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THE ALBANIA HEALTH SECTOR GOVERNANCE STUDY

TECHNICAL REPORT

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The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

CONTENTS

Acronym list	7
1. Executive Summary	9
2. Background	13
3. Objective	14
4. Approach and Methods.....	15
4.1 Approach	15
4.2 Data Collection Methods.....	15
5. Overview of Relevant Laws and Orders.....	18
6. Overview of Health Sector Institutions	19
7. Findings.....	20
7.1 Health System Governance and Leadership.....	20
7.1.1 Developing National Strategic Policy Framework...	20
7.1.2 Priority Setting and Policymaking	22
7.1.3 Provide Regulations, Budgets, Incentives and oversight to Ensure Implementation.....	22
7.1.4 Coalition Building, Coordination among Health Institutions, with Donors, and Other Stakeholders	23
7.1.5 Proposed Support from EEHR.....	23
7.2 Standards and Processes to Ensure and Improve Quality ..	25
7.2.1 Develop, disseminate and implement standards, protocols, clinical guidelines to improve quality	25
7.2.2 Establishment and implementation of Monitoring and Evaluation System	28
7.2.3 Analyzing and Using Data to Inform Policy Making.	28
7.2.4 Accreditation of Hospitals	28
7.2.5 Registration, Licensing and Recertification of Health Providers.....	29
7.2.6 Continuing Medical Education.....	29
7.2.7 Proposed Support from EEHR.....	29
7.3 Hospital Organization, Operations and Management.....	31
7.3.1 Overall Planning for Hospital Sector	31
7.3.2 Financing	33
7.3.3 Hospital Management.....	34
7.3.4 Monitoring and Oversight of Services.....	34
7.3.5 Proposed Support from EEHR.....	35
7.4 Financing and Health Insurance	36
7.4.1 Registering Eligible Population and Collecting Premiums	36
7.4.2 Defining the Benefits Package.....	39

7.4.3	Establishing Payment Terms for Providers.....	39
7.4.4	Selecting Providers.....	39
7.4.5	Overseeing Provider Quality.....	40
7.4.6	Reviewing and Paying Claims.....	40
7.4.7	Oversight of Health Insurance Fund.....	40
7.4.8	Proposed Support from EEHR.....	41
8.	Conclusions	43
	Annexes.....	47
	Annex 1 – Counsultancy Team Scope of Work.....	49
	Annex 2 - Meeting Schedule/Contact List.....	55
	Annex 3 - References.....	58

ACRONYM LIST

CAR	Capability, Accountability, Responsiveness
CME	Continuing Medical Education
COP	Chief of Party
CSO	Civil Society Organizations
EEHR	Enabling Equitable Health Reforms Project
GOA	Government of Albania
HC	Health Center
HII	Health Insurance Institute
HIRD	Health Insurance Regional Directorate
ICD	International Classification of Diseases
INSTAT	Institute of Statistics
IPH	Institute of Public Health
LSMS	Living Standards Measurements Survey
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOES	Ministry of Education and Science
MOF	Ministry of Finance
NCCE	National Center for Continuing Education
NCQSA	National Center for Quality, Safety, and Accreditation
PBMP	Performance-Based Monitoring Plan
PHC	Primary Health Care
RHA	Regional Hospital Authority
SII	Social Insurance Institute
SD	Service Delivery
USAID	United States Agency for International Development
WHO	World Health Organization

I. EXECUTIVE SUMMARY

The Government of Albania (GOA) has recently enacted a series of laws - the Basic Health Care Law, Public Health Law, and the Law on Health Insurance - that are intended to help reform the health care system and provide greater access to affordable, quality health care for all Albanians. Implementation of this legislative framework, which defines the roles and functional responsibilities of the Ministry of Health (MoH), Health Insurance Institute (HII) and other health sector institutions requires sound institutional governance.

USAID/Albania's five-year Enabling Equitable Health Reforms (EEHR) Project is supporting the GOA to implement this legislative framework to advance the health reform process. EEHR undertook this Governance Review, together with an in-depth institutional review of the Health Insurance Institute (HII) and an assessment of the capacity of the health sector Monitoring and Evaluation (M&E) function, in order to identify ways to best support the GOA. This Governance Review assesses the state of the health reform process, areas of success and barriers to effective implementation and recommends concrete measures to build institutional managerial capacity and improve governance. To frame the scope of the review, the review team, together with the EEHR team, agreed to focus on four primary areas of responsibilities that are most critically affected by the changes in the health system, namely:

- Health system governance and leadership
- Standards and processes to ensure and improve quality
- Hospital organization, operations and management
- Financing and health insurance

This report presents a mapping of the health system, with key findings and proposed responses organized along these four areas.

The review approach considered the above four issues in terms of capability, accountability, and responsiveness (CAR). The review method included a key document review, followed by a two-person team in-country conducting interviews with key informants over two weeks. The team interviewed staff in various directorates and departments within the MoH and the HII, as well as officials of the National Center for Quality, Safety, and Accreditation (NCQSA), National Center for Continuing Education (NCCE), Institute of Public Health (IPH), and others. During the two weeks in-country, the review team visited Durres region and Kruje district, meeting with public health officials, HII staff, as well as staff in health facilities. The interviews aimed to fill information gaps identified during the document review, as well as to validate actual practices related to implementation of reforms.

Albania has made significant progress in its transition to single payer health financing with universal coverage for all, using provider contracting mechanisms to ensure high quality, cost effective services. It is an ambitious undertaking to ensure high quality services for both rich and poor and strong oversight is critical to ensure appropriate implementation that supports achievement of the reform goals.

To support this transition, the MOH must evolve from its historical role as provider of health care to steward, policymaker, coordinator and advocate. While no longer controlling the resources, the MOH continues to be responsible for providing oversight and ensuring provision of quality health services. The MOH has struggled with fulfilling this new role, and it is clear that capacity building is required throughout the institution. An ongoing culture of centralized, top-down authority further contributes to the lack of technical capacity. There is insufficient coordination and communication within the MOH, leaving staff with a lack of clear vision and direction, and limiting their ability to influence and mobilize others.

While at central level the MOH is still responsible for developing policies that they do not have budget or authority to implement, the roles and responsibilities of the regional and district health authorities are even less clear. They no longer develop budgets, supervise staff, or oversee hospitals. Analysis of the appropriate functions at central and subnational levels in overall oversight and coordination is needed to define an appropriate role for regional and district health authorities.

At the same time, several auxiliary institutions (HII, NCQSA, NCCE, IPH) have emerged with strong leaders, overlapping mandates, and/or external support that challenge the MOH authority. For the most part, these organizations have been competent in carrying out their specific functions. At the regional and district level, HII is the most visible health authority, conducting regular HC supervision, reimbursing pharmacies, and providing incentive payments to HCs. What is lacking is oversight to ensure that the package of individual functions and coordination of efforts, as currently designed, are leading to better health system performance.

The legislation (Health Insurance Law, Basic Health Care Law, Law on Public Health) repeatedly recognizes the MOH as the institution responsible for policy, oversight and coordination of the sector. However, the formal institutional relationships and managerial systems that allow the MOH to fulfill its role are lacking. These auxiliary institutions (HII, NCQSA, NCCE, IPH) do not have clear, mandated responsibility to report to the MOH, in a way that recognizes the MOH's authority as the leader and overseer for the sector. Without such mandates, which may need to come in the form of national legislation, the MOH has little leverage to ensure that all institutions work collaboratively toward a common vision and fulfill their responsibilities. One possibility for developing a mechanism to strengthen managerial systems is the formation of a permanent, mandated, sector-wide health reform steering committee that would strengthen the oversight role of the MOH. It could provide a forum for health sector institutions to clarify roles and responsibilities, review strategies, coordinate activities and hold one another accountable for fulfilling their responsibilities. Another possibility for strengthening the oversight relationship could be if the MOH were given oversight responsibilities such as review of annual progress reports or resource allocations to auxiliary institutions in the sector.

Throughout the sector, there is not clear alignment of institutional relationships and incentives to hold organizations accountable for fulfilling their mandated responsibilities. One specific gap that arises from the lack of coordination is a strategy for integrating the institutions' individual functions (financing, facility accreditation, continuing medical education, and oversight and supervision) to drive improved quality. This lack of coordination limits the potential impact of each of the functions and wastes limited resources. There is also not an easy answer as to how to help the MOH better understand the importance of its oversight role and hold it accountable for fulfilling its functions. To this end, the role of civil society and non-governmental stakeholders, including patients groups, provider groups, academic and research organizations, and the media, must be explored further. Also, including representatives from these groups in the Health Reform Steering Committee could strengthen their advocacy role in influencing policymaking. The area of service quality may be a very good starting point for EEHR focus, because health institutions have already begun to address quality, there is relatively less overlap among the various institutions, and it is an area where it may be easier to generate civil society interest and promote their participation in advocating for health reform.

Specific recommendations are provided below to improve governance to ensure key functions are carried out. They were made with consideration of GOA, USAID and EEHR interests, although a few may be beyond the scope of the EEHR project. The insufficient authority of the MOH is a root cause of many problems and is not easily addressed. A combination of capacity building, changes in institutional relationships that support the MOH's position of authority, and stronger mechanisms outside the MOH to hold it responsible is needed. Supporting legislation related to these matters may be effective, but may not be feasible within the scope of EEHR. Recommendations to address governance gaps are organized within each of the four functions below.

Health System Governance and Leadership

- Support development of a health reform steering committee as a permanent body: to increase accountability of implementing agencies; to provide a forum for health sector institutions, including non-governmental stakeholders, to improve communication, clarify roles and responsibilities, coordinate activities and advocate for policy reform.
- Support the M&E Directorate to serve as secretariat to the health reform steering committee to strengthen capacity for coordination, planning, advocacy and use of data to inform policy making and planning.
- Support the MOH to improve internal and external oversight, coordination, advocacy and communication.
- Assess, identify and support civil society organizations (CSOs) that could play a positive role in holding the MOH and other institutions accountable.
- Analyze the potential role for EEHR in supporting legislation to enforce the health reform steering committee or to enforce MOH authority and oversight with specific reporting relationships with auxiliary institutions. EEHR might identify potential champions who could take on this advocacy role, and provide support.

Standards and Processes to Ensure and Improve Quality

- Support coordination between MOH, NCQSA, NCCE and HII toward the goal of improving quality of care, including development and implementation of an integrated strategy including financing, facility accreditation, continuing medical education, and oversight and supervision to drive improved quality. This common effort could also serve as the basis to build MOH leadership, strengthen institutional relationships, and improve accountability. EEHR might pilot this process at the regional level to demonstrate impact and develop best practices, while also serving to define appropriate roles for regional health authorities.
- Continue to strengthen the capacity of the M&E Directorate.
- Strengthen capacity of M&E Directorate and IPH to conduct advocacy, for both policy makers and the public.
- Facilitate better bilateral coordination between MOH and NCQSA by developing and implementing a national quality strategy that clearly defines roles, responsibilities, reporting relationships and promotes accountability.
- Facilitate bilateral sharing of information and coordination between NCCE and MOH. This might include encouraging the NCCE and the Directorate of Human Resources and Continuing Medical Education (CME) to meet regularly and develop and implement annual training plans.
- Support MOH to prioritize training needs and advocate for funding from the Ministry of Finance (MOF) and international donors to support training.

Hospital Organization, Operations and Management

- Support MOH Hospital Directorate to define and fulfill its role, clarifying responsibilities of MOH, HII, Regional Health Directorates, and Health Institute Regional Directorates (HIRD). EEHR might consider seconding a staff person that mentors the Hospital Directorate to: develop a proposal for discussion of specific roles, authority, functions and inter-relationships of various institutions; strengthen skills in leading multi-institution meetings and facilitating agreement and follow-up; develop strategy to advocate for additional resources to support activities of all institutions. EEHR may also support a consultant to facilitate such discussions.
- Support stakeholders to develop and implement a coherent policy/plan for the hospital sector. Because one of the key constraints is political willingness to act on hospital rationalization plans, EEHR focus may be in the areas of political analysis and strategic communications to manage

negative public reaction.

- As recommended by the HII Review, support HII to implement case-based payment for hospitals.
- Support hospitals in focus regions to progress toward autonomous institutions, including improving management skills and structures in hospitals, and supporting self-assessment and quality improvement in preparation for NCQSA accreditation.
- Assist MOH to develop guidance for Regional oversight of hospitals in collaboration with HII.

Financing and Health Insurance

- Support focus regions to improve registration systems with a combination of consumer education, provider incentives through HC contracts, and incentives for new registrants. EEHR might also facilitate collaboration with CSOs and media organizations to support this effort.
- Support HII at central level in discussions with other government agencies to obtain data they need on contributors.
- Support focus regions to pilot new HC contracts with capitated payments based on registered insured, and other payments for non-registered patients.
- Improve the capacity of MOH as leader and coordinator for quality-related issues in health insurance. Possible activities might include articulating a national strategy to integrate the functions of financing, facility accreditation, CME, and oversight and coordination, with clear roles for all institutions and subnational entities.
- Support MOH and HII to set and disseminate clear priorities for health insurance, including developing strategies for universal coverage and financial risk protection, in addition to cost containment and efficiency. Activities may include facilitating senior level agreements between MOH and HII, and supporting dissemination of such agreements throughout the respective organizations and the health system.
- Support joint planning between MOH and HII to implement insurance reforms, including an agreed approach and detailed work plan toward case-based payment and improving provider quality.

The recommendations offered here aim to address gaps identified in the areas of capability, accountability, and responsiveness that hinder effective implementation and full potential of the legislated health reforms. While these were developed in light of EEHR's project interests, final selection of activities to be pursued should ensure a complementary set of strategies related to improving governance, support to HII, as well as support of the health sector M&E system.

2. BACKGROUND

The Government of Albania (GOA) has recently enacted a series of laws - the Basic Health Care Law, Public Health Law, and the Law on Health Insurance - that are intended to help reform the health care system and provide greater access to affordable, quality health care for all Albanians. Implementation of this legislative framework, which defines the roles and functional responsibilities of the Ministry of Health (MoH), Health Insurance Institute (HII), other national health institutions and local health departments, requires sound institutional governance. Health sector leaders must understand the role of each institution within the overall system and its relations with the others, effectively manage resources and operations, access and use data for priority-setting and management decision-making and adopt a set of regulations, procedures, systems and tools that effectively operationalize the intent of the legislation.

The USAID-funded EEHR Project is a five-year effort designed to increase access to essential health services for the poor in Albania by helping to remove existing barriers and constraints to reforms at the national level and field testing approaches and tools that support implementation of a feasible set of reforms at the regional level. The project is designed to support and empower Albanian institutions to lead the design, implementation, and monitoring and evaluation of selected feasible and effective health reforms. These activities are aligned with and will support implementation of the MOH's Health Sector Strategy 2007-2013.

EEHR collaborates closely with Albania stakeholders to employ three strategies to improve and expand access to essential health services by the poor in Albania:

- Improve health reform policy and planning to institutionalize effective policymaking processes and to encourage increased reliance on evidence to inform policymaking;
- Improve capacities to implement a set of feasible and effective health reforms in selected regions; and
- Improve advocacy and communication around health reform within the GOA, health sector, donors, and among the general population.

EEHR will support a policy dialogue process and regional implementation of reforms. The project will engage in outreach and advocacy activities so a wide range of stakeholders are encouraged to provide input to policymaking and build consensus on selected health reforms. Monitoring and evaluation data and lessons learned during regional implementation will be continuously fed back into a national-level policy dialogue in order to refine health reform interventions and implement them nation-wide.

EEHR is supporting the GOA to implement this legislative framework to advance the health reform process. EEHR undertook this Governance Review, together with an in-depth institutional review of the Health Insurance Institute (HII) and an assessment of the capacity of the health sector M&E function, in order to identify ways to best support the GOA. This Governance Review assesses the state of the health reform process, areas of success and barriers to effective implementation and recommends concrete measures to build institutional managerial capacity and improve governance. It addresses current issues such as the relationships between the MOH, HII and other health sector institutions, including professional associations (also referred to as professional orders); maps roles and responsibilities within the health system and recommends technical support that EEHR can provide to enhance good governance and increase institutional transparency and accountability.

3. OBJECTIVE

The review maps the governance structures, systems and operations of key health sector institutions, identifies critical issues regarding the effectiveness of their implementation of the reform mandates and recommends measures to improve the organization, operational efficiency, capacity and delivery of the system and its key institutions. (See Scope of Work, Annex 1)

4. APPROACH AND METHODS

4.1 APPROACH

The review team drew upon the CAR Framework to guide discussions and analysis of governance. This framework was not specifically developed for health governance but has been applied in a range of settings including analyzing government effectiveness broadly to analyzing the politics of water supply. The CAR Framework identifies three characteristics that influence whether government authorities effectively carry out their responsibilities:

- Capability
- Accountability
- Responsiveness

Using this framework, the review examines whether the institutions responsible for implementing the new legislation are the appropriate institutions and have the capacity to carry out their assigned functions, whether the mechanisms for holding them responsible are being implemented effectively, and whether there are processes and incentives to identify and respond to concerns of relevant stakeholders.

To further frame the scope of the review, the review team, together with the EEHR team, agreed to focus on four primary areas of responsibilities that are most critically affected by the changes in the health system, namely:

- Health system governance and leadership
- Standards and processes to ensure and improve quality
- Hospital organization, operations and management
- Financing and health insurance

The health system mapping and presentation of key findings and proposed responses are organized along these four areas.

4.2 DATA COLLECTION METHODS

The review team conducted a desk review of key documents including:

- Relevant health sector Laws, Decisions, Orders
- Health sector reviews conducted by the World Bank, WHO, USAID, and others
- Health sector strategy documents, including overall sector strategy as well as HIS strategy, performance monitoring framework, etc.
- Documentation from previous USAID projects
- Contracts between HII and health facilities
- Available information on organizational structures of key institutions (MOH, HII, IPH, etc.)

See Annex 3 for a complete list of documents reviewed.

The team then worked with the EEHR team to identify key informants who could fill information gaps. Interviews were conducted to validate understanding of existing laws and mandates; confirm current practices and the extent to which they differ from mandates, including institutional roles and functions not being carried out; and gather input on recommendations for improvement. Table I includes the initial list of key offices and institutions contacted, along with proposed areas of discussion. In order to address additional questions that arose in the course of the review, to gain an understanding of the health system at all levels, and to identify potential opportunities for

interventions that could be piloted at the regional/district level, the review team expanded on this list, and visited one region and one district.. The team met with officials at the regional health directorate and regional HII in Durres region, the district health directorate and HII agency in Kruje district, as well as the district hospital and a health center in Kruje. See Annex 2 for a complete list of contacts.

TABLE I: PRELIMINARY LIST OF KEY OFFICES AND INSTITUTIONS TO BE CONTACTED

Institution/Department	Key Questions/Areas for Discussion
MOH, Public Health Directory	<ul style="list-style-type: none"> • Benefits package • Role in determining hospital services package
MOH, Financial Planning Directory	<ul style="list-style-type: none"> • Budgeting process for PHC and hospitals • Staff salaries • Other subsidies to HII
MOH, Directory of Health Information	<ul style="list-style-type: none"> • How is data from HII integrated/received/analyzed/used • What data is received directly from facilities
MOH, Directory of Monitoring and Evaluation	<ul style="list-style-type: none"> • Implementation of M&E framework • Data reliability and gaps • Coordination among data providers
HII, PHC Director	<ul style="list-style-type: none"> • Monitoring quality • Payments to PHC providers • Problems encountered with payments • Future plans regarding payments
HII, Information & Statistical Analysis Directorate	<ul style="list-style-type: none"> • Data from hospitals and HCs • Comparison of financial and SD data • Use of demographic and other data for planning • Costing of services
HII, Services Directorate	<ul style="list-style-type: none"> • Service contracting • Package of services for hospitals • Setting fees for providers
HII, Regional Offices	<ul style="list-style-type: none"> • Reimbursement/payment procedures • Role in data collection from facilities • Reviews of HC and hospital claims
NCQSA	<ul style="list-style-type: none"> • Are there updated standards for hospitals? Are there standard treatment protocols by diagnosis? • What are procedures for licensing, accreditation of facilities? • List of licensed and accredited facilities • How does NCQSA work with MOH, HII? Private health providers?
NCCE	<ul style="list-style-type: none"> • What are the specific CME requirements for various professions? • Who will oversee enforcement of CME requirements? • How will professional associations be involved? • How does NCCE work with NCQSA and MOH?
World Bank	<ul style="list-style-type: none"> • Status of WB project implementation • Progress of the Core Group in M&E • Key priorities for remainder of project
WHO	<ul style="list-style-type: none"> • Participation in Core Group • Progress of HIS strengthening • Work in pharmaceutical policy and MOH stewardship

TABLE I: PRELIMINARY LIST OF KEY OFFICES AND INSTITUTIONS TO BE CONTACTED

Institution/Department	Key Questions/Areas for Discussion
USAID	<ul style="list-style-type: none">• Progress of reforms overall• Historical relationships between government institutions• Coordination of donors with Albanian institutions• Role of donors in M&E

5. OVERVIEW OF RELEVANT LAWS AND ORDERS

In order to improve the efficiency of its health care system and increase access to quality affordable health care for all Albanians, the GOA has embarked upon a health reform process. This process began in 1993 with reforms that authorized private provision of pharmaceuticals and dental care. Successive reforms in the funding and provision of health care services created the Health Insurance Institute and extended its role to one of purchaser of public sector services at all levels of the health care system and shifted the role of the MoH to one of policymaking and establishing and monitoring standards of care. Relevant laws and orders effecting these changes are described below. In general, more significant and broader policy changes are enacted through Laws, which are issued by the Council of Ministers, the national law-making body. Decisions, on the other hand, are issued by sector Ministers – the ones below by the Minister of Health, as they are related to health. While these laws and orders provide the legislative framework for changes in the delivery and funding of health care services to improve quality and efficiency of the system, their implementation is dependent upon development and implementation of appropriate policies, standards, protocols and guidelines, as well as institutional capacity.

- **Law 7870 dated 13.10.1994 “On Health Insurance in the Republic of Albania” (amended) and the Decision of the Council of Ministers, no. 613 dated 20.12.1994 “On the Approval of the Statute of the Health Insurance Institute” (amended)** This legislation established the Health Insurance Institute (HII) and mandated it to reimburse for essential drugs and salaries of General Practitioners. It established the HII as a public body governed by an Administrative Council headed by the Minister of Health and managed by a General Director.
- **Law No. 9106 dated 17.7.2003 “On the Hospital Service in the Republic of Albania”** details the oversight of hospitals through a State Hospital Planning Committee and Regional Hospital Authorities, who oversee hospital management and services.
- **Decision No. 857 dated 20.12.2006** - This decision expanded the health insurance scheme to cover a basic package of health care services provided at Primary Health Care Centers.
- **Decision No. 1661 dated 29.12.2008** – This decision further expanded the health insurance scheme by mandating HII to cover services provided by secondary and tertiary hospitals.
- **Basic Health Law No. 10 107 “Health Care in the Republic of Albania, dated 30.3.2009”** – This law provides a legal framework for the national health care system.
- **“Law on Public Health dated May 2009”** This legislation defines public health services and provides a legal framework for their provision.
- **Decision No. 140, dated 17.2.2010 on “Financing Hospital Health Services from the Mandatory Scheme of Health Insurance”** authorizes HII to contract with hospitals, as well as approves the budget and staffing for all hospitals for 2010.
- **Law on Compulsory Health Care Insurance** adopted at the end of 2010 and set to go into effect in 18 months – This law will establish HII as the single payer for public sector health care in the country and will also lay the foundation for HII to contract with private sector health care providers. In addition, the law states that all economically active people in Albania must contribute to the Health Insurance Fund and makes provision for selected categories of non-active people, such as the unemployed and pensioners, to be covered by the state.

6. OVERVIEW OF HEALTH SECTOR INSTITUTIONS

Health care services in Albania are managed and provided primarily through a nationwide system of public health care providers. While the private sector plays an important role in the provision of dental care and pharmaceuticals, its role in the delivery of primary, secondary and tertiary health care is limited. Health care provision by non-governmental organizations is also limited. However, the health sector is undergoing changes and the role of the private and NGO sectors in both delivery and financing of health care will evolve rapidly. These sectors will also play increasingly important roles in governance of the health sector as Albanians come to demand access to better health care. This governance review focused primarily on public sector institutions but the team recommends that EEHR conduct an audit of private sector and non-governmental organizations to identify those which represent important stakeholders and could potentially play an important role in the health reform process. Brief descriptions of the primary public sector health institutions are presented below.

- **Health Reform Task Force** – an ad hoc task force created by the Prime Minister that meets occasionally and informs him of key issues related to the health reform process.
- **Institute of Public Health**– a research and advisory body that monitors epidemiological data collected by the MOH as well as recent findings of the international scientific community; conducts research and writes papers; identifies key issues and informs health sector leaders.
- **Ministry of Health** – historically responsible for all aspects of health care delivery, the MOH has recently seen its role shift to one of steward, policy maker, coordinator and advocate responsible for overall health sector strategy and setting, implementing and monitoring policies to ensure quality of care and performance of the system.
- **Health Insurance Institute** – responsible for financing of health care delivery. HII contracts directly with Primary Health Care Centers and Hospitals and is responsible for costs of staff, drugs and supplies. The MOH continues to be responsible for capital investments.
- **National Center for Safety and Quality and Accreditation (NCQSA)** – supports the MOH to promote and improve the quality of health care services and is responsible for implementation of the national hospital accreditation program.
- **National Center for Continuing Medical Education (NCCE)** – ensures quality of training programs provided to health care personnel, tracks continuing education credits earned by health personnel and implements their relicensing program.
- **Order of Physicians** – ensures that physicians comply with ethical and medical standards, maintains a database of licensed physicians and informs its members of issues pertaining to their profession.
- **Order of Nurses** – ensures that nurses comply with ethical and medical standards, maintains a database of licensed nurses and informs its members of issues pertaining to their profession.

7. FINDINGS

7.1 HEALTH SYSTEM GOVERNANCE AND LEADERSHIP

The Ministry of Health is charged with providing overall vision, leadership and governance for health care in Albania. This is established by the Basic Health Care Law (10 107) Article 4 stating that “the Minister of Health directs the policy, organization and supervision of the health care system.” While the MOH is an important actor in the health system, it is not the only actor and its success is dependent upon its ability to provide leadership and work effectively with others in the system. Table 2 disaggregates governance and leadership into essential sub-functions and presents the role each health sector institution *should* play as defined by the legislative framework. This section discusses each of these sub-functions and the role each institution does play.

7.1.1 DEVELOPING NATIONAL STRATEGIC POLICY FRAMEWORK

The Basic Health care law states that the Ministry of Health “prepares health care system strategy, which includes policies and appropriate health programs and national treatment protocols”. The Ministry of Health has developed the National Health Strategy 2007 – 2013. This strategy is based upon the 2004 Long Term Strategy for Development of the Albanian Health System and presents the following mission statement for the health system: “To improve the health of the population by providing responsive services and financial protection against the catastrophic costs of disease.” In addition, it established the following four priority areas:

- Increasing the capacity to manage services and facilities in an efficient way
- Increasing access to effective health services
- Improving health system financing
- Improving health system governance

The document also presents policies, suggested tasks for policy implementation and budget implications for achieving strategic priorities. This strategy was developed for the period of 2007-2013 and is used by health institutions as the basis for planning. For example, the recently developed Vision, Framework, Health System Performance Outcome Indicators for Monitoring Health Sector Policies, Programs and Institutions in Albania is designed to address the four strategic priorities established in this strategy.

TABLE 2: LEGAL FRAMEWORK FOR THE HEALTH SYSTEM BY FUNCTION – HEALTH SYSTEM GOVERNANCE AND LEADERSHIP (INFORMATION REFLECTS MANDATED OR DOCUMENTED RESPONSIBILITIES, WHICH MAY OR MAY NOT REFLECT ACTUAL SITUATION)

Sub-functions	MOH	HII	IPH	NCQA	NCCE	Hospitals/HCs	Others
Developing National Strategic Policy Framework	<ul style="list-style-type: none"> Prepares health care system strategy, including policies, programs and national treatment protocols Drafted National Health System Strategy 2007-2013 						
Priority setting and policy making	<ul style="list-style-type: none"> Minister of Health directs policy, organization and supervision of health care 	<ul style="list-style-type: none"> Receives policies and strategies developed for the health system from the MOH 	<ul style="list-style-type: none"> Advises MOH on issues of concern 				
Provide regulations, budgets, incentives and oversight to ensure implementation	<ul style="list-style-type: none"> Prepares an integrated plan based on population needs that maximizes resource use for public health care institutions every three years Minister of Health approves regulations for organization and functioning of primary health care services 	<ul style="list-style-type: none"> Finances hospitals and Health Centers 		<ul style="list-style-type: none"> Implements system of accreditation for hospitals and national strategy of quality and safety in the health care system 	<ul style="list-style-type: none"> Provides oversight to CE process and accredits and recertifies medical professionals 		<ul style="list-style-type: none"> Professional associations ensure members respect rules for health care professionals
Coalition building coordination among health institutions; with donors, other stakeholders	<ul style="list-style-type: none"> Responsible for inter-sectorial coordination regarding issues that relate to public health 						

The MOH is both by law and position the organization charged with developing and implementing the national health strategy, however, it has yet to establish its authority and provide leadership to the sector. Positions of authority within the MOH have generally been given to minority political parties within the governing coalition, giving it little leverage to influence the national priorities of the GOA. In addition, MOH leadership has suffered from frequent turnover with four ministers serving in the span of five years.

The current Prime Minister is a doctor by training and has taken a personal interest in the progress of health reform. He has established a Health Reform Task Force comprised of high level officials and senior medical doctors that meets on an ad hoc basis. There is no legislation that mandates its existence, or establishes its authority and purpose – it serves the Prime Minister as an ad hoc advisory body. Nevertheless, this task force presents an opportunity to get important health issues on the national agenda. It also sets a precedent for the establishment of a forum at which high level decision makers gather to discuss health reform issues, strategize and set priorities, coordinate activities and review implementation.

7.1.2 PRIORITY SETTING AND POLICYMAKING

The highly-centralized decision making and poor communication within the MOH has limited priority setting and policymaking both within the MOH, itself, and in the larger health sector. Currently MOH decision making occurs at the highest level with the Minister and his political appointees meeting regularly and making decisions. Many of the new laws require that even fairly routine decisions be made by committees chaired by the Minister of Health. The MOH is organized with both politically-appointed positions and positions for technically-qualified career MOH personnel. While politically-appointed positions in many countries may include the Minister, Deputy Ministers, Chief of Cabinet and Advisors, in Albania, they also include heads of Directorates, heads of Sectors and even Hospital Directors who are often replaced when there is a change of Minister. Frequent turnover at so many levels of the ministry weakens its institutional memory and capacity to provide leadership.

Centralized decision-making within the MOH results in an institutional culture in which there is little communication between politically-appointed decision makers who make policies and set priorities at the central level and technical staff who are tasked with implementation at the central, regional and district levels. This is exacerbated by the inadequate lines of communication and reporting systems through which decisions are communicated down to the technical staff of the Directorates and Sectors. There are also no reporting systems to carry information up and ensure that top-level policymaking is informed by relevant data and technical expertise. These communication gaps are even greater between MOH staff and staff of other health sector institutions such as the NCQSA, NCCE and HII.

A health reform steering committee that is a permanent body, could provide an important forum for implementing agencies to meet regularly, clarify roles and responsibilities, coordinate activities and hold one another accountable for strategy implementation. It could also improve communication and strengthen the leadership of the MOH and provide a venue for non-governmental stakeholders and advocates to influence health care policy.

7.1.3 PROVIDE REGULATIONS, BUDGETS, INCENTIVES AND OVERSIGHT TO ENSURE IMPLEMENTATION

Communication gaps between politically-appointed decision makers and technical staff within the MOH at all levels, and between staff of the MOH and staff of other health sector institutions limit development and dissemination of regulations, needs-based budgeting, management and oversight. While the MOH is authorized by law to develop policies and regulations, its highly-centralized decision making has limited the degree to which policies are communicated and understood by technical staff and, in turn, incorporated into regulations, plans and procedures. Inadequate reporting systems and insufficient use of data to improve planning, monitor implementation and strengthen accountability further hinder MOH oversight of the health system. Recent improvements in the structure and functioning of the MOH M&E Directorate as well as initial annual reports generated by

the M&E Directorate are important first steps in developing effective management systems. The EEHR Project should continue its work to build the capacity of the M&E Directorate and strengthen the M&E function within the health system.

In several instances, the MOH has failed to exert its authority and fulfill its legislated mandate to establish standards, indicators, regulations and protocols. For example, the MOH has yet to issue nationally-accepted standards and indicators for health care delivery. Consequently, other institutions such as the NCQSA and the HII have stepped in to fill the void thereby exacerbating institutional rivalries and confusion over roles and responsibilities. The NCQSA has developed indicators for hospital and HC accreditation, while HII uses another set of indicators in its contract with HCs – both organizations acting without coordination with the MOH or each other. The HII has tried, through its contracts, to develop incentives to improve quality. In effect, however, these “quality” indicators are better suited to improve cost-effectiveness than quality of care. The HII would greatly benefit from technical guidance from the MOH and the NCQSA to develop indicators and incentives that effectively promote improvements in quality of care. Improved coordination and collaboration between the MOH, the NCQSA and the HII can also improve the use of the HII contracting mechanism as a tool to provide incentives for quality improvement.

7.1.4 COALITION BUILDING, COORDINATION AMONG HEALTH INSTITUTIONS, WITH DONORS, AND OTHER STAKEHOLDERS

High turnover of technical staff and recent changes in organizational structure, including the relatively recent formation of the NCCE and the NCQSA, has led to confusion about roles, responsibilities and lines of communication. Rivalries between the various health sector institutions stymie horizontal communication. Currently, horizontal communication between MOH technical units and other health sector institutions occurs primarily through personal relationships. This has created an environment in which people may be less likely to take initiative, do not work together and lack a sense of accountability. Clearly defined roles, responsibilities and communication channels as well as regular meetings and reporting requirements are needed to improve implementation, accountability and responsiveness. These improvements in communication among health sector institutions will be increasingly important as the MOH needs to advocate more effectively to mobilize institutions, such as the NCQSA and HII and international donors, to support and pursue its objectives. They will also be increasingly important as the health sector needs to be more responsive to its most important stakeholders, namely patients and the public. Reporting needs to be developed that increases transparency and improves accountability to the public. This could include efforts such as implementing public relations campaigns, posting MOH annual reports on the MOH website and/or issuing newsletters to inform the public of important issues or new initiatives.

7.1.5 PROPOSED SUPPORT FROM EEHR

EEHR can support the GOA to strengthen governance and leadership in the health system by building capacities of health sector institutions in three main areas as shown in Table 3. First, EEHR can facilitate the establishment of a health reform steering committee which would be a permanent body comprised of key technical staff of health sector implementing institutions. The steering committee would provide leadership in the health reform process including priority setting, establishing mechanisms for accountability, and clarifying institutional relationships and responsibilities. EEHR can facilitate a process to develop the Terms of Reference, including membership guidance and reporting. It can support advocacy for legislative actions to ensure a clearly-defined ongoing role for the health reform steering committee. The MOH M&E Department could serve as Secretariat to the steering committee since it already has established strong collaborative working relationships with all the key health sector institutions and is involved in routine data collection, analysis and reporting. EEHR could provide support to this secretariat and the steering committee in the development and implementation of annual workplans and/or advocacy and research, as appropriate.

A second area in which EEHR can provide support is to build the capacity of the MOH to lead a process for clarifying roles and responsibilities of its own staff internally as well as vis a vis staff of

other health sector institutions and developing clear lines of communication, including reporting requirements and procedures, that ensure staff in all organizations have clearly defined job responsibilities, have the information and resources they need to perform their jobs and are held accountable for performance. EEHR can provide support for regular meetings within the MOH, as well as among MOH and other institutions, to ensure information sharing and an agreed upon common mission. Finally, the EEHR project can provide training to build the capacity of staff of the MOH and other health sector institutions to develop communication strategies that identify key stakeholders and define their information needs, articulate key policy objectives, and develop advocacy materials, briefs and reporting materials.

TABLE 3: MAJOR GAPS IN HEALTH SYSTEM GOVERNANCE AND LEADERSHIP (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
Developing National Strategic Policy Framework	<ul style="list-style-type: none"> MOH has drafted National Health Strategy 2007-2013 but has not provided strong leadership for its dissemination and implementation 	<ul style="list-style-type: none"> No clear mechanism to hold the MOH accountable for providing leadership 	<ul style="list-style-type: none"> The National Strategy has identified appropriate priorities that respond to the needs and has become a reference point for planning 	<ul style="list-style-type: none"> Support development of a health reform steering committee as a permanent body, to increase oversight
Priority setting and policy making	<ul style="list-style-type: none"> Minister sets priorities and makes policies. Highly-centralized decision making limits implementation of policies 	<ul style="list-style-type: none"> MOH not held accountable for communicating priorities and implementing policies 	<ul style="list-style-type: none"> Priorities are responsive to national needs but are not being implemented. 	<ul style="list-style-type: none"> Support the health reform steering committee to strengthen MOH leadership and increase accountability
Provide regulations, budgets, incentives and oversight to ensure implementation	<ul style="list-style-type: none"> MOH capacity to provide leadership is limited HII developing processes that will be based on needs rather than inputs, but, will take time NCQSA and MOH do not collaborate to implement standards. HII steps in to fill the void. Institutional rivalries develop. 	<ul style="list-style-type: none"> MOH is not held accountable for lack of leadership in developing and implementing regulations. 	<ul style="list-style-type: none"> Lack of clarity on roles and responsibilities and poor coordination limit responsiveness. MOH needs to take the lead and advocate other organizations, HII, NCQSA, NCCE, to pursue its objectives. 	<ul style="list-style-type: none"> Support the health reform steering committee as a forum for institutions to improve communication, clarify roles and responsibilities, coordinate activities and increase accountability
Coalition building coordination among health institutions; with donors, other stakeholders	<ul style="list-style-type: none"> Unclear roles and responsibilities and poor communication hinder coordination 	<ul style="list-style-type: none"> No mechanism for coalition building and coordination 		<ul style="list-style-type: none"> Support the health reform steering committee as a forum for coordination and coalition building Support secretariat to strengthen capacity for coordination, planning and advocacy Support the MOH to improve internal and external communication and coordination

7.2 STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY

As part of an overall effort to ensure quality within the health sector, new institutions were created to strengthen and support the MOH. The National Centre for Quality Safety and Accreditation is mandated to improve quality at health facilities and implement a process for accrediting hospitals. The National Center for Continuing Education assures the quality of continuing medical education in order to strengthen the capacity of health care providers to provide quality care. In addition, the HII has developed quality indicators and includes them in their contracts with health centers. While the roles of the MOH and these supporting institutions are defined in various laws as shown in Table 4, in practice there is confusion about responsibilities, duplication of effort and poor coordination of activities which all impact the ability of the system to ensure improvements in quality of care.

7.2.1 DEVELOP, DISSEMINATE AND IMPLEMENT STANDARDS, PROTOCOLS, CLINICAL GUIDELINES TO IMPROVE QUALITY

The MOH has not fulfilled its role to develop, disseminate and implement standards for health. In 2008 the National Centre for Quality Safety and Accreditation (NCQSA) was created to provide technical support for the development and implementation of quality improvement efforts. The NCQSA worked to develop a national quality strategy as well as a system for accreditation of hospitals in order to ensure a standard level of care in hospitals throughout the country. However, the NCQSA has a staff of less than twenty and has insufficient capacity to implement a national accreditation process in a timely manner. In addition, the NCQSA is perceived as having developed its own indicators as opposed to contributing to the development of a single set of nationally-accepted indicators. This perception is further exacerbated by a lack of leadership on the part of the MOH to clearly define the role of the NCQSA vis a vis its own legislated mandate to provide national indicators. The HII, meanwhile, has attempted to fill the void in guidance by developing quality indicators for primary health care that it includes in its PHC contracts. While these so-called quality indicators are intended to serve as incentives to improve quality of care, they are in fact, better designed to improve cost-effectiveness. The MOH must work with the NCQSA and HII to more clearly define roles and responsibilities. For example, the NCQSA could serve as a resource center and provide expertise to develop technically sound standards while the MOH ensures that the standards are appropriate for use in MOH facilities. Finally, both institutions must provide technical guidance to the HII regarding the indicators to be included in its contracts with providers.

TABLE 4: LEGAL FRAMEWORK FOR THE HEALTH SYSTEM BY FUNCTION – STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY (INFORMATION REFLECTS MANDATED OR DOCUMENTED RESPONSIBILITIES, WHICH MAY OR MAY NOT REFLECT ACTUAL SITUATION)

Sub-functions	MOH	HII	IPH	NCQSA	NCCE	Hospitals/HCs	Others
Develop, disseminate and implement standards, protocols, clinical guidelines to improve quality	<ul style="list-style-type: none"> Minister of Health in accordance with orders of professionals establishes professional standards. Minister of Health approves norms and standards of health care Defines diagnoses and treatment protocols 	<ul style="list-style-type: none"> Indicators of quality and performance are included in hospital contracts 		<ul style="list-style-type: none"> Supports MOH in development of standards, indicators and methods of quality improvement Implements accreditation process Develops national quality strategy 	<ul style="list-style-type: none"> Implements professional accreditation and recertification process Identifies and accredits training courses to meet standards 	<ul style="list-style-type: none"> Develop programs and mechanisms for implementation of the national quality strategy Develops internal professional supervision 	<ul style="list-style-type: none"> Orders of physicians and nurses work with MOH to establish professional standards.
Establishment and implementation of Monitoring and Evaluation system (info from M&E Vision and Framework, March 2010)	<ul style="list-style-type: none"> M&E Directorate collates data at National level Determines format and way of reporting data for public and private service providers Public Health Directorate collects data from Health Centers every three months 	<ul style="list-style-type: none"> Collects patient visit data from doctors Provides data to MOH M&E Directorate 	<ul style="list-style-type: none"> Collects data on public health program Shares data with MOH M&E Directorate 	<ul style="list-style-type: none"> Shares data with MOH Directorate 	<ul style="list-style-type: none"> Shares data with MOH Directorate 	<ul style="list-style-type: none"> Medical and nurse personnel are responsible for accuracy of data and medical records HCs collect data on patient visits; report to Public Health Directorate 	
Analyzing and using data for policymaking and planning	<ul style="list-style-type: none"> M&E Directorate develops milestones reports and annual performance reports 	<ul style="list-style-type: none"> Analyzes data to track cost effectiveness of prescriptions 	<ul style="list-style-type: none"> Conducts special studies 		<ul style="list-style-type: none"> Collects information on training needs 		
Accreditation of	<ul style="list-style-type: none"> Develops standards and 			<ul style="list-style-type: none"> Accredits 		<ul style="list-style-type: none"> Hospitals undertake 	<ul style="list-style-type: none"> Council of Ministers

TABLE 4: LEGAL FRAMEWORK FOR THE HEALTH SYSTEM BY FUNCTION – STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY (INFORMATION REFLECTS MANDATED OR DOCUMENTED RESPONSIBILITIES, WHICH MAY OR MAY NOT REFLECT ACTUAL SITUATION)

Sub-functions	MOH	HII	IPH	NCQSA	NCCE	Hospitals/HCs	Others
Hospitals	protocols			hospitals		self-assessment as part of accreditation	defined rules and procedure of accreditation process
Registration, licensing and recertification of health providers	<ul style="list-style-type: none"> Establishes National Board of Recertification and Accreditation (NBRA) chaired by the Minister of Health. NBRA defines process and includes NCCE, HII, NCQSA, Professional Orders, Faculty of Medicine 			<ul style="list-style-type: none"> Ensures that only hospitals which employ recertified staff are accredited 	<ul style="list-style-type: none"> Collaborates with NBRA and Order of Physicians to maintain registry of licensed professionals 	<ul style="list-style-type: none"> Hospital sanctioned if it employs health professionals who are not recertified 	<ul style="list-style-type: none"> Order of Physicians maintains registry of providers Providers earn CME credits in order to be recertified every five years
Continuing Medical Education	<ul style="list-style-type: none"> Established National Center for Continuing Education Council of Ministers decision no 825. Develops policies for CE of human resources in health sector Develops mandatory CME programs 				<ul style="list-style-type: none"> Established Accreditation Working Group implements accreditation system Maintains registry of health providers Accredits training programs except those falling under MOE&S 	<ul style="list-style-type: none"> Required to facilitate CME for medical staff May be sanctioned if they employ staff who do not comply with recertification requirements 	<ul style="list-style-type: none"> Doctors, Nurses Orders: professional associations and academic institutions sit on NAB (National Accreditation Board) Professional Assns evaluate CME activities CME providers conduct internal evaluations Health professionals must attain minimum CME credits to maintain license

The MOH needs to not only lead and coordinate efforts to develop national standards, protocols and guidelines but also ensure their dissemination and implementation throughout the health system. The MOH needs to provide stronger leadership to not only define roles and responsibilities of various institutions and issue nationally-accepted standards but also mobilize resources for their implementation throughout the system. The recent MOH experience in developing and disseminating the Reproductive Health Guidelines illustrates this point. The Guidelines were developed at the central level but have not been disseminated because there were insufficient resources to support dissemination to all facilities and inclusion in training curricula. The MOH needs to strengthen its capacity to plan, advocate and mobilize resources and manage its activities.

7.2.2 ESTABLISHMENT AND IMPLEMENTATION OF THE MONITORING AND EVALUATION SYSTEM

The prior support to the newly-created MOH M&E Directorate to develop a collaborative process for identifying and meeting data needs across institutions has been successful, but further capacity building is required. The M&E Directorate has successfully coordinated a collaborative effort involving the HII, MOH, IPH, NCQSA and NCCE to generate and present its first round of annual reporting on the performance of the health system. However, continued capacity building needs to be done to streamline reporting, improve the quality and timeliness of the data and, importantly, ensure that the data is used to inform decision making. This data will be essential to monitoring outcomes of the health system as well as implementation of health reforms. It also will be an important tool to coordinate activities. EEHR can work with the M&E Directorate to continue strengthening its capacity to collect, analyze and communicate the data.

7.2.3 ANALYZING AND USING DATA TO INFORM POLICY MAKING

Currently, the Institute for Public Health analyzes the epidemiological data it collects to identify health issues and develop a research agenda. It also develops papers to present to top level decision makers. The National Council on Public Health is being formed to serve as an Advisory body to high level policy makers on public health issues. The M&E Directorate will be strengthening its ability and continuing to develop annual performance reports for the health system as well as analyze data to inform health planning and policy making. Both of these organizations will need to clearly understand their roles and responsibilities and coordinate their efforts to ensure that data is incorporated into policy-making and planning. They also will play important roles in informing the Health Reform Steering Committee on key issues that will need to be addressed in health sector planning. In addition reliable data and regular reporting will be very important for planning, monitoring progress and coordinating program implementation. The EEHR project can work with health sector institutions to build their capacity to develop communication strategies that identify key decision-makers, delineate their information needs, strategize ways to present needed information to them and ensure that data informs health sector planning and decision-making.

7.2.4 ACCREDITATION OF HOSPITALS

Although the roles and responsibilities of the NCQSA and the MOH are clear on paper, in practice delineation of responsibilities is unclear and there is limited capacity in both institutions to coordinate and manage the accreditation process. The NCQSA has developed a system for training a staff person in each hospital, identified as the point person for quality. After training, this person works with the hospital to implement a two-year self-assessment program. After addressing needs identified in the self-assessment, the hospital can request the NCQSA to conduct an external accreditation. Not only is this process time consuming but often hospitals cannot find the resources they need to address the issues identified in their self-assessment. Consequently, as currently implemented, the accreditation process will take a very long time and will be difficult to implement consistently throughout the country. As the HII progresses with its contracting of hospitals it will play an increasingly important role in improving the quality of hospital services. Opportunities for using the HII contracting mechanism as a means of providing incentives to hospitals to improve quality through initiatives such as continuous quality improvement programs should be explored and piloted.

7.2.5 REGISTRATION, LICENSING AND RECERTIFICATION OF HEALTH PROVIDERS

In order to improve the knowledge and skill of health providers the Basic Health Law requires health professionals to be re-licensed and re-certified by earning a minimum number (currently 150) of continuing medical education credits every five years. This program is in its first phase and is currently in place for physicians, pharmacists and dentists. It is anticipated that if all goes well, recertification of nurses will be introduced in Phase II, although a specific time frame for this expansion has not been determined.

The NCCE has developed a registry of health workers and maintains a database to track health professionals' CME credits earned and recertification status. The Order of Physicians also maintains a registry of certified physicians in the country. However, there is no clear mechanism to share the information in this database with the MOH Sector of Human Resources Development and CME in order to improve manpower planning and identify critical training needs. Clarification of roles and responsibilities between these organizations, regular reporting and coordination meetings could advance progress towards better identifying and filling MOH staff training needs.

7.2.6 CONTINUING MEDICAL EDUCATION

The NCCE is mandated to accredit continuing medical education courses in an effort to ensure a minimum standard of quality of the CME training courses that physicians complete in order to maintain their certification. MOH health providers come from a variety of educational backgrounds. Consequently, training needs are varied and great. The NCCE supports a website to inform health providers around the country of upcoming courses that it has identified and accredited. The website also informs providers of the number of credit hours they will be eligible for if they successfully complete the course. In addition, many of the courses are offered through internet-based courses and long-distance training. The NCCE maintains a registry of all physicians in the country in order to track the number of CME credits they have earned and monitor their progress towards recertification.

While the NCCE seems to be fulfilling its role in accrediting training and tracking provider credits earned, its capacity is limited in meeting the large and varied demand for training. It has not been able to identify sufficient courses to meet current training needs, such as health management. In addition, health providers working in remote regions of the country are at a distinct disadvantage in terms of accessing training opportunities, especially those that are web-based. Finally, the MOH is supposed to develop and provide certain basic training courses that the NCCE can make available to providers through its system. But, the MOH has not allocated sufficient funding to develop and provide this training. Stronger coordination between the NCCE, the MOH and the Order of Physicians to identify training gaps, develop training courses, explore and develop innovative long-distance training technologies, and advocate for funding to better meet training needs is needed.

Health providers are spread throughout the country and those in rural areas have a disadvantage in learning about and participating in CME programs. In addition, while professionals are supposed to find courses that pertain to their area of specialty, the CME offerings are so limited in Albania that providers often take whatever courses are offered, regardless of the subject matter relevance, just to maintain their certification. The Order of Physicians will be an important group to advocate for changes to address these inequities in the system.

7.2.7 PROPOSED SUPPORT FROM EEHR

There are four primary areas in which EEHR can build the capacity of health sector institutions to strengthen standards and processes to ensure and improve quality (Table 5). First, EEHR can continue to build the capacity and relevance of the M&E Directorate of the MOH to collect, analyze and report reliable data in a timely manner. Timely and reliable data about use of health services can be used by staff to identify weaknesses in services delivery and/or changes in patient needs. Second, EEHR can help to strengthen the use of data for decision making at higher levels of the MOH as well as among other appropriate stakeholders, including the general public. Third, EEHR can support the MOH, NCCE and Order of Physicians to coordinate efforts and develop plans for meeting training

needs over the long term and a process for developing training programs to meet identified needs, including identifying and accrediting innovative technologies for training (such as distance learning). Finally, EEHR can support the NCQSA to develop and pilot a continuous quality improvement process in the focus regions. Potential activities could include:

- the development of quality improvement processes;
- management training of both health providers and administrative staff to streamline and improve reporting systems; and
- developing approaches for using the HII contracts as tools for rewarding improvements in quality of care.

TABLE 5: MAJOR GAPS IN STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
Develop, disseminate and implement Standards, protocols, clinical guidelines to improve quality	<ul style="list-style-type: none"> • MOH and NCQSA have limited capacity to implement quality improvement • HII has developed indicators for its HC contracts but they do not really measure service quality 	<ul style="list-style-type: none"> • No mechanism for ensuring accountability • HII needs technical guidance from the MOH to improve its incentives for quality improvements 	<ul style="list-style-type: none"> • MOH, NCQSA are not responsive to HII needs • MOH is not responsive to patient needs 	<ul style="list-style-type: none"> • Support leadership of MOH to coordinate with NCQSA and HII to develop better incentives that promote quality of care
Establishment and implementation of M&E system (info from M&E Vision and Framework, March 2010)	<ul style="list-style-type: none"> • M&E Directorate completed first round of reporting. Needs continued capacity building to increase reliability, quality and timeliness of data 	<ul style="list-style-type: none"> • No clear lines of communication for M&E Directorate to present its reports 	<ul style="list-style-type: none"> • M&E Directorate responding to need for M&E system 	<ul style="list-style-type: none"> • Continue to strengthen the capacity of the M&E Directorate and the M&E Core and Reference Groups
Analyzing and Using data to inform policy making	<ul style="list-style-type: none"> • M&E Directorate weak in analyzing data and presenting it to decision makers 	<ul style="list-style-type: none"> • No current mechanism for M&E Directorate to analyze and present data and coordinate with IPH in identifying key issues 		<ul style="list-style-type: none"> • Strengthen capacity of M&E Directorate and IPH to conduct advocacy, for both policy makers and the public
Accreditation of Hospitals	<ul style="list-style-type: none"> • MOH and NCQSA weak in implementation of accreditation process 	<ul style="list-style-type: none"> • No mechanism to ensure accountability 	<ul style="list-style-type: none"> • Accreditation process too burdensome to meet needs of hospitals 	<ul style="list-style-type: none"> • Facilitate better bilateral coordination between MOH and NCQSA
Registration, licensing and recertification of health providers	<ul style="list-style-type: none"> • NCCE maintains registry and recertification database • NCCE cannot meet training needs of providers 	<ul style="list-style-type: none"> • MOH does not require NCCE to share information or assist it in planning for manpower and training needs 	<ul style="list-style-type: none"> • NCCE is not meeting training needs of health professionals • NCCE not meeting information needs of MOH 	<ul style="list-style-type: none"> • Facilitate bilateral sharing of information and coordination between NCCE and MOH
Continuing Medical Education	<ul style="list-style-type: none"> • NCCE can manage accreditation system • MOH cannot mobilize sufficient funds to meet training needs 	<ul style="list-style-type: none"> • MOH does not hold NCCE accountable to identify or meet priority training needs. 	<ul style="list-style-type: none"> • CME system does not fully respond to needs of health system 	<ul style="list-style-type: none"> • Support MOH to prioritize training needs and advocate for funding to support training

7.3 HOSPITAL ORGANIZATION, OPERATIONS AND MANAGEMENT

Regulations regarding the hospital sector have been the subject of recent legislation, as well as earlier reforms of the health sector. Responsibilities for planning, financing, management and oversight are specified with the Basic Health Law, the Decisions 140 and 1661, as well as the Public Health Law. In 2003, Law 9106 on Hospital Services was enacted. Since then, elements of that law have been revised through new legislation or regulations, or are no longer practiced.

Table 6 provides the details of these laws and decisions, and the responsibilities of government institutions in the hospital sector. Details on actual practices based on the review team observations are detailed below.

7.3.1 OVERALL PLANNING FOR HOSPITAL SECTOR

The MOH has the legal authority for planning of the hospital sector. The legislation contains guidance for the MOH to conduct regular assessments of the sector to inform planning. It is not clear whether such assessments have been regularly conducted and whether they lead to any changes in hospital distribution and services. According to Law 9106, a State Hospital Planning Committee advises the MOH on hospital planning, while a Regional Hospital Authority oversees distribution of hospital beds within its region. It does not appear that these structures are in place and performing this function.

If the mandated changes in financing of hospitals based on services provided (Decision 140 and 1661) are realized as stipulated, significant changes in the sector will be required. It is likely that with standard payments per hospital stay or per diagnosis, hospitals that have very low occupancy rates (less than 20%) will not be able to generate sufficient funding to maintain their current operations.

The World Bank supported the development of a rationalization plan for the sector, completed in 2010. This plan calls for maintaining 12 regional hospitals and several other specialty hospitals, while the majority of district hospitals are to be transitioned to health centers. This plan has been approved by the Minister of Health, yet implementing it will be a challenge for the MOH because of political resistance. The Hospital Directorate of the MOH was largely in favor of this plan, and said that all actors have known for many years that 10 hospitals could easily be closed with no impact. But such a decision was never taken because of the political costs.

TABLE 6 --: LEGAL FRAMEWORK FOR THE HEALTH SYSTEM BY FUNCTION – HOSPITAL ORGANIZATION, OPERATIONS AND MANAGEMENT (INFORMATION REFLECTS MANDATED OR DOCUMENTED RESPONSIBILITIES, WHICH MAY OR MAY NOT REFLECT ACTUAL SITUATION)

Sub-functions	MOH	HII	IPH	NCQSA	NCCE	Hospitals/HCs	Others
Planning for hospital sector overall	<ul style="list-style-type: none"> • Conduct three year assessments of the sector • WB completed rationalization plan • State Hospital Planning Committee advises MOH • Non-public hospitals licensed by License Comm at MOH in coordination with Mayor • MOH supervises Regional Hospital Authority (RHA) 						<ul style="list-style-type: none"> • RHA decides distribution of beds in region
Financing	<ul style="list-style-type: none"> • Hospital capital expenses covered by MOH • MOH controls [MOH] financed budget 	<ul style="list-style-type: none"> • HII contracts with hospitals specifying method of payment, services planned • HII will finance based on historical budget until costing is done 					
Hospital Management (Decision 140 cites Law 9106)		<ul style="list-style-type: none"> • HII contract controls hospital services, budget, data requirements 				<ul style="list-style-type: none"> • Private hospital with over 50 beds have a FT Medical Director 	<ul style="list-style-type: none"> • RHA Directors oversee mgmt.
Monitoring and oversight of services	<ul style="list-style-type: none"> • Standards and quality indicators approved by MOH • MOH defines hospital standards, diagnoses and treatment protocols 	<ul style="list-style-type: none"> • HII sets quality and performance indicators in contracts 		<ul style="list-style-type: none"> • Develops treatment protocols • NCQSA accredits hospitals 	<ul style="list-style-type: none"> • Accredits CME for providers 	<ul style="list-style-type: none"> • Hospital acts in accordance with MOH standards • Facilitates CME for staff 	<ul style="list-style-type: none"> • Order of Physicians licenses doctors, with recertification every 5 years • RHA provides oversight

There does not seem to be a clear strategy for planning and distribution of hospitals, and it seems different approaches are being pursued. One approach is based on the traditional role for the MOH as the central planner for where hospitals are located, what services they provide, how staffing is structured, and the funding they receive. This approach relies on the role of the MOH as planner, with rationalization studies to support central decision making. Although studies have been done, there does not appear to be enough political will to implement these plans. Another approach envisions that with autonomous hospitals and HII-established reimbursement fees for hospital services, the rationalization process will happen more spontaneously as hospitals become unsustainable based on the income they generate, and are forced to restructure themselves or cease operations. It is not clear which is more politically palatable, or would result in better overall performance for the sector. Regardless of the approach, more important is that there is a coherent and transparent plan for how the hospital sector will be reorganized. The MOH may not have the technical or political capacity to develop and implement such a strategy.

The review team found the Hospital Directorate of the MOH to be demoralized given the recent changes, whereby HII is responsible for hospital financing. The Hospital Directorate still maintains responsibility for funding investment, or capital costs, but staff perception is that the directorate is extremely underfunded and so has limited ability to support hospitals, and lacks authority to ensure needed coordination with HII.

The MOH struggles to effectively fulfill its relatively new and challenging role as policy-maker and coordinator of the evolving health sector. Although defined in the law, there seems to be little recognition that MOH should play a role as coordinator and provide oversight to the sector. There are now two hospital directorates (one in the MOH and one in the HII) and the HII holds more influence with hospitals since they provide the funding. At the same time, the MOH Hospital Directorate seems to have done little to exert authority over areas where coordination is clearly needed. One simple example is that planning for capital investments and operational costs are independent processes, resulting in purchase of equipment for which there is no plan or budget to provide supplies for their use (films for x-ray machines,) to train staff to operate, or to maintain properly.

While the MOH Hospital Directorate recognizes that more coordination is needed, the staff believes that only the Minister of Health was in an appropriate position to initiate this collaboration. It was also their impression that better definition of roles and responsibilities is needed.

7.3.2 FINANCING

Decision 1661 and Decision 140 divided funding for hospitals between MOH and HII, with MOH responsible for hospital investments, while HII is responsible for funding operational costs. Since 2010, HII has contracted with hospitals to provide services, although unlike for PHC, there are no incentive payments based on quality of service volume.

The current situation in hospital budgeting is illustrative of the high degree of centralization in Albania. Although HII contracts the hospitals, and hospitals are by law autonomous institutions, it was Decisions 1661 and 140 from the Council of Ministers that approved the budgets and staff numbers for each hospital for 2009 and 2010. These decisions further stipulate that up to 5.0% of the wage budget can be re-allocated to “goods and services,” and up to 2.0% of the budget may be re-allocated in the other direction, and only if authorized by HII. The central office of HII stated that they do not approve hospital budgets, except for Durres Hospital, which is a pilot for hospital autonomy. Officials at the Durres regional health office and the Kruje district health office also reported that they do not oversee or approve hospital budgets. It was not clear who actually approves hospital budgets before they are sent to the Minister of Health and Council of Ministers.

Hospital budgets and hospital staffing seem to be static from year to year. At the Kruje District Hospital, the total budget and the number of approved staff were exactly the same in 2010 and 2011. Decision 140 included affirmation that staffing at hospitals in 2010 should remain the same as 2009.

Additional financing to hospitals comes in the form of user fees collected, normally referred to as “secondary income.” This income has been increasing in recent years. For example the Kruje

District Hospital reported that it represented approximately 15% of the hospital budget. According to MOH regulation, up to 40% of this income can be distributed to staff in the form of incentives.

As part of the mandate established in 2009 for HII to finance hospitals, HII has enacted many improvements in record-keeping at hospitals. In 2010, all hospitals were provided at least one computer, and training was provided on basic record-keeping software. Beginning in 2011, all hospitals implemented a Unique Medical Record for each patient, with data on diagnosis, treatments, and medicines prescribed. HII is in the process of reviewing the first quarter of data from these new forms and procedures, and likely there will be issues to be ironed out in these early implementation stages. One of the limitations that both HII and MOH pointed out was that use of the ICD 9 standard coding limits the reliability of cost/diagnosis analyses, because coding of diagnoses is less precise. Nonetheless, these data systems could potentially play an important role in providing data for hospital management, and from the perspective of HII, for improved cost efficiency.

7.3.3 HOSPITAL MANAGEMENT

Although hospitals are by law autonomous institutions, there is no clear guidance on specific authorities given to hospital managers or hospital boards. As detailed in the previous section, hospital management has authority only to make minor changes to the hospital budget, and only with HII approval. If they are to function as independent institutions, the authority to restructure budget, shifting personnel budget to investments, for example, should be allowed with specific guidance on oversight structures. The Kruje District Hospital estimated that they could possibly reduce staff by 40% without significant impact on services, but there is no channel for considering such decisions. Similarly, health centers, for which the transition to autonomous institutions (at least financially) began in 2007, also do not have authority over structure of staff or services offered.

Hospital managers are appointed by the Minister of Health, and not necessarily in a transparent, merit-based process. The practice is they are changed when there is a change in the Minister. Thus lack of continuity in management, and limited overall management competency within hospitals is an issue. Frequent changes in hospital management make it difficult to invest in management capacity in a meaningful way.

There does not seem to be clear oversight structures in all hospitals. At the Kruje District Hospital, the review team learned that there is no Board with approval or oversight authority over decisions. The hospital director, with selected other senior doctors, is responsible for distribution of secondary income, staff hiring, and possibly other functions as well. It seems that HII is the only institution that is providing regular oversight of hospitals, and that primarily focuses on service volume and financial management.

More guidance is needed to clarify the authority given to hospitals as independent institutions, as well as to clarify the structures that govern how this authority should be exercised. Competent managers in hospitals are likely better-positioned to identify changes that could improve efficiency and service quality that any central authority – such as re-directing a portion of the existing budget from staffing to medicines and supplies so that treatment protocols can be followed. However, current regulations do not allow hospital managers to make such decisions. Clear guidance for hospital managers on the scope of their authority, together with indicators in HII contracts that better target quality improvements, can provide increased efficiency and quality.

7.3.4 MONITORING AND OVERSIGHT OF SERVICES

Since HII began funding HCs in 2007, it has put in place a functioning system of oversight, although somewhat focused on controlling prescription drug costs. There does not appear to be an established system of monitoring and oversight of hospitals. Hospitals do provide data regularly to HII (admissions, discharges, diagnoses, medication costs, etc.) but it seems that regular procedures for oversight and review are under development. For example, the Durres Health Insurance Regional Directorate (HIRD) meets with all the HC Directors in the region on a monthly basis, and conducts bi-annual supervision in HCs. Such oversight measures were not yet in place for hospitals. This may be attributed to the lack of a clear service package at hospital level.

The responsibility of district and regional health officials in hospital oversight is unclear. They are not involved in supervision of hospital services, staffing, or budget development. Certainly with the limited management skills within hospitals, district and regional health officials may be able to serve a useful function in management and oversight of hospitals. Further review is needed to analyze appropriate functions at national and subnational levels of the health system more broadly, and the role of these subnational offices in oversight and coordination.

7.3.5 PROPOSED SUPPORT FROM EEHR

There are several issues that hamper the MOH's ability to act as an effective leader in hospital organization and management, resulting in little guidance and oversight to HII and to the autonomous hospitals. Removing the financing function from the MOH has served to diminish the Ministry's role and authority over HII, hospitals, and in practice, the overall sector. Although HII has made progress in moving toward case-based payment, they have not sought technical input to ensure that its contracts motivate hospitals toward the efficiency and quality improvements sought. The MOH has not asserted its influence in this area, either. The hospitals seem to continue to function, yet there is little oversight, and little guidance as to how they will become truly autonomous institutions, and what is within their scope of authority. Management skills within hospitals also require support in order for them to realize improved efficiency and quality. Support from EEHR should focus on the three key actors – MOH, HII, and the hospitals – to clarify roles and responsibilities, delineate authority, improve management, and facilitate coordination. Additional targeted assistance to HII to implement case-based financing is also needed.

TABLE 7: MAJOR GAPS IN HOSPITAL ORGANIZATION, OPERATIONS AND MANAGEMENT (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
Planning for hospital sector overall	<ul style="list-style-type: none"> There is not a coherent policy for hospital distribution The MOH is not fulfilling its function as coordinator 	<ul style="list-style-type: none"> MOH is not held accountable for this function 	<ul style="list-style-type: none"> There is no mechanism to ensure stakeholder input (particularly the general population and communities) in hospital planning 	<ul style="list-style-type: none"> Support MOH Hospital Directorate to define and fulfill its role, clarifying responsibilities of MOH, HII, Regional Health Directorates, and HIRD Support stakeholders to develop coherent policy/plan for the hospital sector
Hospital financing	<ul style="list-style-type: none"> HII has made progress toward case based financing, but additional technical assistance may be needed 			<ul style="list-style-type: none"> As recommended by the EEHR Project HII Review, support HII to implement case-based payment
Hospital management	<ul style="list-style-type: none"> Authority of hospitals (and HCs) as autonomous institutions is unclear Hospitals do not have guidance or skills to establish hospital Boards and define their functions 	<ul style="list-style-type: none"> No mechanism in place to hold hospital managers accountable Hospital managers are political appointees so accountability may be distorted 	<ul style="list-style-type: none"> No procedure in place to respond to external stakeholders, although patient satisfaction surveys are planned 	<ul style="list-style-type: none"> Support hospitals in focus regions to progress toward autonomous institutions, including improving management skills and quality Support development of guidance to clarify the scope of authority of key actors
Monitoring and oversight of services	<ul style="list-style-type: none"> MOH capacity to monitor and oversee hospitals is weak 	<ul style="list-style-type: none"> No mechanism to hold MOH accountable 		<ul style="list-style-type: none"> Assist MOH to develop guidance for Regional oversight of hospitals in collaboration with HII

7.4 FINANCING AND HEALTH INSURANCE

A new Compulsory Health Insurance Law was enacted in 2010. The new health insurance law, together with Decision 140 and the Basic Health Care law, provide the overall framework for advancing the goals of universal insurance coverage for all citizens. Overall, HII has the primary responsibility for financing both primary care and hospital services, collecting funds from the insured and disbursing funds to providers, while the MOH is tasked with ensuring appropriate standards and quality, as detailed in Table 8.

Table 8 presents the roles and responsibilities of the health sector institutions in implementing the new financing laws.

7.4.1 REGISTERING ELIGIBLE POPULATION AND COLLECTING PREMIUMS

The HII is responsible for registering the insured individuals and ensuring that they receive an insurance booklet entitling them to insurance benefits. Responsibility for collection of premiums is split between the General Tax Directorate (for those formally employed), the Social Insurance Institute (SII) (for farmers), and the HII (for individuals making voluntary contributions.) In total, there are approximately 1.2 million registered insured (carrying an insurance booklet.) Of the registered insured, the large majority are pensioners for whom no contributions are required – several informants estimated that only 10% to 20% of registered insured are individuals that make voluntary payments. There are other individuals that contribute to the insurance scheme through the Tax Directorate or SII, but do not register at HII with documentation of their contributions to receive an insurance booklet.

The Tax Directorate and SII do not provide information to HII on the individuals who have contributed to the insurance scheme. By law, the Tax Directorate is required to provide information on the total number of contributors, but not identity information. The review team did not verify whether data on the number of contributors is provided to HII regularly, whether those figures are reliable, or whether they could be disaggregated by region, district or below. The more detailed the data available, the more useful it is to HII for calculating payments to providers. This current situation, where insurance status is not easy to determine, makes it harder for health facilities to distinguish between the insured and uninsured, and easier for individuals to claim they are insured. Instead, the HII has carried out a HC-based “census” of their own to assess the population in the facility catchment areas. However, it is not clear how that data is used to determine payments to PHC facilities.

Health centers and family doctors, as part of their contract with HII, are meant to encourage patients and their catchment population to register with HII. HII has also conducted regular education campaigns to encourage registration. Nonetheless, insurance booklet holders represent approximately 42% of the population, based on 2008 LSMS data. The HII estimates that the figure may have increased since the time of that survey due to better implementation of the referral system, which enacted higher fees at hospital level, encouraging people to obtain insurance booklets so that they may access hospital services for free (with a referral.) During one visit to a HC, staff explained the disincentive to encouraging insurance registration because there is no benefit to the HC, while the alternative of a patient that pays out-of-pocket fees, provides the HC with funds they can directly use as needed within general guidelines.

TABLE 8: LEGAL FRAMEWORK FOR THE HEALTH SYSTEM BY FUNCTION - FINANCING AND HEALTH INSURANCE (INFORMATION REFLECTS MANDATED OR DOCUMENTED RESPONSIBILITIES, WHICH MAY OR MAY NOT REFLECT ACTUAL SITUATION)

Sub-functions	MOH	HII	IPH	NCQSA	NCCE	Hospitals/HCs	Others
Enrolling eligible population and collecting premiums	<ul style="list-style-type: none"> Subsidize insured with no co-payments 	<ul style="list-style-type: none"> Register insured individuals 			<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Family doctors to encourage patients to register with HIF 	<ul style="list-style-type: none"> General Tax Directorate and Social Insurance Institute collects funds from employees and farmers Tax Dir. provides info on amount collected, number of contributors State budget subsidizes unemployed indiv and other deficits
Defining benefits package	<ul style="list-style-type: none"> Service package presented by MOH endorsed by HII for Council of Minister approval 	<ul style="list-style-type: none"> Service package defined by technical commissions representing medical, financial, social sectors appointed by Administrative Council of HII 					
Establishing payment terms for providers	<ul style="list-style-type: none"> Working with HII to conduct costing 	<ul style="list-style-type: none"> Decides terms of payment for services and drugs Conducting costing of service Current hospital payment based on historical budget 10% of HC payment based on performance 		<ul style="list-style-type: none"> Develops treatment protocols for costing 		<ul style="list-style-type: none"> Hospitals and HII calculate costs of each service Provide data to HII as specified in contract 	
Selecting providers		<ul style="list-style-type: none"> Establish register of selected health care 		<ul style="list-style-type: none"> Develops process of 			

TABLE 8: LEGAL FRAMEWORK FOR THE HEALTH SYSTEM BY FUNCTION - FINANCING AND HEALTH INSURANCE (INFORMATION REFLECTS MANDATED OR DOCUMENTED RESPONSIBILITIES, WHICH MAY OR MAY NOT REFLECT ACTUAL SITUATION)

Sub-functions	MOH	HII	IPH	NCQSA	NCCE	Hospitals/HCs	Others
		<p>providers that are accredited</p> <ul style="list-style-type: none"> Providers can be removed from Register for not complying with contract 		<p>accrediting all facilities</p>			
Overseeing provider quality	<ul style="list-style-type: none"> MOH to provide standards and supervise their implementation MOH provides data to HII on health status and health performance of Fund 	<ul style="list-style-type: none"> Providers give data on quality to HII per contract 		<ul style="list-style-type: none"> Health facilities to be accredited by NCQSA (10 107) 	<ul style="list-style-type: none"> Accredits CE trainings and tracks CE credits for providers 	<ul style="list-style-type: none"> Required to facilitate CME for medical staff 	
Review and pay claims		<ul style="list-style-type: none"> HII pays hospitals based on historical budget, until service fees are approved by Council of Ministers HIF does not pay for uninsured Local offices of HII make payments based on claims (this is only implemented for drugs) 				<ul style="list-style-type: none"> Provide services as contracted 	
Oversight of Health Insurance Fund		<ul style="list-style-type: none"> HIF governed by Director and Admin Council, with MOH, MOF, Min Social Affrs, etc with Chair elected by full Board in secret 					

Until there is reliable data on who is insured, and the rate of insurance coverage is increased significantly, HII cannot move toward true capitation payment for PHC. Without capitated payment, and provider choice, the goals of improved quality and efficiency will not be realized. Further, without reliable data on the insured, it is difficult to decipher the reasons why the uninsured do not contribute, or investigate alternative mechanisms for insurance contribution.

7.4.2 DEFINING THE BENEFITS PACKAGE

As stipulated in the Health Insurance Law, both MOH and HII have responsibility for defining the benefits package for the insurance scheme, with input from a broader technical commission appointed by the Administrative Council of the HII. Since the Health Insurance Law was enacted, however, there is not a clear plan for how this will be achieved. The gap is in the area of defining hospital services covered. Because there was little data to support decision making, HII funding to hospitals (which began in 2010) is solely based on historical budgets. For PHC, previous work to define the service package was completed with USAID support, and it is clear to facilities and patients the services that should be offered.

Defining the hospital services covered by the insurance scheme requires information on cost of services as well as information on the incidence of use. This data is not readily available because hospitals did not keep records in this manner prior to HII funding. Beginning in 2010, HII provided at least one computer to all of the hospitals that it had contracts with, so that they could begin to generate the data needed for defining the benefits package. Beginning in 2011, HII implemented new data collection systems, including forms to generate a unique medical record per patient, which provides data on the diagnosis, as well as all of the treatments and drugs/supplies provided. This data will be critical as HII transitions hospitals from budget-based to case-based funding.

7.4.3 ESTABLISHING PAYMENT TERMS FOR PROVIDERS

One goal of the Compulsory Health Insurance Law is to transition all funding for public health facilities from a passive budget-based system, to active purchasing by a single payer – HII. The HII has made some progress toward payment for services at Health Center level, moving from the previous system of payment for inputs. For HCs, 80% of payments are budget based, with 10% based on achieving service targets, and 10% based on a mix of service indicators.

Hospital payments to-date are based on historical budgets, and have been static, as described earlier. The MOH and NCQSA have been working to develop appropriate protocols to support full costing of services, as part of their plan to develop the hospital benefits package. Protocols for approximately 200 diseases were developed, but these protocols have not been disseminated. While these protocols may be clinically appropriate, there are questions about whether they were realistic, with one informant responding that for selected illnesses (such as a heart attack) it is unlikely there is a single hospital in the country that would have all the equipment, supplies and staff to follow all protocols. The EEHR HII Review also questions whether costing of service protocols is an essential step in moving toward case-based payment.

7.4.4 SELECTING PROVIDERS

The Health Insurance Law directs the HII to establish a register of selected providers. HII does envision a goal of contracting with high quality, cost effective providers, including a mix of public and private providers, providing insurance holders provider choice, particularly in urban areas. There are two barriers to achieving this vision – HII does not have the authority to stop funding a facility, and MOH's ability to oversee and coordinate the NCQSA and NCCE to ensure quality services is limited. As discussed earlier, the current process for facility accreditation may be difficult to implement consistently, and will take a long time.

There does not appear to be a clear plan for distribution of health facilities, and there is no clear mandate on division of responsibility between HII and MOH on this matter. There are dual visions: one is of the previous centrally-planned provider network where every district and commune would have equal services, and another where economic efficiency (whether there is sufficient volume of patients) would determine whether facilities have sufficient funding to “stay in business.” Neither

approach implemented in isolation would lead to desired improvements in efficiency and quality. A more concrete and practical policy regarding access to health services, and how subsidies might be provided to sparsely populated areas to ensure a minimum level of access, is required.

7.4.5 OVERSEEING PROVIDER QUALITY

The MOH is clearly the institution with responsibility for health provider quality, with Decision 10 107 providing it authority to provide standards and supervise their implementation. However, the MOH does not have sufficient resources, technical capacity, or leverage over affiliated institutions such as the NCQSA, to fulfill its responsibility. In practice, HII has moved ahead within its PHC contracts to hold HCs accountable to standards that it has defined, although these mechanisms are not yet in place in its contracts with hospitals. While these HC standards are often referred to as performance indicators and quality indicators, in reality, the indicators are more oriented toward cost control and efficiency than service quality. See the above Section Standards and Processes to Ensure and Improve Quality for more details related to the role of other institutions in setting and enforcing quality standards.

In setting up mechanisms for monitoring its contracts with providers, HII has put in place systems and staff at the region and district level, and is the institution with the most direct and regular interactions with providers. HII also seems capable of holding providers to specific standards, with regular reporting from providers and analysis by HII, which is communicated back to the providers. HII has put in place the systems to allow effective oversight of provider quality – the gap appears to be related to the lack of formal mechanisms in place to ensure that MOH and other relevant institutions such as the NAB or NCQSA provide input to the indicators set in the HII contracts with providers.

HII also collects more data on provider practices than other institutions. HCs have used Patient Encounter Forms and Prescription Reimbursement Forms for several years, with basic patient information, diagnosis, and treatments prescribed. These forms capture a wealth of data that could be analyzed to see whether providers are following treatment protocols, and whether patients are accessing care appropriately.

7.4.6 REVIEWING AND PAYING CLAIMS

HII has developed systems and procedures for prompt review of reimbursement claims, although this function is limited to reimbursements for medicine costs for outpatient care. At district and regional level, there are HII staff, including financial and medical professionals, who conduct the review and reimbursement. HII seems quite capable in this function, with clear and accepted procedures.

7.4.7 OVERSIGHT OF HEALTH INSURANCE FUND

According to the Health Insurance Law, HII is governed by its Director and Administrative Council, which includes the Minister of Health, Minister of Finance, Minister of Social Affairs and Equal Chances (or their representatives,) as well as other relevant institutions. The Administrative Council is charged with internal oversight, including approving the HII Director, budget, and organizational structure, as well as criteria in contracts with providers, etc. The review team did not gather information on whether the Administrative Council is functioning effectively as this review was not focused on HII management, but did conclude that additional external oversight of HII would be useful.

The primary need for external oversight was not to ensure responsible HII management (which is under the purview of the Administrative Council) but to ensure that the insurance scheme is meeting its goals of universal access, cost efficiency, and quality improvement. This oversight should be one part of the function of an oversight body tasked with leadership and oversight of the whole health sector. While HII seems capable of implementation once design elements are clear, neither the MOH nor another institution seems to be monitoring whether the insurance design is meeting the broader objectives of the health sector.

7.4.8 PROPOSED SUPPORT FROM EEHR

Much progress has been made toward a single payer system. HII continues to move its HC contracts toward performance-based financing, however, more support is needed to move toward universal insurance and a payment system that rewards provider quality. Critical to this goal is increasing the coverage rate, and paying HCs based on the registered insurance holders. Further, more technical support is needed to assist HII to implement case-based payment for hospitals. Lastly, MOH capacity to provide leadership and oversight is weak. Despite high HII capacity to operationalize the insurance scheme, more coordination and oversight is needed to ensure that the design meets the objectives of the sector. The support proposed includes regional level support to increase insurance registration and to pilot new contracts with HCs that move further toward payment based on insured patients. To complement regional efforts, EEHR would also support the MOH and HII to set clear priorities for insurance implementation, and support the MOH to strengthen its leadership role through facilitating joint planning and coordination.

TABLE 9: MAJOR GAPS IN FINANCING AND HEALTH INSURANCE (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
Enrolling eligible population and collecting premiums	<ul style="list-style-type: none"> HII has developed adequate operational systems for insurance registration, but has not focused on increasing the insurance coverage rate 	<ul style="list-style-type: none"> HII has no leverage to induce better cooperation from Tax Directorate of the Social Insurance Institute While PHC providers are responsible for encouraging insurance registration, they are not held accountable 	<ul style="list-style-type: none"> Although health insurance is compulsory, there are no strategies in place or actions planned to tackle the low registration rate (currently approx. 42%) 	<ul style="list-style-type: none"> Support focus regions to improve registration systems with a combination of consumer education, provider incentives through HC contracts, and incentives for new registrants Support HII at central level in discussions with other government agencies to obtain data they need on contributors
Defining hospital benefits package	<ul style="list-style-type: none"> HII and MOH do not appear to have a clear plan for how the package of hospital services will be developed MOH has not taken responsibility for policy guidance on allocation of HII expenditures between PHC and hospital care, or between medicines and other costs 	<ul style="list-style-type: none"> It is unclear who should hold the MOH and HII accountable for timely and reasonable action 	<ul style="list-style-type: none"> Patients are not included in discussions regarding benefits package 	
Establishing payment terms for providers	<ul style="list-style-type: none"> According to the EEHR HII Review¹, HII does not have sufficient capacity to manage a transition to case-based payment for a package of hospital 	<ul style="list-style-type: none"> Despite many accomplishments, HII is not held accountable for faster progress in moving toward 	<ul style="list-style-type: none"> MOH does not provide input on whether HII performance/quality indicators are appropriate 	<ul style="list-style-type: none"> Support focus regions to pilot new HC contracts with capitated payments based on registered insured, and other

¹ Purvis, George, Ainura Ibrahimova, and Flora Hobdari, July 15, 2011. *Albania Health Insurance Institute Review: Challenges and Opportunities, Technical Report*

TABLE 9: MAJOR GAPS IN FINANCING AND HEALTH INSURANCE (BOXES WITH NO INFORMATION INDICATE NO MAJOR GAPS FOUND)

Sub-Functions	Capability	Accountability	Responsiveness	EEHR Response
	services without external assistance	service-based payments to providers	<ul style="list-style-type: none"> There are no mechanisms for aggregating provider feedback or concerns regarding HII's contracts 	payments for non-registered patients
Selecting providers	<ul style="list-style-type: none"> MOH, together with NAB and NCQSA, are responsible for accrediting providers, but capacity within MOH to coordinate and lead this effort is weak MOH capacity to guide policies related to funding basic health services in sparsely populated areas, irrespective of efficiency considerations, is weak 	<ul style="list-style-type: none"> HII is directed by the Health Insurance Law to select providers but does not have authority to NOT contract with a public facility 		
Overseeing provider quality	<ul style="list-style-type: none"> HII has developed good systems for provider oversight, but does not have sufficient technical guidance to ensure its contracts sufficiently reward quality MOH has limited capacity to enforce quality standards 	<ul style="list-style-type: none"> There is no mechanisms to hold MOH accountable for this function 	<ul style="list-style-type: none"> There are no mechanisms to ensure that institutions such as HII or NCQSA are responsive to MOH concerns 	<ul style="list-style-type: none"> Improve the capacity of MOH as leader and coordinator of quality issues
Review and pay claims				
Oversight of Health Insurance Fund	<ul style="list-style-type: none"> The MOH is responsible for oversight, but exerts little leadership and authority over HII or other relevant organizations In addition to leadership and policy setting, MOH capacity in coordinating the relevant actors is also weak 	<ul style="list-style-type: none"> HII's Administrative Council oversees the functions of HII, but there is no institution that oversees whether the insurance scheme is achieving the goals of universal access or financial risk protection 	<ul style="list-style-type: none"> There do not appear to be any mechanisms to collect feedback from patients and the general population 	<ul style="list-style-type: none"> Support MOH and HII to set clear priorities for health insurance, including developing strategies for universal coverage and financial risk protection, in addition to cost containment and efficiency Support joint planning between MOH and HII to implement reforms, particularly related to the benefits package and provider quality

8. CONCLUSIONS

Albania has made significant progress in its transition to single payer health financing with universal coverage for all, using provider contracting mechanisms to ensure high quality, cost effective services. While it is a laudable goal to ensure high quality services for both rich and poor, strong oversight is critical to ensure appropriate implementation that supports the goals of the reform design.

To support this transition, it was intended that the MOH would move from its historical role as provider to one of steward, policy-maker and coordinator. The MOH has struggled with fulfilling this role, and it is clear capacity building is required throughout the institution. An ongoing culture of centralized, top-down authority that leaves staff feeling un-empowered further exacerbates the lack of technical capacity. There is insufficient coordination and communication within the MOH, leaving staff with a lack of clear vision and direction, and limiting its ability to influence others.

While at central level, the MOH is left with developing policies that they do not have budget or authority to implement, the responsibilities of the regional and district health authorities are even less clear. They no longer develop budgets, supervise staff, or oversee the hospital. Analysis of the appropriate functions at central and subnational levels in overall oversight and coordination is needed to define an appropriate role for regional and district health authorities.

At the same time, several auxiliary institutions (HII, NCQSA, NCCE) have emerged with strong leaders and/or external support that challenge the MOH authority. For the most part, these organizations have also been quite competent in carrying out their specific functions. At the regional and district level, HII is the most visible health authority, conducting regular HC supervision, reimbursing pharmacies, and providing incentive payments to HCs. What is lacking is oversight to ensure that the package of individual functions, as they are currently designed, is leading to better health system performance.

The legislation (Health Insurance Law, Basic Health Care Law, Law on Public Health) repeatedly recognizes the MOH as the institution responsible for policy, oversight and coordination of the sector. However, lacking are the formal institutional relationships that reinforce the MOH's position. These auxiliary institutions (HII, NCQSA, NCCE) do not have clear, mandated responsibility to report to the MOH, in a way that recognizes the MOH's position as the leader for the sector. Without such a mandate, which may need to come in the form of national legislation, the MOH has no leverage to ensure that all institutions work collaboratively toward a common vision. An oversight relationship could be further strengthened if the MOH were given oversight responsibilities such as review of annual progress reports or resource allocations to auxiliary institutions in the sector.

Throughout the sector, there is not clear alignment of institutional relationships and incentives to hold organizations accountable for fulfilling their mandated responsibilities. One specific gap that arises from the lack of coordination is a strategy for integrating the institutions' individual functions (financing, facility accreditation, continuing medical education, and oversight and supervision) to drive improved quality. This lack of coordination limits the potential impact of each of the functions. There is also not an easy answer as to how to hold the MOH accountable for fulfilling its functions. To this end, the role of civil society and non-governmental stakeholders, including patients groups, provider groups, academic and research organizations, and the media, must be explored further. The area of service quality may be a very good starting point for EEHR focus, because there is relatively less overlap among the various institutions, and is an area where it may be easier to generate civil society interest.

Specific recommendations are provided below to improve governance to ensure key functions are carried out. They were made with consideration of GOA, USAID and EEHR interests, although a few may be beyond the scope of the EEHR project. The insufficient authority of the MOH is a root

cause of many problems and is not easily addressed. A combination of capacity building, changes in institutional relationships that support the MOH's position of authority, and stronger mechanisms outside the MOH to hold it responsible is needed. Supporting legislation related to these matters may be effective, but may not be feasible within the scope of EEHR. Recommendations to address governance gaps are organized within each of the four functions below.

Health System Governance and Leadership

- Support development of a health reform steering committee as a permanent body: to increase accountability of implementing agencies; to provide a forum for health sector institutions, including non-governmental stakeholders, to improve communication, clarify roles and responsibilities, coordinate activities and advocate for policy reform.
- Support the M&E Directorate to serve as secretariat to the health reform steering committee to strengthen capacity for coordination, planning, advocacy and use of data to inform policy making and planning.
- Support the MOH to improve internal and external oversight, coordination, advocacy and communication.
- Assess, identify and support CSOs that could play a positive role in holding the MOH and other institutions accountable.
- Analyze the potential role for EEHR in supporting legislation to enforce the health reform steering committee or to enforce MOH authority and oversight with specific reporting relationships with auxiliary institutions. EEHR might identify potential champions who could take on this advocacy role, and provide support.

Standards and Processes to Ensure and Improve Quality

- Support coordination between MOH, NCQSA, NCCE and HII toward the goal of improving quality of care, including development and implementation of an integrated strategy including financing, facility accreditation, continuing medical education, and oversight and supervision to drive improved quality. This common effort could also serve as the basis to build MOH leadership, strengthen institutional relationships, and improve accountability. EEHR might pilot this process at the regional level to demonstrate impact and develop best practices, while also serving to define appropriate roles for regional health authorities.
- Continue to strengthen the capacity of the M&E Directorate.
- Strengthen capacity of M&E Directorate and IPH to conduct advocacy, for both policy makers and the public.
- Facilitate better bilateral coordination between MOH and NCQSA by developing and implementing a national quality strategy that clearly defines roles, responsibilities, reporting relationships and promotes accountability.
- Facilitate bilateral sharing of information and coordination between NCCE and MOH. This might include encouraging the NCCE and the Directorate of Human Resources and CME to meet regularly and develop and implement annual training plans.
- Support MOH to prioritize training needs and advocate for funding from the MOF and international donors to support training.

Hospital Organization, Operations and Management

- Support MOH Hospital Directorate to define and fulfill its role, clarifying responsibilities of MOH, HII, Regional Health Directorates, and HIRD. EEHR might consider seconding a staff person that mentors the Hospital Directorate to: develop a proposal for discussion of specific roles, authority, functions and inter-relationships of various institutions; strengthen skills in leading multi-institution meetings and facilitating agreement and follow-up; develop strategy to advocate for additional resources to support activities of all institutions. EEHR may also support a consultant to facilitate such discussions.
- Support stakeholders to develop and implement a coherent policy/plan for the hospital sector.

Because one of the key constraints is political willingness to act on hospital rationalization plans, EEHR focus may be in the areas of political analysis and strategic communications to manage negative public reaction.

- As recommended by the HII Review, support HII to implement case-based payment for hospitals.
- Support hospitals in focus regions to progress toward autonomous institutions, including improving management skills and structures in hospitals, and supporting self-assessment and problem quality improvement in preparation for NCQSA accreditation.
- Assist MOH to develop guidance for Regional oversight of hospitals in collaboration with HII.

Financing and Health Insurance

- Support focus regions to improve registration systems with a combination of consumer education, provider incentives through HC contracts, and incentives for new registrants. EEHR might also facilitate collaboration with CSOs and media organizations to support this effort.
- Support HII at central level in discussions with other government agencies to obtain data they need on contributors.
- Support focus regions to pilot new HC contracts with capitated payments based on registered insured, and other payments for non-registered patients
- Improve the capacity of MOH as leader and coordinator for quality-related issues in health insurance. Possible activities might include articulating a national strategy to integrate the functions of financing, facility accreditation, CME, and oversight and coordination, with clear roles for all institutions and subnational entities.
- Support MOH and HII to set and disseminate clear priorities for health insurance, including developing strategies for universal coverage and financial risk protection, in addition to cost containment and efficiency. Activities may include facilitating senior level agreements between MOH and HII, and supporting dissemination of such agreements throughout the respective organizations and the health system.
- Support joint planning between MOH and HII to implement insurance reforms, including an agreed approach and detailed workplan toward case-based payment and improving provider quality.

ANNEXES

ANNEX I – COUNSULTANCY TEAM SCOPE OF WORK

Enabling Equitable Health Reforms Project Health System Governance Review Health Systems Governance Expert/Team Leader Scope of Work

Consultant Name: Grace Chee

Title: Health Systems Governance Expert/Team Leader

Reporting to: Chief of Party

Period of Performance: on/about 11 April –11 June, 2011

Estimated LOE: 27 work-days (11 work-days in Albania)

Project Description: The Enabling Equitable Health Reforms (EEHR) project is a five-year initiative to increase access to essential health services for the poor by supporting the implementation of health care reforms in Albania. Project activities are aligned with goals of the Ministry of Health's Health Sector Strategy 2007 – 2013 to improve performance of the health system and the health status of Albanian population. EEHR provides technical assistance and resources to assist key stakeholders in the application of reforms at the national level and helps develop and field-test approaches and tools that support implementation of reforms at the regional level. The project encourages the involvement of all key stakeholders in policy making and planning, and supports an evidence – based policy making process.

In close collaboration with the MOH and other health system partners, EEHR employs three broad approaches to implementing reforms that will build good governance within the health care system and increase access to essential health services:

- Institutionalization of evidence – based policy making, and regular monitoring and evaluation of system performance;
- Introduction of country-tailored tools and mechanisms to implement a set of realistic, effective health reforms in selected regions; and
- Increasing advocacy for and communication about health reform within the GOA, the health sector, donors, and among the general population to promote on-going support and momentum for the reform process. Helping to build an informed and empowered public that understands its rights and responsibilities within the reformed health care system and supports a new culture of transparency and accountability.

Background of Activity: The Government of Albania (GOA) has recently enacted a series of laws - the Basic Health Care Law, Public Health Law, and the Law on Health Insurance - that are intended to help reform the health care system and provide greater access to affordable, quality health care for all Albanians. Implementation of this legislative framework, which defines the roles and functional responsibilities of the Ministry of Health (MOH), Health Insurance Institute (HII), other national health Institutions and local Health Departments, requires sound institutional governance that understands the role of its component within the overall system and its relations with the others, effectively manages resources and operations, is able to access and use data for priority-setting and management decision-making and adopts of a set of regulations, procedures, systems and tools that effectively operationalize the intent of the legislation.

Within this complex transitional context it is important to identify the state of the health reform process, identify areas of success and barriers to effective implementation and consider concrete measures to build institutional managerial capacity and improve governance. Such a review will also help policy makers address current issues such as the rapidly evolving role of the private sector and the relationship between MOH and professional associations, clarify systems' roles and responsibilities and enhance good governance and institutional transparency and accountability

Objective: Map the governance structures, systems and operations of key health sector institutions at all levels, identifying critical issues regarding the effectiveness of their implementation of the reform mandates and recommending measures to improve the clarity, operational efficiency, capacity and delivery of the system and its key institutions.

Activities: In close collaboration with the Chief of Party (COP) / EEHR Project team and local institutional partners:

- As Team Leader, liaise with EEHR Project staff to review the Health System Governance Review objectives, methodology and schedule and identify relevant documents for examination.
- Review key GoA, MOH, HII, WB, WHO, EEHR Project and other documents, statutes, regulations and reports, including the information collected through the HII Review conducted in April-May 2011.
- Prepare draft review approach, design, methodology and work-plan.
- Conduct initial consultative meetings with EEHR, USAID, MOH, HII and other key institutions.
- Following input from USAID, revise and implement work-plan data collection through site-visits, meetings and interviews.
- Review and analyze information and prepare preliminary findings and recommendations including:
 - Draft mapping analysis of Albanian health system structures at all levels;
 - List of key findings;
 - Identification of critical areas blocking or constraining effective implementation of reforms;
 - Recommendations for addressing any over-arching or national-level constraints to reform;
 - Recommendation of possible practical priority reform activities at regional level that could be implemented by the EEHR Project.
 - Recommendations concerning establishment of an on-going coordinating mechanism to facilitate communication, linkage and integration between key components of the health care system; and
 - Other findings or recommendations
- Present preliminary findings and recommendations to EEHR, USAID, MOH and other key partners.
- Based on feedback prepare present final Albanian Health Care System Governance Review Report and Review Summary Document for dissemination. (following departure from Albania).
- As team leader serve as main point of contact with EEHR COP, coordinate the conduct of team activities and insure the technical quality and timeliness of the work and deliverables.

Location: Tirana, Albania, with some travel to regions.

Deliverables:

- Governance Review Design and Work-Plan. (No more than eight pages)
- Albanian Health Care System Governance Review Report, including:
 - Mapping analysis of Albanian health system structures at all levels;
 - List of key findings;
 - Identification of critical areas blocking or constraining effective implementation of reforms;
 - Recommendations for addressing any over-arching or national-level constraints to reform;
 - Recommendation of possible practical priority reform activities at regional level that could be implemented by the EEHR Project.

- Recommendations concerning establishment of an on-going coordinating mechanism to facilitate communication, linkage and integration between key components of the health care system; and
 - Other findings or recommendations
 - Annexes including lists of documents and reports reviewed and meetings and interviews conducted in conduct of this activity.
- Governance Report Review Summary for broad distribution to Health System stakeholders and public (no more than 12 pages).

**Enabling Equitable Health Reforms Project
Health System Governance Review
Health Systems Governance Expert
Scope of Work**

Consultant Name: Joanne Jeffers

Title: Health Systems Governance Expert

Reporting to: Chief of Party

Period of Performance: on/about 11 April – 11 June, 2011

Estimated LOE: 25 work-days (11 work-days in Albania)

Project Description: The Enabling Equitable Health Reforms (EEHR) project is a five-year initiative to increase access to essential health services for the poor by supporting the implementation of health care reforms in Albania. Project activities are aligned with goals of the Ministry of Health's Health Sector Strategy 2007 – 2013 to improve performance of the health system and the health status of Albanian population. EEHR provides technical assistance and resources to assist key stakeholders in the application of reforms at the national level and helps develop and field-test approaches and tools that support implementation of reforms at the regional level. The project encourages the involvement of all key stakeholders in policy making and planning, and supports an evidence – based policy making process.

In close collaboration with the MOH and other health system partners, EEHR employs three broad approaches to implementing reforms that will build good governance within the health care system and increase access to essential health services:

- Institutionalization of evidence – based policy making, and regular monitoring and evaluation of system performance;
- Introduction of country-tailored tools and mechanisms to implement a set of realistic, effective health reforms in selected regions; and
- Increasing advocacy for and communication about health reform within the GOA, the health sector, donors, and among the general population to promote on-going support and momentum for the reform process. Helping to build an informed and empowered public that understands its rights and responsibilities within the reformed health care system and supports a new culture of transparency and accountability.

Background of Activity: The Government of Albania (GOA) has recently enacted a series of laws - the Basic Health Care Law, Public Health Law, and the Law on Health Insurance - that are intended to help reform the health care system and provide greater access to affordable, quality health care for all Albanians. Implementation of this legislative framework, which defines the roles and functional responsibilities of the Ministry of Health (MOH), Health Insurance Institute (HII), other national health Institutions and local Health Departments, requires sound institutional governance that understands the role of its component within the overall system and its relations with the others, effectively manages resources and operations, is able to access and use data for priority-setting and management decision-making and adopts of a set of regulations, procedures, systems and tools that effectively operationalize the intent of the legislation.

Within this complex transitional context it is important to identify the state of the health reform process, identify areas of success and barriers to effective implementation and consider concrete measures to build institutional managerial capacity and improve governance. Such a review will also help policy makers address current issues such as the rapidly evolving role of the private sector and the relationship between MOH and professional associations, clarify systems' roles and responsibilities and enhance good governance and institutional transparency and accountability

Objective: Map the governance structures, systems and operations of key health sector institutions at all levels, identifying critical issues regarding the effectiveness of their implementation of the

reform mandates and recommending measures to improve the clarity, operational efficiency, capacity and delivery of the system and its key institutions.

Activities: In close collaboration with the Chief of Party (COP) / EEHR Project team and local institutional partners:

- Work with Team Leader and EEHR Project staff to review the Health System Governance Review objectives, methodology and schedule and identify relevant documents for examination.
- Review key GoA, MOH, HII, WB, WHO, EEHR Project and other documents, statutes, regulations and reports, including the information collected through the HII Review conducted in April-May 2011.
- With Team Leader and EEHR staff, prepare draft review approach, design, methodology and work-plan.
- Conduct initial consultative meetings with EEHR, USAID, MOH, HII and other key institutions.
- Following input from USAID, help revise and implement work-plan data collection through site-visits, meetings and interviews.
- With Team Leader and EEHR staff, review and analyze information and prepare preliminary findings and recommendations including:
 - Draft mapping analysis of Albanian health system structures at all levels;
 - List of key findings;
 - Identification of critical areas blocking or constraining effective implementation of reforms;
 - Recommendations for addressing any over-arching or national-level constraints to reform;
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 - Recommendations concerning establishment of an on-going coordinating mechanism to facilitate communication, linkage and integration between key components of the health care system; and
 - Other findings or recommendations
- Present preliminary findings and recommendations to EEHR, USAID, MOH and other key partners.
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 - List of key findings;
 - Identification of critical areas blocking or constraining effective implementation of reforms;
 - Recommendations for addressing any over-arching or national-level constraints to reform;
 - Recommendation of possible practical priority reform activities at regional level that could be implemented by the EEHR Project.
 - Recommendations concerning establishment of an on-going coordinating mechanism to facilitate communication, linkage and integration between key components of the health care system; and
 - Other findings or recommendations

- Annexes including lists of documents and reports reviewed and meetings and in2terviews conducted in conduct of this activity.
- Governance Report Review Summary for broad distribution to Health System stakeholders and public (no more than 12 pages).

ANNEX 2 - MEETING SCHEDULE/CONTACT LIST

Mon, May 16

8:00 AM – 8:30 AM	Meeting with the COP for the EEHR project, EEHR project office
9:00 AM – 10:00 AM	Meeting with Dr. Klodian Rjepaj, Director of Minister Cabinet, MOH Ministry of Health
11:30 AM – 12:30 PM	11.30 Meeting with Prof. Isuf Kalo, Director of NCQSA, NCQSA
2:00 PM – 3:00 PM	Meeting with EEHR team, EEHR office

Tue, May 17

10:00 AM – 11:00 AM	Meeting with Prof. Enver Roshi, IPH Director and with Dr. Alban Ylli, Chief of the Department of Epidemiology / Statistics and Health Systems in IPH, Institute of Public Health
10:30 AM – 11:30 AM	11.30 Meeting with Dr. Entela Shehu, Director of NCCE, National Center for Continuous Medical Education
12:30 PM – 1:30 PM	Debriefing with USAID, Sheraton Hotel
3:00 PM – 4:00 PM	Meeting with World Health Organization, WHO office

Wed, May 18

9:00 AM – 10:00 AM	Meeting with Prof. Pellumb Pipero, Director of Policy and Planning, MOH
10:00 AM – 11:00 AM	Meeting with Dr. Erol Como, Chief of Ambulatory Health Sector, MOH
11:00 AM – 12:00 PM	Meeting with the Order of Physicians, Order of Physicians
12:00 PM – 12:30 PM	Meeting with Mrs. Ana Lipe, and Mr. Donard Stermasi Financial Planning Directory, MOH
12:30 PM – 1:00 PM	Meeting with Dr. Petro Mersini, MOH
1:00 PM – 1:30 PM	Meeting with Mrs. Manjola Pino, Specialist at the Directory of Information Technology, MOH

Thu, May 19

9:00 AM – 3:00 PM	Attend the workshop on Monitoring and Evaluation; Conduct meetings with technical specialists, DIPLOMAT Hotel
3:00 PM – 4:00 PM	Meeting with the Mr. Holgert Thies, Consultant to the HII, Sky Tower Hotel

Fri, May 20

- 8:00 AM – 1:30 PM Field trip to Durres
District of Durres
Meeting with Regional Director of Public Health
Dr. Lida Boshku – Deputy Director of Durres Regional Hospital
Dr. Evelina Balliu – Director of Ambulatory Services (Family
Medicine)
Dr. Shpetim Leka – Deputy (Technical) Director of Public Health
Directory
Dr. Vasil Ziu – Director of Public Health Directory
Meeting with the Regional HII Directory
Redi Saraci – Director of Regional Directory of HII
Kujtim Ajazi – Director of Medical Doctor Department
Altin Dedja – Director of Hospital Department
Harallamb Boshku – Director of Reimbursement Department
Mimoza Deda – Finance Department
Keida Beja – Director of Statistical Department
- 2:00 PM – 4:00 PM Debriefing with the M&E team (Cheryl Cashin and Mirela Cami),
EEHR Office

Mon, May 23

- 9:00 AM – 12:00 PM Meetings at the HII central offices, HII
Naun Sinani – Advisor to the general director of HII
Albana Adhami – Director of the Family Doctor Department
Miranda Blea – Director of IT Department
Rudina Mazniku – Director of Hospital Department
Aleksander Haxhi – Chief of the Sector of Political Developments
- 6:00 PM – 7:30 PM Attending the C-Change Project Closing Out Event, Public Health
Director (MOH) – Dr. Gazmend Bejtja

Tue, May 24

- 10:00 AM – 11:00 AM Meeting with the staff of the Hospital Directory
MOH
Dr. Maksim Bozo
Dr. Silvana Novi
Dr. Vjollca Duro
- 11:00 AM – 12:00 PM Meeting at the Human Resource Department
MOH
Meeting with Petrit Ponari – Director of Human Resource
Department (MOH)
Meeting with Arjold Bushi – Specialist at the Human Resource
Department

3:00 PM – 3:30 PM Meeting with the World Bank
WB Offices
Meeting with Lorena Kostallari – World Bank Country Representative

Wed, May 25

9:30 AM – 10:30 AM Meeting with the Prime Minister Health Advisor, EEHR office
Meeting with the PM Health Advisor – Dr. Mirela Tabaku

11:30 AM – 1:00 PM Visit the German Hospital in Tirana
Meeting with Dr. Roland Fasol – Surgeon

Thu, May 26

All Day Field Trip to Kruja District
Kruje District
Meetings at the Public Health Directory
Ilir Tabaku – Director of Public Health
Hysen Varoshi – Juridical Department in the Public Health Directory
Bujar Topciu – Finance Department in the Public Health Directory
Lulzim Vogli – Deputy / Economic Director of the Hospital of Kruja
Meetings at the District Agency of HII
Dr. Miranda Treni – Director of the HII District Agency
Fatmira Topciu – Finance Director of the HII District Agency
Visit a Health Center in the district
Dr. Pranvera Pengili – Family Doctor and the Director of the Health Center

Fri, May 27

10:00 AM – 11:30 AM Debriefing with USAID, EEHR project office
Dr. Zhaneta Shatri – USAID Health Team Leader
Dr. Agim Kociraj – USAID Health Specialist

ANNEX 3 - REFERENCES

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