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HEALTH REFORM AND FINANCING IN ALBANIA: RESULTS ACHIEVED AND TASKS REMAINING

THE ROLE OF PRO SHËNDETIT PROJECT, 2004 – 2009

ASSESSMENT REPORT

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ORGANIZATION OF THIS ASSESSMENT

This assessment of health care financing reform in Albania is presented in six parts: *Section A* provides background, describing how the financing system has evolved from 1994 to the present. *Section B* lists and analyzes the problems that still need to be addressed in the area of health financing reform, distinguishing those needs that have been met and those that remain to be met. *Section C* describes the processes and activities undertaken by Government and by donors—by PRO Shëndetit in particular—to resolve the problems identified in *Section B*. *Section D* lists PRO Shëndetit achievements and products that have served to resolve the problems and needs identified, and meet the requirements of the USAID Contract. *Section E* suggests the tasks that are yet to be completed and some of the obstacles that remain to be cleared. *Section F* outlines possible future directions for health financing reform in Albania and the potential role that technical cooperation could play in supporting any reform efforts undertaken by the Government.

A. BACKGROUND

The basic physical and organizational infrastructure of the Albanian health system was put in place in the years during and following the introduction of the Soviet “Semashko” health system model in the 1940s. That model relied heavily on central planning, command, and control, and evolved into a wide network of facilities delivering basic levels of primary and acute care services. Ever since the collapse of communism in 1991, attempts to reform the system through changes in health policy and financing have built upon the foundation of that inherited system. During the 1960s, an extensive primary health care (PHC) system—of more than 4,000 health centers and health posts—had been developed that provided every village with at least a midwife responsible for antenatal care and immunizations. As more doctors became available from Albanian medical schools (the first established in 1959), the 1970s saw an increased emphasis on hospital care, and hospitals were constructed in every almost every one of 36 districts to provide basic inpatient care, with polyclinics for specialist outpatient care. By the 1980s, the Ministry of Health (MoH) provided and regulated all health services down to the district level, exercising highly centralized control over budget utilization and personnel management. While controlled from the center, direct administration of services—hospitals, polyclinics, and PHC centers—was the responsibility of District Health Offices (DHOS). The MoH directly supervised the tertiary care inpatient facilities in Tirana and the associated teaching hospitals, that have grown in number and size in the last two decades.

When Albania’s first democratically-elected government took power in 1991, therefore, an extensive system of rural clinics and district hospitals was already in place. Although quality of services may have not been the best, population coverage was high, and visits to PHC clinics for antenatal care and immunizations were also high—perhaps as much as three times higher than today’s visit rate of between one and two visits per person per year. The overall system of healthcare services in Albania was—at that time—exclusively organized, managed, and financed through the MoH, in the conventional manner of a centralized, bureaucratic hierarchy performing the full range of budget and administrative functions required.

But radical changes took place following the severe recession of 1990 – 1992 that led to a substantial decline in government revenues. Spending on healthcare fell by about one-half. With salaries going unpaid and with drugs becoming virtually unavailable outside the urban areas, the availability of almost any healthcare in rural areas declined precipitously.¹

This crisis ushered in a period of changes and reforms that continues to this day. To provide background for the listing of the problems that have been addressed since then, and of the needs that still require attention, it is useful to note the most important reform efforts that relate to health financing issues during the last fifteen years.

Responding to this first crisis, *the Government established the Health Insurance Institute (HII)*² to manage a modest health insurance fund to be financed by earmarked payroll contributions.³ It covered only (partial) reimbursement of expenditures on essential drugs and paid the salaries of General Practitioners (GPs), giving supplemental payments (incentives) for GPs agreeing to serve in rural or remote areas.⁴ Legislation also made the HII an autonomous public body governed by an 11-member

¹ For a detailed account of the historical background of the current healthcare system, see: Nuri, B. In: Trgakes, E., ed. *Health care systems in transition: Albania*. Copenhagen, European Observatory on Health Care Systems, 2002: 4(6).

² Authorized by the *Law on Health Insurance in the Republic of Albania*, No. 7870, dated 13 April 1994, declared with Decree No. 950, dated October 25, 1994, the provisions of which took effect March 1, 1995.

³ For wage-earners, the required contribution is 3.4% of wages (half paid by employees, half paid by employers); for self-employed and unpaid family workers, the contribution required is 7% of the minimum wage in urban areas, 5% of the minimum in the fields, and 3% of the minimum in mountainous areas. The minimum taxable wage per month is Lek 16,100 (about USD 160) and the maximum is Lek 65,000 (about USD 640).

⁴ For a detailed description of the rules and formulae that dictated the level of compensation for GPs (which essentially paid GPs in the most remote areas about twice as much as those in urban areas), see A. Fairbank, “Costs and Utilization of Primary Health Care Services in Albania: A National Perspective on a Facility-level Analysis,” Bethesda, MD; Partners for Health Reformplus, Abt Associates, Inc., June 2004, pp. 5 – 9.

Administrative Council⁵, and managed by a General Director who is “elected and discharged by the Minister of Health with the proposal of the Administrative Council.”⁶ The Minister of Health is also “responsible for the health policy of the HII.”⁷ The HII benefits took effect on March 1, 1995, when the payroll contributions also took effect.

In 1993, *the Government* abandoned its attempts to provide dental services and the full range of needed prescription drugs, and *allowed a private sector to develop for the services of dentists and retail pharmacists*. While the pros and cons of allowing medical doctors and hospitals to also engage in private practice have been debated since then, there has been no equivalent legalization of the for-profit private practice of medicine—in ambulatory or acute care inpatient services.⁸

*There was an effort to decentralize the Government, authorized by a 1992 law,*⁹ which led to the creation of the Ministry of Local Government and Decentralization (MoLG&D) in 1998. Some funds from the MoH budget were transferred to the MoLG&D to be included in block grants to *local governments*, which then *were each given responsibility to decide how much of that grant to allocate for its local health center or health post for operations and maintenance*. Difficulties in funding essential operating costs in some municipalities in 2003, however, led to those items being removed from the block grant and transferred instead from the MoH to local governments “conditionally” or through “earmarks”, which meant that the amounts were still determined centrally (though disbursed through District Health Offices of the MoH).

In 1999, *another change was initiated with the creation of the Tirana Regional Health Authority (TRHA)*. It began operations in early 2000 as a pilot/demonstration project to test an approach to organizing and financing PHC using an autonomous regional body separate from the MoH. In this case, of Albania’s twelve regions, the region chosen was that in which the capital city, Tirana, is located. This project, the Health Systems Recovery and Development Project, was funded by a number of donors, principally the World Bank and the Department for International Development (DFID) of the United Kingdom. After a negative evaluation at the end of the project in 2004, the staff and operations of the TRHA became part of the HII/MoH system as it had evolved elsewhere in the country.

By the year 2000, then, and through 2003, responsibilities for financing and management of primary health care delivery was considerably dispersed to several agencies.¹⁰ The HII paid for salaries of General Practitioners (GPs) and subsidized the costs of outpatient prescription drugs (for those insured by the HII). The MoH maintained its authority to select, deploy, and supervise (but not to pay) GPs, to select, deploy, supervise, and pay all nurses, and to manage and finance all hospitals.¹¹ But the responsibility for allocating budgets for operations and maintenance of PHC facilities had been largely given to the local governments (except for those monies “earmarked” by the MoH in 2004 and after), with the TRHA operating as a unique body under its status as a pilot project at that time. Responsibility for investments in PHC facilities was transferred to the MoLG&D in 2005 for transfer to the local governments.

⁵ *Law on Health Insurance in the Republic of Albania*, No. 7870, dated 13 April 1994, *op cit.*, Articles 17 through 22. The Administrative Council is composed of three members proposed by the Council of Ministers (from the MoH, Ministry of Labour, and Ministry of Finance), one member each from the Social Insurance Institute and the HII, one member from the largest trade union, one member from the largest farmer organization, and the remaining members (one each) representing, and nominated by, “interested parties”, i.e., physicians, employers, pharmaceutical manufacturers, and pharmacists.

⁶ *Law on Health Insurance in the Republic of Albania*, No. 7870, dated 13 April 1994, *ibid.*, Article 23.

⁷ *Law on Health Insurance in the Republic of Albania*, No. 7870, dated 13 April 1994, *ibid.*, Article 24.

⁸ There are numerous “private” medical practices, and some not-for-profit private hospitals in operation, and practitioners in government facilities are known to accept monetary gifts in return for services. But for-profit medical practice has not yet been legalized.

⁹ *Law on the Organization and Functioning of Local Government*, No. 7572, dated June 10, 1992.

¹⁰ Details of these successive financing changes were described and analyzed in A. Fairbank, “Organization and Financing of Primary Health Care in Albania: Problems, Issues, and Alternative Approaches,” Technical Report No. 21, Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates, July 2003.

¹¹ Except for the Durres Hospital, which had become a pilot/demonstration project of the HII.

Recent reforms, however, have served to reverse this fragmentation in the flows of health financing.¹²

First, in 2003, the MoH regained authority to allocate the budgeted funds for operations and maintenance of all PHC facilities, as these funds were shifted back to the MoH from the MoLG&D.

Second, in the 2005, the HII was designated as the future sole source of PHC financing in the Government's authorization¹³ of a pilot/demonstration project of this function by the HII in the Berat and Lezhe.

Third, the TRHA (receiving a negative final evaluation) was discontinued as a pilot project, and its operations became part of the HII/MoH system as it had evolved.

Fourth, in December, 2006, the Council of Ministers decided¹⁴ to launch nationwide the policy of HII being the sole source of PHC finances—effective as of January 1, 2007. It also provided that HII would contract directly with each Health Center (HC) for all PHC services delivered from that HC, and that payment for those services would be, in part, performance-based—in order to increase quality and utilization of services.¹⁵ This policy also included the expectation that each Health Center would gradually achieve relative autonomy in governance, administrative, management, and budgetary matters.

During the period 1995 to 2006, although the MoH had lost much of its authority (to the HII and the MoLG&D) over budgetary control of direct service delivery in PHC,¹⁶ and had lost considerable staff to the TRHA, it nevertheless remained the solely responsible for health strategy, health policy, and health program development. In spite of the fact that the HII was given authority to pool funds and become the sole source of PHC financing (in 2003), there was no agreement (for several years) between the HII and the MoH (the Minister of Health being the Chair of the HII Administrative Council) on launching a pilot/demonstration project to test implementation alternatives. The impasse was broken during 2006, when agreement was reached to launch such a pilot/demonstration project in Berat and Lezhe (with technical support from PRO Shëndetit I), but this project was scrapped in favor a implementing the policy nationwide (without pre-testing) starting in 2007.

Meanwhile, the MoH had undertaken multiple efforts to devise an overall healthcare system strategy, which included efforts to write new laws to govern a new approach to organizing and financing health services. The important activities in this effort were:

- The drafting of a long term strategy for national health system development,¹⁷ which endorsed the decision to define separate and distinct roles for the HII (as solely responsible for pooling funds to finance and purchase health care services) and the MoH (as solely responsible (a) for making strategy and policy for the health sector, (b) for performing a stewardship role as monitor, regulator, and enforcing of minimum quality and performance standards by all providers, and (c) for deciding on investments needed in the health sector).

¹² A complete, detailed analysis of the status of health financing reform during this period is found in PRO Shëndetit, *Health care financing and reform in Albania: A situational analysis*, Report to USAID under Contract No. 182-C-00-03-00105-00, Bethesda, MD: University Research Corporation, 2005.

¹³ Council of Ministers' Decision No. 811, dated 16 December 2005, "Approval of Project for Financing the Primary Health Care Services, in Berat Region, from Health Insurance Institute as a Single Source Financer", an amendment to Section 36 of Law No. 7870 that created the HII, and to Sections 24 and 26 of the Law No. 8379, dated 29 July 1998, "For defining and implementing the state budget of the Republic of Albania."

¹⁴ Council of Ministers' Decision No. 857, dated 12 December 2006, "On Financing Health Services in the Primary Health Care from the Mandatory Schema in Primary Health Care", an amendment to Law 7870 that created the HII.

¹⁵ The HII would pay each HC the equivalent of 85% of its estimated historical budget (monthly), and would divert 15% of the Health Centers' historical budgets into performance-based payments. The bases for those payments are to be based (1) on the level of activity (10%), and (2) on the level of quality at each facility (5%).

¹⁶ As noted, the MoH did in 2004 regain from the MoLG&D some budgetary control to " earmark" health funding for operations and maintenance.

¹⁷ Ministry of Health/Albania, *Ten-year Development Strategy of the Albanian Health System*, Tirana,: MoH, 2002.

- The drafting of four pieces of health legislation¹⁸, two of which directly addressed the issue of health financing (after extensive work, and assistance from an international consultant, the drafts were shelved on the approach of a nationwide election);
- The design of a new World Bank project to follow the TRHA pilot/demonstration, involving negotiations with the MoH and the Ministry of Finance; this project design effort was accompanied by a broader effort by the Bank at negotiating conditions for a Development Policy Operation (DPO)¹⁹ for Albania—some of which conditions touched on health financing²⁰ and health policy; and
- The drafting of the MoH’s long-term vision for the health sector, published as its *Health System Strategy for 2007-2013*. The report described a “vision” of a “health system capable of offering basic health services that are easily accessible, of acceptable quality and efficient, aiming to reach modern standards.”

The HII is now in the third year of its implementation of single-source financing and contracting with individual Health Centers, including the implementation of the 15% of the total budget to be disbursed (1) 10% on the basis of performance (number of visits), and (2) 5% on the basis of six measures of quality of care.

¹⁸ This drafting effort was preceded by a revision of the 2002 strategy issued by the MoH: Ministry of Health/Albania, “The Long-term Strategy for the Development of the Albanian Health System,” Report produced with support from WHO/Europe, DFID, and Italian Cooperation, Tirana: MOH, April 2004.

¹⁹ World Bank, “International Development Association Program Document for a Proposed Credit in the Amount of SDR 6.8 million (US\$10 million equivalent) for a First Development Policy Operation to Albania,” Report No. 38441-AL, February 28, 2007. The conditions set for each of three tranches of the credit to be disbursed were: (1) the Government has taken action, satisfactory to the IDA, to stem the HII deficit and curb pharmaceutical expenditures (DPO1); (2) enactment and start of implementation of health care and health finance laws satisfactory to the IDA (DPO2); and (3) satisfactory implementation of health care and health finance laws, including revised legal status of health care providers (DPO3).

²⁰ For a detailed discussion of proposed health financing changes, see A. Fairbank, “Note on Healthcare Financing Options for the Government of Albania,” Report to the Ministry of Health (contract #P099823-DPLII), 13 December 2007.

B. HEALTH FINANCING IN ALBANIA: PROBLEMS ADDRESSED AND NEEDS REMAINING

THE DISCONNECT BETWEEN LAW AND POLICY AND THE ACTUAL EXPENDITURE OF RESOURCES FOR HEALTH

During all efforts of the past decade to codify (in law, strategy, and policy) both a new role of the HII, and a redefined role for the MoH, there has been an evident lack of substantive connection between law-making, strategic planning, the allocation of resources (budget-making) for health, and implementation of programs in the health sector.

For example, the MoH unveiled its *Ten-year Development Strategy of the Albanian Health System* in 2002 designed “to improve population health status by improving the availability of high-quality services”.²¹ But the broad goals of the document were not translated into action plans that could be implemented. A revised strategy that was issued only two years later also did not include action plans. At roughly the same time, there were other laws passed by the Albanian Parliament that seemed to encourage institutions other than the MoH (the HII and local governments) to “share” the MoH’s traditional, primary role in the government health services delivery system. First there was authorization for health to become a “shared function” with local governments.²² Second, there was a general authorization for the HII to become the single source of payment for health care.²³ Third, there was the revised MoH strategy referred to above.²⁴

In the more recent example, the MoH’s *Health System Strategy for 2007 -2013* is organized around four priorities:

- *Increasing the capacity to manage services and facilities in an efficient way*; (by introducing “a new public-private mix and innovative organizational schemes...”);
- *Increasing access to effective services* (by “providing widespread free essential public health services” and by “providing access to a basic list of essential quality pharmaceuticals...in conformity with cost-effectiveness principles, at affordable prices for the population...”);
- *Improving health system financing* (by “increasing pre-paid coverage” through funds-pooling as “the only way to protect the weakest sectors of the population, regardless of their ability to pay” and by “reducing informal money flows...”); and
- *Improving health system governance* (“strengthening the MoH’s capacity to develop policies, strategies, and planning at the national level”; improving transparency and accountability”; and “establishment of a health information system...to be able to respond for the alternative cost-effective solutions in the health sector”).

These strategic elements, however, were not translated into specific programmatic initiatives with any detailed design or plan for implementing operational steps or system reforms that may be required to achieve the strategic goals. At the same time, the historical program-oriented budgeting performed by the

²¹ Ministry of Health/Albania, *Ten-year Development Strategy of the Albanian Health System*, Tirana, MoH, 2002.

²² Although the *Law on the Organization and Functioning of Local Governments*, No. 7572 (dated 10 June 1992), referred to health as a “shared function” which was defined as being “priority health service and protection of public health,” a more precise definition of what was meant by those words was deferred to a future law that never came to be.

²³ The Albanian Parliament passed an amendment (Law No. 8961, dated 24 November 2002) to the 1994 Health Insurance Law (No. 7870) that originally created the HII. The amendment gave the HII the legal basis for becoming the single source of payment for health care, but did not elaborate (until 2005) on the attendant implications and requirements.

²⁴ Ministry of Health/Albania, “The Long-term Strategy for the Development of the Albanian Health System,” Report produced with support from WHO/Europe, DFID, and Italian Cooperation, Tirana: MOH, April 2004.

Ministry of Finance, and upon which the MoH's budget is based, continued to be planned according to methods used in the past—without reference to any needs of MoH's Health System Strategy. These programmatic categories are:

- Planning, management, and administration;
- Primary health care services;
- Secondary and tertiary healthcare services; and
- Public healthcare services.

The budgetary line items within each of these programmatic categories in the budget are:

- Salaries (600);
- Benefits (601);
- Goods and services (operations and maintenance) (602);
- Transfers (inter budgetary) (604, 605, and 606); and
- Capital spending (230, 231).

In order for the Government budget to be programmed to support the new Health System Strategy, the new strategic initiatives would need to be operationally programmed into the programmatic and budgetary categories listed above. But, this has not yet been completed. Moreover, the health care law and the health financing law would need to be consistent with, and supportive of, each other, and of the new Health System Strategy.

FRAGMENTATION IN THE FLOWS OF FINANCING FOR PHC LEADING TO DIFFUSED ACCOUNTABILITY FOR RESULTS

Until the Government's specific authorization for the HII to become the sole source of financing for PHC (starting in 2007) by pooling all related funding sources, there were three separate and distinct institutional sources of funds for local PHC services: the MoH, the HII, and the MoLG&D. (The recent changes that have occurred to ameliorate the fragmentation of financing flows for PHC are illustrated in Appendix A. But this fragmentation of financing sources undermined the reasonable axiom that responsibility for budget and financing of any service delivery should be in alignment with accountability for its management, quality, and performance. After much debate, and consideration, the Government agreed that consolidation of all sources of funding in one agency (the HII) would facilitate the alignment of accountability for results with responsibility for budget expenditures.²⁵

While this decision did serve to advance the third goal of the Health System Strategy ("to improve health systems financing"...through funds-pooling..." and to improve "allocation by a single strategic purchaser"), the HII was only responsible for the small fraction of the budget devoted to PHC (hospitals continued to be under the MoH²⁶). Moreover, even within the HII, funding of services at Health Centers remained a separate function from the function that funded covered drugs – one that itself was compromised by the fact that a Committee of the MoH decided on the list of drugs to be entitled for HII reimbursement, without regard to cost or available budget. This was an example of the third major system problem facing Albania's health sector.

²⁵ As recommended in A. Fairbank, *op cit.*, pp. xvi-xxii. It was first decided by the Council of Ministers' (COM's) Decision No. 811 (16 December 2005) to approve a pilot/demonstration of HII acting as sole source of financing for PHC in Berat Region, and then decided by the COM's Decision No. 857 (12 December 2006) to make a "mandatory scheme" of HII's role as sole source PHC financier to be applied nationwide.

²⁶ A recent decision by the COM has given the HII responsibility for hospitals, even though control over specific hospital fund disbursements is held by the Minister of Finance.

LACK OF AGREEMENT ON DEFINED ROLES OF THE MAJOR INSTITUTIONS INVOLVED IN THE HEALTH SYSTEM: THE MOH, THE HII, AND LOCAL GOVERNMENTS

Although the Government gave to the HII specific authority over PHC financing (as pooler of all funds, and as strategic purchaser of services from “autonomous” Health Centers), and resolved how the MoH and the HII would integrate their respective roles in PHC (see Appendix B for an illustration), there remains a lack of clarity about the locus of responsibility for other important roles—specifically, in the areas of governance, management and supervision of staffs and facilities (clinical as well as financial), and monitoring and enforcement of minimum standards of quality. Some of the outstanding issues and their manifestations are:

Governance of Health Centers: While HCs are now receiving global budgets payments, on a monthly basis, for all costs of operating them (with an added opportunity for performance-based and quality-based payments also provided), and while the Director of each HC is accountable to the three-member HC Board, the regulations for the make-up of, and appointment to, the Boards has not been finalized. Furthermore, the degree of authority such Boards may have in managing the HCs is unclear, except that they can hire and fire the HC Director. The current arrangement is that the Board Chairperson is the District Public Health Director (of the MoH) for all of the HCs in the respective district. The second Board member is the Regional Director for HII for all HCs in the region. The third member is a representative of the local government. HC Directors that are currently serving were appointed under the authority of the respective Regional Directors of the HII, although their continuing employment as Director of the HCs would be subject to the Board’s approval. There is an evident potential for conflict between representatives of the MoH and of the HII, through their local representatives as named to particular HC Boards, without more precise clarification of the rationale and specifics of the regulations that would apply to HC governance by “local HC Boards”.

Incongruent Administrative Structures of the MoH and the HII: After its creation in 1995, the HII established a series of administrative branches to handle its payments to GPs and to pharmacists and to manage the issue of HII booklets to insured enrollees. These branches were supervised by Regional HII Offices, which themselves were managed by the central HII headquarters in Tirana. The MoH administrative structure has historically been focused at the District level, with hospitals, health centers, and public health activities all managed by a District Health Office (DHO) of the MoH. Although the District no longer exists as an administrative jurisdiction in the organization of the Government generally (as a result of the 1992 *Law on Decentralization*), the MoH has continued to organize and fund its facilities, personnel, and programs through District Offices (until the HII was given a major role in PHC).

After the HII assumed the role single-source financier of (to be) autonomous HCs, the MoH would have had no direct role in the operations of HCs (it no longer hired, deployed, supervised, and paid the nurses there) if it had not been agreed that the District Health Director be named Chairman of every HC Board in the respective district (although public health services would continue to be administered through the DHOs).

Coordination of Capital Investment Budgets with Operating Cost Budgets: While it was established that the MoH would retain budgetary responsibility for capital investments in buildings and equipment needed in the health system, there remained the question of how that responsibility could be effectively and efficiently executed without close coordination with local facilities and with the HII (which were responsible for operation, repair, and maintenance of all the facilities constructed, and were much more informed about the nature of local needs for increased (or decreased) capacity for service delivery).

INEFFICIENCIES IN ALLOCATIONS AND USES OF RESOURCES IN THE PHC SYSTEM

The fragmentation of budget financing of PHC in the past led to inefficiencies in the use of both financial and human resources. To some degree, these inefficiencies were the direct result of the fact of fragmented financing that led to diffused responsibility for management the HCs, and for deployment and supervision of HC staff. Because no one particular agency was responsible for HC management, there was no accountability for results.

There were minimal supplies at most HCs, and physicians did little more than write prescriptions for patients for most presenting conditions, and refer the rest to specialists. The geographic distribution of doctors was explicitly designed to reflect the geographic distribution of the population, as they were each assigned to cover a particular number of people, and were paid according to the number of citizens registered with them (with minimum and maximum registration levels mandated). However, the physicians serving more remote populations would be at the HC infrequently, perhaps no more than once or twice per week, and their inability to do much more than write prescriptions increased the rate at which the rural population would bypass the local HC in order to visit specialist at the nearest polyclinic. The nationwide average of doctor visits per person per year declined to a level not much higher than one—much lower than it had been before 1991. Nurses were deployed unevenly throughout the nation and worked under no one’s direct supervision, as the doctors in the HCs were responsible to the HII, not to the MoH.

Prescription drugs comprised a major expense of the HII, but the only control the HII exercised over their use was to limit the number of prescriptions a doctor could prescribe per month—with monetary penalties threatened against those who violated the limits. Much more significant to overall costs was the prices of drugs on the approved drug list, which list was determined by an MoH Committee over which the HII had no control. Expenditures by the HII on benefits doubled from 1996 to 2000—rising to Lek 2.6 billion (over USD 17 million) in 1999, before stabilizing in 2000. By 2005, however total drug expenditures by the HII rose to Lek 6.9 billion (about USD 57 million²⁷) by 2005, at an average annual increase of 23% (including a 55% jump for 2004 over 2003). There was a decline of 17% for 2006, however, due to imposition of stricter controls and the imposition of the flat fee of Lek 100 (about USD 1) per prescription. By 2006, prescription drugs accounted for almost 60 percent of the HII budget—more than three times the amount paid for GPs.²⁸

While the policy of sole source financing from HII to HCs under unified management was initiated in 2007, the policies affecting prescription drug spending have not been substantially modified since the 2006 reforms, and that part of the HII budget remains unrelated to the HCs’ (now contracted) budgets.

INEQUITIES IN ACCESS AND IN RELATIVE COST BURDENS OF THOSE NEEDING PHC SERVICES

There are two main sources of inequities in PHC service delivery—in terms of accessing services and sharing its costs. First, less than half of the population is “insured” for HII benefits. Second, the burden of the costs of providing those benefits is unequally shared across the population.

The HII was designed as a mandatory contributory (social) health insurance program to promote nationwide access to primary health care (or, at least, to promote access to GPs and to subsidized prescription drugs) for:

- Those in the active (working) population who pay the required contribution on a regular basis; and
- Those vulnerable groups in the non-active (non-working) population and who do not have to pay—except, in most cases, for the copayment when purchasing prescribed drugs.

The HII law that made non-active groups²⁹ eligible for the same health insurance benefits as active (working) groups without requiring them to pay also gave them lower co-payments generally for prescription drugs—a large number being exempted from any co-payment.³⁰

While the number of active contributors to the HII was as high as 660,000 in 2004, there was uneven compliance, and the number of contributors dropped to just under 500,000 in 2006. It is anticipated, however, that collection initiatives taken in 2007 will increase the number of contributors considerably.

²⁷ This, and subsequent percentage growth rates in Lek, include a substantial appreciation of the Lek against the dollar of about 25%.

²⁸ Data from A. Fairbank, “Note on Healthcare Financing Options for the Government of Albania,” Report to the Ministry of Health, 13 December 2007, Table 2.

²⁹ These groups are: pensioners; women on maternity leave; children and students not working; disabled persons; the unemployed; persons receiving social assistance; and persons in compulsory military service.

³⁰ Pensioners were covered for 100% of the reimbursable costs of prescription drugs in 2005.

While there are no data (nor HII estimates) on the number of non-actives insured for HII benefits (only data on the number who actually received the benefits), it is reasonable to assume that—if only 40% to 45% of the population is covered for HII benefits³¹—roughly one million non-actives are eligible and insured for HII benefits. But, although they comprise about two-thirds of all HII beneficiaries, the non-actives are estimated to receive considerably much more than two-thirds of the benefits.³² Thus, while there is adequate access to PHC services for vulnerable groups, there are many in other groups (active and non-active) who are not covered (because they are neither contributing nor registered as being in a vulnerable group), and those who do contribute pay considerably more than the costs of the benefits they receive. While it is reasonable (and fair) that the higher-income individuals help to subsidize the benefits of the vulnerable populations, the relatively small (net) value of the benefit to the higher-income working population constitutes both a disincentive for contributors to enroll (i.e., by getting an HII booklet) and a disincentive for non-contributors to start paying as required by law (i.e., for compliance to remain relatively low).

BASIC PACKAGE OF PHC SERVICES REQUIRED FOR DELIVERY AT HEALTH CENTERS UNDEFINED AND ITS COSTS UNKNOWN

The law establishing the HII did not specify what services its GPs were obliged to provide to beneficiaries, except for prescriptions for drugs as needed for the conditions diagnosed. This situation was rectified by the 2006 law giving the HII sole-source financing authority nationwide as it required a specific list of services to be provided and conditions to be treated. This list was later refined and finalized by a Committee of the MoH.

There was also a requirement in the COM Decision No. 857 (of 12 December 2006) that the costs of the minimum benefit package be calculated, as it would help the HII's and HC's budget negotiations if there were reliable information on what the minimum benefits package would cost. Even rough estimates of the costs, however, faced the difficulties of there being no data available on:

- what treating any particular condition should cost (under optimal, efficient conditions),
- how the patterns of utilization might vary across different HC catchment area populations, and
- what levels of expenditures are currently made for treatment of any particular diagnosis, both for HC-based services as well as for needed prescription drugs purchased at private retail pharmacies (purchases that are largely subsidized by the HII).

³¹ As estimated in A. Fairbank, *op. cit.*, p. 13.

³² A. Fairbank, *ibid.*, Table 7.

C. PROCESSES USED TO ADDRESS THE PROBLEMS IN HEALTH FINANCING

PROVISION OF TECHNICAL ASSISTANCE TO POLICY AND PROGRAM DEVELOPMENT

There were a number of multilateral and bilateral donors who provided assistance to the Government of Albania in the strategic and programmatic development of health policy, in general, and of primary health care (PHC) policy, in particular. Apart from USAID's assistance through PRO Shëndetit I and PRO Shëndetit II, there were numerous other technical reports and consultancies which contributed in some fashion to development of a consensus among policymakers. **While many contributors focused on analytical and prescriptive approaches, PRO Shëndetit contribution was both analytical and practical and was directed (much more than other technical assistance efforts) on supporting the process of implementing the policies and programs agreed upon (mainly through policy analysis and technical development of program and materials for, and actual conduct of, training for HII staff on their new roles and responsibilities).**

I. ANALYSIS OF SITUATION AND NEEDS

It had become apparent to Albanian health policymakers by 2003 that the system for delivering PHC in Albania was suffering from fragmentation of financing flows and from diffused responsibility (and accountability) for the system's performance. Since there was a consensus, from 2004 onwards, that health care financing and organization needed to be reformed, there were efforts in 2004 to pass new laws codifying a legislative agreement. An international consultant helped to draft three laws, including two that specifically focused on health financing, "The Act on Financing Health Services through Health Insurance" and "The Act on the Health Insurance Fund of the Republic of Albania." These drafts were to have been passed in 2004, but met with skepticism from both the World Bank and the World Health Organization in their reviews. Because a national election was imminent, none of the laws was passed. Since the drafts laws did not pass in Parliament, special work was undertaken to have the Minister of Health obtain a decree from the Council of Ministers for starting a pilot project testing HII financing of autonomous providers in the Region of Berat. The Prime Minister signed his approval of the pilot project, but was not able to have the decision approved by the Council of Ministers before the election.

As a result of the intense discussion of the laws, however, it had ultimately been agreed that HII should be the sole source of financing for PHC (or, at least, that the idea should be tested), but there was no agreement between the HII and the MoH about how that new policy should be implemented and how the HII and MoH should share responsibilities. During the year 2005, there were a number of technical assistance efforts by a number of groups that analyzed the situation, identified the needs for change, and offered suggestions for programs and policies that could implement the changes suggested. **PRO Shëndetit contribution was a Situation Analysis³³ in March 2005 that identified the major problems evident at the time, and recommended a series of concrete steps that should be taken to change policies and programs to reform the way PHC was being delivered.**

PRO Shëndetit I's analysis was a comprehensive summary of its own experiences since its inception in 2003, and of previous USAID-funded PHC support.³⁴ **After the release of that Situation Analysis, a**

³³ PRO Shëndetit, "Health care financing and reform in Albania: A situational analysis," Tirana: PRO Shëndetit Project, for USAID, March 2005.

³⁴ PRO Shëndetit I overlapped one year (2003) with USAID's centrally-funded PHRplus Project which had been working on PHC service delivery in Berat Region since 2001, as well as on policy and program development with the HII and the MoH, for both of which it had performed analytical work on the single-source financing issue. These efforts were summarized in: Cook, M, McEueun, M., & Valdelin, J., "Primary Health Care Reform in Albania: A Pilot to Provide Evidence for Health Policy,"

discussion between HII and the MoH began regarding a pilot/demonstration project of single-source financing by the HII in the Berat Region—a discussion which received technical assistance from PRO Shëndetit I’s health financing staff. This led to an understanding between the HII and the MoH, and approved by Council of Minister Decision No. 811 (of 16 December 2005) authorizing the project to begin in 2006.

Coinciding with PRO Shëndetit I efforts was the analytical work commissioned by the Ministry of Health to a consulting firm that issued a report³⁵ in December, 2005, that summarized and reaffirmed the course proposed, and options suggested, both by USAID’s PHRplus Project as well as the PRO Shëndetit I Project. The World Bank also issued a lengthy study of the health system and its financing,³⁶ which was followed by its Development Policy Operation (DPO) (finalized in early 2007) that offered a loan to the Government on certain condition that certain actions were taken relating to health financing.³⁷ As part of the discussions between the World Bank and the MoF on conditions for the DPO, a number of health financing options were considered—including one that would have replaced the HII contributory tax scheme with general revenues or some sort of tax earmarked for health. The MoH commissioned a study of the options, which studied the alternatives. The study report recommended that the HII contributory tax be maintained, primarily because its elimination would have created a much larger cost burden on the Government simply from the implied expansion of coverage to the whole population of HII PHC benefits that now cover less than half of the people.³⁸

During 2006, PRO Shëndetit took the lead in organizing discussions in the Berat Region, on single-source financing, collaborating with representatives of the HII and the MoH there to define the budgets for each of the HCs in the Region, and developing training on contract management as would be needed in both the HII and at the HC level when single-source financing was to begin.

II. ASSIST THE MOH AND THE HII TO DEFINE THEIR RESPECTIVE ROLES

Although there were no clear objectives nor a realistic implementation schedule associated with the 2004 Long-term Health Policy issued by the MoH, and even though the effort at reaching a legislative consensus on new laws fell short that year, a consensus on the appropriate direction for reform did coalesce, by the end of 2005, around the policy of single-source financing of PHC (if not for all medical care services) by the HII. There was a Policy Dialogue workshop held in Durres in February, 2006, that helped to solidify understanding and support for health financing reform. It was attended by Albanian health officials, multilateral and bilateral donors, and international experts, on the subject of single-source financing and contracting with autonomous providers. (A list of the PowerPoint Presentations made by presenters at the Workshop is included as Appendix C.)

Once authorized, the Berat pilot project to test the design and implementation of single-source financing came to be focused on developing a global budget for each HC in the test regions (the pilot area expanded to include the Lezhe Region in the north as well as the Berat Region to the south),

PRO Shëndetit I assisted the HII in that effort, particularly through its technical support of three working groups that were created by appointing relevant technical and leadership officials from both the concerned government agencies. One working group was a policy/decision making group appointed to oversee the implementation of the program, one was appointed to develop the economic issues of the expected decree, and one was appointed to develop the legal language of the that decree.

Bethesda, MD: The Partners for Health Reform^{plus} Project, Abt Associates., Inc., February 2005; and in Fairbank, A., “PHC Financing and Organizational Reform in Albania: A Review of the PHR^{plus} Experience, Assessment of the Current Situation, Recommendations for the Future,” Report to the USAID, April 2005.

³⁵ CIDC/PriceWaterhouseCoopers, “Health Sector Modernization Project: Preparation for Health Finance Reform, Proposals for Change,” Final Report, December, 2005.

³⁶ The World Bank, *Health Sector Note, Albania*, Washington, DC: World Bank, 2006.

³⁷ Conditions were that HII drug expenditures were controlled, that health care and health care financing laws were enacted, and that they were implemented as enacted. See The World Bank, “International Development Association Program Document for a Proposed Credit in the Amount of SDR 6.8 million (USD 10 million equivalent) for a first Development Policy Operation to Albania,” Unpublished report No 38441-AL, 28 February 2007.

³⁸ Fairbank, A., “Note on Healthcare Financing Options for the Government of Albania,” Report to the Ministry of Health (contract #P099823-DPLII), 13 December 2007.

On June 1, 2006, the policy working group had approved three documents developed largely by the technical working group. The first was a “Common Regulation for Contracting of Primary Health Care Services”. This document defined the agreement among the Ministry of Finance (MoF), the Ministry of Health (MoH), and the HII. It concerned the objectives of the implementation and the institutional and administrative parameters to be observed in its execution. The second document was a model “Contract between the Regional Director of Health Insurance and each Health Center” in a region. The third document was a list of “Rights and Responsibilities Related to the Health Centers’ Core Function”. **PRO Shëndetit I staff provided major technical input to the development of these three documents, and also gained agreement with the leadership Working Group on “Next Steps” needed to start implementation in Berat and Lezhe as of January 1, 2007.**

III. STUDY TOURS TO NEIGHBORING COUNTRIES TO EXPLORE THE RANGE OF POTENTIAL SOLUTIONS

For the staffs of the HCs to be able to take on the new roles and responsibilities to be asked of them, they will require new knowledge and skills that are pertinent to these new roles. Albania is following the path of the central and eastern European countries that made the “transition” from state-financed, government-sponsored delivery system to ones that operated on contracts between a “fund” and multiple “providers”. As it was thought that direct knowledge of the experiences (good and bad) of the neighboring countries in the region would help Albania’s transition, **PRO Shëndetit organized a number of study tours so that Albanian health professionals could have access to the relevant technical experience of their colleagues in other countries.** The first such Study Tour was made by Albanian officials to the Czech Republic in November 2004, and a second was made to Lithuania in January 2005. Both trips exposed Albanian officials to the pros and cons of various approaches to PHC contracting and single-source financing. After the consensus was reached on single-source financing through the HII, a third tour, designed for 13 members of the working groups (described above), was made to Slovenia in October, 2006, to gain knowledge about how PHC contracting and payment methods were operating there.

PROMOTING AND FACILITATING SINGLE-SOURCE (POOLED) FINANCING THROUGH THE HII

I. REVISING LAWS AND REGULATIONS

In addition to finalizing the health care strategy during 2004, an initiative was taken to improve the current legal system regarding health care, hospitals, health insurance and health financing. A series of four laws was drafted. Two of these draft laws specifically focused on health financing:

- The Act on Financing Health Services through Health Insurance
- The Act on the Health Insurance Fund

These draft laws were prepared by a technical working group composed of experts from the Ministry of Health and the Health Insurance Institute, supported by an international consultant. The draft laws contain some strategic and structural decisions, in particular the establishment of a single payer in the health system – the Health Insurance Institute. This was intended to limit the fragmentation of funding and improve the purchaser’s capacity to negotiate contracts with providers. If the control were properly used, it could support improvement in the efficiency and quality of services provided. An additional emphasis in the draft laws was reaching universal coverage through the (HII) insurance scheme. The anticipated benefit of including the whole population in the same fund was that it would simplify targeting of resources to those in need, and, in general, would make cross-subsidization, more efficient.

While there were great hopes from the MoH and HII (and others) that these laws would be passed in Parliament during the fall of 2005, the laws were ultimately put on hold after it was decided that the Parliament would not consider them before the election in 2005. The laws received scrutiny and comments from the World Bank, the World Health Organization³⁹ and other active players such as PRO

³⁹ A particularly constructive contribute was made by A. Couffinal and T. Evetovits, “Comments on health financing draft law: Report of a WHO Mission to Albania,” Copenhagen: World Health Organization/Europe, 2004.

Shëndetit I. The general view was that the draft laws were a good starting point, but improvements of certain sections were needed before the laws should be passed in Parliament.

II. POOLING PHC FUNDING FROM ALL SOURCES

Anticipating the COM Decision No. 811 authorizing the pilot project testing single-source financing and autonomous (unified) management of HCs in Berat, **the PRO Shëndetit I project began technical support activities with HC staff and HII staff in Berat to familiarize them with the anticipated reforms, discuss the implications of a global budget (including part of it comprised by performance-based payments), and to conduct workshops on implementation issues and on the expectation drafting of new regulations and a model contract (with HII) in the to-be-formed Working Groups.**

These activities were also begun in Lezhe after it was added as a pilot region. However, in November, the Government of Albania decided to implement the sole-source financing of PHC through the HII nationwide as of January 1, 2007, without waiting to see the results of the pilot projects in Berat and Lezhe. This decision required a great deal of work to be completed by the end of the year in order to make the Health Centers and the officials of the respective agencies (MoH and HII) ready to start on the first of the year. These tasks included the processes of designating the specific HCs that would be participating, creating global budgets for them, (based on historical spending data from the MoH, the MoLG&D, and the HII), and determining the structure and content of the 15% of the global budget that was to be dedicated to performance-based payments to the HCs. **The PRO Shëndetit II Project was a predominant source of technical assistance to these processes to assist the broader project while also maintaining its focus on the two pilot projects for which it has taken responsibility.**

The decision by the government to expand single-source financing of Primary Health Care nationwide as of the first of the year (January 1, 2007) led to a series of quick decisions: first, there was a need to consolidate all elements of the budget in the HII, to allocate it by region, and then to allocate it by health center; second, there was a need to identify which health centers were to be considered autonomous entities to be given their own budget (the number of PHC facilities (health centers and health posts (ambulances)) was consolidated to comprise about 400 HCs, down from the previous 530 HCs, in order to introduce economies of scale to the budget management process); third, once these HCs were designated, the historical salaries and benefits of all staff assigned to the 400 units were summed (a major shift was to include MoH's budget for nurses into the individual budgets for each HC, joining the similar budget of HII for GPs); fourth, estimated budgets for operations and maintenance were allocated for each HC⁴⁰ to add to the global budget; and fifth, each health center needed a have a Chief Doctor appointed (as well as a Board of Directors) who would be responsible for managing the funds coming in monthly installments to newly created bank accounts for each health center; and sixth, there was a need to determine how the 15% withhold of the total (100%) budget would be allocated to each health center in order to create incentives to improve quality and overall performance.

III. REFORMING PAYMENT PROCESSES UNDER UNIFIED HC CONTRACTS

Once the 100% global budget for each center was determined, the amount received, on a monthly basis, was to be 85% of the global total. In order to phase in the payments (while the other 15% in performance-based payments were being structured), the HII decided that, for the first four months of 2007, each health center would receive only 85% of their total allocated budgets, with the proviso that the other 15% would be provided once the two formulae for allocating the money was decided (one would apply to 10% and was to be based on utilization and registration statistics, and the other was to apply to 5% and would be based on measures of quality improvements in the HCs). In subsequent years, the basic payment of 85% would be given the usual cost-of-living/merit increase as a percentage increase in the monetary amount, and the performance payments would be supplemented after that 15% total had also been increased by the same percentage. (Methods for calculating how much each HC would receive are discussed below.)

⁴⁰ There was a particular problem allocating the funds for operations and maintenance (item 602 in the budget) for urban HCs. While the 602 expenditures were known for every facility in a commune, that line item had to be averaged across all health centers in urban areas because it was not possible to break down the actual amounts given to each center from the District Health Offices.

IMPROVING INCENTIVES TO BOOST QUALITY AND PERFORMANCE IN HC

I. REFORMING GOVERNANCE OF HCS TO PERMIT INCREASED AUTONOMY

Considerable changes in governance of HCs resulted from the reform. First, each HC became solely accountable for its financial performance to the HII Regional Director (as well as to its Board). Second, each HC hired an economist (sometimes several HCs would share the same economist) to keep the books, keep track of accounts payable and receivable, and make payments for salaries, supplies, and utilities/maintenance as needed. Third, each HC was supervised by a Director of the HC who, while initially selected by the HII after nomination by the MoH, would be accountable to the Board of the HC; and fourth, the three-member Board of each HC was to be comprised of the MoH's District Health Director (for HCs in that district) (Chairman), the Regional Director of the HII (for HCs in that region), and a representative of the community in the catchment area of the HC.

Considerable efforts were made by PRO Shëndetit II health finance staff to create training materials and to conduct training for Director of the HC and economists (on contracting and complying with HII rules and regulations) and for HII regional staff (on their obligations to supervise the HCs, negotiate their annual contracts, and to be clear on the role of the MoH in relation to the HCs). These training efforts were originally focused in the five regions in which PRO Shëndetit II was working (Berat, Korca, Diber, Lezha, and Shkoder). After needed training was completed in these regions, PRO Shëndetit II was asked by the HII to help them to do training in the remaining regions. PRO Shëndetit was able to contribute in most of the needed training.

III. DESIGNING PERFORMANCE-BASED PAYMENT FORMULAE

PRO Shëndetit II worked on helping the HII develop the mechanisms of performance indicators (based on utilization indicators that would determine 10% of the budget) and bonus payments (based on quality indicators that would determine 5% of the budget). These were begun in 2007 partially (no 5% bonus payments were given, as the mechanism and indicators were not finally decided), and then they were fully implemented in 2008 in a preliminary way. For the performance indicator (based on visits per doctor per day), they started with high number of visits as the “norms” (16 and 13 visits per doctor per day, for urban and rural, respectively) for the performance thresholds of urban and rural HCs; if the average visits were fewer in a clinic, it received proportionally less of the 10% performance payment. The (quality) bonus payment was, at first, to have 12 indicators, and a HC had to succeed in reaching all 12 indicators in order to get all of the 5%; otherwise (even missing one indicator) they received no bonus payment. But it was determined that this would not work.

The HII paid out only about two-thirds of the 10% performance-based incentive pool in 2007, as very few HCs reached the threshold (of 16 visits per GP per day for urban HCs and 13 visits per HC per day for rural HCs); those under the threshold received payments in the same proportion as their visit rates were relative to the respective thresholds. The thresholds were reduced for 2008 and later, as the initial thresholds seemed too higher.

The HCs received no money from the 5% bonus payment mechanism in 2007, as the methodology was not finalized. The staff of the HII later reviewed the bonus indicators and reduced them to six from twelve, and selected those that were relatively easy to measure and, at the same time, difficult for the HC to manipulate. The HII also decided to give a fixed proportion of the 5% the level of which would be determined according to how close they had come to the threshold levels of each of the indicators. Payments according to this formula were made quarterly from the first quarter of 2008 and after.

IMPROVING THE FINANCIAL MANAGEMENT AND COST ANALYSIS SKILLS OF THE HII AND HCS

I. TRAINING FOR HII SUPERVISORS AND HC MANAGERS/ECONOMISTS

PRO Shëndetit II staff also did considerable training, strengthening the capacity at the HC level, clinic directors, economists, as well as HII regional staff on management issues – just in five prefectures. Staff prepared the materials and two manuals for training HC and HII staff. It was

planned to finish training within 2008 for all Albania, because it was agreed with HII that PRO Shëndetit II was paying only for its five prefectures and the HII was paying for the other seven. **The manuals** were developed to support HC management and supervision of HCs for all HII people in a region. They **were prepared by PRO Shëndetit II staff together with HII senior staff from the Audit Department, Doctors Department, and Control Department.**

One training manual (for HC directors and economists) focused on:

- training in contracting, using the encounter form, tracking the relevant indicators, the content of the performance and bonus payments, how to measure them, and how to get the money;
- training in budgeting, how the health center is financed, and issues on payments of doctors and nurses, (it had not been decided yet what to do with the Lek 400 from each uninsured person—that decision was made in June 2007); and
- training in procedures for procurement and tenders.

The other training manual focused on:

- training in supportive supervision for HII staff was conducted, and manuals for supportive supervision were provided to HII office in all prefectures in the country.

For management training for clinic directors and economists in the HCs (using the first manual), **PRO Shëndetit II developed a plan and a budget, and submitted them to the HII and to World Bank, so that they could finance and conduct the training in districts that PRO Shëndetit II did not cover.**

II. DEFINING THE BASIC PHC BENEFITS TO BE COVERED BY THE HII HCS

A major step forward was made when a PHC Technical Committee of the MoH completed work on the list of procedures and conditions that were to be considered part of the minimum package of benefits (MBP) to be provided by the HII to insured enrollees. This definition of the MBP had been required (with a preliminary list included) in the Common Regulations that were approved by the HII and the MoH, and included in the COM Decision No. 857 (of 12 December 2006) in “Appendix 1: List of services in PHC from the mandatory health insurance scheme.” in late 2006. Included in the Common Regulation was a further requirement that a cost estimate of the MBP (to HII) be made. Pursuant to that requirement, the HII requested that the PRO Shëndetit II project perform such a cost estimate.

Estimating the costs of providing the MBP, however, presented some methodological and practical obstacles. First, there were inadequate data available from HII’s own M2 data set on payments actually made to doctors and to pharmacists for the HII benefit. These data do not have diagnosis codes associated with the prescriptions that were reimbursed and/or with visits made. However, the encounter form introduced by the PRO Shëndetit I project did include data on diagnoses related to the prescriptions actually written by the GP during the visit.

Agreeing to perform an expenditure analyses of the minimum benefit package, PRO Shëndetit II merged the two data sets, grouped particular diagnoses codes appropriately into the categories of services or conditions specified in the MBP, and then totaled the costs per condition for all HCs in each of the five prefectures in which PRO Shëndetit II had been working (and where there were data for at least 12 months starting on July 1, 2006). Analysis could only be performed for the five prefectures in which PRO Shëndetit II was working, because the encounter form had been started first in those areas, and thus only those areas provided adequate data on which to perform analysis.

The final report⁴¹ by PRO Shëndetit II of the costing exercise presented voluminous data from the five prefectures and also discussed the usefulness (or lack thereof) of attempts to cost out a more refined Minimum Benefits Package for PHC to be guaranteed by the HII. The paper described the disease pattern of HC users, the utilization of services in urban, rural, and mixed urban/rural areas (and the main cost drivers of PHC services (i.e., human resources and drugs) and their variations across prefectures. [Since the main cost drivers were human resources and drugs, and since HC inventory data

⁴¹ PRO Shëndetit II, “Analysis of HII Expenditures towards the Minimum Benefit Package of Primary Care in Five Prefectures in Albania,” Report to USAID, Tirana: University Research Corporation, February 2008.

(on supplies and their rates of use) were not available, these latter costs were not included in the study. The study underscored large variations in costs per unit of PHC (owing to the two cost drivers of medical staff and reimbursed drugs).

In addition to the lengthy main report of MBP costs, the PRO Shëndetit II Project also produced a more reader-friendly Technical Brief that summarized the main findings in a shorter document.⁴²

Subsequent to the preliminary list of the MBP services being defined, and its approximate current costs being estimated through expenditure analysis by PRO Shëndetit staff, the Minister of Health established, in October 2008, a 16-member Working Group for the review and refinement of the preliminary list of the MBP. This technical Working Group was assisted by a 23-member group of experts who were authorized by the Public Health Department of the MoH to provide technical support.

The overall process was led by the MoH and the PRO Shëndetit II Project, with the technical assistance of the American Academy of Family Physicians (AAFP) and the World Health Organization office in Tirana. The objectives of the document,⁴³ **were:**

- To define the basic services of PHC, to be provided in every HC of Albania;
- To be used by the MoH and the HII to determine and plan human resource needs, the general budget for PHC, HC equipment and instrument needs, the referral system, and necessary skills and training of PHC staff;
- To offer a basis for negotiating contract between the HII and HCs; and
- To introduce basic PHC services that are provided by HCs throughout Albania.

⁴² A. Fairbank, , "HII Expenditures towards the Minimum Benefit Package of Primary Care in Five Prefectures in Albania: A Technical Brief," Report to USAID for the PRO Shëndetit II Project, Tirana: University Research Corporation, April 2008.

⁴³ Ministry of Health/Albania, *Basic Package of Services in Primary Health Care*, Report funded by USAID and prepared by PRO Shëndetit II Project in collaboration with the MoH, Tirana: MoH, December 2008.

D. PRODUCTS AND ACHIEVEMENTS

PRODUCTS

The following comprise the reports and manuals that were produced by, or on behalf of, the PRO Shëndetit Projects (I and II):

PRO Shëndetit I, “Three-years Strategic Plan, August, 2003 - August, 2006, PHC Reform, Albania” University Research Corporation, September 2004.

PRO Shëndetit I, “Study Tour, Staff of the Health Insurance Institute and the Ministry of Health, Albania, to the **Czech Republic**, 23-28 November 2004, Report to USAID.

PRO Shëndetit I, “Program, Primary Health Care Reform, January 23-30, 2005, Vilnius, **Lithuania**: Relevant Issues (Report Prepared on a basis of work groups and panel discussions on 27-28 January 2005), Report to USAID.

PRO Shëndetit I, “Health care financing and reform in Albania: A situational analysis,” Tirana: PRO Shëndetit Project, for USAID, March 2005.

Fairbank, A., “PHC Financing and Organizational Reform in Albania: A Review of the PHR^{plus} Experience, Assessment of the Current Situation, Recommendations for the Future,” Report to the USAID, April 2005.

Rittmann, J., “Report on Training Needs and Curriculum Development for Health Center Reform in Albania “, Report to USAID, June 2006

PRO Shëndetit I Two-page Briefer, “Health Financing Activities,” September 2005

PRO Shëndetit II, “Analysis of HII Expenditures towards to Minimum Benefit Package of Primary Health Care Services in Five Prefectures of Albania,” PRO Shëndetit, Full Report to USAID and to the HII, February 2008.

Fairbank, A., Hobdari, F., “HII Expenditures towards the Minimum Benefit Package of Primary Health Care in Five Prefectures of Albania: A Technical Brief,” Report to PRO Shëndetit and USAID, April 2008.

PRO Shëndetit II, “Preliminary Assessment of Health Reform and Finance: Activities of PSh I and PSh II (Draft: Preliminary Report for Review), January 2009.

PRO Shëndetit II and HII, Training Manual, “Managing and Financing the HC “, for HC Directors and Economists

PRO Shëndetit II, Training Manual, “Supportive Supervision “for HII Regional Directors and Staffs

Also notable are the publications and reports of other agencies for which PRO Shëndetit provided a significant level of technical assistance, or for which the Project’s activities and achievements were a major input technical support and/or assistance. These include:

- Council of Ministers, Albania, *Decision No. 811*, dated 16 December 2005, “Approval of Project for Financing the Primary Health Care Services, in Berat Region, from Health Insurance Institute as a Single Source Financer”, an amendment to Section 36 of Law No. 7870, and to Sections 24 and 26 of the Law No. 8379, dated 29 July 1998, “For defining and implementing the state budget of the Republic of Albania”.
- Council of Ministers, Albania, *Decision No. 857*, dated 12 December 2006, “On Financing Health Services in the Primary Health Care from the Mandatory Schema in Primary Health Care”, an

amendment to the Articles 4, point, 2, letter “b” of Article 36 of Law No. 7870, (based on Article 1000 of the Constitution).

Ministry of Health/Albania, “Basic Package of Services in Primary Health Care,” Report by PRO Shëndetit Project for review by the U.S. Agency for International Development, December 2008.

There were also a significant number of PowerPoint Presentations made by PRO Shëndetit staff or consultants at numerous workshops related to health financing reform. A partial list is included below:

Erol Como and Poul Thim, “Single purchase in practice: The case of PHC reform in Berat,” Presentation at Durres Policy Dialogue Forum on Health Financing Reform, February, 2006.

Alan Fairbank, “Assessing Health Financing Reform in PHC: Achievements and Challenges,” Workshop for the HII and PSh II, Tirana, 20 February 2009

Flora Hobdari, Maniola Sejrani, Alan Fairbank, “ Analysis of the HII Expenditures towards the Minimum Benefit Package of PHC “, TAG meeting, Tirana, December 2007

Alan Fairbank, Flora Hobdari “Performance-based payment: options, implications, discussions and recommendations”, Workshop for the HII and PSh II, Tirana, May 2007

Joseph Rittmann, Flora Hobdari, “ Training for HC Reform “, Workshop for the Work Group for PHC Financing Reform, MoH , Tirana, 22 May 2006.

The Work Group for PHC Financing Reform, “Implementation of the Single Source Financing in Berat Region”, Workshops in Berat and Lezhe, May 2006.

Poul Thim, “New contract between HII and HCs “, Workshop in Berat, 29 June 2005

ACHIEVEMENTS

The achievements of the health financing reform unit of PRO Shëndetit I (2003-2005) and of the PRO Shëndetit II Projects (2006-2009), led by Ms. Flora Hobdari, Health Financing Adviser, were of two kinds. First, there were the analytical and policy analysis contributions they made through publications that are included in the list above. These studies and reports were key inputs into their principal activities towards collaborative program design and implementation. Second, there were the numerous and extensive consultative meetings, and training sessions with the staff of the HII and of the MoH, that served to make them aware of the changes being made in health financing, to familiarize them with their respective new roles in the reformed system, and to make them competent to perform the new duties and responsibilities required of them.

The principal efforts made by the Projects in this regard were the results of close collaboration and consultation with HII and MoH staff, as the final products were products of those staffs – with PRO Shëndetit being responsible for the broad range of technical assistance that supported their development. Major examples are:

Agreement by consensus among Albanian policymakers that PHC financing should be reformed in two major ways:

- By pooling all funding of PHC into the HII and make it a single-source of all payments to PHC facilities for services they provide; and
- By making PHC facilities autonomous administrative units, with each Health Center (and associated health posts) clinically managed by a Director of the HC responsible to a 3-member Board of Directors, and financially managed by an Economist accountable both to the Director of the HC, the Board, and to the Regional Director of the HII.

The legal foundation for the required changes were embodied in a decree that authorized PRO Shëndetit to assist the implementation of a pilot project in Berat and Lezhe (COM Decision No. 811 of December, 2005) and in a follow-on decree (COM Decision 857 of December, 2006) that authorized the reform policies to be implemented nationwide starting in 2007.

Development of the three major documents required by COM Decision 857:

- A Common Regulation spelling out the respective authorities of the HII and the MoH in pooling PHC funds in the HII, and of the HII in contracting with individual HCs for delivery of PHC services;
- A Model Contract to be used by the HII and each respective HC that specified the organizational and service requirements of the HC to be performed in return for the payments to be provided by the HII, with 85% of the historical budget provided in a monthly lump sum and the remaining 15% made available as performance- and quality-based payments if the HC could meet or exceed certain standards (this Model Contract included a summary specification of the Minimum Benefit Package (MBP) to delivered by each PHC); and
- A document outlining the Roles of Responsibilities of each HC and of the staffs now to be employed by the HC instead of by the HII or by the MoH.

DOCUMENTATION OF TECHNICAL ASSISTANCE TO PROSHENEDIT II BY ALAN FAIRBANK

Alan Fairbank, Trip Report, 3 October – 18 October 2006 (submitted 25 August 2006)

Alan Fairbank, Trip Report, 1 August -11 August 2006 (submitted 18 August 2006)

Alan Fairbank, Trip Report, 4 April – 7 April 2007 (submitted 12 April 2007)

Alan Fairbank, Trip Report, 30 April – 11 May 2007 and 28 May – 1 June 2007 (submitted 20 June 2007)

Alan Fairbank, Trip Report, 12 July – 31 July 2007 (submitted 16 August 2007))

Alan Fairbank, Trip Report, 1 October – 19 October 2007 (submitted February 2008)

Alan Fairbank, Trip Report, 30 November – 12 December 2008 (submitted 30 December 2008)

E. TASKS TO BE COMPLETED, OBSTACLES REMAINING

REMAINING TASKS

Tasks still to be completed, of course, are innumerable, as periodic or ongoing reform is necessary to improve the performance of any health system. In Albania, there are certain immediate needs of the HII that warrant prompt attention by policymakers, researchers, and program managers.

I. RESEARCH ON THE FUNCTIONING AND EFFECTS OF THE PERFORMANCE-BASED PAYMENTS

There are two kinds of performance-based payments. The first is a payment that rises (up to 10% of the HCs' budget) in direct relation to the number of visits conducted per doctor per year in a clinic—up to a maximum, that are the norms for the location of the HC. The second is a payment (that can be up to 5% of the HC budget) that rewards, in some different degrees, achievements of progress towards five different quality related goals. There is a maximum amount to be awarded for achievement of each one of the five goals, but partial payments for each are awarded in proportion to the measured quality indicator at the HC relative to the target indicator.

In 2007, for the 10% payment, the norms were 16 visits per person per doctor per day in urban HCs, and 13 visits per doctor per day in rural HCs. Because these norms were too high, only a small portion of the 10% allotted for these payments was actually paid out. For 2008 and 2009, the norms were reduced: 12 visits per doctor per day for urban HCs, 10 visits per doctor per day for mixed urban/rural HCs, and 9 visits per doctor per day in remote rural areas.

Research is needed to determine:

- If there was an increase in visits over the 2007 – 2009 period, how much was it, and whether increase was real and not an artifact of changed visit-recording procedures;
- Whether the norms are set appropriately and whether the categories of HCs to which they apply are appropriate for maximizing the effects of the performance-based incentives;
- Whether and how a performance-based indicator for nurse visits may need to be added to this incentive (if only to decrease the incentive of doctors to divert nurse visits to their own account of visits); and
- Whether, and to what degree, any increase in visits may be related to an improved perception of quality of the HC among the local population, and/or that it has been accompanied by a decrease in bypassing.

II. RESEARCH ON THE PROCESS OF NEGOTIATING BUDGETS WITH HCS AND ITS POSSIBLE IMPACT ON EFFICIENCY

Since the indicator “visits per doctor per day” is as much a function of the number of doctors staffing the clinic as it is the total number of visits, an independent look at the numerator and denominator of that indicator is needed – one that seeks to compare facilities that serve similarly sized populations of similar densities. It would also be useful to research how the definition of a visit has changed since 2007, and whether (and to what degree) the reported visits include any home visits by doctors.

A objective of this research component would be to assess the degree to which the performance-based (visit-based) indicator has had any positive effect on efficiency. Until the services offered at HCs are improved by the arrival of the supplies and equipment being donated by the World Bank project, it is sufficient to define efficiency on the basis of whether staffing is appropriate to workload. Some rural HCs may have too many doctors (and/or nurses), and some urban HCs may not have enough doctors (and/or nurses). [This question relates to the suggestion above that nurses may need to be given their own

performance-based pay incentive if only to establish a baseline (comparable to the one for doctors) of the workload on nurses.

III. RESEARCH ON GOVERNANCE AND MANAGEMENT PRACTICES

Current governance arrangements (i.e., the makeup and authority to appoint members to HC Boards of Director) are still apparently subject to change. The authorities and requirements of the Board are also not finalized. To contribute to the effort to finalize them in a way that supports improved HC performance, research on the impact of current arrangements and practices may be needed.

Furthermore, there have been numerous sessions organized and conducted by the PRO Shëndetit II Project to provide appropriate training so that HC managers and staff, as well as Regional Directors of HII, adapt their management practices, styles, and behavior to the new reform realities. Research may show a need to change some current practices (and perhaps regulations), and/or the need for additional or refresher training related to management (administrative, clinical, and financial) of HC network being supervised by the HII.

IV. RESEARCH ON ADEQUACY OF DATA REPORTED RELATIVE TO DATA NEEDED FOR REGULAR SUPPORT OF NEGOTIATING PROCESS BY THE HII ON ANNUAL HC BUDGETS

In the process of performing a rough estimate of HII expenditures on the preliminary Minimum Benefits Package (MBP) for PHC, PRO Shëndetit analysts were required to merge HII M2 data set with the encounter form data that PRO Shëndetit had promoted to be used in all PHCs. Still, the merged data set, which should be available on a continuous basis, does lack some data elements that could relate utilization to budgets and to finance, in order to provide information useful in negotiating annual budgets with the HCs.

V. FURTHER ANALYSIS OF THE COST OF THE PHC MBP AS REFINED AND FINALIZED BY THE MOH

Analysis of resources needed to provide the MBP to all Albanians requiring its services will need to be approached from the point of view of “what costs should be” rather than “what expenditures have been”. The former would include an assumption of more efficient production of a wider range of services, and would assume the present of supplies and equipment as will be donated by the World Bank. The completed analysis of “what expenditures have been” does not help the HII to know how far from desired efficiency levels the current budgets of HCs are. One odd finding of that recent MBP expenditure study was that fully one-fourth of all spending by the HII on PHC services and drugs were not related to conditions specified in the MBP. Research is therefore indicated as to what diagnoses and conditions are generating this level of cost to the HII, and whether the HCs are the appropriate place for them to be handled.

VI. RESEARCH ON THE NEEDS FOR SKILLED ADMINISTRATIVE STAFF IN THE HII

There appears to be a shortage of technical staff in some departments of the HII, which will become more serious if and when additional demands are made on the HII (e.g., if and when hospital financing is channeled through the HII as a source of all funding for medical care services provided with government subsidies in Albania.

VII. RESEARCH ON THE NEEDS OF THE HII TO DOCUMENT NUMBERS, IDENTITIES, AND TYPES OF ELIGIBLE ENROLLEES

A critical component needed to facilitate the long-term goals of the HII is complete and regularly updated data on those eligible to receive HII’s services and receive its drug (and/or other) subsidies (whether they are contributors or enrolled by government buy-in as members of a vulnerable group). Although this goal will probably require external expert technical assistance and a long-term work plan, research on what needs are to be filled by such an information system, with identity cards, could be initiated now. Among the many benefits of such an ID medical insurance card system is the convenience provided both to all enrollees (the card would replace the booklet) and to the HII in its need to collect enrollee eligibility, use of services, and payment-related data in a timely fashion.

OBSTACLES REMAINING

Significant obstacles remain blocking more rapid progress in developing a more efficient and effective PHC delivery system (that may also include hospital services soon) for enrollees. Some of the most important to be overcome are:

- Lack of coordination among international and bilateral technical cooperation initiatives to advocate and support a consistent set of health financing and health reform policies;
- Lack of a comprehensive mapping of the health needs of the population as compared to the structural (physical) and human resources available (and currently being applied) to meet those needs [which has led to inefficient excesses of facilities and specialties in some areas, and a scarcity of them in other areas];
- Insufficient numbers of staff with adequate technical training to handle professional and managerial tasks that will be increasing in the coming months;
- Inadequate data for performing research tasks on a regular or a special-subject basis, and for assisting the HII and the HCs to negotiate fair contracts that also incorporate effective incentives for improved efficiency;
- Inadequate understanding (among the population in general, and beneficiaries in particular) of, and information about, the changes that health financing reform has brought to the HII and its delivery system, making them less likely to take full advantage of the improvements that have been made, and that are likely to be made in the future;
- Inadequate training of staff, depriving them of the up-to-date technical knowledge appropriate to the tasks they are being required to carry out in the HCs and in the HII;
- Lack of a clear mutual understanding and appreciation of the distinct and separate roles of the HII and of the MOH, and a clearly stated law or laws governing their relationship and the general framework on which a long-term strategy for health development will be based; and
- Limited encouragement of private sector involvement in medical care service delivery, possibly promoted through the development of public/private partnership to boost investment in health and to develop of financial/accounting, organizational development, and pertinent management expertise to administer the services delivered through such arrangements, made according to the Government long-term strategy and policy.

F. POSSIBLE FUTURE DIRECTIONS

Future directions for technical cooperation to improve PHC service delivery in Albania would build upon past work by USAID through the *PHRplus* and PRO Shëndetit Projects, are, but not limited to:

In order to assist the Government to define how public/private partnerships in health could help to improve efficiency, effectiveness, and quality in PHC services delivery, there could be a demonstration project developed that illustrated the requirements and benefits of a Health Center operated with true autonomy of management, so that numbers and assignments of personnel could be adjusted to maximize efficiency and so that services could be developed that met local needs in the most effective manner – integrating use of generic drugs with standardized treatment protocols for the most common ailments;

“Activity-based costing” of the MBP of PHC services, as now planned for a final effort of the PRO Shëndetit Project, could be expanded into a more broadly based effort to use similar costing exercises (that are transformed into model budgets) as part of the budget negotiations between the HII and the HCs;

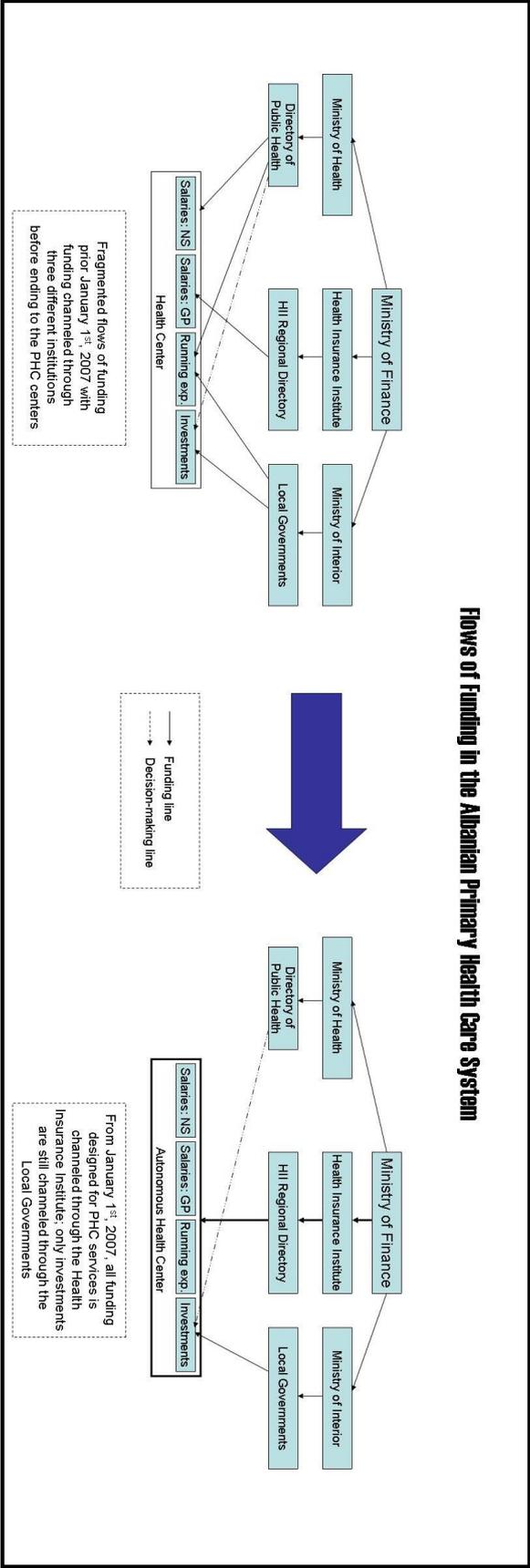
Prior to further development of the pooled funding concept using HII as a single-source for all Government-sponsored medical care (including hospital funding), it is necessary to clarify (through legislation and regulation) the distinction between being insured and uninsured (e.g., in terms of access to benefits, in terms of above-board, posted co-payments (in lieu of informal payments, etc.); it is also necessary to clarify how any privatization of medical care services might interact with the public insurance function; and

A detailed geographic mapping (possibly using GIS technology) of the existing health care delivery should be developed to identify how the physical and human (i.e., services and supplies) resources are distributed relative to the distribution of the population; this is needed in order to understand to degree to which there is a maldistribution of facilities and specialties across the country and, more importantly, how the PHC services can best be integrated into a system that generates referrals as appropriate but takes care of most prevention and basic curative care conditions at the Health Center—the appropriate point of first contact.

APPENDIXES

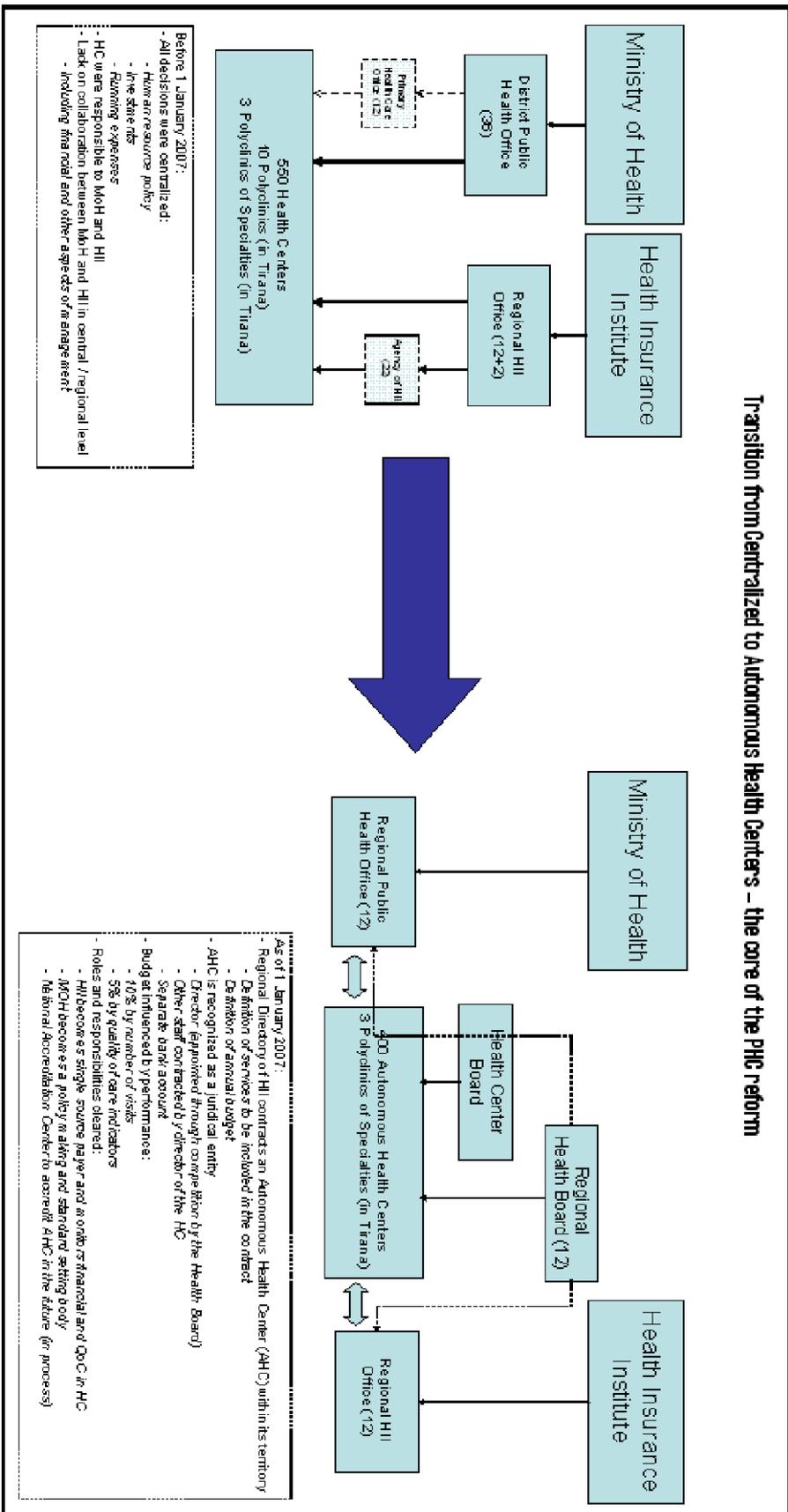
APPENDIX A

Flows of Funding in the Albanian Primary Health Care System



APPENDIX B

Transition from Centralized to Autonomous Health Centers – the core of the PHC reform



APPENDIX C

- PowerPoints in Policy Forum: February 24-25, 2006
- Single Purchaser in practice—the case of PHC reform in Berat (E. Como & P. Thim)
- Fragmentation and its consequences in the Albanian health care system (Tamas Estovitz]
- Reducing Fragmentation in Pooling and Purchasing: Single Purchasers in Eastern Europe
- (World Bank)
- From fragmented to unified financing arrangements: the Single Purchase systems of Krygyzstan and Moldova (J. Kutzin)
- Albania Health Sector Note: Key Findings and Recommendations (D. Haazen)
- A Phased Approach Changing Roles and Responsibilities for health financing reforms in Albania (K. Maddock)
- Single Purchaser Model for Albania: Concept and Implementation Strategy (K. Maddock)
- Options in Revenue Collection: Strengths and Weaknesses: Lessons for Albania (World Bank)
- Fragmentation and its consequences in the Albanian health financing system (T. Estovitz)

