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REGIONAL ASSESSMENT

TECHNICAL REPORT

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ACRONYMS

ADHS	Albanian Demographic Health Survey
MoH	Ministry Of Health
HII	Health Insurance Institute
IPH	Institute of Public Health
HC	Health Center
PHD	Public Health Department
RHID	Regional Health Insurance Directorate
LSMS	Living Standards Measurement Survey
PHC	Primary Health Care
NGOS	Non-Government Organizations
USAID	United States Agency for International Development
M&E	Monitoring & Evaluation
HRISG	Health Reform Implementation Support Group

EXECUTIVE SUMMARY

The aim of the assessment described in this report is to guide the USAID-funded Enabling Equitable Health Reform in Albania (EEHR) project in identifying two regions where project activities will be implemented. As it is graphically described in the Project Framework (Annex) the activities of the EEHR project will be much more than just focusing in improving implementing capacities in two regions. The reform measures, tools and instruments will be developed based on the local needs, and (following the six health system building blocks) will be tested in the regional hospitals and will be structured with the intention not only to make these hospitals perform better, but to inform national level Policy and Planning process and the Health Insurance Institute on different measures that should be taken at national level to assure successful implementation of the reform that will bring benefits for the entire health care system.

The assessment involved a two-step process:

The first step aimed to narrow the geographical focus of the assessment and to identify regions that would need to be further evaluated. This task was performed using a desk review of the existing data (DHS 2008 - 2009 and LSMS 2008) on 10 health system and socio economic indicators (infant mortality, antenatal care, contraceptive use, malnutrition in children, adult health indicators, health insurance coverage, primary health care (PHC) expenditures per inhabitant and expenditures per visit in PHC, etc.) The reviewing and the analysis of data and also some geographical consideration revealed that further evaluation was needed for six regions: Kukes, Elbasan, Korce, Gjirokaster, Lezhe, and Vlore.

The project team drafted the questionnaires that were designed to collect information on specific issues from every institution as well as from different levels of decision-making or service provision. Organizations interviewed included the Public Health Departments (PHD), Regional Directorates of the Health Insurance Institute (RDHII), hospitals, Health Centers (HC), media outlets, and NGOs. A special questionnaire was developed to assess legislation compliance.

The questionnaires were shared and consulted with the Ministry of Health (MOH), Health Insurance Institute (HII), and other health agencies, and were also reviewed by the USAID health team. Comments and suggestions were carefully considered and reflected. Questionnaires were tested in the region of Lezha.

Second step – field visits were conducted during October- November 2011. Following the EEHR project “philosophy” of applying a collaborative approach and ensuring country ownership of the interventions, the project team in consultation with the MOH and HII agreed to create a joint team of specialists from the MOH, HII, Institute of Public Health (IPH) and the project staff to visit the six pre-selected regions and to make the assessment.

The team was required to summarize in a report the analysis of the information collected, key findings and to come up with recommendations on the two best - positioned regions for EEHR project activities’ implementation. The report presents the assessment methodology and the analyses of the information collected. In order to rank the regions were used several criteria, and a score from (1 to 6) was given to each criteria / group of criteria.

According to the assessment team, the regions that meets best the set criteria in question was given 6 (maximum), and 1 point (minimum) was given to the prefecture that meets less the criteria in question.

It is the authority of the MoH to give the final approval, and the EEHR team trusts this will be reached during the consensus meeting, that the project is planning to organize in February 2012.

KEY FINDINGS

Governance and Decision-making

The hospitals in particular require that the financial method not to be based on the historical budget but to compile budgets that take into consideration their proposals on the needs, which differ from one hospital to the other. Coverage with primary health care services is present in all the regions and the usage of these services is high. While the usage of hospital services is different, at the district level is low compare with the usage of hospital services at the regional level. This is characteristic for the most of district hospitals in districts visited during the assessment.

Data collection at district or region level in the two levels of services is functioning normally, however there are some gaps in their processing or usage in order to take steps, or interventions, to improve the epidemiological situation or the trend. The referral system influenced on the improvement of primary health care services both in terms of increased productivity of the doctors and even in enhancing the quality of the service.

The correct functioning of the referral system has eliminated the overload of work in hospitals, informal payments and indirectly has reduced the secondary incomes.

Some regional structures (PHD, RHID, and Hospital Directorate) have some gaps in some specialties, mainly at the district level (such as for example, doctors or pharmacists and that are substituted by other professions) by hindering the achievement of functional tasks of these directorates.

Quality of services

In general, regional hospitals have staff and infrastructure which responds to the level of contracted service. Meanwhile, infrastructure, equipment, and specialized doctors in hospitals at the regional level do not meet the approved standards, something which would enable the fulfillment of the health needs of the inhabitants in the areas they cover. In most cases, they only provide 3-4 services out of eight services which they should provide as according to the financing contract and that comes as a result of the absence of specialized doctors. There are hospitals with contemporary medical technology, but in some cases those technological equipment are yet to be unpacked due to the absence of specialist doctors who should use that equipment.

Some hospitals at the district level do not provide contracted basic services; as a result time has come to review their status. Regionalization of hospital services and the transformation of district hospitals into institutions that treat only urgent cases, before referring, is an action that nowadays is proposed even by the health personnel.

Role of Media and NGOs

Non-profit organizations (NGOs) operate mostly at regional levels rather than at district levels. Most noticeable regions were Korca, Elbasan, Vlora and Kukes. In general, in regions where they operate, NGOs aim the direct intervention in community (mostly in vulnerable groups, such as children in rural areas, Roma children, or even the poorer people through concrete assistance or health education). NGOs seem to have their Action Plan and health institutions are considered mostly as supporting the activity of NGOs rather than authors of the Action Plan.

Though the community is considered as an important element for the successful and sustainable implementation of reforms, it is still perceived as weak and not interested in being part of the reform or decision-making process.

Lack of journalists who deal only with health issues is one of the most noticeable factors. Media operate in two directions; through news or reports with a direct contact with doctors on different diseases.

RECOMMENDATIONS

In the end totaling the number of points and using a descending order for ranking, it was arrived in the conclusion that the regions of Kukes and Korca are ranked at the first 2 places; thus they meet

best the set criteria. Thus, these are the two regions recommended for the EEHR project to plan and implement reform measures.

The payment method of hospital services must be changed from the support on the historic budget towards financing which leads to stimulation of improvement of access and quality of health (payments for each case is recommended)

Based on the actual state of hospitals at district level (the greatest number), which cannot provide the basic contractual services, their status must be reviewed in order that they respond to the health needs of the population towards a more efficient utilization of resources in their disposal.

Health information system in all health institutions, HC, and PHD, but especially in hospitals starting with the collection and processing of the data, their analyzing, and utilization in the decision-making process requires strengthening.

The sector of monitoring & evaluation (M&E) at regional levels must be unified and its activity expanded from the center-region to the districts which comprise the Region. The establishment of capacities of persons in charge for the collection and reporting of national indicators is an immediate necessity.

Grouping of HC in large areas would create the possibility of providing health care services into two shifts, as a necessary instrument for the increase of the access of the population to healthcare services and improvements to the referral system.

Regionalization of the hospital service and adaptation of district hospitals into providing treatment only for “emergency cases” before they are referred to, is an action which is also currently proposed by the medical staff.

Directors of health institutions must draft concrete cooperation monthly plans with NGOs and local media in relation to the reform in the health care sector by taking into consideration the national calendar of health promotion

I. METHODOLOGY

As mentioned earlier, the purpose of regional assessment process was to identify two out of 12 Albanian prefectures where to focus the implementation of project activities. The two prefectures will then be proposed for selection to the newly created HRISG. This exercise was also aimed to complement the capacity building efforts that the EEHR project has initiated, in strengthening the evidence-based decision making in Albanian health sector. This section on methodology is organized in two parts, one explaining the preparations for the process and another on regional assessment implementation and reporting.

I.1 PREPARATIONS FOR REGIONAL ASSESSMENT

The selection of the prefectures is a process that started with the determination of the number of the prefectures that had to be assessed and their reduction from 12 to 6 (at the very beginning), based on the analysis of the existing data at prefecture level regarding key health and other indicators. Some of the indicators used were those of health status and service utilization (infant mortality, child malnutrition, contraception, prenatal care, adult health) and other indicators on payments and costs for health care and health insurance coverage. Data source were the Albanian Demographic and Health Survey 2008-09 and Living Standards Measurement Study 2008. The indicators definition used were the same with those used for the surveys in question.

Based on the initial analysis, the top 6 prefectures identified for regional assessment were Kukes, Elbasan, Korçe, Gjirokaster, Lezhe and Vlore. The complete rankings by individual indicator are presented in table I and also in Map I

As seen from Table I, the final ranking of the first 6 prefectures resembles to that of the distribution of poverty, but with one difference: the prefecture of Dibra is replaced by the prefecture of Vlora. Some of the main arguments of this shifting are:

- Achievement of a geographical balance north-south and east-west in the 6 selected prefectures (excluding the capital)
- Better road infrastructure with Vlora
- Worse indicators in Vlora related to the percentage of married woman of the reproductive age who use contraceptives
- In average the health of adults is worse

FIGURE I: MAP OF SIX IDENTIFIED PREFECTURES



than in Dibra

- Higher percentage of the families that encounter catastrophic payments for the health services in Vlora compared to Dibra

TABLE I. INITIAL RATING

Ranking	Indicators									
	Poverty*	Infant mortality rate	Malnutrition among children**	Lack of usage of contraceptives	Care before birth***	Health of adults****	Coverage with health insurance	PHC Cost per Capita	PHC Visit Cost	Catastrophic Payments for Care
1	Kukes	Kukes	Elbasan	Gjirokastrer	Shkoder	Korçe	Shkoder	Diber	Kukes	Korçe
2	Elbasan	Fier	Kukes	Kukes	Gjirokastrer	Gjirokastrer	Tirane	Gjirokastrer	Diber	Lezhe
3	Diber	Diber	Gjirokastrer	Vlore	Diber	Fier	Kukes	Berat	Gjirokastrer	Gjirokastrer
4	Korçe	Shkoder	Durres	Tirane	Elbasan	Vlore	Elbasan	Shkoder	Shkoder	Elbasan
5	Gjirokastrer	Berat	Shkoder	Diber	Kukes	Tirane	Lezhe	Kukes	Elbasan	Tirana
6	Lezhe	Elbasan	Korçe	Lezhe	Korçe	Elbasan	Diber	Korçe	Berat	Shkoder
7	Fier	Vlore	Diber	Fier	Vlore	Shkoder	Gjirokastrer	Tirana	Lezhe	Vlore
8	Shkoder	Durres	Fier	Durres	Lezhe	Lezhe	Fier	Elbasan	Vlore	Fier
9	Berat	Tirane	Tirane	Shkoder	Fier	Kukes	Durres	Lezhe	Korçe	Diber
10	Durres	Gjirokastrer	Vlore	Berat	Tirane	Diber	Vlore	Durres	Durres	Berat
11	Tirane	Korçe	Berat	Elbasan	Durres	Berat	Berat	Fier	Fier	Kukes
12	Vlore	Lezhe	Lezhe	Korçe	Berat	Durres	Korçe	Vlore	Tirana	Durres

* Rural areas (from highest to lowest)
 ** Percent of children that are below minus two Standard Deviations from the Height for Age Z-score
 ***Four or more visits before birth in rural areas (from highest to lowest)
 **** Non-standardized Rural Health Rural (from highest to lowest)

EEHR Project used several criteria in selecting the prefectures for the regional assessment and later for implementation of the activities. Some of these criteria such as health status, geographical position (balance: north-south) and socio-economic characteristics were taken into account during the preparation phase. For the ones that more information was needed (like factors that influence the prioritization and chances of success for the intervention, compliance with rules and regulations etc) data collection was scheduled for the second part of the process, when field visits would be undertaken and additional information collected.

The questionnaires were designed to reflect specific issues for every institution as well as the levels of decision-making or service provision (PHD, RDHII, Hospitals, HC, media, NGOs and a special questionnaire for compliance with legislation). The questionnaires were improved to reflect the comments and suggestions of colleagues by MoH, HII and other governmental health agencies, and USAID. The testing of questionnaires was conducted in the prefecture of Lezha during September.

1.2 IMPLEMENTATION OF REGIONAL ASSESSMENTS

The regional assessment process consisted of meetings, individual and/or discussions in groups with representatives of health authorities (public health, health insurance and hospital managers; health center directors) as well as with representatives of local governments, civil society and media (mayors, NGOs and radio and TV journalists).

Data collection was conducted by a group composed from the representatives of EEHR Project and MoH, HII, IPH and USAID. Data collection was organized from September 2011 - December 2011. The field visits ranged from 3-4 days in each prefecture, with semi-structured interviews in all districts that were part of the prefectures in question. The notes from the assessments in the prefectures were collected and one copy is kept by EEHR Project.

The team decided that the information collected to be organized into two large groups. The first group would contain all the information that identified issues that needed the attention of the health authorities but that were similarly outstanding for all the prefectures assessed. The second group included all the data collected that was outstanding but that could be used to rank the prefectures relative to each other.

The data collected was first described in trip reports (per each prefecture) and later analyzed by the assessment team during several consecutive meetings. As the main objective was to rank prefectures so that two of them could be recommended for intervention, the team reviewed the issues that came up from the assessment questions and grouped them by relevance and importance. As the questionnaires developed included specific sections (governance, quality of service, and role of civil society and media) but were also tailored for each of the institutions reviewed, the assessment team decided to identify a set of 10 indicators on which to rank (and later compare) the prefectures assessed.

The ten criteria identified were governance, organizational structure, referral system, information collection, media and NGOs, experience with donors, and compliance with rules and regulations. It was decided that for simplicity each of these criteria would have the same weight during calculations. Where each criterion had two or more sub-criteria, the team decided on weights as displayed in Table 2.

The team ranked the prefectures by giving 6 points (maximum) to the prefecture that had the better off situation for each criteria, and with 1 point (minimum) the prefecture that had the worse off situation for the criteria in question. After completing the scoring for all the criteria (that do not have sub-criteria) and the sub-criteria of those composed criteria, we do the calculations starting with the composed criteria and later of the total of points for each prefecture at all the criteria together. Then the regions were ranked according to descending order. The regions that ranked at first 2 places are proposed to be the ones where the project will implement its intervention.

Note that this scoring provides for a relative positioning of the regions within the group. To explain this let's take the hypothetical situation of a group of talented athletes in a 100 meters sprint race. While all the 6 athletes (prefectures in our case) score very close to the record time for a 100 meters sprint race, they all reach the finish in close but eventually different times. Same situation is valid for our assessment. Despite of the relative (to each other) ranking, all prefectures assessed scored very high during this assessment.

1.3 LIMITATIONS OF THIS METHODOLOGY

One of the limitations of this methodology is the amount of subjectivity when comes to ranking the prefectures by the criteria listed in Table 2. While the team is convinced that the relative ranking of the prefectures assessed is valid, it also understands that quantifying all of the results of the criteria used might require more work and explanation. Another limitation stems from the fact that assessment team was designed to cover the largest area within the limited period of time, and as the team divided in sub-groups that assessed different institutions at a given moment within each prefecture, the final ranking is a product of a general agreement among the team members, based on the discussion.

2. GENERAL FINDINGS

The regional assessment conducted during October- November 2011 in 6 identified regions, produced the following general findings.

2.1 GOVERNANCE AND DECISION-MAKING

2.1.1 STRUCTURE AND ORGANIZATION

- The organization of health institutions depends on the status that they have, regional or district. In general the Directorates of the Public Health, Regional Directorates of HII or Hospital Directorates in all the regions or districts have identical structures and operate according to the approval of the central institution.
- There are some cases where the structure of Directorates of Public Health and Hospital Directorates operate based on a regulation compiled by them but which are not yet approved by the central institutions , as in RPHD Kukes, in PHD Gramsh, and in Hospital Sarande.
- The structure of the Health Center and the number of health personnel is based on the number of the inhabitants that these centers should cover. The activities of the Health Centers are determined in the basic package of the services. In relation to the contracted services, mainly by the Health Center, not enough time is spent to provide services in the field of health education and promotion due to the engagement of the doctors in fulfilling a number of documents during their activity.
- Some regional structures (PHD, RHID, and Hospital Directorate) have some gaps in some specialties, mainly at the district level (such as for example, doctors or pharmacists and that are substituted by other professions) by hindering the achievement of functional tasks of these directorates. In general most of the representatives of health institutions required to have some interventions in the aspects that were directly linked to the everyday work, be that on improvement of the infrastructure, on the maintenance of the premises, on the supply with new equipment or the financing method.
- The hospitals in particular require that financing method not to be based on the historical budget but to compile budgets that take into consideration their proposals on the health service needs, which differ from one hospital to the other. Some directors of the regional hospitals, who actually do not have enough budgets, have proposed a re-distribution of funds in the last quarter of the year from the hospitals that have not used their forecasted budget.

2.1.2 COOPERATION AND COMMUNICATION AMONG INSTITUTIONS

As for the cooperation, health institutions cooperate among themselves mainly based on the approved institutional regulations. However some of the heads of health institutions (mainly PHD and RHID) do not communicate among them. While on one hand in the urban areas, communication with the local government it is almost inexistent, or it is achieved based on the respect and personal acquaintances, on the other hand in communes there is cooperation with the local government in the supportive supervisions organized by RHID.

2.1.3 DECISION-MAKING

- Decision-making is a process organized based on the interior regulation; the director has the power and exerts the decision-making authority. During the decision-making process, the heads of the health institutions, there are some cases where they cooperate with the chiefs of the sectors or chiefs of the hospital services.
- In some hospital services there is a lack of medical consultations that might be used as supportive instruments in assisting the Director to conclude health decisions on behalf of the

institutions run by him/her (this is more common in the district hospitals.)

- As for HC, decision-making operates according to its status and the regulation of Regional health Authority/PHD. In relation to decision-making of HC boards, there are decision making cases when they do not fully transmit the interests of all the interested stakeholders for the development of health sector of the respective geographical units.
- All the decisions, orders or laws related to reform are archived in every institution and are sent into the respective institution for implementation. In general they are discussed with the technical staff during weekly or monthly meetings. Changes in the heads of the institutions, very often is accompanied with the loss of legislative files of the directorate and the whole process of information must start from the beginning for the newly-appointed director.
- The decisions for the increase of capacities related to management or leadership are taken based on the level of the institutions. The need for managerial capacity building is larger in the regional health institutions, while at the district level there is greater demand for professional capacity-building. This is considered by the stakeholders interviewed as a very important issue, but it was not described in concrete subject-specific terms.

2.1.4 PRIORITY FIELDS

Interventions in the infrastructure of health institutions and in accurate management of human resources are considered by the representatives of the institutions as fundamental, something which will ensure the success of health sector reform.

Respecting the contract of specialization of the doctors who work in the respective regions, and the enhancement of financial authority of health centers (HC) for minor investments in the improvement of infrastructure, play an important role.

Most of the heads of hospital services reported inadequate financial resources, especially in the purchase of medicaments and equipment used for treatment or even for laboratory kits. At the same time, some of the heads of regional hospitals (for example, in Pogradec) raised concern that the purchase of medicaments for those hospitals at regional level led to delays and shortages in the supply with medicaments and examination laboratory kits. Furthermore, the lack of national standards in relation to the work load of the medical staff in hospitals was also observed.

2.1.5 INFORMATION, COLLECTION, ASSESSMENT, AND ITS USAGE

- Institutions have in their structure some sectors or individuals that are responsible for the collection and reporting of data in relation to the monthly activity of the institution or the completing of the health indicators. Most important sectors in this respect are the sectors of statistics (Regional Directorate Statistics of Health Care - RDSHC) and monitoring-assessment within the Regional Directorates of Public Health. What is obvious in relation to the information is the lack of necessary information systems for the planning and monitoring of activities, mainly in hospital services, and the lack of online connection between different hospital services.
- Most of health institutions have computers but not always people use them for the collection and analyzing of the health indicators. The health institutions at the regional and district level have not enough financial and human resources to realize the connection of the computers.
- Mainly, the data generated from the system is only collected and transmitted to central institutions in hard copy and electronic form. In most of the cases, data is not assessed and not used by the heads in the decision-making process (with exception to the cases of structures of Regional Directorate Statistics of Health Care (RDSHC) that are used more in PHD-Vlora, or Saranda Hospital). The interviewees do not mention problems or difficulties concerning the collection of information but in some cases there are delays in transmitting, this mostly occurs in health centers of rural areas.

2.2 QUALITY OF HEALTH SERVICES

- Demographic movement has not impacted the health coverage and it is mainly achieved with primary health care coverage in all the regions with exception to some very remote areas, which

are covered by the nearest health center.

- However, some directors of health institutions raised concern for the short term prospective of health care coverage with doctors, since currently the service is provided by retired doctors or doctors close to retirement age and the demand for employment in those areas does not exist or is practically insignificant.
- In general, regional hospitals have staff and infrastructure which responds to the level of contracted service, part of the contract is the annex which specifies the type of services offered by the hospital. Meanwhile, infrastructure, equipment, and specialized doctors in hospitals at the regional level do not meet the approved standards, something which would enable the fulfillment of the health needs of the inhabitants in the areas they cover. In most cases, they only provide 3-4 services out of eight services which they should provide as according to the financing contract and that comes as a result of the absence of specialized doctors. There are hospitals with contemporary medical technology, but in some cases those technological equipment are yet to be unpacked due to the absence of specialist doctors who are qualified to use that equipment, for example in Tepelene and Erseke.
- Strengthening of referral system supports rationalizing of the utilization of health services by the population. The referral system has had an impact in increasing the percentage of the population included in the insurance scheme (that is, receiving health insurance cards) and the performance of doctors and improving of the provision of health services.
- In the primary care it increased the level of identification of morbidity by the family doctor and at the hospital level, it has positively impacted the decline of unnecessary treatments. Besides the positive impacts, the application of the referral system has identified some issues, for example, inability to provide primary health service coverage during afternoon hours and the lack of unification of treatment protocols between the primary service and specialist doctors sometimes resulting in debates between patients and family doctors.
- Some inhabitants of geographic areas, who were closer to a city that belongs to another region in the administrative division concerning health centers or even the closest hospitals, though they were insured, were obliged to pay for health service (for example, the case of inhabitants in Mokra, region of Korça, who received their health services in Librazhd – region of Elbasan, or some areas in the region of Berat which receive the service in Gramsh- region of Elbasan, or even the case of inhabitants in certain areas of Saranda who receive health service in the hospital of Gjirokastra).
- In some hospitals there is increase of tendency related to cases classified as “emergencies.” This is considered as a way to avoid the referral system.
- Organization of reception in the entrance of hospitals and Health Centers that the team visited during the assessment process may have the effect of contributing to reductions of informal payments .
- Secondary incomes (tariffs of services for the uninsured people), among health facilities are generally perceived as decreasing. One of the reasons cited is the increase of percentage of coverage with health insurance and strengthening of referral system.
- High tariffs for health services in some cases may stimulate the avoidance of the referral system and sometimes stimulates informal payments for the uninsured. But this seems to be a relatively infrequent phenomenon (2 hospitals out of 18 mentioned it as phenomenon) due to the proper functioning of the reception at the entrance in regional or district hospitals.
- As for the secondary incomes (tariffs of services for the uninsured people), some hospitals refer that they are stable, but most cite that they are decreasing. In district hospitals levels, it is insignificant to enable any investment or staff motivation. Also, the way secondary incomes are utilized might be reviewed in order to reward personnel with high performance. The current decision regarding to the use of the secondary incomes do not directly motivate the staff.
- Private sector is well-developed in the pharmaceutical and dental service while concerning other health services they are more present in regional levels, in the regions of Vlora, Gjirokastra, and

Korça, and the main private services include diagnosing examinations and ambulatory consultations. There is not a lot of information coming from the directors of public health institutions over the activity of private health services. Regarding to the private sector it is obvious that in the most of regions visited by team in this sector are working people that are also working in the public sector. Another thing is that are also some private services working without a license.

2.3 THE ROLE OF OTHER STAKEHOLDERS IN THE PERFORMANCE OF HEALTH SERVICES

Some of the cooperation that we might mention are the ones with USAID, Medicos Del Mundo, DORCAS (a Christian relief and development organization) , WHO, and World Bank. Their contribution was focused mainly on the improvements to infrastructure, in certain equipment and medicaments, and enhancement of health personnel capacities in the management of cases.

- Non-government organizations (NGOs) operate mostly at regional levels rather than at district levels. Most noticeable regions were Korca, Elbasan, and Kukes and some NGOs are “Another Vision” , “World Vision” in Elbasan, Tabita Foundation, Center for Development of Civil Society, in Korca, Quo Vadis-Youth Center, Vatra Center, Peace Corpus in Vlore . In general, in regions where they operate, NGOs aim the direct intervention in community (mostly in vulnerable groups, such as children in rural areas, Roma children, or even the poorer people through concrete assistance or health education). NGOs seem to have their Action Plan and health institutions are considered mostly as supporting the activity of NGOs (Government Health Institutions support the NGOs in different ways: Approve the action plans already developed; make available to the NGOs, staff / specialists from the health institutions. Sometimes they support through provision of logistical infrastructure (premises, vehicles, etc) rather than aligners of the Action Plan. Government Health Institutions indeed do not get involved as co-authors in setting priorities, developing actions plans, and in designing concrete interventions. They act mostly as passive receivers / partners in the design process, which is considered to be one of the key weaknesses.
- Though the community is considered as an important element for the successful and sustainable implementation of reforms, it is still perceived as weak and not interested in being part of the reform or decision-making process.
- Media representatives consider media as a very important instrument in the implementation of the reform because media plays a crucial role in informing the public. Despite sharing the same opinion on the importance of media in the implementation of the reform, their level of engagement in health issues in different regions varies.
- Lack of journalists who deal only with health issues is one of the most noticeable factors. Media operate in two directions; through news or reports with a direct contact with doctors on different diseases: for example Egnatia TV has the program “Alo Doctor”, TV Korca has a program with direct specialists answering the public calls .
- In some regions or cities, (Korça , Kukes, Vlora, Pogradec and Saranda,) media (TV-Kukes, Radio Kukes, Egnatia TV, TV 6+1 Vlore,) seem to be more active by having a close cooperation with PHD and organize their activity based on the health promotional calendar. They have even covered elements of the reform, for example, issues on coverage with health insurance (payment methods and profits from the health system after the inclusion in insurance scheme).

3. RECOMMENDATIONS

3.1 GOVERNANCE AND DECISION-MAKING

3.1.1 STRUCTURE AND COOPERATION WITH THE OTHERS

- Every proposal for change to institutional structures must be submitted for discussions in the technical regional directorate of the given institutions prior to the approval by the head of the central institution. In order to enable presence of the specialists (doctors and pharmacists) in the regional structures (PHD, RDSHC, and Hospitals Directorates) and especially the ones in district level, one good solution could be the reviewing of payment methods and contractual terms. Identification of possibilities for the inclusion of the public health specialists or nurses with higher education in sectors of PHD that lack doctors on certain fields, would be possible solution to consider.
- In order to ensure the successful implementation of the reform, a cooperation/understanding agreement could help the directors of our health institutions and local governments to contribute together in the improvements to the health system in their regions.

3.1.2 FIELDS WHICH NEED TO BE IMPROVED OR SUPPORTED THROUGH REFORM

- One of the key factors of the success of reform is management and leadership. In this aspect, directors of local health institutions (especially PHD and Hospitals) need training programs in these fields as a requirement for the management of institutions.
- Based on the actual state of hospitals at district level (the greatest number), which cannot provide the basic contractual services, their status must be reviewed in order that they respond to the health needs of the population towards a more efficient utilization of resources in their disposal.
- The contracts of specialization of the doctors must be reviewed in order not to allow the avoidance from the obligations to work in the hospitals as stipulated in the contract.
- The payment method of hospital services must be changed from being tied to the historic budget towards financing linked to performance, which promotes improvement of access and quality of health (payments for each case is recommended).

3.1.3 DECISION-MAKING IN INSTITUTIONS

Creation of the position of managers, where directors of health institutions during the period which they are in charge must not be involved in any other professional activity and this is mostly needed in regional hospitals. Collegial decision-making must be institutionalized in hospital directorates. Meanwhile for the governing Boards of Health Centers, in their functional regulation it is needed that decision-making process fully conveys the interests of all stake-holders interested in the development of health system in their respective geographic units.

3.1.4 RECOGNITION AND IMPLEMENTATION OF LEGISLATION

Concerning the legislation, every institution must improve the method of archiving the protocol of all legal and sub legal acts. The establishment of a database for legislation according to the profile of the institutions and updating of the websites of the MoH and HII, would facilitate this process.

3.1.5 MANAGEMENT AND LEADERSHIP IN INSTITUTIONS

The establishment of capacities in management and leadership is considered as a necessity by every director of health institutions interviewed. A more clear strategy followed by an educational program would improve future decision-making and institutional autonomy.

3.1.6 HEALTH INFORMATION AND UTILIZATION

Strengthening of the health information system in all health institutions, HC, PHD, but especially in hospitals, starting with the collection and processing of the data, analysis, and utilization in the decision-making process.

The sector of monitoring & assessment at regional levels must be unified and its activity expanded from the center of regions to the districts which comprise the Prefecture. The development of the capacities of persons in charge for the collection and reporting of national indicators is an immediate necessity.

3.2 QUALITY OF THE SERVICES

- To better respond to demographic transition and geographical distribution, a review of the health institutions network is needed in the primary health care as well as in hospital care. In this direction, it is recommended to consolidate some HCs and review the status of certain hospitals at the district level.
- In remote rural areas where the possibilities of coverage with family doctors are few, the expanding the capacity for diagnosis and treatment by nurses must be considered as a possible solution to a lack of access to health care workers, based on the nurses' professional competencies.

3.2.1 THE FUNCTIONING OF THE REFERRAL SYSTEM

- In order that the poor are not excluded from access to health care services and especially from the specialized services, legal initiatives could be undertaken to include them in the health insurance scheme. Implementation of the new legislation on health insurance would be a real opportunity to solve this problem.
- Grouping of HC in large areas would create the possibility of providing health care services into two shifts, as a necessary instrument for the increase of the access of the population to healthcare services and improvements to the referral system.
- Regionalization of the hospital service and adaptation of district hospitals into providing treatment only for "emergency cases" before they are referred to, is an action which is also currently proposed by the medical staff of the facilities visited.
- Populations of certain remote geographical areas, that are nearer to healthcare services of another region, despite the fact that they live in another administrative division, should be allowed to access health care services in either district.

3.2.2 SECONDARY INCOMES AND THEIR UTILIZATION

Secondary incomes shall not be considered as a target but must be seen as a mandatory instrument to prevent further usage of unnecessary health services and stimulate the inclusion in the health insurance scheme. They should be used as a rewarding and motivating instrument for the medical personnel in order to prevent the phenomenon of informal payments.

3.3 THE ROLE OF OTHER STAKEHOLDERS IN THE REFORM OF THE HEALTH CARE SYSTEM

- The role that civil society organizations have towards the vulnerable population and the media in the implementation of health reform (monitoring and transparency) should be considered by the health sector as a powerful tool for the success of the reform and for the improvement of health services in the country

- Directors of health institutions must draft concrete cooperation monthly plans with NGOs and local media in relation to the reform in the health care sector by taking into consideration the national calendar of health promotion.

3.4 REGIONAL ASSESSMENT

TABLE 2: TITLE

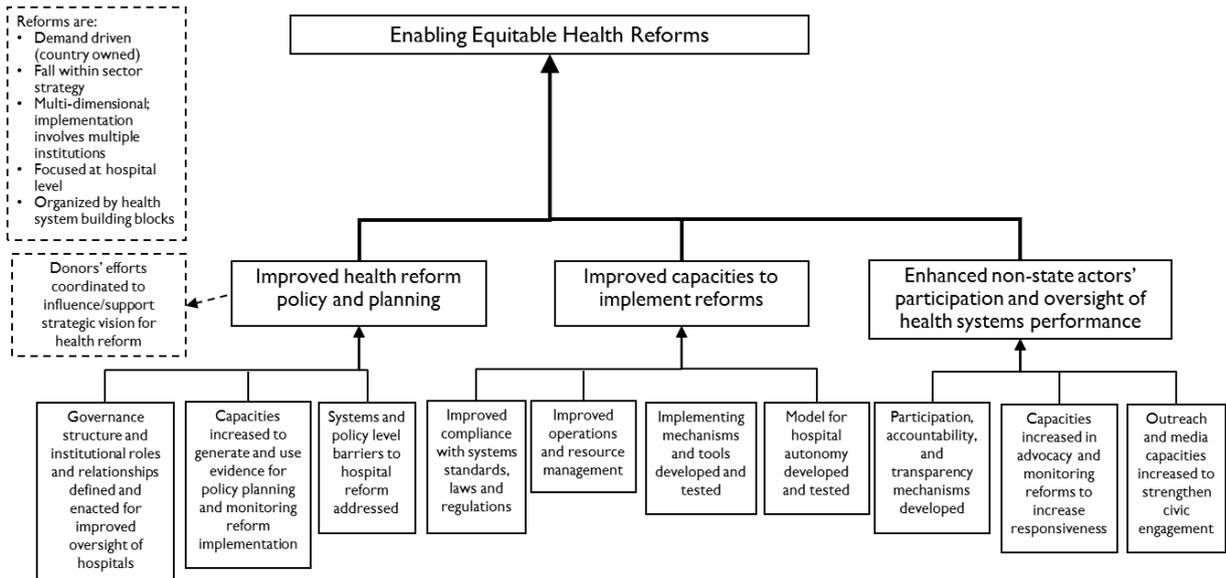
Criteria	Lezha	Kukes	Elbasan	Korçe	Vlore	Gjirokaster
Governance	3	6	1	5	4	2
- Decision-making (50%)	3	6	1	5	4	2
- Managment (50%)	3	6	1	5	4	2
Organization structure	2	5	3	4	6	1
Inter-institutional relations	2	6	4	3	1	5
Referential system	1.8	4	6	5	1.2	3
- Functioning (80%)	2	4	6	5	1	3
- Avoidance (20%)	1	4	6	5	2	3
Health insurance	4.8	2.8	2.9	4.2	4.7	1.7
- Coverage (75%)	6	2	3	4	5	1
- Secondary Revenues (5%)	1	2	5	4	6	3
- Informal payments (20%)	1	6	2	5	3	4
Information	1.8	3.4	1.2	4	6	4.6
- Gathering (20%)	1	5	2	4	6	3
- Elaboration (30%)	2	3	1	4	6	5
- Utilization (50%)	2	3	1	4	6	5
Media	1.9	3	4.3	6	3.8	2
- Existence (30%)	4	3	5	6	1	2
- Contribution (70%)	1	3	4	6	5	2
NGOs	3.3	5	1.3	6	3.7	1.7
- Existence (30%)	4	5	2	6	3	1
- Contribution (70%)	3	5	1	6	4	2
Donors	4	6	2	5	1	3
- Existence (30%)	4	6	2	5	1	3
- Contribution (70%)	4	6	2	5	1	3
Implementation of Legislations/Regulations	3	4	2	6	5	1
TOTAL	27.6	45.2	27.7	48.2	36.4	25.0

TABLE 3: REGIONAL RANKING

Ranking	
Korçe	48.2
Kukes	45.2
Vlore	36.4
Elbasan	27.7
Lezha	27.6
Gjirokaster	25.0

Based on the analysis, the team ranked the regions in the following way (see the table) .The regions that ranked at first 2 places are proposed to be the ones where the project will implement its intervention

ANNEX A: PROJECT FRAMEWORK



ANNEX B: SCHEDULE OF MEETINGS

Lezha Region

September 23, 2011

- 9:30 Meeting with. Fatmir Dushkaj, Public Health Department, Lezhe
- 10:30 Meeting with. Albina Deda, Director, Regional Health Insurance Directorate, Lezhe
- 11:00 Meeting with. Nevruz Bara, Director, Regional Hospital, Lezhe

October 21, 2010

- 9:30 Meeting with. Aleksander Picaku, Director, Public Health Department, Rreshen
- 10:30 Meeting with. Bardhok Marku, Director, Health Insurance Agency, Rreshen
- 11:00 Meeting with. Gjovalin Bushi, Director of Hospital, Rreshen
- 13:00 Meeting with. Martin Ndoj, Director, Health Center, Rubik

Kukes Region

October 25, 2011

- 9:30 Meeting with Nikolin Martini, Director, Regional Public Health Department, Kukes
- 10:30 Meeting with Mirela Shehu, Head of M&E sector, Kukes
- 11:00 Meeting with. Emin Ferhati, Director, Regional Hospital, Kukes
- 12:00 Meeting with Hasan Halili, Mayer, Kukes Mayer
- 12:00 Meeting with Qemal Elezi, Director, Regional Health Insurance Directorate, Kukes
- 14:00 Meeting with Besnik Lleshi, Director, Health Center Bardhoc, Kukes
- 16:00 Meeting with Petrit Palushi, Director, Kukes Radio

October 26, 2011

- 9:30 Meeting with Seit Jaku, Director, Has Hospital
- 10:30 Meeting with Naim Nezaj, Director, Public Health Department Tropoje
- 12:00 Meeting with Fatmir Xhepexhiu, Director, Health Center Krume Has
- 14:00 Meeting with Baudin Murati, Director, Kukes TV

Elbasan Region

November 2, 2011

- 9:30 Meeting with Bujar Kllogjri, Director, Regional Public Health Department, Elbasan
- 10:30 Meeting with Mustafa Pashja, Director, Regional Health Insurance Directorate Elbasan
- 12:00 Meeting with Pjerin Xhuvani, Director, Regional Hospital Elbasan
- 14:00 Meeting with Ermal Kumaraku, Director, Health Center Nr 4, Elbasan
- 15:00 Meeting with Aida Gjata, Director, Health Center Nr 1, Elbasan

November 3, 2011

- 9:30 Meeting with Gentian Tafaj, Director, Public Health Department Gramsh
- 9:30 Meeting with Luiza Malkja, Director, Public Health Department Peqin
- 11:00 Meeting with Fatdil Merzhezha, Director of hospital, Gramsh
- 11:00 Meeting with Naim Gjevori, Director of hospital, Peqin
- 13:00 Meeting with Liliana Rama, Director, Health Center, Gramsh
- 13:00 Meeting with Gazmend Sejдини, Director, Health Center Peqin

Korca Region

November 9, 2011

- 9:30 Meeting with Ylli Qirinxhi, Director, Regional Public Health Department Korce
- 10:30 Meeting with Eduard Shaholli, Director, Public Health Department Devoll
- 10:30 Meeting with Bujar Isak, Head of services, Regional Hospital Korce
- 11:30 Meeting with Landi Gusho, Director, Regional Health Insurance Directorate Korce
- 12:30 Meeting with Albert Hoxha, Director of Hospital, Devoll
- 12:30 Meeting with Perikli Polena, Director, Health Center nr.3 Korce
- 13:30 Meeting with Edmond Toska, Director, Health Center Devoll

November 10, 2011

- 9:30 Meeting with Alketa JAICARI, Director, Public Health Department Pogradec
- 11:00 Meeting with Artan Pilinxhi, Director of Hospital, Pogradec
- 13:00 Meeting with Violeta Collaku, Director, Health Center Hudinisht Pogradec

Vlora Region

November 16, 2011

- 9:30 Meeting with Agim Hasani, Director, Public Health Department, Sarande
- 9:30 Meeting with Lorena Imeri, Director, Public Health Department, Delvine
- 10:30 Meeting with Lorenc Xervoi, Director of Hospital, Delvine
- 10:30 Meeting with Resul Pirro, Director, Health Insurance Directorate, Sarande
- 12:00 Meeting with Arben Vogli, Director of Hospital, Sarande
- 14:00 Meeting with Elida Nikolla, Director, Health Center, Sarande
- 15:00 Meeting with Besnik Memushi, Director, Health Center Lukove

November 17, 2011

- 9:30 Meeting with Brunilda Ndreu, Director, Regional Public Health Department Vlore
- 11:00 Meeting with Besnik Elezi, Director, Regional Hospital, Vlore
- 11:00 Meeting with Krenar Malaj, Representative of Civil Society, Vlore
- 12:30 Meeting with Alketa Agolli, Director, Regional Health Insurance Directorate Vlore
- 14:00 Meeting with Erion Ymeraj, Director, Health Center Narte, Vlore
- 15:00 Meeting with Ermal Sika, TV 6+1, Vlore

Gjirokastra Region

November 24, 2011

- 9:30 Meeting with Arenc Brahimaj, Director, Regional Public Health Department, Gjirokaster
- 9:30 Meeting with Irena Shahini, Director, Public Health Department Permet
- 10:30 Meeting with Arben Kuro, Head of Services, Regional Hospital Gjirokaster
- 10:30 Meeting with Maksim Proko, Director of Hospital, Permet
- 12:00 Meeting with Teuta Kalemi, Director, Regional Health Insurance Directorate, Gjirokaster

- 12:00 Meeting with Valbona Lipe, Director, Health Center, PERMET
- 13:00 Meeting with Leonard Kalemi, Director, Health Center Dervican
- 14:00 Meeting with Ditar Hodaj, Director, Public Health Department Tepelene
- 15:00 Meeting with Astrit Zeneli, Director of Hospital, Tepelene

ANNEX C: FIELD TRIP CALENDAR

September 2011

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23 Lezhe	24	25
26	27	28	29	30		

October 2011

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21 Lezhe	22	23
24	25 Kukes	26 Kukes	27	28	29	30
31						

November 2011

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	1	2 Elbasan	3 Elbasan	4	5	6
7	8	9 Korce	10 Korce	11	12	13
14	15	16 Vlore	17 Vlore	18	19	20
21	22	23	24 Gjirokaster	25	26	27
28	29	30				