

Albania
Ministry of Health
World Bank

Health System Modernization Project

Technical Assistance for Framework for Provider Autonomy

Grant No. TF 055804
Project ID No. P08/2814

Report including the Role of Local Authorities in Each Type of Health Facility
April 2008



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Acronyms

AHC	Autonomous Health Center
AHSS	Albania Health System Strategy
APHCC	Autonomous Primary Health Care Center
CEEC	Central and Eastern European Countries
CME	Continuous Medical Education
CPD	Continuing Professional Development
CPG	Clinical Practice Guideline
DRG	Diagnosis Related Groups
DH	Durres Hospital
DRH	Durres Regional Hospital
FD	Family Doctor
GDP	Gross Domestic Product
GP	General Practitioner
HC	Health Center
HII	Health Insurance Institute
HQ	Headquarters
HSMP	Health Sector Modernization Project
LOS	Length of Stay
LTSDHSA	Long Term Strategy for the Development of Health Sector in Albania
M & E	Monitoring and Evaluation
MOH, MoH	Ministry of Health
OOP	Out of Pocket
PHC	Primary Health Care

PHRplus	Partners of Health Reform Plus
Pro SHENDETIT	Improving Primary Health Care in Albania Project
RDHII	Regional Directory of Health Insurance Institute
RDPH	Regional Directory of Public Health
QA	Quality Assurance
QM	Quality Management
QMS	Quality Management System
SFM	Sector of Family Medicine
SIAS	Sector of Information and Statistical Analysis
SME	Sector of Monitoring and Evaluation
ToR	Terms of Reference
TRHA	Tirana Regional Health Authority

1 Executive Summary

An overview is provided on the role of local government in health care services in various countries in Europe. We have examined the relative strengths and potential weaknesses of the various arrangements that have been made across Europe to provide an interface between health care services and local government. We identified that a decentralised approach does not solve all structural and policy dilemmas at a single stroke. Furthermore, there is no single model, or permanent – because this is an evolving process - solution that Albania or indeed, all countries should seek to adopt. There are multiple models of decentralization, each developed to fit the particular context and circumstances of an individual country. We also suggest that decentralization in practice is neither unitary nor consistent across any given country's health sector. Typically, health systems in which some areas are decentralized will have other areas that have been centrally controlled or may be recentralized. Thus the practical question for policy-makers is the mix of decentralization and recentralization strategies in a given system and the balance between those strategies.

To develop a devolved arrangement, which involves local government in the health system strategy, is labour-intensive. It is hard to introduce, difficult to maintain, and requires continual re-adjustment if it is to be successfully sustained over time. Developing a decentralization strategic approach will require going beyond the all-purpose notion of “democracy”, “efficiency”, and “participation” to identify the real decision-making factors that have to be balanced. Since this balance ultimately is a political question, there are always trade-offs between these factors.

Last but not least is the fact that we believe that the legitimacy of local government in the eyes of the population is dependent upon its ability to provide needed services. If decentralization impedes the delivery of those services, the result can be to de-legitimize local democracy generally. Accordingly, we propose that a longer term approach is adopted in Albania whereby there is local government representation on health management boards and that there is a gradual development of closer working links between health and local government.

2 Activities since last Report

This is the fourth Output report for the Autonomy project. We described in our first report the issues surrounding the extent and degree of autonomy. We evaluated the structure, nature and extent of autonomy and performance of autonomous institutions.

Our second report provided details on the background of how autonomy models have been developed in other countries. We also provided some examples from international experiences and how other countries have approached this issue. In our third report we examined some of the practical implications for the introduction of the developing reforms in the health sector in Albania. We highlighted that in this context, the incentive is for managers and management boards to act decisively in order to achieve more effective and efficient health care services. Experience elsewhere shows that encouragement to be decisive brings with it some benefits to the organisations as a result of this.

In the second report we produced an analytical framework based on current economic and organizational management literature. Additionally, we examined the approach adopted by several industrial and developing countries on the different approaches adopted by them.

Many countries have adopted the first steps toward hospital and PHC autonomy, but it is also somewhat too early to assess whether these approaches will all lead to successful outcomes for the countries' concerned. In general terms it has taken the public hospital and health systems in industrial countries to move from centralized to contract-based management more than ten years to reach their present arrangements. The change process also continues and is not complete. We have seen that these experiences only give a taste of the variety of options and the complexity of the change process. Consequently they do not provide a clear menu of reform measures to be taken.

Some tangible benefits can be gained by a process of incremental introduction of real autonomy public hospitals and also PHC services. Enabling a separation of the health institutions from the close centralized approach and introducing a management arrangement that is both flexible and able to respond brings benefits to the system. However as time goes by and the hospital managers gain in skills and experience, it will be possible for more opportunities for further reforms to emerge.

We concluded in our second report that Albania's pace of change had been modest compared with some countries. There are also advantages in this- since it is possible to benefit from knowing of the errors to avoid in the process experienced by other countries. Significant changes are still required within the Albanian health services. The challenges will not be smaller but decisions will be made in the light of experience elsewhere.

3 Setting the Context of Local Government and Health

3.1 The European Situation

In 2007 the European Observatory published “Decentralisation in Health Care”. This considered the appointed and elected levels of government and the impact of this on other governmental structures. It is important in the Albanian context since it considered the role undertaken in some counties by local government in the provision of health care services. One argument in favour of decentralization is to bring government decisions “nearer to the people” and to encourage community involvement, i.e. to increase democracy (Ranson and Stuart 1994). Tiebout (1956) argues that elected local governments have more opportunities and stronger incentives to accommodate local preferences, and to meet socio-economic and demographic challenges.

Most countries have a mixture of both elected and appointed levels of government for health care, but at least two levels of elected governments – central and local governments – are present in all countries. While governmental levels that are responsible for other matters as well as health care are mainly elected, in a number of countries, government bodies and levels dealing specifically with health care are, as a rule, appointed. These specific health care bodies are mainly found in tax-funded countries and include hospital districts in Finland, health regions in Norway, Local Health Enterprises in Italy, as well as Regional Hospital Agencies in the largely Social Health Insurance-funded French health care system. These appointed health care government levels are not necessarily less responsive to local needs, since they can still be accountable to elected governments. Furthermore, it is important to understand the functions and powers of these government levels. The common characteristic for Social Health Insurance countries is that the governance unit for the SHI system is either appointed or selected by the constituent (not-for-profit private) organizations in a particular sub-sector. Non-elected bodies typically perform functions such as the collection of funds and reimbursement of services.

Despite considerable variation in terms of levels of government and their functions, several broader trends can be observed. Countries generally have more than the two levels of government that some health policy analysts have suggested as adequate. Nevertheless, most often only two or three of these levels have significant responsibilities in health care. The average size of the different levels varies widely and each country seems to have a unique design of its government units, but there are common features, such as the fact that the largest local government in a country usually coincides with a capital city, and that many countries have some regions with special status and arrangements. No relationship was observed by the European Observatory between the country’s population size and number of levels of government, average size of administrative units or responsibilities allocated to different levels. This may imply that, in practice, country size might matter less for

decentralization than sometimes is suggested or, alternatively, that this exercise was not able to detect this correlation due to the limited number of indicators.

3.2 Concepts for Characterizing Decentralization and Re-Centralization

Decentralization has been on the political agenda in many European health systems over the past decade. However, there are considerable differences in the meanings attributed to the term and divergent ideas about its defining characteristics. There are a number of complexities in characterizing decentralization trends in health care. A comprehensive framework is sometimes needed to capture the complexities and paradoxes of real-life decentralization. Based on a public administration perspective, the following definition of decentralization can be offered:

The transfer of formal responsibility and power to make decisions regarding the management, production, distribution and/or financing of health services, usually from a smaller to a larger number of geographically or organizationally separate actors.

This definition can be a useful starting point. It consists of several elements. First, "Transfer of formal responsibility and power to make decisions," indicates that decentralization implies a shift in formal accountability and decision making structures, usually from a smaller to a larger number of institutional actors either within the same organizational structure or at different organizational levels. This transfer can be within political levels (devolution), within administrative levels (de-concentration), from political to administrative levels (bureaucratization) or to relatively independent institutional levels (delegation/autonomization within the public sector). Finally, there can be transfer of responsibility to private actors (privatization).

Second, the term "usually" in the definition refers to the fact that decentralization also may be at a horizontal level or based on functional principles and thus not necessarily transferring authority to a larger number of actors (Mintzberg 1979; Boyne 1992; Pollitt 2005). Examples include the creation of semi-autonomous public agencies, which involves transfer of power from central ministries to arm's-length central agencies. Other examples include internal shifts in decision competence from managerial staff to professionals or "street level bureaucrats" (Lipsky 1980).

Third, the definition includes the terms "responsibility" and "power". "Responsibility" is linked to decision-making and should be understood as formal responsibilities for making decisions, for which someone can be held accountable by representatives of citizens within the public sector (elected politicians or appointed bureaucrats), and/or health care consumers, management boards, shareholders, etc. within private sector organizations. Public authorities may delegate responsibility for certain functions to privately owned and managed organizations or network structures, as is commonly seen in SHI systems (Saltman et al. 2004). In such cases, there will usually be a dual responsibility structure where operating

units answer to both private management boards and public or semi-public agencies via contracts or through a statutory grant of authority. Somewhat differently, the degree of “power” is linked to the scope for decision making, i.e. the range of decisions one can take, including the degree of discretion and the importance in terms of impact on producers and consumers of health services. The specific institutional set-up including the legal framework and the norms and routines that develop in the system normally determines the scope and level of discretion. It should be evident from this that neither “responsibility” nor “power” are absolute measures. They should be understood as relative terms to be analysed in specific contexts.

Fourth, the term “health services” should be understood in a broad sense as products or services, where some degree of public involvement is considered necessary within a particular health system context. Decisions regarding health services may relate to arranging health care services, management, production, distribution and/or financing of public goods (and private services in SHI countries). This means that both high-level decisions regarding the structure and organization of health services and more ongoing production-related decisions might be decentralized. We do not necessarily see that in the context of Albania, such an approach would be appropriate at present. It would be an option however, for the longer term.

3.3 Some Conclusions for Decentralization versus Re-Centralization

It may be apparent from the definition, that decentralization can be analysed in both dynamic/process terms and static/structural terms. It is important to apply these different perspectives at different times. We need to look at dynamic/process perspectives, such as the implementation and politics of decentralization processes, and structural perspectives in terms of the institutional arrangements and the functional arguments underpinning them. Our initial typology of decentralization is designed to deal with both dynamic and structural components of decentralization.

The Table below illustrates the typology and thus the relationship between the concepts described in this report. The Table describes a simplified and ideal typical perspective, while actual processes and even forms of structures will often be characterized by lack of clarity, overlapping structures and combination models. Nevertheless, it is useful as a conceptual starting point for characterizing the main features and development trends. The structural dimensions listed on the vertical axis represent typical constructions of political/administrative levels ranging from the central/state level to group/individual level. These distinctions are commonly used and to some extent codified in national legislation. However, the exact combination, size and scope of influence vary significantly across countries; moreover, national structures may contain combination models and exceptions to this.

1 Decision-making and Responsibilities in Health Care Functions

	Political	Administrative	Organisational	Private
		<i>Bureaucratization</i> →	<i>Delegation/ autonomization</i> →	<i>Privatization</i> →
Central/ state	Devolution ↓	<i>Deconcentration</i> ↓	<i>Public management delegation</i> ↓	<i>Management delegation</i> ↓
Regional Local/municipal Organizational Group/individual				

Note: Structural dimensions in bold. Process dimensions in italics.

4 Drawing Lessons for Policy-Making

As has been already described, decentralization has been an important factor in the strategic thinking of European health policy-makers for many years. It has been an integral part of social health insurance systems from their formal beginnings in Germany in 1883, in the delegation of key decision-making responsibility to the not-for profit private funding structures that have emerged in some countries.

Tax-funded health systems have also made decentralization central to their organizational structure. In the Nordic countries, operating responsibility for hospitals has been at regional level in Sweden since 1864 (Heidenheimer and Elvander 1980), followed in the 1950s by a swelling of additional Swedish as well as Danish, Norwegian, and Finnish decentralization initiatives. Moreover, in the Nordic Region, decentralization involved not only shifts from national to regional responsibility, but from regional to municipal roles as well.

In Finland, for instance, hospitals are owned and partly funded by federations of municipalities. In southern and central Europe, similarly, starting in the 1980s in Spain and the 1990s in Italy and Poland, decentralization was adopted as a central organizational strategy in the health sector. In the United Kingdom, health-related decision-making has been decentralized to its four constituent countries (England, Scotland, Wales and Northern Ireland).

This strategic role for intra-country decentralization has been further strengthened by the growth of the European Union. As the European Union grew and as additional countries became members, an increasing number of decisions that had previously been taken by national governments were being taken at a supra-national level in Brussels. By decentralizing some of its remaining authority downward to (typically) regional governments, national governments sought to reinforce decision-making structures that were more closely associated with their citizenry's specific interests and culture – hence the popular 1980s phrase about a “Europe of Regions”.

In the early 2000s, however, this uncritical adoption of decentralization has come under substantial scrutiny. In the Nordic Region – previously strong advocates of decentralization in the health sector – countries are adopting various types of recentralization. In January 2002, the Norwegian state took ownership and operating control of all hospitals away from the 19 elected county councils, and then vested management responsibility in five new, state-appointed regions. In January 2006, the Danish state took back financial responsibility for the hospital sector from 14 elected county councils, and from January 2007 five newly designed regional governments started handling hospital management. Moreover, the number of municipal governments in Denmark is being reduced from 275 to 100. In Sweden, there are strong expectations that the existing 21 county councils (already reduced from 26 in 1990) will be merged into six to eight large regional bodies. Both the Gothenburg and Malmö

metropolitan areas have already formed a large new regional government. In Finland, there are heated debates about changing the future structure and responsibilities of both municipal governments (currently 470) and central hospital districts (currently 22).

Moreover, evidence of re-centralization can also be observed in central Europe. In 2003, Poland recentralized funding responsibility for the health sector, merging 16 regional insurance funds into one national body. Slovakia reduced the number of income funds from 13 in 1996 to five in 2004. Latvia reduced 32 territorial sickness funds in 1993 to eight regional sickness funds in 1998. Even in large countries like Italy and Spain, where pressures to maintain administrative decentralization and extend decentralization are strong, fissures are opening up in the ability of regional governments to adequately match available funding to needed services, leading to tense relations with national governments that retain control over a large part of financial resources for the health sector.

From a perspective of policy development, these contradictory trends and countertrends regarding decentralization are well mirrored in the available theory. It is possible to easily construct a strong argument both for and against decentralization. The existing economics, political science, sociology, organizational theory, and management literature, does not provide a compelling case either for or against decentralization. Similarly, conceptual frameworks, seeking to provide analytic criteria by which to assess and evaluate types and levels of decentralization, do not inherently lead to either positive or negative conclusions.

So what, then, should a policy-maker for Albania conclude? How should one interpret the available evidence, and how then should more effective organizational strategies be focused? We will endeavour to provide some answers in the sections that follow from here.

4.1 Interpreting the Evidence

When we draw together the wide range of issues and experiences, it is possible to see that this can lead to the following set of observations about the characteristics of decentralization as they currently present themselves within health care systems:

- Decentralization is not a “magic bullet”, capable of solving all structural and policy dilemmas at a single stroke.
- There is no set model, no perfect or permanent solution that all countries should seek to adopt. Rather, there are multiple models of decentralization, each developed to fit the particular context and circumstances of an individual country.
- Decentralization in practice is neither unitary nor consistent across any given country’s health sector. Typically, health systems in which some areas are decentralized will have other areas that have been centrally controlled or may be recentralized. Thus the practical question for policy-makers is the mix of

decentralization and recentralization strategies in a given system and the balance between those strategies.

- Decentralization is not a static organizational attribute, but it reflects a permanent process of re-adjusting the mix, the balance between decentralizing and recentralizing forces in every health system. Any particular fixed equilibrium is fragile and will build up pressures internally that will contest the existing alignment, eventually forcing a re-alignment and an equally fragile new equilibrium.
- Adopting decentralization as a health system strategy is labour-intensive: it is hard to introduce, hard to maintain, and requires continual re-adjustment if it is to be successfully sustained over time.
- The recurring nature of the decentralization–recentralization cycle does not reflect how much experience a country has with decentralization. Nordic countries with decades of experience are just as susceptible to the same structural and organizational dilemmas as countries in Central and Eastern Europe.
- Developing a decentralization strategy requires going beyond the all-purpose notion of “democracy”, “efficiency”, and “participation” to identify the real decision-making factors that have to be balanced. Since this balance ultimately is a political question, there are always trade-offs between these factors.
- The legitimacy of local government in the eyes of the population is dependent upon its ability to provide needed services. If decentralization impedes the delivery of those services, the result can be to de-legitimize local democracy generally.
- There appear to be few, if any, links between decentralization and the evidence on specific policy outcomes.

These observations add up to a simple but powerful conclusion. The decision to decentralize, together with the strategic mix of decentralized and centralized elements settled upon, is not so much an evidence-based decision as a political decision. Ultimately, a decentralization strategy is based upon the values, objectives, and preferences of the decision-makers, which will necessarily be context-dependent. This is important to consider in the context of Albania.

4.2 Potential Strategies for Policy-Making

The complexity that surrounds the decentralization–recentralization debate can be confusing and misleading. It can make it difficult to pick apart and assess the various arguments that different proponents and opponents make. Different theorists use different definitions of decentralization and, drawing on different academic disciplines, often make conflicting and contradictory claims for their particular views. The evidence base among countries in Europe

and beyond is similarly complex and contradictory. This situation leaves policy-makers in the difficult position of not knowing which argument is correct or which model is most appropriate for their particular situation.

The lack of a clear model to follow should not be translated as meaning that decentralization is per se a bad strategy, or that countries – particularly larger countries with complicated funding and/or service delivery systems – should not pursue it. Nor should it be seen as providing intellectual justification for adopting a less sophisticated single-factor or otherwise over-simplified approach to the process of structural change in health system. Rather, by making policymakers aware of the complexity involved in adopting decentralization-based approaches, these dilemmas will hopefully encourage them to step back to consider the larger picture, and will serve to emphasize the importance of working simultaneously with the multiple different dimensions involved in designing and implementing a successful decentralized arrangement.

The essential element is to recognize that decentralization-related decisions need to be regularly revisited and re-adjusted, so as to maintain the fit of the particular mix adapted to the changing situation both organizationally (internally) and in the broader political, social and economic context (externally). If the central question for policy-makers is the mix of decentralized and centralized/ recentralized components at any given point in time, the central policy challenge is to constantly ensure that the present structure adequately responds to evolving policy needs and objectives.

Once decision-makers acknowledge the complexity and contradictions in dealing with decentralization, it becomes easier to develop a strategy that fits the institutional and political context that it must work within. There are a set of analytical tools available to assist any further serious consideration of implementing a decentralised approach. The first is to break decentralization up into the three functional components – political, administrative, and fiscal – and to evaluate the pros and cons of any proposed structural change in terms of its likely impact on these three areas of activity. The second tool presents three key factors that can be used to evaluate a proposed decentralization strategy: performance, legitimacy, and self-interest. Applying these analytical categories makes it possible to explore the likely future impact of a particular strategic initiative on the overall outcomes that the health system can achieve.

It also can serve as a practical barometer to signal the types of implementation dilemmas that are likely to arise when putting a particular strategy into place. The practical aspects of adopting this multi-dimensional, regular readjustment approach, and of using the two analytical tool sets, can be readily observed when one digs a bit deeper into the current health sector reform process noted at the beginning of this chapter. In the Nordic countries, for example, one can observe clear signs of political (Denmark, Norway) as well as fiscal

(Denmark) recentralization. Similarly, one notes that administrative decentralization (although in larger regional units) remains broadly intact in these countries.

Further, the impetus for both political and financial recentralization appears to revolve predominantly around performance (waiting lists; new technology) and legitimacy (equity) issues. In both Denmark and Norway, national governments have responded to pressures created by the changing external context. Socially, citizens are no longer willing to wait for elective procedures, and they blame national politicians for not “fixing the problem”. Economically, the projected arrival of expensive new diagnostic and therapeutic technologies indicate that larger catchment areas for service delivery units will be essential. As a result, in the new rebalancing of decentralization and recentralization that is underway in these countries, the previous predominance of local democracy has given up some ground to the need for larger, more administratively competent and more economically efficient service delivery units. In effect, the context has changed, requiring in turn that the balance between decentralized and centralized elements be revisited and re-adjusted.

Several additional points can be made about this issue of context. Countries like Denmark and Norway have relatively small populations, are relatively small geographically, and are economically affluent. Moreover, in all the Nordic countries, key interest groups have a long tradition of moderating their claims in the collective interest. Thus, structurally speaking, these Nordic countries have more latitude to respond to problems in the decentralization–recentralization mix and more cooperation from the various health sector actors in correcting those problems.

The process of decentralization raises quite different context questions in the countries of Central and Eastern Europe. The historical context means that they have had limited experience in designing their health systems, and they have an insufficient number of trained planning personnel. Another difficulty is the scarcity of resources available for health care development, and, further, the possibility of recentralization is a sensitive issue since it reminds citizens of the prior communist period. These countries may also face the dilemma that meaningful decentralization is often constrained by the concern about potential corruption in regional and local level governments. There are therefore additional dilemmas for Albania and other Eastern European countries to consider in dealing effectively with the complexities of decentralization.

4.3 Policy Lessons

The wide disparity of objectives, expectations, and national configurations that have been attributed to decentralization complicate any effort to draw universal lessons from recent European experience. Extracting lessons is made even more problematic by the increasing divergence of national strategies, with intensifying decentralization in some countries (Italy, Spain) while a growing counter-trend of recentralization has begun (Poland) or taken

substantial root (Denmark, Norway) in others. An additional confounding factor is the increasing “melting” of public–private boundaries and the creation of new public– private partnerships in ways that further cloud the analytic waters, particularly in central Europe. These multiple conflicting trends each appear to be strengthening a process which, coupled with increasing concerns about possible major structural reforms in several countries including Finland, Germany, potentially Sweden or Switzerland, suggests that generalizations about the direction that Europe as a whole is taking can only be made at the broadest level.

One major generalization would appear to be the fading character of decentralization as being the “strategic cornerstone” for European health policy-making. In both tax-funded as well as social health insurance-funded systems, decentralization seems to have lost its status as the preferred organizational arrangement when a government seeks to enhance the performance of its health care system. Instead, decentralization is now recognized to be only one of several alternative possibilities, which often needs to be balanced with a similar measure of centralization if it is to successfully achieve the objectives set for it. This shift in perception, while reflecting what has been true in practice for many years, nonetheless has a dramatic, if not radical, character. National governments appear to be removing key decision-making responsibilities from decentralized units and assuming them themselves, and/or their administrative units do so. In turn, this means that a basic assumption that decentralization was an efficient, effective and more democratic strategy for decision-making is now eroding. In its place, it would appear that decisions falling in two of the functional categories – e.g. political/policy-making and fiscal/budget-making – are being in varying degrees recentralized. Only administrative functions appear to be retaining a decentralized status.

The reasons for this strategic change of direction across European health systems are not as yet entirely clear. Certainly one key factor is the basic political reality that, when things go badly in a country’s health care system – or, more precisely, are perceived by a substantial number of the population as no longer meeting their expectations – it is the national political level that receives the blame, and, consequently, national policy-makers understandably feel they require the necessary levers or authority to resolve the problems that need to be addressed. These problems are seen to represent predominantly policy-related political matters (access, equity, quality) as well as the fiscal factors necessary to effect change.

Additional elements in this policy mix are the capabilities that new information technology gives to central system actors to monitor and assess ongoing activity lower down in the health system, as well as the push from the rapid advance of medical technology toward more intensive, more expensive, and often more centralized diagnostic and therapeutic instrumentation.

A further apparent set of factors concerns the growing interaction of global and regional European economic issues. The impact of a globalizing economy has put considerable pressure on national policy-makers to restrain growth in health financing so as to help lower the relative cost of labour in a highly competitive international environment. Similarly, the introduction of the Euro as a common currency across many European states has reinforced both the need to restrain public sector spending generally as well as the overall impact of the European single market on health system decision-making.

Another factor extends from concern about the imminent retirement of post war workers (the so-called “Baby Boomers”) and broader worries about the impact of an ageing population on health sector (as well as pension sector) expenditures. Although ageing in fact appears to be less significant an outcome influencing factor than previously thought, and governments do in practice have a range of potential policies that can be introduced to further blunt its effect, policy-makers appear to believe that more centrally defined decision-making will be necessary to coordinate the political and fiscal response to this broad demographic challenge.

Conversely, it would appear that the administrative dimension of decentralization remains largely in place as a settled element of the broader picture. In Norway, where all ownership and management of hospitals was recentralized in 2002 into central government hands, the national government immediately decentralized administrative responsibility in two ways: to five newly created administrative units (the regions) and also, within those regions, to a series of entrepreneurially-based, semi-independently managed public firms (here, state enterprise) structures. Even when administrative elements were centralized, there was little interest on the part of central government to retain day-to-day managerial control – quite contrary to the observable pattern with both political and fiscal dimensions of decentralization.

Given this broad policy context and the range of factors at work within it, the kind of policy lessons that can be drawn from the wide range of experience in this volume is necessarily quite general. Ranging over the evidence about decentralization strategies the following six policy lessons appear most prominent:

- Means not ends. Decentralization is a policy mechanism intended as an instrument to achieve a specific (or a set of specific) objectives such as efficiency, effectiveness, political democracy, etc. It is not a policy objective in and of itself. For a decentralization strategy to be successful, consequently, it should clearly specify the broader political, administrative or fiscal objective(s) it is designed to achieve.
- Heterogeneously applied. Decentralization is hardly ever applied as a uniform universal strategy that cuts across all categories of health sector activity. Rather, decentralization typically occurs in some health system sub-sectors but not in

others. This complex heterogeneous approach is particularly apparent with political issues: for instance, no European government has decentralized major aspects of national standard-setting or regulatory control.

- Dynamic not static. Decentralization strategies are not set in concrete. Approaches which no longer meet constantly evolving political, administrative or financial objectives as defined by policy-makers may need to be changed or eliminated. Recentralization has particularly reflected questioning about the ability of decentralization to achieve financial efficiency.
- Context counts. As part of an overall strategy of governance and government, decentralization occurs within a broader social and cultural context. How decentralization strategies transform into institutional structure and process decisions will necessarily depend on the composition, character, values and norms of the broader social system in which they must operate.
- Regulation remains essential. The concept of decentralization has little in common with geopolitical fragmentation. Allocating political, administrative or financial responsibility to the lower levels of government (or even outside the public sector) does not mean abandoning all central government standards or accountability. Well-designed regulation, particularly for equity and information distribution standards, is a key ingredient in successful local control.
- Outcomes vary. Decentralization strategies appear to be most stable when they pursue administrative objectives. In particular, the devolving of autonomy to local management in parallel with an emphasis on management training and development can deliver significant positive outcomes. Conversely, decentralization appears to be increasingly volatile when targeted on political and, particularly, financial objectives. It may well be that changing technological, clinical, media, and popular conditions may limit or even eliminate effective financial decentralization in the short-to-medium-term future.

To conclude, the most fundamental policy lesson is that decentralization is a learning process rather than a fixed managerial framework. It is permanently in flux, reflecting the constantly changing character of the organizational and managerial systems it is working within. If policy-makers approach the introduction of decentralization as only one stage in a permanent process of evolving managerial strategies, its potential as an effective instrument will increase considerably.

5 Local Government Involvement in Albania

Following on from the pilot projects with the Tirana Regional Health Authority model for PHC and the Durres Regional Hospital autonomy model, current policy development in Autonomy in Albania has resulted in the development – for PHC - of Boards, which will supervise the work of the new “independent” PHC units. These boards will comprise not only representatives from the MoH and the HII, but also representatives of the Local Authority, and this represents a first stage in the development of options for a broader role for the “community” in managing or supervising the delivery of healthcare services – all the time within the clear overall policy direction of the MoH.

An additional role of the Local Government in the primary health care sector is the role of the Regional Council (Keshilli i Qarkut) in coordinating the capital investments in the PHC. The decision on how many new health centers and health posts need to be built in the region is taken by the Ministry of Health based on the requests from the regions and available budgets, but the decision-making on where to build and the actual process of tendering and supervision of the construction is taken at the Regional Council. The relationship between the APHCC and the Regional Councils is, therefore, crucial to ensure the optimal addressing of the community and patients’ needs when planning and executing new capital investments in the PHC.

As far as the hospital sector is concerned, the role of the regional structures is unclear and, practically, non existent. The Prefect (Government’s representative in the region) has a degree of authority over the regional hospitals limited in supervising the compatibility of the activity of the hospital with the country’s legal framework. Elected local/regional government structures do not have any role in the management of the regional or local hospitals.

As has been described, this process has many forms in many countries with differing healthcare organisational structures, and it is worth illustrating several examples referred to earlier. The UK model of Health Boards (slightly different in each of England, Scotland, Wales and Northern Ireland, as their structures have begun to diverge, but similar in essence) has a board comprising half its membership as the salaried executive staff of the health unit, i.e., the Chief Executive, the Medical Director, the Chief Economist, with perhaps one or two others, balanced with an equal number of “non-executive” directors, including a chairman who is always a non-executive, who comes from not only local government, but the wider local community. Here may be found representatives of charities, senior business figures from the community, etc, and this is normally in this context seen by them as a contribution to civic activity. The funding comes from the central government and the board decides on its expenditure within the central “MoH” guidelines, and there is no separate HII equivalent body.

In France, there is a parallel system of public and private hospitals and the PHC doctor can refer the patient to either, and the “Caisse” – the HII equivalent – will pay either institution exactly the same fee for the same procedure. The patient only pays additional fees for such things as a television in the room etc.

The public hospitals are normally municipal-owned and are run by a board appointed by the municipality, and they are under its direct management. The private hospitals are mainly – with a few charity/religious foundation exceptions – independent private business entities - and in both contexts, the “Caisse” has a major role in monitoring the quality assurance element of care, expecting full data from all institutions concerning outcomes, infection rates, re-admission rates etc, and it also has a firm range of guidelines on refusing to fund re-admissions for the same condition within given time guidelines, unless there are clear and compelling reasons.

In Denmark, the government has devolved all delivery of Healthcare down to the local-Regional – government level, and the funds are passed down on a needs analysis basis, and are under the control of the regional authority which then has the responsibility to deliver all healthcare services, PHC, SHC, etc.

This brief set of examples illustrates the very broad range of options available for the development of an element of Local Government – or wider community – involvement in the management and supervision of healthcare delivery, and presents a few of the options which the MoH and the HII might wish to examine as the next steps in the process of developing Autonomy.

Central to this examination and choosing of options for future development are two elements, the first is a clear structure of “contracts” which define what range and level of services is delivered and by whom, and also an assessment of the role of the HII in the longer term – what is to be its role, beyond its funding responsibility in future developments.

Different countries approach this question differently, with different choices made. The important issue is that the question is a real one, and needs to be debated as an issue for the medium to long term development of the Albanian Healthcare organisation and structure. Later in this Output Report, we will make some proposals concerning the possible way forward for involving local government in the healthcare services of Albania.

6 Third Sector Models

In the long term, there are additionally other models which can be used as vehicles for delivering health care services. In the UK and a number of other European countries, the voluntary and community (third) sector has grown in terms of both income and employment over the lifetime of the present Labour government. The state in one form or another increasingly funds it and the balance between grants and contracts continues to move towards the latter. The government has embarked on a planned expansion of provision of public services by the voluntary and community organisations. It has mixed objectives, which may be contradictory. Local government and health have been identified as two areas for third sector expansion. Yet in both cases there are concerns about the possible damaging impact of this policy development. The redefinition of public services as those paid for (but not necessarily delivered) by the state allows for the widespread use of external providers. Some believe further contracting out to the private sector will follow contracting out to the third sector.

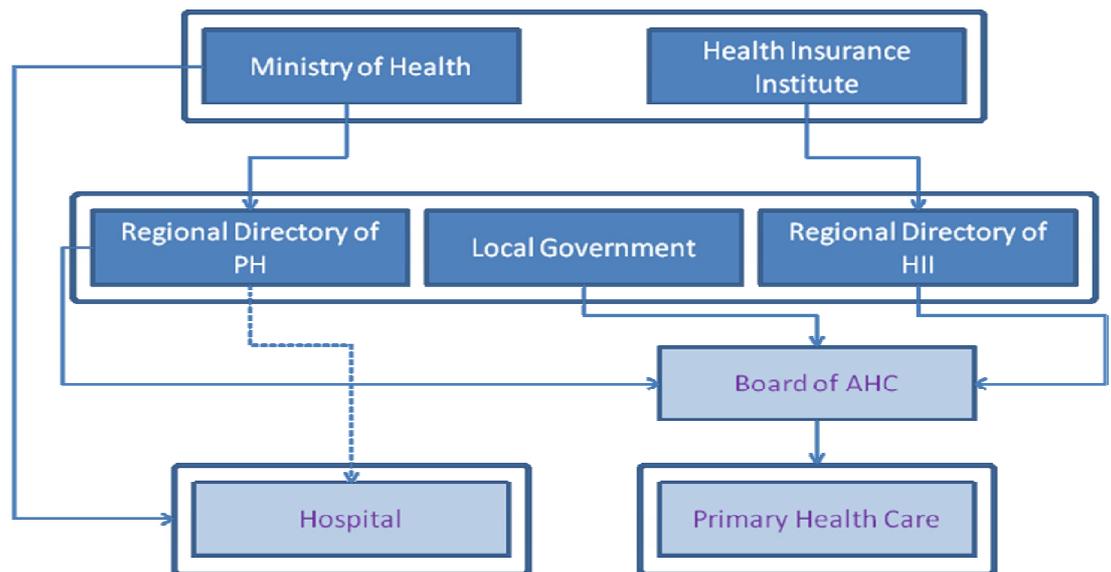
The third sector is itself divided on the question of whether it should replace the public sector in mainstream service delivery. Some third sector organisations see their independence as a key part of their way of working and their very reason to exist. They see an extended public service delivery role as potentially risking that independence. In addition some commentators have identified a paradox associated with any large scale third sector shift to mainstream public service delivery. Focusing on delivering professional and cost-effective public services may clash with their civil society role. It is difficult to remain a neighbourhood-based, grassroots group and contribute to service delivery.

Professionalizing and restructuring the organisation to deliver public services risks dividing volunteers and paid staff through creating a hierarchical structure and reproducing the bureaucrat client relationship typical of government bodies. It would need Government to break down the operational and financial structures and it would demand a large scale shift to an approach based on collaboration instead of competition. For these reasons we have included reference to this area as simply an indicator of the way ideas are developing in other countries and would not see this as a viable route to be followed at the present time in Albania.

7 Practical Issues Related to Autonomy Implementation

Whereas the relationship between Primary Health Care Centres and Regional Health Authorities in Albania is evident and more regulated (mainly through the Board of the Autonomous PHC Centre), the regional hospitals maintain a direct relationship with the Ministry of Health. This is partly due to the lack of a structure dealing with hospital care in the Regional Directory of Public Health. Furthermore, the Ministry of Health has a separate Directory (Directory of Hospital Care) under the General Directory of Services and Health Planning that maintains direct liaisons with the Regional Hospitals. On the other hand, the non-regional hospitals have a direct relation with the Local Directory of Public Health as the director of the last is also director of the Local Hospital. As far as the relationships between the hospitals and the HII are concerned, they are inexistent, as HII does not yet purchase hospital services in Albania (with the exception of few so called 'expensive diagnostic services' whose provision is regulated by laws and mutual agreements). In the rest of the analysis, we focus on the relationships between the Regional Health Authorities and the regional hospitals.

1 Lines of 'dependence' in hospital and PHC settings



EPOS Health
Consultants

Throughout the present consultancy the extent of autonomy Albanian Healthcare Institutions enjoy was analyzed by five autonomy dimensions:

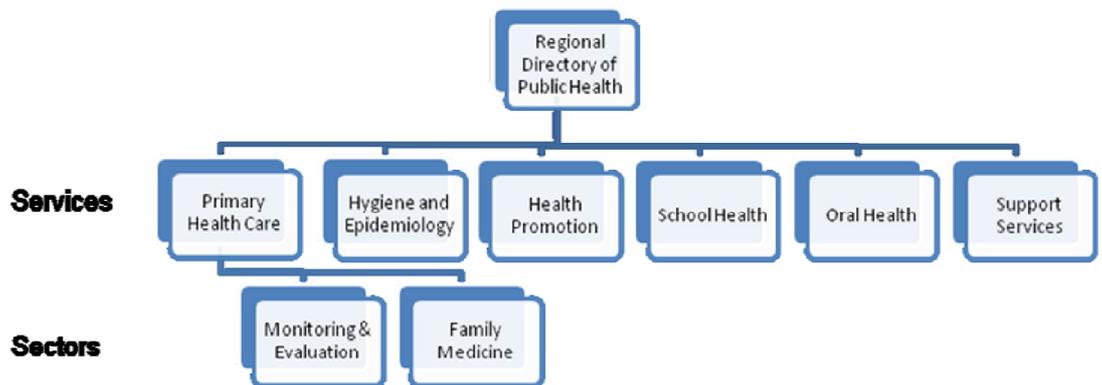
- Clinical autonomy
- Human Resource autonomy
- Managerial autonomy

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- Financial autonomy
- Administrative autonomy

The above components of autonomy will be used to guide the process of providing recommendations on the type of relationships both types of healthcare organizations (Regional Hospitals and PHC) should have with each of the Regional Health Authorities (Regional Directory of Health Insurance Institute and Regional Directory of Public Health).

2 The Regional Directory of Public Health (RDPH)



Out of the many services and sectors of the Regional Directory of Public Health (RDPH), the consultancy team was particularly focused on the recently established Service of Primary Health Care and its two core units – the Sector of Monitoring and Evaluation and the Sector of Family Medicine. The role of the other sectors (such as Hygiene and Epidemiology, Health Promotion, School Health and Oral Health) is obvious and relays on the need to report relevant health information, comply with national standards and regulations, involve in national programs, etc. The relationship with the Support Services also needs a further consideration.

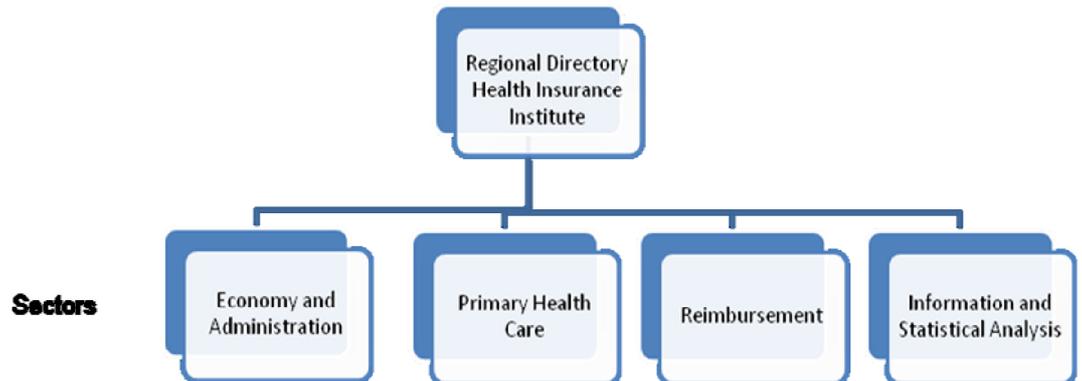
- Sector of Monitoring and Evaluation: based on new regulations that were recently passed, SME monitors the degree of implementation of the basic package of services, the health indicators, the quality assurance programs, sets annual targets and follows up implementation, monitors the quality of care, monitors patients' satisfaction, as well as coordinates CME and CPD programs in the regional level. Among others, this sector monitors important national (vertical) Public Health programs such as the MCH, Family Planning, etc. The consultancy team noticed that the USAID funded project ProShendetit is closely collaborating with the MOH in putting into efficiency this important sector. In view of the APHCC autonomy is

crucial that such monitoring and evaluation be conducted in a participatory and facilitative, rather than a traditional way. Another important recommendation is the need to coordinate the activity of the SME of RDPH with the activity of the PHC Sector of the Regional Directory of HII (see below) in order to avoid overlapping and duplication of work which might damage the process of autonomy giving (in other words, too many controls make you feel less autonomous).

- Sector of Family Medicine: the relationship between SFM and the APHCC needs a careful consideration. This sector is responsible (among others) for supervising the implementation of the basic package of services, supervising the health centers, evaluating the medical equipment that is used and collaborates with the directors of the APHCC in assessing the needs for equipment and infrastructure improvements. Therefore, it is of a paramount importance to draw very carefully the decision-making lines, as the implementation of such functions can either enhance and improve the autonomy or limit and affect the extent it is exercised. The above observation on the need to avoid duplication and overlapping between the activity of this sector and the 'homolog' sector of the Regional Directory of HII applies here as well.
- Department of Support Services: it is not clear to the consultancy team whether the Department of Support Services of the RDPH will provide for the non-capital 'investments' at the APHCC or whether this function will be exercised by the Regional Directory of HII or the APHCC themselves. First, the consultancy team will advise the revision of the mere definition of 'non-capital investment' as this term currently applies to small purchases on the level of few thousands LEK(1). Second, the preferred solution from the above options would be to delegate the authority for making non-capital investments to the APHCC rather than retaining it at the level of a regional or local health authority.

¹ During the field visits, the consultancy team was presented with situations where the Directors of APHCC could easily provide for repairing existing equipment, but not for purchasing new ones, although the expenditures for the 'repair' were exceeding the price of a new substitute.

3 The Regional Directory of Health Insurance Institute (RDHII)



RDHII is made up of four sectors as represented in the hierarchy map above. The consultancy team came up with the following observations and recommendations as far as the relationship between the Autonomous Primary Health Care Centres (APHCC) and each of the sectors (units) is concerned:

- Sector of Economy and Administration: all financial issues based on the contract between the RDHII and the APHCC go through this sector, such as the release of the contracted budget, authorizations of payment (if any), release of performance and quality of care bonuses, financial audits and checks (based on the contractual obligations), etc. The main recommendation of the consultants is to define in details all the needed procedures and relations between this sector and the APHCC in order to ensure that the APHCC enjoys full autonomy within the boundaries of the legislation and mutual contractual obligations.
- Sector of Primary Health Care: this sector has a strong tradition for the regular (annual, semi-annual and random) supervisory visits performed at each PHC doctor based on the previous contract (between the RDHII and the individual Family Doctor). In the new circumstances of the establishment of the APHCC, the supervisory procedure needs to be reconsidered. Certain functions such as supervising the adequacy of maintaining the patients' charts and health records can be coordinated with the Monitoring and Evaluation Sector of the RDPH as well as with the doctors associations or representatives (peer reviewed chart audit). At the same time, the supervisory team should take into account the new development of autonomy and focusing the supervision towards the Health Center as a whole rather than on individual doctors.
- Sector of Reimbursement: the procedures of supervision and reporting between PHC doctors and this sector are fairly standard, with each individual doctor having to respect the prescription rules as well as a monthly limit for the amount of

reimbursable drugs. The strict control over both these aspects is justified in the context of the cost-containment efforts of the Health Insurance Institute, but the somewhere large variations between the amounts, Family Doctors are entitled to use for reimbursement is an issue that needs elaboration. The consultancy team looked at this issue from the point of view of clinical autonomy. First, how much does the rather difficult-to-change limit in reimbursable funds affects the clinical decision making of the doctors? Second, how much does the clinical 'freedom' of the doctors differ between a 'low' and a 'high' reimbursement fund doctor?

- Sector of Information and Statistical Analysis: it has been a frequent observation throughout the present consultancy that autonomy does not mean lack of accountability. SIAS plays a crucial role in ensuring the accountability of the APHCC. As stipulated in the contract between the RDHII and APHCC, 15% of the annual budget is allocated based on productivity and quality of care. A well functioning Health Information System is crucial in ensuring the transparent allocation of such funds. The relationship between APHCC and SIAS should be regular with information flows in both ways (provision of information and feedback). The experience of the first year of the implementation of the PHC reform shows that the information supporting the allocation scheme was not always present and/or not always properly used. In addition, the health information is crucial to the regional health planning process (see above) as well as to the strategic planning process of the HII itself.

The relationship between APHCC and regional hospitals with the Regional Health Authorities is very complex and no report can exhaust it completely. Annex 1 in the following presents an example of how the procedure of recruiting medical staff in the hospitals is affected by regulations and procedures that are presently out of the reach of directors of regional and local hospitals. Similar situations might exist and pose limitations on the other components of autonomy – managerial, financial, administrative, as well as human resource and clinical. Therefore, the use of the matrix suggested in the Report on the Technical Presentation of International Experiences (see output 2 of the present consultancy) could assist the Albanian central and regional health authority in overcoming the difficulties and limitations in the way of the 'autonomization' of healthcare institutions of the country.

8 The Next Steps

We have mentioned earlier the Pilot projects with the Tirana Regional Health Authority model for PHC and the Durres Regional Hospital autonomy model, together with the development of management Boards. These boards comprise not only representatives from the MoH and the HII, but also representatives of the Local Authority, and this has represented a first stage in the development of options for a broader role for the “community” in managing or supervising the delivery of healthcare service.

There are many factors that influence health and well being of a community. Some of these factors are environmental and are often the responsibility given to local government. As health policies and strategies are developed there are often advantages in ensuring that all the public sector service providers are harnessed together in order that the improvement of the health of each community are addressed on the broadest basis.

In the previous chapter we have highlighted a number of the issues presently facing the healthcare services in Albania, and without repeating the key points identified, there are a number of issues that should be addressed by the MoH / Government in order to take forward the process of reform.

It is important therefore for local government not only to have a role in helping to address the broader health improvement issues, but that they also feel that they are an important part of the process.

1. Our first recommendation therefore, is that each health Board established has representation from the local authority. Regional facilities may need to have representation, which reflect the areas served.
2. Second, consideration should be given to developing a framework for strategic health planning on a regional basis. Developing such a framework will require support from all of the providers of health care within the region, especially local government.
3. Third, consideration should be given to local government being responsible in the longer term for the co-ordination of strategic health issues for their area.
4. Fourth, local government should be encouraged to work together with the health providers, planning together, to ensure that each health facility has access to appropriate water, energy and other infrastructure needs and supplies.

9 Conclusion

The objective of this project is to assist Albania in developing an effective model of autonomy within its Healthcare system, and in particular this Output has tried to focus on the involvement of Local Government in this process.

It would have been easy to simply outline a model of describing direct representation of Local Government elected members on Health Boards, and easy to defend simply doing this, since it is a model in place, with often excellent results, in a number of contexts.

The team have however, taken the opportunity here to give a – hopefully - broad ranging view of the way in which this very important topic is being looked at and changes implemented across Europe, because we believe that this overview underlines the important fact that this is – everywhere - a continuing process, which is being embarked upon, and one which will need to be monitored and “fine- tuned” in the future. Local government can have a role in healthcare services but there also needs to be some clear definitions of the extent of the autonomy that the Government is willing to provide to healthcare institutions.

Healthcare has always been described as a partnership between patients and healthcare providers, but the planning of healthcare delivery is a responsibility of Government and National Government should always deliver this in partnership with Local Government. The description of the options for this partnership will, we hope allow a debate in Albania on both the short and longer-term models for this partnership.

Annex 1: Limitations of Human Resource and Clinical Autonomy in the Hospital and PHC Sector

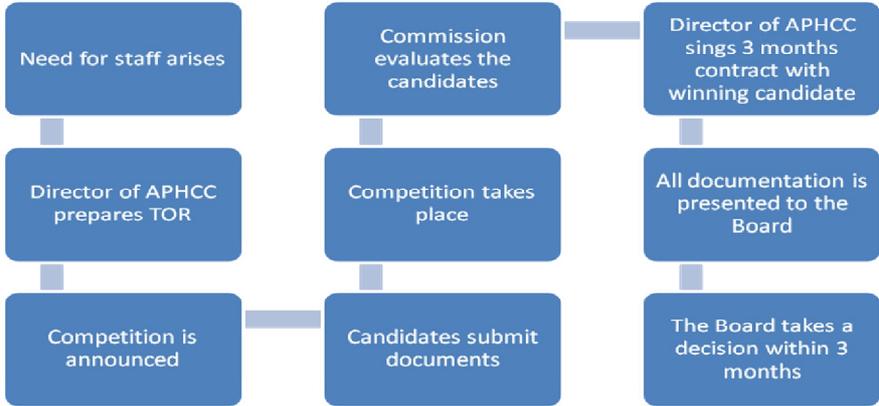


Limitations of Human Resource and Clinical Autonomy in the Hospital and PHC Sector

Human resource autonomy: recruiting processes

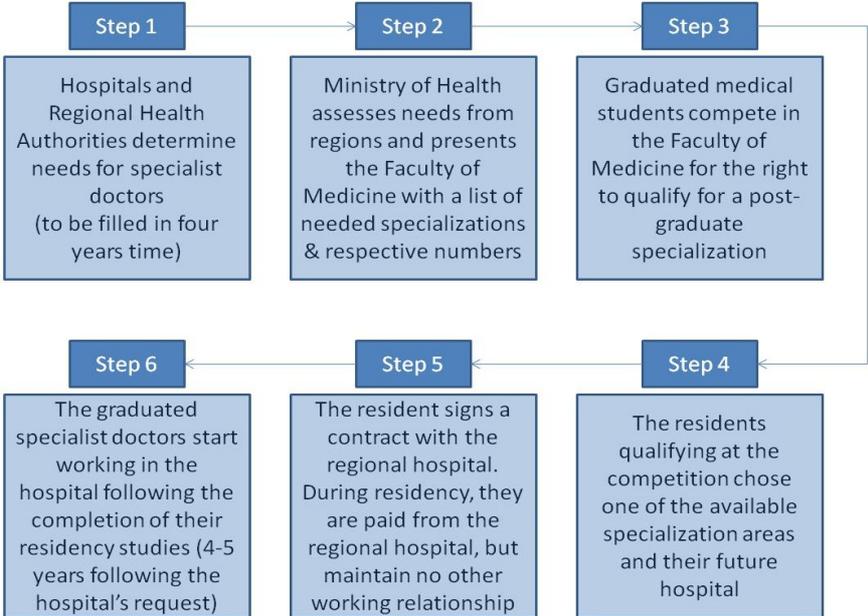
Being among the largest combined public employers in the country, the healthcare organizations present an area of mixed interest as far as Human Resource autonomy is concerned. Decision making in respect to the Human Resource policy of the autonomous PHC Centers starts with the Director of the APHCC, but decisions in respect to hiring-and-firing should be endorsed from the Board that examines the procedure that is followed and endorses the appointment within 3 months from the acceptance of the documentation.

1 The recruitment process at the APHCC level



On the other hand, the director of the regional hospital enjoys full authority/autonomy in recruiting nurses, although the process needs to be further regulated and standardized. The doctors are appointed based on a complex process that requires at least a four years anticipation and projection of hospital's needs. The following scheme is self-explanatory. Furthermore, its complexity and low reflectiveness to the hospital's needs is also self-evident:

2 Hiring specialized doctors in Hospital's settings



A few considerations on clinical autonomy

The situation analysis performed in the context of this project highlighted that hospital doctors seem to enjoy an unregulated clinical autonomy, whereas PHC doctors' clinical autonomy seems to be over controlled. The PHC doctors appear to be overloaded with administrative and clerical procedures whereas the diagnostic and clinical evaluation of the patients seems an exclusive right of the specialized doctors. In addition, the provision of drugs is strictly regulated through the drug protocols and adherence to such protocols is closely monitored by the Regional Directories of the Health Insurance Institute (see above). In PHC, the main criteria for selecting drugs is the price and little emphasis is put on effectiveness. In Hospital Care the process of selecting drugs is unregulated and left to the clinical decision of the doctors. There are no Clinical Practice Guidelines either in PHC or hospitals.

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