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ALBANIA HEALTH INSURANCE INSTITUTE REVIEW: CHALLENGES AND OPPORTUNITIES

TECHNICAL REPORT

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CONTENTS

Acronym list **7**

1. Executive Summary **9**

2. Background **11**

3. Objectives **12**

4. Methodology **13**

5. Findings **14**

5.1 Health Insurance Development in Albania (1995-2010) 14
5.1.1 Revenue Collection 14
5.1.2 Pooling of Funds 14
5.1.3 Provider Payment Systems 16
5.2 The Future of Health Insurance Reform 19
5.3 Management and Organization of HII 20
5.3.1 Governance and Management 21
5.3.2 Administration and Organization 21
5.3.3 Management Functions 22
5.3.4 The Relationship between HII and Other Key Institutions 22

6. Recommendations **25**

6.1 Develop a Strategic Plan for HII 25
6.2 Develop a Plan to Strengthen HII Management and Organization in Line with the Strategic Plan 25
6.3 Continue to Refine and Improve Provider Payment Systems 26
6.3.1 PHC Payment System 26
6.3.2 Drug Reimbursement 26
6.3.3 Hospital Payment System 26
6.4 Continue to Consolidate and Strengthen Hospitals 27
6.5 Link Payment to Quality 27
6.6 Increase Insurance Coverage 28
6.7 Continue Efforts to Reduce Informal Payments 28

7. Conclusion **29**

Annexes **31**

Annex A: Contacts and field Work Schedule 33
Annex B: List of Reference Documents 35
Annex C: Case-Based Provider Payment Systems: An Introductory How-To Outline 37
7.1 Annex D: HII Organizational Structure 39
Annex E: HII Revenue and Expenses 1995-2010 40

ACRONYM LIST

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

1. EXECUTIVE SUMMARY

The Health Insurance Institute (HII) has made significant progress over the last 15 years to move toward a single-payer model for the implementation of compulsory health insurance coverage in Albania. This progress has been made in coordination with a national strategy for health reform by the Government of Albania (GOA), the Ministry of Health (MOH), and other GOA and health sector institutions. The process of health reform and health insurance development has been supported by the United States Agency for International Development (USAID), the World Bank (WB), the European Union, and others. While the overall health reform efforts in Albania have perhaps evolved slower than envisioned, HII has pushed forward to develop and implement new reimbursement schemes for pharmaceuticals and primary health care (PHC) centers. Recently, HII has moved into payments to the secondary and tertiary hospital sector, ensuring that it will play an increasingly critical role in the health reform process in Albania. The effective implementation of the new Law on Compulsory Health Care Insurance, as well as the future of national health reform efforts, will depend strongly on the future success of HII.

This report is one of the first outputs of the new five-year USAID-funded Enabling Equitable Health Reforms (EEHR) Project. The objective of the report is to present an institutional review and analysis of HII and to make recommendations for continued strengthening and capacity building as needed. The report consists of two major sections: Findings which describes and analyses HII in the context of its role in the health system today and its planned role in the near future; and Recommendations which includes recommendations for HII as well as suggested technical assistance priorities to support their further development and capacity building given their new roles and responsibilities.

HII has grown significantly from its beginnings in 1995. Revenue has grown from 872 million Albanian Lek (ALL) in 1995 to 25.8 billion ALL in 2010, with expenditures likewise increasing from 414 million ALL to 25.3 billion ALL over the same period. The number of personnel has increased to a present level of 610 personnel in 12 regional offices and three branches. HII reimbursement programs cover 690 pharmacies, 160 agencies and 80 drugstores, 421 primary care health centers in 36 districts, and more recently 39 secondary and tertiary facilities in the hospital sector. In 2010, HII developed and implemented formal contracts with over one thousand providers. The MOH is a key partner for HII, setting overall health policy (including health financing policy in theory) and chairing HII's Administrative Council. However, as in most countries that have transitioned payment of health care providers to a new and quasi-independent entity, coordination between MOH and HII on key policy issues could be improved and the relationship strengthened. It is within the context of this relationship, and the movement toward a single payer system for Albania, that EEHR, in agreement with HII and USAID, conducted this institutional review of HII management and organizational activities, programs, and services.

It is the conclusion of this institutional review that HII has made significant progress and has fully established itself as a reimbursement mechanism for payment of pharmacies and PHC facilities in Albania. The recent expansion into hospital payment is still in the very early stages. As international experience has shown, the secondary and tertiary sector provider payment systems are more difficult to develop and implement. HII will need to develop effective financial and quality improvement systems with incentives, which can reward performance at the institutional level, and which could contribute substantially to the restructuring of the entire secondary and tertiary health sector. The HII will need to move from being just a "payer" for hospital services, toward becoming a "strategic purchaser" of hospital services which will eventually include prospective rates of payment, with specific service delivery, quality, and performance indicators. Such a system may take many years to accomplish and will require working closely with the MOH and other stakeholders.

This report outlines the recommendations and the technical assistance required to increase capacity building in HII and its related partner institutions. HII would benefit from a strategic vision and plan agreed upon with the GOA and MOH as it moves forward. As HII's responsibilities have increased significantly recently, this strategic planning may need to be accompanied by management and organization planning, including reviewing the number and functions of departments, lines of responsibility among departments and staff, and management and technical capacity. In order to develop and implement these new programs, HII requires technical assistance to increase capacity in the areas of management, organization, financial and risk management, information technology, and provider payment systems (PPS). The PPS for PHC may continuously be refined – HII may consider implementing per-capita allocations of funds and keeping performance-based payments above the per capita rate. At hospital level, HII should take concrete initial steps to begin development of a case-based/case mix provider payment system.

Maintaining an effective relationship between the HII and the MOH should continue to be a high priority. The MOH and HII also will need to support business planning for hospitals, including identifying any opportunities for optimization of hospitals. It is also important to understand barriers to greater levels of insurance coverage among the population and to take steps to expand coverage. Lastly, HII should develop mechanisms to link payment to improvements in quality of care and continue efforts to reduce informal payments.

2. BACKGROUND

This HII institutional review was conducted as part of the implementation of the EEHR Project's Year 1 work plan in agreement with USAID and HII.

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

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

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

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

One of the main priorities of the MOH in its Health Sector Strategy concerns the improvement of health system financing. This review of HII – the key institutional partner on health financing with new responsibilities codified in the recently passed Health Financing Law – relates to the capacities needed to effectively perform its emerging and expanding role in the health sector.

3. OBJECTIVES

The objectives of this in-depth institutional review of HII are to:

- Help HII assess its readiness and capacities to perform existing tasks and take on new responsibilities in the health sector; and
- Identify areas for institutional capacity building, including potential areas of EEHR Project support.

4. METHODOLOGY

The review was conducted in April-May 2011. The methodology used for the review consisted of:

- Collection and review of background documents prior to field work;
- Meetings to discuss objectives and processes with the EEHR team at the project office;
- Interviews with USAID and other counterparts;
- Interviews and data collection with key stakeholders at HII, MOH, and other relevant health sector institutions;
- Site visits to regional facilities (Shkodra) and a private hospital in order to observe conditions and discuss various issues, relationships, roles, and responsibilities; and
- Analysis of findings and presentation of recommendations.

A local health finance specialist was deployed prior to the arrival of two international consultants to perform the initial identification, collection, and review of documents relevant to HII's evolving history and mission, organizational structure, processes, and relationship with other health sector institutions. The consultants reviewed over 100 laws, Council of Minister decisions, reports, papers, and documents for this report. Building on this work, the consultant team met with key local stakeholder institutions and others to construct a draft description and analysis of HII's operational/functional relationship with the MOH, other key health institutions, PHC facilities, hospitals, the private sector, Ministry of Finance (MOF), the Prime Minister's Office, and other government and civil society stakeholders.

The institutional review team also carried out a review (not an audit) of the various departmental and section functions and activities of HII. The team reviewed formal departmental descriptions, interviewed departmental personnel and discussed systems, problems, and issues with them. The team reviewed documents and key functions and tasks of each department. Lastly, the team travelled to one region, meeting with the HII office to review their operations, visiting a regional hospital and a municipal health center, and meeting with other stakeholders in both the public and private sectors.

The consultant team for this review included George Purvis, MBA, an international Health Systems and Health Finance consultant who has worked on health reform in the Eastern European region for the last 20 years; Ainura Ibraimova, MD, an international Health Insurance specialist and a former Deputy Minister of Health and Director General of the Mandatory Health Insurance Fund in Kyrgyzstan; and Flora Hobdari, PhD, an international Health Finance consultant with over 15 years of experience working with HII, its institutional partners, and donor-funded projects in Albania on health financing reform.

The consultant team worked closely with EEHR Project staff and the team's findings and recommendations were reviewed by Project staff in Albania and technical specialists in Abt Associates' home office.

5. FINDINGS

5.1 HEALTH INSURANCE DEVELOPMENT IN ALBANIA (1995-2010)

Establishment of HII was a major part of health care reforms in Albania that began in the mid-1990s. HII was created based on Law No. 7870, dated 13.10.1994 "On Health Insurance in the Republic of Albania" (amended) and the Decision of the Council of Ministers, No. 613, dated 20.12.1994 "On the Approval of the Statute of the Health Insurance Institute." HII was established to manage a health insurance pool of funds to be financed by earmarked payroll contributions.

The legislation stated that HII was to become an autonomous public body governed by an Administrative Council and managed by a General Director. Under the new structure, HII was required to develop operations in all 36 districts of Albania and build the capacity of its staff. HII activities began with the funding of the reimbursable drug list in March 1995, and then followed with the coverage of wages of general practitioners (GPs) at the PHC level. HII supported the issuance of a number of legal acts for the payments of GPs/family doctors, established a prescription system, created and implemented the health booklet for the insured, and developed contracts with individual providers. As described in further detail below, HII's role has evolved over time, with the health insurance scheme expanding in 2007 to include all PHC services, not only GP salaries, and further expanding to include secondary and tertiary hospitals in 2009. While financing of health services has been pooled at the national level, management of health services has been decentralized to health centers and hospitals.

The next three sections describe HII's activities in regard to the three functions of a health financing system: 1) revenue collection; 2) pooling of funds; and 3) purchasing of services.[1]

5.1.1 REVENUE COLLECTION

HII introduced a new funding stream in the health sector through payroll contributions earmarked for health. This funding mechanism was in addition to MOH and local government budgets. For wage-earners, the required contribution is 3.4% of wages (half paid by employees, half paid by employers); for self-employed and unpaid family workers, the contribution required is 7% of the minimum wage in urban areas, 5% of the minimum in the rural areas, and 3% of the minimum in mountainous areas.[2] Payroll contributions are collected by the General Tax Directorate. Annex E provides a summary of HII revenues from payroll contributions (insurance) and other sources from 1995-2010, as well as the Institute's corresponding expenditures.

5.1.2 POOLING OF FUNDS

Pooling of health care funds spreads the risk of large, catastrophic medical expenditures collectively among pool members and not individually by each member, and also has the benefit of permitting pro-poor redistribution of resources. The story of HII is the story of gradual consolidation of Albania's health care pool of funds at the national level.

Although it was initially designed as a single payer system, early in its history, HII funding covered partial reimbursement of expenditures on essential drugs (for those people insured by HII) and paid the salaries of GPs, including providing supplemental payments (incentives) for GPs serving in rural or remote areas. The MOH maintained its authority to select, deploy, and supervise (but not to pay) GPs, and to select, deploy, supervise, and pay all nurses, and also cover investment costs. Due to the

[1] Kutzin, J. A descriptive framework for country-level analysis of health care financing arrangements. Health Policy 56 (2001): 171–204.
[2] Law No. 7870, dated 13.10.1994 "On Health Insurance in the ROA."

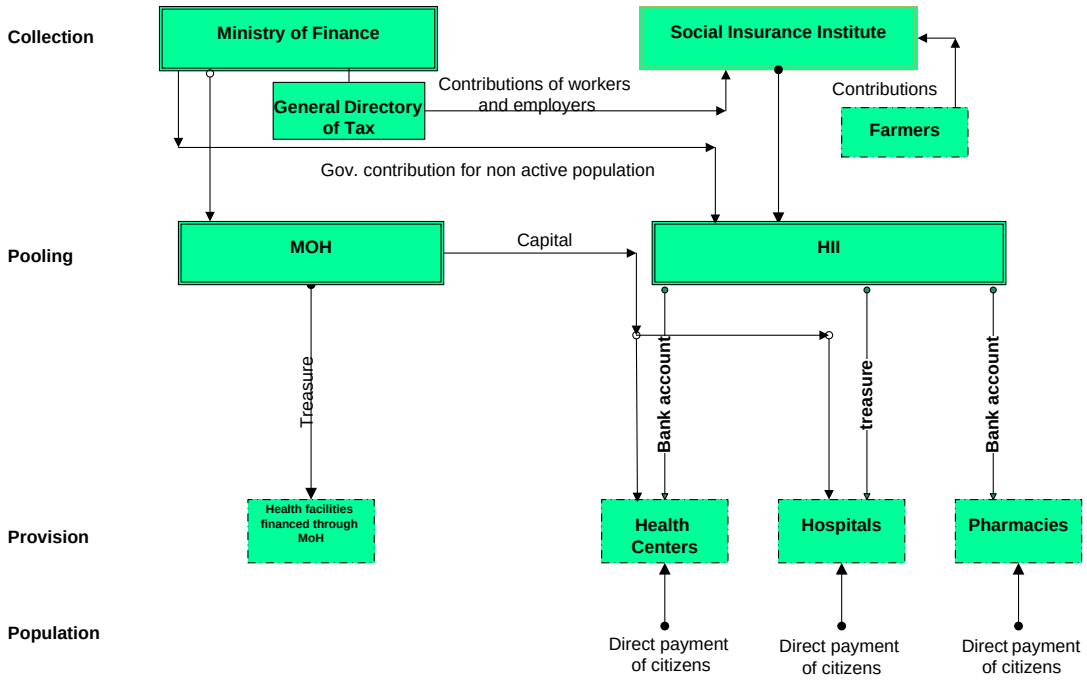
political commitment to decentralize authority across all sectors, local governments financed PHC facility operations and maintenance. In 2005, the responsibility for investments in PHC facilities was transferred to the Ministry of Local Government and Decentralization which then transferred funds to the local governments. However, this did not change the fact that PHC facilities continued to be funded from three sources – MOH, HII, and local governments contributed to the financing of PHC provision in a way that was fragmented and not designed with the best coordination of management in mind. This fragmented system resulted in unclear accountability for performance and an inability at the facility level to allocate funds across funding streams in a flexible manner based on need. Throughout this period, the MOH continued to manage and finance all hospitals.

This fragmentation of health care funding also resulted in inequality across regions in terms of the distribution of health care resources. As of 2004, the lower the poverty rate in a region, the higher the per capita allocation from all public sources. These historical funding arrangements have resulted in current budgets at PHC levels being weighted toward richer areas as opposed to being more equitably distributed per capita.

Current health financing funding arrangements are relatively new. In December 2006, the Council of Ministers decided to launch nationwide a new policy of HII to become the sole source of PHC finances, to be effective as of January 1, 2007.[3] The next step undertaken by the GOA (Decision of the Council of Ministers, No. 1661 dated 29.12.2008) was to transfer all the funds for financing recurrent expenses of the general hospitals under HII.

Decision No. 140 (17.02.2010) mandated that financing of all general hospitals be transferred to HII according to the mandatory insurance scheme. This decision created a large national pool of health care funding covering the majority of hospital and PHC facility expenses. Only capital expenses for investments in both PHC and hospitals, as well as direct funding for a small number of health care facilities, are still covered by MOH. In Albania, the GOA decision to pool the majority of health care funds at the national level has resolved many of the issues resulting from fragmentation of funds, and this was a major step forward toward implementation of an effective and equitable single payer system. Figure 1 depicts current health funding flows as described above.

Figure 1: Health Care Funding Flow in Albania (2011)



[3] Decision of the Cabinet of Ministers No. 857, dated 20.12.2006.

5.1.3 PROVIDER PAYMENT SYSTEMS

Reimbursement System for Pharmaceuticals

Pharmaceutical expenditures are the largest single component of health expenditures in Albania. In 2006, pharmaceutical expenditures in Albania were estimated at around 2.65% of GDP.[4] In 2010, it is estimated that drugs account for 72% of out-of-pocket health expenditures and 34% of total health expenditures (Albania NHA, 2010[5]). Therefore, the issue requires special attention.

The health insurance scheme was started with the reimbursement of drugs listed in the Essential Reimbursement Drug List for the insured population (those possessing a health booklet) with a prescription issued by a GP. This list has been expanding over the years, adding new drugs as needed. The pharmacies in the cities and towns are all private (the hospital pharmacies are public), and they have contracts with the HII for reimbursement for listed drugs disbursed with prescription. There are various payment categories, and some drugs are reimbursed 100%, but on average the HII reimburses approximately 75-80% of the price of the drug, and the patient pays the other 20-25% as a copayment in the pharmacy. The partial reimbursement of prescription costs depends on the therapeutic class of the product and on the type of patient, for instance whether the patient is an employee or voluntarily insured, those with mild and moderate disabilities, social welfare recipients, children one year of age and older, students, expectant and new mothers, and soldiers. Military veterans can be prescribed any branded product (i.e., a registered drug) regardless of the drug's reimbursement status.

Pharmaceuticals are distributed primarily through private pharmacies which procure products from private wholesalers. HII has contracts with about 80% of the pharmacies in Albania. HII reimburses the pharmacy based on the information provided. In fact, HII has developed an effective pharmacy information system, which has a good database that allows HII to account for the number and value of prescriptions by pharmacy, region, GP, and drug name.

At the PHC level, each Health Center (HC) can procure directly the drugs that are required for operating the HC. There is a formal list of drugs required for each HC. The budget of the HC covers the operation of the HC, but does not include the amounts for outpatient drugs prescribed. At the hospital level, there is a budget for drugs as part of the total budget of the hospital. Regional hospitals have recently been authorized to procure drugs directly.

PHC Provider Payment System

From 1995 through 2007, HII funded only GP salaries. It was clear during this transition period that HCs had little or no management or operational autonomy. MOH and the HCs themselves were unable to monitor important elements of their medical activities, and no one was directly responsible for the success or failure in providing services to the population. The HCs had no indicators for measuring and evaluating the performance of providers, and there were few financial and professional incentives to improve the quality of their services.

In 2007, the GOA initiated a comprehensive reform of the health system. This led to a change in the method of funding providers, and began the transition of HII to a single-payer. This was followed by steps to consolidate the PHC budgets in HII, and to allocate it by region, and then to allocate it by Health Center. The Director of the HC (as well as a Board) would be responsible for managing the funds in the bank accounts for each HC. A contract process was designed between HII and each HC to specify the package of services to be provided in the HC in order to receive payments from HII.

HII is now in the fourth year of implementation of single source financing with individual HCs. In 2011, the HCs are receiving 80% of its historical (last year's) budget on a monthly basis, plus a 10% performance payment that is disbursed on the basis of volume of services (number of visits), and a 10% bonus based on achievement against nine quality indicators. Payments to the HCs are made monthly for the performance payment and quarterly for the bonus payment. Six of the indicators

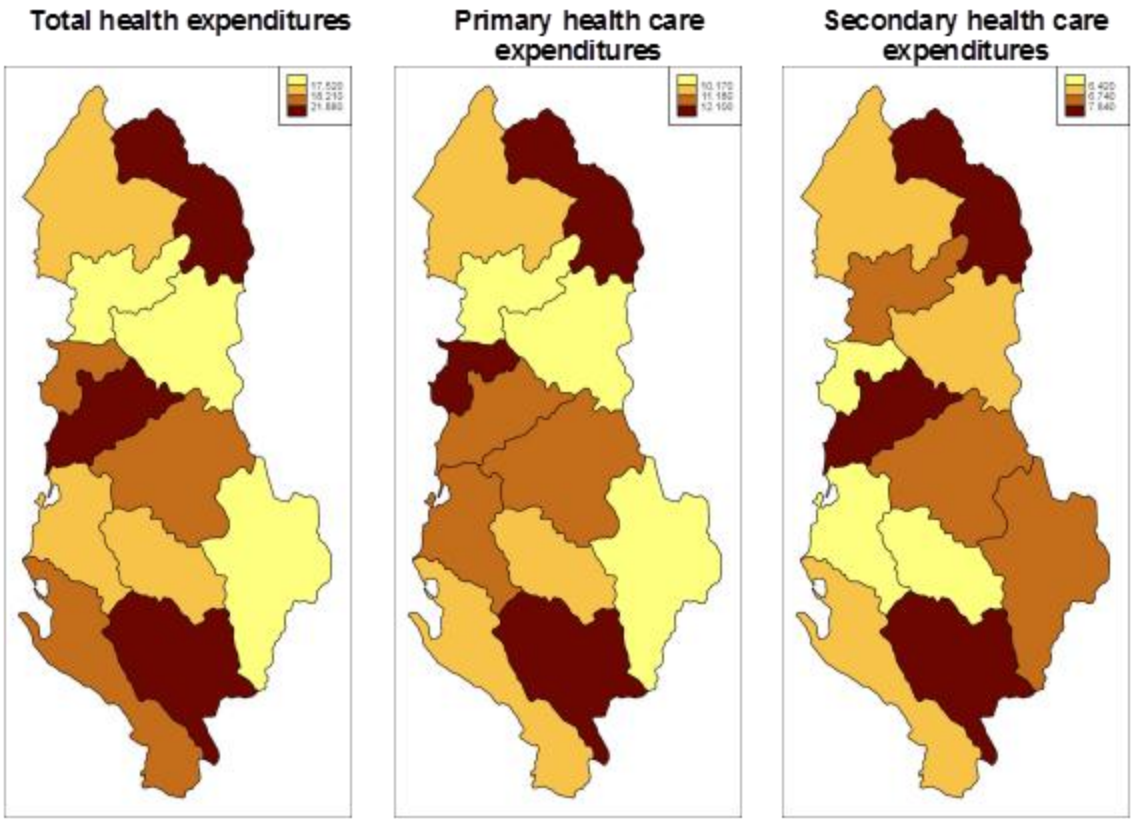
[4] Hana, I., et al, "Pharmaceutical Expenditures in Albania," 2006.

[5] Support to the Albanian National Health Account - Health System Modernization Project, Development and Institutionalization of National Health Accounts (NHA), Albania, July 27, 2010

that the scheme has defined in the contracts with service providers are directly or indirectly related to the continuous monitoring of morbidity. This mechanism was designed to create incentives for HCs to improve quality of care and effectiveness in operations. Over the last three years, due to the application of these new methods, results have been significant.

Global budgets are based on historical budgets, harking back to the time when facility budgets were determined in part by regional budgets which varied by income of region (as opposed to a per capita allocation). Thus, unequal distribution of health care funds across the regions is still in place, according to the 2010 NHA (See Figure 2: Regional Allocation of Total Health Care Expenditures per Inhabitant in ALL, 2009). Further analysis is required to understand the level of inequalities across the regions. HII might consider per-capita allocation of PHC funding to address this issue, and keep performance-based payments above the per capita rate.

FIGURE 2: REGIONAL ALLOCATION OF TOTAL HEALTH CARE EXPENDITURES PER INHABITANT ALL, 2009



Source: Support to the Albanian National Health Account (NHA), 2010.

Hospital Provider Payment System

The Decision of the Council of Ministers, No. 1661 dated 29.12.2008, established the financing of hospital care services from the health insurance scheme. According to this Decision, the hospitals became autonomous institutions with juridical independence managed by a board. The relationship between HII, the service purchaser, and the hospital as service provider is outlined in the annual contract. The innovative feature of these contracts is the establishment of performance indicators, quality monitoring indicators, and preparing and implementing clinical protocols. If successful, the implementation of these increases in autonomy will support the reforms and improve both the efficiency and quality of the hospital sector and broader health system. In 2009, HII provided service contracts with 11 regional hospitals, 24 municipal-level hospitals, and four university hospitals. These new contracts are intended to improve service delivery at hospital level by:

- Changing the way hospitals are funded, with the intention of moving from funding based on

historical budgets to more progressive financing methods, such as case-based/case mix payments;

- Increasing hospital management autonomy in order to increase incentives for efficiency and quality improvements; and
- Introducing clinical practice guidelines and treatment protocols for all services to standardize quality as well as the cost of services.

The budget of the hospital includes the following items:

- Wages and other expenses, related to personnel payments;
- Personnel social security and health insurances contributions; and
- Medical supplies and other services and expenses.

The provider payment mechanisms for the funding of hospitals have not yet changed. Funding for hospitals is carried out through the GOA Treasury system by line item, based on historical budget, which is input-oriented (e.g., the number of beds). This budget system contributes to excess capacity and may not allow for facility-level flexibility to adjust spending based on needs. In the contracts, HII has tried to create some autonomy for hospitals to purchase according to their specific needs, but in fact, this latitude of autonomy is very narrow. According to a GOA decision, hospitals may redistribute funds, according to the following limitations:

- Up to 2% of "Expenses for goods and services" can be reallocated to "Wages and insurances;" and
- Up to 5% of "Wages and insurances" can be reallocated to "Expenses for goods and services."

The Decision of the Council of Ministers No. 140 (17.02.2010) transferred the financing of all general hospitals to HII according to the mandatory insurance scheme. Capital expenses for the investments in the hospitals are still covered by MOH.

Hospitals and HII are obliged to calculate the costs of each service in accordance with the standards defined by the MOH. HII efforts to determine the real costs of hospital services could capture inefficiencies inherent in the current service delivery system and lead to a significant increase in government spending for services for hospitals. This process was meant to begin in 2010. HII will finance the contracted services based on the historical budget, until the drafting of the service costs is completed.[6]

Hospitals remain inefficient overall. In some hospitals there are low bed turnover and low bed occupancy rates. There are a number of smaller hospitals that have little or no equipment nor physicians, and no patients; but continue to receive financing through the HII. The MOH is working on the rationalization of hospital services with a view to restructure and strengthen all 11 regional hospitals and convert municipal hospitals into day hospitals and specialized outpatient centers. However, restructuring activities have not as yet been carried out.

The change of funding mechanisms can provide strong incentives for hospitals to operate more efficiently. However, it will be necessary to transition to the "strategic purchasing" of hospitals services using a case-based/case mix PPS for the payment of hospital services in order for this to occur.

"Strategic purchasing strategies can improve equity by compensating providers adequately for treating higher cost patients; drive better quality of care by financially rewarding best practices and improved outcomes; and create incentives for providers to be more efficient or more responsive to consumers. Purchasing reforms can contribute to improving the transparency of resource allocation

[6] Many countries in the region are moving away from costing activities against medical standards and alternative costing methodologies may be more appropriate to setting payment rates, including costing efforts that define relative costs of hospital services against the average cost, rather than absolute costs against individual clinical standards at a fixed point in time.

in the health sector and are also the vehicle for health financing policy reforms to translate into operational change in the health sector."[7] This is the HII goal.

HII is planning gradual movement toward changing the historical cost payment system to a case-based payment system. The rational for this is the need to reduce excess capacity and increase efficiency in the hospital sector. Ideally, high cost patients will be offset by high volume, low cost patients, which allows for cross-subsidizing and lowering overheads. Implementation of this type of payment system will help to:

- Reorient hospitals toward providing services to patients rather than creating or maintaining infrastructure (buildings) and excess staff;
- Create the conditions and incentives for restructuring the health delivery system by re-profiling or closing inefficient hospitals and departments;
- Create incentives for hospitals to supply higher quality services using fewer or lower cost inputs; and
- Introduce competition for providers and choice for patients to increase the responsiveness of the health system to patients' needs and the population as a whole; and eventually allowing payment by strategic health purchasers to private as well as public hospitals.

5.2 THE FUTURE OF HEALTH INSURANCE REFORM

The GOA, through MOH and HII, has made significant efforts to reform the health care system, and progress in financing PHC services over the last 15 years. A number of effective changes have been made in the funds flow and pooling of funds for the health care sector as outlined in the previous section. At present the HII is primarily a "payer" for health care services, but in the medium term, it needs to move toward becoming a "strategic purchaser". This is a new concept for Albania and may not be easily understood, nor easily implemented under the existing laws, decisions, rules, and regulations. It will be a difficult process. In addition, only 40% of the population is reportedly insured at present despite stated policy goals to move toward universal coverage.

As stated in its regulatory documents, HII will eventually be renamed a national Health Insurance Fund (HIF). As a "strategic purchaser" the HIF will not only make payments for services, but will purchase health services through a prospective process of setting the "price" for the service, as well as the conditions of delivery of the service, through a contractual tendering process with both public and (eventually) private facilities including service delivery, quality, and performance indicators. While full implementation of this process is a long way off, HII needs to begin to prepare for these changes now.

Recently the Parliament approved the Law on "Compulsory Health Care Insurance." This law increases the coverage of the fund to the entire population of Albania. The law aims to transform HII into the strategic buyer or purchaser of health care services based on contracts with providers of these services. Further, the law aims to improve and further develop the insurance scheme by making it more flexible in respect to its activity and simultaneously increase its efficiency for Albanian contributors. Specifically, the law aims to:

- Transform HII into a Health Insurance Fund with a fuller role and autonomy with the intention to enhance transparency and strengthen the financial stability of the Fund's structures;
- Improve the procedures of drafting the service packages;
- Increase the role of the scheme in the process of negotiations with various service providers, based on transparent criteria and procedures and taking into account the health needs of the population to have access to health services of packages funded by the schemes;
- Increase competition between public and private providers in order to lead to offering full, cost

[7] Implementing Health Financing Reform: Lessons from Countries in Transition; edited by Joseph Kutzin, et al., EU Observatory Series, WHO, 2010.

effective and best quality services to the Albanian population;

- Improve the current system of pooling and collection of contributions as well as payment mechanism, and transform it into a more transparent and functional system; and
- Calculate the contributions of inactive population on the basis of the average between the maximum and the minimum wage.

According to this law, the Compulsory Health Care Insurance Fund is a public, autonomous legal entity charged with managing the Health Insurance Fund (a compulsory health care insurance system) in compliance with national health care policies defined by MOH. The HIF budget will be approved together with the State Budget, and HIF will be the only public legal entity that provides and manages compulsory health care insurance in the Republic of Albania.

These changes will require HIF to become more autonomous, more transparent, and to become a true national agency for health care purchasing and procurement of health care services, from both the public and private sectors. HIF will need to work even closer with the MOH on policy and quality issues, as well as access, equity, insurance fund contribution rates, and health insurance enrollment programs.

According to the new Law on Compulsory Health Care Insurance, compulsory health care insurance and the payment of the relevant contributions are obligatory for individuals economically active and with permanent residence in Albania. The Compulsory Health Care Insurance covers the following categories of the economically non-active individuals, whose contribution payment is financed by the state budget or by other sources as defined by law, such as:

- Beneficiaries from the Social Insurance Institute;
- Individuals who may be entitled to economic assistance, in compliance with the relevant legislation;
- Individuals registered as unemployed by the National Employment Service;
- Individuals who perform the compulsory military service;
- Children under 18 years of age;
- Pupils and students under 25 years of age on condition that they do not have incomes obtained by an economic activity; and
- Other categories of individuals as defined by a specific law.

The individuals not included in the above list, have the right to join the compulsory scheme voluntarily. Thus, this law anticipated coverage by the health insurance scheme of all categories of the Albanian population. This Law removes the fragmentation of funding and introduces the concept of purchaser – provider contracts.

According to Article 10 of the law, the package of services for the compulsory insurance includes:

- Medical examinations and treatment in public PHC centers and public hospitals;
- Medical examinations and treatment in private primary health care providers and private hospitals to an extent agreed with HIF; and
- Drugs, medical devices, and treatment by contracted health service providers.

5.3 MANAGEMENT AND ORGANIZATION OF HII

This section includes a management and organizational review of HII. It begins by discussing the governance and management positions and then provides a review of existing management positions, functions, tasks, and activities.

5.3.1 GOVERNANCE AND MANAGEMENT

HII was created in 1994 based on Law No. 7870.[8] HII was organized as an autonomous legal entity and autonomous administrator of the health care insurance fund. HII's main governance structure is the Administrative Council (AC). The Administrative Council includes 11 representatives, one each from of MOH, Ministry of Labor, Social Affairs and Equal Opportunities, and MOF, the General Director (GD) of HII or his/her representative, the Director of the Social Insurance Institute or his representative, a representative of the workers' syndicate, a representative of the health care providers as defined by the Order of the Medical Doctor, a representative of the self-employed individuals and a representative of the consumers' association who represent the beneficiaries of the Fund. The Minister of Health is the Chairman of the Administrative Council.

The General Director is the Senior Manager and Chief Executive Officer (CEO) of HII. The General Director is responsible for all the standard executive functions, including nominating the directorate as a counseling body composed by the vice director general and directors of HII departments, for preparing the internal regulation of the scheme, defining and approving the organogram and the salary levels, nominating HII personnel including directors of regional branches, deciding upon administration tasks and problems, proposing the budgets, financial plans and annual reports, three-year perspectives and regulations for financial aspects and contributions to the AC.

5.3.2 ADMINISTRATION AND ORGANIZATION

HII has a consolidated administrative structure. Besides the headquarters in Tirana, HII has 12 regional directorates, three branches in Tropoje, Saranda, and at the University Hospital Center in Tirana. HII has approximately 610 employees; 142 are working at the HII headquarters in Tirana and 468 in its 12 Regional Directorates and three branches.

Directors of departments and of regional offices as well as agency supervisors are appointed by the General Director. As depicted in HII's Organizational Chart (Annex D), major HII departments are:

- General Director and the Directorate Staff
- Vice-General Director
- Economic Department
- Department of Drugs Pricing and Reimbursement
- Department of Primary Healthcare
- Department of Hospital Service
- Department of Information and Statistical Analysis
- Department of Human Resources
- Juridical Department
- Department of International Relations and Services
- Department of Internal Auditing
- Department of Primary and Pharmaceutical Control
- Department of Hospital Control

The various major departments are composed of specific "sections" under each department head, which have specialized functions and activities.

Administrative expenses of HII have increased in absolute terms from 25 million ALL in 1995 to 573 million ALL in 2010. As a percentage of total revenue, administrative expenses fluctuated from 2.9% in 1995 to 6.2% in 2000 to 5.6% in 2005 to 2.2% in 2010 (Annex E), decreasing significantly when

[8] Law No. 7870 dated 13.10.1994 "On Health Insurance in the Republic of Albania" (amended) and Decision of the Council of Ministers No. 613 dated 20.12.1994 "On the Approval of the Statute of the Health Insurance Institute" (amended).

funds for hospital payment were transferred to HII. A challenge for HII will be keeping the total cost of administration of the fund to acceptable limits, considering efficiency and quality performance issues. In order to have an efficient management of the administrative costs, the funds intended for administration should not exceed 3% of the total revenue. HIF is challenged to ensure that these expenses are managed effectively and kept under control, especially personnel costs.

5.3.3 MANAGEMENT FUNCTIONS

Management is often defined as "getting things done through others." The five Management functions are normally defined as those of: Planning, Organizing, Staffing, Directing, Controlling. Standard definitions of each of these and examples are as follows:

- Planning – Developing policies and procedures, budgets, and various planning tools and mechanisms to ensure the organization is "predetermining a course of action;"
- Organizing – Arranging the various tasks, people, and activities so as to effectively and efficiently carry out the objectives of the organization;
- Staffing – Hiring the people and training them as needed to perform the objectives of the organization;
- Directing – Providing leadership, instructions, and delegation to effectively carry out the tasks assigned and objectives of the organization; and
- Controlling – Developing various mechanisms and systems to ensure the "work goes as planned."

A thorough review of these five management functions in each of the 12 major departments in HII, resulted in the consultant teams' opinion that HII "meets or exceeds" standard expectations of effective and efficient management of health insurance programs and activities in a transitional economy. However, improvements always can be made, and the team identified several potential issues in regard to the staffing, organizing, and controlling functions.

One concern that the team identified is that the "span of control" of the General Director (GD) – the number of persons reporting to the GD – is unusually large for a health insurance fund CEO. A look at the organizational chart shows 11 Department Directors at the central office, plus another 12 Regional Directors, plus approximately six people in the Directorate report to the GD. This means that the GD has approximately 30 managers and staff people reporting to her directly.

HII has over 600 personnel positions in total. The type, number, specialty, and function of each staff member should be reviewed further, especially in the context that the pharmaceutical and PHC systems are generally well developed and fully implemented. With the hospitals becoming the new major area of implementation of payments, contracts, planning and control systems, personnel may be reassigned to hospital activities rather than adding additional personnel.

One of the main functions of HII is "control" and a review of the organizational chart shows that many of the departments are involved with control functions and mechanisms. While it is expected that a "payer" should have sufficient control functions, systems, and mechanisms, the consultant team (as well as stakeholders) highlighted the large number of these functions.

HII has developed adequate operational systems for insurance registration, but has not focused on increasing the insurance coverage rate.

5.3.4 THE RELATIONSHIP BETWEEN HII AND OTHER KEY INSTITUTIONS

The review team met with many key partners and stakeholders of the HII. While relationships are complicated with a number of stakeholders, especially the MOH, the views and opinions of the relationship were generally positive and collegial. Health reform can be a difficult and frustrating process, and these strains can produce difficult relationships. In light of these tensions, it is apparent to the review team that HII has generally good relationships with the vast majority of its partners and stakeholders. The development of a new "vision" for HII as it begins to operate more like an

insurance fund will require bringing these stakeholders fully into the process of strategic planning for the new Health Insurance Fund.

Ministry of Health

The relationship between HII and MOH is a complicated and often difficult one, but generally works effectively. Some of the difficulty is natural in the context of the separation of payer from provider, and the movement toward a new single payer system, and is common in all transitional economies that have made this change. The HII/MOH relationship is the most important issue in the effective and efficient functioning of the health care system. The HII is guided by policies that are determined and managed by the MOH. The Minister of Health is the Chairman of the Administrative Council, to which the HII reports. At present, there is no "formal" coordinating mechanism between the two organizations. Problems between the two organizations are usually worked out between the various technical experts in each of the organizations. Most of these difficulties are normal operating problems and exists in all countries. However, there also are a number of governance and management issues that continue to cause problems between the parties and deserve further attention to resolve.

National Center of Quality, Safety, and Accreditation (NCQSA)

NCQSA was established in 2006 to build the appropriate system and mechanisms for assessing, monitoring, and improving the quality of medical services throughout the health system in Albania. This institution develops standards and accredits providers of health services. While some excellent development work has been done, this work now needs to be effectively implemented throughout the health system. Accreditation, licensing, and supervision of health care providers rely on the MOH for both public and private sector facilities. Quality management is a major concern both in the PHC and the hospital sectors. The relationship between NCQSA and HII is not as close as it might be. The NCQSA feels that it is not always invited into the quality management and quality improvement process. According to the NCQSA, HII does not always utilize "evidence-based" quality indicators or effective quality measurement mechanisms. While some of this disagreement may be the institutional desire to use one's own design system, as opposed to a system suggested by others, there is a need to effectively coordinate policy, planning, and implementation of quality improvement mechanisms and to understand respective roles. If improvements in quality are to be effectively implemented and new inroads made with clinical guidelines and protocols, this relationship between the two organizations will need to be strengthened.

PHC Providers

Significant efforts have gone into improving the PHC system governance and management structure over a number of years. A previously effective policy to utilize a three-person health center governance board at the PHC level (MOH, HII, and Local Government representatives, all with equal authority) has been recently reversed due to the MOH desire for more control over the management process. Previously health center managers were able to hire and fire staff, and now the MOH representative on the boards have taken over this management function. This has produced significant dysfunctional consequences in the governance and management of the health centers and has pushed back much of the progress previously made over the last few years.

Durres Hospital

The regional hospital in Durres has been a pilot model for hospital reform for both MOH and HII. The hospital has had a contract with HII for 10 years, has had financial and training program assistance from a number of donors, has developed its own Governance Board, and has effectively implemented a number of the autonomy reforms that are hoped for throughout the hospital system. While much has been written about the success of Durres, the hospital still has major funding issues, has 30% of its patients coming from outside the region, has a 25-50% increase in patients during the tourist season, many of which are uncompensated and put special strains on the hospital's finances. While Durres may serve as a model, it may be a challenge to replicate such a significant investment in other hospitals throughout the country. In addition, the hospital may require special consideration under a case-based system due to its special programs.

Other Hospitals

There is confusion between the role of governance and management at the secondary care level. Hospitals recently have become autonomous institutions reporting to a governing board. But aside from Durres Hospital, these boards have yet to be established or implemented. MOH continues to provide both management and governance functions, with Hospital Directors reporting directly or indirectly to the Minister of Health. So a major issue in the implementation of new regulations and the new contracts between purchaser (HII) and provider (hospitals) is the establishment of increasing levels of autonomy for the hospitals. The best way to increase autonomy is to establish these hospital boards and let the governance structure do its job, and let the hospital managers go about managing the institutions. With the present structure the hospital directors can be removed at will, and usually are, when the political party changes. This is not effective governance or effective management.

If the improved efficiency of the hospital system is one specific goal, the MOH will need to move out of the role of management of facilities, and into a policy setting role, which is outlined in the design of the reforms. This will not happen unless the hospitals have an effective management and governance structure and hospital directors are rewarded for performance and efficiency. And it is only through restructuring of hospital infrastructure, beds, personnel and services that significant, system-wide efficiency improvement can be achieved. The hospital system needs to move toward being operated more as a business with efficiency, performance, and quality improvement as its major goals. The delay in moving toward converting small town hospitals into outpatient centers and day hospitals is one example of not managing the business effectively and a clear mix between the roles of governance (policy setting and oversight) and management (operations). The hospital directors clearly understand what is expected, but they have not as yet been given the tools to manage effectively or efficiently. This will not change until governance and management functions are clearly distinguished from one another and capacity is built in these functions.

Private Sector in Health

Another major issue for the new HIF will be bringing the private sector into the health insurance process. Under the new Law, the HIF will be permitted to contract with the private sector. However, very little is known about the private sector in health. There is little published information available and until the NHA is fully functioning there will be little data available. It is clearly evident that there are private pharmacies and dentist practices, and there are some private practice physicians but relatively few are successful, and many public physicians see private patients after normal public service hours. There is no official estimate of the size or composition of the private sector in health.

In order to collect some information on the private sector, the team visited the American Hospital in Tirana. The CEO is a cardiologist and one of two investors in a 70 bed facility on the grounds of the old military hospital. The project is about $30 million equity capital investment with an annual operating budget of approximately $25 million. The Hospital has about 600 staff including 100 local doctors and 25 international doctors. The hospital has two locations in Tirana (the initial 70 bed facility as well as a new 80 bed facility) and two locations outside the city, which primarily operate as outpatient polyclinics. The hospital specializes in high technology procedures in heart surgery, renal transplant, eye surgery, and may begin conducting liver transplants. It is well-equipped with a variety of high technology equipment including CT, MRI, and Gamma Camera, etc. They also have a contract with the public Mother Teresa Hospital to handle that hospital's renal dialysis patients, which is paid for by the State Budget. The CEO estimated 90% of the American Hospital's revenue is cash and is received from clients prior to admission. A fee schedule of all services is available and all revenue accounting is done through a professional accounting firm. Open competition on price and quality between the private and public sectors for government health services is welcomed by the management of this facility.

6. RECOMMENDATIONS

The following recommendations emerged from this institutional review of HII. The consultant team encourages Albanian stakeholders to review and discuss the recommendations in light of the sector's health reform strategy, future plans, and available resources. Recommendations may be discussed within HII, among other health sector stakeholders including the MOH and NCQSA, and even by the Prime Minister's task force or at other Government levels as appropriate.

6.1 DEVELOP A STRATEGIC PLAN FOR HII

HII needs to develop a more comprehensive "vision" of its new emerging role, responsibilities, and functions within the wider national context of compulsory health insurance coverage for all of the population. This could be carried out through a strategic planning process that would bring together key stakeholders including MOH, HII Administrative Council and management, and hospital and health center representatives, to engage in a highly interactive process of environmental assessment (Strengths, Weakness, Opportunities and Threats), discussion of critical issues facing HII, development of strategic objectives to effectively address critical issues identified, and finally development of work plans for the next 3-5 years.

Part of the strategic planning process may include support to 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, supporting dissemination of such agreements throughout the respective organizations and the health system, joint planning between MOH and HII to implement insurance reforms, and agreements between them on an approach and detailed work plan toward implementing case-based hospital payment and improving provider quality at all levels. Specific steps may include development of:

- A broad and comprehensive view of the new mission and vision for HII to transition to a health insurance fund over the next few years;
- A clear strategy and plan to improve relationships and coordination with the MOH given the new roles of each;
- A clear strategy and plan for improving the governance and management of the hospitals and primary health care facilities;
- Strategic objectives for HII/HIF for 3-5 years;
- A work plan to follow the strategic objectives for 3-5 years; and
- A human resources resource plan, including training and staff development activities.

One major advantage of a highly interactive process is to bring all stakeholders along together into a shared vision of the future of the HII/HIF and the needed changes and necessary resources required. The process can be carried out in a number of ways depending on the time and resources available, including bringing in an external facilitator.

6.2 DEVELOP A PLAN TO STRENGTHEN HII MANAGEMENT AND ORGANIZATION IN LINE WITH THE STRATEGIC PLAN

HII has grown significantly in its role, responsibilities, revenues, expenses, organization, and personnel. As a result, there is a need to review the organizational structure through a formal organizational and management analysis (potentially by an objective professional human resources firm) that would review roles, responsibilities, authorities, the span of control, the number of management levels, and various related organization and management functions, tasks, and activities.

The team feels that two Deputy General Director positions or some arrangement to reduce the span of control of the CEO might be considered to be a more effective organizational arrangement. Specific steps may include:

- An in-depth organizational analysis of functions, responsibilities, work-flow and information flow for all departments and sections;
- Reduce the span of control for the General Director and Department Directors;
- Rationalize the relationship of position titles, responsibilities, salaries, etc.;
- Increase management development for key Department Directors; and
- Review the required number of personnel by department and section.

The development of the Management and Organizational Plan could be carried out in a number of ways depending on the time and resources available. Again, there are consultants and consulting firms that specialize in this type of activity.

6.3 CONTINUE TO REFINE AND IMPROVE PROVIDER PAYMENT SYSTEMS

6.3.1 PHC PAYMENT SYSTEM

Global PHC budgets were being formed on the historical data, and concern still remains in terms of equal distribution of funds across the regions. The 2010 NHA process reports unequal distribution of funds across the regions. More analysis is needed to understand the level of inequalities across regions. HII should consider a more effective capitation rate for the entire population moving to per-capita allocations of PHC funding and keeping performance-based payments above per-capita rate. While significant improvements have been made, further work is required to improve regional inequities. The pay-for-performance system (quarterly bonuses based on achievement against indicators) should be evaluated to determine its effectiveness, and expanded as appropriate, perhaps to include a larger set of performance indicators or to increases the level of bonuses on current indicators to further motivate providers toward quality improvement.

6.3.2 DRUG REIMBURSEMENT

Pharmaceuticals are a large part of the total HII budget, and in hospitals, drugs are usually the largest single component of the total cost. Hospitals also mentioned to the team that they often go months without funds for drugs. Consequently, it is important to improve controls on drug prescription, usage, and abuse. The review found that some issues may lie in the size of the drug formulary, the generics policy, and the limited implementation of existing policies. It is unlikely that anyone can effect much change at the national level due to various factors involved, but something could be done at the HII level to improve policy implementation. While much has already been done by HII, there is a need to do even more and this is an area where donors might play a critical role.

6.3.3 HOSPITAL PAYMENT SYSTEM

HII needs to plan for the development and implementation of a case-based reimbursement provider payment system for hospitals which moves away from historical cost and moves toward rewarding individual institutional performance based on the mix of clinical cases. This will require significant amounts of capacity building within HII and within its partner organizations, as well as procuring the required technical assistance to design and implement these programs. The development of a case-based/case mix reimbursement plan for hospitals is a more complex process than for PHC facilities. Some initial guidance is provided in Annex C. The plan might include:

- Clear objectives, outputs, criteria, performance measures;
- The model for future payment systems for hospitals;
- The required databases and information system/information technology/informatics support systems;

- M&E development and coordination; and
- Needs for training and development of personnel.

A number of USAID and World Bank (WB) projects in the former Soviet Union have developed expertise in provider payment systems and publications and tools are available from these projects to support this process.

6.4 CONTINUE TO CONSOLIDATE AND STRENGTHEN HOSPITALS

The issue of HII funding a number of smaller hospitals in smaller cities and towns that often have little or no equipment, and often no doctors, is a waste of scarce resources. The MOH has plans to convert these hospitals into outpatient centers. This has already been done successfully by other countries throughout the region. Both USAID and the WB have helped with this process in other countries, so there is a great deal of experience to drawn upon. The MOH and HII should consider using the HII purchasing mechanism as the driving instrument to support MOH in implementing the Rationalization Plan.

Business plans have become the key developmental tool for moving hospitals from a historical cost basis to a performance-based system. With the inclusion of 39 hospitals into the single payer system, there is a need for the development of formal business plans for a 3-5 year period for each of the hospitals (or at least the larger hospitals) in line with the coming changes in provider payment systems. Business plans are usually one component of a larger hospital strategic planning process for a 3-5 year period. The process of developing a strategic plan along with business plans for each hospital could significantly improve the relationships between HII and MOH, as the hospitals will feel more a part of the developmental process and will better understand what the HII is trying to achieve. These business plans along with the improvements in management autonomy at the hospital level could serve to bring about significant improvement in quality and efficiency of the system as a whole. Specific steps might include:

- Forecast revenues and expenses with proposed changes in reimbursement;
- Establish capital equipment and renovations required including health information systems/information technology;
- Rationalization of district hospitals (inpatient to outpatient);
- Identify health information systems/information technology/informatics needs in the hospitals including M&E;
- Plan for management development in the hospitals; and
- Develop a human resources plan including training and personnel development.

6.5 LINK PAYMENT TO QUALITY

Albania should continue to move toward more evidence-based medicine and evidence-based practices throughout the entire health care system. MOH, HII, and NCQSA would benefit from a joint strategy on quality management and quality improvement activities. The MOH through NCQSA should set the standards of care and then work with the professional associations and the health facilities to implement these standards. The HII should develop a utilization review system and medical audit process to sample and test against these standards. Quality standards and incentives for quality should be strengthened in the contracts between HII and MOH health facilities, and some process of measurement and audit of these standards should be enforced to ensure that the populations covered by the purchaser are receiving the level of quality for which HII is paying providers. In addition, HII might have a role in stimulating quality improvement through pay-for-performance systems.

6.6 INCREASE INSURANCE COVERAGE

With only 40% of the population enrolled in insurance (having an insurance booklet) and stated goals of universal coverage, further study is needed to understand the factors responsible for this low coverage. GOA and HII may need to develop policies to increase the level of insurance coverage of its citizens and to take steps to identify a package of services for the entire population that is attractive to the needs of the people and affordable to the GOA. There are different approaches to achieve these difficult challenges. One of the first major tasks is to increase the awareness and attractiveness of health insurance coverage to the population (marketing campaigns, a mass enrollment campaign, and a variety of public education messages). Another task may be to streamline and simplify the enrollment process or administrative process to receive an insurance booklet. Another major task is to refine and potentially limit the benefit package for uninsured citizens, enshrined in Law (ambulance care, emergency care, etc.). It is also possible to combine these various approaches. In order to accomplish increased coverage of the population, MOH and HII will need to simultaneously improve access, efficiency, and the quality of services provided in public facilities.

6.7 CONTINUE EFFORTS TO REDUCE INFORMAL PAYMENTS

The issue of reducing informal payments is a difficult one and was not the focus of this review. However, from discussion with stakeholders this is a continuing problem. Experience in other countries has shown that an effective system of copayments can begin to solve this problem. Experience has shown that patients and families will pay a large copayment or a large informal payment, but will resist paying both. MOH and HII should move toward policies for putting the informal payments on the table and bringing in more formal funds to be used effectively to improve the delivery and quality of care.

7. CONCLUSION

It is the conclusion of this institutional review that the HII has made significant progress and has established itself as the major mechanism for effective and efficient reimbursement of pharmacies and payment to PHC facilities in Albania. The recent expansion into hospital reimbursement is still in the very early stages. HII will need to move from being just a "payer" for health services to a "strategic purchaser" of health services which will include prospective rates of payment, with specific quality and performance indicators. In order to develop and implement these new programs, HII will need increased capacity building in the areas of management, organization, finance, information technology, and case-based/case mix provider payment systems. This capacity building is critical if HII is to continue to be successful in a difficult and complicated environment for health reform. HII will need to work even closer with its partner organizations in the MOH to develop and implement these new systems in a timely and effective manner in lockstep with other planned health sector improvements. All of these needs should ideally come together in a formal process of developing a new vision and strategic plan for HII for the next 3-5 years.

ANNEXES

ANNEX A: CONTACTS AND FIELD WORK SCHEDULE

Monday, 25 April 2011

10.00 Meeting in the Project office with Mr. James Statman, COP and Ms. Zamira Sinoimeri Senior Health Policy Adviser, EEHR Project.

Tuesday, 26 April 2011

09.30 Meeting with Mrs. Zhaneta Shatri, CTO USAID, Mr. Stephen Herbaly, General Development Officer USAID and Mr. Agim Kociraj, Health Specialist USAID

11.30 Meeting with Mr. Isuf Kalo, Director of National Center for Quality Assurance and Accreditation of Health Institutions.

13.00 Meeting with Mr. Saimir Kadiu, Director of Financial Planning Department and Implementation of World Bank Project, in MoH.

15.30 Meeting with Mr. Gazmend Bejtja, Director of Public Health Dept. in MoH and Mr. Erol Como, Director in Public Health Dept.

Wednesday, 27 April 2011

10.00 Meeting with Mrs. Elvana Hana, General Director of HII.

11.45 Meeting with Mr. Bajram Caka, Director of Economic Dept. in HII

14.00 Meeting with Mrs. Lorena Kostallari, WB

Thursday, 28 April 2011

09.00 Meeting with Mrs. Miranda Bleta, Director of Information Dept. in HII

10.00 Meeting with Mrs. Fjoralba Memia and Mrs. Laureta Mano, Juridical Dept, in HII

Friday, 29 April 2011

9.00 Meeting with Mr. Gjon Lleshaj, Director of Audit Dept. in HII

10.00 Meeting with Mrs. Emira Verli, Director of Foreign Affair Dept. in HII

11.00 Meeting with Mr. Besnik Bruci, Director in Drug Reimbursement Dept.in HII

12.00 Meeting with Mr. Devis Thaci and Mr. Feriz Ahmetaj, directors in the Hospital Control Dept. in HII

13.00 Meeting with Mrs. Rudina Mazniku, Director of Hospital Dept. and Mr. Aleksander Haxhi and Mrs. Arjana Kulicaj, directors in the Hospital Dept. in HII

Monday, 2 May 2011

Visit in Shkodra Prefecture;

10.00 Meeting in RDHI with Mr. Millan Janku, Director of RDHI in Shkodra

11.30 Meeting in the Regional Hospital with Dr. Namik Kameri, Director of the Hospital.

12.30 Meeting in HC Rajoni Nr. 2 with Dr. Ilir Hasani, Director of the HC.

Tuesday, 3 May 2011

09.00 Meeting with Mrs. Ana Lipe, Director of Financial Planning Dept. in MoH.

10.00 Meeting with Mr. Pellumb Pipero, Director of Policy & Planning Dept. in MoH.

10.30 Meeting with Mr. Petro Mersini, Director of Hospital Dept. in MoH.

11.30 Meeting with Mr. Gazmend Koduzi, Director of PHC Dept. in HII.

12.00 Meeting with Mr. Petraq Shtrepi, chief of Monitoring and Evaluation Sect. in MoH, Ms. Ledia Xhafaj and Ms. Sonila Reshka specialists of the Sect.

14.00 Meeting with Mrs. Ledia Lazri, Head of Office, WHO

Wednesday, 4 May 2011

10.00 Meeting with Mrs. Zhaneta Shatri, CTO USAID and Mr. Agim Kociraj, Health Specialist USAID

Thursday, 5 May 2011

09.00 Meeting with Naun Sinani, Adviser of GD of HII

09.30 Meeting with Pjerin Kodracaj, Director of Pharmacy and PHC Control Dept. in HII

10.00 Meeting with Mrs. Elvana Hana, General Director of HII

11.15 Meeting with Mrs. Majlinda Dedja, chief of Human Recourse Dept. in HII

13.30 Meeting this Mrs. Klodian Alajbeu, CEO "American Hospital" in Tirana.

15.30 Meeting with the staff of the EEHR Project

Friday, 6 May 2011

09:00 Meeting with Mr. Tauland Baku, Director of Durres Hospital

ANNEX B: LIST OF REFERENCE DOCUMENTS

Law No. 7870, dated 13.10.1994 "On Health Insurance in the Republic of Albania" (Amended)

Law No. 10107, dated 30.3.2009 on "Health Care in the Republic of Albania"

Law No. 10138, dated 11.5.2009 on "Public Health"

Law No. 9106, dated 17.7. 2003 on "The Hospital Service in ROA"

Contract between HII and HC, 2011

Contract of Durres Hospital, 2011

Contract between HII and Pharmacy, 2011

Contract between HII and an Importer of Drugs

Decision of the Council of Ministers, No. 613, dated 20.12.1994, "On the Approval of the Statute of the Health Insurance Institute"

Decision of the Council of Ministers No. 857, Dated 20.12.2006

Decision of the Council of Ministers No. 1661, Dated 29.12.2008

Fairbank, Alan, "Health Reform and Financing in Albania: Results Achieved and Tasks Remaining- the Role of PRO Shendetit project, 2004-2009."

Hana, I., et al., "Pharmaceutical Expenditures in Albania", 2006.

Health in Albania, National Background Report, MOH, April, 2009.

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Kutzin, J. A descriptive framework for country-level analysis of health care financing arrangements. Health Policy 56 (2001): 171–204

Langenbrunner, J., et al, eds., Designing and Implementing Health Care Provider Payment Systems: How-To Manuals," World Bank, 2009.

The Long-Term Strategy for the Development of the Albanian Health System, DFIF/MOH, April 2004.

Report on the Role of Local Authorities in Each Type of Health Facility, Health System Modernization Project, The World Bank/MOH, April 2008.

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Pharmaceutical Pricing and Reimbursement Information, Albania 2009, WHO, March 2009.

Social Health Protection in Albania: Challenges and Opportunities, Publication on Health Insurance Development, GTZ Conference Reader, September 2009.

PRO Shendetit II "HII Expenditure for PHC benefit package: An Analysis of Five Albanian Prefectures. Technical Report," Tirana: PRO Shendetit Project for USAID, May 2008.

ANNEX C: CASE-BASED PROVIDER PAYMENT SYSTEMS: AN INTRODUCTORY HOW-TO OUTLINE

The development and implementation of case-based hospital Provider Payment System poses both challenges and opportunities for the health system. To develop case-based hospital payment system several steps need to be undertaken. They include:

- Developing case grouping criteria;
- Calculating case group weights;
- Calculating the base rate;
- Developing additional payment parameters;
- Designing the information system;
- Designing the billing system; and
- Refining the case grouping.

The development and implementation of a case-based hospital payment system is an ongoing iterative process of collecting and analyzing data, developing payment parameters and other components of the system, implementing the system, collecting more data through the process of implementation, monitoring system behavior and refining the system. In addition, several of the steps will be carried out simultaneously. For example, while case grouping criteria are being developed, some cost analysis should be initiated to get an idea of variation in resource intensity across cases to inform the definition of the groups. The average cost per case within each group is recalculated after the groups are defined and refined as more data become available during implementation of the payment system. Also, the development of the billing system can start simultaneously with the design of the payment system. "How-To Manuals" developed by WB and USAID are available.[9]

The development of an initial diagnosis-related group (or clinical statistical group) model depends to a large extent on the volume and quality of available data on hospitalizations and hospital financing parameters. The more data is available the more equitable and statistically representative the system will be. International experiences has shown that it is more practical to start with implementing a relatively simple case based payment system (simple being defined as few diagnostic groups) with its subsequent improvement as the clinical and financial information is accumulated.

The development of databases requires a particular attention to the correctness and full-scope entry of the following data: admission date, discharge date, clinical diagnose at discharge (manipulation/surgery code), patient's sex, date of birth, hospital department specialty, department's code.

It is suggested that the development and implementation of payment methods in hospitals should be split into a preparatory stage and subsequent stages 1, 2, and 3.

The preparatory stage includes:

- Designing information and billing systems:
  - Development of a Hospital Discharge Form;
  - Development of hospital database software;
  - Assessment of the available information systems; and
  - Development of software for the financial database.
- Training of hospital personnel:
  - Ensure that doctors use correct diagnostic codings

[9] Langenbrunner, J., et al, eds., Designing and Implementing Health Care Provider Payment Systems: How-To Manuals, World Bank, 2009.

  - Taking measures on the necessary data being generated
  - Cost analysis in the pilot hospitals
- HII has managed to much of collect this data. An analysis of the existing statistical reporting data for the subsequent development of hospital departments' weights is required. Thus, the payment methods will depend on the availability of the required statistical data.

Stage 1:

This stage begins when a simple (base) discharged case payment method is developed and includes:

- Development of a simple average cost per case payment system
- Calculation of the base rate
- Simulation analysis of the hospitals' abilities to operate in the new environment and activities to increase their competitiveness
- Continued generation of the necessary data by the new payment system
  - Hospital database
  - Financial database (hospital cost- accounting analysis)

Stage 2:

This stage begins with the development of the first version of the DRG (department-level case grouping or diagnostic related groupings) system:

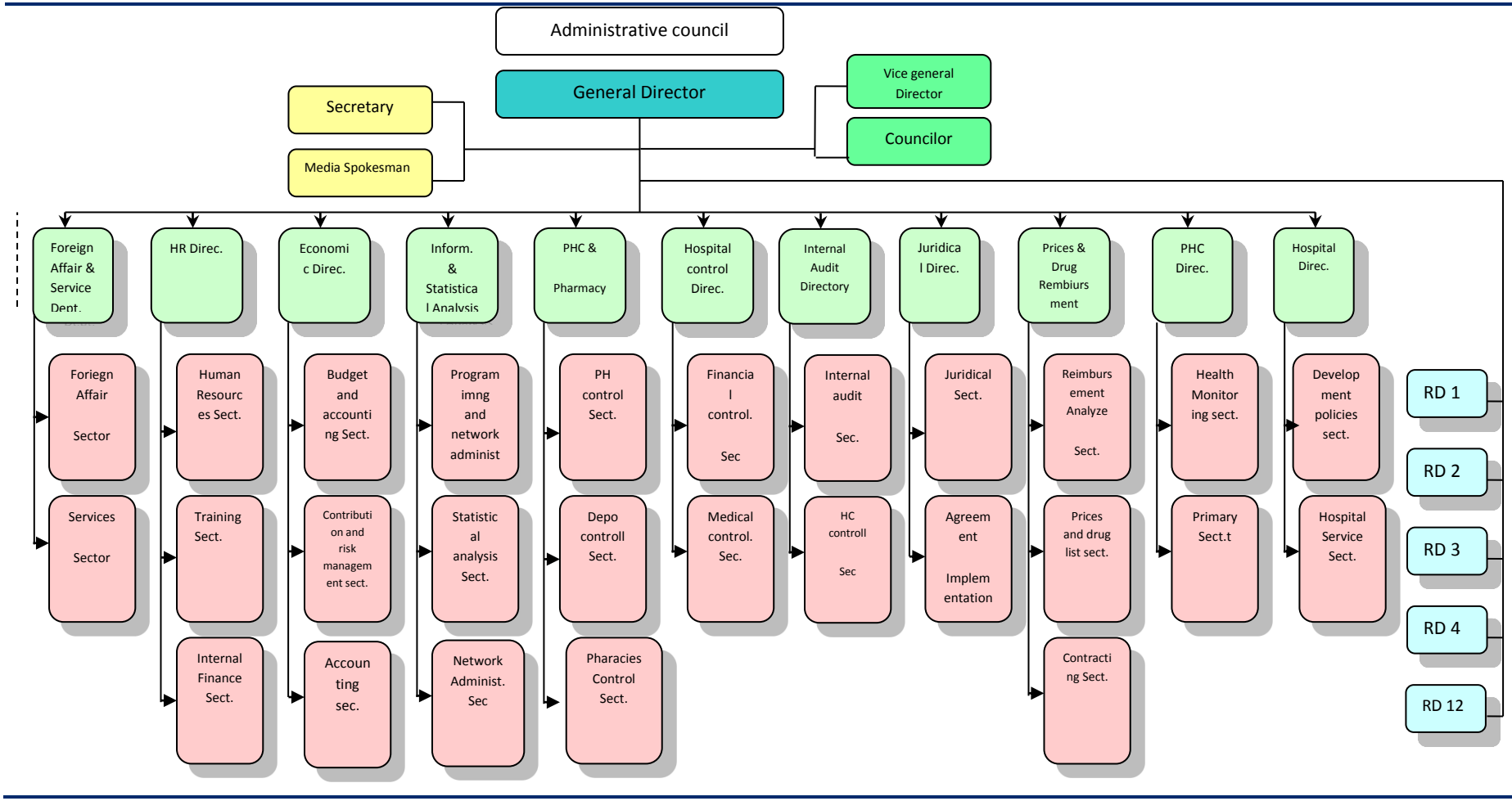
- Development of a billing system and its implementation
- Implementation of the department-level case grouping system
- The necessary data are being generated by the new payment system

Stage 3:

This stage begins with the development of the second version of DRG (diagnosis case grouping)

- The data collected in the database - not less than 100,000
- Development of diagnosis-based case grouping

7.1 ANNEX D: HII ORGANIZATIONAL STRUCTURE



ANNEX E: HII REVENUE AND EXPENSES 1995-2010

Budget structure (IN MILLIONS)	1995			1996			1997			1998			1999			2000		
	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%
Revenues	**1,131**	**872**	**77%**	**1,621**	**1,482**	**91%**	**1,584**	**1,754**	**111%**	**2,418**	**2,298**	**95%**	**2,951**	**2,655**	**90%**	**3,000**	**2,826**	**94%**
from which:																		
State budget	501	376	75%	521	507	97%	790	790	100%	1,273	1,071	84%	1,300	1,300	100%	1,300	1,300	100%
Health Insurance	630	496	79%	1,100	953	87%	794	947	119%	1,070	1,177	110%	1,459	1,311	90%	1,543	1,458	95%
Other revenues	0	0		0	22		0	17		75	50	67%	192	44	23%	157	68	43%
Reserve Fund																		
Expenditures	**1,131**	**414**	**37%**	**1,286**	**1,270**	**99%**	**1,584**	**1,623**	**102%**	**2,351**	**2,380**	**101%**	**2,728**	**2,592**	**95%**	**2,908**	**2,437**	**84%**
from which:																		
Drug reimbursements	1,023	304	30%	881	867	98%	1,159	1,202	104%	1,726	1,783	103%	1,909	1,941	102%	2,030	1,705	84%
General practitioners	74	72	97%	327	320	98%	345	343	99%	430	432	100%	549	475	87%	583	529	91%
Administrative expenditures	34	25	74%	78	64	82%	76	75	99%	162	137	85%	208	154	74%	219	176	80%
Investments		13			19		4	3	75%	33	28	85%	62	22	36%	76	26	35%
RHA of Tirana AND Durres Hospital																		
Tertiary examinations																		

Budget structure (IN MILLIONS)	2001			2002			2003			2004			2005		
	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%
Revenues	**3,528**	**3,447**	**98%**	**3,786**	**3,611**	**95%**	**4,559**	**4,647**	**102%**	**5,150**	**5,181**	**101%**	**6,893**	**6,557**	**95%**
from which:															
State budget	1,678	1,678	100%	1,750	1,619	93%	2,100	2,100	100%	2,350	2,350	100%	3,250	3,250	100%
Health Insurance	1,800	1,695	94%	1,956	1,902	97%	2,359	2,349	100%	2,690	2,680	100%	3,233	3,234	100%
Other revenues	50	74	148%	80	90	113%	100	198	198%	110	152	138%	110	72	66%
Reserve Fund													300		0%
Expenditures	**3,113**	**2,967**	**95%**	**3,786**	**3,604**	**95%**	**4,559**	**4,366**	**96%**	**5,450**	**5,760**	**106%**	**6,893**	**6,870**	**100%**
from which:															
Drug reimbursements	1,749	1,681	96%	1,687	1,697	101%	2,101	2,249	107%	3,046	3,492	115%	4,371	4,373	100%
General practitioners	627	601	96%	901	876	97%	1,100	992	90%	1,095	1,069	98%	1,104	1,092	99%
Administrative expenditures	229	222	97%	307	300	98%	347	315	91%	354	340	96%	372	365	98%
Investments	30	23	76%	107	78	73%	140	121	87%	100	59	59%	52	51	99%
RHA of Tirana AND Durres Hospital	478	440	92%	784	653	83%	871	688	79%	815	800	98%	938	933	99%
Tertiary examinations										40	0	0%	56	56	100%

Budget structure (IN MILLIONS)	2006			2007			2008			2009			2010		
	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%	Plan	Fact	%
Revenues	**6,502**	**6,371**	**98%**	**10,082**	**9,972**	**99%**	**11,160**	**10,983**	**98%**	**24,211**	**23,010**	**95%**	**25,649**	**25,836**	**101%**
from which:															

State budget	2,805	2,805	100%	5,545	5,545	100%	5,937	5,937	100%	17,832	17,543	98%	19,635	19,402	99%
Health Insurance	3,647	3,365	92%	4,487	4,155	93%	5,173	4,966	96%	6,329	5,377	85%	5,914	6,304	107%
Other revenues	50	201	402%	50	272	544%	50	80	160%	50	90	180%	100	130	130%
Reserve fund															
Expenditures	**6,502**	**6,246**	**96%**	**10,082**	**9,069**	**90%**	**11,160**	**10,377**	**93%**	**24,211**	**22,982**	**95%**	**25,649**	**25,268**	**99%**
from which:															
Drug reimbursements	3,630	3,619	100%	3,997	3,494	87%	4,270	4,216	99%	4,840	4,856	100%	5,900	5,927	100%
PHC	1,210	1,090	90%	4,779	4,537	95%	5,525	4,949	90%	6,000	5,722	95%	5,930	5,899	99%
Administrative expenditures	402	359	89%	505	405	80%	525	486	93%	624	579	93%	665	573	86%
Investments	100	36	36%	190	42	22%	130	42	32%	110	11	10%	100	48	48%
Durres Hospital + other hospitals	1,007	1,007	100%	501	501	100%	590	590	100%	12,527	11,738	94%	13,054	12,821	98%
Tertiary examinations	153	135	88%	110	90	82%	120	94	78%	110	76	69%	0		