



**USAID** | **EEHR**  
FROM THE AMERICAN PEOPLE | ENABLING EQUITABLE HEALTH REFORMS

# THE ALBANIA HEALTH SECTOR REVIEWS 2011

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

July 25, 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by the Enabling Equitable Health Reforms in Albania (EEHR) project.



# THE ALBANIA HEALTH SECTOR REVIEWS 2011

## SUMMARY OF FINDINGS AND RECOMMENDATIONS

### DISCLAIMER

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



# CONTENTS

<b>1. Executive summary</b> .....	<b>7</b>
1.1 Key Findings .....	7
1.2 Priority Recommendations.....	8
1.3 Next Steps.....	8
<b>2. Background</b> .....	<b>8</b>
<b>3. Objectives</b> .....	<b>9</b>
<b>4. Findings</b> .....	<b>10</b>
4.1 Health System Governance and Leadership.....	10
4.2 Standards and Processes to Ensure and Improve Quality ..	11
4.3 Hospital Organization, Operations and Management.....	12
4.4 Monitoring and Evaluation Function: Current Status.....	12
4.5 Financing, Health Insurance and the HII.....	14
<b>5. Recommendations</b> .....	<b>15</b>
5.1 Health System Governance and Leadership.....	15
5.2 Standards and Processes to Ensure and Improve Quality ..	16
5.3 Hospital Organization, Operations and Management.....	16
5.4 Financing, health insurance, and the HII .....	16
5.5 Strengthen the Health Sector Monitoring and Evaluation Function .....	17
<b>6. Next Steps</b> .....	<b>17</b>



# I. EXECUTIVE SUMMARY

USAID/Albania's five-year Enabling Equitable Health Reforms (EEHR) Project is supporting the Government of Albania (GOA) to implement a recently enacted legislative framework to advance the health reform process. EEHR undertook a Governance Review, together with an in-depth institutional review of the Health Insurance Institute (HII) and an assessment of the capacity of the health sector Monitoring and Evaluation (M&E) function, in order to identify ways to best support the GOA. The consultancies:

- Identify gaps in the functioning of the health system, and opportunities for strengthening
- Inform reform implementation prioritization
- Developed recommended actions, solutions, next steps for the sector
- Provide detailed advice on improving the Health Sector Monitoring System and Health Financing functions
- Identify areas for EEHR project activities (what kind of support is most important and desired)

This document briefly summarizes the key findings of all three consultancies, priority recommendations for GOA and EEHR attention, and suggested next steps for dissemination, analysis, and utilization of report findings. See Annex I for details on proposed next steps for dissemination and analysis.

## I.1 KEY FINDINGS

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

To support this transition, the MOH must evolve from its historical role as both payer and provider of health care to steward, policymaker, coordinator and advocate. The legislation repeatedly recognizes the MOH as the institution responsible for policy, oversight and coordination of the sector, including responsibility for quality. The MOH has struggled with fulfilling this new role, and it is clear that capacity building is required. An ongoing culture of centralized, top-down authority further contributes to the lack of technical capacity. There is insufficient coordination and communication within the MOH, limiting staff ability to influence and mobilize others.

Greater oversight is needed to ensure that the package of individual functions, as they are currently designed, is leading to better health system performance. The auxiliary institutions (HII, National Center for Quality, Standards, and Accreditation, etc.) do not have clear responsibility to report to the MOH, in a way that recognizes the MOH's position as the leader for the sector. Thus, the MOH has inadequate leverage to ensure that all institutions work collaboratively toward a common vision.

At the national level, the new M&E Department in the MOH is functioning and gradually establishing its place in the health system. The Core Working Group has been meeting regularly, and the first products of the Monitoring System have been drafted with EEHR support. The Monitoring System is functioning among the various institutions at the technical level, but it needs to be strengthened further and the system is lacking a mechanism for bringing results to the decision making level.

Cooperation and sharing of data between the main actors in the regional health system (RHD, HII, and the regional hospital) is weak and maybe worsening. HII is the main holder of data related to financing, service utilization, and clinical performance, but these data are not consistently shared outside of HII. The result is that the data available to the RHDs or national MOH for monitoring or policy-making is not of sufficient quality and quantity.

The consultancies found that the HII has established itself as a fully-functioning reimbursement mechanism for pharmacies and primary health care facilities. HII will need to reorient its organizational structure and strengthen administration capacity to meet challenges of expanding, changing role in the sector, particularly as it takes on the hospital payment function, health insurance law role (Health Insurance Fund), and further develops methods to improve quality. PHC funding progress has been significant but more progress needed. Hospital payment system input based, and the hospital system remains inefficiently organized. There is an improving although inadequate connection between funding and quality. And while HII relationships with other health institutions are generally good, they could be improved, particularly the institution's relationship with MOH.

## 1.2 PRIORITY RECOMMENDATIONS

- A health reform and policy steering committee that is a permanent body, could provide an important forum for implementing agencies to meet regularly, clarify roles and responsibilities, coordinate activities and hold one another accountable for strategy implementation. It could also improve communication and strengthen the leadership of the MOH and provide a venue for non-governmental stakeholders and advocates to influence health care policy. In addition, the relationship between the MOH and HII needs to be strengthened and improved.
- It is recommended that HII pursue a Strategic Planning exercise, and reorient the management structure and strengthen administrative capacity to align with that exercise.
- Continued improvements in provider payment systems, including creating a stronger link between quality and performance and payment, are recommended. Per capita based payment at the PHC level should be considered, as should case-based payment at the secondary levels of care.
- Efforts to expand insurance enrollment should be continued and expanded.
- As a corollary to the hospital rationalization plan, it is time to develop training and capacity building in management at the hospital level (in preparation for reforms in the payment system).
- A realistic essential package of priority health services should be defined, including services at all levels of care, and access and quality tracked as a measure of system performance.
- M & E processes need further standardization at the national level. The role of the Regional Health Departments must be defined and strengthened, particularly these office's roles in the M & E function must be improved.

See the section below on Recommendations for further details.

## 1.3 NEXT STEPS

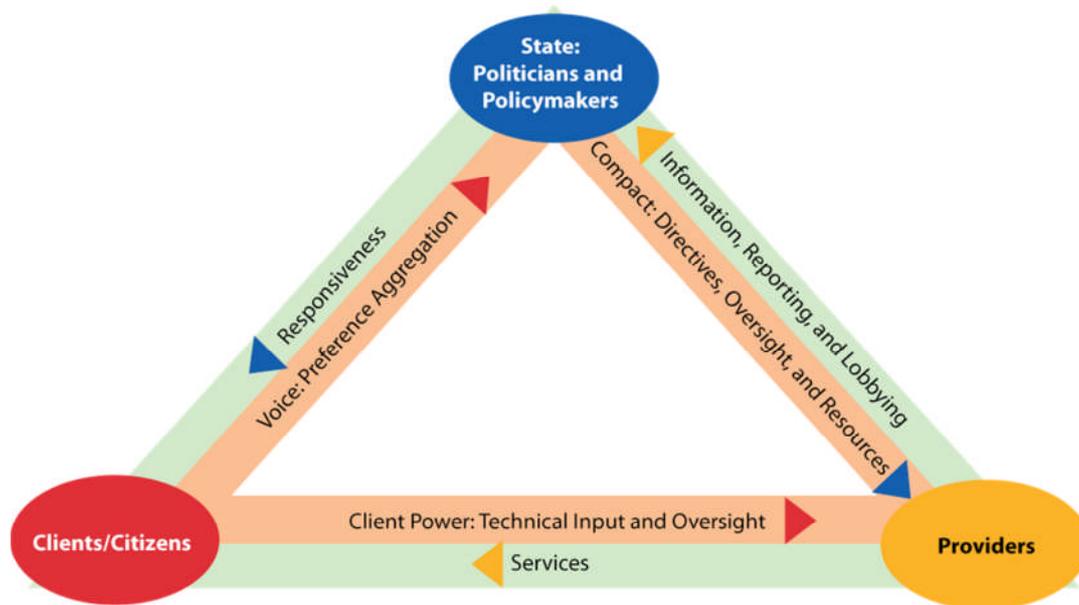
MOH and HII, with EEHR support and inputs from other stakeholders, will analyze the recommendations, prioritize and agree together on priority reforms for implementation and EEHR project activities. At that time, and in close collaboration, MOH and USAID with EEHR support will select EEHR project regions. In parallel, EEHR will proceed with system strengthening activities such as supporting the MOH in the development of an overarching health policy and reform steering committee; planning for a Leadership Development Program for national institutions; and constructing an Advocacy Strategy for the sector and EEHR project, including defining roles of non-government actors in health advocacy.

# 2. BACKGROUND

USAID/Albania's five-year Enabling Equitable Health Reforms (EEHR) Project is supporting the GOA to implement a recently enacted legislative framework to advance the health reform process. EEHR undertook a Governance Review, together with an in-depth institutional review of the Health

Insurance Institute (HII) and an assessment of the capacity of the health sector Monitoring and Evaluation (M&E) function, in order to identify ways to best support the GOA. Governance of a health sector involves government actors, providers, and patients or users of the system. The quality of governance is defined by the relationships among these actors. Thus, the EEHR project will work to support the GOA, as well as mechanisms to leverage and enhance productive contributions from the non-government actors such as the media, NGOs, provider groups, patient advocacy groups, and the general public.

FIGURE 4.I. KEY ACTORS AND RELATIONSHIPS GOVERNING A HEALTH SYSTEM



Source: Brinkerhoff and Bossert (2008)

The Governance Review assesses the state of the health reform process, areas of success and barriers to effective implementation and recommends concrete measures to build institutional managerial capacity and improve governance. It looks at governance of the over all health system, focusing on institutional roles and responsibilities as outlined in legislation, and identifying gaps in current functioning and capacity. The M & E Function Review includes an analysis of the current status of the Health Sector M & E Function and identifies areas that can be strengthened, particularly with EEHR project support. The review of the Health Insurance Institute focused on capacity building needs to fulfill this institution’s increasingly pivotal function in the system as well as next steps for health financing reform. Note that the HII consultancy was not a management review, but rather a needs assessment in the context of the broader health finance reform plans of Albania.

### 3. OBJECTIVES

The studies performed through EEHR consultancies had the following objectives:

- Map the governance structures, systems and operations of key health sector institutions at all levels, identifying critical issues regarding the effectiveness of the implementation of the reform mandates and recommending measures to improve the clarity, operational efficiency, capacity and delivery of the system and its key institutions.
- To assess M&E System and provide expert technical assistance to the EEHR Project, MOH M&E Department to use the Health Sector Monitoring System as a tool that will provide:

- Information, analysis and evidence to use in the process of health sector priority-setting and policy development; and
- On-going dialogue to address current and emerging health sector challenges and ensure effective coordination of all stakeholders in the health sector.

Although HII was considered as part of the Governance Review study, EEHR and the team of consultants designed, and implemented a special study in conducting the institutional review of the HII. Among other things, the review explored the relationship between HII and hospitals. Findings of the review will be used to guide HII and the EEHR project in increasing HII's institutional capacity, defining priority health financing activities for implementation, developing strategies to enhance the relationships between HII and health facilities/hospitals, and identifying technical assistance needs within the project's result framework, focused on increasing access to essential health services for the poor.

## 4. FINDINGS

### 4.1 HEALTH SYSTEM GOVERNANCE AND LEADERSHIP

The MOH is charged with providing overall vision, leadership and governance for health care in Albania. The Basic Health care law states that the MOH "prepares health care system strategy, which includes policies and appropriate health programs and national treatment protocols." The MOH has developed the National Health Strategy 2007 – 2013 which presents the sector's mission statement, strategic priorities, policies, tasks for policy implementation and budget implications and is used by health institutions as the basis for planning.

While the MOH is both by law and position the organization charged with developing and implementing the national health strategy, it has yet to establish its authority and provide leadership for the sector. Positions of authority within the MOH have generally been given to minority political parties within the governing coalition, giving it little leverage to influence the national priorities of the GOA. In addition, MOH leadership has suffered from frequent turnover with four ministers serving in the span of five years. The impact of this is magnified by the fact that politically-appointed positions within the MOH include heads of Directorates and Sectors and even Hospital Directors who are often replaced when there is a change of Minister. Frequent turnover at so many levels of the ministry weakens its institutional memory and leadership capacity. Additional findings regarding sector governance and leadership are as follows:

- A health reform task force is established:
  - There is no legislation that mandates the existence and establishes the authority and purpose of this task force
  - Serves as an ad-hoc advisory body
  - Presents an opportunity to get important health issues on the national agenda
  - Sets a precedent for the establishment of a decision – making forum
- Priority setting and policy making:
  - Priority setting and policy making at the MOH has been limited by highly centralized decision – making, frequent turnover at the leadership levels, unclear roles and responsibilities and poor communication
  - There is no effective reporting system to communicate decisions to the implementation levels: this communication gap is greater between MOH and other health sector institutions.
- The development of regulations, budgets, incentives and oversight to ensure implementation:

- A highly – centralized decision-making has limited the degree to which policies are communicated and understood by technical staff and, in turn translated into regulations, budgets and implementation plans.
- Critical areas that need to be strengthened include disseminating regulations to the health facilities, providing necessary training and ensuring supervision
- Coalition building, coordination among health institutions, with donors and other stakeholders:
  - Coordination both among staff within directorates of the MOH as well as between MOH staff and technical counterparts in other health institutions is not sufficient.
  - High turnover of technical staff, changes in the organizational structure, as well as relatively recent formation of new MOH supporting institutions, such as the NCCE and the NCQSA, has led to confusion of roles, responsibilities and lines of communication.

## 4.2 STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY

The NCQSA and the NCCE were created to strengthen and support the MOH in efforts to improve quality. The NCQSA is mandated to improve quality of care and implement a process for accrediting hospitals. The NCCE assures the quality of continuing medical education to strengthen the capacity of health care providers to provide quality care. While the roles of the MOH and these supporting institutions are defined in various laws, in practice there is confusion about responsibilities, duplication of effort and poor coordination of activities.

- Develop, disseminate and implement standards, protocols, clinical guidelines to improve quality:
  - MOH and NCQSA have limited capacity to implement quality improvement
  - HII has developed quality indicators of its HC contracts but they do not really measure quality
  - No mechanisms in place for ensuring accountability
  - MOH, NCQSA are not responsive to HII needs
- Analyzing and using data to inform policy making:
  - M&E directorate still lacks the needed capacity to analyze data and present it to decision-makers.
  - IPH monitors epidemiological data and conducts special studies to identify health issues and develop a research agenda.
  - A National Council on Public Health is being formed to serve as an advisory body to high level policy makers on public health issues.
- Accreditation of hospitals:
  - Although the roles and responsibilities of the NCQSA and the MOH are clear on paper, in practice there is limited capacity to coordinate and manage the accreditation process and delineation of responsibilities is unclear.
  - As currently implemented the accreditation process will take a very long time and will be difficult to implement throughout the country.
- Registration, licensing and recertification of health providers:
  - NCCE and the Order of Physicians have developed databases on CME; however these is no clear mechanism to share the information with the MOH sector of human resources, in order to improve manpower planning and identify critical training needs.
  - CME courses are limited and do not cover the training needs of providers all over the country.
- Continuing medical education:

- While the NCCE seems to be fulfilling its role in accrediting training and tracking providers' credits earned, its capacity is limited in meeting the large and varied demand for training.
- Health providers from remote areas are at a distinct disadvantage in terms of accessing training opportunities.
- There is not a good coordination between MOH, order of physicians and NCCE in regard to CME program.

### **4.3 HOSPITAL ORGANIZATION, OPERATIONS AND MANAGEMENT**

Key findings on hospital organization, operations and management are as follows:

- Overall planning for hospital sector:
  - There is not a coherent policy for hospital distribution.
  - There is no mechanism to ensure stakeholder input in hospital planning.
- Hospital financing:
  - HII has made progress towards case – based financing.
- Hospital management:
  - Authority of hospitals and HCs as autonomous institutions is unclear.
  - Hospitals do not have guidance or skills to establish hospital boards and define their functions.
- Monitoring and oversight of services:
  - MOH has insufficient capacity to monitor and oversee hospitals' activity

### **4.4 MONITORING AND EVALUATION FUNCTION: CURRENT STATUS**

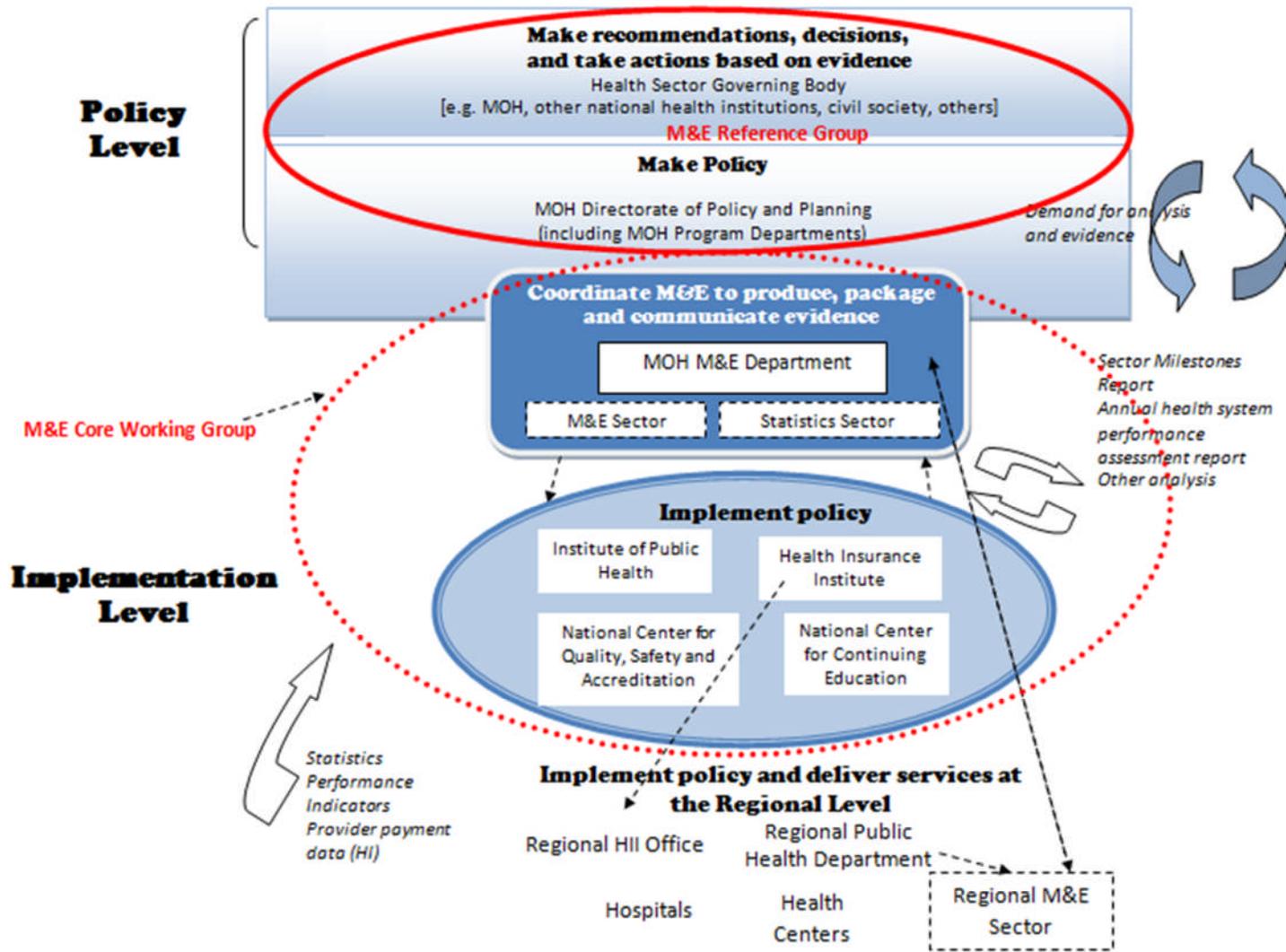
#### **The Health Sector Monitoring & Evaluation Function: National Level**

The new M&E Department in the MOH is functioning and gradually establishing its place in the health system. M&E directorate has successfully coordinated a collaborative effort involving HII, MoH, IPH, NCQSA and NCCE to generate and present its first round of annual reporting on the performance of the health system. The Core Working Group has been meeting regularly, and the first products of the Monitoring System have been drafted with EEHR support. The Monitoring System is functioning among the various institutions at the technical level, but it needs to be strengthened further. These first steps are useful and in the right direction. However, the system is lacking a mechanism for bringing results to the decision making level.

#### **The Health Sector Monitoring & Evaluation Function: Regional Level**

Cooperation and sharing of data between the main actors in the regional health system (RHD, HII, and the regional hospital) is weak and maybe worsening. The data flow to the MOH from regions is problematic. MOH should enforce data reporting requirements. HII is the main holder of data related to financing, service utilization, and clinical performance, but these data are not consistently shared outside of HII. The result is that the data available to the RHDs or national MOH for monitoring or policy-making is not of sufficient quality and quantity for monitoring, evaluation, and health policy decision-making.

FIGURE I. SCHEMATIC OF POLICY PROCESS AND M&E FUNCTIONS

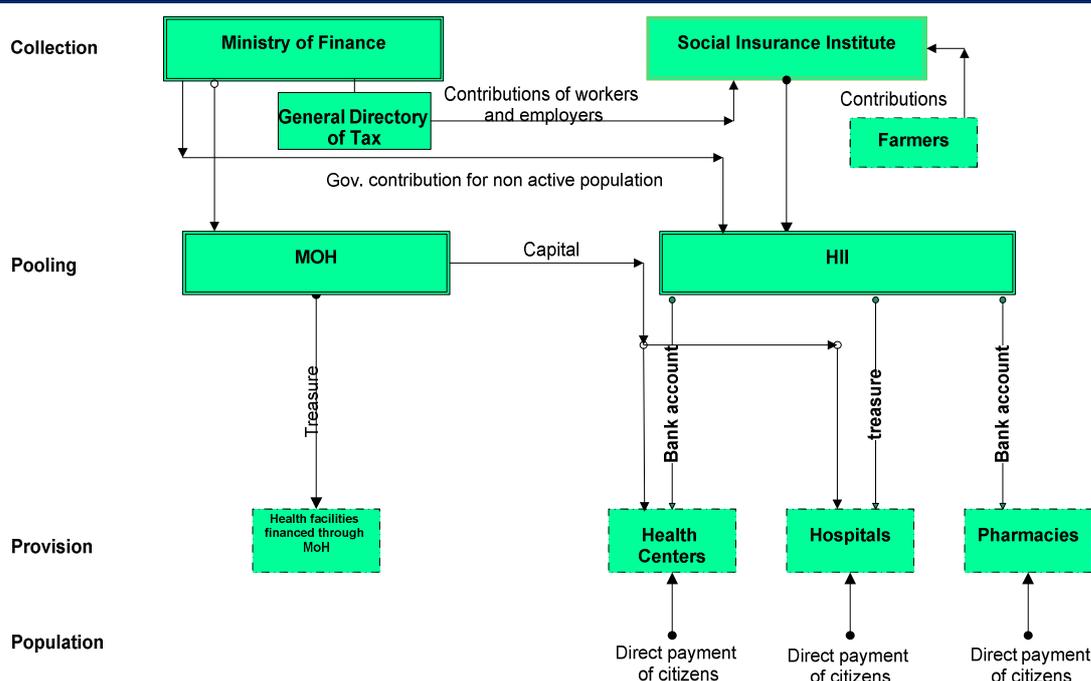


## 4.5 FINANCING, HEALTH INSURANCE AND THE HII

There are complex issues in enrolling eligible population and collecting premiums. HII estimates that there are approximately 1.2 million registered insured (carrying an insurance booklet.) Of the registered insured, the large majority are pensioners for whom no contributions are required. The HII is responsible for registering the insured individuals, but responsibility for collection of premiums is split between the General Tax Directorate (for those formally employed), the Social Insurance Institute (SII) (for farmers), and the HII (for individuals making voluntary contributions.) Many individuals that contribute to the insurance scheme through the Tax Directorate or SII do not register at HII with documentation of their contributions to receive an insurance booklet. Health centers and family doctors, as part of their contract with HII, are meant to encourage patients and their catchment population to register with HII. Nonetheless, insurance booklet holders represent approximately 42% of the population, based on 2008 LSMS data. Other key findings are grouped as follows:

- Defining a hospital benefits package:
  - HII and MOH do not appear to have a clear plan in developing the hospitals' package of services.
  - Patients are not engaged in discussions regarding benefits' package.
  - MOH has not taken responsibility for policy guidance on allocation of HII expenditures between PHC and hospital care.
- Overseeing provider quality:
  - HII has developed good systems for provider oversight, but does not have sufficient input to ensure appropriate elements of quality are included.
  - MOH capacity to enforce quality standards is weak.
- Oversight of HII:
  - The MOH is responsible for oversight, but exerts little leadership and authority over HII or other health institutions.
  - In addition to leadership and policy setting, MOH capacity in coordinating the relevant actors is weak.
  - There is not a mechanism to collect feedback from patients and the general population .
- Health Insurance Institute: Challenges and Opportunities
  - HII has established itself as a fully-functioning reimbursement mechanism for pharmacies and primary health care facilities.
  - HII will need to reorient its organizational structure and strengthen administration capacity to meet challenges of expanding, changing role in the sector, particularly as it takes on the hospital payment function, health insurance law role (Health Insurance Fund), and further develops methods to improve quality.
  - PHC funding progress has been significant but more progress needed.
  - Hospital payment system input based
  - Inefficiency in the hospital system
  - Inadequate connection between funding and quality
  - HII relationships with other health institutions good, could be improved

**FIGURE 2: HEALTH CARE FUNDING FLOW IN ALBANIA (2011)**



## 5. RECOMMENDATIONS

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

### 5.1 HEALTH SYSTEM GOVERNANCE AND LEADERSHIP

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

## 5.2 STANDARDS AND PROCESSES TO ENSURE AND IMPROVE QUALITY

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

## 5.3 HOSPITAL ORGANIZATION, OPERATIONS AND MANAGEMENT

- Support MOH Hospital Directorate to define and fulfill its role, clarifying responsibilities of MOH, HII, Regional Health Directorates, and HIRDs. EEHR might consider seconding a staff person that mentors the Hospital Directorate to: develop a proposal for discussion of specific roles, authority, functions and inter-relationships of various institutions; strengthen skills in leading multi-institution meetings and facilitating agreement and follow-up; develop strategy to advocate for additional resources to support activities of all institutions. EEHR may also support a consultant to facilitate such discussions.
- Support stakeholders to develop and implement a coherent policy/plan for the hospital sector. Because one of the key constraints is political willingness to act on hospital rationalization plans, EEHR focus may be in the areas of political analysis and strategic communications to manage negative public reaction.
- Support hospitals in focus regions to progress toward autonomous institutions, including improving management skills and structures in hospitals, and supporting self-assessment and problem quality improvement in preparation for NCQSA accreditation.
- Assist MOH to develop guidance for Regional oversight of hospitals in collaboration with HII.

## 5.4 FINANCING, HEALTH INSURANCE, AND THE HII

- Support focus regions to improve registration systems with a combination of consumer education, provider incentives through HC contracts, and incentives for new registrants. EEHR might also facilitate collaboration with CSOs and media organizations to support this effort.
- HII should consider conducting a strategic planning exercise to prepare itself as an institution for taking on the full functions as delineated in the recently passed law on health insurance.
- Support HII at central level in discussions with other government agencies to obtain data they need on contributors.
- Support focus regions to pilot new HC contracts with capitated payments based on registered insured, and other payments for non-registered patients

- Improve the capacity of MOH as leader and coordinator for quality-related issues in health insurance. Possible activities might include articulating a national strategy to integrate the functions of financing, facility accreditation, CME, and oversight and coordination, with clear roles for all institutions and subnational entities.
- Support MOH and HII to set and disseminate clear priorities for health insurance, including developing strategies for universal coverage and financial risk protection, in addition to cost containment and efficiency. Activities may include facilitating senior level agreements between MOH and HII, and supporting dissemination of such agreements throughout the respective organizations and the health system.
- Support joint planning between MOH and HII to implement insurance reforms, including an agreed approach and detailed workplan toward case-based payment for hospitals and improving provider quality.

## 5.5 STRENGTHEN THE HEALTH SECTOR MONITORING AND EVALUATION FUNCTION

- Strengthen Core M & E Processes
  - Standardize key processes, products of the Monitoring System
  - Strengthen the program departments of the MOH to plan their activities, set milestones, measure progress, and improve performance
  - Appoint a focal person for M&E in each health institution
  - M & E in job description
  - M&E Department and focal persons in each institution to be trained in research methods, data analysis, M&E and making better use of data for decision making
  - Training for MOH and national health sector institutions in modern performance improvement techniques (supported by NCQSA)
- Strengthen data sources, quality and flows:
  - Clearly establish the role of the RHD M&E Sectors in the implementation of the M&E Framework.
    - For example, make RHD responsible for routine data collection & analysis of information needed for policy—e.g. routine health facility surveys and clinical audits
  - Provide regional level training in data collection, analysis, M&E and use of data for decision making
- Establish a mechanism to bring results of the M&E system into an evidence-based policy and decision-making process.

## 6. NEXT STEPS

The following next steps are proposed. See Annex I for a detailed proposal and action plan for consultancy dissemination, analysis, and GOA prioritization of health reform implementation and EEHR project activities.

- Selection of priority reforms and implementation
  - MOH, HII with EEHR support will analyze the recommendations, prioritize and agree together on the activities
  - Consolidated brief to be produced and disseminated

- Internal meetings in September
- Work with MOH to develop TOR for overarching governing mechanism for health policy and reform
  - Build on current relationships/committees
  - Identify roles for non-government stakeholders
- Wider stakeholder meeting: October/November
- Selection of EEHR project regions
  - Close collaboration with government to establish criteria and select regions
  - Secondary data analysis
  - Visits to regions (September, October 2011)
    - Validate findings
    - Test feasibility of potential EEHR-supported activities to implement reform
- EEHR will pursue with the GOA parallel system strengthening activities
  - Support development of Terms of Reference for Health Reform and Policy Steering Committee
  - Leadership Development Program planning
  - Advocacy strategy
    - Including role of the non-government sectors