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ANALYSIS OF LEGAL AND REGULATORY FRAMEWORK FOR HEALTH FACILITY/ HOSPITAL AUTONOMY IN ALBANIA

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

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ACRONYMS

AC	Administrative Council
BOD	Board of Directors
COM	Council of Ministers
DH	Durres Hospital
EEHR	Enabling Equitable Health Reforms Project in Albania
HUCT	Hospital University Center of Tirana
HMU	Hospital Management Units
HII	Health Insurance Institute
MOH	Ministry of Health
MOF	Ministry of Finance
PHC	Primary Health Care
UHC	University Hospital Center

EXECUTIVE SUMMARY

Public hospitals in Albania must be governed and managed differently to become more effective and to continue to access state funding to provide essential services for the population. Specifically, the hospitals need greater autonomy – managerial, financial, and contractual – so that they can operate more nimbly and effectively and respond to market and regulatory changes.

USAID Enabling Equity Health Reform Project in Albania (EEHR) commissioned this report to review health care legislation, by-laws and regulations, policies, and other relevant regulatory documents related to hospital autonomy to identify barriers to autonomy including legal or regulatory gaps and/or contradictions and to provide recommendations to address any gaps/barriers identified. This report defines autonomy as it derives from the legal documentation. A list of all regulatory documents reviewed is included as an Annex 4.

The new law on compulsory health care insurance coming into force in March 2013 will allow private hospitals access to Health Insurance Institute (HII) funding. Thus, public hospitals will need to be capable of competing along the cost and quality dimensions with private hospitals for government funding.

Currently, hospital management has limited ability to generate revenues and to allocate resources to meet market demand. The Ministry of Health (MOH) and other centralized bodies such as the Council of Ministers (COM) have authority over investment decisions as well as salary ranges. These are key decisions that in reformed health systems have been proven to be more effective at a decentralized level, for example as the purview of the hospital board of directors or the management team.

The current laws and regulations governing the hospital sector provide incomplete guidance on the required governance structure and rights and responsibilities related to hospital governance and management. There are significant gaps in the laws and regulations and those that do exist are not uniformly enforced.

This report analyzed the current legal framework and the practical experience of regional hospitals, including the pilot reform hospital in Durres which is deemed to be a model of success, and primary health care (PHC) facilities. Specific recommendations include moving forward to promote the policy formulation process supporting hospital autonomy. In the short term, a COM's decision could pave the way for increased autonomy at Queen Geraldine Maternity Hospital in Tirana and for the application of the Durres model to two other regional hospitals – Korca and Lezha – where the EEHR project is working, as well as for the longer term goal of amending hospital-related legislation. The experiences of the Queen Geraldine Maternity Hospital, Korca Regional Hospital, and Lezha Regional Hospital can be monitored and evaluated to inform legal and policy reform that would impact a national roll out of increased hospital governance autonomy in sync with ongoing health financing reforms.

I. BACKGROUND

The USAID Enabling Equity Health Reforms Project in Albania (EEHR) is supporting pilot activities of reform implementation in two regional hospitals (Lezha and Korca) and one specialty hospital (Queen Geraldine Maternity Hospital) in Tirana. These efforts are designed to implement and institutionalize tools and mechanisms for improved hospital management and administration. Such improvements would provide health policymakers with blueprints for implementing hospital-level reforms. The freedom of public hospitals to allocate resources where and when needed to respond to the population needs for hospital care is essential to ensure that management improvements are effective and that the government's commitment to offer health care to the people of Albania is achieved.

Public hospitals still provide the majority of hospital services in Albania. However, there is a growing private hospital sector that is starting to compete with the public hospital sector.

Currently, only public hospitals are entitled to receive government funding through the Health Insurance Institute (HII). This competitive advantage of public hospitals over private ones, however, is temporary. The new law on compulsory health care insurance coming into force in March 2013 will allow private hospitals access to HII funding.¹ The changing regulatory base and market realities in health care are expected to provide a strong stimulus to public hospitals to improve the quality of services through more effective use of available resources. Allowing public hospitals greater management autonomy will be essential to enable them to become more effective users of resources.

The issue of hospital autonomy is assuming greater importance in the health system of Albania. The primary care sector was the first one to be granted management autonomy. Such autonomy has been recognized as one of the cornerstones of the success of primary care reform in the country. The lessons learned from the autonomy in primary care should be applied to hospitals as it can provide a powerful and much needed boost to the hospital reform process.

Public hospitals have complex lines of authority that involve reporting to different superior institutions such as the Council of Ministers (COM), Ministry of Health (MOH), the Ministry of Finance's Treasury System (MOF) and the Health Insurance Institute (HII). Decision-making for a number of management functions such as decisions on capital investments is centralized and slow. And yet, centralization currently serves to counterbalance the influence of hospital directors who are frequently changed and may not yet possess the technical and leadership competencies and skills to be effective hospital managers.

2. OBJECTIVE

This report aims to review and analyze the legal framework for public hospital autonomy in Albania. It will seek to identify gaps, contradictions and barriers to autonomy in laws and regulations. It also will explore the discrepancies between the de facto and de jure situation regarding hospital autonomy, and, in this context, the extent to which the legal framework impedes or supports the autonomy of public hospitals. Finally, the report will propose recommendations on how to remedy

¹ Article 10 of the Law No. 10383 dated 24.02.2011 "On Compulsory Health Care Insurance in the Republic of Albania."

the existing legal impediments to autonomy so as to enable the public hospital system to fulfill the following public mandate and expectations:

- Public hospitals provide patients with health care services under the commitment of the state to the health of the population as they relate to type, quantity, and quality of service, service delivery locations, and financial conditions for delivery of services;
- Public hospitals are responsive to the expectations of patients/public and are competitive with private hospitals for the future funding from the HII;
- Patients are served appropriately in terms of professional care, ethical norms, and proper environment; and
- Public hospitals are managed in a way that increases their capability to retain the competencies of medical staff.

3. METHODOLOGY

This legal framework review was based on desktop review of primary and secondary legislation sources as well as studies and interviews from/with stakeholders from the MOH, HII, and a number of hospitals including Durres Hospital, Lezha Hospital, and Queen Geraldine Maternity Hospital in Tirana. The consultant began with developing an inventory of the existing laws, by-laws, strategies as well as institutional arrangements relating to hospital autonomy, and assessed them for any inconsistency or missing regulations. Then, the consultant reviewed the health care legislation, by-laws and regulations, decisions, orders, policies, and/or other relevant regulatory documents related to health facility/hospital autonomy, conducted a structured analysis, and prepared the report. Conclusions and recommendations for the improvement of the current legislation were based on the desk review and structured analysis, as well as select experiences of Albanian hospitals (gathered via interviews).

See Annex 4 for a complete list of legal and regulatory documents reviewed, including all laws and regulations governing hospitals.

4. LEGAL AND REGULATORY FRAMEWORK FOR HOSPITAL AUTONOMY IN ALBANIA

The legal base for hospital autonomy in all its components – financial, human resource, contractual, etc., is spread out through a number of laws and regulations (see Annex 4 for a list of laws and regulations reviewed for this paper).

The main law that covers the organization and functioning of the public hospitals is the Law No. 9106 dated 17.07.2003, “On Hospital Service in the Republic of Albania” (hereinafter “hospital

law”).² The scope of the law is laid out in its first article of the law – to regulate the organization, financing, functioning and audit of hospital activity. All these areas play a decisive role for management autonomy. Thus, the situation with regard to management autonomy aspects of public hospitals has to be assessed on the above law’s regulations as well as by looking at their impact on current management of public hospitals.

The following sub-sections of the paper provide an analysis of hospital autonomy in terms of the entities related to hospital autonomy, legal status of hospitals, hospital financing, human resource management, and contracting.

4.1 DEFINITION OF HOSPITAL AND MANAGEMENT AUTONOMY

The word “autonomy” is not used in the laws and regulations of hospitals. The law, however, uses the word “independence” which for all practical purposes could be considered a proxy for autonomy. Thus, Article 11 of the law “On Hospital Service in the Republic of Albania” provides that hospitals function on an “independent basis.” The law falls short of defining independence, a term defined in dictionaries as “self-regulating” and “not subject to control by others.”

Hospital autonomy in the context of Albanian health system may be defined as: *The degree to which decision-making regarding issues of hospital day-to-day management and hospital governance related to human resources; budgeting and finance, clinical management, procurement, contracting, is delegated by MOH and Hll to a hospital governing body (such as a board of directors) and the hospital manager (director).*

4.2 BODIES OF HOSPITAL GOVERNANCE AND AUTONOMY

The hospital law provides for the existence of several bodies (entities) responsible for public hospital governance. These are the regional public hospital authorities consisting of – the administrative council (AC), the director’s office of the regional hospital authority, and the medical committee. The administrative council is tasked with the following responsibilities: appoints and dismisses the directors of the hospitals in the region, proposes draft budgets, implements the national health strategy and health policies approved by the MOH. The other two bodies of the regional hospital authority, the director of the authority and the medical council, while mentioned in the law, do not, in fact, appear to have functions related to hospital governance. See Annex 2 for a table describing the management structures of various types of hospitals in Albania and recommendations for improvements.

While some duties of the AC resemble those of a board of directors, other essential governance responsibilities are not vested in the AC. The articles of the hospital law related to regional hospital authority were never enforced. Thus, such authorities were not established and in their absence, their respective duties, such as appointing hospital directors, remained within the authority of the MOH.

The hospital law required the COM and the MOH to issue implementing regulations for specific articles of the law within six months of its entering into force (Article 52). While making two bodies responsible for the development of certain implementing regulations of the law, the law did not assign responsibility for the establishment of the regional health authorities and their bodies. The COM Decision No.1661 of 2008³ made an attempt to remedy this omission by assigning the MOH the authority to establish the AC of regional public hospital authority and nominate its members in cooperation with local government within six months from the effective date of that COM Decision. This MOH competence on establishing the AC is also implied in the regulation of Article 17 “Dissolution of the administrative council” where it is provided that the dissolution of the AC can be realized through an order of the Health Minister. The Minister also has the right to call

² Law No. 10137 dated 11.05.2009 amended the law on hospital services in Albania. Article 20 of that amendment limits the scope of the hospital law to only public hospitals.

³ COM Decision No.1661, dated 29.12.2008, “On financing of hospital health services from the compulsory health care insurance scheme.”

extraordinary meetings of AC, at any time.⁴ As of the writing of this report, ACs have not been created.

As mentioned above, Article 11 of the hospital law states that regional hospitals are functionally independent. If the intent of the legislator was to entitle hospitals with self-regulatory functions, that was challenged by the provision of Article 23 (2) granting the Minister of Health the authority to define the organization, the structure, and the regulations of functioning of the public hospitals.

The regional hospital director is appointed by the Minister of Health. The rest of the hospital personnel, including deputy directors, are appointed and dismissed by the director. Hospital directors report that they have to receive the approval of the MOH for the appointment of their deputies. There is no evidence in the laws and regulations that such approval is required.

University Hospitals in Albania follow a different path to hospital governance. The university hospital centers, different from other hospitals, are regulated also by the Law on Higher Education.⁵ The Law No. 10037 of 2010 on amendments to the Law on Higher Education is focused in the special regulations for university hospital centers (UHC) and provides in Article 5 that such centers are units of both the education and health sectors.

According to Article 10, the university hospital centers are to be managed by the Board and the General Directory. The Board meeting convenes at least four times a year. The board is the highest governing body, which is headed by the Minister of Health or Deputy Minister delegated by the Minister, and composed of the following four members:

- Rector of the Higher Education Institution;
- Dean of the Medicine Faculty;
- Chair of Professors Council of Medicine Faculty; and
- General Director of Health Insurance Institute and the General Directory.

The Board approves development strategy and policies, as well as designs the technical-financial programs of the center's activity in compliance with governing policies for health, higher education and scientific research, and designs the strategic development plan of universities and faculties in the field of health.

The Board functions include:

- Proposes to Prime Minister two candidates for nomination in the position of General Director of UHC, already selected through competition;
- Selects, in the base of the competition results, the candidates for the position of deputy directors to be nominated by the General Director and the Rector of the higher education institution;
- Decides on the heads of the Services in the UHC, based on the candidates preselected by the ad-hoc competition commission;
- Approves the draft budget plan, the structure and the personnel chart of UHC;
- Approves the activity report of UHC;
- Approves the financial activity report and the balance sheet of UHC;
- Approves the statute of UHC and its functioning regulations; and
- Performs other functions in compliance with this law and the statute and regulations of UHC.

The General Directory of UHC is the only executive body that (under the monitoring of the Board) manages and organizes the medical, financial, administrative and technical activity of the center. The General Director is the management authority of UHC.

⁴ Article 15 point 2 of the Law No. 9106 dated 17.07.2003 "On Hospital Service in the Republic of Albania."

⁵ Law No. 9741, dated 21.05.2007 "On Higher Education in Republic of Albania," as amended by Law No. 9832, dated 12.11.2007 and the Law. No. 10037 dated 22.07.2010.

4.3 THE LEGAL STATUS OF PUBLIC HOSPITALS AND ITS IMPACT ON HOSPITAL AUTONOMY

Implementation of the law on hospitals of 2003 has been ineffective in general and in particular with regard to the establishment and functioning of Administrative Councils. The reasons behind that relate mostly to inappropriate organization, composition, delineation of responsibilities of the authority to establish the AC and appoint its members. With reference to that law, the role of the hospital directors is absent while the regional authority directory is more clearly defined but has never been established.

With regard to UHCs, their Boards and Directories are regulated separately by the law on higher education. In reference to that law, it seems that all UHCs have the same Board. This may create problems to cover the governance of four UHCs. From the perspective of the composition, none of the board members is expected to have any significant managerial role since the Minister of Health and HII General Director are very busy with other issues and other appointed members have academic profiles.

Recommendation: The legal framework on establishment, composition, competencies and functional regulations of hospital management boards has to be changed and improved.

According to Article 23 of the hospital law, public hospitals are nonprofit institutions with independent budgets. Article 29 of that law stipulates that the hospitals carry out their financial activity in compliance with law and by-laws for institutions with independent budgets. There are two issues related to the organizational format of hospitals and their “independent budget” that need further discussion. One issue is that the laws of Albania, which regulate the types of organizations that could be incorporated in the country, do not foresee the existence of and the definition for non-profit institutions. The hospital law effectively introduces this new organizational format but fails to provide the necessary detail that would enable it to be operationalized in line with the intent of the legislator.

Public hospitals are not incorporated in any of the forms provided for commercial companies that have to be registered in the National Registration Center (NRC) nor as nonprofit organizations that have to be registered in the Tirana District Court. Thus, the public hospitals are neither registered in NRC nor in the Tirana District Court. They are registered in the tax office and hold a NIPT (Identification Number of Taxable Person) for declaring and paying the social and health insurance for their employees, taxes and other purposes.

Article 25 of the Civil Code of the Republic of Albania provides that institutions which do not have economic purposes (do not exercise economic activity) are not registered (incorporated). Public hospitals that (according to the law) are non-profit institutions are considered fitting this definition and are not required to be incorporated. Given that public hospitals are allowed to collect fees from patients for hospital and other services, it could be argued whether public hospitals are not exercising economic activity and as such should not be incorporated as entities that exercise such activity instead.

The second issue related to Article 29 is that its text refers explicitly to other regulations on institutions with independent budgets. Such regulations, however, do not exist and there is no other reference to institutions with independent budgets anywhere in the laws. The only reference to the term “independent budget” in another law could be found in the articles of the law No. 7776, dated 22.12.1993 on Local Budget. That law however, neither provides a definition of the term, nor

contains a context within which the term, as used, would support an interpretation by analogy of the meaning of independent budget in the hospital law.

A more detailed analysis was prepared recently by MOH and HII in the form of a report that emphasized that public hospitals should be corporatized and governed by a BOD.⁶

4.4 HOSPITAL AUTONOMY RELATED TO FINANCING AND BUDGET⁷

The hospital law provides that public hospitals can be funded from the following sources – the MOH, HII, local government, and national and international donors (Article 24). The MOH provides funding for hospital investments. The HII provides hospitals with operating funds based on a formal contract. The funding currently is not performance based. It follows historic levels indexed for inflation.⁸ Funding from HII is itemized into budget line items.⁹ Hospitals are allowed to move funds between the line items with the permission of the HII.¹⁰ They can move between 2% to 5% of the amount in a line item.

Article 24 of the hospital law does not specify an important income source for public hospitals – the so called “secondary income” which is derived from the so called “economic activity” of the hospital, such as collecting parking fees and the fees (tariffs) for providing health care services to the uninsured and to those holders of public health insurance who chose to seek hospital services in violation of the rules of referral and various co-payments (COM Decision No. 383 of 19.06.2004 and MOH Order No. 559 of 16.10.2009).¹¹

The use of the secondary revenues is managed based on the Guidance No. 9, dated 28.03.2009 “On the use of the revenues collected by the hospitals from their activity and donations,” issued by the Administrative Council of HII. The competence to HII AC to decide on the use of the secondary revenues is given by the COM Decision No. 1661, dated 29.12.2008.

According to the HII AC Guidance No. 9 the secondary revenues include the revenues from tariffs for hospital services and revenues from economic activity. The revenues from monetary and material donations are to be used only for the purposes described in the donation document.

The *current* situation with regard to components of secondary incomes and their use is changed by two decisions of AC HII amending Guidance No. 9. Based on the HII AC Guidance No. 9 of 2009 and its amendments from 2010 and 2012, the secondary revenues obtained by the hospitals include:

- The incomes from the hospital services provided to self-referring patients, such as the revenues from the visits, tests and different examinations and issue of certificates for documentation purposes. It is worth noting that HII AC Guidance No. 6 dated 11.05.2010 excluded from secondary revenues the incomes from the reimbursement of examinations for insured persons made at tertiary facilities (tertiary examinations). These incomes are considered part of HII financing for Hospital University Centers.
- The incomes from the economic activity such as the incomes from rent, car parking in the

⁶ Reforming Hospital Payment in Albania, Report 3, MOH and HII, February 22, 2012.

⁷ *Financial management autonomy*: means the right of the hospital managing unit to decide on spending an overall and not itemized budget and the freedom to generate and spend secondary revenues on needed investments, setting personnel bonuses and using as operational expenses.

⁸ Point 18 of the COM Decision No. 140 dated 17.02.2010 “On the financing of hospital health services from the compulsory scheme of health insurance care” as amended.

⁹ Point 5 and the Appendix 2 of the COM Decision No. 140 dated 17.02.2010 “On the financing of hospital health services from the compulsory scheme of health insurance care” as amended.

¹⁰ Point 19 of the COM Decision No. 140 dated 17.02.2010 “On the financing of hospital health services from the compulsory scheme of health insurance care” as amended.

¹¹ COM Decision No. 383 dated 19.06.2004 “On the adoption of procedures, tariffs and extend of coverage of unique, tertiary examining services, included in the health insurance” as amended by COM Decision No. 592 dated 18.08.2011 “On some additions and amendments to the Council of Ministers Decision No. 383 dated 19.06.2004 “On the adoption of procedures, tariffs and extend of coverage of unique, tertiary examining services, included in the health insurance.”

hospital territory, stationery services, photocopies, different printing and other incomes.

Such incomes are to be transferred into the related branch treasury account and to be used by the director of the hospital based on certain allocation determined below:

- 30% is to be used for investments;
- 40% is to be used for buying of goods and services; and
- 30% is “to cover the service costs associated with payments of employees with service contract” (see HII AC Decision of 14.05. 2012 amending Guidance No. 9 of 28.03.2009).¹²

Before this amendment, the 30% was used for personnel bonuses. Public hospital revenues from all its sources have to be transferred to the state budget and managed through an account in the regional treasury branch.¹³ The use of funds in a treasury account is controlled so amounts held in the account and payments made via the account have to be compliant with the rules and limitations set in the treasury and laws and regulations on hospital financing and budgets. Under the rules of the treasury system, some funds left in a treasury account after December 31 are returned to the state budget. Such loss of rights over budget funds allocated to the hospital creates a disincentive for efficiency improvements. Secondary revenues are not channelled to the state budget at the end of the year. According to Guidance No. 2, dated 06.02.2012 of the MOF “On standard procedures of budget implementation,” the secondary revenues as well as incomes from donations are considered as “out of limit revenues.” This makes them transferable (added) to the facility’s budget for the subsequent year.

According to the new law on Compulsory Health Insurance coming into force in 2013, HII will provide funding to both public and private hospitals.¹⁴ Private hospitals will have more incentives to find ways to be more efficient than public hospitals as they have freedom to use the funds they will receive from the HII when and where they feel they need them most. Public hospitals on the other hand will not have such freedom. They will be limited by various regulations on the amount, the ways, and the timing of resource usage as outlined above.

The ability of public hospitals to fund themselves from secondary income is further limited by the pricings for services approved through COM and MOH decisions. The ability to adjust prices of hospital services is a key to responding to changes in market and economic conditions. Prices of hospital services have a serious influence on the decision of patients to use particular services at particular locations and particular time. Without the ability to change prices of hospital services, public hospitals cannot respond to the competitive moves of private providers who are free to set pricing based on changes in their competitive strategies, market and economic realities. Public hospitals report significant pricing disadvantage in a number of service categories compared to their private counterparts.

¹² The number of the employees with service contract is to be approved with special decision of Administrative Council of HII.

¹³ COM No. 432.2006 “On creation and administration of the revenues created by budgeting institutions.”

¹⁴ Law No. 10383 dated 24.02.2011 “On Compulsory Health Care Insurance in the Republic of Albania.”

The financing system of the public hospitals currently is based on the historic preceding budget allocated and contracted by HII with each hospital. The lack of the costing system creates difficulties that relate to the disproportional funding coverage for each hospital since there is no proportional distribution of funds based on concrete measurable factors such as expenditures for served patients and costing for the services provided.

With regard to the secondary incomes, they are based on the prices set by CoM and MoH and managed according to AC HII Guidance.

Recommendation: The budget allocated to each hospital should be based on inherent factors and along with secondary incomes should be managed and used without limitations in terms of prior approvals and already set itemization in percentages but depending on the real hospital needs.

Finally, unlike private hospitals which can access loans and equity to meet their financial needs, public hospitals are not allowed by law to borrow. Based on the Article 57 of Law No. 9936 dated 26.06.2008 “On Management of Budget System in Republic of Albania,” COM is the only authority at central level that has the right to take loans and the Minister of Finance has the authority to take loans within limits set by the annual budget law from judicial and/or natural persons.

4.5 HOSPITAL AUTONOMY FOR HUMAN RESOURCE MANAGEMENT

The largest percentage of hospital costs are attributed to personnel salaries and benefits. Effective management of human resources provides a lever to effective management of the largest cost driver in the hospital. Therefore, a key objective of the hospital manager should be to manage the staffing structure in a way that optimizes a system where volume and type of care required under their contracts with HII are challenged by the amount of available resources. To successfully manage optimization, decision-making authority should be decentralized for all aspects of human resources, including determining the staffing structure of the hospital.

The allocation of human resources of hospitals is determined by the MOH. For instance, the personnel structure for Queen Geraldine Maternity Hospital in Tirana is set by MOH Order No. 856/1 dated 26.01.2008.

Article 23 of the hospital law provides that the Minister of Health defines the organization, the structure as well as the regulations on the functioning of the public hospitals. The MOH approves the organizational structure of the hospital and with it the staffing positions across various departments/units. Employment in the public health service, including hospitals, and recruitment of hospital personnel is based on MOH Order No. 511 dated 13.12.2011 “On the criteria of employment in the public health service.” According to this order, the recruitment of hospital personnel has to be led by the hospital director, who establishes an ad-hoc commission to carry out the selection procedures among job applicants and employs the candidate selected by the commission.

The hospital law provides that the nomination and dismissal of the hospital directors is within the competence of the administrative council of the regional hospital authority. The administrative council acts upon a proposal from the executive director of the regional hospital authority.¹⁵ In the absence of these two structures, the nomination and dismissal of the hospital directors is exercised by the Minister of Health. In practice, hospital managers are frequently changed. Such practice negatively impacts continuity of leadership which is essential for long-term performance improvement at hospitals.

¹⁵ Article 14/dh of the Law No. 9106 dated 17.07.2003 “On Hospital Service in the Republic of Albania.”

Staff salaries are defined by COM Decision. Thus, hospitals are not in a position to offer competitive salaries for medical staff as private hospitals, nor can they offer bonuses. This undermines the ability of public hospitals to compete with private hospitals for the retention of qualified medical staff.

Part of the effective management of human resources includes the ability to transfer staff temporarily from one hospital department to another to meet unexpected surges of demand. The hospital directors have the right to transfer personnel between hospital departments to meet such needs.

The appointment and dismissal of hospital directors is currently under the discretion of the Prime Minister for the UHC Directors and the Minister of Health for other hospital directors.

Recommendation: To improve the efficiencies and effectiveness of services in public hospitals, recruitment, promotion, and remuneration are matters that should be governed by hospital managing units and not determined centrally. Boards of directors should be delegated the function to appoint and dismiss hospital directors based on their qualifications and objective measures of their performance.

4.6 CONTRACTUAL AUTONOMY

Contractual autonomy is broadly regulated by Articles 9 and 26 in the hospital law. According to these articles, hospitals have the right to enter into contracts / agreements with Albanian or foreign public or private health insurance companies. Public hospitals have thus far only entered into contract with HII which is a public health insurer and not with private health insurers.

According to the law on hospital services and COM Decision No. 140, dated 17.02.2010, “On the financing of the hospital services of the health care from the scheme of the obligatory health care insurance” as amended, public hospitals have an independent budget and operate in the capacity of contracting authority for procurement of services and goods for the hospital. Thus hospitals have the right to conclude contracts with vendors on their behalf.

Thus, the public hospitals follow the public procurement rules and procedures. They procure goods and services using funds allocated in their budget as well as the 30% of the secondary revenues earmarked for investments and 40% earmarked for goods and services.

When procuring goods and services, including medicines, hospitals are required to abide by Law No. 9643, dated 20.11.2006 “On Public Procurement” as amended in 2007 and 2009. As per its Article 4, the law is applicable to all public procurement procedures except the cases for procuring services and goods with high sensitivity for the national security and a special category of services. This article allows the possibility to regulate the procurement of certain areas/good/services with special laws. One such special law could be that for the procurement of pharmaceuticals.

For contracts exceeding Albanian lek 480,000 (including VAT), there are two by-laws, one issued by the COM¹⁶ and the other by the MOH¹⁷ that regulate the procurement of some categories of services and goods by the Ministry of Interior and MOH on behalf of public hospitals. Centralized procurement procedures by a central buying body are applied¹⁸ when some contracting authorities need to procure the same goods, services, and/or works. This procedure is recommended when the centralized buying provides economic benefits and when the contracting authority that acts as central buying body has sufficient knowledge for the items to be procured. Based on Point I of

¹⁶ COM Decision No. 53 dated 21.01.2009 “On putting the Ministry of Interior in charge to carry out the public procurement procedures for and on behalf of Prime-Ministry, Ministries and the depending institutions for some goods and services” as amended by COM No. 139 dated 03.03.2010.

¹⁷ MOH Guidance No. 656 dated 15.12.2010 “On the organization way and carrying out some centralized public procurement procedures in Ministry of Health.”

¹⁸ COM Decision No. 1 dated 10.01.2007, “On Public Procurement Rules” as amended by COM Decision No. 153 dated 22.03.2007, COM Decision No. 135 dated 03.02.2008, COM Decision No. 392 dated 08.04.2008, COM Decision No. 822 dated 18.06.2008, COM Decision No. 46 dated 21.01.2009, COM Decision No. 495 dated 15.05.2009 and COM Decision No. 398 dated 26.05.2010.

COM Decision No. 53, dated 21.01.2009 “On putting the Ministry of Interior in charge to carry out the public procurement procedures for and on behalf of Prime Ministry, Ministries and subordinated institutions for some goods and services” as amended by COM Decision No. 139, dated 03.03.2010, the Ministry of Interior acts as central buyer and is in charge to carry out procurement procedures on behalf of public hospitals for buying services and goods such as: vehicles, gas, stationeries, office equipment and furnishings, clothes and uniforms, electronic and telecommunication equipment, private security services, cleaning services, painting of buildings, etc.

According to MOH Guidance No. 656, dated 15.12.2010 “On the organization way and carrying out some centralized public procurement procedures in Ministry of Health” the MOH acts as central buyer and is in charge to carry out procurement procedures on behalf of public hospitals for buying medical equipment (medical devices, laboratory and dental equipment, etc.) and hospital hotelier equipment and furniture.

The law favors transparency and efficiency of procurement versus speed and flexibility. The law fits best the agenda of organizations whose annual demand of goods or services are easily predictable and fluctuate little from one year to the next. The question of how many patients will suffer, from what kind of disease and will seek care, in which hospitals, is complicated and opens up huge potential for forecasting/planning errors. The end result of such practice often manifests itself in hospitals either running large deficits of certain drugs or finishing the year with large stockpiles of unused drugs. There is a loss for the hospital, the patient and the state whenever there is a gap between actual demand and available supply. Addressing these problems requires a combination of continuous and collaborative planning and forecasting and a flexible procurement process allowing for more frequent purchases of drugs. The current procurement law and regulations provide little room for flexibility and with it little autonomy to procure in a way that enables demand and supply equilibrium at the lowest amount of resource spent.

The law on public procurement which is applicable to hospitals has created issues regarding the procurement of medicines, causing delays and stock outs in public hospitals.

Recommendation: A special regulation should be developed to govern the procurement of medicines. Such a regulation is permissible under the law on public procurement.

5. THE EXPERIENCE OF DURRES REGIONAL HOSPITAL AS A PILOT FOR HOSPITAL AUTONOMY

The regional hospital in Durres was granted autonomy under COM Decision No. 560 dated 23.10.00.¹⁹ The decision was grounded on the articles of the constitution and the law on health insurance and the law on health care.

COM Decision No. 560 declares the hospital to be a state owned non-budgetary institution. Being considered an extra-budgetary institution, the hospital has some key advantages over other public hospitals. First, it is allowed to have its own bank account (outside of the treasury system). Not being subject to treasury rules, it is allowed to retain all unused revenues from state and non-state sources at the end of the year thus having a powerful incentive to work more efficiently. Furthermore, Durres Regional Hospital is allowed to use the funds from public and private sources with the discretion of the director and the BOD. Finally, it allows the hospital to set their salary scale more flexibly (see discussion below).

The COM Decision No. 560 splits decision-making authority for hospital affairs among the MOH, HII, BOD, and the hospital manager. Thus, the HII Administrative Council decides the issue of remuneration of employees (COM Decision No. 76 dated 19.01.2007 “On some changes and amendments to COM Decision No. 560”). According to the director of Durres hospital, the hospital has developed and follows a pay scale for various positions. The scale is approved by the BOD. MOH is responsible for capital investments (Preamble). The hospital is organized and run in line with its statute (Preamble).

The BOD of Durres Hospital is responsible for economic and finance activity (Article 3). The BOD has the power to hire and fire the hospital director and its deputies upon approval of the MOH (art.13) The BOD approves the hospital contract with HII, the hospital strategic plan, and budget, the hospital structure, number of employees and wage levels, and how income is allocated (COM Decision No. 560, Article 11 of the Statute as amended by COM Decision No. 76 of 2007). The BOD is a self-regulating body, meets at least four times a year, and members receive remuneration for sitting on the board (COM Decision No. 560, Articles 8, 10, and 11).

According to an amendment in the COM Decision No. 560 from 19.01.2007, the right to determine the level of wages was granted to the HII AC. Furthermore, according to the director any changes in the organizational structure of the hospital have to be approved by the MOH. This questions the meaning or the enforcement of Article 11 of COM Decision No. 560 which appears to have left this authority explicitly within the purview of the BOD.

The director of the Durres Regional Hospital is accountable to both the BOD and the MOH, is the official representative of the hospital, reports to the BOD, proposes the hospital budget to the BOD; hires and fires hospital staff in consultation with the BOD, signs contracts and decides issues of staff training (COM Decision No. 560, Article 14 (5, 6 and 9)).

¹⁹ COM Decision No. 560 dated 23.10.2000, “On approval of the pilot project for inclusion of Durres Hospital in the scheme of Health Care Insurance,” as amended by COM Decision No. 237 dated 12.04.2006 and COM Decision No. 76 dated 19.01.2007.

The enactment of the hospital law in 2003 did not have an impact on the Durres Hospital pilot as it did not specifically overrule decision No. 560. The hospital law has no language that relates to the Durres Hospital pilot. Thus it neither repealed nor reasserted explicitly Durres as a hospital with pilot status.

There are two notable aspects about the relation between the hospital law and the pilot. The first is that the scope of the hospital law is to relate to all public hospitals in the country. The second is that it did not explicitly recognize Durres Hospital as being allowed to have a different (special) status. One could argue that the lack of recognition of the special status of Durres Hospital could be construed to mean that the law implicitly revoked the status of Durres Hospital as the new law has higher juridical power than the COM Decision No. 560 (*lex superior derogat legi inferiori* (a law higher in the hierarchy repeals the lower one)). Durres Hospital continued to operate as pilot for nine years after the law was enacted. If, despite the lack of exemption for Durres in the hospital law, the COM is not considered to be in conflict with it, one could argue that the existence of the pilot after the hospital law was enacted is legitimate in the context of one of the following assumptions:

- The Durres pilot is assumed to constitute a part of the implementing structure of the law. Thus the type of budget independence that Durres was granted *de facto* operationalized the concept of independent budget that the law mentions but does not define.
- The COM decision for the Durres Hospital should be viewed as having the rank of a special law which prevails when in conflict with a general law (in this case the hospital law) (*lex specialis derogat legi generali* (a special law repeals a general law). This argument is somewhat weak however, given that COM decisions are clearly of lower rank than law.
- The enforcement of the hospital law was insufficient, as it allowed the pilot of Durres to continue and set a precedent leaving an open door for other pilots to be accommodated. This argument is supported by the fact that COM Decision No. 560 of 2000 was amended twice, once in 2006 and again in 2007, after the law entered into force in 2003.

The regional hospital in Durres has more autonomy compared to other hospitals in Albania. The results from the pilot in Durres have demonstrated the benefits of this autonomy – more efficient use of resources for the outcomes achieved.

Recommendation: The level of autonomy granted to Durres hospital can be extended to other regional hospitals in Albania through a similar COM Decision.

6. LEVEL OF AUTONOMY OF PHC PROVIDERS IN ALBANIA

The primary health care providers have been operating with certain level of financial, human resource, and contractual autonomy for more than five years. The autonomy to PHC facilities, called Health Centers (HC), was granted by COM Decision No. 857 dated 20.12.2006 as amended.²⁰

²⁰ COM Decision No. 857 dated 20.12.2006 “On financing of primary health care services from compulsory scheme of health care insurance” as amended by COM Decision No. 680 dated 10.10.2007, COM Decision No. 564 dated 07.05.2008, COM Decision No. 509 dated 13.05.2009, COM Decision No. 520 dated 09.06.2010 and by the COM Decision, No. 53 dated 26.01.2011.

This Decision was issued as a follow on from the successful implementation of primary health care services financing piloted in the region of Berat. Decision No. 857, together with its Appendix 2 called “Common Regulation for the PHC Services Contracting,” defines the extent of decentralized governance and management, and the scope of financial, human resource and contractual autonomy of HCs.

6.1 OWNERSHIP STATUS OF HEALTH CENTERS

The PHC centers are public judicial persons, non-budgetary and non-profit with a separate bank account (Article 3 of Decision No. 857). HC facilities are reportedly owned by the MOH.

Governance and Management: The HCs are governed by a Health Center Board (HCB). HCBs function at the district level and are responsible for the governance of more than one HC. HCBs are composed of three members; the Director of the Public Health Directory,²¹ the representative of regional directory of HII, and the local government representative. The HCB is required to meet at least four times a year. Their key functions are to appoint and dismiss the HC director, to appoint and dismiss the medical staff of HC and review the HC activity. HII is granted the right to request the HCB on the dismissal of the director based on poor performance results (Article 25 of Appendix 2). The Director of the HC manages the work of the HC. In 2006, the head of HC was entitled to hiring and firing the staff based on MOH guidelines and manages the human and other resources of the HC. Following the amendment of Decision No. 857 in 2010 the hiring and firing rights for the medical staff are transferred to the HCB. The HC functions on the basis of a statute approved by the MOH (Article 4 of Decision No. 857 as amended in 2010).

6.2 FINANCING AND CONTRACTUAL AUTONOMY

The HCs are allowed to be financed from multiple sources, HII financing according to the contract with HII, payments from uninsured individuals, funds from the MOH, Ministry of Finance, or Ministry of Interior, different organizations, bank loans, donors, and other sources (Article 11 of Appendix 2). Capital investments are covered by the MOH in accordance with an annual investment plan (Article 10 and Article 18 of Appendix 2). The funding from HII to HCs consists of fixed payment, monthly performance-based payment, and quarterly bonuses (Article 12 of Appendix 2). The HC receives 80% of all payments as fixed, up to 10% for volume-based performance, and up to 10% for quality performance based on nine quality indicators as provided in Annex B amended by COM Decision No. 53 of 2011.

A key element in the financing autonomy of the HC is the freedom to open bank account in the second level banking system (Article 14 of Appendix 2). This makes the HC free to operate financially outside the Treasury rules. Appendix 2 however, sets strict rules for allocation of HC resources according to budget line itemized by HII. HC budget has to be broken down into three budget line item specifics (600, 601, and 602). Appendix 2 sets specific limits on transferring funds between these line items (Articles 16, 17, 18). It also defines that HC cannot keep a surplus at the end of the year more than 2% of its annual budget (Article 19 of Appendix 2). The use of secondary income is also limited as the HC is required to follow MOH and Ministry of Finance guidance on this subject (Article 18 of Appendix 2 and of Decision No. 857) while incomes from fees serve to co-finance the maintenance costs of HCs and are to be used in compliance with AC HII Guidance (Article 7 of COM No. 857 as amended in 2008). The MOH and Ministry of Finance approve the tariffs for the services offered by HCs for uninsured persons and the services which are outside of the basic packages of PHC services (Article 7 of COM Decision No. 857).

HCs are allowed to procure goods and services following the current laws and regulations on public procurement in Albania.

²¹ Only in Tirana is established as a pilot the Regional Health Authority to monitor the activities of Tirana health centers. The director of the Regional Health Authority is the Head of the Tirana HCB.

6.3 HUMAN RESOURCES

The number and composition of medical and non-medical staff at the HC is determined jointly by MOH and HII (Article 8 of Decision No. 857). Initially, the head of the HC was allowed to hire and fire all HC personnel. Upon establishment of the Health Center Boards, in 2010 through CoM Decision No. 520, dated 05.06.2010, the competence of hiring and firing medical personnel is given to the HC Board. Currently, only the hire and fire of support (non-medical) staff is under the discretion of the HC Director, based on Labor Code regulations (Article 26 of Appendix 2).

PHC facilities in Albania maintain a certain level of autonomy. Current differences in the degree of autonomy between hospitals and PHCs are notable in the dismissal of the HC director by a HCB as opposed to the MOH for hospitals; the payment from HII is broken down into portions one of which is performance-based payment and the lack of such type of payment in the case of hospitals; the permission for HCs to operate from own bank account and retain unused funds up to 2% of the annual budget at the end of the year in their bank account versus the obligation of hospitals to operate from within a Treasury account and not allowed to retain any funds at the end of the year (except secondary incomes). In addition, HCs have the right to obtain bank loans which the hospitals currently do not.

Recommendation: The level of autonomy granted to PHC facilities can be extended into the hospital sector through a similar COM Decision.

7. CONCLUSIONS

Except for regulations related directly to the Durres pilot and the PHC sector, the rest of the general legal and regulatory base provides little support for health facility and hospital autonomy. The hospital law, the key regulatory mechanism for hospitals in Albania, and its enforcement are weak. Two entities described in the hospital law and granted responsibilities for hospital governance therein – Administrative Councils and regional hospital authorities – have not been established, with the result that the majority of hospitals in Albania have very little autonomy related to: staffing and departmental structure, compensation levels, use (and accumulation) of financial resources from public and private sources, acquisition and disposal of assets, taking loans, setting prices of hospital services, etc. The MOH retains significant authority including the authority to define the organization, structure, and functioning of hospitals and to appoint and dismiss hospital directors.

UHCs are regulated by the Law on Higher Education, and more specifically special regulations in an amendment to the Law. These regulations set up a managing structure for UHCs that includes a Board of Directors and the hospital's General Directory. The regulations define the members of the Board and its functions. However, these Boards are highly centralized and are not really functioning. Under this Law, the Prime Minister maintains the authority to select General Directors of UHCs from two candidates that have been competitively selected and nominated by the Board.

The sustainable improvement of hospital management and operations has been further challenged by leadership turnover due to the frequent replacements of hospital directors. This has often resulted in a leadership vacuum which may negatively influence future hospital autonomy, unless the appointment practice is reconsidered to ensure not only continuity of leadership, but also transparent, merit-based selection against a defined set of qualifications and a clear process for dismissal based on documented failure to achieve performance objectives.

Experiences from Durres hospital and the PHC sector have demonstrated that health facility autonomy could be instituted in other health facilities in Albania with relatively minor changes in the legal base – such as a COM Decision that effectively waives the application of certain laws to the facility. Allowing health facilities and hospitals to maintain their own bank account outside the Treasury systems also has been critical to increasing autonomy.

8. RECOMMENDATIONS

It is recommended that improvements be made to the current legal and regulatory framework in Albania to more explicitly define and support increased autonomy of public hospitals. The two main pieces of legislation to be amended or replaced include the 2003 Hospital Law and the 2007 and 2010 amendments to the Higher Education Law regarding University Health Centers.

Given the long timeframe typically required to develop or amend laws, it may be necessary for the Albanian Government to rely on COM Decisions in the short- to medium-term, such as COM Decision 560 which granted Durres Hospital its autonomy, to grant increased autonomy to Queen Geraldine Maternity Hospital in Tirana (as a University Health Center) and Regional Hospitals in Korca and Lezha. Any new COM Decision will need to be in compliance with the new law on compulsory health insurance that will take effect in 2013. A matrix of recommendations, both general and specific to each EEHR pilot hospital, resulting from this legal analysis is below.

Recommendation	
General (short-term)	1) Establish an MOH working group on hospital management with the objective of increasing the managerial and financial autonomy of public hospitals, including making specific recommendations to amend or replace laws/regulations to address shortcomings identified in this legal review, to govern EEHR pilot hospitals in the short-term and to govern all hospitals in Albania in the long-term
Queen Geraldine Maternity Hospital in Tirana (short-term)	2) Based on the MOH working group’s recommendations, put a process in place to further amend the Higher Education Law, specifically to amend existing articles of amendments regarding boards of directors of University Health Centers in order to: <ul style="list-style-type: none"> • Revise board membership composition • Clarify roles and responsibilities of hospital boards and directors along a spectrum of issues, including strategic planning, financing, secondary sources of revenue, human resources, purchasing and contracting, quality management, community relations, etc. • Include necessary regulations to allow hospitals to respond appropriately to the new reality of payment/contracting for services per the new health insurance law coming into effect in 2013 3) Support the establishment of a Board of Directors (BOD) at Queen Geraldine Maternity Hospital and development of hospital bylaws regarding its governance 4) Provide technical support in the conduct of initial BOD meeting(s) at the hospital 5) Monitor functioning of the Queen Geraldine BOD and, if successful, extend it to other UHCs/tertiary hospital institutions in Albania
Regional Hospitals in	6) Based on the MOH working group’s recommendations, develop a

<p>Korca and Lezha (medium-term)</p>	<p>COM Decision, similar to the COM Decision No. 560 for Durrës hospital, to increase the level of autonomy for EEHR pilot regional hospitals in Korca and Lezha, including establishing hospital BODs and granting the ability for the hospitals to open bank accounts outside of the Treasury system</p> <p>7) Adapt and update the content of COM Decision 560 for the new COM Decision so that it is relevant for Korca and Lezha and complies with the health insurance law which will come into effect in 2013</p> <p>8) Support MOH in facilitating approval and issuance of the COM Decision</p> <p>9) Support implementation of COM Decision in pilot regional hospitals</p> <p>10) Monitor for lessons learned and extend (in the longer term) successful approaches to other regional hospitals (see below)</p>
<p>General (long-term)</p>	<p>11) Based on the MOH working group's recommendations, put a process in place to amend or replace the 2003 Hospital Law in order to:</p> <ul style="list-style-type: none"> • More explicitly define hospital autonomy • Regulate the establishment, as well as illustrative membership and functions of hospital boards, to be further elaborated through hospital charters • Clarify roles and responsibilities of hospital boards and directors along a spectrum of issues, including strategic planning, financing, secondary sources of revenue, human resources, purchasing and contracting, quality management, community relations, etc. • Allow hospitals to open bank accounts independent of the Treasury System • Include necessary regulations to allow hospitals to respond appropriately to the new reality of payment/contracting for services per the new health insurance law coming into effect in 2013 • Allow hospitals the freedom to set their own fees for hospital services within a range of government recommended baseline fee-for-service levels and include a clause with a process to update the recommended fee-for-service levels regularly based on solid market and economic studies • Include special provisions on procurement of pharmaceuticals to allow public hospitals greater flexibility in balancing the supply and demand of drugs in a way that ensures an optimal level of customer service and costs

See Annex 3 for more detailed recommendations.

ANNEX I

EXAMPLES OF GOVERNING BOARD²² AND ADMINISTRATOR RESPONSIBILITIES²³

RESPONSIBILITY	GOVERNING BOARD	ADMINISTRATOR (Or Delegate)
Long-term strategic plan	Approves and helps formulate	Recommends and provides input
Short-term plan	Monitors and provides input	Establishes and carries out
Day-to-day operations	No role	Makes all the management decisions
Budget	Approves	Develops and recommends
Capital Purchases	Approves	Prepares requests
Decisions on building, renovation, leasing, expansion	Makes decisions, assumes responsibility	Recommends and has contractual authority
Supply purchases	Establishes policy	Purchases according to Board Policy and maintains an adequate audit trail
Repairs	Establishes policy	Authorizes repairs up to prearranged amount including amount that can be spent without Board approval
Cleaning and maintenance	No role	Sets up schedule
Fees	Adopts policy as part of budget process	Develops fee schedule
Billing and credit and collections	Adopts policy	Proposes policy and implements

²² Note that “Governing Board” in this table has the same meaning as “Board of Directors” as described in this report.

²³ *Governing Board Orientation Manual*, Washington State Hospital Association, Seattle, Washington, www.wsha.org.

RESPONSIBILITY	GOVERNING BOARD	ADMINISTRATOR (Or Delegate)
Hiring of staff	No role	Approves all hiring
Staff responsibilities and job assignments	No role	Establishes
Firing of staff	No role	Makes final termination decision
Staff grievances	No role	The grievances stop at the administrator
Personnel policies	Adopts	Recommends and administers
Staff salaries	Approves budget	Approves salaries with recommendations from the supervisory staff
Staff evaluation	Evaluates only the administrator	Evaluates other staff
Board reports	Approves and accepts	Prepares
Medical staff	Approves bylaws, appointments and reappointments	Receives reports and maintains relationship
Quality management	Approves and monitors	Establishes quality plan and implements
Corporate compliance	Approves and monitors	Establishes compliance plan and implements
Advocacy	Knowledge of issues, communication with elected officials	Knowledge of issues, communication with elected officials
Community relations	Keeps community informed	Keeps community informed
Community health status	Approves and collaborates with community	Establishes plan and priorities

ANNEX 2

ILLUSTRATIVE TABLE OF MANAGEMENT AND GOVERNANCE STRUCTURES AT PUBLIC HOSPITALS IN ALBANIA

Public Hospitals	Management and Governance Structures	Legal reference	Recommendation
Durres Hospital	<ul style="list-style-type: none"> • Hospital Board • Director • Hospital Medical Commission • Technical Administrative Council 	<ul style="list-style-type: none"> • COM Decision No. 560, dated 23.10.2000, as amended • Statute • Internal Regulation 	<ul style="list-style-type: none"> • Composition and competences to be elaborated • Ex officio membership appointment procedures to be established
University Hospital Centers	<ul style="list-style-type: none"> • Board • General Directory 	<ul style="list-style-type: none"> • Law No.9741, dated 21.05.2007 as amended "On High Education" 	<ul style="list-style-type: none"> • Composition to be elaborated and expanded with representatives from community
Other Regional Hospitals	<ul style="list-style-type: none"> • Directory • Technical & Administrative Council 	<ul style="list-style-type: none"> • Law No. 9106 date 17.07.2003 "On Hospital Service" 	<ul style="list-style-type: none"> • Administrative Council or Board to be established

ANNEX 3

INCREASING THE AUTONOMY OF PUBLIC HOSPITALS TO FOSTER THEIR DEVELOPMENT

Hospital Autonomy Components	Current Status	Limitations	Legal basis	Recommendations
Managerial autonomy	<ul style="list-style-type: none"> Public Hospitals are partially autonomous 	<ul style="list-style-type: none"> Limit ability to freely manage its long term & short term activity 	<ul style="list-style-type: none"> All legal basis listed in this report 	<ul style="list-style-type: none"> More ability to be granted to hospital managing unit (HMU) to manage autonomously
Management Units	<ul style="list-style-type: none"> Hospitals are managed by MOH, HII & Directory 	<ul style="list-style-type: none"> No managing units in place to manage the hospital activity except Durres Hospital 	<ul style="list-style-type: none"> Law No.9106 dated 17.07.2003, "On Hospital Service in the Republic of Albania." Decision of the COM No. 560 dated 23.10.2000, "On approval of the pilot project for inclusion of Durres Hospital in the scheme of Health Care Insurance," as amended by COM Decision No. 237 dated 12.04.2006 and COM Decision No. 76 dated 19.01.2007. 	<ul style="list-style-type: none"> HMU to be established by Minister of Health & start to operate effectively The hospital director should be a non-voting member Training of HMU members on managerial skills
Human Resources autonomy²⁴	<ul style="list-style-type: none"> The Hospital Directors and deputies are nominated /dismissed by MOH. The hospital 	<ul style="list-style-type: none"> Centralized procedures for the nomination /dismissal of directory members. Frequent changes of personnel 	<ul style="list-style-type: none"> Law No.9106 dated 17.07.2003, "On Hospital Service in the Republic of Albania." Order of the Minister of Health No. 511, dated 13.12.2011 "On the criteria of employment in the public health 	<ul style="list-style-type: none"> Directory members to be appointed by HMU. Continuous training programs and specializations should be considered and planned for the physicians, nurses and administrative staff.

²⁴ **Human resources management autonomy:** means the right of the hospital managing unit to decide on hiring and firing of all hospital employees including the director and deputy directors and the freedom to set terms and conditions of employment contract, discipline and incentives.

Hospital Autonomy Components	Current Status	Limitations	Legal basis	Recommendations
	<p>personnel are hired/fired by the Hospital Director.</p>	<ul style="list-style-type: none"> • Rigid structure 	<p>service.”</p> <ul style="list-style-type: none"> • Labor Code of the Republic of Albania 	<ul style="list-style-type: none"> • It is not clear which structure is in charge for disciplining the hospital personnel.

Hospital Autonomy Components	Current Status	Limitations	Legal basis	Recommendations
Financial autonomy	<ul style="list-style-type: none"> Hospitals financed by compulsory scheme of health insurance managed by HII Hospital manages a budget itemized by HII 	<ul style="list-style-type: none"> The budget allocated to hospitals is based on historic budget and not on evidence of needs (such as number of patients). No freedom to move from one budget line to the other as the need might arise 	<ul style="list-style-type: none"> Law No. 10383 dated 24.02.2011 "On Compulsory Health Care Insurance in the Republic of Albania." COM Decision No. 140 dated 17.02.2010 "On the financing of hospital health services from the compulsory scheme of health insurance care" as amended. Complementary Guidance of the MOF No.2/1 dated 15.02.2012, "On Implementation of Year 2012 Budget." 	<ul style="list-style-type: none"> The hospital budget to be managed by the HMU in accordance with the needs. A bank account should be opened by each hospital independent of the treasury system.
Secondary Revenues Management	<ul style="list-style-type: none"> Fees & tariffs set by COM & MOH 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> COM Decision No. 383 dated 19.06.2004 "On the adoption of procedures, tariffs and extend of coverage of unique, tertiary examining services, included in the health insurance" as amended by COM Decision No. 592 dated 18.08.2011. MOH Order No 559 dated on 26.10.2009. 	<ul style="list-style-type: none"> More competencies on setting fees and tariffs for the services provided by the hospital to be granted to HMU. HMU should set those tariffs within limits set by the COM Decision.
	<ul style="list-style-type: none"> 100% to be used by the hospital under limitations & approvals imposed by HII & MOH 	<ul style="list-style-type: none"> Are used as provided by the HII AC Decision and upon prior approval of MOH 	<ul style="list-style-type: none"> COM Decision No. 140 dated 17.02.2010 "On the financing of hospital health services from the compulsory scheme of health insurance care" as amended by COM Decision No. 24 dated 19.01.20011. COM Decision No. 1661 dated 29.12.2008, "On financing of hospital health services from the compulsory health care insurance scheme" as amended by COM Decision No. 210 	<ul style="list-style-type: none"> HII AC Decision to be repealed. Destination of the secondary revenues to be decided only by the HMU without any limitation. These revenues can be used for bonuses or to hire new personnel, non-budget funded personnel. A new order of the MOH that gives the right to the HMU to decide on destination of the secondary revenues to be drafted and approved.

Hospital Autonomy Components	Current Status	Limitations	Legal basis	Recommendations
	<ul style="list-style-type: none"> • 40% for services and goods; • 30% to be used for the cover of the service costs for payments of employees with service contract. • 30% for investments upon prior approval of MoH 	<ul style="list-style-type: none"> • 	<p>dated 25.02.2009.</p> <ul style="list-style-type: none"> • HII Administrative Council Decision dated on 28.03.2009 as amended in 2010 and 2012 	<ul style="list-style-type: none"> • HMU to find possibilities to generate secondary revenues by business activity. • To be decided by HMU based on the needs of each hospital.
Clinical Management	<ul style="list-style-type: none"> • Diagnosis and treatment protocols are set by MOH 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> • COM Decision No. 140 dated 17.02.2010 “On the financing of hospital health services from the compulsory scheme of health insurance care” as amended by COM Decision No.24 dated 19.01.20011. 	

ANNEX 4

LAWS

Law No.9106 dated 17.07.2003, “On Hospital Service in the Republic of Albania.”

Law No. 7870 dated 13.10.1994, “On Health Insurance in the Republic of Albania” as amended by Law No. 8005 dated 04.10.1995, by Law No. 8961 dated 24.10.2002, by Law No.9207 dated 15.03.2004, by Law No. 9368 dated 07.04.2005, and by Law No. 10043 dated 22.12.2008.

Law No. 10107 dated 30.03.2009, “On Health Care in the Republic of Albania.”

Law No. 10296 dated 08.07.2010, “On Financial management and controlling.”

Law No. 9936 dated 36.06.2008, “On the management of the budget system in the Republic of Albania.”

Law No. 10487 dated 05.12.2011, “On the Budget of the year 2012.”

Law No. 8615 dated 01.06.2000, “On Doctor’s Ordinance.”

Law No. 9741 dated 21.05.2007 as amended by Law No 10307, dated 22.07.2010 “On High Education in Republic of Albania.”

Law No. 9323 dated 25.11.2004, “On Drugs and Pharmaceutical Services,” as amended by Law No. 9523, dated 25.04.2006, by Law No. 9644, dated 20.11.2006, by Law No. 10008, dated 27.10.2008, by Law No. 10137, dated 11.05.2009, by Law No.10350, dated 11.11.2010 and by Law No. 10410, dated 31.03.2011.

Law No. 10081 dated 23.02.2009 “On licenses, authorizations and permits in Republic of Albania.”

Law No. 10137 dated 11.05.2009 “On some amendments and changes in the legislation in force on licenses, authorizations and permits in Republic of Albania.”

Law No. 9643 dated 20.11.2006 “On Public Procurement” as amended in the year 2007 and 2009.

Law No. 7582 dated 1992 “On state enterprises.”

Law No. 10405 dated 24.03.2011 “On competences to set salaries and bonuses.”

Law No. 7926 dated 1995 “On transforming of state enterprises into commercial companies.”

Law No. 10383 dated 24.02.2011 “On Compulsory Health Care Insurance in the Republic of Albania.”

COUNCIL OF MINISTERS DECISIONS

Decision of the COM No. 87 dated 15.02.2006, “On the administration and reimbursement of the costs of refundable prescriptions” as amended by COM No. 727 dated 30.10.2007.

Decision of the COM No. 560 dated 23.10.2000, "On approval of the pilot project for inclusion of Durrës Hospital in the scheme of Health Care Insurance," as amended by COM Decision No. 237 dated 12.04.2006 and COM Decision No. 76 dated 19.01.2007 .

Decision of the COM No. 140 dated 17.02.2010, "On the financing of the hospital services of the health care from the scheme of the obligatory health care insurance "as amended by COM Decision No. 24 dated 19.01.2001, COM Decision No. 531 dated 27.07.2011, the COM Decision No. 15 dated 11.01.2012 and the COM Decision No. 314 dated 09.05.2012.

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