

Organization and Financing of Primary Health Care in Albania: Problems, Issues, and Alternative Approaches

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- ▲ *Implementation of appropriate health system reform.*
- ▲ *Generation of new financing for health care, as well as more effective use of existing funds.*
- ▲ *Design and implementation of health information systems for disease surveillance.*
- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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Abstract

The Albanian health system has recently experienced organizational and budgetary changes that have given important roles to relatively new agencies. Since 1995, the Health Insurance Institute (HII) has become a major funder of doctors' salaries and drugs for primary health care (PHC) services. Since 1998, as part of the government's decentralization initiative, the Ministry of Local Government and Decentralization (MoLG&D) has channeled budgets for operating and maintenance costs of PHC facilities (previously funded by the Ministry of Health (MOH) budget) through block grants to local governments, which then determine how much is allocated to PHC. The effects of these changes have been to fragment the funding and administration of PHC services in Albania, which had previously been the exclusive responsibility of the MOH. While these changes have taken place, USAID and others in the donor community have partnered with the government to rehabilitate and reequip many health facilities that had been damaged during the civil unrest earlier in the decade. In this uncertain environment, the USAID-funded PHR*plus* Project is developing model PHC clinics in four sites in one region of Albania in an effort to demonstrate ways to improve systems performance. One element of the project is to assist the Government of Albania to design and implement improved methods for the planning, budgeting, and financing of these PHC services. A major part of the technical assistance in these areas has been to analyze the complex and disparate sets of data on flows of funding, how they have changed, and how those changes have affected accountability for PHC systems performance. Using these data, this report develops the basis for designing alternative ways to organize and manage the PHC service delivery system, taking account of a recent change in government policy that would unify all funding for PHC in one agency—the Health Insurance Institute (HII). After developing and applying criteria for choosing among two options for reorganizing management of PHC, assuming the HII would become the single source of financing, this paper recommends an alternative that would create regional health offices to supervise and manage PHC in each region, with increased levels of autonomy for individual PHC practices. The report also describes the principal elements of a proposal for a pilot project to test in one region the implementation of the recommended reorganization of PHC using the HII as a single source of PHC financing.

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Acronyms

CPG	Clinical practice guidelines
DfID	Department for International Development
GED	Group of Experts on Decentralization
GP	General practitioner
HII	Health Insurance Institute
IMCD	Interministerial Commission on Decentralization
MOH	Ministry of Health
MOF	Ministry of Finance
MoLG&D	Ministry of Local Government and Decentralization
O&M	Operating and maintenance
PHC	Primary health care
RHO	Regional health office
RHO/PHC	Regional health office/Department of Primary Health Care Delivery
RHO/QA	Regional health office/Department of Quality Assurance
TRHA	Tirana Regional Health Authority
USAID	U.S. Agency for International Development

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Executive Summary

Background

The Ministry of Health (MOH) recently unveiled the *Ten-year Development Strategy of the Albanian Health System* (the MOH Strategy), designed to improve the population's health status by improving the availability of high-quality health services. To achieve its ambitious goals, the MOH Strategy depends on an implementation capacity that has recently experienced major organizational and budgetary changes. These changes have given important roles in health to relatively new agencies—the Health Insurance Institute (HII) and the Ministry of Local Government and Decentralization (MoLG&D)—and have blurred the lines of managerial authority and responsibility. Budget flows from the HII that were intended to add resources, and those from the MoLG&D that were intended to “decentralize” certain tasks and functions of the MOH, have had the effect of fragmenting the financing and management of primary health care (PHC).

In response to the evident problems that have resulted, the Government of Albania is currently considering how it might reorganize the financing and management of PHC in order to make its approach to PHC service delivery more effective and efficient. To help with that effort, the *PHRplus* Project, sponsored by USAID, has undertaken to develop four model PHC practices in Berat and Kucove and to develop the supportive mechanisms that would serve to sustain them: community support; an information system; training to ensure improved service quality; and planning, budgeting, and financing methods that would include performance-based incentives. Evidence from these pilots will be used to determine reforms that would be replicated in other areas of Albania.

One significant achievement of the project's first year has been the development of a working partnership with the Government of Albania in two major areas of health reform to support PHC service improvements: health financing reform and government decentralization. In the area of health financing, Parliament recently passed an amendment to the Health Insurance Law giving the HII the legal basis for becoming the single source of payment for health care. This gave endorsement to the prime minister's announcement (at the launching of the MOH Strategy on October 7, 2002) that the government's policy goal is to have HII be the sole source of payment for PHC by 2004, and for all health care by 2005.

With respect to decentralization, the various responsible agencies (the Ministry of Finance (MOF), the MOH, and the MoLG&D) represented on the Interministerial Commission on Decentralization (IMCD) are working on an action plan to define how the law making health a “shared function” of central and local governments will be implemented. To some extent, this definition will have to accommodate requirements imposed by the financing reform soon to be designed and implemented. However, the approach to organization and management of the health system is also a matter for deliberate choice. *That is, the government has a unique opportunity now to design the kind of health system that it wants to develop over the next 10 to 20 years.*

Purpose of This Paper

The purpose of this paper is to address the critical organization and management needs of PHC in Albania and to propose alternative approaches to the systems currently in place. In doing so, it hopes to give technical support to the work of the IMCD and to the efforts of the HII and MOH to design the organizational and management structure for single-source health financing. To accomplish this, the paper will describe the current problems and issues that health policymakers face in the area of PHC service delivery, propose a conceptual approach for considering alternative solutions to the current problems and criteria for choosing among them, and present options (with a recommendation) for a new approach to the organization and management of PHC. It is expected that the approach the government selects will include the major health financing reform announced recently by the prime minister: unifying the source of payment for PHC in one agency, the HII.

Current Problems and Issues in Primary Health Care: Findings and Conclusions

- ▲ Budget flows to fund PHC services in Albania are fragmented into three major sources from which money is channeled to facilities and providers: the MOH, the HII, and the MoLG&D. While the MOH is still responsible for providing the majority of the PHC budget, it is only nominally responsible for supervising and managing the staff and facilities used to deliver PHC services.
- ▲ Viewed in their entirety, the data on the varied levels and fragmented sources of financing for PHC in Albania convey a clear message: money for PHC services flows through too many channels and in uncertain amounts in uncertain fashion for there to be proper accountability for its ultimate uses. Without proper accountability, there is little opportunity to design and implement the reformed provider payment methods that would serve as incentives for performance and quality improvements.
- ▲ “Decentralization” efforts have focused on transferring control over budget allocations from central to local governments. Little or no attention has been devoted to ensuring that the specific organization and management functions required for effective service delivery are being (or can be) performed under the “decentralized” system.
- ▲ There is no scarcity of government budget funds, in the aggregate, for PHC. Although the level of funding seems to be adequate (comprising about 43 percent of the total amount the government spends on health), it appears to be inefficiently allocated. The productivity of PHC facilities is highly variable, with rural health centers and health posts averaging three visits per day in 1999 and urban facilities averaging 19 per day. Increased funds may be needed to fund operating costs at many health centers, but in general the policy problem is not so much an inadequacy of funds, but a misallocation of them.
- ▲ The disconnect between the new law specifying health as an undefined “shared function” of central and local governments and the persistent reality of budget flows based on an old decree needs to be resolved. However, the solution adopted for the 2003 operating and maintenance PHC budget should not serve to preclude steps needed to be taken to reach a long-term solution to the fragmentation problem.
- ▲ A long-term solution for the organization and management of government-sponsored PHC (if not for higher levels of care) should focus on the center “sharing” functions in health for which local governments can perform a valuable role without being required to be

responsible for major staffing and resource requirements (however funded) or demanding technical standards. This solution should include several major elements:

- △ A distinction should be made between what the government(s) should do to provide population-based, public health services and what services the government(s) should (or may) provide for personal, curative care. Local governments are capable of “sharing” responsibility for the former, but not for the latter.
- △ Responsibility for budget and financing of any function required to produce a service should be in alignment with accountability for its management, quality, and performance.
- △ “Decentralization,” as defined by law, can be achieved in the health sector simply by deconcentrating selected MOH functions to regional offices and then having those offices establish working relationships with Regional Councils and other local governments, mainly with respect to their “sharing” in the provision of population-based, public health services.
- ▲ Consolidation of all sources of funding in one agency would go a long way toward aligning accountability with responsibility. Since the HII already has the major share of funding for PHC and has an institutional prerogative as the provider of social health insurance, it is logical that further steps be taken to seek a solution that utilizes the HII’s strengths in unifying financing as a major ingredient in resolving the fragmentation of administration and management. Unifying the sources of funding will not produce much benefit without complementary efforts to clarify lines of responsibility and accountability for the services to be financed.

Conceptual Approach to Designing Alternatives

The challenge presented requires that policymakers seek a new system of organizing and managing health and medical care so that two goals are met simultaneously:

- ▲ Define health as a “shared function” of central and local governments so that there is clear allocation of responsibilities for the various aspects of health care service delivery and of public health functions
- ▲ Decide how the distinct functions of financing and management are to be performed by having the stakeholders agree as to which of them is to be given responsibility for which specific elements of these functions

The various aspects of these distinct issues—decentralization and health financing—overlap when one addresses the issues of organization and management of health services delivery. In seeking concrete solutions to the problems manifested in both issues, it is useful to outline two elements of the conceptual approach:

- ▲ The need to clarify the important policy decisions that have already been made as distinguished from those policy questions that are yet to be answered
- ▲ The need to specify the criteria for designing alternative solutions and associated policy options, and for deciding among them

In designing alternative solutions, it should be explicitly acknowledged that it is possible that some elements of the alternatives considered might include sharing responsibilities for delivery of

certain services with the private sector, thereby seeking to take advantage of the benefits to be gained from regulated, market-based competition.

Public Health Policy: Settled Issues

A significant degree of consensus appears to already exist regarding certain aspects of the future of the Albanian health system. Some of these are strategic assumptions that are expressed in similar form in the MOH Strategy.

First, *the role of the (central) MOH is changing from that of a management body to a policymaking body* able to formulate health policy and strategy, prepare guidelines for accreditation and quality control, regulate private sector activities, and lead intersectoral work, with carefully planned decentralization of planning and management functions.

Second, *there will be some degree of regionalization of health care management operations*, including regional-level management of personal, curative services as well as public health services.

Third, since the creation of the HII in 1995, the principle of financing medical care and drugs through social insurance has been established. Recently, the role of the HII as the single source of payment has been agreed to in principle and in law, and this is now in the process of being defined in concrete terms. While it is proposed that the HII ultimately become responsible for funding of acute care as well as primary care services, a current proposal would initially limit the HII to pooling funds for PHC services delivered in PHC facilities, and would test its performance as a single source of payment in a single region, using the PHR*plus* pilot sites to demonstrate whether or not this would work.

Fourth, because the HII is to be the sole source of financing for medical care, there will necessarily be a functional (and perhaps institutional) distinction between the administrative staff responsible for managing the provision of medical care and the administrative staff responsible for financing that care. Coordination between the two would be essential, although each administrative staff would represent different functional skills and interests: managing the delivery and quality of care on the one hand, and ensuring value for price on the other hand.

Public Health Policy: Open Questions Yet to Be Decided

Policymakers have not yet resolved a number of policy questions related to the issues raised above. These open questions define, in large measure, the issues to which the options and solutions proposed are addressed.

First, the role that local governments can and should play in the health system is still very much undefined. Any reorganization of the management of government health services should include a resolution of the role local governments will have and should establish a clear legal basis for any flow of funds to them, or of taxes levied by them, to support that role.

Second, depending on what role local governments play, the MoLG&D's role in financing that needs to be reviewed and, as indicated, revised. The MoLG&D could continue to provide financing of any health-related responsibilities that local governments might be given to carry out those functions deemed to be "shared" with the central government.

Third, the particulars relating to the redesign of the administrative structure and the process for managing the public health functions will need to be decided.

Fourth, decisions must be made regarding the design of the administrative structure and process for managing the PHC services, staff, and facilities; the regulation of their activities; and the need to ensure the quality of their services.

Fifth, thoughtful consideration should perhaps be given to the potentially beneficial role that the private sectors could play, in partnership with the public sector, in the financing and delivery of medical care services. Policymakers' current focus on reforming the supply side of the medical care market through the reorganization of decentralized government-sponsored facilities could benefit from complementary consideration of the demand side of the market—how to make providers more responsive to patients' needs and perceptions of the quality of care.

Criteria for Assessing Alternative Approaches and Solutions

Government health policy now needs to define criteria for judging and choosing among alternative solutions to address the problems and issues presented above. In the process of choosing a particular solution, policymakers will necessarily make implicit choices about how to answer the policy questions so far left unanswered. The criteria outlined below are proposed to assist in designing and choosing a solution.

- ▲ There should be clear organizational lines of responsibility for performance of the tasks and functions that are required to produce the services to be provided and, implicitly, accountability for results and performance. (These organizational arrangements can be different for different types of services.)
- ▲ The lines of responsibility for financing also should be clear and should parallel and reinforce the lines of responsibility for performance. These lines of responsibility for financing could be different for different types of services (i.e., public health, preventive health, and curative care).
- ▲ Organization and financing of the production of health care services should include incentives to reward high quality, promote efficiency, and be responsive to patient needs. Explicit mechanisms to encourage responsiveness to patients' needs should be incorporated. Implicit mechanisms should not be contrary to improved performance and accountability. Excessive or redundant bureaucratic structures and processes should be avoided.
- ▲ Explicit methods that would increase providers' accountability to their patients for the quality of the services they provide should be adopted.

Decentralization and Health Financing Reform: Accommodating Established Policy in the Design of Alternatives

In addition to meeting the four general criteria listed above, alternative organizational and management approaches need to accommodate established policy with respect to decentralization and health financing reform.

With respect to decentralization policy, distinctly different efforts are required—within the broad framework of the law passed in 2000—in each of the three broad categories of health services needed to protect population health: (1) environmental health services, (2) public and preventive health services, and (3) personal, curative medical care services. In the category of *environmental health services*, there is no real debate. Local governments have been delegated responsibility for providing drinking water, sanitation and solid waste disposal, and environmental protection.

In the second category, *public and preventive health services*, government will have to have a central role, although this needs to be more clearly defined. These are public goods with benefits accruing mostly to the community as a whole and not to individuals. Thus, government must fund these services if they are to be made available at all. In place of the previous system of providing these services through District Public Health Directories, it would be appropriate to consider alternatives that would seek to utilize those staff and their technical resources reorganized with clear lines of responsibility and associated flows of funding.

In the third category, *personal, curative medical care services*, it has been decided that funding will be consolidated in the HII, with budget transfers from the MOH and the MoLG&D being added to revenues from social insurance contributions the HII regularly receives. There are numerous alternative configurations to how curative care facilities could be organized and managed to facilitate their receipt of HII payments. It is not feasible for local governments to take full responsibility of the delivery of any services in this category since they have neither the human nor the financial resources to make a meaningful contribution. The national interest in providing uniform benefits and uniform standards of care, and in achieving economies of scale in social financing of these services, argues for a uniform national policy and program for medical service delivery.

Moreover, since the quality and productivity of the delivery of personal, curative services is critically dependent on the incentives structured into the financing as well as the management arrangements, it is necessary to accommodate any proposed alternatives to the government's recent policy decision to unify all sources of financing in the HII. This newly established policy is intended to resolve the problems created by fragmentation, particularly as it has affected the delivery of ambulatory care. Without the careful design and implementation of complementary organizational arrangements and compatible management processes, however, making the HII a single source of health financing could have unintended, negative consequences.

Crafting Alternative Solutions for Health Services Organization and Management

There are two important dimensions to the design of alternative organizational and management solutions:

- ▲ Specify how those responsible for the management of PHC services would relate to those responsible for the financing of those services
- ▲ Specify how individual facilities would be organized and managed (in relation to PHC management and PHC financing) and what payment method would be applied

The authors propose two sets of solutions that address these specifications: the first set are descriptions of solutions implied by the consensus that seems to have been already achieved; the second set presume the described consensus on settled policy issues in presenting options that would involve decisions on policy questions not yet answered. The open questions center on setting policy with respect to two main questions:

- ▲ What degree of autonomy should be given to individual facilities to manage and finance the services they deliver?
- ▲ What is the nature of executive authority to be exercised by government bodies over these facilities, and how does that executive authority relate to the financing authority?

Proposed Components of Reorganization with Consensus Presumed

- ▲ Deconcentration for the Production of Public Health Services – The production of public health services—those preventive and promotive services traditionally organized and delivered by government and referred to in the decentralization law as “the system of priority health services and for the protection of public health”—could be the “joint function” or shared responsibility of a regional health office and local governments. Thus, a new regional health authority responsible for these services would, in effect, represent a deconcentration of centralized bureaucratic authority and would have some autonomy to respond to the specific needs and demands of the local people (in the region) as expressed by their local governments. The local governments themselves would have explicitly delegated responsibilities for implementing (and perhaps financing) the various programs for any specific services designed and required (in these public health functions) by the regional health authority.
- ▲ Unification of the Source(s) of Financing for PHC Services in One Agency – The HII, acting through decentralized regional offices, would serve as the single source of payment for PHC services initially, taking the responsibility for negotiating payment methods and rates for the PHC services to be delivered by the organization of providers chosen from the alternatives suggested below. Since the requirements of authorizing and implementing this proposal are significant, its widespread implementation should be contingent upon a consensus on PHC provider organization, governance, and accountability, and on pilot testing of any proposal.

Components of Reorganization Yet to Be Decided

The following paragraphs propose that the delivery of personal, curative medical care (PHC services, in this particular case) be the responsibility of provider organizations (i.e., health centers, polyclinics) that would be, more or less, under the management control of a regional government authority. The dimension of the proposal that is yet to be decided is the degree of management control to be given the regional authority—or, conversely, the degree of autonomy to be given to provider groups.

Two general alternatives are described in the main report, and one of these is recommended below. In order to test various elements of the proposed design, a more detailed proposal for a pilot project is also described. The design of the pilot project, to be tested first in one region, would require that consensus among the MOH, the HII, and the MoLG&D be achieved with respect to the general major organization and management issues that are addressed in the overall recommendation and in the proposed pilot project design.

Organizing and Managing PHC Delivery Sites: Recommended Option

Given the above assumptions underlying the selection of alternatives, the two options described in detail in this report give differing levels of autonomy to the PHC providers and facilities—each implying distinctly different ways of organizing and managing the production of PHC services at the regional level. The following is the recommended option.

General Recommendation: A regional health office (RHO) would be established and would include a Department of Primary Health Care Delivery (RHO/PHC), which could have two divisions—one urban and one rural. The scopes and natures of their budgets, responsibilities, and authorities (in relation to PHC facilities and providers) could be different according to the specific elements and requirements of the different regions. The RHO would remain under the technical

supervision of the MOH, but would be politically accountable to a regional government authority and financially accountable to the HII, as described below.

The RHO would establish a Department of Quality Assurance (RHO/QA) that would have responsibility for inspecting each clinic and issuing findings if the clinic failed to meet the minimum standard of quality. These findings would be publicly disseminated to provide patients with timely information about any variations in service quality that the RHO/QA detected from one clinic to another. These findings could also ultimately be used as an element of the payment methodology developed by the HII to give providers incentives to improve and maintain service quality.

The HII would be the single source of payment for all costs associated with the PHC services for eligible individuals, except for any copayments that might be required for some services, as with currently reimbursable drugs. The payment amounts transferred from HII to the providers would be negotiated between the HII and the provider organization. The HII would represent the interests of the covered beneficiaries who are contributors or are government-sponsored enrollees (i.e., vulnerable population groups). HII would try to get them the highest quality and quantity of services for the lowest possible price. The providers (or their representatives) would be responsible and held accountable, both by HII as the payer and by the RHO/QA as the accreditor, for providing the services as contracted for with the HII. The providers (or their representatives) would be responsible for documenting their costs in order to justify to the HII any request for changed payments in the future as compared to those that had been agreed to in the past. *A significant reform implied in this proposal is the necessity to develop and support a new cadre of staff through the training and deployment of regional managers and head nurses with skills needed to manage PHC facilities.*

1. Introduction

Recent efforts to implement reform of Albania's health system have brought to the fore a number of problems and issues that exist in its current organization and financing—particularly with regard to primary health care. This paper was written to describe the current situation, analyze the problems, and discuss the various issues underlying them. Alternatives to current arrangements and ways to test a recommended alternative are explored and outlined. This introduction provides the background of the problems and issues identified, and outlines the specific objectives of this paper.

1.1 Background

In October 2002, the Ministry of Health (MOH) unveiled *the Ten-year Development Strategy of the Albanian Health System* (the MOH Strategy) designed to improve the population's health status by improving the availability of high-quality health services. To achieve its ambitious goals, the MOH Strategy depends on an implementation capacity that has recently experienced major organizational and budgetary changes. These changes have given important roles in health to relatively new agencies—the Health Insurance Institute (HII) and the Ministry of Local Government and Decentralization (MoLG&D)—and have blurred the lines of managerial authority and responsibility. Budget flows from the HII that were intended to add resources, and those from the MoLG&D that were intended to “decentralize” certain tasks and functions of the MOH, have had the effect of fragmenting the financing and management of primary health care (PHC)¹.

In response to the evident problems that have resulted, the Government of Albania is currently considering how it might reorganize the financing and management of PHC in order to make its approach to PHC service delivery more effective and efficient. To help with that effort, the *PHRplus* Project, sponsored by USAID² has undertaken to develop four model primary health care practices in Berat and Kucove and to develop the supportive mechanisms that would serve to sustain them: namely, community support; an information system; training to ensure improved service quality; and planning, budgeting, and financing methods that would include performance-based incentives. Evidence from these pilots would be used to determine reforms that would be replicated in other areas of Albania.

One significant achievement of the project's first year has been the development of a working partnership with the Government of Albania in two major areas of health reform to support PHC service improvements: health financing reform and government decentralization. In the area of health financing, Parliament recently passed an amendment to the Health Insurance Law giving the HII the legal basis for becoming the single source of payment for health care.³ This gave endorsement to the

¹ Although the *Law on the Organization and Functioning of Local Government*, No. 7572, dated June 10, 1992, referred to health as a “shared function” defined as being “priority health service and protection of public health,” it did not elaborate further on a more precise definition of those terms, deferring that task to a future law.

² A different type of project is the Tirana Regional Health Authority, funded by the World Bank and DfID.

³ On November 24, 2002, the Albanian Parliament passed an amendment (Law No. 8961) to the 1994 Health Insurance Law (No. 7870) that addresses this issue.

prime minister's announcement (October 7, 2002) that the government's policy goal is to have HII be the sole source of payment for PHC by 2004, and for all health care by 2005.

With respect to decentralization, the various responsible agencies (the Ministry of Finance (MOF), the MOH, and the MoLG&D) represented on the Interministerial Commission on Decentralization (IMCD) are working on an action plan to define how the law making health a "shared function" of central and local governments would be implemented. To some extent, this definition would have to accommodate requirements imposed by the financing reform soon to be designed and implemented. However, the approach to organization and management of the health system is also a matter for deliberate choice. *That is, the government has a unique opportunity now to design the kind of health system that it wants to develop over the next 10 to 20 years.*

1.2 Purpose of This Paper

The purpose of this paper is to address the critical organization and management needs of PHC in Albania and to propose alternative approaches to the systems currently in place. In doing so, it hopes to give technical support to the work of the IMCD and to the efforts of the HII and MOH to design the organizational and management structure for single-source health financing.⁴ To accomplish this, the paper offers the following:

- ▲ Describes the current problems and issues that policymakers face in the area of PHC service delivery,
- ▲ Proposes a conceptual approach for considering alternative solutions to the current problems and criteria for choosing among them
- ▲ Presents options (with recommendations) for a new approach to organization and management of PHC

It is expected that the approach the government selects will include the major health financing reform announced recently by the prime minister—unifying the source of payment for PHC in one agency, the HII.

⁴ This paper thus assumes that this financing reform is settled government policy, but that the specific arrangements for the organization and management of the services to be financed by the HII are yet to be determined.

2. Organization and Financing of PHC Service Delivery: Problems and Issues

During the past decade there have been substantial changes in the ways in which PHC services have been organized and financed in Albania. In essence, changes have occurred in the channels by which funding authority flows for PHC services and who decides how much is provided in the budgets for PHC. As a result of several major policy shifts since 1995, budget funds for PHC that used to flow exclusively from the MOH to its facilities and staff throughout the country are now flowing through a variety of channels—through the HII and the MoLG&D, as well as through the MOH. This has caused fragmentation of administration and management of PHC facilities, as well as a diffusion of accountability for PHC system performance.

This section describes how the organization and financing of PHC services has changed in the past five years. It describes the major changes that have taken place, provides data on the sources of different categories of funding for services, and shows how decisions are now made to allocate and disburse funds through the various channels by which the money flows to its final purposes in supporting PHC services.

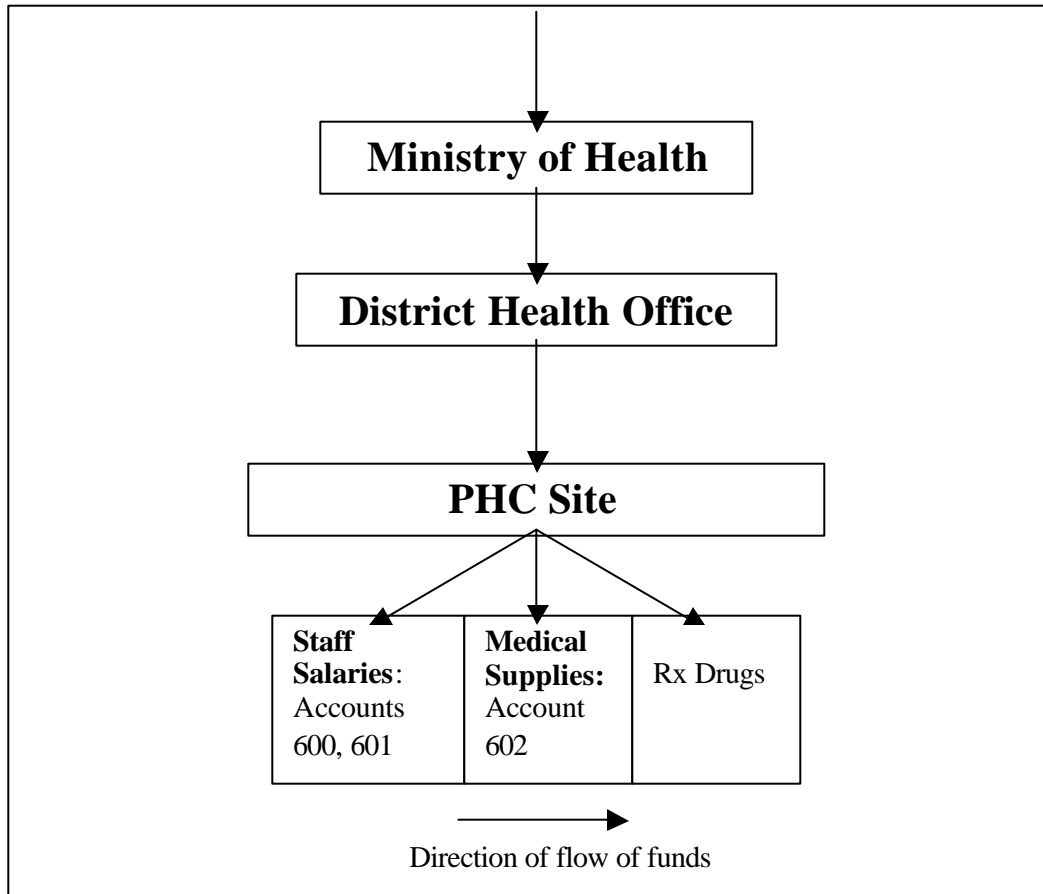
2.1 Summary of the Evolution of the Organization and Financing of PHC

Three important developments have recently occurred to influence the organization and financing of PHC in Albania:

- ▲ The creation of the HII in 1995
- ▲ The transfer of responsibility for the PHC operating cost budget from the MOH to the MoLG&D starting in 1999
- ▲ The creation of the Tirana Regional Health Authority in 1999

Prior to 1995, PHC in Albania was exclusively organized, managed, and financed by the MOH, in the conventional manner of a centralized, bureaucratic hierarchy performing the full range of budget and administrative functions required to operate a government-sponsored health care delivery system. (The relationships of the various levels of the system and corresponding budget authority are graphically represented in Chart A.)

Chart A: Flow of Funding Authority for PHC—Before 1995



Fiscal and political crises of the early to mid-1990s led to a deterioration in the ability of the government to maintain deployment of physicians in rural areas and to provide a consistent supply of essential drugs to its citizens. The seriousness of the situation led, in part, to the first major change in 1995, when the HII was created. Using funds raised from a mandatory 3.4 percent tax on wages,⁵ HII assumed responsibility for paying general practitioners (GPs) and reimbursing most of the costs of outpatient prescription drugs. The MOH continued to pay for other PHC costs.

The second major change came in 1998, when, in order to implement “decentralization” under the 1992 law that created local governments (communes, municipalities, and districts),⁶ the central government decided to give local governments the authority to allocate money to fund the operating and maintenance (O&M) costs of PHC facilities.⁷ To accomplish this, budget funds for the O&M costs of PHC facilities were transferred to the MoLG&D for distribution to local governments

⁵ Authorized by the *Law on Health Insurance in Republic of Albania*, declared with Decree No. 950, dated October 25, 1994, the provisions of which took effect March 1, 1995.

⁶ *Law on the Organization and Functioning of Local Government*, No. 7572, dated June 10, 1992.

⁷ Authorized by the Decree on Local Government Authorities, Functional Tasks, and Funding, No. 204, dated March 26, 1998, pursuant to the *Law on the Organization and Functioning of Local Government*, No. 7572, dated June 10, 1992.

through block grants.⁸ Starting in 1999, some local governments began to decide how much of their block grants to allocate for PHC O&M costs. Some other items in the PHC budget also were transferred to local governments “conditionally,” or through “earmarks,” which meant that the amounts were still determined centrally.

In 1999, another change was initiated with the creation of the Tirana Regional Health Authority. The authority began operations in early 2000 as a pilot/demonstration project to test an approach to organizing and financing PHC using a project that was separate from the MOH and local government. In this case, the project was implemented only in one region, where the capital city, Tirana, is located. This project was funded by a number of donors, principally The World Bank and the Department for International Development (DfID) of the United Kingdom.

2.2 Detailed Descriptions of the Evolution of the Organization and Financing of PHC

2.2.1 The Health Insurance Institute

When the HII was established, some of its important aims were

- ▲ to finance important ingredients of PHC that needed attention (to improve deployment of general practitioners and to increase the availability of affordable prescription drugs);
- ▲ to do so in a way that engendered confidence among contributors that their dedicated payroll tax contributions would be used, and could only be used, to ensure that contributors had adequate access to GPs and drugs; and
- ▲ to lay a firm foundation for developing a social health insurance plan.

The compulsory health insurance contribution to the HII is a relatively small part (a rate of 3.4 percent) of a much larger mandatory social insurance contribution assessed against wages at a composite rate of almost 40 percent of wages.⁹ Employees and their employers (for persons employed in the modern sector) share the cost of the health insurance contribution to the HII, with half of the 3.4 percent payroll tax coming from employees and half coming from employers. By law, revenue from the contributions is earmarked to go to the HII exclusively for paying general

⁸ The block grant program not only consolidated some O&M budget funds for health, education, and social assistance sectors into one funding mechanism, but it redistributed those amounts. A formula was applied so that the amounts of the block grant (per capita) received by each local government would be closer to the national average block grant per capita—promoting greater equity in distribution of those funds than there had been previously.

⁹ Health insurance contribution rates are different for different categories of people. For self-employed persons in cities, the rate is 7 percent of the minimum wage per year. For field areas of the country, it is 5 percent of the minimum wage per year, and for mountain areas, it is 3 percent of the minimum wage per year. In practice, these contributions are essentially voluntary. The HII pays the Social Insurance Institute a service fee of 1 percent of gross collections to compensate it for the costs of collection. One reason for extensive noncompliance is that no one can enroll in HII separately from enrollment in the full range of general social insurance programs, which requires substantial contributions beyond those listed above for HII (employers, by law, are required to contribute an amount equivalent to 29 percent of their employees' wages and salaries as their contribution towards the various elements of the social insurance program; an additional 9.5 percent is deducted from employees' pay as their contribution. These percentages include the contributions (1.7 percent each) for health insurance).

practitioners to serve in all areas of Albania and for reimbursing enrollees for a substantial portion of the cost of essential prescription drugs.¹⁰

Persons that are actually subject to the monthly payroll deductions required in the formal sector do not comprise much of the population (about 25 percent). Fewer actually pay the required contributions (about 40 percent of that 25 percent, or about 340,000, according to 1999 data) (Bladen et al., 2000). Many persons in need of prescription drugs would have been left out of the plan were it not for the provision in the law requiring the state to contribute to the HII on behalf of certain segments of the “inactive” population.¹¹ The amount of the state contribution on their behalf is theoretically whatever is needed to cover their use of the benefits, according to an actuarial estimate of that need made by the HII.¹² But the annual amount the MOF transferred to the HII in the last three years has actually decreased, from Lek 1.3 billion in 1999 and 2000, to Lek 1.2 billion in 2001. Meanwhile, the amount collected in contributions has increased steadily from Lek 1.3 billion in 1999 to almost Lek 1.9 billion in 2001. (Chart B shows the budget authority for the various inputs to production of PHC services was split as a result of the creation of the HII.)

Although the HII solved the two immediate problems of PHC service production (inadequate deployment of GPs—at least in relation to previous norms—and insufficient supplies of prescription drugs), the solution neglected to consider other important ingredients of a comprehensive system for delivering PHC, namely,

- ▲ the need for sufficient complementary funds for supplies,
- ▲ the need for clear channels of responsibility for overall performance and quality of PHC service delivery, and
- ▲ the need for budgeting and financing arrangements to be in alignment with the ability of managers to hold staff accountable for its performance.

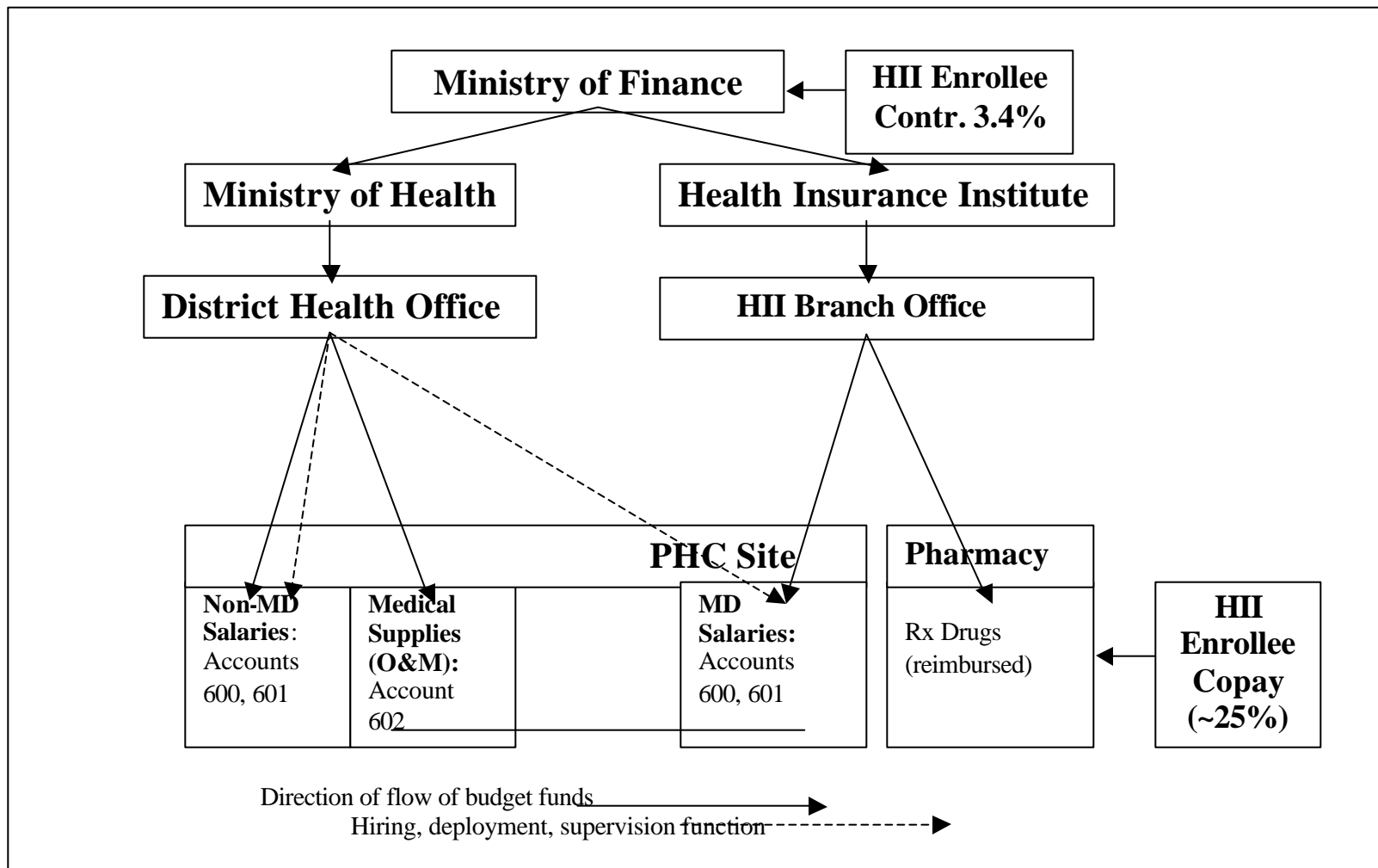
Not only were these necessary ingredients not addressed, but the budget transfers that were made (from 1999 on) to promote decentralization had the effect of fragmenting the financing and management of PHC still further.

¹⁰ The HII reimburses “a part of drug’s price in open pharmaceutical network, and the expenses of service from a general practitioner of family doctor” (Article 4 of Law 7870 of October 13, 1994).

¹¹ Children, nonworking students, elderly on pensions, disabled, unemployed, persons receiving social assistance, mothers on maternity leave, veterans, and citizens performing compulsory military services.

¹² In reality, contributors pay much more (as much as three times more) than they receive in benefits. This means that the risk-spreading benefits of the program are enjoyed more by the “inactive” population for whom the state pays than by the contributors whose contributions subsidize the benefits of the “inactives.”

Chart B: Flow of Funding Authority for PHC—1995–1998



2.2.2 The Law on Decentralization and Its Implementation¹³

Associated changes in the flow of funds occurred alongside the complications of concurrent changes in the political structure and processes due to decentralization. In 1999, the MoLG&D had begun to distribute (and redistribute) to local governments funds that had previously been channeled through social sector ministries (health, education, and social assistance). The Council of Ministers decreed in March 1998, that local governments had the authority to “administer and (be) fully responsible for...administration, maintenance, supplying with general commodities, water, power, heating, painting and other services...in relation to (in health care) nurseries, ambulatory service health centers and clinics, dental clinics, and DDD service,” and for “supervision of the health care service at a district level.”¹⁴ In practice, this new authority led the MoLG&D to take over the MOH’s responsibility for distributing the budgeted funds for O&M expenses (Account 602 monies to fund “supplies and other services” for health centers and health posts). [It is not clear whether such budgeted funds for polyclinics were also included.] These funds were transferred from the MOH budget to the MoLG&D budget starting in 1999 in the amount of about Lek 400 million. (See Charts C and D for graphical representations of the resulting fragmentation of budget authority for funding of PHC services.)

For 1999 and thereafter, the level of funding for O&M costs (of PHC and public health functions) and the range of tasks (within O&M) to be funded by the block grants was not earmarked in the grants or otherwise identified. Each local government was free to decide how much it wanted to spend for the tasks it was given. Funding for the expenditures of health care workers’ salaries (other than GPs, who were paid by the HII) remained as it was in 1998 and earlier. These same arrangements continued in 2000, 2001, and 2002, with the exception of funding for polyclinics and health centers in municipalities in “district” centers (as described below).

Following the debate on decentralization that led to Decree No. 204 in 1998, there was an extended effort to develop a new law that would update the 1992 law and establish a new, comprehensive policy on how “decentralization” would proceed in the future. This effort culminated in the development of a National Decentralization Strategy that was given legal expression in a new law Parliament passed and signed in mid-2000.¹⁵ This new law established that “priority health service and the protection of public health” would be a “shared function” of both central and local governments. But while it abolished the old local government law (of 1992) and “any other acts contrary to this law” (including, of course, Decree No. 204), it left the actual implementation of the “shared functions” for further definition in the future, “according to the manner defined by law.”¹⁶ Since then, while an IMCD has been deliberating on these issues and a Group of Experts on

¹³ Information in this section relies for the most part on The Urban Institute, “Local Financing of the Social Sectors,” unpublished memo by Francis Conway, October 2002.

¹⁴ *About Local Government Authorities, Functional Tasks, and Funding*, dated March 26, 1998, pursuant to Law No. 7572, June 10, 1992.

¹⁵ The Law on Organization and Functioning of Local Governments, No. 8652, dated July 31, 2000.

¹⁶ Article 72.7 of Law No. 8652.

Decentralization (GED) has been formed to advise the committee,¹⁷ no further laws have been passed, and a more precise definition of the “shared function” referred to has not been established. Meanwhile, the budget flows created by Decree No. 204 in 1998 have continued under the authority of budget guidance issued by the MOF and MoLG&D.

Besides further fragmentation in the flow of funds, this extended disconnect between the new law passed by the Parliament and the continuing practices of budget making has caused considerable confusion and delay—as well as budget shortfalls—at the local government level. Because the new (2000) *Law on Organization and Functioning of Local Governments* abolished the old (1992) law on local governments and “any act contrary to this law,” the only legal basis for continuing block grant funding was the annual budget implementation guidance prepared by the MOF and MoLG&D. Effective January 1, 2001, however, the new law had abolished the District Councils and replaced them with Regional Councils. As the Regional Councils were to be created starting on January 1, 2001, they had no authority prior to that date to create budgets. Thus, the O&M expenditures for PHC that had been the responsibility of District Councils (which ceased to exist by January 1, 2001) were assigned on an interim basis to be spent through the prefectures (representative of the central government) in each of the new regions for the budget year 2001. This included funding for O&M costs at PHC facilities in each of the old “district” municipalities. Although this interim assignment to the prefecture expired at the end of 2001, it was not until March 6, 2002, that the municipalities affected were informed that they had been given responsibility (as of the 2002 budget) for paying for PHC O&M expenses out of their block grants from MoLG&D.

As then stated in guidance no. 889 of the Finance Department of the MoLG&D,¹⁸ responsibility was as follows:

- ▲ (For the health centers, city and village clinics): The maintenance and operating expenditures (water, electricity, fuel, drug purchasing) for the health centers and clinics are competencies of the communes and municipalities. The funds are included in the grant of every commune and municipality except Tirana district.
- ▲ (For the polyclinics, Dental Clinics, Sanitation and Epidemiological Directorate): The maintenance and operating expenditures (water, electricity, fuel, drug purchasing) are competencies of the municipality that covers the institution area. The MoLG&D delegates the funds as a grant.

The local governments, of course, had already budgeted their block grant allocations for the year 2002, and had not included any budget allocations for the health competencies mentioned. The MoLG&D resolved this problem by providing a supplemental grant to the respective municipalities to fund the O&M costs of the polyclinics and health centers. The Ministry drew the money from a special reserve set aside in the block grant pool to compensate local governments for unusual expenditures. Unfortunately, only enough money was provided to fund about 50 percent of what was budgeted in the previous year. This shortfall has put a serious strain on the operations of those facilities that had depended on those funds, and some were reported to have had barely enough to pay

¹⁷ The action plan of the IMCD for the year 2002 (About the accomplishment of obligations set forth on Chapter XI of Law No. 8652, dated July 31, 2000, “About Organization and Functioning of Local Government”) assigned the GED the task of “drafting the policy paper concerning the determination of the competencies of local government in the field of primary health care and protection of public health.” The MOH is given the task of “adaptation of laws on the bases of the GED paper” on the above.

¹⁸ “Subject: On the shared functions of the Local and Central Government on Health and Education and the local government function on Sport”, Finance Department, MoLG&D, March 6, 2002.

for basic utilities, such as light and heat.¹⁹ It also has raised the question of how the O&M costs of PHC facilities would be handled in budgets for 2003.

Although the MoLG&D's directive of March 2002 referred to "shared functions" (as stated in the new law of July 2000), there has not yet been any determination, in law or otherwise, of the definition of such a "shared function," which in health is referred to in the new law as "priority health service and the protection of public health." In practice, the "competencies" named have been in terms of specific budget responsibilities that are "conditional," "earmarked," or "unconditional." The administrative and managerial responsibilities to accompany the budget responsibilities have not yet been identified in law or regulation. As a result, as budget and administrative responsibility has become fragmented, accountability for performance has become quite diffused.

Since the MoLG&D has absorbed the Account 602 budget for PHC, it has carried that 1998 amount forward, increasing it by 5 percent per year as it included it with other O&M budgets from other social sectors when lumped into the block grant. However, the MoLG&D does not know how much the local governments (that is, those which received "unconditional" block grants) actually have allocated to health, let alone what those allocations actually purchased. The communes are required to report that information to the MOF, which has data showing the decline in communal councils' allocations to PHC.

2.2.3 The Tirana Regional Health Authority

Events occurring in this broader context of "decentralization" efforts led to the creation of the Tirana Regional Health Authority (TRHA). TRHA began operations in early 2000 as a pilot/demonstration project in an attempt to organize and finance PHC as an autonomous regional body separate from both the MOH and local government. The financing of the TRHA's facilities and services also had multiple original funding sources (from the MOH, the HII, and the MoLG&D) as previously described, but the channels by which the funds flow to the TRHA, and the responsibilities exercised by the various agencies, are specific to the unique design features of the project. While it is beyond the scope of this paper to describe or analyze the TRHA experience so far, there are likely to be numerous lessons to be learned by the time the project is completed in 2004—the most important being to determine how relevant the project may be for use in other parts of Albania.

2.3 Recent Levels and Trends in Spending on PHC

Levels and trends in recurrent government health spending are detailed in Table A1 and summarized in Table A2, which shows the portion of the expenditures that were devoted to PHC activities by various agencies. The three years, 1998-2000, show actual expenditures reported by the relevant agency, except for the MoLG&D spending figures, which are the author's estimates.

Tables B and C show the budget category breakdowns for the municipalities of Berat and Kucove and the communes of Otlak and Kozare (which are the sites of the four health centers selected to participate in the PHR*plus* Project).

¹⁹ An estimated Lek 100 million from the MoLG&D reserve fund was subsequently supplemented by about Lek 74 million from the MOF.

Table A-1: Health Care and PHC in Albania: Detailed Levels and Trends in Spending 1998-2002

(Lek in thousands)

Summary: Ministry of Health

2002 PHC: Ministry of Health

	<i>Projected Projected Proj.</i>											
	1998	1999	2000	2001	2002	% Incr	1998	1999	2000	2001	2002	
Staff	4,109,695	4,427,941	4,778,821	5,208,915	5,677,717	9%	Staff	1,641,662	1,816,980	1,973,620	2,151,246	2,344,858
Supplies	1,679,800	1,738,614	2,046,306	2,107,695	2,070,926	3%	Supplies	366,245	373,769	389,421	401,104	413,137
Drugs	749,000	861,386	941,694	1,007,613	1,078,146	7%	Drugs	138,055	135,831	145,659	155,855	166,765
Admin							Admin					
TOTAL	6,538,495	7,027,941	7,766,821	8,324,223	8,826,789		TOTAL	2,145,962	2,326,580	2,508,700	2,708,205	2,924,760

Summary: Health Insurance Institute

PHC: Health Insurance Institute (includes 50% of Rx drugs)

	<i>Projected Projected Proj.</i>											
	1998	1999	2000	2001	2002	% Incr	1998	1999	2000	2001	2002	
Staff	390,515	425,800	455,654	528,211	686,674	30%	Staff	390,515	425,800	455,654	528,211	686,674
Supplies	0	0	0	0	0	0	Supplies	0	0	0	0	0
Drugs	1,784,035	1,941,150	1,705,164	1,721,470	1,549,323	-10%	Drugs	892,018	970,575	852,582	860,735	774,662
Admin	130,898	202,917	249,938	296,642	296,643	5%	Admin	130,898	202,917	249,938	296,642	296,643
TOTAL	2,305,448	2,569,867	2,410,756	2,546,323	2,532,640		TOTAL	2,305,448	2,569,867	2,410,756	2,546,323	2,532,640

PHC: Ministry of Local Government and Decentralization

PHC: Ministry of Local Government and Decentralization

	<i>Projected Projected Proj.</i>											
	1998	1999	2000	2001	2002	% Incr	1998	1999	2000	2001	2002	
Staff	0	0	0	0	0	0	Staff	0	0	0	0	0
Supplies	391,714	352,543	317,288	307,770	298,537		Supplies	391,714	352,543	317,288	307,770	298,537
Drugs	0	0	0	0	0		Drugs	0	0	0	0	0
Admin	0	0	0	0	0		Admin	0	0	0	0	0
TOTAL	391,714	352,543	317,288	307,770	298,537		TOTAL	391,714	352,543	317,288	307,770	298,537

Source: MoH, Albania, Ten-year Development Strategy of the Albanian Health System, Tirana, MOH/Government of Albania, October 2002.

Notes: Assumes LGs allocate what MOH would have in 1998, then 10% less yearly, then decline slows in 2001 and 2002 to 3% per year.

PHC includes polyclinics, dental, H&E departments, and health centers/posts.

Only 50% of total HII reimbursements for Rx drugs are presumed to be PHC-related; 50% is assumed for inpatients & the chronically ill.

Table A-2: Primary Health Care in Albania: Levels and Trends of Spending 1997-2001

(Lek in thousands)

Summary	ALL AGENCIES						Percent of Total Health Budget Devoted to Primary Health Care					
	1997	1998	1999	2000	2001	2002	1997	1998	1999	2000	2001	2002
Staff	3,679,665	4,500,210	4,853,741	5,234,475	5,737,126	6,364,392	Staff	45%	46%	46%	47%	48%
Supplies	1,356,194	2,071,514	2,091,157	2,363,594	2,415,465	2,369,462	Supplies	37%	35%	30%	29%	30%
Drugs	612,276	2,533,035	2,802,536	2,646,858	2,729,083	2,627,469	Drugs	76%	74%	70%	69%	65%
Admin	0	130,898	202,917	249,938	296,642	296,643	Admin					
TOTAL	5,648,135	9,235,657	9,950,351	10,494,865	11,178,315	11,657,966	TOTAL	52%	53%	50%	50%	49%

ALL PHC	ALL AGENCIES						Percent of Total PHC Budget by Agency Source of Funds					
	1997	1998	1999	2000	2001	2002	1997	1998	1999	2000	2001	2002
Staff		2,032,177	2,242,780	2,429,274	2,679,457	3,031,532						
Supplies		757,959	726,312	706,709	708,873	711,673	MoH	44%	44%	48%	49%	51%
Drugs		1,922,090	2,076,981	1,850,823	1,877,325	1,716,088	HII	48%	49%	46%	46%	44%
Admin		130,898	202,917	249,938	296,642	296,643	MoLG&D	8%	7%	6%	6%	5%
TOTAL		4,843,124	5,248,990	5,236,744	5,562,297	5,755,937	TOTAL	100%	100%	100%	100%	100%

Source:

Ministry of Health, Albania, "Health System Strategy: 2000-2010 for Albania," Draft May ,2000.

1997 Table 28, p. 62

1998 Table 29, p. 63

1999 Table 30, p. 63

2000 Table 6, p. 17

NOTE: PHC includes polyclinics, dental, H&E departments, and health centers/posts.

Table B: Health Care and PHC in Berat, Albania: Levels and Trends of Spending, 1998-2002

BERAT MUNICIPALITY: ALL HEALTH SPENDING

Population: 44, 191

(in millions of Lek)

Summary: Ministry of Health

	Actual 1998	Actual 1999	Actual 2000	Projected 2001	Projected 2002	Projected 2002 % Change
Staff	142	153	169	187	204	9%
Supplies	69	81	84	96	99	3%
Admin	32	25	9	75	80	7%
TOTAL	243	260	263	358	383	

Summary: Health Insurance Institute

	1998	1999	2000	2001	2002
Staff	17	17	18	22	28
Supplies	0	0	0	0	0
Drugs	83	76	81	86	77
Admin/Other	3	5	6	8	8
TOTAL	103	98	105	115	113
HI Contributions	31	35	32	50	
State Transfer, Inactives	34	75	75	75	
Total HII Income	65	110	107	125	

Summary: Ministry of Local Government and Decentralization

(no basis for estimation; need to obtain data)

	1998	1999	2000	2001	2002
Supplies	na	na	na	na	na
TOTAL	na	na	na	na	na

OTLAK COMMUNE (BERAT DISTRICT)

Population: 12,352

(In millions of Lek)

Summary

	1998	1999	2000	Projctd 2001	Projctd 2002
NonMDs (MOH)	2.1	2.3	2.5	2.8	2.3
MOLGD	0.5	0.3	0.3	na	na
TOTAL	2.6	2.5	2.8		

PHC (estimated): ALL AGENCIES

(in millions of Lek)

	1998	1999	2000	2001	2002
Staff MDs (HII)	17	17	18	22	28
Staff (MOH)	28	31	34	37	41
Supplies (MOLGD)	18	18	19	20	21
Drugs (HII)	83	76	81	86	22
TOTAL	145	142	151	164	112

Staff for PHC are estimated at 20% of the total staff for Berat.

Supplies (MOLG) are estimated at 30% of total staff compensation.

Table C: Health Care and PHC in Kucove, Albania: Levels and Trends of Spending 1998-2002

KUCOVE MUNICIPALITY

Population:: 18,100

(In millions of Lekh)

Summary

	Actual 1998	Actual 1999	Actual 2000	Projected 2001	Projected 2002	Proj. % Incr 2002
Staff	32	33	37	40	43	9%
Supplies	12	14	14	15	13	3%
Transfers (604)	11	17	11	10	11	7%
Admin						
TOTAL	56	64	61	65	67	

Summary: Health Insurance Institute

	1998	1999	2000	2001	2002	% Incr
Staff	5	5	6	7	10	30%
Drugs	18	23	26	21	20	-5%
Admin/Other	1	1	0	0	0	5%
Total Spending	24	30	33	28	30	
HI Contributions	17	18	21	22		
State Transfer, Inactives	7	8	10	10		
Total HII Income	24	26	31	32		

Summary: MOLGD (communes only through 2001; includes municipality in 2002)

(estimated; needs confirmation)

	1998	1999	2000	2001	2002
Supplies	2.6	2.4	2.1	2.1	5.6
TOTAL	2.6	2.4	2.1	2.1	5.6

KOZARE COMMUNE (KUCOVE DISTRICT)

Population: 6,605

(In millions of Lek)

Summary

	1998	1999	2000	Projected 2001	Projected 2002
MOH/NonMDs	4.1	3.9	4.3	4.8	5.2
MOLGD/Supplies	0.9	0.6	0.7	0.8	0.8
TOTAL	5.0	4.6	5.0	5.5	6.0

PHC (estimated): ALL AGENCIES (Berat only)

	1998	1999	2000	2001	2002
Staff MDs (HII)	5	5	6	7	10
Staff (MOH)	6	7	7	8	9
Supplies (MOLGD)	5	5	5	5	6
Drugs (HII)	18	23	26	21	22
TOTAL	34	40	45	41	46

Staff for PHC are estimated at 20% of the total staff for Berat.

Supplies (MOLGD) are estimated at 30% of total staff compensation.

In order to put the aggregate (national) levels and trends of spending, and their proportions, into some perspective, the pertinent data relating to facilities, staffing, and utilization are presented in Table D, along with the mathematical averages that may have some import.

Chart D shows the relative magnitudes of the budgetary flows as were earlier shown (without the budget figures added) in Chart C.

Analysis of the data summarized here supports the following observations and conclusions.

Chart C: Flow of Funding Authority for PHC—1999 and Beyond

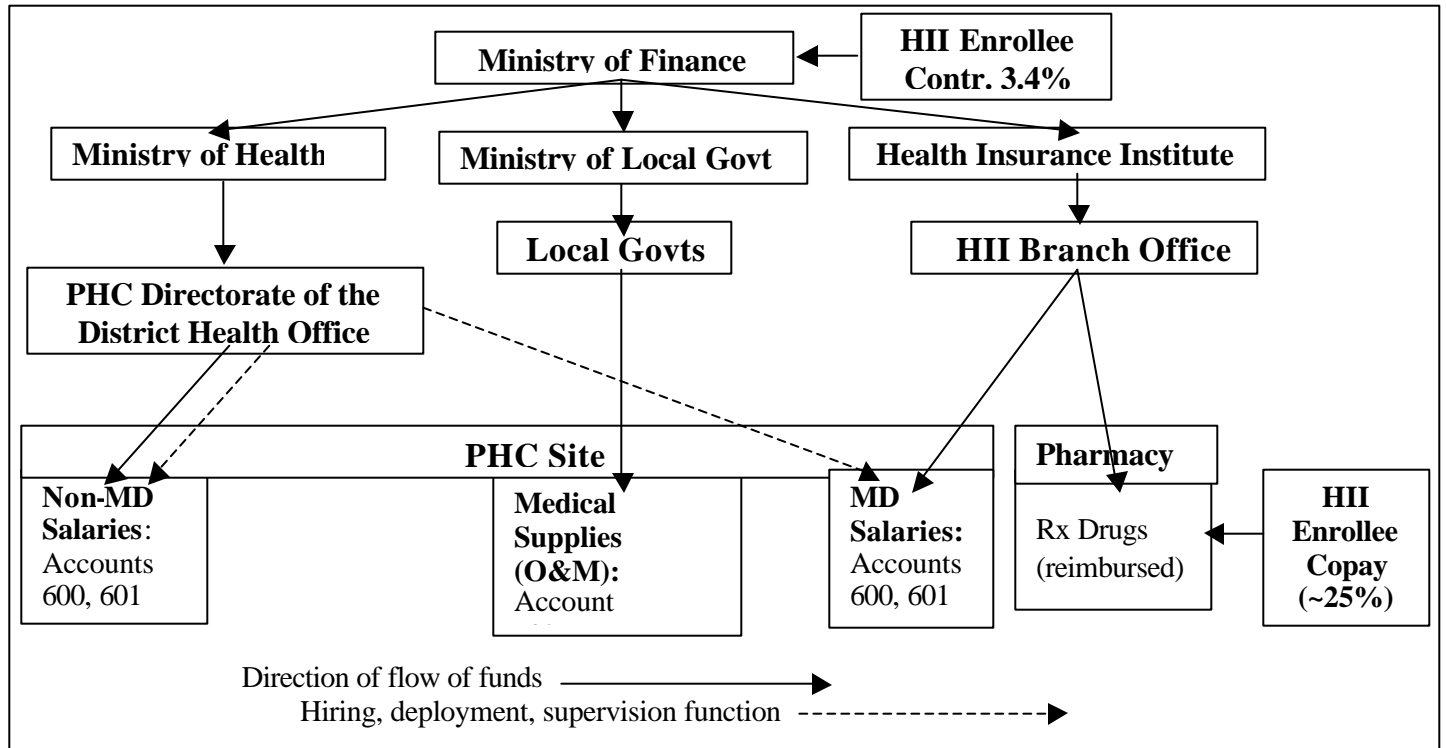
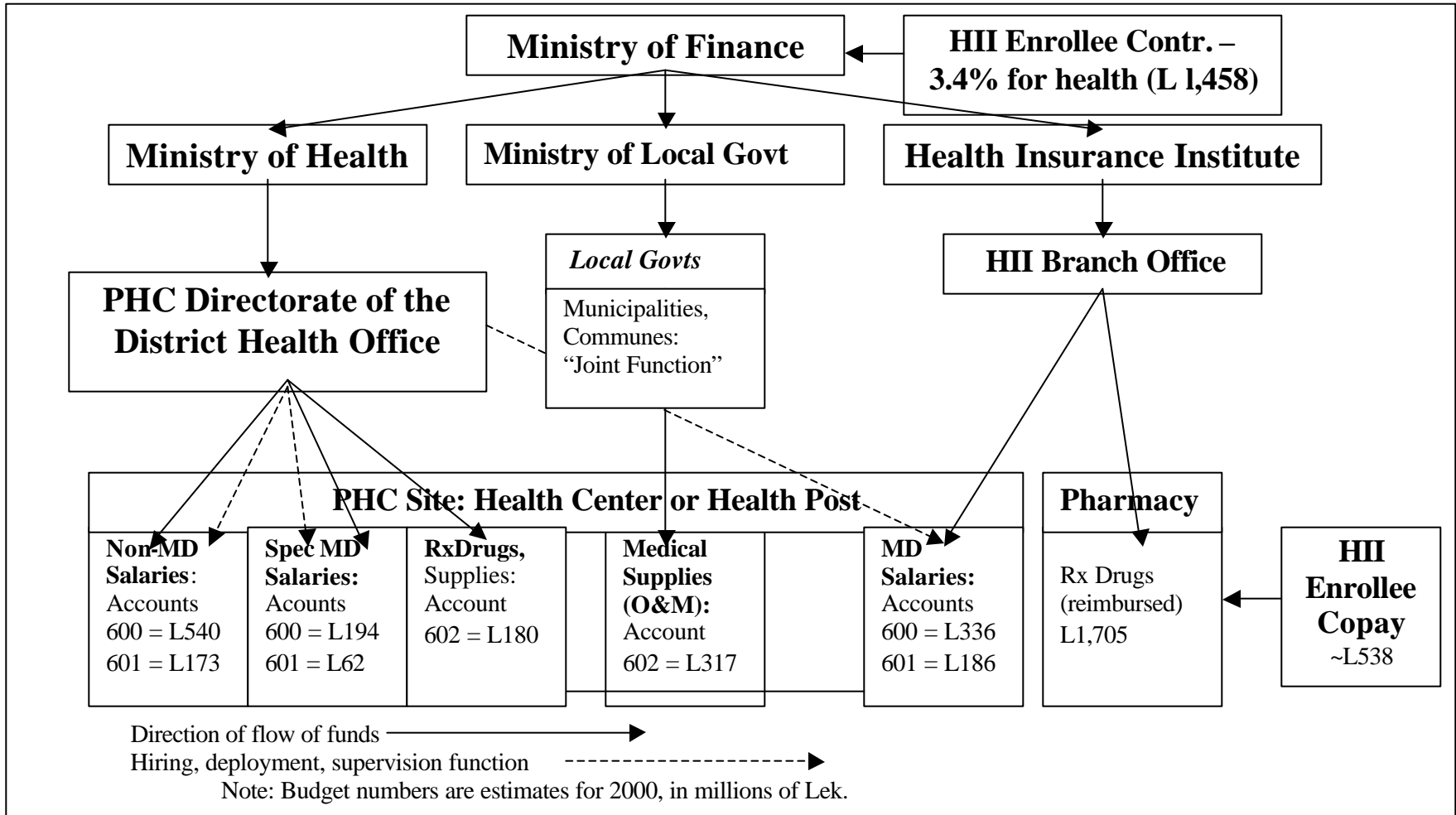


Chart D: Flow of Funding Authority for PHC—1999 and Beyond (Detail)



2.3.1 Financing of Primary Health Care

There is no scarcity of government budget funds, in the aggregate, for PHC. The PHC funds comprise an estimated 43 percent of the total amount the government spends on health (see Table D). This is as high as it is because about half of all funds for personnel are devoted to PHC and more than 36 percent of the social insurance financing through the HII is estimated to be spent reimbursing outpatients for prescription drugs²⁰.

Table D: Summary Statistics (Estimated) on Facilities, Staffing, and Costs: Primary Health Care, Albania 1998-1999

<i>Facilities, 1999</i>	Number	Total Visits	Visits per Facility/Yr	Visits per Facility/Day	Rx per Year		
Polyclinics	53	2,535,947	47,848		184		
Health Centers/Posts	2,200	3,060,734	1,391		5	2,700,000	
Urban	324	1,565,071	4,830		19		
Rural	1,876	1,495,663	797		3		

<i>Staffing, 1999</i>	GPs	Pediatricians*	Specialists	Total MDs*	Nurses*
Polyclinics			363	363	670
Health Centers/Posts	1,557	1,102		2,659	4,300
Hospitals			1,303	1,303	7,760
TOTAL	1,557	1,102	1,666	4,325	12,730

* Distribution by facility type is estimated.

<i>Costs, 1998</i> (in millions of Lek)	MOH Staff	HII Staff	MOH Supplies	MoLG&D*	TOTAL	Cost per Visit (Lek)	Cost per Rx (Lek)
Polyclinics	591			202	793	313	
Health Centers/Posts	821	430			391	1,642	537
TOTALS	1,412	430	202	391	2,435	435	700

Sources:

Facilities and staffing data from C. Bladen et al, 2000, pp. 7-9 (Location of pediatricians is not clear from source.)

MOH cost data from "Health Reform Strategy 2000-2010, Ministry of Health, Albania," 2001 draft, Table 29, p. 63

HII cost data from HII Annual Report, 1998 (Cost per Rx includes an average 25% copayment by beneficiaries.)

*MoLG&D cost data estimated at the difference between MOH Account 602 in 1997 and MOH Account 602 in 1998.

²⁰ This percentage share for PHC assumes that 50 percent of HII reimbursement for Rx drugs is PHC related and the rest is spent for inpatients and for treatment of chronic illnesses, like diabetes and hypertension.

While the aggregate level of resources for PHC seems adequate, there is some evidence that it is inefficiently allocated (Bladen et al., 2000). The HII's funding of PHC (more than one-third of the PHC total) is devoted to financing deployment of GPs according to population (19 percent of its 1999 budget) and to reimbursing for prescription drugs (73 percent of its 1999 budget). Of the 1,553 physicians who contracted with the HII in 1999, 794 (more than half) were located in rural areas, where they could receive compensation between 150 to 350 percent of that of urban HII physicians—even though their productivity was much less than that of urban PHC physicians. Rural health centers and health posts averaged three visits per day in 1999 while urban facilities averaged 19 visits per day. During the 1990s, the total number of outpatient visits per capita dropped by half from 3.2 to 1.6, while the number of health centers and health posts decreased by less than 25 percent. During the same period, at a time when the rural population was declining, an established pattern emerged whereby patients bypassed health centers and health posts to visit specialists at polyclinics in urban areas.

There is little question that insufficient funds exist for operating expenses at health centers and health posts, and local governments seem to have neither the willingness nor the ability to raise or allocate sufficient funds. But in the absence of adequate supplies, and with physicians predominantly focusing on writing prescriptions, there is little for the MOH-funded nursing staff to work with in many of the PHC facilities.

Thus, while increased operating funds may be needed for PHC at many health centers, the policy problem is, in general, more a result of the misallocation of funds. Note in Table D, for example, that highly utilized polyclinics have a cost per visit (excluding the cost of drugs) considerably below that of health centers and health posts (Lek 313 versus Lek 537²¹).

A delivery model that would assist Albania in improving its allocation of government funds within PHC would need to explicitly address the organization and financing questions that are raised by the fragmentation of authority, budgeting, and accountability for performance.

Currently, user fees patients pay at the point of service are only a minor source of funds for PHC. Officially, only those patients who are not enrolled in the HII are required to pay a nominal fee (Lek 200 per visit, about US\$1.30), and these receipts are deposited into a supplementary account that is dedicated for salary supplements to the staff and to purchase needed supplies and drugs. There is anecdotal evidence, however, that informal payments paid directly to the staff are the practice at many facilities, and this may be most prevalent at the higher level polyclinics and hospital outpatient departments. While there is no reliable information available about the relative importance of this source of funds, patients' willingness to pay for needed services is a potentially important consideration when designing a future health financing policy.

2.3.2 Decentralization and the Role of the MoLD&G in PHC Financing

When the MoLG&D gave authority (beginning with Decree No. 204) to local governments to be responsible for funding the O&M costs of PHC facilities, the MOF transferred the entire amount of the budget for "supplies and services" (Account 602) that had been allocated in the MOH budget to health centers and health posts throughout the country. This amounted to about Lek 400 million and

²¹ Of course, the high average cost of visits to health centers and health posts is predominantly a reflection of low productivity at these facilities. That is, it reflects relatively low utilization (in the denominator) more than it does relatively high total costs (in the numerator).

was added to similar accounts collected from the other social sector ministries to create an amount to be distributed to the local governments as an “unconditional” block grant, which each local government would be able to allocate among the designated functions as specified in the law.

Since 1998, the MoLG&D has been phasing in a formula to determine how the block grant monies would be redistributed so that the relative shares of the block grant received by the local governments would not be as inequitable (on a per capita basis) as they had been. The effect of the formula, when fully phased in, would be to narrow the large dispersion of “Lek per capita” averages that each local government would receive, as compared to what they had been receiving directly from the line ministries.

Because the MoLG&D receives no reports from local governments about the precise sectoral allocations (whereas the MOF does), it does not know the relationship between its assumption about the proportion going to health (which it may base on the original level transferred from the MOH) and the local government’s real expenditures towards PHC. (In the case of the TRHA, MoLG&D has specific information based on its determination that Lek 142 million would be transferred annually to the TRHA for purposes of supporting the project. This was supplemented in 2001 by the HII’s contribution of Lek 261 million, and in 2002 by a contribution of Lek 464 million.)

The task for the immediate budget cycle is to determine how the O&M funds for PHC facilities can be provided to meet the need, while at the same time preserving an opportunity to develop a long-term solution to the problems created by fragmentation in budgeting and financing, and, hence, in administration, management, and accountability for quality, productivity, and performance by PHC service providers.

2.3.3 Decentralization and the Private Sector

The above analysis has focused on the efforts to decentralize management of the supply of government health services, with a particular focus on PHC. It should be noted, however, that no matter how the supply of services is organized and managed, the demand side of the medical care market has always been fully decentralized—with individual patients making individual choices about their sources of care and, when fees are charged, about how much to pay for that care. Presently, most sources to supply medical care are those sponsored by the government. Management of these services is currently experiencing a significant but so far uncertain transformation under the decentralization initiative. However, although current public policy requires that only modest user fees be charged at government facilities, there are reports that informal payments are very often required to access medical care, as noted above, and the amount requested may be substantial.

Whatever the current frequency and magnitude of such payments, the potential purchasing power that is represented by patients’ willingness to pay for medical care could, when combined with very significant payments from third-party insurance (now provided by the HII for limited services²²), provide the basis for private investments in new sources of supply—giving patients alternatives to the existing government sources. The two principal advantages of privatizing (at least ambulatory) medical care would be (1) that consumers would be able to hold providers accountable for their quality (switching providers until satisfied), and (2) that providers would have the incentives, as well

²² Current law requiring that the HII pay doctors’ salaries (no matter what their productivity) would have to be changed to link payments to specific services for specific covered individuals.

as the managerial flexibility, to be efficient in the production of services.²³ While the political and economic environment would need to be more explicitly supportive of expansion of the private medical care sector than it is now,²⁴ it is worthwhile to note that there could be a role for the private sector as well as the government sector in the supply of medical care.²⁵ Moreover, behavioral incentives that are commonly used in the private sector to promote efficient and effective models of delivering medical care could be used, or adapted for use, in services still sponsored by, and/or financed by, the government sector.²⁶

2.4 Channels of Disbursement of Budgeted Funds

The five major spending categories in the MOH budget are as follows:

- ▲ 600 – “salaries,” which include the basic cash compensation to employees
- ▲ 601 – “social insurance contributions,” which are the payments for social and health insurance associated with the salaries in 600
- ▲ 602 – “supplies and services,” or the general expenses for operation and maintenance of the services delivered and the facilities in which they are delivered
- ▲ 603 – “subventions,” which comprise reimbursements from the HII for the portion of the cost of prescription drugs purchased by HII enrollees
- ▲ 604 – “internal transfers,” funds that flow from one part of the budget to another part of the budget (e.g., state contributions to the HII for the inactive population).

In the past, local offices of the line ministries of the central government have prepared budgets according to fairly strict guidelines sent down by the MOF, which suggested that they make requests on the basis of the previous year’s expenditures, plus an increase for inflation or other costs. This increase had been averaging 7 percent annually, according to reports, until the redistribution of funds through the block grants under decentralization made all budget preparations extremely unpredictable. Local governments prepare budgets under somewhat looser rules, and these are changing every year as the amount of “unconditional” funds local governments receive increases.

²³ Note that privatization of the means of production of medical services is an extreme form of decentralization in that it gives full autonomy to the individual practice to decide what level and kinds of investment in staff, supplies, and equipment may be needed, and to be responsible for patients’ perception of the quality of the services then produced. Subject to a regime that regulated quality and enforced consumer protections, the practice would then be accountable mainly to those who paid for the services (i.e., the patient and the patient’s insurer).

²⁴ In April 2003, the Council of Ministers approved a draft law (for Parliament’s subsequent consideration) that would make the environment considerably more supportive, enabling the licensing of private hospitals and of private providers opening their own clinics.

²⁵ Patients’ ability to “shop around” for the best quality would be limited for primary health care in rural areas, and certainly for secondary and tertiary care in all areas. Competition among private ambulatory care providers would thus only be feasible in urban areas, and among a limited number of relatively small private hospitals in Tirana.

²⁶ For a discussion of the issues involved in planning market-based reforms to the health sector, see R. Saltman, “Applying Planned Market Logic to Developing Countries’ Health Systems: An Initial Exploration,” Discussion Paper No. 4, Forum on Health Sector Reform, Geneva: World Health Organization, 1995 (WHO/SHS/NHP/95.7). For a review of several such recent health sector reform experiences of relevance to Albania, see H. L. Fuenzalida-Puelma, “Health Care Reform in Central and Eastern Europe and in the Former Soviet Union: A Literature Review,” unpublished consultant’s report to The Open Society Institute, Budapest, Hungary, March 2002.

However, once budgets are submitted in final draft by September 15th of each year, the MOF makes the final decisions.

Until 2002, the O&M spending in PHC has been “unconditional” to the communes and to some municipalities, and “conditional” to the municipalities in which the 36 (former) District Councils were located. The gradual “decentralization” of authority to make budget decisions (that accompanies the move toward “unconditional” transfers of O&M funds through the block grants) would give local governments more leeway to establish their own priorities. Still, they will not have any real control over staff or services, will not be held accountable for performance (and, indeed, will be able to avoid accountability), and will continue to be required to follow the strict method the MOF uses to actually disburse the funds. Although the Prefecture was used in 2001 to be the central government regional representative for transferring the O&M budget funds to municipalities (that is, those where the former District Councils were located), it no longer performs that function. Even without the Prefecture being involved, though, it appears that the apparatus of control of the flow of money (represented by the budget) is tightly controlled by the center. Whatever body has authority to make budget decisions, the process by which the money is authorized for release and disbursement is still controlled by the local representatives of the MOF.

Although the following language is over four years old, it seems consistent with current reports about the channels and methods of disbursing budgeted funds:

Field offices of the MOF exercise considerable oversight of local government finances and are located at the district level throughout the country. The MOF has three departments operating at the local level. The Budget Office is the local government’s counterpart when preparing their budgets for central government approval. All local government finances, including local tax and fee revenues, are held in an account administered by the local Treasury Office (Banks et al., 1998).

2.5 Conclusions

Several conclusions are supported by the above data and analysis:

- ▲ Viewed in their entirety, the data on the varied levels and sources of financing for PHC in Albania convey a clear message: money for PHC services flows through too many channels and in uncertain amounts in uncertain fashion for there to be proper accountability for its ultimate uses. Without proper accountability, there is little opportunity to make reformed provider payment methods serve as incentives for performance and quality improvements.
- ▲ The disconnect between the new law specifying health as an undefined “shared function” of central and local governments and the persistent reality of budget flows based on an old decree needs to be resolved. However, the solution adopted for the 2003 O&M PHC budget should not serve to preclude steps needed to be taken to reach a long-term solution to the fragmentation problem.
- ▲ A long-term solution for the organization and management of government-sponsored PHC (if not higher levels of care) should focus on the center “sharing” functions in health for which local governments can perform a valuable role without being required to be responsible for major staffing and resource requirements (however funded) or demanding technical standards. This solution should include several major elements:

- △ A distinction should be made between what the government(s) should do to provide population-based, public health services and what services the government(s) should (or may) provide for personal, curative care. Local governments are capable of “sharing” responsibility for the former, but not for the latter.
 - △ Responsibilities for budget and financing of a function (required to produce a service) should be in alignment with accountability for its performance.
 - △ “Decentralization,” as defined by law, can be achieved in the health sector simply by deconcentrating selected MOH functions to regional offices and then having those offices establish working relationships with Regional Councils and other local governments, mainly with respect to their “sharing” in the provision of population-based, public health services.
- ▲ Consolidation of all sources of funding in one agency would go a long way toward aligning accountability with responsibility.²⁷ Since the HII already has the major share of funding for PHC and has an institutional prerogative as the provider of social health insurance, it is logical that further steps be taken to seek a solution that utilizes the HII’s strengths in unifying financing as a major ingredient in resolving the fragmentation of administration and management.
 - ▲ There is some evidence that production of PHC services suffers from numerous inefficiencies, including imbalances in staff deployment and the general insufficiency of needed complementary inputs such as supplies and basic equipment. To help remedy these shortcomings, a more prominent role for the private sector might be considered as part of the government’s strategy of decentralization. The least that should be considered is the use of incentives to improve quality and overall service availability (as are often found in private enterprises) for use in government enterprises. Consideration of a greater role for the private sector in PHC service delivery²⁸ would seek to take advantage both of the potential benefits of private sector investment and of the potential efficiencies to be gained, particularly in urban areas.²⁹ When patients are given alternative sources of care, and when those alternative sources are allowed to benefit from competing to provide better quality services at minimum cost, it is possible that more and better quality PHC services can become available at a lower cost. Government’s investments in buildings and staff could then possibly be reduced in favor of its adopting a reoriented role aimed at providing quality assurance and consumer protection through the regulation of service standards by setting and enforcing standards of care. Such a strategy would emphasize the benefits to be gained from encouraging the system to be more responsive to patient demand for services, rather than focusing on the supply of services regardless of patient demand

²⁷ On November 24, 2002, the Albanian Parliament passed an amendment (Law No. 8961) to the 1994 Health Insurance Law (No. 7870) to address this issue.

²⁸ This may become possible if the draft law legalizing private medical practice is approved by Parliament (see footnote #26 above).

²⁹ The private sector offers the potential for benefits from competition in areas where the concentration of population (e.g., in urban areas) makes it possible for numerous alternative sources to exist. The high costs of investment required of higher levels of care (i.e., secondary and tertiary care hospitals) will likely make it impossible to create the minimum number of alternatives (with the possible exception of Tirana). Thus, there is reason for government to retain its dominant role for PHC in rural areas and for hospital care in all areas outside the capital.

3. Conceptual Approach to Designing Alternatives

The challenge presented by the problems and issues described in this paper is for policymakers to seek a new system of organizing and managing health and medical care so that the following two goals can be met simultaneously:

- ▲ Define the term “shared functions,” as stated in the 2000 decentralization law,³⁰ to determine how central and local governments shall perform their “shared functions” for the “system of priority health service and protection of public health”
- ▲ Decide how the distinct functions of financing, on the one hand, and management of service delivery, on the other, are to be performed and by whom³¹

The various aspects of these distinct issues—decentralization and health financing—overlap when one addresses the issues of organization and management of health services delivery. In seeking concrete solutions to the problems manifested in both issues, it is useful to outline two elements of the conceptual approach:

- ▲ The need to clarify the important policy decisions that have already been made as distinguished from those policy questions that are yet to be answered
- ▲ The need to specify the criteria for designing alternative solutions and associated policy options and for deciding among them

In designing alternative solutions, it should be explicitly acknowledged that it is possible that some elements of the alternatives considered might include sharing responsibilities for delivery of certain services with the private sector. Such alternatives would seek to take advantage of the potential benefits to be realized from giving providers incentives to be more responsive to the needs and demands of patients at the point of service.³²

³⁰ From Chapter IV, Article 11, of the *Law on the Organization and Functioning of Local Government*, No. 8652, dated July 31, 2000, which took effect August 23, 2000.

³¹ For personal, curative medical care services, the MOH remains responsible, at least nominally, for supervising and managing staff and facilities, and the HII has been named as the (future) single source of financing of services. It is still to be determined how and to what degree any local government (or, perhaps, the private sector) will be given responsibility to participate in any management and funding decisions.

³² While the policy issues raised by such alternatives are important and deserve thoughtful consideration, they are beyond the scope of the technical issues addressed in this paper.

3.1 Organizing the Delivery Health Care Services: The Policy Context

3.1.1 Settled Policy Issues

A significant degree of consensus appears to already exist regarding certain aspects of the future of the Albanian health system. This is important to keep in mind when considering alternatives to the current system. Some of these are strategic assumptions that are expressed in similar form in the MOH Strategy

First, the role of the (central) MOH is changing from that of a management body to a policymaking body able to formulate health policy and strategy, prepare guidelines for accreditation and quality control, regulate private sector activities, and lead intersectoral work, with carefully planned decentralization of planning and management functions.

Second, there will be some degree of regionalization of health care management operations, including regional-level management of personal, curative services as well as public health services. Regional-level health administrations could be created to assume some degree of management responsibility for delivery of health and medical services. In any event, there will be a rethinking of the institutional map in the health sector, implementing the principle articulated next.

Third, since the creation of the HII in 1995, the principle of financing medical care and drugs through social insurance has been established. Recently, the role of the HII as single source of payment has been agreed to in principle and in law,³³ and this is now in the process of being defined in concrete terms. Although the HII has only partial responsibility until 2004 for payment of a limited portion of PHC costs,³⁴ it has been given authority to become the single source of payment for a defined package of medical and health services, ultimately including acute care services. At this stage, there is a proposal that HII would initially limit itself to pooling funds for PHC services delivered in PHC facilities, and would test its performance as a single source of payment in a single region, using the PHRplus pilot sites to demonstrate whether it would work or not.

Fourth, because the HII is to be the sole source of financing for medical care, there will necessarily be a functional (and perhaps institutional) distinction between the administrative staff responsible for managing the provision of medical care and the administrative staff responsible for financing that care. Coordination between the two would be essential, although each administrative staff would represent different functional skills and interests: managing the delivery and quality of care on the one hand, and ensuring value for price on the other hand.

3.1.2 Open Policy Questions Yet to Be Decided

As of January 2003, policymakers had not yet resolved a number of policy questions related to the issues raised in this paper. These open questions define, in large measure, the issues to which the options and solutions proposed below are addressed.

³³ The legal basis for accomplishing this change was created on November 24, 2002, when the Albanian Parliament passed an amendment (Law No. 8961) to the 1994 Health Insurance Law (No. 7870) that addresses this issue.

³⁴ See the *Law on Health Insurance in Republic of Albania*, declared with Decree No. 950, dated October 25, 1994, the provisions of which took effect March 1, 1995.

First, the role that local governments can and should play in the health system is still very much undefined. Any reorganization of the management of government health services should include a resolution of the role local governments will have and should establish a clear legal basis for any flow of funds to them, or of taxes levied by them, to support that role. There has been some progress on this score as the capacity of local governments to levy their own taxes has been clarified in a law that Parliament passed in December 2002.

Second, depending on what role is decided upon for local governments, the MoLGD's role in financing that needs to be reviewed and, as indicated, revised. The MoLGD could continue to provide financing of any health-related responsibilities that local governments might be delegated to carry out those functions deemed to be "shared" with the central government, or local governments could raise revenues by levying local taxes.³⁵ The source and/or designation of these funds may have to change from the current budgeting arrangements, but the change would reflect the decision on the role of local governments and an agreed-upon definition of health as a "shared function."

Third, the particulars relating to the redesign of the administrative structure and the process for managing the public health function will need to be decided.

Fourth, decisions must be made regarding the design of the administrative structure and process for managing the PHC services,³⁶ staff, and facilities; the regulation of their activities; and the need to ensure the quality of their services. There are two important dimensions of this design: (1) to specify how those responsible for the management of PHC services would relate to those responsible for the financing of those services and (2) to specify how individual facilities would be organized and managed (in relation to PHC management and financing) and what payment method(s) would be applied. Furthermore, the PHC management role could be specified anywhere in the spectrum of control, from strict supervision and control on the one end, to monitoring and oversight on the other. The level of management control exercised would depend on the degree of autonomy given to individual facilities.

Fifth, thoughtful consideration should perhaps be given to the potentially beneficial role that the private sectors could play, in partnership with the public sector, in the financing and delivery of medical care services. Policymakers' current focus on reforming the supply side of the medical care market through the reorganization of decentralized government-sponsored facilities could benefit from complementary consideration of the demand side of the market—how to make providers more responsive to patients' needs and perceptions of the quality of care.

3.2 Assessing Alternative Approaches and Solutions

Ideally, the process of reorganizing the management of health care services should be conducted in two stages. The first stage would be a deliberate consideration of alternate visions for the kind of health care system that policymakers want to see created in Albania.³⁷ Specific policy goals would then be set according to the policy direction implied by the general vision chosen. Short-term

³⁵ The Assembly of the Republic of Albania has drafted a *Law on the System of Local Charges* that sets out the rules under which local governments are given authority to levy and collect local taxes.

³⁶ PHC services are defined here to include polyclinic and health center services. Ultimately, according to the new financing reform, it would make sense to incorporate management of hospital services under the same reorganization, which would also accommodate the new financing reform stipulating the HII as the single source of all health care payment to facilities.

³⁷ Some elements of a vision are already in place, as noted in section 3.1.1. Others have yet to come into focus.

objectives, and the programs and financing needed to achieve them, would then be set with reference to the long-term goals implementing that broad vision. In the absence of such a reference point, it is likely that policy decisions could be made for short-term considerations and that policies may be put in place that are unintentionally counterproductive.

Once a general agreement is reached on the kind of health system Albania wants to build, looking ahead 15 to 20 years, it would be necessary to define criteria for determining how best to organize the journey—to configure its management and financing in a manner that would achieve the goals and principles implied by the long-term vision.

This section defines explicit criteria for judging and choosing among alternative solutions to address the problems and issues presented above. In the process of choosing a particular solution, it will be necessary for policymakers to make implicit choices about how to answer the policy questions so far left unanswered (ideally with a long-term vision in mind).

3.2.1 Criteria for Assessing Alternative Solutions

Once a vision for the future is in focus and articulated, the policies and programs to implement it need to be specified. These policies and programs should address possible solutions to the identified problems.

The following criteria are proposed for designing and choosing a solution:

1. **There should be clear organizational lines of responsibility for performance** of the tasks and functions that are required to produce the services to be provided and, implicitly, accountability for results and performance. (These organizational arrangements can and should be different for different types of services.)
2. **The lines of responsibility for financing should be clear and should parallel and reinforce the lines of responsibility for performance.** These lines of responsibility for financing could be different for different types of services (i.e., public health, preventive health, and curative care). (For curative care services, the financing system can be divided into two levels: rules governing allocations to the facility level and rules governing the distribution of funds for staff and supplies at the facility level.)
3. **Organization and financing of the production of services should include incentives that reward providers (directly or indirectly) for effective, productive, and efficient delivery of high-quality services.** Explicit mechanisms to encourage responsiveness to patients' needs should be incorporated. Implicit mechanisms should not be contrary to improved performance and accountability. Excessive or redundant bureaucratic structures and processes should be avoided.
4. **Explicit methods to increase providers' accountability to their patients for the quality of the services they provide should be adopted.**

Alternative solutions to the problems identified that offer answers to the open policy questions will be analyzed using these criteria in section 6.

3.2.2 Ingredients for the Design of Alternatives

The design of alternatives has two major ingredients: a detailed specification of the tasks and functions that need to be performed to produce PHC services and a detailed description of the various institutional resources that are currently available and could potentially be given roles in performing those tasks and functions. Alternative plans for using the institutional resources are then developed to address the performance of the tasks and functions. Each alternative approach is assessed against the criteria posed earlier for judging the appropriateness of the option.

3.3 Organizational and Managerial Tasks to Be Performed

Before proposing institutional options for organizing and managing PHC provision, it is helpful to list the organizational and managerial tasks that will be needed. In other words, before discussing who should do the job, one needs to understand what the job is.

- ▲ **Quality Assurance:** Each clinic should be inspected periodically and evaluated against a minimum standard of quality, and the information should be made available to both payers and patients. In the future, certification for achieving the minimum quality standard could be made a prerequisite for HII payments, or HII payment levels could vary according to the achievement of certain levels of quality and/or productivity. Additionally, clear information on the relative quality of providers should be available to patients to enable them to choose among alternatives on the basis of objective information.
- ▲ **Internal Quality Improvement:** Clinical staff could be organized to participate in ongoing quality improvement efforts. This might include regular quality data group meetings; in-service training by specialists visiting from hospitals, polyclinics, or the university; dissemination to facility staff of CPGs and other information aimed at improving the quality of care; review of medical records and CPG checklists; and periodic meetings with representatives of the institution responsible for quality assurance.
- ▲ **Staff management and supervision:** It should be clear what institution or agency is responsible for hiring, deploying, supervising, and firing facility staff. This should be the responsibility of the entity that manages the facility. Autonomy for facilities management would be determined by the degree to which a facility manager had responsibility and authority to hire and fire facility staff.
- ▲ **Management of the internal service delivery operations of the facility/system:** The specific tasks would include patient registration, medical record organization/filing/retrieval; patient scheduling and patient flow; physician and staff scheduling; operation of the HIS; community outreach and marketing; and coordination with public health programs. One could distinguish facility management tasks that are generally administrative from those that are generally clinical in nature.
- ▲ **Management of the financial/accounting operations of the facility/system:** The range of tasks implied in this area would depend entirely on the degree of financial autonomy a facility might be given and on the method of provider payment. At one extreme, a facility would be strictly accountable, through budgeted line item funding, for a staff responsible to a higher authority. At the other extreme, a facility could operate as if it were a private enterprise, with wide latitude given the facility's owner (be it a commune, municipality, community board, group of doctors, etc.) to determine fees charged, services provided, and level of staff

remuneration. Whatever the degree of autonomy, this area would include responsibility for internal audit and accounting and revenue and cost reporting.

- ▲ External accounting: Regardless of the degree of autonomy given to individual facilities, an external audit would be required of each facility's internal accounting and cost reporting for all funds received and paid out: revenue for operations, including user fees, when relevant; staff compensation; procurement of supplies; and bonus pool/incentive payments if any.
- ▲ Procurement: The system for procurement and inventory control of supplies, materials, medical equipment, and (if relevant) drugs could be more or less centralized, depending on the degree of autonomy given to facilities. Centralized procurement will realize the economies of scale that a fragmented system could not achieve.
- ▲ Health planning: Monitoring of the supply and demand for PHC services is needed to identify opportunities for rationalization, including recommending the closure or merger of underutilized PHC facilities. This task is greatly facilitated when funding follows the consumers' choice of provider and the provider has an incentive to satisfy patients. Then facilities that consumers underutilize can be identified. (In rural areas, where competition among autonomous providers is not practical or feasible, explicit planning of the location and service profile of PHC facilities will be needed.)
- ▲ Coordination with public health activities: There would need to be provisions to coordinate public and preventive care activities within PHC facilities. Facilities should share information about their patient activities and participate in public health programs, including disease surveillance, vital statistics, health education, and disease prevention.

3.4 Institutions and Agencies with Current or Potential Roles

Having clarified what tasks and functions need to be performed, the authors now describe the current and potential roles that various relevant institutions could play. Discreet components to alternative solutions to the question of who should do the job are described briefly below. These include agencies that although not yet in existence, could offer, conceptually speaking, benefits as logical components of solutions to be proposed in later sections.

1. *Central Ministry of Health:* The central office of the MOH is in transition to an agency that focuses primarily on policy and planning for the country's health system—carrying out a stewardship function rather than a management function. Until recent reforms, it was an organization that directly staffed and managed facilities that provided public health services and those that provided personal, curative care services at hospitals, polyclinics, and health centers. The central MOH's facilities and operations were managed by District Public Health Directorates, each of which had separate units responsible for hospitals, primary health, and public health. In converting its mission primarily to policy and planning, the MOH lost numerous staff (most of whom transferred to the TRHA). The central staff now numbers fewer than 100 employees, and the skills and responsibilities of the remaining staff may need to be adjusted to meet the demands the MOH will be expected to fulfill in its new role.
2. *District Public Health Directorates:* Operating responsibilities for the government health facilities and activities throughout the country have been traditionally carried out by Public Health Directorates in each of the 36 districts. The size and organization of each directory depended on the size of the local population. Of the 36 district offices, 12 were located in

districts large enough to warrant a separate unit for public health, 10 had public health supervised by the PHC directory, and the remaining 14 had coverage of the public health functions by other districts. Current district health personnel of the MOH continue to be nominally accountable to the central MOH. For hospital management, there is no ambiguity about this, but for PHC and public health, the actual lines of responsibility and accountability have been blurred by decentralization initiatives that seemed to shift some measure of accountability for these functions to District Councils. In 2000, the law replaced District Councils with Regional Councils³⁸ (qarkus), composed of elected representatives of municipalities and communes. There remains an ambiguity about the lines of responsibility and accountability of District Public Health Directories, primarily because the flow of funds to activities they supervise is fragmented among several agencies (namely, the HII and the MoLG&D).

3. *The Health Insurance Institute:* Although the HII is legally restricted in how it may disburse its revenue, an amendment to the Health Insurance Law that passed in November granted HII greater flexibility to assume responsibility for pooling funds for health care services and for paying providers and facilities. Although the HII has branch offices in at least each district and has the administrative capacity to begin the transition to a broader financing role, much still needs to be done to design and implement the various components of a new regime for managing the services and paying for them in a way that installs the most desirable incentives to providers and patients alike. As a financing intermediary, HII should define its role carefully so that it does not assume too much responsibility for micro-managing facilities or for financing their services.
4. *Local governments:* All of Albania is covered geographically by a locally elected council. Communal Councils govern in some 306 communes, and Municipal Councils govern in some 65 municipalities. A specified number of elected officials from these councils indirectly represent the population in regions by serving on qarkus, or Regional Councils, of which there are 12—each comprising the area previously governed by 36 District Councils (i.e., each region is made up of three former regions). The responsibilities of these local governments are specified in the Law on the Organization and Functioning of Local Governments passed in 2000. Implementation of that law, and the development of administrative capacities to carry out the requirements of that law, has only begun. Implementation of the law is the responsibility of the MoLG&D.
5. *A Regional Health Office (not currently in existence):* A relatively autonomous regional health office (RHO) could be established for the pilot region. The RHO would report to the MOH on technical matters and to the HII and MOF on financial and budget matters. To the extent that it was made specifically accountable to the regional government (qarku), the RHO would report to it. (This would be determined by the nature of the accountability, e.g., if it received funds from the qarku, it would be more accountable to it for those funds received.) The scope and nature of the RHO's budget, responsibilities, and authorities would be developed according to the specific tasks for which it would be responsible.
6. *A Regional MOH Office (not currently in existence):* Current district health personnel of the MOH could be consolidated into a regional office, which would, in effect, “deconcentrate” the authority of the central MOH office (at least for public health functions) to the regions.

³⁸ A Regional Council is called a “qarku,” pronounced “charku,” and is composed of elected members of municipal councils and communal councils in the region.

The regional office would be part of the MOH and therefore accountable to it (at least for public health functions). But it could be given clearly delegated tasks and authorities to make independent decisions on staffing and allocation of funding among line items. This would represent a decentralization (in the sense of deconcentration) of centralized ministerial authority. The regional office would be required to provide regular reporting to regional, municipal, and commune political bodies about the activities they are performing within their respective jurisdictions. A regional health office that managed the delivery of personal, curative services might NOT be accountable to the central MOH if some other arrangement were decided upon (more on this follows).

7. *Regional Managers (not currently in existence)*: PHR*plus* proposes a new kind of staff category to address the insufficiency of managerial capacity in the RHOs. The role of the regional manager is critical to financing reforms that give the PHC facility more autonomy over spending and operations. Such a regional manager could be employed by a regional body (e.g., a regional health office, the regional MOH office, or the qarku). Such a staff person could supervise the managerial tasks of head nurses (see below) at more than one facility. This model may be appropriate for a group of rural PHC facilities.
8. *Facility Managers—Head Nurses (not currently in existence)*: PHR*plus* proposes a new kind of staff category to address the lack of managerial capacity in the PHC facilities. The role of facility manager–head nurse is critical to financing reforms that give the PHC facility more autonomy over spending and operations. In this case, it is proposed that the head nurse would receive the additional training needed and then would be employed by and work full time at one PHC facility, where he or she would be supervised by a regional manager.
9. *Health Care Entrepreneurs (for any initiative involving the private sector)*: Entrepreneurs who are willing and able to invest in the development of PHC practices in urban areas would be needed in the event the government chose to encourage private medical care practice³⁹ alongside government-sponsored care. A regulatory regime, including licensing and quality assurance authorities, would be a prerequisite for any privatization initiative.

³⁹ This would be possible if and when Parliament passes the draft law approved by the Council of Ministers in April 2003 (see footnote #26 above).

4. Alternative Approaches to Health Care Financing

To develop a system for financing health care services, a series of questions must be answered. There are two levels of policy questions: first, what are the sources of financing; second, how are these funds distributed to support the production of health-related services.

4.1 Sources of Financing for Health Services: Mobilizing Resources

At the most basic level, health care financing is a process of identifying the various sources of funds needed to pay for health care, collecting them, and distributing them to providers of care. Where risk-sharing arrangements exist, the process will involve collecting money from healthy persons in order to pay providers to care for those who become sick. (Both the government, through its collection of broad-based taxes, and any health insurance plan are in the business of spreading the cost of caring for the sick across a wider population that includes mostly healthy people.) In any population, the health care needs of a small minority are responsible for the vast majority of spending. One could finance this care by asking the people who need it to pay user fees at the point of service—just as people do for food, clothing, and shelter. To avoid imposing such “taxes” only on those who become sick, however, Albania, like most countries, uses a more equitable “social transfer” system so that those who can afford to pay finance the care of the sick and needy.

This sort of financing is done best by “taxing” the broadest possible population base to pay for the care of the sick. For example, income taxes or sales taxes are good ways to raise funds according to this criterion. In general, the sources of financing health care services can be summarized as the following:

- ▲ Broad-based taxes (e.g., on income, consumption/sales taxes)
- ▲ Narrow-gauge taxes (e.g., on gasoline, cigarettes, travel)
- ▲ Employment/wage taxes or mandatory employer contributions (e.g., the 3.4 percent contribution from wages—1.7 percent deduction from payroll—for the HII)
- ▲ Contributions by covered persons for specific health benefits (e.g., insurance premiums)
- ▲ Payments for care at the point of service (e.g., informal or formal user fees)

The breadth of the financing base gets narrower as one goes down this list of alternatives. At its narrowest, patients must pay the required fees out of pocket—whether required formally (by fees assessed and posted) or informally (by providers asking for direct payment). Increasingly, the health system in Albania is heavily financed by out-of-pocket payments from patients—particularly for informal (i.e., unauthorized) fees. Since many who are in need of services cannot work and/or cannot afford to pay for services, there is general agreement that it is better to finance health care broadly, at

least for those who cannot afford to pay, from sources at the top of the list. Government needs to play the role of a fund collector, even if it does not play the role of accountable provider or employer of the professional work force. Since some level of user fees is a reasonable component of any financing regime, it is important that the system collect those fees and be held accountable for their use.

4.2 Assigning Responsibility for Delivering Services

There are several types of options for selecting an organization to be accountable (or at financial risk) for delivering the services. The following are organizations that could be responsible for service delivery:

- ▲ Central government entities (e.g., MOH, prefectures)
- ▲ Local governments (e.g., regions, municipalities, communes)
- ▲ More or less autonomous administrative organizations (e.g., the TRHA)
- ▲ A single-payer organization (like HII)
- ▲ Private sector entities

Traditionally, government has been solely responsible for health care service delivery in Albania. While regional and local offices abound in most countries to perform operational and planning activity, it is not that common to find decentralization of responsibility for delivering services in Albania. It would be possible to decentralize the central government's accountability to the prefecture (the qarku being the political counterpart of the central government's regional office), but doing this would require providing a high degree of autonomy in managing operations at this decentralized level—something that is very difficult to achieve in government organizations.

Quasi-governmental authorities (e.g., the TRHA) are a possible alternative to finding a local entity that might be made accountable for organizing and delivering health services to a population. Typically, these organizations receive annual funding from government and other sources. A regional office may be a good option for decentralization because it can often avoid civil services rules relating to government employment and perhaps (theoretically) is less sensitive to changes in government and budgeting vicissitudes. The TRHA has actually not been implemented as an entity accountable for organizing the provision of services, since it still operates facilities on a budget-based resource transfer model—with multiple sources of payment (the MOH, the HII, and the MoLG&D) providing the funding regardless of performance and in ignorance of costs for any given package of services.

The concept of an accountable regional organization would require that the organization receive a budget or a contract for delivering a specific package of services to a defined population, provide those services directly or through some contracting mechanism with providers and institutions, be distinct from the institution providing the financing (to which it would have to justify its costs and negotiate a payment arrangement), and be responsible to some oversight board or trustee group.

A national, single-payer organization is a common approach to assigning responsibility for health care delivery. Such organizations typically manage a fund that pools into one agency's account several separate streams of financial flows (e.g., taxes, employer contributions, premium payments by individuals, budget transfers) and could contract with qualified providers and institutions to provide

covered services to eligible individuals. The “pooling” of funds into a national fund (rather than relying on government budgets) tends to smooth the year-to-year availability of funds for health care, possibly avoiding the unpredictabilities of government budget allocations and associated politics. Although a single-payer organization could be a government organization, it would be entrusted (by law) with the responsibility of maintaining solvency of the fund and for protecting the accessibility and quality of the services it purchases on behalf of citizens.

This reasoning is the basis for the recent decision to assign responsibility for the pooling of all health funds to the HII. Whether management responsibility should also be exercised by the same agency responsible for pooling funds and paying for services is a critical policy question. Financing services and managing services are distinct functions that need to be coordinated, but need not be performed by the same organization.

In most countries, single-payer organizations do not usually have the responsibility for organizing and managing providers, nor the nonfinancial resources needed to deliver care. Rather, they negotiate a payment method and payment rates with the organization that is responsible for delivering services. The single-payer organizations typically pay institutional and professional providers in one of two ways:

- ▲ By providing eligible persons with insurance contracts, allowing them to receive covered services from many participating providers who submit bills and are paid according to agreed-upon fee schedules
- ▲ By negotiating contracts with providers who are then paid for delivery of covered services to eligible persons according to the terms of the contract

Insurance arrangements and preset fees are more common in places where there are many private providers, too numerous for each to be negotiated with one at a time. They are also common where enrollees value their freedom in choosing among different providers (insurance is a portable form of financing in the sense that a patient who is insured is usually able to use that insurance at any one of a number of alternative providers, although some insurance plans might have limited networks of providers—called preferred provider organizations—with whom they would have negotiated lower payment rates).

4.3 Choosing the Method of Payment to Providers (Choosing the Kinds of Incentives)

A critical element in every health system is the motivation of providers at the points of service (i.e., the clinic, the hospital) to provide the best patient services possible (i.e., quality service, effective communication with patients, correct service mix, proper follow-up and referral care) and to work at a high level of productivity. Creating the motivational incentives for these behaviors is a challenge.

Whether providers are part of government or private organizations, there seem to be three keys to creating motivation at the point of service. One key is providing some measure of *organizational autonomy to providers*. This would place the financial fate of the persons working together largely under their own control and would give policymakers leverage. The second key ingredient to creating point-of-service motivation is setting up *financial incentives* for the employees of the clinic or hospital that will motivate performance in ways that promote policy objectives. The third ingredient

for establishing point-of-service control is *performance measurement* and feedback of the results to the persons at the point of service.

Autonomy does not necessarily mean privatization. There are several levels of autonomy that can be used when contracting. If the clinic or hospital is a government facility and employees are salaried, then partial autonomy can be created by creating “performance bonus pools” where employees are able to receive supplements to their income if the group performs more work, or works with better results. An alternative way of creating autonomy at the worksite is through “global budgeting.” This is achieved when the clinic or hospital is given funds according to some annual operations plan and the director (or some operating committee) is free to decide how the money is to be spent. Typically, these budgets are conditional on volumes of care, so that if volumes are higher than planned, the budget increases. The most autonomous arrangement is when the clinic or hospital is a private organization, with the freedom to fail if revenues do not cover costs.

In contracts with “autonomous” clinics or hospitals, the incentives of the contract need to be constructed deliberately to reinforce policy preferences. When the clinic or facility is government owned, then bonus pools or global budgets could be used to instill an attitude of “autonomy” (e.g., they would think “what I earn is related to how effective I am in my work at achieving the objectives of the contract incentives”).

In instances where there is more autonomy (where the professionals are not salaried employees of the government, or the facilities are not units of the government), there would be considerably more flexibility in designing incentives. Specifically, contracts would need to describe how to pay the providers and institution for services delivered. The approach used for payment would determine (and also be determined by, in some sense) the following:

- ▲ What the costs of the services would be
- ▲ Who would bear the risks of unanticipated events (e.g., epidemics, high cost of drugs) that influence costs

If, for example, the government is the responsible entity and it owns the hospital, then unexpected increases in the costs of x-ray film would be borne by the government, which would have to accommodate the increase somehow. But if the hospital were privately owned by doctors and the contract with the responsible entity were to deliver services for a comprehensive fixed price per day, then the problem of the price increase would fall on the owners, not on the government. This shift in “financial risk” occurs as a result of the contractual agreement as to the payment method for the covered services. Unanticipated events always produce a financial risk, and either the payer or the provider must bear that risk or share it. The payment method that is used would set the responsibilities for paying for these unanticipated events (whether they are good or bad).

Essentially, there are several basic payment options for providers or institutions that provide the services in contracts with a provider group through a regional office, a single payer, or the government. Each option will carry a very explicit set of incentives for persons at the point of service. These incentives arise because each payment option would be different in terms of the method used to determine how additional revenues could be made to flow to the point of service. Depending on the objectives of the payer, these “incentives” could be manipulated to align the motivation of persons at the point of service with the objectives of policymakers. No single approach is best, and often many need to be used to create the correct incentives that may vary by treatment setting, geographic location, or type of provider. The following are some basic options for structuring contracts with autonomous provider entities:

- ▲ **Cost-based reimbursement:** At the end of the year, an accounting of the costs incurred by the autonomous provider would take place. If costs are high, payment to the provider would be high. This method does not create any incentives for efficiency.
- ▲ **Prospectively set reimbursement for each unit of particular services:** Fees are set by the payer or by the accountable entity. The amount paid overall to a provider would be equal to the fee, multiplied by the number of units of service provided. The incentives of such an approach to contracting would be to produce units of service efficiently (because of the fixed price) and to produce as many units of services as possible.
- ▲ **Capitation:** A fixed amount is charged per person in the covered group (or in the covered geographic area) that would be eligible for service, regardless of whether any in the group become patients. This payment would be the only payment whether the clinic served three patients per day or 25 patients per day. The incentives here are to discourage or limit utilization of services (because the provider will not receive more revenue for more use). Since it is possible that providers being paid by this method might deny necessary as well as unnecessary use by insured patients, public authorities will need to carefully regulate this type of contract in order to protect patients from unscrupulous providers.
- ▲ **Global budgets:** An overall amount of money that should be adequate to cover the resource needs of some planned volume level is negotiated and agreed to. The manager would have discretion to move the spending across categories to meet needs and create internal incentives. This would create similar incentives to capitation, although the incentives on volumes of services could be mitigated through adjustments to revenue based on the actual volume of services.

Whichever approach is used to organize/manage services, on the one hand, and finance services, on the other hand, it is critical that those performing both functions know the costs of providing the covered services. Developing the needed cost data, and processing it, is just one example of the myriad areas in which coordination is required between the managers and financiers and services.

5. Alternative Organizational Approaches

5.1 Accommodating Decentralization Policy

The broad variety of services needed to protect and promote better health in the population can be categorized as environmental health services,⁴⁰ public and preventive health services,⁴¹ and personal, curative medical care services.⁴² While “decentralization” has been initiated in health and the other social sectors as a way of improving the delivery of at least some of these services,⁴³ the term “decentralization” itself is a broad term that denotes a number of distinctly different efforts. In recognizing these distinct definitions and approaches to decentralization, one needs to acknowledge that the different categories of health-related services will require different approaches, and that there are specific functions and tasks (refer to section 3.3.1) that only the central government can perform most effectively and efficiently.

5.1.1 Alternative Definitions of Decentralization

The broad range of alternative approaches to decentralizing responsibility and/or authority for government-sponsored PHC services can be categorized as the following:⁴⁴

- ▲ *Deconcentration of responsibility* for a function(s)⁴⁵ from a central office to a local office covering a specific geographic area (while some autonomy may be granted in budget and staff decisions, accountability to the central office is retained)
- ▲ *Assignment of full and exclusive authority* to a local government so that no other level of government has any authority for that function
- ▲ *Delegation of authority* (without assignment, i.e., not permanent) to a local government to perform a specific function(s)
- ▲ *Assignment of “shared” authority* to perform a function(s), with some part of the authority assigned to one level of government and another part assigned to local government

⁴⁰ Clean water, sanitation and waste disposal, and protection from environmental pollution

⁴¹ Communicable disease control, disease surveillance, nutrition supplements and surveillance, childhood immunizations, safety inspection of food, water, and drugs, health promotion and education, reproductive health, and accident prevention

⁴² Diagnosis and treatment of illnesses and injuries when they occur

⁴³ Important considerations for determining government’s role in providing health-related services are discussed in detail in **Annex A**.

⁴⁴ Issues of decentralization in the health sector are discussed in more detail in **Annex B**.

⁴⁵ The meaning of “responsibility for a function” as used here (and below) implies unambiguous responsibility for performance of all tasks needed to produce a discreet service, or a category of services. It is explicitly not meant to justify the “deconcentration” or “decentralization” of discreet administrative tasks or budget line items (e.g., for operating costs only), which results in fragmentation of financing and administration.

“Deconcentration” is the assignment of responsibility for a function of a particular organization to an office that covers a specific local geographic area. Thus, moving particular duties from a central to a peripheral location means that a local or regional office of a national ministry would exercise such duties. The local office is not given authority to make budget or staff decisions, rather merely the responsibility to carry out decisions made by the center. If there is a transfer of responsibility and authority over the function from one level downward to another level of government, this transfer is termed “decentralization” to distinguish it from “deconcentration.” If the transfer of such responsibility and authority is permanent, it is called “devolution.” If the transfer is not permanent and could be reclaimed, however, the transfer is called a “delegation” of function(s). Functions that are performed by local governments are “own functions,” and are permanently granted as “own exclusive functions” if they are to be exercised solely by them. “Delegated functions” are those that are performed by local governments on behalf of higher levels, and “shared functions” are those over which local governments exercise some authority by law and other higher levels also exercise some authority over the same functions.

Historically, the Albanian government has exercised centralized authority and control in trying to produce the full range of all three categories of health-related services. Under decentralization initiatives, however, there have been significant changes. First, local governments have been assigned exclusive authority for most environmental services: clean water, sanitation, and solid waste disposal. Environmental pollution control is a function local governments share with central government. Second, there has been a major effort to experiment with regionalizing the administration of public and primary health services in and around Tirana. The TRHA is partly an effort at deconcentration and partly an effort to share responsibility for the relevant functions between the TRHA, the MOH, and the HII. Third, the stipulation in the 2000 law on decentralization was that “priority health service and the protection of public health” be a “shared function” of central and local governments.

Of the three changes noted above, only the first was unambiguous and relatively straightforward to implement. Local governments are now fully in charge of providing clean drinking water and disposing of solid waste within their geographic boundaries.⁴⁶ Both the second and third changes were fraught with ambiguity from the start. The implementation of the TRHA has suffered from differing interpretations (by the institutions involved) regarding both the specifics and the boundaries of its authority, particularly as to how TRHA was to relate to the HII. Similarly, the implementation of the concept of health as a “shared function” (outside of Tirana) has been to divide responsibility for the PHC budget administratively by line item, but without making explicit changes regarding management of the delivery of specific services. The wording in the 2000 law that was the basis⁴⁷ for the decentralization initiatives (by the TRHA and the MoLG&D) reflects a lack of resolution to the ongoing legislative debate about the appropriate approach to decentralization in the health sector.

Under these circumstances, the most urgent need is to define plausible alternatives for organizing and managing the delivery of specific services that meet the criteria that are applicable, as noted above. Once such alternatives are considered that reflect a vision for the future and the goals and objectives of the MOH Strategy, policymakers should select the one that best meets the criteria listed above, giving due weight to the various institutional strengths and resources that are available for the tasks and functions to be performed. In a broad sense, it is settled government policy that the choices

⁴⁶ Clean water, sanitation, and pollution control are necessary for the maintenance of the public's health, but are not traditionally considered public health activities. They are mentioned here to give an example of services that local governments have been assigned as their “own exclusive functions.”

⁴⁷ The legislative discussions that led to the wording occurred concurrently with the early stages of TRHA's development and subsequent to the decision to transfer funds for PHC operating costs from the MOH budget to the MoLG&D budget to be included in the block grants for local governments.

made should have design elements that take advantage of whatever benefits a “decentralized” approach can offer. However, the detailed requirements of “decentralization” policy will not determine policymakers’ choices, but rather will be determined by them.

5.1.2 Three Distinct Categories of Health-Related Services

Because of the differing characteristics of the health-related services in each category, possible alternative organizational approaches will also differ. In the first category, *environmental services*, there is no real debate. Local governments now have been delegated responsibility for providing drinking water, sanitation and solid waste disposal, and environmental protection. It is also appropriate that these kinds of services be the responsibility of local governments.

In the second category, *public and preventive health services*, government will have to have a central role. The private sector could play a role as contractors providing services under government supervision, but there is no effective (profit) incentive for direct private investment in the production of these services because there is no reliable prospect of sufficient demand. These services are public goods with benefits accruing more to the community as a whole and much less so to individuals. Thus, government must fund them if they are to be made available at all. In place of the previous system of providing these services through District Public Health Directorates, it would be appropriate to consider alternatives that seek to utilize those staff and technical resources organized with clear lines of responsibility and associated flows of funding.

In the third category, *personal, curative medical care services*, it has been decided that funding will be consolidated in the HII, and budget transfers from the MOH and MoLG&D will be added to revenues from social insurance contributions regularly received by the HII. There are numerous alternative configurations of the manner in which curative care facilities could be organized and managed to facilitate their receipt of HII payments. It is not feasible for local governments to take full responsibility of the delivery of any services in this category. They have neither the human nor the financial resources to make a meaningful contribution. The national interest in providing uniform benefits and uniform standards of care, and in achieving economies of scale in social financing of these services, argues for a uniform national policy and program for medical service delivery. This program could include some role for the private sector if it were so decided.

5.1.3 Tasks and Functions Best Performed by Centralized Institutions in a Decentralized System

National government and the Ministries of Health always have important roles to play in effective health care systems. These functions, and others, are important even in situations where MOH does not run hospitals or employ physicians and nurses. The following are among the functions that governments often continue to pursue, even with heavy decentralization:

- ▲ Raising tax revenues from individuals and employers
- ▲ Planning health policy and public health programs
- ▲ Setting policy regarding coverage, eligibility, and flows of new technology
- ▲ Regulating quality and standards of care

- ▲ Regulating data and coding standards
- ▲ Training health and medical care professionals and technicians
- ▲ Setting standards for, and giving technical support to, public and preventive health services

Public and preventive health is a particularly critical function in Albania as it is in many countries where its effectiveness can make enormous contributions to population health status.⁴⁸ It would be a mistake if the redesign and decentralization of the Albanian health care delivery system were to follow the current practices of many systems in the developed nations, at least in terms of their mix of resources devoted to public relative to personal health care. The payoff of investments made in certain public health activities is likely larger than the investments made in many personal health care services.

The positioning of control and financing of public health in the decentralization plan is an important decision. If the *integration* of public health issues and personal health care delivery is viewed as important, then it may make sense to vest the responsibility for both in one place (so that coordination and integration are easier). This could be at a central level or at a level closer to the populations targeted to receive the services—the region or municipality. If the particular public health issues are different in different regions of the country (urban, coastal, rural), and if these differing needs must be reflected in integrated approaches to public and personal health care, then it would make sense to vest responsibility for both at a decentralized level.

Quality of services provided is the most difficult aspect of health systems to control. In terms of provider judgment, and in terms of provider behaviors, quality issues are always subject to the specifics of any particular case, making aggregation and summary indicators often unreliable and inconsistent. Moreover, the dimensions of quality (structure, process, outcome) are almost impossible to measure in a reliable way outside of very controlled research studies. This means that it is difficult to motivate high quality by creating contractual incentives for producing high quality. Yet, the real key to producing consistently good services and the best technical care will be attitudes about quality improvement and information available at the point of service. Creating such a “culture” of quality improvement is not readily done, though it is a noble objective in health systems around the world.

Quality of care is key to creating demand for services, generating compliance with provider’s orders, and sustaining confidence and support for health policy and for the responsible government officials. Good health care systems have explicit features aimed at regulating quality based upon minimum standards of various service types. Usually all providers (government as well as nongovernment) are subject to such regulations, and compliance is always required in contracts signed with providers.

Regulating the quality of care is usually a function retained by the national government (not decentralized), although there may be delegation of data collection to decentralized government or nongovernment organizations. Approaches to regulating quality in developing countries include the following:

- ▲ **Accrediting hospitals and other health facilities:** A process is developed to have a team of experts visit a facility annually, or less frequently, to examine all aspects of facility operations using a preset protocol. The team determines if the facility (1) passes and is fully

⁴⁸ The relative importance of various determinants of population health status is reviewed in **Annex A**.

accredited, (2) fails and has 90 days (or some short period) to bring operations to the standards or be shut down, or (3) conditionally passes, subject to a plan to bring identified deficiencies into compliance.

- ▲ **Licensing facilities and active regulatory actions to manage processes and outcomes in service delivery:** These processes would include periodic, random chart reviews and consumer satisfaction surveys by authorities. It is essential that patients be given an opportunity to voice their opinion about the quality of care that they receive.
- ▲ **Developing a clinical practice guideline program:** Committees of professionals develop standards for action and decision making to address frequent and important presenting problems, and promulgate these standards to organizations and providers. Contracts with providers usually require compliance with such standard of practice, which is subject to periodic audit of medical records.
- ▲ **Building professionalism and professional registration and credentialing:** A registry (list) of medical and nursing personnel and their credentials is kept. This is an important step in preventing untrained persons from practicing medicine and in gaining compliance in instances where courts or government officials take actions to forbid further professional practice. Usually this sort of infrastructure is developed through the support of voluntary professional organizations (family and general doctors, nurses, cardiologists, dentists).

Usually the primary issue in quality regulation is the role of the professionals and professional organizations relative to the role of the government. A secondary issue is the mix of resources dedicated to improving health through medical care relative to the resources devoted to improving health outcomes by means of public health interventions. This issue is discussed in the paragraphs that follow.

The central government also has a critical role to play in establishing the framework for *individuals and communities* to influence the operation of the health care system, and to emphasize the importance of their role. The general rule here seems to be that individuals and groups of individuals in communities can be a very powerful force for improving care and shaping reforms at the point of service. While health care cannot be allocated at all levels according to market principles, and the role of the patient should not be likened to a consumer in that way, the actions of patients and communities of citizens/patients can be powerful and productive forces in shaping health care at the point of service. This can be done in several ways:

- ▲ Wherever reasonable and possible, give patients a choice about where they receive care, or which provider they use within a facility. Obviously, having a choice of obstetric providers makes more sense than having a choice of cardiac surgeons.
- ▲ Give patients an incentive to access care at the appropriate level of the system—first, by making quality services available at all levels, and second, by imposing financial disincentives (i.e., bypass fees) to patients who self-refer directly to specialists at higher levels.
- ▲ Set incentives at the point of service that reward providers and institutions for being successful in producing higher volumes of care (e.g., getting consumers who have a choice to vote with their feet in selecting the provider they prefer).
- ▲ Have the patient pay some formal copayment (possibly moving to get the informal payment

institutionalized as a formal payment level); paying something is important to making the patient feel accountable.

- ▲ Make use of formal “community advisory boards” to generate feedback to providers and possibly some control as well.

5.2 Accommodating Financing Reform: Pooling Funds in the HII

Many of the management and administrative problems noted above have been the direct result of the fragmentation of the flow of funds to pay for the inputs needed to deliver PHC. Creation of the HII and establishment of the principle of social insurance to supplement budgeted funds (in 1995) was followed (in 1999) with the decentralization initiative. Each had a legitimate policy rationale in its own right, but their implementation resulted in the violation of the first two criteria for efficient and effective organization and management—that there be clear lines of responsibility and of accountability, both for performance and for financing, and that the decision-making authority for financing be supportive of the authority for performance.

An important component of PHC is population-based public and preventive health services. In contrast to personal, curative care services offered in outpatient settings, where the quality and productivity of service delivery is critically dependent on the incentives structured into the management and financing arrangements, it is reasonable to give separate consideration to the organization and financing of these public and preventive health services, as they currently are.

A recent government policy decision to unify all sources of financing in the HII applies to personal, curative care offered in outpatient settings. It is intended to resolve the problems created by fragmentation, as it affected the delivery of ambulatory care. But without careful design and implementation of complementary organizational arrangements, and of compatible management processes, making the HII a single source of health financing could have unintended, negative consequences. To minimize this possibility, it is first necessary to articulate the steps to be taken to consolidate all funding with the HII, and then to suggest how the organization and management of the services to be funded would best be designed and implemented. In both areas, it is important to keep in mind that the sequencing of the discreet steps in the reform process, and the appropriate pilot testing of new approaches (as needed), be given due consideration.

The HII currently uses its revenues to fund only two inputs for PHC services: salaries of general practitioners and reimbursement of outpatient drugs for enrollees. Its two current revenue sources are contributions from enrollees (mostly through payroll deductions of wages in the formal sector) and budget transfers from the government (to fund the enrollment of vulnerable populations).

Once the HII becomes the sole source of PHC funds, it will receive budget transfers for two major items now channeled through other agencies: salaries and benefits for non-GP personnel (now in the MOH budget) and operating and maintenance costs of PHC facilities (now in block grants provided to local governments through the MoLG&D). The pooling of these budget funds with the HII current sources and amounts of revenue will enable the HII to reform its method of paying for PHC services. The new method should include performance-based incentives to personnel to improve the quality and quantity of services provided. Arriving at the optimum method of payment and the appropriate level of payment would ideally be decided after pilot testing of alternatives.

The following dimensions of provider payment method need to be tested:

- ▲ The services provided in the benefit package, possibly differentiated according to the category of beneficiary, including
 - △ HII contributing enrollees (contributing 3.4 percent of wages);
 - △ HII enrollees from vulnerable populations (funded now by budget transfer to the HII); and
 - △ Nonenrollees
- ▲ The method (annual budget, use-related payment, etc.) and unit of payment (per facility, per visit, per capita, etc.)
- ▲ Level of payment
- ▲ Level of copayments required from patients

Proposed approaches and concrete steps to be taken to design and test the implementation of alternative methods of paying providers and of incorporating desired incentives into the payment method are the subject of a proposal currently being developed by the HII in consultation with the MOH.

6. Crafting Alternative Solutions for Health Services: Organization and Management

Previous sections have proposed a conceptual approach to designing alternatives for restructuring and reorganizing health services delivery in Albania. They have also discussed the criteria for assessing alternatives. The alternatives are to be designed to address the needs of established government policy on decentralization and of the recent authorization given the HII to become a single source of financing for personal health services. In addressing the organization and management needs of producing health-related services, the authors have adopted a comprehensive view of the health sector, grouping these services into three categories: environmental services, public and preventive health care, and personal, curative care. The organization and financing needs are different for each category. There is no debate on the first category, and there is some need to address the requirements for the second category. The most important issues to be addressed are in the third category. The authors will address these issues primarily as they concern PHC, but are mindful that the solutions in this area have large implications for the way hospital care is financed and managed.

This section presents alternative solutions to the organizational issues and problems (and recommendations) in three steps. First, alternative ways of organizing the general structure of responsibility for health care service delivery are described. Exhibit 1 provides a summary of how each of five proposed alternatives (and associated financing) may be judged relative to the each of the three assessment criteria. The first alternative describes a general approach to organizing for *the delivery of public and preventive health services*. Since there is little question about the need for the MOH and the Institute for Public Health to have primary roles here, no other alternatives are suggested. The other four alternatives propose different approaches to organizing the executive authority responsible for *the delivery of primary health care*.

Second, after noting that the criteria seem to generally favor a regional locus of executive responsibility for health and medical services (at least for PHC services), a matrix is provided in Exhibit 2 that describes the proposed roles of the relevant agencies with respect to organization and financing for each category of health-related services. This matrix acknowledges two conclusions from the application of criteria in Exhibit 1: that delegation of executive responsibility to municipalities and communes would be unfeasible, and that the appropriate locus of executive authority should be at the regional level (regional health office, or RHO). Exhibit 2 suggests three general approaches to creating an RHO (all three assume that the MOH would continue a policy planning and technical support role): (1) the RHO would be a deconcentrated office of the central MOH accountable to the Parliament through the central MoH, (2) the RHO would be accountable to the qarku, and (3) the RHO would be accountable to the HII. (There could conceivably be an integration of two or more of these general approaches.) How this executive authority would be defined, and how it would relate to the relevant stakeholder institutions (the MOH, the qarku, the prefecture, the MoLG&D, and the HII), would need to be determined.

Exhibit 1: Applying Criteria for Alternative Approaches to Organization and Management

<i>Option for PHC Organization and Management</i>	<i>Responsibility for financing is assumed by....</i>	<i>Clear lines of responsibility of performance & accountability for results</i>	<i>Clear lines of responsibility for funding—amounts & payment method</i>	<i>Incentives in organization, financing methods reward quality, productivity, & performance*</i>
<i>1. For public and preventive health: deconcentrated MOH with some autonomy for MOH regional offices</i>	MOH: all line items in MOH budget; as alternative, convey budget as grant unconditionally to qarku if it is given responsibilities	If MOH is solely responsible, this can be achieved; if responsibility shared with qarku, division of responsibility needs clarity by specific service	Management accountability should parallel budgeting decision making; qarku responsibility needs budget responsibility	Budget funding has few inherent incentives, but could be structured into management methods
<i>2a. For personal, ambulatory care (PHC services): deconcentrated MOH: some autonomy for MOH regional offices</i>	HII: all relevant line items in health budgets pooled with the HII, adding to its revenues from enrollee contributions	RHO is solely responsible for management of facilities; the HII is responsible for financing	Division of management and financing responsibility needs clarity, but should be well-coordinated, maybe by unified leadership	Performance incentives must be structured into payment methods
<i>2b. For personal, ambulatory care (PHC services): organization & management delegated to qarku; technical direction by MOH</i>	Pooled budget transferred to qarku in block grant; alternatively, transfer budget thru MoLG&D	Defining boundaries between administrative and technical responsibility is extremely difficult	Defining clear boundaries between management and financing responsibility is extremely difficult	Budget funding has few inherent incentives, but could be structured into management
<i>2c. For personal, ambulatory care (PHC services): management of PHC delegated to municipalities and communes</i>	Health budgets consolidated in MoLG&D for transfer to local govts; HII as purchaser for enrollees	MoLG&D accountability for performance of local govts in health is outside its expertise; current capacity is nonexistent	Source of financing would not have much control over use, unless grants were conditional	Full responsibility given to small units makes it difficult to structure consistent incentives
<i>2d. For personal, ambulatory care (PHC services): management of PHC, as well as financing, performed by the HII</i>	All relevant line items in health budgets pooled with the HII	Making HII accountable for facilities management would require major institutional transformation	Management and financing responsibilities would coincide in the same organization	Performance incentives must be structured into payment methods

Exhibit 2: Proposed Structural Reorganization of Management of Health Care Delivery: Roles for Different Agencies Involved, Assessed for Each Category of Services

Category of Health-Related Services	Proposed Organization and Management Responsibility				Proposed Financing Responsibility		
	Central office of the MOH	Deconcentrated regional offices of the OoH/RHO	Local governments	Individual PHC facilities	HII	MOH	MoLG&D
Environmental: clean water; sanitation & solid waste disposal; pollution control	No role, except to identify any health risks during public health surveillance activities	No role, except to identify any health risks during public health surveillance activities	Exclusive functions of local govts	No role	No role	No role	Responsible for ensuring adequate funding is allocated by local govts
Public/preventive: communicable disease control; disease surveillance; child immunization; safety of food, water, & drugs	Policymaking role, with technical direction from Institute of Public Health	Primary responsibility for delivery of these services, using former district supervisory staff	Delivery of certain services <i>could be</i> delegated to local govts (qarku, bashkia, or communes)	Delivery of some services identified as part of benefits package	No role, except as some of services may be in basic benefits package	Primary responsibility for funding through adequate budgets	Funding responsibility <i>should</i> accompany (if) management responsibility is delegated
Personal, curative: emergency care, ambulatory care, acute care, and rehab/long-term care	Policymaking role, setting strategic direction and leading health planning tasks	RHO has primary responsibility for managing staff and facilities—some autonomy for facilities	No role recommended; but oversight and monitoring of delivery of services <i>could be</i> performed by local govts	Delivery of services identified as part of benefits package (could differ by payment method)	Responsible for pooling all sources of funds and for paying for services provided	Possible residual role for budget funding of specialized and referral/teaching hospitals	No role

Third, one must recognize that acceptance of the general structure of responsibility for the management and financing of services does not answer the more detailed, nuts-and-bolts questions about the relationship of the higher level (regional) authority (or authorities) to individual facilities and the degree of autonomy to be exercised by those facilities. Most particularly, further choices must be made to determine the manner and methods by which personnel at the facilities will have access to the needed supplies and equipment and be held accountable for their performance and quality. This involves defining the level of autonomy that facilities and their managers will have with respect to all of the tasks and functions to be performed in producing the range of services specified for each level of facility. (If complete autonomy is given to private providers, they would have total responsibility for procuring the necessary staff, supplies, and equipment, and public authorities would be responsible for licensing them and regulating their quality.)

Even without opting for a private sector alternative, facilities still owned by public authority could exercise some level of autonomy across a broad range of functions. At one extreme, each facility would have little autonomy to decide its staffing and budget, and to carry out the general organization and management tasks of the services it delivers. These functions would be performed by the RHO subject to agreement with the regional office of the HII on their funding and method of payment. At the other extreme, each facility would be given a high degree of autonomy to make important decisions about its own operations, although, for this option, the HII's financing role and method would be more central. The payment method the HII uses would be designed to provide financial incentives to facility staff to be efficient and effective in producing high-quality services. The two options presented are at each end of the spectrum defining the degree of facility autonomy. Both assume that some kind of RHO is formed to perform quality control, technical support, regionalized maintenance and procurement support, and general monitoring and oversight of practice management. These options are described below and are presented in a matrix in Exhibit 3. How each of the options is assessed against the criteria for feasibility assessment presented in section 3.2.1 is illustrated in a matrix in Exhibit 4.

Exhibit 3: Design Options for a PHC Pilot

Option	Which Decentralized Unit Is Responsible for Allocating Resources?	What Key Transition Interventions Would Be Required?	How Would Clinics Get Paid?	Who Regulates Quality?	What Is the Role of the PHC Unit of the RHO?	Other Comments
<p>1. RHO Autonomy</p>	<p>RHO\PHC Gets global budget from HII—global budget or capitation rate based on standard coverage package, population, and volumes of care</p>	<p>HII strengthening RHO/DPHC Management strengthening Possibly local community boards</p>	<p>Annual budgets for staff supplies and equip. with pools for bonus</p>	<p>RHO/DQA</p>	<p>Primary executive for PHC</p>	<p>Complete decentralization of PHC to the regional level Could be an urban area only option, or it could be applied to an entire region composed of both urban and rural places</p>
<p>2. Clinic Autonomy (assumes RHO role would be needed as prerequisite to any privatization)</p>	<p>Clinics get global budget directly from HII after three-way negotiation with RHO</p>	<p>Hire and train managers in the clinics HII strengthening Local community boards</p>	<p>Global budget based on standard package and volumes of care</p>	<p>RHO/QA</p>	<p>Monitor performance of PHC and negotiate annual global budgets</p>	<p>Could be considered a second phase of Option 1 Complete autonomy for clinics, no funding authority for RHO Possible path for privatization and consumer choice</p>

Exhibit 4: Applying Criteria for Assessing Feasibility of Alternative Designs for a PHC Pilot

Option	Clear organizational lines of responsibility for performance of tasks and functions required; clear accountability for results and performance	Clear lines of responsibility for financing and parallel to clear lines of responsibility for performance	Organization and financing of services include incentives to reward providers for effective, productive, and efficient delivery	Explicit methods adopted that would increase accountability for providers to patients
1. RHO Autonomy	Feasible— If clinics are responsible to RHO/PHC for all staff and all procurement functions, and are accountable for quality and outcomes, with no fragmentation in authority over different parts of facility functions; practice managers needed at clinics	Feasible— If all sources of funding are unified under the HII, which then coordinates with the RHO/PHC in the process of contracting with facilities for services according to numbers enrolled, managers needed at clinics	Feasible— If part of payment to facilities includes pools out of which improved productivity and attainment of quality goals can be rewarded	Feasible— If quality ratings and consumer satisfaction survey results were made available to the public
2. Clinic Autonomy (a private sector alternative feasible in the future and only in urban areas)	Not feasible— Unless and until clinics are supervised by trained managers with clear lines of accountability, either to payer (e.g, the HII) or clinic owner (or both)	Feasible— As long as regional managers and head nurses can be held accountable for financial management to the payer and clinic owner	Feasible (in the future)— Incentives would be implicit in autonomous operation with payment methods explicitly rewarding for maximizing units of service produced at highest quality produced at minimum cost	Feasible (in the future)— If clinics were rewarded for enrolling patients, having incentives for increased productivity, with patients having access to information on quality and other patients' satisfaction

6.1 Options for Decentralization in a Pilot Program

The opportunity to examine unsettled issues of health care system design using a pilot site is a common strategy in policymaking. This section examines some of the main issues and possible configurations for a pilot dealing with the specific reform issues of PHC. Following a presentation of some of the areas of reform design that seem to have been settled through ongoing discussions, the authors offer some options for designing a pilot project for testing the workability of certain aspects of PHC organization and incentives.

Assumptions about the Reforms for the PHC Pilot

Some specific and immediate options for decentralizing PHC can be identified, along with the corresponding implementation activities that will be needed to build capacity to support the reforms. The idea of a pilot reform region(s) will make this decision-making process somewhat easier, since final decisions can await pilot results.

Some decisions about the nature of reform appear to have been made, and others await pilot results. The remaining key issues concerning PHC include the following:

- ▲ **Extent of the pooling of funds to support the implementation of decentralized responsibility for delivering services.** Will all health care funds be pooled and distributed through the HII? If PHC funds and their distribution continue to be the responsibility of more than one organization (HII, MOH, and MoLG), there can be no clear financing and management incentives at the level of the provider of service.
- ▲ **The role of formal user fees in helping to pay for needed services.** It is reported that providers currently demand and collect “informal” user fees as a condition of their providing services. To the extent this is true, it leads to severe inequities and uncertainties among patients about the true cost of getting care when they need it. The question arises as to what extent Albania wants to (or needs to) organize systematically and thus bring under control what is already a largely private system for providing medical care that is using government facilities. (This step has already been accomplished for dental and pharmaceutical services.) If modest user fees are not to be formalized and officially collected, then perhaps the privatization of the organization of services should be considered.
- ▲ **The definition of primary health care.** What benefits are included; what services will be referred to higher levels? What public and preventive health services will be included?
- ▲ **The role of the Institute of Public Health and the system of disease surveillance.** There is a disconnect between the current Law on Local Government and the existing laws regarding communicable disease surveillance. Is this to be a national or regional responsibility?
- ▲ **The levels at which health planning will be done for infrastructure, health work force, and quality.**
- ▲ **The degree of decentralization/deconcentration.** Will the authority and executive functions be retained centrally? Will they be regionalized? Will they be decentralized even further to the facility level?

- ▲ **Risk pooling in a regionalized system.** If the regions are to be autonomous in regard to health planning and management, what is to be done with poor or underserved regions in terms of budget setting so that there are appropriate transfers to the low-income areas? How will severely underutilized rural clinics be phased out?

The purpose of the pilot design would be to build confidence among policymakers in devising and implementing solutions to these issues.

Some of the thinking on these issues is fairly well advanced. It appears that the question of how best to pool funds and risk across population groups and regions has been settled by the decision to assign the responsibility for pooling PHC funds to the HII. The idea would be to put all PHC service delivery funds (not administrative funds) for the MOH system together with the HII's current funds for the pilot region. The pooling of funds would have three primary benefits:

- ▲ To allow the payment policy to be designed so that equity can be achieved across population groups and areas. This is accomplished by distributing funds across clinics according to the needs of the populations rather than by the magnitude of tax receipts from those areas.
- ▲ To allow a single organization to become expert at administering payment policy and disbursement and related insurance administration functions.
- ▲ To divorce the funding aspects from the delivery of service aspects so that the providers of services are made directly accountable for their performance, according to the policy of payment—which is set by someone else. For example, the policy may be to pay more to providers who do more. Although managerial controls (as apart from single-payer contracting) can achieve this objective, the separation of financing from provision of care offers a second and independent authority for promoting better performance of the providers of service (e.g., providers need to satisfy both their managers in the RHO/PHC and the single payer authority—the HII—who makes payment).

The pilot should use the HII and its administrative systems to distribute funds and monitor performance as directed by the payment provisions of the pilot. The HII would perform standard single-payer functions that would include the following:

- ▲ Distribute funds according to policy about payment methods for distribution to accountable entities—according to risk-pooling policies—to ensure equity for places and providers serving disproportionate populations of the poor and the sick
- ▲ Verify that funds were used for intended purposes
- ▲ Audit quality and coverage issues, as set by policy
- ▲ Contract with qualified providers only, using criteria set by policy
- ▲ Control payment integrity by maintaining data on eligibility of persons served by differing schedules of benefits or different provider entities
- ▲ Maintain computer systems for monitoring costs, usage, and performance

A second issue where agreement about the pilot seems widespread concerns the extent of decentralization and the location of the accountable, executive function. The prevailing view is that

the pilot should assess the reasonableness and performance of a regional PHC office as a department separate from the MOH hierarchy. The regional PHC office (hereafter RHO\PHC) would become the autonomous resource allocation and planning agent for primary care in the pilot region. The RHO\PHC unit would have the flexibility to make local policy regarding how resources would be allocated across sites in the region, and would work with the HII to ensure that financing policies are consistent.

6.2 Design Options for the PHC Pilot

Within these broad assumptions about the pilot, there are two options for organization that deserve consideration for pilot implementation. Exhibit 3 shows these two design options. In both options, a significant reform would be to develop and support a new cadre of staff through the training and deployment of those who would be responsible for managing the facilities (regional managers and head nurses).

Option 1: RHO Autonomy. An RHO would be established for the pilot region and would include a Department for Primary Health Care Services. This unit would be responsible for planning, resource allocation, and delivery of PHC services (a separate department would be responsible for public health services) in the region. Funds for PHC service delivery of agreed-upon services in the amount of a capitation payment (or global budget) would be set aside for the region in the HII account. The RHO/PHC unit would be responsible for allocating these monies to the PHC clinics throughout the region, for negotiating budget and resource needs with each health center, and for establishing performance standards for centers against which to monitor results.⁴⁹ Each health center may have some modest (to be determined) degree of autonomy to adjust resource usage and procedures⁵⁰, although the RHO would retain managerial control of the centers rather than award full autonomy to them. Health centers would earn bonuses for better than expected performance based upon these standards and agreed-upon bonus arrangements according to priorities for each center to be set by the RHO/PHC unit. Quality standards would be set and monitored by a Department of Quality Assurance (RHO/QA). The RHO would require development of a community steering body be established for each center to enable community leaders and citizens to participate in governance of the centers.

The advantage of this design for a PHC pilot is that it decentralizes authority for PHC to the level of the region (or, from the perspective of the municipalities and the communes, it centralizes authority at the regional level) and provides incentives for the regional authority (RHO/PHC) to conserve its (fixed) budgeted funds by promoting better allocations of PHC funds throughout the region and encouraging economy in provision of services. This design also recognizes the unknown potential for decentralizing (in the future) even further (by granting greater autonomy to each facility) once regional managers and head nurses have been trained in sufficient numbers to make such a step feasible. In the meantime, the RHO/PHC retains strong management controls and staffing responsibility over the clinic sites. The following activities would be required to implement this pilot:

- ▲ Establish the RHO/PHC unit and build capacity to manage clinics and monitor performance

⁴⁹ Ultimately, at the conclusion of the pilot, the scopes and natures of RHO budgets, responsibilities, and authorities (in relation to PHC facilities and providers) could be different according to the specific elements and requirements of the different regions. The RHOs would remain under the technical supervision of the MOH, but would be politically accountable to a regional government authority, and financially accountable to the HII, as described below.

⁵⁰ This is contingent on the training and deployment of practice managers to perform this function.

- ▲ Establish a model program to train personnel skilled in all aspects of managing clinics and supervising the tasks and activities listed below
- ▲ Establish a regime within the RHO/PHC unit to deploy, support, and supervise these regional managers and head nurses in their new roles and positions
- ▲ Define the PHC benefit package (or exceptions) and the associated resource requirements (e.g., coverage for Rx, coverage for home visits, deliveries)
- ▲ Establish financing requirements for funding PHC in the pilot area: policies regarding financing such as user fee levels, waiver policies for user fees, Rx coverage and costs, referral policies, bonus potentials, salary levels, and needs for equipment and supplies
- ▲ Establish policies about how formal user fees would replace informal payments;
- ▲ Establish quality control procedures for the pilot (i.e., guidelines, facility standards) and processes to be followed
- ▲ Establish policies regarding who is/can be a provider of PHC services under the pilot, including units within polyclinics, units within hospitals
- ▲ Establish method(s) for allocating pooled funds for the region to PHC qualified providers; options could include (1) paying by services provided, (2) paying by numbers enrolled (rostered patients), and (3) paying by budgets based on expected volume
- ▲ Establish a PHC unit within the HII to hold funds and adjudicate payments, and to maintain systems for monitoring performance and providing feedback to providers and systems for auditing and verifying
- ▲ Create simulated data on the pilot and conduct training exercises for all parties based upon simulation data, systems, and role playing
- ▲ Train provider staff on budgeting, budget monitoring, and the performance measurement system and bonus potential
- ▲ Establish procedures for the HII to pay expenses for the PHC resources (i.e., salaries, supplies, equipment, bonuses) from the pool
- ▲ Establish procedures for making periodic reports against budgets for the fund distributions
- ▲ Establish monitoring procedures for the MOH authorities higher than the RHO
- ▲ Create the pool of funds for the pilot RHO, and deposit in the HII account
- ▲ Authorize beginning of the pilot

Option 2: Clinic Autonomy. This pilot design would feature complete financial autonomy for each authorized PHC provider.⁵¹ This means that each provider would contract with the HII and the RHO for an annual global budget, which they would allocate as required. They would carry unexpended funds in their own bank accounts, from which supplies, salaries, equipment, and facility upkeep would be paid. Bonuses for staff would be based upon achievement of the budget (e.g., target volume levels, performance standards pertaining to referrals and Rx usage, etc.). To assist in managing funds, purchasing of resources, and improving business practices, the PHC providers would be required to hire practice managers, who would plan for and manage global budgets. RHO/PHC would regulate quality and provide a standard methodology for managers to use in planning and budgeting for each facility. The RHO would also monitor the performance of the facilities and providers within facilities and make recommendations to the oversight body for each facility to whom the director of the facility would be responsible. That group might be composed of key RHO officials (QA, PHC), the director of the facility, and several local officials and consumers.

The benefit of this pilot design is to create autonomy for some of the larger PHC provider organizations in the pilot region. This autonomy (and global budgets) would tend to create the most pronounced incentives for raising demand for services and promoting high staff productivity. If it were possible in the pilot to demonstrate that capacity for clinic management can be built and that it can lead to good results, then this pilot design would offer an important path to PHC reforms. This path would establish the HII single payer as a purchaser of services from qualified and autonomous PHC provider entities whether public or private sector.

The steps needed to implement Option 2 in a pilot project would include all of those noted for Option 1, plus the following:

- ▲ Establish procedures for qualifying provider entities for participation in this autonomy pilot
- ▲ Develop methods for allocating a regional PHC budget to global budgets for individual providers
- ▲ Develop extensive facility-specific cost information enabling the estimation of costs per service by type of service
- ▲ Help provider facilities recruit and train personnel and other key provider staff in financial management, accounting controls, business plan development, global budgeting, and performance measurement

6.3 Recommended Design Option for PHC Pilot Project

Recognizing the ways in which each of the options does or does not satisfy the requirements originally noted in section 3.2.2, as summarized in Exhibit 4, it is recommended that Option 1 be chosen for detailed design work as the preferred option for the PHC pilot project. Because the prerequisites for this option are not currently in place (trained regional managers and head nurses, extensive cost information, etc.), it would be feasible only if extensive time and resources could be

⁵¹ Achieving authorization for clinic autonomy would involve a lengthy transition process from the current line-item, budget-based financing (from three sources). It would also require the development of a cadre of practice managers who would assume responsibility for managing the logistics and financial operations of each facility. It could conceivably consist of private practices being established in urban areas, sooner or later, if complete autonomy of the ownership and management of PHC facilities were decided to be the policy where competitive forces could have benefits.

made available to make it work initially. Given the deficiencies in the current administrative and management structure that need to be addressed and the complete lack of human resources trained in the business and clinical management tasks that would be required of Option 2, time and resources would need to be devoted to the immediate organizational and management needs of the system. In the long term, it may be feasible to work towards greater autonomy for individual facilities, ultimately even establishing some of them as private practices. But the immediate need is to develop structures and processes whereby the functions of planning, budgeting, and financing of PHC can be designed and directed to support more efficient service delivery with the HII as a single source of payment.

Annex A: A Conceptual Foundation for Considering Decentralization in Health: Determinants of Population Health Status

To provide a conceptual foundation for considering the complex issues involved in decentralization in the health sector, it is useful first to catalogue and discuss the full range of functions and services that need to be performed or provided in the sector. Once the full spectrum of services people need to promote and protect their health status is outlined, one can then turn to the task of considering how they are currently being provided, where the gaps and weaknesses are, and what changes might be made to improve the performance of the system in producing them. This comprehensive overview of what is needed will provide the broad context for government to consider how decentralization can and should be used to ensure that the needs are met.

It is a fundamental principle of the practice of public health that the determinants of a population's health status are infinitely more complex than the task (as difficult as it is in itself) of effectively providing medical care to sick individuals. Many of them are less related to the direction and substance of government health policies or programs than they are to underlying socioeconomic conditions, which are usually not affected by government actions. Of course, it is equally fundamental a truth that sick individuals are much more interested in accessing the medical services that would restore them to better health than they are in considering what they might have done (or should do in the future) to prevent the illness in the first place. Even after being restored to good health, individuals are also much less likely to have the knowledge and understanding of how to protect their health or prevent an illness in the future, and, in many cases, they do not have much control over many of the critical determinants.

There are a range of socioeconomic factors that determine a population's health status, however, the fact remains that the provision of a whole range of services can, and does, have a role to play in maintaining and improving the overall health of a population—with personal, curative services being just one. Just what services should be produced for improved health status, and how, is the first of a series of key questions that are fundamental to the formation of public policy in the health sector. The series of key questions are as follows:

What services are needed by households to produce better health?

What functions must be performed to produce these services?

Who (or what agency) does or should perform those functions?

How are these functions being performed now?

In producing the various needed products and services, what is the role of the following:

- ▲ The household (in determining its own health status)

- ▲ Government (it can prohibit, mandate, regulate, finance, provide)
- ▲ The private sector (it can make investments to respond to economic demand and has incentives to minimize cost and to maximize profit)

To help answer these questions, one can first categorize the major factors that determine how healthy a particular population is. These factors include the following:

- ▲ Supportive social, cultural, political, and economic environments in the community
- ▲ A clean, safe, and healthy physical environment, in the home and in the community
- ▲ Availability of services in the community that can
 - △ promote a healthy environment;
 - △ prevent illnesses, injuries, and deaths in the community; and
 - △ serve to diagnose and cure illnesses and injuries when they occur.

Government has a particularly important role to play in determining what services are to be made available and how they are provided. For each of these three categories listed, the *services* that are needed in the community can be listed as follows:

For a healthy environment

- ▲ Clean water,
- ▲ Sanitation/waste disposal services, and
- ▲ Protection from environmental pollution.

For prevention of illness, injuries, and deaths

- ▲ Childhood immunizations;
- ▲ Communicable disease/vector control;
- ▲ Disease surveillance;
- ▲ Nutrition supplements and surveillance;
- ▲ Health promotion and education;
- ▲ Monitoring and inspection of food, water, and drugs for safety;
- ▲ Reproductive and prenatal/postnatal health care for women; and
- ▲ Accident prevention on the roads, on the job, and in the home.

For diagnosis and treatment of illnesses and injuries when they occur

- ▲ Primary health care services,
- ▲ Emergency care services,
- ▲ Acute care services, and
- ▲ Rehabilitative and long-term nursing care.

Albania is currently undergoing an extended transition from the communist regime's method of providing services using a highly centralized command-and-control approach. During this transition, which includes the design and implementation of decentralization of government functions in several sectors, there is considerable fluidity (and uncertainty) about the locus of responsibility for many functions, particularly in the area of health. As will be detailed in the next section, recent changes—some unrelated to decentralization efforts—have led to a fragmentation in the flow of budgeted funds as well as in the lines of authority and accountability for performance.

A consideration of alternatives, both in overall goals and in their implementation, needs to start with a basic understanding of the current situation. This can be done by answering as accurately as possible the following questions about the general political structure and process for making decisions about policies and the allocation of public resources—particularly as they may be used to support the production of needed services:

What needed services are produced and by whom?

How are those services produced and distributed in Albania?

Where does responsibility lie for production and/or distribution?

How is production financed and managed?

How are inputs procured, production processes organized, and outputs priced?

How is accountability for outcomes and quality of the goods or services implemented?

In the health sector, since government is so central to arriving at answers to these questions, consideration of the questions needs to be supplemented by a series of questions specifically concerned with the exercise of government and political control; that is, within the public sector:

Who has what authority to

- ▲ make law, policy, or regulation;
- ▲ decide on allocation of public resources; and
- ▲ hold people accountable for these decisions.

Who has responsibility to

- ▲ implement policies and programs, and

- ▲ enforce laws and regulation and be accountable for that.

Where are the gaps in the current distribution of responsibilities?

How can these gaps best be filled under current circumstances?

Finally, one needs to ask about the role that *consumers* play in accessing the *services* needed to produce their own good health. After all, to the degree by which consumer demand determines the availability of the services needed, it is patients' and consumers' choices that heavily influence the utilization and/or consumption of what is produced. In recent years, it has become clear that weaknesses and gaps in production of primary health care in rural and remote areas has prompted residents to bypass local clinics and to seek treatment at polyclinics in urban areas. Because there has been a substantial investment and continuing budget support to numerous health centers and health stations in rural areas, the fact that patients are hardly ever using them warrants careful consideration of their benefits in relation to their costs.

Health Services for Better Health Status: A Focus on Primary Health Care

The comprehensive perspective taken above is much broader than the concerns of the project, which are to develop and model ways improve the delivery of primary health care. To the extent to which PHC includes prevention and promotion, the authors' concerns thus focus on two areas, with the second being a secondary, though important, concern of the project:

- ▲ The services needed for PRIMARY diagnosis and treatment of illnesses and injuries when they occur
- ▲ The services needed for the prevention of illness, injuries, and deaths, which are
 - △ childhood immunizations;
 - △ communicable disease/vector control;
 - △ disease surveillance;
 - △ nutrition supplements and surveillance;
 - △ health promotion and education;
 - △ monitoring & inspection of food, water, and drugs for safety;
 - △ reproductive and prenatal/postnatal health care for women; and
 - △ accident prevention on the roads, on the job, and in the home.

The first category of services is being delivered primarily by GPs in approximately 2,200 health centers in mostly rural areas of Albania, and these are now mostly financed by the HII. The organization and management of these services are now quite fragmented, however, in large part because of the fragmentation of their financing among three separate agencies—the MOH, the HII, and the Ministry of Local Government and Decentralization (MoLG&D).

Furthermore, the second category of services—generally referred to as public health domain⁵²—constitutes services that would not be produced at all in the absence of government action. Because they are public goods (i.e., they do not attract private investment in their production), they are best organized and delivered by the public sector. How these should be organized, managed, and financed is a distinct (though related) question from how primary (personal, curative) health care should be organized, managed, and financed. Because of the approach to decentralizing the latter, however, there are impacts on the former. Thus, the two are logically dealt with simultaneously, within the framework proposed here.

⁵² Some of these are performed by the Institute of Public Health and some by the Ministry of Health. Because of recent decentralization initiatives, there has been some question about where the responsibility for some of the services now lies.

Annex B: Producing Health-Related Services: Determining Roles and Responsibilities under Decentralization

There are numerous ways in which various actors in the health sector function and interact in order to produce the services needed to diagnose and treat illness and to promote better health. Government can, and usually does, play a major role in the health sector, but what role it plays depends critically on what choices society makes. On the one hand, some services would actually never be produced unless the government were to do so (preventive and promotive services, for example). On the other hand, many kinds of personal, curative care services can be, and often are, provided by private providers, if there is sufficient demand for them—that is, if enough people have sufficient willingness and ability to pay for them (which attracts investments in supply-side capacities to provide them). Where there is a vigorous private sector, though, persons with low incomes may have difficulty accessing services when they need them. Providing equity of access to such services to all people, regardless of income level, often then becomes a major goal of government’s role in the health sector.

One large advantage of relying on the private provision of personal, curative care services is that private parties are induced to make the necessary capital investment in the facilities and equipment needed to produce the services. With less pressure on government from the public to deliver personal, curative services, at least in theory, it can then focus its resources on services that are more cost-effective in promoting population health status. Government is also not as much at risk for failing to make the kinds of capital investments (in curative care provision) that are the most effective, needed, and desired by the people.

There can be, however, many problems in relying too much on market-based provision of medical care, and there is always an important and necessary role for government in regulating its provision. In fact, governments have many policy levers with which to influence private behavior in the sector—on both the supply and demand sides. Government can pass legislation that prohibits or mandates certain activities; it can issue regulations governing private sector behavior; and it can use its revenue-raising capacities to finance health services in any number of ways. One of the most common approaches is to organize the direct delivery of services in government facilities that are staffed by government employees.

Much more could be said about the complicated nature of the interrelationships of public and private sectors in the field of population health. There is, as noted above for example, the large question of the degree to which the provision of personal, curative care services actually improves the overall health status of the population—in comparison to, say, the provision of clean water and sanitation. While governments often spend large amounts on curative services that are typically a popular government-provided benefit, it is conventional wisdom (among public health professionals, at any rate) that public investments would be more cost-effective in improving population health status if reallocated away from curative and toward preventive and primary health care.

Regardless of one's view on this question, however, and even if the relative roles and responsibilities between the sectors could be agreed upon and defined, there are numerous policy questions subsequently raised about how a government should carry out its functions and duties with respect to improving the population's health status. Once a goal and strategy are determined as public health policy, there is then the question of how best to try to implement them. It is precisely with respect to this point that decentralization of government authority (for financing, management, administration, etc.) has been advocated. Its main justification and its principal rationale are that the implementation of public health goals is facilitated by a decentralized approach. As a general prescription for government organization, decentralization is also said to facilitate implementation of public policy goals in other sectors as well, primarily because it is believed to make government more responsive to local needs and concerns.

Decentralization, however, can have any number of different meanings, and it can have different prerequisites and implications in different sectors. Making health a "joint function" of central and local governments, for example, implies a need for vastly greater local "competencies" and capacities among local governments in the health sector than perhaps in any other sector. It would not be, for example, valid to presume that granting authority to local governments to allocate money to health (from block grant funds) would lead to development of sufficient capacities in health, even if money were made available in large amounts. The technical and administrative requirements of organizing the delivery of health and medical care are simply too complex and demanding for local governments to succeed merely by the assumption of budget allocation authority. When the budget allocation authority only relates to a small (though important) part of the budget, the potential benefits are even harder to imagine.

As the theory and practice of decentralization in the health sector in Albania are discussed, it is useful to summarize the criteria for assessing alternative ways to decentralize the health sector (or to organize the distribution of authority and accountability among various actors and institutions). The result should achieve the following, each of which tends to reinforce the others:

- ▲ Improvements in incentives to reward and reinforce good performance, quality of care, appropriate referral patterns, and efficient production and utilization
- ▲ The matching up of authority with responsibility and accountability
- ▲ The establishment of clear lines of decision-making authority and administrative responsibility
- ▲ The congruence of the flow of funds with the flow of authority and channels of administrative accountability

These criteria will be discussed further and applied when practical alternatives for the situation in Albania are suggested in section 4. What follows is an introduction to the issues raised by decentralization, first, in general, and, second, for the health sector, in particular.

Decentralization: What forms can it take?

Decentralization in General

There can be a wide variety of motivations and justifications for decentralizing government functions. The objectives of doing so can also vary according to the particular dimension—technical, political, or financial—of the function or agency being decentralized. Generally, decentralization

usually seeks to increase local participation and to redistribute political power by giving local governments more autonomy to make political and budgetary decisions. Technically, it is sometimes recommended as a means to improve administrative and service delivery effectiveness. Financially, decentralizing decision making on resource allocation is thought to increase efficiency by giving local government greater control over revenues and resources, and to sharpen accountability for performance and expenditures. But there are several reasons why theory may not always be translated into practice.

For one thing, there are many different objectives that could be served by decentralization, and some of them conflict with others. Such conflicts can often find themselves expressed in legislation passed at different times in different laws, and the result can be confusion and argument. There can be different types of decentralization according to the degree to which they focus on different political decision making or program implementation authorities. For example, a government agency or ministry could decentralize by deconcentrating authority from the central office to field offices at a variety of levels (e.g., regional, district, local). Or, it could decentralize by delegating responsibility or transferring specific authority to agencies not under its direct control. Or, it could decentralize by devolving political powers over budget and functions, through legislation and regulation, from central to local government units by formally allocating powers over budgets and functions. Failure to distinguish the nature of the decentralization being pursued and to define precisely its policy objectives can again lead to confusion and conflict.

So, it is clear that the word “decentralization” does not have one clear and unambiguous meaning, and that it is likely, in practice, to connote a mix of changes that depend upon political, technical, and institutional factors—not just upon changes in legal statutes. Moreover, the prerequisites and implications of “decentralizing” government authority or functions in different sectors are also likely to be quite different.

Decentralization in the Health Sector⁵³

Decentralization in the health sector is a particularly difficult goal and process for three major reasons:

- ▲ There are a wide variety of services that need to be produced in the health sector, and the production of some of them is most efficiently done in a fairly centralized manner; some of them might not even be produced unless the central government arranged for it to be done for all parts of the country.
- ▲ For those services the production of which can reasonably be decentralized (at least in theory), the prerequisites and implications of doing so can differ substantially between one type of good or service and another.
- ▲ The production of many health and medical services requires highly specialized technical knowledge and expertise, which is usually in short supply relative to demand; moreover, competent management skills to oversee the effective and efficient production of such services is even more scarce.

⁵³ For a detailed discussion of the issues related to decentralization and health systems reform, see *PHRplus*, “Issues for Implementers: Decentralization and Health System Reform,” Bethesda, MD, Abt Associates, Inc., 2002.

Because of these factors, any effort to decentralize the production of services in the health sector needs to proceed with all deliberate consideration, perhaps piloting and experimenting with alternative approaches before final decisions are made about the approach to be legally mandated.

Decentralization: What does it mean in Albania? What should it mean?

Decentralization in General

The initiative of the Government of Albania to decentralize has the general objective of promoting democracy and better governance by giving local governments specific responsibilities and authorities with respect to certain government functions that previously were centrally controlled. One major tool used to implement the decentralization law finalized in legislation passed on July 31, 2000, was the creation of block grants given annually to local governments. Municipal councils and communal councils were given authority to allocate monies from their block grants for specific sectoral functions. Since 1998, the process of decentralization has proceeded in large part by aggregating certain budget items from sectoral ministries and then redistributing them in block grants to local governments. The redistribution occurred by the use of a mathematical formula determining how much each local government would get, and was intended to provide more equity in the distribution of the funds. [A more detailed description is given in section 3.]

The transition period for local governments thus required that they adjust to three major changes at once:

- ▲ Assuming responsibility for performing “delegated” or “shared” functions that had previously been performed by central ministries and their district representatives
- ▲ Assuming responsibility for deciding how to allocate the block grant to the various sector programs in support of these new responsibilities
- ▲ Adjusting to the changed total amounts included in the block grants (depending on the result of the formula, as compared to the previous—disaggregated, nonblock grant—amounts they had been receiving, local governments could receive less or more than they had in the past)

While the authority local governments were given to make allocation decisions and to be responsible for certain functions was shifting down to local governments (e.g., in education, water, and health sectors), the control over disbursement of funds remained within the control of the central treasury in the Ministry of Finance, represented locally by branch offices.

Decentralization in the Health Sector

Decentralization in the health sector has proceeded primarily as a devolution of authority to local governments for a certain part of the government health budget—that part almost entirely consisting of the budget for operating costs of primary health care facilities. While this implies some degree of delegation of authority, the legislation authorizing local governments to become involved in health uses the term “joint function” as specifically distinct from “delegated function”—the health responsibilities of local government being the former and not the latter. These responsibilities are now by law shared between the central government ministry and the government councils of about 65 municipalities and over 300 communes.

At the same time, while there appear to be elements of deconcentration of the authority of the Ministry of Health to regional bodies, this change is so far only implicit in the creation of the Tirana

Regional Health Authority, which is a pilot of the general principle of deconcentration. Meanwhile, the “district offices” of the MOH have gradually been stripped of most of their authority over primary health care, which is now largely financed by the Health Insurance Institute and the Ministry of Local Government. The MOH retains budget for nonphysicians’ salaries in primary health care, although it is still in control of polyclinic and hospital budgets in their entirety. Authority and budgets for performing public health program functions has been, to some unknown degree, negatively affected by the loss of line authority for primary health care by district health offices.

So far, the decentralization efforts as they have involved the health sector appear to have been determined by the general decentralization policy of the government, with little technical analysis or consideration given to the specific prerequisites and implications of decentralizing in the health sector in particular.

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