output 5, Chapter 2 for a full analysis of the case study on payment and costing of hospital services.

3.4.3 Introduction of capitation payment system for PHC in Albania

The third case study included under output 5 analyzed key issues related to capitation (e.g. calculations, registration of beneficiaries, priorities for the introduction of a capitation payment system in Albania, etc.). Following aspects are summarized below:

Pro & Contra capitation – Enrollment related issues

International experience with the introduction of 'simple' or 'sophisticated' capitation needs to be well coordinated with the existence of fee-for-service (or co-payment) as the existence of patient co-payments could encourage the development of a two-tier system where 'community service card' patients may be under-served to increase profits while 'fee-for-service patients' are over-served to increase profits. Therefore, the primary health care strategy of a country should focus on reducing health disparities. This is an important consideration made during the development of the strategy on contracting and payment mechanisms development for Albania. However, it is not achievable where the groups the disparities are likely to be under-served while those with better health status are likely to be over-served.

¹⁴ Please, refer to Module 3 of the Training Manual for detailed guidelines for transforming a 'line-item budget' into a 'global budget'.

Another crucial dimension of capitation is the development of enrollment procedures which apply to the inhabitants of a defined catchment area. Countries follow various approaches for enrollment depending on their administrative particularities as well on the patients attitudes. However, there is a common trend to set-up mechanism that create less incentives to refuse the enrollment of people with poor health status and/or high health needs, or to refer them quickly to other services, so that the cost is born by another provider such as a hospital.

An advantage being put forward for capitation is that it allows the most appropriate person, including nurses, to be used, rather than doctors. Often the main reason doctors insist on seeing patients is to get the fees, which makes transparent the orientation of general practice. This practice may 'upgrade' nurses' work as they are not only registering patients and complete statistical forms under the GPs supervision but are being recognized as having a value only because it doesn't cost the GPs income.

Enrolment may be mandatory or compulsory depending on the evidence that is produced as to what advantages enrolment offers to patients within a certain health care system. It should be assessed, if it offers lower costs, if choice is less limited (than without enrolment) and if it may facilitate patients accessing the services they want. The efficient introduction of enrolment also depends on the public information policy to be followed on all administrative levels and to what extent patients will be offered real possibilities to seek care elsewhere. Public awareness also depends on the administrative support (mainly provided by Health Insurance Institutions) to overcome difficulties of enrolment and in allowing people to change doctors under capitation.

The strategy for contracting and payment mechanism for Albania states that capitation will offer better coordinated care and that providers will be responsible for the health of their enrolled populations. However, in order to achieve this objective evidence needs to be produced to show that enrolment achieves all positive outcomes (e.g. collect and evaluate information about how patients use primary medical care services and how they choose where to attend).

In Albania patients have traditionally been able to use a number of providers for different purposes and to choose specialist with particular expertise in an area. Health Centers need to recover the trust of the population but it is obvious that some HCs might provide services that others do not depending on the capacities of the GPs as there is often a great deal of uncertainty surrounding diagnosis and treatment and varying levels of practitioner experience and skills. Albanian patients show by their attitude that they value the ability to decide where they receive care. Therefore, it is reasonable to conclude that people will continue with the same provider while it is convenient and while they receive a good standard of care. If primary medical care ceases to be convenient and/or satisfactory then people should be free to move to other GPs.

While capitation is mainly planned for insured persons, no funds will follow non-insured persons. This category of population should be strongly encouraged to join the health insurance system so that the 'capitated' amount will also take into account this category of population and mostly in terms of pharmaceuticals, laboratory needs, etc. The proposed strategy for Albania needs to be more specific on this issues in the near future and mostly in relation with the provisions of the Draft Law on Health Insurance Fund (dated 27 February 2008).

Some of the key questions that need to be addressed – also in relation to the Basic Benefit Package - by the corresponding authorities in Albania in the near future are as follows:

- **Choosing enrolment:** Who will ensure that people make an informed choice about whether to enroll? What information will people be given to make a decision? If GPs try and enroll their patients, what protection will there be that unbiased information is given? How will consumers be made aware of the services a HC offers and does not offer? (For example, will a HC have to state if it cannot provide a woman for vaginal exams?) It is also possible that some doctors will simply enroll or not enroll their patients without consulting them at all. How will this process of enrolment be monitored?

- **Changing provider:** Will a patient have to go through a process to change from one enrolled provider to another? Will there be a time limit on how often this can happen?

- **Using a range of providers:** If a patient wishes to use a provider other than one within the enrolled practice, what will the process be for doing so? Will the patient be able to simply present at the second provider, or will there be an administrative process to be gone through (e.g. reimbursement, vouchers, health cards)? Will there be a cost? Will it possible for the patient to do this in confidence from the first provider, or will some transaction take place that informs the first provider that his or her client has visited someone else? What guarantee will there be that the second provider must see the patient and not decline because he or she doesn't hold the 'capitated' funds?

- **Cream-skimming:** What process will be put in place to ensure that providers do not decline to enroll high use users, such as those with chronic illnesses, mental health problems, and elderly people?

Other aspects to be addressed in the design of the capitation & enrolment procedures in Albania include the following:

Many factors could contribute to make the GPs avoid or encourage to enroll patients. Among these are the financial incentives common in capitation systems, such as bonuses for limiting expensive services (e.g. hospitalization). The need for such measures might be increased by the fact that, without them, GPs will be in a position to offload care (and shift costs) to the secondary care, for example without loss of income. As there will be more pressure to manage costs, doctors might be unable to avoid such incentives. Countries experience demonstrates that insufficient financial incentives for GPs are often the main reason for the failure to reduce the use of hospital services.

Other factors contributing to risk avoidance include diagnosis, treatment, and management of chronic illnesses, such as AIDS and heart disease, which drain scarce resources and physicians' time. Briefly, risk avoidance can never be eliminated entirely as methods that can reduce this problem (e.g. mixed payment systems and risk-adjusted capitation rates) also reduce efficiency. Physicians maybe in a 'lose-lose' situation under capitation. Guided by personal and professional ethics, they want to give the best possible care but find themselves locked into a system where their own financial well-being conflicts with their patients' best interests.

Priority issues related to registration of population in Albania and the role of HCs

The issue of registration is to be dealt with in a different way as the enrolment; the latter one requires that the population of a certain catchment area is 'officially registered' and that a person can identify himself upon request of the doctor. In Albania it is crucial that the identification of each citizen (name and address) is done properly in order to allow enrolment procedures to be introduced efficiently. This part of the case study refers is based on the results of discussions that were held with staff of HII at central and regional level as well as with members of the HCs and follows the aim to summarize the priority measures to be taken to improve registration of population in Albania.

Registration and reporting

Accuracy of the data in registering is the first necessary step in defining clear indicators for the payment system, especially for capitation. It is crucial to avoid double registration, which is due to the 'chaotic' free movement of people in Albania, and the right of patients to choose their GP. This situation has created a lot of problems with registration such as:

- a. Double registration of population;
- b. HC do not report in time;
- c. HC do not report all the movements of population and do not follow the established rules;
- d. The local authorities do not have accurate statistical data and the HCs do not have sufficient human and financial resources to support the registration of patients;
- e. This negative situation has financial consequences for the HCs, in particular related to the funds for reimbursement of drugs and other services provided by the HCs and is related to the low quality of services.

Possible solutions:

1. The computerization of the system can solve a lot of problems, especially if all the Albanian citizens will have the health card. Currently, not even all insured persons are equipped with the health booklet, so it is difficult to identify the insured and uninsured. Moreover, due to high level of corruption among the medical staff insured and uninsured are paying out of their pocket to receive the necessary health care;
2. Revising the payment norms of GPs will motivate them to improve the registration of their patients;
3. In some small HCs (e.g. Pogradec in Korca Region) they have completed the registration of their population last year. This experience need to be applied also to all HCs in the country as it will also help the further steps in computerization of the health information.
4. HII to issue specific regulations how to proceed with special categories like: students who are resident in a city and staying in Tirana University for a certain period of time, Albanian emigrants who are coming and going time after time, people from rural who live in urban areas, but they do not prefer to be transferred there, because of the land ownership and other privileges registered as self-employed.

5. Reporting of the main indicators to be obligatory for all categories of physicians, GP, Pediatricians, obstetric-gynecologist, who are registering the visits of children, mothers, pregnant women, and not only for the family doctor.
6. A very important issue is development of a better network with local authorities, who are responsible for registering the population.
7. Registration to be included as an incentive for the contract 2009. That's why it is important to increase the awareness of the population to do registration as a way to receive their benefits from health care insurance system. Here to be engaged the Personnel of HC, of the regional offices of HII,
8. In order to avoid abuses and incorrect registration, one option would be to calculate the salary of the GP in the same way as for the nurses (not based on the registered population) but on the number of visits they do, level of the mortality, referrals to the specialists or hospitals, the number of patients visits for the first time, the reporting in time and correctly, etc.

Strategic Changes and Recommendations for future action by HII

The strategic plan for contracting and payment mechanisms developed under the project provided an overview of major tasks that are necessary, collectively, to deliver the benefits of the revised financing of health care reform. Based on the case study results on capitation and in relation to the contracting arrangements we would like to underline the main activities that are structured round 4 main blocks (Budgeting, Contracting, Provision of Medical services, Monitoring of performance). Each block in addition to the cross-cutting field of IT is a major change management project which the key partners in the health system reform (MoH and HII) need to take into consideration adequately also in the context of implementation of the forthcoming Law on Health Care Insurance Fund (HCIF). Therefore, it is necessary to adjust the process of strategic change to remove the barriers to reform and allow the full benefits of the changes envisaged be rapidly delivered throughout Albania.

In order to achieve sustainability of results the following important principles need to be followed during the process of strategic change:

- Full implementation of the Health Financing reform strategy will take a minimum of 5 years and all health service priorities and service changes cannot be attempted at once.
- The planning and redevelopment of the health services should be undertaken in a certain number of planning cycles (up to 4); each planning cycle may require up to 2 years for completion and several planning cycles will be required to deliver the full benefits of the Health Financing Reform Strategy.
- In each cycle, a small subset of health service priorities should be identified, developed and successfully implemented. These priorities will include not just health service changes, but also other essential changes, for example, in health policy, health financing, restructuring and management as indicated above.
- The first planning cycle should focus on the reform of the health purchasing system through the approval of a new legal framework related with the health purchasing system and the implementation of new financial mechanisms. Such mechanisms may

include at least following components: a BBP for all citizens (state financed), a supplementary BBP for the most vulnerable groups of population (state financed) and a voluntary benefits package (privately financed).

- Redevelopment of the systems and methods of financial management for each of the components mentioned previously must be implemented early in the reform, under a decentralized framework.
- Significant macro financing barriers to the reform strategy must be resolved, in particular, the lack of working capital to fund sufficiently the launching phase of the change process, addressing the significant issue of criteria for regional allocation of budgetary resources.
- Significant policy barriers to the strategy in the form of legal and other regulatory barriers and the lack of clear enabling policy for some of the critical changes to support the health service priorities identified so far by the TA projects, in particular those of the World Bank.
- The approval of the new Law on Health Insurance Fund including a real and tangible commitment to its implementation at all administrative levels is essential in order to advance in strategic changes.

The acceptance of these principles and the completion of further work to resolve the associated issues of detail is part of the essential preparation for the implementation of the health reform strategy in Albania.

3.5 PREPARATION OF THE TRAINING PROGRAMM ABROAD

In addition to the delivery of outputs 1-5 summarized above in the FR the project initiated contacts to various health insurance institutions in order to organize a study tour that would fit the requirements of the future development of the health financing system in Albania taking into account the LTSHSD and the Draft Law on Mandatory Health Care Insurance Fund. Study visits and other training programs abroad can be very useful tools to function as “eye-opener” and to provide very specific information about the practice in a relevant international setting. Based on the aspects mentioned above the project elaborated a very detailed 8 days study tour programm that includes all speakers, who confirmed to participate as needed. The contact details of the key person (Dr. Aurora Dragomiristeanu) for the organization of the study tour is also provided and she can be contacted by the HR Department of HII when the decision on carrying out the study tour has been taken.

Study Tour to Romania

Draft Programme

Day 1: Sunday

TBD

Pick-up at the airport

Contact: Dr. Aurora Dragomiristeanu

Phone No. : +40722 751147

- TBD** **Check in at Hotel Minerva**
- 15.00 – 18.00** **Visit Tour Bucharest – Village Museum**
- 19.00 – 21.00** **Dinner (Reception of the participants)**

Day 2: Monday

- 9.00-9.30** Presentation of the study tour participants and the study tour plan;
- 9.30-11.00** **Session 1 – Introduction in the Social Health Insurance System in Romania (and brief comparison to Albanian Health Insurance System)**
- The health care system reforms in Romania and Albania will be presented in a comparative way with emphasis on the role of the main actors in the health insurance system.
- Venue:** National Health Insurance House – Conference Room
Presenters: DR.VASILE CIURCHE – PRESIDENT OF NATIONAL HEALTH INSURANCE HOUSE; A REPRESENTATIVE OF THE ALBANIAN DELEGATION
- 11.00 -11.30** **Coffee break**
- 11.30-14.30** **Session 2 – Visit to National Health Insurance House**
 Short presentation of main functions and responsibilities of Contracting, related to primary and hospital care
- Venue:** National Health Insurance House
Presenters: STOELEANA – DIRECTOR OF BUDGET DIRECTORATE; LILIANA LUKACS –GENERAL DEPUTY DIRECTOR OF RELATIONS WITH PROVIDERS DIRECTORATE; CHIEF PHYSICIAN
- 14.30-16.00** **Lunch Break**
- 16.30-17.30** **Session 3 – Visit to the Ministry of Public Health**
 Tasks and responsibility of the Ministry of Public Health and District Public Health Authorities in the social health insurance system; the autonomy of the health care providers; the roles of family practitioners in the health status evaluation program
- Venue:** Ministry of Health –Administrative Council Room
Presenters: DR ADRIAN PANA – GENERAL DIRECTOR, GENERAL DIRECTORATE OF HEALTH POLICY, STRATEGIES AND QUALITY MANAGEMENT
 DR CRISTINA VLADU – DEPUTY GENERAL DIRECTOR, GENERAL DIRECTORATE OF HEALTH POLICY, STRATEGIES AND QUALITY MANAGEMENT
- 17.30-18.00** De-briefing of the day

Day 3: Tuesday

9.00-11.00 Session 1 – Visit to Center for Diagnostic “Prof.Dr.Victor Babes”

Learning about contracting system and new autonomous health providers in order to strength the capacity of the newly established structures

Venue: Bucharest, Center for Diagnostic “Prof.Dr.Victor Babes”

Presenters: CONF.DR.PETRE CALISTRU

11.00-11.30 Coffee break

11.30-12.30 Session 2 – Outsourcing

Learning about collaboration between public and private providers.

Venue: Bucharest, Center for Diagnostic “Prof.Dr.Victor Babes”

Presenters: CONF.DR.PETRE CALISTRU

13.00-15.00 Session 3 - Legislative framework

Elaboration of important laws concerning the structure and organization of the new Romanian health care system (Social Health Insurance Law, College of Physicians law, Public Health Law and Hospital Law). Policy issues, interests of main actors, resistance to change and change management.

Venue: Bucharest - Health Commission of Romanian Senate

Presenters: DR. GABRIEL POPA – SENATOR, MEMBER OF HEALTH COMMISSION OF ROMANIAN SENATE, PETRU MOVILA DEPUTAT, MEMBER OF HEALTH COMMISSION OF DEPUTY CHAMBER OF ROMANIAN PARLIAMENT

15.00 – 16.30 Lunch Break

16.30 – 19.30 Transfer to Poiana Brasov

Day 4: Wednesday

9.00-11.00 Session 1 – Visit to District Public Health Authority Brasov and Neurology and Psychiatry Hospital in Brasov

Main tasks and responsibilities of DPHA. Role of district public health authority in planning of services, financial planning, human resource planning, planning of equipments.

Organizational structure of hospital. Financial planning and hospital management; Hospital information system;

Venue: Brasov

Presenters: DR. ALEXANDRU GRIGORIU – DIRECTOR OF NEUROLOGY AND PSCHIATRY HOSPITAL IN BRASOV

11.00-11.30 Coffee break

11.30 -13.00 Session 2 – Visit to District Health Insurance House Brasov

Contract negotiation; Reporting System – focus on type of provided services under the contract; Quality parameters for accreditation and quality assurance

Venue: Brasov

Presenters: DR. ELEMER WUSINSKY – CHIEF PHYSICIAN AND REPRESENTATIVES OF EACH VISITED DEPARTMENT

13.00-14.00 Lunch Break in Brasov

15.30-17.0 Session 3 – Health care system reform – Transition from a tax-based system to a pluralistic social health insurance system

Shift from an integrated, centralized, state owned and controlled tax-based system to a more decentralized and pluralistic social health insurance system, with contractual relationships between health insurance funds as purchasers and health care providers;

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Presenters: PROF. DR. CRISTIAN VLADESCU – PROFESOR IN PUBLIC HEALTH AND HEALTH MANAGEMENT, UNIVERSITY OF MEDICINE TIMISOARA

17.00-17.30 De-briefing of the day

Day 5: Thursday

9.00- 11.00 Session 1 – The framework contract

Presentation of the content of framework contract. Changes in the FC during the years (resources allocation, payment mechanism, reporting system, provider's accreditation), lesson learnt from Romanian experience

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Presenters: DR. CEPOI VASILE - CONSOLER OF THE HEALTH COMMISSION IN THE DEPUTY CHAMBER OF THE PARLIAMENT

11.00-11.30 Coffee break

11.00-13.00 Session 2 – Main elements of the Romanian contract of health services

The aim of this session is to demonstrate how the contractual parties (medical services providers and DHIF as a financial organization) are negotiating in order to obtain benefits: a high quality level service to the insured people and a higher payment for medical providers. Presentation of different model of contracts and contracting process, lesson learnt from Romanian experience

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Presenters: DR. CEPOI VASILE - CONSOLER OF THE HEALTH COMMISSION IN THE DEPUTY CHAMBER OF THE PARLIAMENT

13.00-14.30 Lunch Break

14.30-16.30 Session 3 – Aspects regarding standardization of information for insured persons and management information system, reports and monitoring

The aim of this session is to present the main data collected in electronic format for the evidence of insured peoples; information flow; control and monitoring; integration of the health information system at the district level. Will be presented the main data collected in electronic format from hospital;

information flow; reporting system; control and monitoring of contracted services; DRG - case study.

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Presenters: DR. DANIEL CIUREA – CONSULTANT IN THE CENTER FOR HEALTH POLICIES AND SERVICES

16.30-18.00 De-briefing of the day

20.30

Dinner

Venue: Poiana Braşov, Sura Dacilor

Day 6: Friday

9.00-10.30

Session 1 – Site visit to transportation hospital Brasov

Organizational structure of hospital. Financial planning and hospital management; Hospital information system; the contract of services – particularities.

Venue: Braşov

Presenters: REPRESENTATIVES OF EACH VISITED DEPARTMENT

11.00-11.30 **Coffee break**

11.30-13.30

Session 2 – Organization and management of social health insurance network; parallel health sectors and their insurance houses.

Statute of national and district health insurance houses; particularities of parallel insurance houses; framework contract; adapting a provisional benefits package to available resource levels - defining the package of services to be purchased; management and decision making process in social health insurance network.

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Presenters:

EC.GABRIELA ION – DIRECTOR OF HEALTH DIRECTORATE TRANSPORTATION HEALTH INSURANCE HOUSE

13.30-14.30 **Lunch Break**

14.30-16.00 **Session 3 – Financial Planning of a Health Care System in transition.**

Lessons learnt the experience from pilot projects; the budget planning process for main sectors of health care provision; new criteria of financial resources allocation and the changes implemented in the transition period. The changes in the hospital financial management.

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Presenters: DANA BURDUJA - CONSULTANT IN THE CENTER FOR HEALTH POLICIES AND SERVICES

16.00-16.30 **Coffee break**

16.30-17.30 Topic of session #4 – Hospital financial management.

The changes in the hospital financial management – accounting system and cost of services. Financial autonomy of the hospital: hard budget vs. soft budget.

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Presenters: DANA BURDUJA - CONSULTANTS IN THE CENTER FOR HEALTH POLICIES AND SERVICES

Day 7: Saturday

9.00-11.00 Session 1 – Action Plan workshop

Based on the recommendation for strategic plan, and lessons learnt the participants will develop an action plan for the proposed changes in the Albanian health care insurance system.

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Facilitators: Dr.Aurora Dragomiristeanu – Public Health and Health Management; Dr. Dana Otilia Farcasanu – President of Center for Health Policy and Services

11.00-11.30 Coffee break

11.30-12.30 Session 2 – Presentation of the Action Plan

Venue: Poiana Braşov, Hotel Piatra Mare/Alpin/Ana

Facilitators: Dr.Aurora Dragomiristeanu – Public Health and Health Management; Dr. Dana Otilia Farcasanu – President of Center for Health Policy and Services

12.30-13.00 Session 3 – Evaluation of study tour

Venue: Poiana Braşov, Hotel Piatra Mare

Facilitators: Dr.Aurora Dragomiristeanu – Public Health and Health Management

13.00 -14.30 Lunch

14.30 -17.00 Visit to Bran Castle

Venue: Bran

Day 8: Sunday

9.30 Departure from Poiana Brasov

10.30-12.30 Visit to Peles Castle – Sinaia

12.30-14.0 Lunch Break

TBD Transfer to airport/Departure

Program facilitators:

Dr.Aurora Dragomiristeanu – Public Health and Health Management

Dr. Dana Otilia Farcasanu – President of Center for Health Policy and Services

4. APPENDIX

4.1 OVERALL PERFORMANCE PLAN (FINAL)

Overall Plan of Operations (Draft 2)						
Project: Technical Assistance for Capacity Building on Contracting and Payment Methods		A World Bank financed Project		Country: Albania		
Planning Period		Prepared on 18.10.07 by Antonis Malagardis (revised 01.12.07)		Consultant: CONSEIL SANTE		
Activities/ Tasks/ Outputs			Agreed objective Verifiable indicators	Reason of deviation (if applicable)	Comments on constraints & assumptions	
Activities	Target Date	Responsible				
Task 0	Inception Phase	November 30,2007	AM	Inception Report is finalized	n/a	Good cooperation with MoH & HII
	0.1 Setting-up the project team	September 28,2007	AM	Local Staff/Office premises/Equipment avail	n/a	Availability according to workschedule
	0.2 Interviews with main stakeholders	November 9,2007	AM	Report on interviews	n/a	Administrative officials are ready to co-operate
	0.3 Establish Joint Working Group	octobre 9, 2007	AM	Decision of HII to set-up JWG/Minutes	n/a	Participation to JWG as planned
	0.4 Organize project Kick-off meeting	novembre 5, 2007	AM	Agenda & Participants List & Minutes	n/a	Participation to the meeting as planned
	0.5 Submit Final Inception report	December 14,2007	AM	Final inception report	n/a	MoH, SII and Hospital data are available in time
Task 1	Development of Provider Payment and Contracting Methods & Implementation Plan	November 16,2007	SH	Final policy document	n/a	MoH, SII and Hospital data are available in time
	1.1 Draft options paper based on Albanian context, Long term Strategy for Health System Reform (LTSHSR) & International Best practice	November 30,2007	SH	Document is distributed for comments	n/a	Active participation of counterparts
Output A1	1.2 Final Provider Payment Policy Document & Draft Implementation Strategy	December 14,2007	SH	Final Policy & Implementation strategy	n/a	JWG meet as planned; relevant authorities submit comments
Task 2	Development of Final implementation Plan	November 30,2007	SH	Final Implementation Plan	n/a	Relevant authorities co-operate as needed
	2.1 Discuss Payment & Contracting implementation plan with counterparts	November 21,2007	SH	Report on implementation plan review	n/a	Active participation of counterparts
	2.2 Reach agreement on payment & contracting policy implementation plan	November 30,2007	SH	Decision of counterparts on implementation	n/a	All stakeholders co-operate as needed
Task 3	Preparation of a qualification program	December 14,2007	GM	Reports on needs assessment	n/a	Data accessibility
	3.1 Define institutional requirements	November 16,2007	GM	A model for organization in HII is defined	n/a	Relevant authorities co-operate as needed
	3.2 Develop staff qualification program for MoH and HII	November 30,2007	GM	Programm & Job descriptions	n/a	Data accessibility
	3.3 Carry out TNA of MoH and HII staff	December 14,2007	GM	Report on training needs assessment	n/a	Active participation of counterparts
Output A2&A3	Report on Qualification Programm & Assessment of Staff Capabilities	December 21, 2007	GM	Final Report on Qualification Program	n/a	Relevant authorities co-operate as needed
Task 4	Preparation & delivery of an in-country training program	1/26/2008 & 6 months delivery	AM	Report on training strategy and program	n/a	Accessibility to requested data
	4.1 Selection of local trainers	December 14,2007	MX	ToR for each trainer are finalized	n/a	Participation of relevant entities

	4.2 Draft training manuals	January 12,2008	AM	Draft of Training Manuals	n/a	Active participation of counterparts
	4.3 Revise Training Manuals	January 26,2008	AM	Final version of Training Manuals	n/a	Relevant authorities submit comments
Refer to Task 6	4.4 Define training calendar & Locations	January 13,2007	MX	Training Calendar & Training Locations		Agreement of beneficiaries as needed
	4.5 Workshop on general qualification for MoH, HII and IPH staff (25 persons)	20-21 February 2008	AM	Agenda & Participants List	n/a	Participants willing and available to collaborate
	4.6 Training for MoH, HII & IPH (40 persons)	5-6 March 2008	MX	Agenda & Participants List	n/a	Participants willing and available to collaborate
	4.7 Train of Trainers (10 persons)	19-20 March 2008	AM	Agenda & Participants List	n/a	Participants willing and available to collaborate
	4.8 2 Training courses in regions for MoH, HII and Health providers (375 persons)	April 2008	AM	Agenda & Participants List	n/a	Participants willing and available to collaborate
Output A4	Training Manuals	février 15, 2006	AM	Training Manuals ready for use	n/a	Counterparts approve Manuals as needed
Task 5	Preparation and implementation of case studies	juillet 31, 2008	AM	Case studies implemented	n/a	Counterparts co-operate as required
	5.1 Selection of priority data, define information needs and select data sources	January 19,2007	AM		n/a	
	5.2 Selection of case studies	January 26,2007	AM	List of case studies	n/a	Active participation of counterparts
	5.3 Development of a study agenda for the short and medium term is developed	février 25, 2007	AM	List of specific studies	n/a	Beneficiaries discuss and agree
	5.4 Elaboration, presentation and use of case studies	juillet 31, 2007	AM	Case studies used appropriately	n/a	Active participation of counterparts
Output A5	Report on case studies and analysis of international experience	juillet 31, 2007	AM	Final Report on case studies submitted	n/a	Counterparts approve Report as required
Task 6	Preparation of the Training Calendar and training locations	January 19,2007	MX	Training Calendar & Training Locations	n/a	Agreement of beneficiaries as needed
	6.1 Preparation of a training calendar	January 6,2008	MX	Draft Training Calendar	n/a	Relevant authorities & institutions confirm their availability
	6.2 Selection of Training locations	January 6,2008	MX	Locations defined	n/a	Relevant authorities & institutions decide as required
Task 7	Preparation of a training Progr. abroad	mars 7, 2008	AM	Training program ready	n/a	Counterparts approve as required
	7.1 Propose a training program abroad	February 4,2008	AM	Draft Proposal	n/a	Active participation of counterparts
	7.2 Support to establish contacts	février 15, 2007	AM	Preliminary contacts established	n/a	Contacted institutions respond as needed

4.2 MAIN CONTACTS

CLIENT	
Name	Position
Saimir KADIU	Director, Financial Planning Department and Implementation of World Bank Project

CONTACTS in ALBANIA HEALTH SYSTEM	
Name	Position
Ministry of Health (MoH)	
Dr Arben IVANAJ	Deputy-Minister
Dr Edmond STOJKU	Head of MoH Directorate of Health Policy and Planning
Dr. Gazmend BEJTJA	Director of PHC Department
Dr. Erol Chomo	PHC Specialist
Ms. Aida Ioanidi	Director of HR Department
Ms. Ana LIPE	Budget Unit
University Hospital Center 'Mother Theresa' Tirana	
Dr Bajram BEGAJ	Medical Director
Ms Ledina MANUSHA	Economic Director
Mr Ilir AKSHIJA	Head Statistics Unit
Ms Besa CUKALLA	Head External Relations + PR
EPOS Project in Tirana	
Dr Erion Dasho, MD, MPH	Regional Representative
Health Insurance Institute (HII)	
Ms Elvana HANA	General Director
(*) Dr Gazmend KODUZI	Director of PHC department
(*) Ms Ermira Verli	Director of HR Department
(*) Dr Enida XHUMARI	Specialist, Department of PHC
(*) Albana ADHAMI, MD	Head of Family Medicine Department
(*) Aleksander HAXHI	Specialist
(*) Naun SINANI, MD	Specialist, PHC Department
(*) Ms Florida KOSTAQI	Specialist, Legal Department
(*) Ms Leonora HORANLLIU	Head of Budget Department

Note : (*) Member of the project Joint Work Group (JWG) set-up on October 9, 2007