

EXPERTS GROUP REPORT

REVIEW OF THE MINISTRY OF HEALTH IN ALBANIA

FOCUS ON STEWARDSHIP FUNCTION

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Contents

ACKNOWLEDGEMENTS	3
1. EXECUTIVE SUMMARY	4
2. INTRODUCTION	5
2.1. OVERVIEW OF ALBANIAN HEALTH SYSTEM	6
3. METHODOLOGY	8
3.1. LIMITATIONS.....	9
4. ORGANIZATIONAL STRUCTURE OF THE MINISTRY OF HEALTH AND METHODS OF WORK	10
5. FUNCTIONS OF THE MINISTRY OF HEALTH	14
5.1. POLICY DEVELOPMENT	14
5.2. THE REGULATORY FUNCTIONS AND CAPACITIES OF THE MOH	17
5.3. INTELLIGENCE FUNCTION OF THE MOH	20
6. CONCLUSIONS OF THE MISSION	24
7. ANNEXES	26
7.1. TERMS OF REFERENCE	26
7.2. TABLE WITH FINDINGS, RECOMMENDATIONS AND SUGGESTED ACTIONS.....	28
7.3. EU INTEGRATION	31
7.4. LIST OF PEOPLE INTERVIEWED.....	33
7.5. PARTICIPANTS IN THE FOCUS GROUP DISCUSSIONS	34
7.6. ORGANIZATIONAL SCHEME OF THE MOH	35

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1. Executive summary

At the request of the Ministry of Health (MoH) of Albania the WHO Regional Office for Europe invited a group of international experts to review the stewardship role and functions of the MoH. The mission took place in Tirana, 1-8 December 2008.

This report contains an introduction, the methodology, the main findings on the stewardship functions and the organizational culture as well as conclusions and recommendations.

In addition to the background materials received before the mission, the expert group obtained information from roughly 40 interviews carried out confidentially with staff of the ministry, other government ministries and agencies, many stakeholders and the donor community. The expert group had full access to people and documents. The spirit of meetings was very positive and co-operative. All the participants in the interviews were very frank, and open to new ideas. They recognized the weak points of the structure and functioning of the MoH and they stressed the need for assistance and support to improve the training of the personnel in their new roles and functions. This training is seen as a necessary step in the gradual introduction of changes and improvements.

The expert group recognizes that the staff in the Albanian MoH operates in a difficult socio-economic environment: salaries are low, the working conditions are not ideal, the country has not sufficient resources and living conditions are difficult in general.

Despite many beneficial reforms in recent years, the expert group still identified gaps in the policy-making, regulatory and intelligence functions of the ministry. Capacities should be strengthened and proposals for doing so are suggested. The organizational culture of the MOH needs change in order to reach out and open up, with better communication vertically and horizontally, both internally and externally.

The institutional review led to six recommendations, which were introduced to the health minister at the end of the mission:

- strengthen the policy-making role and capacities in the Ministry of Health;
- improve the regulatory and enforcement capacity of the Ministry of Health;
- strengthen the health intelligence and information systems in the country;
- change the practices in recruitment, personnel management and staff development in the ministry and related bodies;
- clarify the role and lines of accountability of the political and high-level administrative staff;
- improve the lines communication and flow of information internally, horizontally and vertically, and externally, with all relevant stakeholders, NGOs and the media.

Fairly detailed proposals were given about how to implement the recommendations, if accepted. There may be a follow-up mission by the expert group in late January or early February 2009, if so requested.

2. Introduction

A WHO/EURO mission worked in Albania in the period December 1-8, 2009 in order to assist the Ministry of Health to carry out an institutional review of the ministry of health with particular focus on the stewardship and governance functions. The mission members were Kimmo Leppo, team leader and a former Director-General of Health of the Finnish Ministry of Social Affairs and Health, Hans Stein, health consultant on EU Health Policy and former high level civil servant in the German Health Ministry, Vladimir Lazarevik, public health expert and former deputy minister of health in Macedonia and Besim Nuri, public health expert and former deputy minister of health in Albania. The mission was carefully prepared and closely supported by Isy Vromans, special adviser, from the WHO/EURO office and Anshu Banerjee, WHO representative in Albania.

The main objectives of the review mission were the following:

1. Provide options to the Ministry that can contribute to the further development of the Ministry as a modern, flexible and transparent organization, focusing on its core business of strategic policy and decision making and that is able to lead the Albanian Health Reform in good cooperation with its agencies and stakeholders;
2. Provide an analysis of the strengths and weaknesses of the Ministry;
3. Provide an analysis of the division of tasks and responsibilities of the core Ministry and its agencies and institutes, including recommendations on the positioning of the tasks of purchasing, service provision and inspection;
4. Provide building blocks for an institutional and organizational development strategy;
5. Identify opportunities for change and improvement (including the identification of potential 'change masters' within the ministry and potential 'quick wins'). The complete document of the terms of reference is in the appendixes of this report.

The concept of stewardship was elaborated by WHO experts and published for the first time in the World Health Report 2000; Health systems - improving performance. It encompasses the following roles:

- formulating health policy – defining the vision and direction;
- exerting influence – approaches to regulation;
- collecting and using intelligence.¹

Most recently the health system stewardship function has been defined as the ability of ministries of health to formulate strategic policy direction, to ensure good regulation and the tools for implementing it, and to provide necessary intelligence on health system performance in order to ensure accountability and transparency. The stewardship function implies also a series of strategies, measures and incentives to ensure implementation and make things happen.

The WHO/EURO Regional Office organized a European ministerial Conference in Tallinn, Estonia in June 2008, with the participation of 53 countries. The purpose was to highlight the impact of health systems on health status and economic growth, and for assessing effective strategies on improvement of health system performance. The conference adopted the Tallinn Charter that aims to launch a broad policy dialogue for exploring the social well being that lies at the centre of the triangle of interactions between health systems, health and wealth.

¹ The World Health Report 2000. Health systems – improving performance. The World Health Organization. 2000. Page 122

From this perspective, strengthening health systems stewardship is for sure a critical endeavour² for all member states.

In the aftermath of the Tallinn conference and the WHO/EURO Regional Committee of September 2008, Albania was among the first countries to request the WHO support for the review of its ministry of health stewardship and governance functions and to obtain recommendations on how further to improve these functions and the related capacities.

The Ministry of Health in Albania must be congratulated for its prompt response to the Tallinn Charter by not only adopting it, but acting on it immediately by commissioning an external review of its stewardship functions.

2.1. Overview of Albanian health system

Albania is undergoing a deep political, social and economic transformation. The internal stability of the last ten years, the gradual process towards accession in the EU, the acceptance as a candidate country by the NATO alliance and the steady economic development are important factors that have influenced the country progress. Moreover, the recent developments in Kosovo have created an optimistic feeling among the Albanian population. Despite these positive changes, the country still faces serious economic, political and social challenges.

The health system of Albania reflects the challenges of the economic and social transition towards the market economy and the difficult process of developing the democratic institutions. The health status of Albanians is rather good compared to other countries with similar per capita revenues. The life expectancy is 73,3 years for men and 78,4 years for women (2003), another example of the “Mediterranean paradox” in a context of poverty and low per capita revenue (3290\$/capita³ in 2007), epidemiological transition and deficient health services. The infant mortality was estimated at 27/1000 live births for the period 1993-2003, one of the highest in the region, while maternal mortality ratio reported by MoH was 14,7 deaths in 2005. Data published by INSTAT in 2004 indicate that the leading causes of mortality are cardio-vascular diseases (286/100 thousand), cancer (93/100 thousand) and accidents and injuries (39/100 thousand).

The infectious diseases are still a matter of concern in spite of the successful EPI program implemented in the country. Hepatitis, TB, mumps and epizootic infections are some of the major communicable diseases that affect Albanians. Contamination of drinking water, food quality, smoking and unhealthy behaviour, traffic conditions, environment pollution and occupational health problems are the most important risks that influence adversely the health of the Albanian population.

Health care is provided by a network of about 670 health centres and 1400 health posts spread all over the country. The Primary Health Care network is presently financed by the Health Insurance fund and these settings are supposed to become gradually autonomous in the near future. The secondary and tertiary care is offered by 52 public hospitals and a network of specialized outpatient facilities attached to them. Despite the extensive network of

² Stewardship/governance of health systems in the WHO Region. Draft resolution of the Regional Committee. Tbilisi, Georgia, September 15-18, 2008

³ World Development Report 2009

health facilities, the quality of care is not good. The number of hospital beds is 3/1000, and the rate personnel/population is 1.2/1000 for physicians and 3.6/1000 for nurses/midwives. Albania spends about 5, 6% of the GDP for health, with almost half of it from direct out-of-pocket payments. The country has not sufficient financial, human and technology resources to provide the required services to the Albanian population.

The MoH is presently the main provider of secondary care in the country. It allocates the budget to hospitals and to other health organizations in the country. However, with the new amendments in the legislation this purchasing role and budget for the hospitals in 2009 will be transferred to the Health Insurance Institute. The drug distribution system and dentistry are fully private, while private medical services are concentrated in laboratory services and specialized outpatient care. According to the media, the health system of the country is undergoing through an important “crisis of confidence” due to the under-the-table payments in public facilities and poor quality of services.

3. Methodology

The methodology of the review consisted of two phases. The first phase started with a desk review of existing documents, papers and information related to the health sector in Albania. Existing literature was consulted on already developed and available practical tools for assessing the stewardship function of ministries of health⁴ and approaches in organizational analysis and institutional development⁵. The second phase consisted of a field mission with a series of interviews conducted with the Albanian Ministry of health and its stakeholders such as, the Health Insurance Institute, the Institute of Public Health, INSTAT, members of Parliament, International Organizations and partners, etc. A detailed list of institutions and organization covered by the interview process is included in the Annexes (sections 7.4 and 7.5).

The team developed an analytical framework and a set of possible questions to be asked during the interviews. The start of the mission followed individual communication between the WHO Copenhagen office and each of the four experts. The team leader of the experts group was assigned and two teleconferences with the experts were organized. All logistic and field preparation for the mission was facilitated by the WHO country office in Albania and the WHO European Regional Office in Copenhagen. The teleconferences enabled a clear understanding of the scope of the mission and a discussion on the interview methods. Discussed were the proposed structure of the interviews, while the suggested questions were critically reviewed. The team members were asked to express their preferences for the composition of the interview teams. They were also asked whether they had preference to interview specific institutions and directorates, according to their expertise and knowledge.

The expert group met in Albania before the start of the mission. The group was divided in two interview teams each consisting of two health experts with various backgrounds in health policy and management. Each team included one public health expert from Western Europe with excellent and long term experience in the EU integration processes and senior health policy decision making, and one public health expert with practical experience in the governance of health systems and specific knowledge and understanding of the culture and situation in Albania and/or the Balkan region.

The expert team reviewed the questionnaires and agreed to conduct the interviews following a basic structure and coverage of questions, allowing for modifications as deemed appropriate for each interview. The duration of the interviews and the selection of the specific questions depended of the professional profile, position and experience of the respondents.

Before the start of the interviews, the expert group presented the general review methodology to the Minister of health, and asked her about her specific expectations of the mission.

The teams conducted the interviews according the agreed schedule and agenda. Each of the interviews lasted between 30 – 60 minutes, while a few interviews took up 1.5-2 hours. The interviewed subjects were asked questions in a semi-structured way by both team members.

Each interview day was completed by a joint debriefing meeting chaired by the team leader, where the teams reported their findings. The debriefings enabled to exchange information and

⁴ Good governance for improving health system performance: a methodological framework to assess governance in health (2005) WHO EMRO

⁵ Dawson, S. (1996) Analyzing organization (Palgrave)

improve the methodology. At the last interview day the experts group agreed to draft the most important conclusions and recommendations first individually, according to their own perception. The conclusions were shared and discussed among the team members. The team leader of the expert group summarized the conclusions and selected some key findings and recommendations to present to the minister of health.

The last day of the mission the team decided on the content of the report and division of the workload between the individual members. The team leader was responsible for coordinating the draft report. Before submission of the final report a teleconference was held to discuss the structure, content and approval procedure of the final report.

3.1. Limitations

The methodology of this institutional review had certain limitations. The main limitation is the short duration of the review process. The experts group had no time to discuss the findings in sufficient detail with all concerned parties. The conclusions are based on the responses of the interviewed people and their view and understanding of the current situation in the ministry of health. More in depth interviews and further analysis on the performance of the ministry of health are required to be able to draw more evidence based conclusions.

4. Organizational structure of the Ministry of Health and methods of work

The ministry of health in Albania is, according to the current legislation and internal regulations, divided in two main levels: a political and an administrative level. The political level consists of the minister, deputy ministers, chief of cabinet, and advisers. All of them have political functions and are appointed by the government or the minister of health. The administrative part of the ministry consists of a general secretary as the highest civil servant position; followed by two general directors, the director of finance and the director of internal audit and at a lower level, seven directors of various directorates, several sector supervisors and other employees in the administration (section 7.6).

The status of the civil servants and their positions is regulated by the Civil Service Law, while discharge and release from duties is regulated by the Labour Code of the Republic of Albania. The two general directorates are divided by their functions. The general directorate for health policies and planning is responsible for the management and stewardship functions of the ministry of health. The general directorate for supportive services is providing support to all directorates. Each of the two general directorates has sub-directorates further developed by sectors. In total there are nine directorates: public health, hospital planning, pharmaceuticals, health technology and information, juridical services, licensing and external relations and integration, internal services, human resources and internal audit. The personnel in each of the directorates vary and the current name of the directorates does not always reflect precisely their scope of work.

The organizational structure and the position of the various directorates is not static, but depends on the minister's preferences and vision for the development of the ministry of health. The minister decides on the changes in some of the existing directorates or sectors within the ministry. The changes are implemented in collaboration with the Department of Public Administration (DOPA), which is part of the Ministry of Interior in Albania. DOPA is the responsible department that coordinates and approves changes in the organizational structures of the ministries and recruitment practice according to the Civil Servant Law.

Over the transition period the ministry of health in Albania has suffered from frequent changes of the ministers of health. These changes have left marks in the structure of the organization. The changes have not touched only the political levels of the ministry, but went more deeply into the administrative structure of the organization. Opposite to the existing legislation that protects the status of the civil servants, the shift of the ministers of health is followed by replacement of the secretary general, director generals and often changes in some of the heads from other directorates and sectors, even at regional and district level. The discharge of the civil servants against the existing legislation has resulted in court charges successfully won by the civil servants. Therefore, it is often said that Albania pays two administrations in parallel: one working in the ministries and another that is winning the cases in court due to irregularities in cases of discharge from their duties.

The organizational structure and its performances very much affects the division of the work load and individual responsibilities of the employees. The MoH has developed detailed written regulations for the scope and responsibilities of each of the positions. However, these written regulations have not been implemented in practice.

At present there is no clear division of individual roles and responsibilities in the ministry of health. This frequently results in overlaps in the chain of command and responsibilities shared among the high political levels of the deputy ministers, followed by common

problems in the administrative levels among the general secretary, general directorates and other sectors in the ministry of health. Frequently the appointment of new directors and chiefs of sectors does not follow a merit based career path, but it is due to the political interference to get a protégé appointed. The new employees who come with each change of the minister of health do not enjoy the civil servant status. Most of them are aware that their career in the ministry will most probably end with the new elections or change of the minister.

The lack of experience of the newly appointed managers often reflects on the collaboration of the civil servants with their supervisors in the ministry. It is not unusual that some of the supervisors or directors are frequently bypassed or not informed about certain activities in their directorates or in the ministry of health in general. The lack of respect in the hierarchy of command in the organization may also lead to the unequal distribution of the workload in the organization making some departments more overburdened than others.

Particular cause of concern in the MoH is the internal and external communication and information sharing. Within the organization the communication flow is usually top down oriented (vertical) and there is little horizontal communication between the departments and directorates. There is no structured way for the employees to be informed about the ongoing projects, activities and work of the ministry. Even high ranking officials sometimes have to learn from the media about new developments within the ministry. While the high political level tends to have regular weekly meetings, this is not practice on the lower levels in the organization.

The building of the ministry of health is being renovated but it gives an impression that it consists of small offices with two to three people sharing one office. There seem to be only few meeting rooms which hampers the possibilities for formal communication and for meetings to share experiences, problems and concerns in a structured way.

The communication with the external parties and partner organizations does not follow regular procedures and it is mainly based on personal relationships among employees in the ministry and other partners. Thus, the frequent changes in the personnel result in discontinuation of tracks of communication and create problems in sustainability of started projects and policies.

The existing setting of the organization does not enable sufficient administrative support for the core functions of a modern ministry of health. There is a permanent lack of institutional memory causing discontinuity in the work and the performance. The changes in the top leadership are not followed by a formal hand-over of the functions by the new appointees, and each new appointment results in the start of the work all over again. For the partner organizations the ministry of health does not act as a united institution, but as a collection of individuals. Most of the relationships within and outside the organization are based on personal communication, not on institutionalized communication. If a certain individual is removed from the position he or she was holding, there is no established system to keep record of ongoing activities. This creates problems both within the organization, as well as in maintaining the stability of the relationships with outside partners.

The ministry of health in its everyday work deals with a lot of fire fighting and provides ad hoc solutions for the acute problems. The established practice of work in the ministry for dealing with some policy issues is setting up working groups consisting of specialists from the ministry of health and from the other agencies and institutions concerned. This is mainly due to the lack of human resources in MoH. There are no adequate resources for policy-making development of strategies and formulation of laws and by-laws etc. Even the existing

staff in the ministry trained in field of health policy is very often engaged in more operational activities such as procurement, instead of focusing on strategic policy making.

However, it is remarkable how the MoH succeeds to attract external people and to get them contributing to the working documents. These external people (experts or representatives of different organizations) who are invited to participate and contribute in the working groups of MoH are usually not paid, which in a long run may influence their motivation to participate in the future.

The new agenda for reforms set up by the government creates additional concerns among the employees in the ministry of health. This particularly refers to the big 'budget and procurement department' who will lose most of their workload and power with the transfer of the budget for the hospitals from the ministry of health to the Health Insurance Institute. Also the hospital directorate is faced with an additional challenge, as the opening of the new National Centre of Quality, Safety and Accreditation of Health Institutions will necessitate a division of the tasks and responsibilities.

The frequent changes of the top decision making officials creates poor motivation among the technical (administrative) staff that prevails until nowadays. The employees are aware of the fact that the only way of building an institutional career is by having political support. Such practice does not enable development of a long term merit-based career as a civil servant and deters good quality personnel to apply for new jobs in the ministry.

On the positive side, it should be stressed that in 1995 Albania didn't have a single expert trained in public health, health management, health policy and other related areas, while today many of the MoH staff have been trained abroad in these areas. The key challenge remains how to maintain and engage these technical staff to support the political level in the ministry regardless of the changes.

The external environment in which the MoH operates has been difficult and with many competing priorities. The health sector has coped relatively successfully with extremely unusual situations the country went through in the last ten years such as: 1) the internal political turmoil of 1997 which left behind 2000 dead and almost 11 thousand wounded people; 2) the war in Kosovo and the crisis of displaced people (about 450 000 were sheltered and received health care in Albania); 3) several "minor" emergencies such as the polio epidemic of 1996, the hepatitis epidemic of 2005, the victims of the accidental blast near Tirana in 2007 etc etc. All these have diverted attention from the policy making functions and have drained a lot resources and energy.

Recommendations

1. The Albanian ministry of health as an organization is facing a transformational challenge. The ministry needs to use the transformational stage and to renew its image as an organization that is positive and open for change. The upcoming reforms should enable the ministry to move away from the existing work mainly concentrated in the area of procurement of goods and services, towards an organizational structure that supports the key functions of the ministry of health such as strategic policy making, regulation and law enforcement and use of intelligence on the health sector performance. All other tasks that do not belong to the core-business should be performed by other bodies than the MoH.

2. In order to build its new profile the MoH should strengthen its human resource capacities. Big administrative changes in the structure of the ministry with appointment of each new minister should be replaced by a strong organizational structure with clear divisions between technical administration and political leadership. The human resources directorate of the

ministry of health should consider revisiting the scope of work and responsibilities of each individual, sector, and directorate in the ministry of health. This can be done with assistance of the Department of Public Administration and in close collaboration and with engagement of the employees. There should be a strong political agreement to announce new employment opportunities in the MoH in close collaboration with the DOPA, based on a transparent and merit-based recruitment process. If the ministry wants to attract good quality people it should make it clear that recruitment of new personnel will not be politically motivated.

3. The ministry should consider establishing a new approach to the communication, reporting and giving of directions. In the first stage the MoH may consider introducing a new system of regular communication or weekly meetings between the departments, sectors on each level. The heads of the departments will report to their supervisors on the results of the meetings. It is also recommended that once per month all chiefs of the departments meet with the minister and the senior decision makers. In addition, there should be an active dissemination of the minutes of the meetings on each level in the organization. This can be done by storing the documents on all related, ongoing and forthcoming projects on the intranet of the ministry, or by creating an information library accessible to all employees.

4. In order to improve the transparency in the health sector the ministry can also consider the publication of a regular newsletter to inform the public on its ongoing activities.

5. DOPA may consider proposing to the government changes in the legislation to enable the introduction of a formal system for the handover of the political positions and the ongoing activities. For civil servants the handover should be defined very precisely and including a transition period of at least three months where the new person/s will be able to get more involved in the work of the ministry of health. Such approach would enable continuity of the work despite the frequent changes.

5. Functions of the ministry of health

5.1. Policy development

The first part of this section deals with concepts, principles and challenges that are important in policy-making. This part may seem theoretical and in reality such an ideal type ministry may not exist, but it is believed that this presentation gives a useful benchmark of a “best practice” policy-making organization.

Policy development is a very key function of government and stewardship. It deals with defining the courses of action to be pursued by the government in power, and putting them into practice. It involves policy formulation on the one hand, and policy implementation on the other hand. Both elements are essential. There is often a tendency to focus on policy formulation phase, and not pay enough attention to the crucial implementation phase.

Effective formulation (design) of policies requires assessment of the issues at hand, including the goals and objectives, and the options available to reach them. This involves both value judgments that express what is desirable or considered politically and ethically acceptable, and understanding relevant factual (theoretical, empirical or experiential) knowledge regarding the attainment of goals.

A systematic approach to map such territory is called policy analysis. Such an exercise makes use of all disciplines necessary to shed light on the nature of the problem and the ways to solve them. The skills needed in health policy may include a vast array of substantive fields of knowledge, such as public health, medicine, epidemiology, law, economics and finance, sociology, political science, engineering, management and organizational studies, and many others. Policy analysis is a truly multidisciplinary endeavour, which means that ministries responsible for policy-making should have at their disposal a wide range of expertise. Some of the special knowledge may be acquired from outside the ministry, but it is necessary for the ministry to have a core group of staff with skills in policy analysis and planning.

Policy development is a complex process, which will not work well without involvement of various stakeholders and interest groups. Usually, the more there is consultation and participation of those concerned in the preparatory phase, the better and smoother the implementation. Even if there are different values or conflicts of interest between various players, it is better to deal with them openly and seeking possibilities for interest alignment than to impose policies in a confrontational manner. It is of utmost importance to anticipate implementation issues already in the policy design phase. Often the feasibility, resource implications, enforcement mechanisms for implementation, as well as methods for monitoring, evaluation and need for possible reconsideration, are not given the attention they would merit.

In terms of topics for policy development, all activities for which the ministry is responsible, must of course be borne in mind. Timeliness of issues depends on the policy agendas of the government. However, there are certain particular areas of policy that deserve special attention practically everywhere.

First, there is a need for an overarching national health policy or health plan, which includes a plan action that sets out the practical steps to be taken, by whom, when and how. There should be a medium- or preferably long-term financial plan for both recurrent and investment

expenditure and sources of revenue, and this should, of course be updated at regular intervals. Investment policy in terms of resource allocation by level of care (public health, PHC, secondary and tertiary care) is essential. One of the most important (and often neglected) areas of policy-making in a labour-intensive and skills-intensive field like health is policy for human resources for health. This should look at both qualitative and quantitative aspects of human resources and their deployment in the short-, medium- and long-term. It goes without saying that in addition to these very key generic types of policy there are plenty of other areas for policy development, depending on the government's political agenda.

The tools required for making policy happen, may range from law-making, regulation and enforcement, to strategic institution-building or other capacity building, training and education of professionals, public information, and so on. Communication strategy is often a crucial part of policy development.

Since health and needs for care are largely determined outside the traditional confines of the health sector, the health ministry should be capable of working effectively with other ministries, the donor community, NGOs and other interest groups, the private sector and the media. Confidence-building and exerting influence through public relations, advocacy, persuasion and negotiation require a lot of skills in "health diplomacy".

Also global and international dimension of health policy have become more important than ever before. Major influences that require attention and response are issues related to globalization, such as GATS, revised IHR, the FCTC, intellectual property rights (TRIPS) related to public health, and the migration of health professionals. The EU has become a major player in fields like pharmaceuticals, mobility of professionals and patients, and environmental health (water, chemicals etc.). This requires a lot of energy and effort, in particular from small countries whose administrations are already strained by domestic pressures.

Time frames for policy-making often pose problems. There may be such an urgency felt for reforms or regulation, that due process for proper analysis, identification of options, choosing interventions, careful decision-making and preparing for implementation is made impossible by too short-term timelines. On the other hand, many health policies, particularly in the fields of health promotion and disease and injury prevention, are long-term endeavours, and in some cases (say, tobacco control, for instance) it may take 10 years before the health gains can be seen. Such areas of high impact but delayed returns may not receive the attention they deserve, because they extend over the political time horizon of one government. Steady progress and continuity in policy development from one minister or government to another should be striven for.

Health ministries in countries are often ranked among the less important or even marginal positions in government and portfolios, compared with powerhouses such as MOF, MOI, and MTI. The only way out of this is to strengthen the capacities for policy development and strategic management in MoHs. This requires time and effort but can be done. The key is to transform the MoH from a reactive to a proactive policy stance, to make it attractive for politicians and multidisciplinary civil servants alike by improving recruitment, methods of work and organizational culture. MoH in a country should be visible and seen as the champion for health.

The current situation in Albania

The mission team did not have time enough to analyze the policy-making functions of the MoH in any detail. It may be that certain aspects of these functions should be further

explored during a possible follow-up mission. The MoH has been able to produce and approve many policy and strategic documents with or without the support of different donor agencies. Many of these strategies have tried to introduce reform elements not easy to be implemented and their degree of implementation has been different. Taking into consideration the relatively little size of the ministry and the heavy workload on management and operational issues, this should however be considered an achievement. Some of these policies include: Long-Term Strategy for the Development of the Albanian Health Care System, Public Health and Health Promotion Strategy, National Strategy for Contraceptive Security, National Strategy for Safe Blood Transfusion, Mental Health Policy Document, National Strategy for HIV/AIDS Control and Prevention, National Strategy for Drug Request Reduction, Tobacco Control Strategy, Oral Health Strategy, and others.

Nevertheless, the picture we saw reflected many areas with room for improvement. Such improvements can only be made in the medium term, but in order to gain momentum, should be started in a phased process as soon as possible. It seems to us, that at least in the following areas performance could and should be improved through capacity-building in a few years time.

First, there is a lack of continuity in health policy development in Albania. The approach is short-term, and changes with each individual government or minister, usually of a short duration.

Second, certain important skills and capacities are in too short supply. These include at least policy analysis, law-making and regulatory capacity, and overall development of policies for human resources for the future.

Third, there is far too little attention paid to the implementation of approved policies. Many laws appear in the statute book without being properly enforced. Many policy papers are papers only, not policies that have been implemented.

Fourth, there seems to be a tendency to overlook the importance of reaching out from the ministry. The communication between stakeholders in policy development could be much improved. Relationships with donors, NGOs, professional bodies and other sectors need a lot of strengthening. This relates to the activities described above as health diplomacy.

Fifth, there is a need to strengthen the international dimension in policy development. Domestic issues are, of course, burning and they dominate the scene. However, the international scene is developing rapidly, and a country like Albania should be better able both to benefit from it and to contribute to it.

Comment [b1]: Het is voor mij nog steeds niet duidelijk wat hij hier wil zeggen. Misschien bedoelt hij dat als ze met de EU mee moeten doen dat ze dan moeten monitoren wat er internationaal gebeurt zodat ze het zelf in hun eigen wetten kunnen aanpassen.

Sixth, the crucial policy-making role of the MoH is hampered by the fact that there are many operational activities carried out at the ministry level, which takes out energy and effort that could be better allocated to functions that can only be done by the government. In order to strengthen capacities for policy-making and other key roles of the ministry outlined in other sections of the report, it is necessary to get rid of functions and tasks that can be performed elsewhere. Headroom for investment in stewardship must be found somewhere, and the obvious choice would be such reallocation of resources in the MoH.

Recommendations

1. Prepare a medium-term plan for institutional strengthening of the MOH and related bodies. Start from delegating functions and tasks that can be carried out elsewhere,

such as procurement, audit, and direct access of individuals or families to the highest policy-makers. Make a recruitment plan for the next 2-3 years to strengthen the missing or weak capacities currently available for policy analysis, law-making and enforcement, human resources for health and the international dimension. Roles that are strongly supportive for policy-making can partly be developed in agencies or institutes subordinate to the ministry in close collaboration (such as the national public health institute or a proposed central agency for health information).

2. Build up an organizational culture that fosters co-operation and open communication, reaching out to stakeholders, other sectors, different levels of the health system, to communities and to the media. This may entail some reorganization, but far more important is the leadership and style of management. Such change takes several years determined action.
3. Whatever the substantive topics for policy development in the years to come, anticipate implementation challenges and prepare from them at an early stage. Do not accept policy papers without an action plan for implementation.

5.2. The regulatory functions and capacities of the MOH

The regulation functions - or as they are also called “the rule of law”- are not only an essential function and task of every ministry of health but also a sub-function of stewardship. They consist of all the legislative measures, be it laws, regulations, directives, rules or other legal instruments relevant to health and to the health systems. They are needed to transform strategies and policies into reality, to enforce them, to monitor and to control their enforcement. It is necessary to modernize and to fill the existing gaps in the existing current legislation in different sections of health policy such as regulating private practice, hospital planning, financial rules and regulations, health service provision, infrastructure, quality assurance health technology, human resources, accreditation and licensing, pharmaceuticals, telemedicine, trader related health issues just to name some of the present priority areas. Different as the legal framework in line with national customs, culture and traditions might be, tone should ensure that independent of the systems they are fair, just and are enforced impartially, particularly where the concern human and patients rights.

The legal measures are essential for establishing and enforcing patient’s rights including the right of equal access to good quality health care everywhere and for everyone. The importance of patient’s rights in health is demonstrated by the fact that the “Charter of Fundamental Rights of the European Union” contains health care as a fundamental right: *“Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices”*.

The role and importance of law in health is today quite often neglected and underestimated especially by the medical professions. In reality laws and their enforcement belong to the core tasks of any health ministry. They are most definitely not just a supportive action. Laws may just be an instrument, but they are essential tools for transforming visions, strategies and policies into reality. The success of any health strategy depends to a great extent on the quality of their legal framework with which they are enforced.

The issues that have to be regulated today and in the future are not only very often of an innovative nature, but also of great complexity. They require a sufficient number of well trained, qualified and experienced – especially in health matters- legal staff. The capacities have to be in line with the needs of policies.

However, even if making laws, implementing and enforcing them is an important task of any health ministry, as a rule they cannot do it all by themselves. The exception are those issues- mostly sublegal matters of minor importance- for which the ministry has the sole power to regulate them.

As far as lawmaking is concerned, a ministry is just one partner in a time consuming, well structured, democratic, legislative process. The MoH as a rule takes the first step by preparing a draft of the law, then all the other concerned ministries have to agree, the Council of Ministers has to decide on it and to submit it to the Parliament. Even if the final formal decision lies with the parliamentary institutions, who in their committees examine the draft in detail, conduct hearings where affected stake-holders and scientific experts comment on the law, the MOH has to accompany the process by first defending its draft and at a later stage assist in finding alternative wordings. This is a very similar if not identical process in any democratic parliamentary system.

As far as implementing and enforcing the legal framework is concerned, this differs greatly according to the health system, whether it is a centralized one and run by the ministry itself including licensing and inspection or whether most of the tasks are delegated to regions, communities, health insurances, health professions, independent agencies or even non-governmental organizations. In both cases the MOH has to monitor and evaluate the process to see if and to what extent the laws and regulations are implemented and what measures should be taken if this is not the case. In many European countries the lacking enforcement of smoking bans is an example for the limited success of a law, not accepted by the general public.

The European Integration, an overall priority of the Albanian Government is an enormous political and economic task, be it for the member states, be it for accession countries. But in order to achieve the harmonization and to establish an internal market, an extensive amount of legislation is permanently needed on the European as well as on the national level. As EU integration also concerns health to quite a large and steadily growing extent, it also belongs to the core regulatory tasks of every European MOH. Already the accession process makes it necessary to transform the “*acquis communautaire*” in health into national law. Later the decisions on health related new EU directives, their transformation and enforcement will be a permanent work load. This work can only be done in close cooperation with Ministry of Integration. As far as health issues are concerned, the main burden will be on the MOH. *(Details of the tasks are described in Annex 7.3 taking account of the experiences of countries, which have recently joined the EU).*

The current situation in Albania

MoH has undertaken several initiatives to strengthen its regulatory capacities including the development of two new organizations: 1) the National Centre for Quality, Standards and Accreditation of health settings and 2) National Centre for Continuing Education in health. They are expected to contribute in development and implementation of regulatory frameworks of the health sector in Albania. Many important laws have been written and approved recently despite the low number of people in the legal directorate. These include among others the Mental Health law, HIV/AIDS Law, Blood safety law, new Law on Drugs (Pharmaceuticals) and the Tobacco Law.

The mission team was not able to analyze the law making and enforcement activities as well as tasks related to the EU Integration in sufficient detail. It may well be that especially the EU

issues, which in most cases are of a legal nature, might have to be further explored in the future. This applies especially for those issues, where even to-day or at least in the near future EU funds, notably those for assisting EU accession countries, could also be used for improving the health situation.

It is noted that most people interviewed not only showed a great and positive interest in the accession process, but also were acquainted with the “acquis communautaire“ in health matters. This is not really surprising, as important risks that affect health in Albania to-day – smoking, unhealthy behavior, infectious diseases, food quality, safety and occupational health, environmental pollution, quality of drinking water - are also topics for which European legislation exists, that has to be transformed into national law. Establishing European standards by national law and enforcing them in reality therefore is not only necessary for the accession process, but will at the same time contribute step by step to improving the health status of the Albanian people.

In both cases- regulatory activities in general and Integration – organizational structures - exist at the MOH. There is presently as a part of the DG “Supportive Services“ a directorate of “Juridical Services, Licensing, External Relations and Integration” with four sectors, two of which are relevant to the issues described in this chapter. The others are for licensing private health activities and for public relations.

The sectors we examined were:

- ° the sector for Juridical services, whose main task is “the leading and the guiding of activities for the preparation of the legal and sub-legal framework in support of health policy and strict implementation of the legislation in the health sector (Art.21/1 Int. Regulation).
- ° the sector for “Integration and Foreign Relations” whose main task is “to play a key role in the representing the MOH in integration issues. The responsibilities of this sector include “the coordination and monitoring of the EU in integration process with regard to the obligations and commitments of the MOH “the “drafting and proposing suggestions on aspects of integration in the area of health with other units of the MOH” as well as the cooperation with the Ministry for European Integration (Art.18/1 Int. Regulation)

The different tasks of these units are described in great and sufficient detail in the Internal Regulations. This description however does not sufficiently show the political importance of their tasks, nor does it convey an idea of the growing work load these two sectors will have to bear in the future. This burden is especially high as the close cooperation with other units of the MOH often requires the establishment of working groups, as a rule headed by these units. Moreover in the case of law-making the permanent cooperation with the parliamentary institutions, in the case of integration the negotiations with the Ministry of Integration and later on with European Institutions are time consuming and thereby increase the work burden. These tasks can only be mastered with adequate organizational structures within the MOH, taking account of the political relevance of their tasks and a sufficient number of well trained, qualified legal staff. The present classification as “Supportive services” is in no way justified. Considering the political importance of their work, essential for the success of the MOH, their present work-load especially its expected growth in the future, they appear to be grossly understaffed.

Recommendations

1. Improve the regulatory and enforcement capacities of the Ministry.

2. Upgrade the political relevance and influence of these directorates/sectors by removing them from the “Supportive Services” and place them in the policy area. Considering their political importance as well as their mainly cross cutting tasks, it seems adequate to affiliate them directly to the Secretary General. This would strengthen their position in their cooperation with other sectors.
3. Establish an independent new directorate/sector “EU Integration”, that is not only responsible for coordination and monitoring within the ministry of the other units and representing the ministry in the cooperation with the Ministry of Integration and other ministries whose responsibilities are of relevance for health (Health in all policies); its responsibilities should also include leading the activities and the preparation of the legal framework in the accession process, drafting the respective health legislation and applying the technical assistance to TAIEX in the health sector.
4. Establish a permanent working group for cross cutting EU issues as well as a number of working groups preparing the transformation of EU health directives during the accession process and later. All groups should be chaired by the “EU Integration Directorate”.
5. Strengthen the quantitative capacities of the legal and Integration sectors by increasing their mainly legal staff, limit turnover and thereby enable continuity.
6. Strengthen the qualitative capacities of the staff of these units by enabling and supporting their participation in continuing education, special training courses, seminars, weekend work -shops, summer schools etc related to regulatory measures needed to implement policy priorities. At present this would mean concentrating on EU Integration issues. Special funds for this task could be made available from the EU Commission and/or third countries.
7. Strengthen the Integration process by enabling a stage of 6-12 months for staff in an EU institution (especially the DG Sanco of the EU Commission), in another country who has recently become a Member State or the Albanian Representation in Brussels.

Of course all these measures taken together would have the biggest effect. But they should also be considered as independent steps in a permanent and pragmatic step by step process.

5.3. Intelligence function of the MoH

One of the main sub-functions of stewardship is intelligence. Policy formulation and decision-making processes based on the best available evidence need a strong intelligence support. “*Intelligence* is broader than *health information*. It implies identifying and interpreting essential knowledge for making decision from a range of formal and informal sources such as routine information, research, the media, opinion polls, pressure groups etc.”⁶.

In order to support informed decision-making, three different categories of information are needed:

- a) current and future trends in health system indicators and health system performance;

⁶ Health system performance assessment. Debates, methods and empiricism. By Christopher J.L. Murray and David Evans. 2003, page 292.

- b) information on important contextual factors and actors;
- c) possible policy options based on national and international evidence and experience. An important role of the intelligence is also to ensure that all actors of the health system have access to data and information in order to contribute to the health system development and outcomes.

The intelligence function at the current MoH-Albania is carried out by the Directorate of Health Technology and Information (DHTI). This directorate is organized in two separate units: the Sector for Information Technology and the sector of Monitoring, Evaluation and Data Collection. The directorate has gone through a reorganization process in recent years and apparently the results of this process have not been satisfactory. Through all the interviews, the mission received a very clear message that this directorate is one of the MoH structures that needs to be reorganized and its human and resource capacities strengthened.

Some of the problems related to DHTI can be summarized as follows:

- a) insufficient capacities (quantitative and qualitative) to perform adequately the classical functions of a Health information unit. In fact, this directorate has only two technicians dealing with information collection and processing, while two additional people work on monitoring and evaluation (M&E);
- b) lack of clarity in the definition of functions of the two sectors. Apparently, the M&E function is not clearly defined. Presently MoH has requested the World Bank assistance to provide support in formulating the role, functions and activities in this area and to develop capacities of the personnel operating in this sector;
- c) confusion of roles between the health information intelligence and information technology support. Presently, there are many IT technicians in the directorate that deal mostly with IT support for MoH and they identify IT technology with health information.

An assessment of the Albania's health information system carried out in July 2008 by MoH with the technical support of WHO revealed that:

- a) the capacity of the MoH and its affiliated agencies on core health information sciences was partially adequate;
- b) HIS related legislation is scattered among a huge number of laws and normative documents and does not cover all HIS key aspects (e.g. obligations of private sector, data sharing between institutions);
- c) there are inadequate mechanisms for legislative enforcement;
- d) data management is totally inadequate⁷.

The DHTI has not been able to produce an official strategy related to development of the HIS in Albania. The architecture of the Albanian HIS is not clear and it is becoming more complex due to specific interventions of several donor agencies in this area. The DHTI does not have resources or capacities to perform routine monitoring and supervision of HIS performance at all levels of the public system, neither to support periphery levels for data collection, management and analysis. Furthermore, DHTI has very limited capacities to gather the existing information produced by many other institutions and agencies, while data

⁷ Assessment of the Health Information System in Albania. Report prepared by Ivdity Chikovani, Curatio International Foundation, Tirana 2008

from the private sector are not collected at all. Consequently, this information is not adequately used for policy-making, planning and decision-making processes. Sometimes, there are tensions between different health and other agencies related to sharing micro-data and the country lacks a centralized health intelligence unit that could bring harmony and coordination.

The authorities of MoH are aware of most of the problems related to capacities, structure and functions of the DHTI and they have expressed very clearly the will to introduce rapid changes for improvement. This becomes even more imperative in view of the very important financing reform of the health sector of Albania. In order to deal with this priority, MoH and the most important stakeholders carried out an HIS assessment exercise, with the technical support of WHO. This process led to the formulation of an assessment report and strategic vision (July 2008), that was followed by a short-term action plan developed by WHO funded foreign experts (October 2008). Some of the most important steps suggested in the plan deal with capacity building at the central level. It is not clear if these documents will become the national strategy and action plan of MoH on HIS. These papers were not mentioned over the mission, despite the fact that everybody considered health intelligence as a priority area in the framework of MoH review and stewardship capacity building.

The country needs to make additional efforts in order to change the culture of “secrecy”. Health information and data are a public good and they must be diffused and made available to government and non-government agencies as well as communities who contribute to the development of the health sector. This needs to be done in order to make the system more transparent and involve partners and communities in important health debates and policy-making processes. MoH must be able to produce and diffuse data and information on health status of Albanian people and health sector performance, trying always to make benchmarking and comparisons with other countries.

Data publication and transparency will hopefully produce broader debates and will involve to a larger extent patients, consumers and communities in the consultation processes related to health sector policy-making. In fact, some of the mission interlocutors considered that “MoH is detached from people and consumers and power and authority are over-centralized”. This makes of MoH a vulnerable organization and an easy target for all problems and failures of the health system. Transparency is needed more than ever due to a certain “trust crisis” installed in health care between physicians and other providers and patients and consumers as a consequence of under-the-table payments and episodes of unprofessional health care services and fatal errors, as reported by the media. In this situation, the MoH oversight and transparency on the performance of the health care system is needed more than ever.

Recommendations

1. Improve the knowledge base and health information systems in the country in an incremental development process with careful considerations of the roles of different actors, their needs and capabilities. Formalize the national strategy for HIS and develop the necessary conceptual, legal and organizational framework for the new HIS in Albania. The roles of different agencies should be clearly stipulated in a Law on Health Information in Albania.
2. Strengthen the **Directorate of Health Information** and transform it in a *central intelligence unit* which is capable of handling the information for policy-making, supervision, monitoring of implementation and evaluation of health status and health system performance. In addition, this directorate will be a focal point for the

development of the Albanian HIS (architecture of the system, legislation, regulation, coordination etc). The Directorate of health information should be separate from the IT support function as the latter is a clearly supportive function. Nevertheless, IT specialists could contribute to the design and organization of the new HIS.

3. Data collection and processing and most parts of data analysis should take place in a *central national agency* or centre, subordinate to the ministry of health (**national health information centre**). This centre will gather all health related information produced in the country. MoH should not directly assume this very important responsibility due to the very heavy and technical workload related to data collection and processing.
4. Develop additional capacities for dialogue with the public. A communication strategy of MoH needs to be clearly formulated and implemented, in order to get important information on people's experiences, perceptions and opinions on health care.
5. Publish and diffuse health status and health performance indicators on a yearly basis in order to increase accessibility to information and transparency of the health system.

6. Conclusions of the mission

1. It was found out considerable improvements in the stewardship functions of the Ministry of health in Albania could be made within the next few years. Main recommendations focus on the key tasks that the Ministry and nobody else can perform: policy-making, law-making and enforcement, recruitment of personnel and health intelligence and information systems.
2. The policy making role of MOH should be strengthened by focusing on strategic issues. This entails that tasks that can be performed by other bodies than MOH, be diminished by delegation or transfer to lower levels of administration. On the one hand strengthening this role of the MOH means that new skills and capacities are developed in key policy areas, such as policy analysis in general, and in substantive policy fields like human resources for health, pharmaceuticals, promoting health and preventing Non-Communicable Diseases and injuries, and in international health. On the other hand this requires exerting influence on other sectors through health diplomacy, building alliances, networking with NGOs, and dealing with the media. The policy orientation in the future ought to be proactive, participatory, and long-term.
3. The capacity of the MOH in law-making, regulation and enforcement should be enhanced. More legal staff is needed not only for filling existing gaps in current legislation and modernizing it, but also in order to prepare the country for integration with the EU, in all fields related to the *acquis communautaire*.
4. The knowledge base and health information systems in the country should be improved in an incremental development process with careful consideration of different actors, their needs and capabilities. The ministry should establish a central health intelligence unit as soon as possible, with the task of providing best available information for policy-making, supervision, follow-up of implementation of reforms, and evaluation of system performance. Most of the data collection, processing and major parts of data analysis could be carried out in a central agency subordinate to the ministry. The role of the ministry and other agencies should be stipulated clearly in the law.
5. Changes are needed in the practices for recruitment, personnel management and continuous education of MOH staff. The first step should be strict enforcement of existing rules and regulations for recruitment to the letter. The rapid turnover of staff can be avoided and the necessary continuity can only be achieved by following the principles of good public administration approved in the country in general.
6. The roles of political and high-level administrative staff require clarification. The minister should be relieved from unnecessary duties by, for instance, not letting the civil servants to bypass their superior to have direct access to the minister, and not giving access to individual patients or families directly. Clear lines of accountability and reporting should be created between the political functionaries and the hierarchy of civil servants. The role of the permanent secretary as the head of civil service in the organization should be strengthened.
7. The lines of communication and flows of information should be improved both vertically and horizontally. The organizational culture should in the future be based on trust and confidence, co-operative mode instead of silos, isolation and individualism. The MOH should be seen as a modern and dynamic institution instead of a collection of separated units and practitioners.

8. The recommendations made above are possible in the medium term, and the process should be started as soon as possible. The report contains a lot of more detailed steps that could be taken, some even immediately, if the recommendations are well received.

7. Annexes

7.1. Terms of Reference

Introduction

Strengthening the performance of the Albanian health system is one of the priority areas for collaboration between WHO Europe and the Ministry of Health of Albania. As part of this several activities are planned within the Biennial Collaborative Agreement (BCA) between Albania and WHO Europe for 2008-2009. Those activities relate to stewardship, health financing, service delivery and resource generation.

One of the main priorities for 2008-2009 is enhancing the stewardship role and capacities of national health authorities for policy development, implementation and evaluation. Within this framework, the Ministry of Health has asked WHO to organize a review of the stewardship and management functions of the Ministry. The recently appointed new Minister fully is fully supporting the review.

Background of the request is that the Ministry wants to have guidance on how to improve the functioning and internal organization of the Ministry in order to be able to take reforms forward. There seems to be particular room for improvement in strategic policy making and internal management practices such as communication and cooperation. Due to high turnover of staff members in decision making positions business practices need to be continuously re-established. A good performing ministry is an essential condition for the Albanian health reform; therefore the review should be done as soon as possible.

The review can also be seen in the context of the government's commitment to implement the Tallinn Charter, acknowledging the Stewardship role of the Ministry of Health. Aim of the review is to contribute to the development of a sustainable and strategic organization that is able to serve political leaders of various political origins in a loyal and competent way.

Objectives of the review

- Provide options to the Ministry that can contribute to the further development of the Ministry as a modern, flexible and transparent organization, focusing on its core business of strategic policy and decision making and that is able to lead the Albanian Health Reform in good cooperation with its agencies and stakeholders;
 - o Protect health
 - o Guarantee access to health care
 - o Safeguard people from impoverishment
 - o Ensure greater efficiency and equity
- Provide an analysis of the strengths and weaknesses of the Ministry;
- Provide an analysis of the division of tasks and responsibilities of the core Ministry and its agencies and institutes, including recommendations on the positioning of the tasks of purchasing, service providing and inspection;
- Provide building blocks for an institutional and organizational development strategy;
- Identify opportunities for change and improvement (including the identification of potential 'change masters' within the ministry and potential 'quick wins');

Tasks

1. Develop a methodology for the review that is approved by the MoH, including a communication plan and a planning;
2. Conduct a desk-research, based on available documents of the Albanian MoH, taking into account similar reviews of ministries of health in other countries;
3. Introduce the Review to the MoH;
4. Conduct interviews with the MoH, its agencies, regional health authorities, stakeholders and donor organizations;
5. Support MoH staff in the implementation of the communication plan;
6. Maintain a good working relation with the MoH and the Advisory Committee;
7. Write a report, including recommendations, that is approved by the MoH;
8. Present the results to the MoH;

In a second mission:

9. Present the results with approval of the MoH, to the other interviewed parties;
10. Co-facilitate a two-day seminar to discuss options for improvement.

Output

1. An introduction of the Review Methodology for the MoH;
2. A power point briefing on the preliminary results for the Minister;
3. A report including recommendations for the Albanian MoH;
4. A brief evaluation of the review process as such, to help WHO draw lessons from the project, providing building blocks for a methodology and a manual.

From a second mission:

5. A two-day seminar with the MoH and other invited parties;
6. A report on this seminar with recommendations for next steps to follow up the reform process;

Profile

1. A team of four experts, who together have excellent expertise in governance, health systems reform, strategic policy making, organization analysis and human resource policies. Good technical knowledge, interviewing, communication and advising skills are essential. Understanding of the Albanian context and the health reform in Albania is important.
2. Proficiency in the English language is essential, Albanian; Italian and/or French are desirable.

Time frame

The work will take place as soon as possible, preferably starting in November 2008.

7.2. Table with findings, recommendations and suggested actions

Findings	Recommendations	Suggested actions
Policy-making function		
Insufficient policy-making capacities	Increase the critical mass of personnel with good training in policy analysis, law-making, health administration, public health etc.	<ol style="list-style-type: none"> 1. Formulate a recruitment plan for the next 2-3 years. 2. Define and apply strict merit-based criteria in hiring personnel 3. Stimulate the staff to get training abroad in policy analysis, law-making, health policy and planning, health management, public health etc.
Insufficient professional expertise for performing the new functions resulting from the health sector reform	Increase capacities in specific areas such as monitoring and evaluation, health diplomacy, health intelligence, human resource policy and planning, communication strategies and responsiveness to population, etc.	<p>Formulate and implement a medium-term plan for institutional strengthening and developing staff capacities in these areas through short and medium-term training</p> <p>Benefit at maximum from the technical assistance provided by donor agencies</p>
Weak capacities in HRH (human resources for health) policies and planning	<p>Reinforce the Human resource policy and planning capacities of MoH</p> <p>Develop a national strategy and action plan of HRH in Albania</p>	<p>Strengthen capacities of the directorate of Human resources in terms of quality and quantity in order to perform the functions planning and projections of HRH</p> <p>Support the directorate with foreign Technical assistance (TA)</p>
Implementation capacities of MoH are weak	Strengthen and improve implementation capacities	<p>Prepare always action plans attached to policy and/or documents</p> <p>Develop and implement a functional monitoring and evaluation system</p>
Regulatory functions		
Insufficient regulatory capacities	Improve the regulatory and enforcement capacities of MoH	Increase and enhance quantitative and qualitative capacities of MoH personnel dealing specifically with <i>regulatory</i> frameworks of the health system in Albania.
Insufficient human capacities to develop and enforce regulatory frameworks	Strengthen the qualitative capacities of the staff	<p>Strengthen capacities of MoH personnel staff through continuing education courses, seminars, summer schools etc. in different regulation topics such as evaluation and control of high cost technology, regulation of providers (public and private), monitoring of quality, development of health service packages, planning and mapping of health service facilities, EU integration issues etc.</p> <p>Look for special funds from the EU commission to facilitate this process</p>

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Law-making capacities of MoH are not sufficient	Strengthen the law-making capacities of the legal directorate, in view of the accession process in the EU	Increase the number of the legal staff and limit their turn-over in order to enable continuity
Weak capacities related to EU integration	Increase and strengthen EU integration capacities within MoH	Establish an independent directorate (or sector) of EU integration Establish a permanent working group for cross-cutting EU issues and other satellite groups for specific EU integration themes
<i>Intelligence function</i>		
Weak health information capacities that does not allow an appropriate policy-making process	Strengthen health information system and capacities in support of the policy-making processes	1. Establish a Directorate of Health Information in charge for: a) development, regulation, definition and unification of the health database and architecture of the system; b) intelligence function to feed policy-making process; 2. Establish a National Health Information Centre as an agency of MoH (data collection, cleaning and processing)
Insufficient transparency with the general public and other stakeholders	Increase communication with the general public, the media and different stakeholders	Develop communication strategy Publish health indicators and health system performance indicators
There is a gap between patients/consumers and MoH	“Rapprochement” of MoH to patients/consumers in order to put the patient at the center of the health system	Create a special interface between MoH and consumers and their organizations (special unit with a strategy)
<i>Organizational structure and methods of work</i>		
Excessive operational work	Decentralize (delegate or outsource) the operational functions of the health sector (procurement of goods)	Decentralize operations at periphery levels Provide to hospitals full autonomy for their operations
Frequent turn-over of personnel in the administration of MoH	Respect for and enforcement of the Civil Service Law	1. Hire personnel on the basis of long-term contracts and through a transparent and merit –based process 2. Reduce number of people that can be freely appointed and contracted 3. Develop carrier plans in the public administration 4. Introduce performance indicators for the personnel at MoH headquarters
Responsibilities of MoH directorates are defined in paper but there seems to be a lack of clarity and overlapping in practice	Better clarification of responsibilities and functions of directorates, sectors and individuals in cooperation with DOPA (Department of public administration)	MoH to go through periodic retreats and exercises of organizational strategic planning (every year and every second year). At the beginning, this can be done with the support of TA
Deficient communication flow (horizontal and vertical) inside MoH	Improve vertical and horizontal communication between directorates	1. Increase group communication between decision-makers (less one-to-one meetings)

<p>Lack of sufficient education and training in public administration and management</p>	<p>Increase the capacities of personnel in public administration and management techniques</p>	<ol style="list-style-type: none"> 2. Establish new systems of communication, reporting and giving directions 3. Keep lower levels informed and involve them in different policy-making and other processes 4. Introduce a system of regular minutes accessible to everybody in the respective level 5. Create an internal network of MoH (intranet) <ol style="list-style-type: none"> 1. Continuing education in public administration good practice and innovation. This can be done through the donors and with the support of ITAP (Institute for Training of the Public Administration) 2. Consider the possibility for developing e National School of Public administration (recommendation for the GoA)
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7.3. EU Integration

EU Integration is an overall policy priority for the Albanian government. Although it seems to be envisaged only for the year 2017, quite a lot of activities have to be undertaken right now. One of the main tasks is the transformation of the “**aquis communautaire**” into Albanian law.

The aim of this annex is to provide additional information concerning the commitments, tasks, and responsibilities of the MOH related to the EU Integration of Albania. The general description of the situation and recommendations are given in Chapter 4.2. “The Regulation functions and capacities of the MOH”. This information takes into account some of the experiences the health ministries of recent accession countries have made.

The importance of Health as a component of EU Integration is quite often neglected and underestimated. It is true, that the Health competence of the EU is limited. Except for a few exceptions it does not contain “Harmonization”. It is mainly focusing on coordinating, complementary and supportive action. Nevertheless the EU health activities are permanently increasing, it is on the way of becoming even an EU priority. The Treaty of Lisbon, which presently is not ratified by all member States yet- will increase the EU power.

The Internal Regulation of the MOH in its Art. 18.1. describes the ministerial functions in Integration, its obligations and commitments in great and quite sufficient detail. However it does not name and describe the content of EU health matters. This knowledge is needed to estimate the burden of work to be expected.

These concern legal measures (acquis) and supportive activities in various programmes:

- The Key EU Public Health Acquis and supportive activities based on Art .152
- Health as a “border – crossing” issue (“Health in other policies”);
- Financial support for Health issues and pre accession assistance (IPA and Taiex);
- Taken together the EU actions are quite extensive and cover practically the whole area of Public health and health care;

The Key Public Health Acquis, which has to be transformed, consists of:

- decisions and regulations on communicable diseases
- 6 directives on blood, tissues, cells and organs
- a large number of directives on nutrition
- directives, decisions, regulations, resolutions on tobacco
- directives and regulation on safety and health at work
- regulations on veterinary and phytosanitary legislation
- directive on “application of patients rights in cross –border healthcare including financing, access, centres of reference, health technology assessment

(Commission proposal will be decided by Council and EP in 2010)

The Supportive activities (financing of projects) takes place in the **Programme for Community action in the field of health**. Its main objectives are actions to improve citizens’ health security, to promote health, including reduction of inequalities, to generate and disseminate health information and knowledge. As these objectives are in line with

priorities of Albanian health policy it seems advisable that **Albania participates in the programme even before accession** has taken place. This requires a formal, agreement with the Commission.

Moreover the EU has agreed on a general **EU Health strategy** as well as strategies on mental health, nutrition, tobacco, alcohol, healthy lifestyles, socio-economic determinants. Although these strategies do not require formal transformation into Albanian law, it is recommended that values and principles of these strategies are applied before accession.

The size of the scope of **health across the European Commission (Health in all policies)** can be shown by the following examples, some of which even have to be transformed into national law:

Nutritional promotional campaigns, competition rules in health markets, education in healthy life-styles, coordination of social security, Open method of coordination in healthcare and long Term care, environmental health including air quality, water quality,

Pharmaceuticals, medical devices, biotechnology, cosmetics, chemicals, data collection, health statistics, development of e-health tools and services, illegal drugs, Internal market with its 4 freedoms including health professionals as well as patients, Public health research in the Research framework program, regional policy.

Even if the MOH is not responsible for all of these subjects, they have to cooperate with the other ministries in order to ensure that health interests are sufficiently taken account of.

There is no general **EU health budget**, out of which measures in the member states and the accession countries can be funded. But other funds such as the **structural funds** as well as the **regional funds** could be used for financing even health care infrastructure. Precondition is that the Member State who requires these funds has to apply and show that he fulfills the conditions. The Commission also **assists EU accession countries** to put in place the *acquis* including the health *acquis* with its instruments for Pre-accession Assistance (IAS) and Technical Assistance and Information Exchange (TAIEX).

The purpose of this overview, which is in no way complete, was to show what tremendous work load will have to be met in the MOH on the Integration issue. This fully justifies the **establishment of a strong and well staffed Integration directorate.**

7.4. List of people interviewed

1. Anila Godo , Minister of Health
2. Zamira Sinoimeri, Deputy Minister of Health
3. Arben Ivanaj, Deputy Minister of Health
4. Petro Mersini, Adviser to Minister of Health
5. Saimir Kadiu , Director of the Directorate of Economics MoH
6. Gazmend Bejtja, Director of Public Health MoH
7. Igli Stambolla, Director of Auditing of the Ministry
8. Alban Ylli Director, IPH
9. Eduard Kakarriqi, Head of the Department of Epidemiology
10. Silva Bino, Head of Department of Infectious Diseases
11. Xheorxhina Kuli, Director Mother Teresa Hospital
12. Hektor Sula, Mother Teresa Hospital
13. Eliona Basha, Mother Teresa Hospital
14. Alfred Priftanji, Dean of the Medicine Faculty
15. Ehadu Mersini ,Teacher in the Nursing Faculty (Many years working in the MoH)
16. Sokol Dedja, Former Secretary General of MoH
17. Gerta Picari, Secretary General MoH
18. Anjeza Rustemi, MoH Director of Pharmaceuticals MoH
19. Fedor Kallajxhi, MoH Director of Hospital Planning MoH
20. Erieta Kambo, Director Health Center Vora
21. Laureta Mano, Juridical Director HII
22. Gazmend Koduzi, Director of the Physician Directorate HII
23. Isuf Kalo, National Center for Accreditation, Quality and Patient Safety
24. Pellumb Abeshi, General Director Ministry of Environment
25. Mira Galanxhi, Director Demographic Data INSTAT
26. Arjana Kazazi, Ministry of Finance, Budget Directory
27. Antoneta Njehrrrena, Head of Legal Sector
28. Musa Zeneli, Head of Thallasemia NGO
29. Blerta Selenica, Head of the Department for Public Administration
30. Mirela Tabaku, Adviser to the Deputy Prime-minister
31. Din Abazaj, President, Chamber of Physicians
32. Shaqir Krasta, Secretary General, Chamber of Physicians
33. Entela Shehu, National Center for Continuous Education
34. Tritan Shehu, Head of the Parl. Commission for Health
35. Lajla Pernaska, Member of Parliament, Member of Commission for Foreign Policy, Chair of sub-commission for issues of minors and gender equality
36. Olimbi Hoxhaj, Executive director, Albanian Association of PLWHA (people living with HIV/AIDS)

7.5. Participants in the focus group discussions

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Name	Agency	Position
Elsona Agolli	UNFPA	Programme Analyst-RH
Wezi Msisha	World Bank	Health Specialist
Mariana Bukli	UNICEF	Health Officer
Enkelejda Sula	SDC	National Programme Officer
Eriona Minka	GTZ	Project Coordinator
Holger Thies	CIM	Advisor to Health Insurance Institute
Renato Toska	World Vision	Health Access & Advocacy Coordinator (New)
Mike O'Brien	World Vision	Health Access & Advocacy Coordinator (Previous)
Erjeta Dobi	Albanian Red Cross	Health Coordinator
Agim Kociraj	ProShendetit	Service Delivery Specialist

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MINISTER

7.6. Organizational Scheme of the MoH

Minister Cabinet
Chief of Cabinet
Press spokesperson
Advisers
Secretary

Deputy Ministers

Secretary General

General Directorate of Health Policies and Planning

Directorate of Financial Planning

General Directorate of Supportive Services

Directorate of Internal Audit

Public Health Directorate
Hospital Planning Directorate
Pharmaceutical Directorate

Health technology and information Directorate
Juridical Services Licensing, External relations & Integration Directorate
Internal Services Directorate
Human Resources Management & Continuous Education Directorate

Sector of Family Medicine & Dental Services
Sector of Mental health & Drug Issues
Sector of Reproductive Health
Sector of Hospital Planning
Sector of Epidemiology and Hygiene
Sector of Standards in Hospital Service

Budget sector
Sector of Investment and Assets Management
Sector of Procurement

Sector of Information Technology
Sector of Monitoring & evaluation Data Collection
Sector of Juridical services
Sector of Licensing of private Health Activities
Sector of Finance
Sector of Internal Services
Office of Archive and Protocol

Sector of Human resources management & Continues education
Sector of Standards & Nursing Care