



**USAID**  
FROM THE AMERICAN PEOPLE



Partners for Health Reform*plus*

# Primary Health Care Reform in Albania: A Pilot Project to Provide Evidence for Health Policy

---

*February 2005*

---

Prepared by:

---

**Margaret Cook, RN, MBA**  
University Research Co., LLC

**Mark McEuen, MA**  
Abt Associates Inc.

**Jan Valdelin, PhD**  
Abt Associates Inc.

This document was produced by PHR*plus* with funding from the US Agency for International Development (USAID) under Project No. 936-5974.13, Contract No. HRN-C-00-00-00019-00 and is in the public domain. The ideas and opinions in this document are the authors' and do not necessarily reflect those of USAID or its employees. Interested parties may use the report in part or whole, providing they maintain the integrity of the report and do not misrepresent its findings or present the work as their own. This and other HFS, PHR, and PHR*plus* documents can be viewed and downloaded on the project website, [www.PHRplus.org](http://www.PHRplus.org).



Abt Associates Inc.  
4800 Montgomery Lane, Suite 600 ■ Bethesda, Maryland 20814  
Tel: 301/913-0500 ■ Fax: 301/652-3916

*In collaboration with:*

Development Associates, Inc. ■ Emory University Rollins School of Public Health ■ Philoxenia International Travel, Inc. ■ Program for Appropriate Technology in Health ■ Social Sectors Development Strategies, Inc. ■ Training Resource Group ■ Tulane University School of Public Health and Tropical Medicine ■ University Research Co., LLC.

*End-of-Project Report*





## **Mission**

*Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:*

- ▲ *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.*

## **February 2005**

### **Recommended Citation**

Cook, Margaret, Mark McEuen, and Jan Valdelin. February 2005. *Primary Health Care Reform in Albania*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

For additional copies of this report, contact the PHRplus Resource Center at [PHR-InfoCenter@abtassoc.com](mailto:PHR-InfoCenter@abtassoc.com) or visit our website at [www.PHRplus.org](http://www.PHRplus.org).

**Contract/Project No.:** HRN-C-00-00-00019-00

**Submitted to:** USAID/Tirana

and:

Karen Cavanaugh, CTO  
Health Systems Division  
Office of Health, Infectious Disease and Nutrition  
Center for Population, Health and Nutrition  
Bureau for Global Programs, Field Support and Research  
United States Agency for International Development



# Abstract

The U.S. Agency for International Development-funded Partners for Health Reform *plus* Project provided technical assistance to the government of Albania from 2001 to 2005 in the design and implementation of a sub-set of its health sector reform strategy, focused on strengthening the primary health care (PHC) sector. An integrated PHC service delivery model was designed, implemented and evaluated in two districts to inform national health policy, for later refinement and replication on a wider scale. The model integrated five major components – family medicine training for PHC providers, a facility-based health information system, service delivery reorganization and quality improvement, financing reforms, and community involvement. The model addressed the low quality of primary health care, lack of any data on PHC patients or costs, bypassing of PHC clinics for specialty polyclinics or hospitals, fragmented financing and management of PHC, and the absence of community involvement. The pilot was a bottom-up approach that informed the development of an integrated PHC delivery system that is affordable to the Albanian economy.

---



# Table of Contents

Acronyms .....	xi
Acknowledgments .....	xiii
Executive Summary .....	xv
Introduction .....	1
1. Country Setting .....	3
2. Health And Health Care In Albania .....	5
2.1 Health Profile .....	5
2.2 Health Care System .....	6
2.2.1 Policy .....	6
2.2.2 Health Insurance .....	7
2.2.3 Organization and Infrastructure .....	8
2.2.4 Health Expenditure and Financing .....	9
3. PHC Situation Analysis .....	11
4. Strategy to Strengthen PHC .....	15
4.1 PHC Model of Care .....	15
4.2 Description of Pilot Implementation .....	16
4.3 Monitoring and Evaluation Strategy .....	19
5. Description of the PHC Model by Component .....	21
5.1 Family Medicine Training for PHC Providers .....	21
5.1.1 PHC Physician Training .....	21
5.1.2 PHC Nurse Training .....	27
5.1.3 PHC Provider Training Toolkit .....	27
5.2 Service Delivery Reorganization and Quality Improvement (QI) Activities .....	28
5.2.1 Improving Management Capacity and Processes .....	28
5.2.2 Defining the Services for PHC .....	29
5.2.3 Inputs to Begin Quality Improvement Activities .....	30
5.2.4 Clinical Practice Guidelines .....	30
5.2.5 Measuring Compliance with Guidelines .....	31
5.2.6 Measuring Quality Improvement .....	33
5.2.7 Institutionalizing Quality Monitoring Processes .....	34
5.2.8 Service Delivery and Quality Improvement Toolkit .....	35

5.3	Financing and Organization .....	36
5.3.1	Analysis of the Financing and Management Situation for PHC.....	36
5.3.2	Revised Financing and Management Approach .....	36
5.3.3	Using HIS Data for Better Management .....	37
5.3.4	Improving Facility Management .....	38
5.3.5	Single-Source Financing Pilot .....	38
5.3.6	Regional Health Authority.....	39
5.3.7	Informal Payments.....	39
5.3.8	PHC Financing and Organization Toolkit .....	40
5.4	Health Information System (HIS) .....	41
5.4.1	Designing and Testing a PHC HIS for Albania.....	41
5.4.2	Refining and Expanding the HIS.....	41
5.4.3	Using HIS Data.....	43
5.4.4	Replicating the PHC HIS.....	43
5.4.5	PHC HIS Toolkit .....	44
5.5	Community Involvement.....	45
5.5.1	Outreach Education .....	45
5.5.2	Screening for Chronic Diseases.....	45
5.5.3	Patient Satisfaction Surveys .....	46
5.5.4	Community Involvement Toolkit .....	46
6.	Replication of Reforms .....	47
6.1	Assumptions for Replication .....	47
6.2	PHC Reform Framework.....	48
6.3	Initial Reform Phase .....	50
6.3.1	Quality Improvement.....	50
6.3.2	PHC Health Information System (HIS).....	51
6.3.3	Interdependent Roles for MOH and HII.....	51
6.3.4	Basic PHC Services .....	52
6.3.5	Utilization of Health Centers .....	52
6.3.6	Health Insurance Coverage.....	52
6.3.7	Basic Equipment.....	53
6.3.8	Training for Doctors and Nurses .....	53
6.3.9	Timeframe, Expense, and External Support for Initial Reform Phase .....	54
6.4	Mid-term Reform Phase .....	55
6.5	Long-term Reform Phase .....	56
7.	Conclusions .....	57
	Bibliography .....	59



---

## List of Tables

Table 1: Macroeconomic Expenditure Indicators .....	3
Table 2: Basic Health Indicators for Albania, Romania, Bulgaria, and CSE, 2001 .....	6
Table 3: Number of Health Care Facilities, 1990, and 2000 .....	8
Table 4: Public Health Expenditure Indicators .....	9
Table 5: Pilot Facility Statistics (January 1, 2003 – June 30, 2003).....	17
Table 6: Pilot Facility Staffing.....	18
Table 7: Description of Baseline and Follow-up Survey Instruments .....	19
Table 8: Planned Number of Trainers and GPs to be Trained .....	24
Table 9: Selecting an Approach to Replicate Physician Training.....	27
Table 10: Compliance with Practice Guidelines.....	32
Table 11: Framework for Primary Care Reform: Suggested Phased Interventions .....	48

---

## List of Figures

Figure 1: Albania Health Care System Situation Analysis .....	12
Figure 2: PHR <i>plus</i> Albania Primary Health Care (PHC) Strategy .....	16
Figure 3: Time Sequence for Teaching 24 Modules of Family Medicine .....	25
Figure 4: Time Sequence for Teaching 4 Modules in Family Medicine .....	26



# Acronyms

<b>ALL</b>	Albanian Lek
<b>CEE</b>	Central and Eastern Europe
<b>CPD</b>	Continuous professional development
<b>CPG</b>	Clinical practice guideline
<b>CSE</b>	Central and Southern Europe
<b>EOM</b>	End-of-month
<b>EU</b>	European Union
<b>GDP</b>	Gross domestic product
<b>GP</b>	General practitioner
<b>HII</b>	Health Insurance Institute
<b>HIS</b>	Health information system
<b>INSTAT</b>	Institute of Statistics
<b>IMF</b>	International Monetary Fund
<b>IRD</b>	Intensive Research and Demonstration
<b>LSMS</b>	Living Standards Measurement Survey
<b>MOF</b>	Ministry of Finance
<b>MOH</b>	Ministry of Health
<b>MOLGD</b>	Ministry of Local Government and Decentralization
<b>NGO</b>	Nongovernmental organization
<b>PHC</b>	Primary health care
<b>PHR<i>plus</i></b>	Partners for Health Reform <i>plus</i> Project
<b>PRIME</b>	Partnership in International Medical Education
<b>QI</b>	Quality improvement
<b>RHA</b>	Regional health authority
<b>TOT</b>	Training of trainers
<b>USAID</b>	U.S. Agency for International Development
<b>WHO</b>	World Health Organization



# Acknowledgments

This report compiles many sources of information and documentation written by *PHRplus* staff overseeing or involved in project activities in Albania between 2001 and 2005 in order to document *PHRplus* Project achievements. Key *PHRplus* staff and consultants in Albania reviewed and contributed to the document. Catherine Connor, *PHRplus* Project Deputy Director for Operations, provided internal technical review of the report. The authors wish to acknowledge the excellent and insightful contributions of all authors and reviewers. *PHRplus* wishes the government of Albania success in capitalizing on our joint accomplishments in designing, testing, monitoring, and expanding interventions to strengthen primary health care and continue to improve the health of the population of Albania.



# Executive Summary

By the late 1990s, government stakeholders in Albania had adequately diagnosed and described key deficiencies in the health sector. However, strategies to address these deficiencies were less clearly defined and were rarely put into practice due to weak national stewardship, limited capacity to design and implement reforms, and constrained health sector budgets. U.S. Agency for International Development (USAID) technical assistance was offered to assist the government of Albania to design and implement a sub-set of health sector reform strategies to strengthen the primary health care (PHC) sector and to be piloted in one region of Albania. The aim of the pilot was to test the reforms on a small scale to provide evidence to inform policy, resulting in a well-documented PHC model that could be refined and replicated on a wider scale.

Project interventions were designed in June 2001 by the globally funded Partners for Health Reform*plus* (PHR*plus*) Project for USAID/Tirana after in-depth consultations with the Albanian Ministry of Health and other local counterparts, site visits to representative PHC centers and other facilities in several districts, and meetings with donor organizations working in the health care sector in Albania. PHR*plus* began implementation in Albania in early 2002 and phased out project support to activities in March 2005.

Despite donor investments in PHC infrastructure, the quality of primary health services remains low and PHC facilities offer a limited scope of services in comparison with care offered in other countries at a comparable level. This is partly due to the lack of necessary equipment and supplies, and partly related to the low level of knowledge and skills of PHC practitioners. Over time, minimal funding for PHC, limited continuous medical training, and no foundation of evidence-based medicine upon which to build have contributed to a deterioration of provider skills and decreasing utilization rates. Patients self-refer to seek higher quality care, often incurring additional costs in terms of travel, time, and higher formal and informal fees. Low utilization of PHC does not allow doctors and nurses adequate patient volume to maintain knowledge and skills. PHC facilities in Albania have little management autonomy and lack processes to continuously improve quality of care. Disorganized patient records and limited reliable patient information and medical statistics also impede the provision of higher quality and more continuous patient care. From the larger health system perspective, Albania had passed numerous health sector reforms on a national scale, generally without piloting or evaluating the reforms. Policymakers had little experience using pilots to test reforms and learn lessons before wider replication.

---

## Summary of Key Accomplishments and Results

The PHR*plus* Project in Albania developed and tested an integrated PHC model, many elements of which are being replicated both by the government and by other donor organizations. Implementation of the model resulted in the development of family medicine training materials and approaches, quality improvement tools and processes, and a PHC health information system (HIS). Analysis of financing and management constraints at the PHC level led to the development of concrete recommendations regarding PHC financing, organization, and management, while simultaneously increasing capacity of central-, regional-, and facility-level counterparts to better manage their resources, staff, and service delivery.

PHR*plus* provided refresher training in family medicine topics to more than 70 physicians and 40 nurses. Thirty midwives and 213 nurses received additional training in reproductive health, family planning, and counseling skills. Physician retraining resulted in a dramatic increase in PHC physician knowledge of evidence-based practices reflected in clinical practice guidelines. Knowledge, as reflected in multiple-choice questionnaires, increased from 24 to 67 percent. Most physicians in the pilot program cited the training as the most valuable component of the PHR*plus* model. They described it as very important in upgrading their knowledge and skills. PHC nurses also described their training as very valuable in helping them improve the care they provide to patients. They increased their knowledge and competence from a pre-test score of 40 percent to an average post-test score of 84 percent.

Service delivery reorganization activities resulted in a more defined scope of services for PHC and the development and use of 21 clinical practice guidelines for PHC sensitive conditions. Meeting requirements for medical charting improved in pilot sites from 52 percent to 89 percent in only four months. In one month alone, according to chart audits, compliance with guidelines for hypertension, diabetes, asthma, tonsillitis, and lower respiratory infection increased anywhere from 2 percent to 15 percent. Overall compliance with four of these guidelines averaged 75 percent. In one facility, use of the new guideline for lower respiratory infection and development of a related patient information sheet resulted in a decrease in the percent of visits where an antibiotic was prescribed from 40 percent to 24 percent.

PHR*plus*' PHC health information system was the first intervention tested in the four pilot sites. By generating data on patient diagnoses and characteristics, the HIS was a key input in defining the scope of PHC services and the provider training curriculum. Responding to government interest in the system, the HIS was refined with local counterparts, resulting in:

- ▲ Costs for encounter forms cut in half;
- ▲ Encounter forms completed in a third of the original time;
- ▲ Data entry time reduced by 40 percent; and
- ▲ Routine monthly reports generated in less than five working days after month's end.

After endorsement of the newly streamlined HIS by the Ministry of Health, its use has expanded from the initial four sites to 44 sites in less than six months, with plans and budget for nationwide expansion in place. USAID will continue to provide technical assistance to the expansion of the HIS through the ProShendetit Project.

To improve relationships with the community, PHR*plus* helped the pilot facilities provide health information to target groups: women of reproductive age, adolescents, and chronic disease patients. Routine patient satisfaction surveys were introduced to provide a mechanism for the population to provide feedback to their PHC facility and to help providers be more responsive to individual and community health needs. One pilot facility conducted outreach in the community through risk factor screening for hypertension and diabetes.

To improve the relationship between the PHC providers and the broader health system, PHR*plus* laid the foundation for a Ministry of Health and Health Insurance Institute reform pilot in Berat region to help define roles and relationships for PHC facilities in terms of management and supervision and to integrate fragmented financing. In terms of service delivery and quality, PHR*plus* helped to document the PHC model that was piloted to inform replication efforts. The project also worked at the regional level to better define key regional management functions, establishing a regional quality assurance function and



helping regional health administrators to use health information to improve quality and management effectiveness. Quantitative and qualitative research on the practice of informal payments helped inform key stakeholders to design appropriate interventions to address this growing problem. Improved management and financing of PHC facilities, once achieved, can significantly reduce costs and increase the effectiveness of the health system in Albania.



# Introduction

By the late 1990s, government stakeholders in Albania had adequately diagnosed and described key deficiencies in the health sector (Albanian Ministry of Health 1999). However, strategies to address these deficiencies were less clearly defined and were rarely put into practice due to weak national stewardship, limited capacity to design and implement reforms, and constrained health sector budgets. U.S. Agency for International Development (USAID) technical assistance was offered to assist the government of Albania in the design and implementation of a sub-set of health sector reform strategies to strengthen the primary health care (PHC) sector and to be piloted in one region of Albania. The aim of the pilot was to provide evidence to inform policy, resulting in a well-documented PHC model that could be refined and replicated on a wider scale. The Partners for Health Reform*plus* (PHR*plus*) Project designated Albania as an Intensive Research and Demonstration (IRD) site, supplementing USAID/Tirana funds with additional core project money to monitor and evaluate the impact of the PHC pilot.

Project interventions were designed in June 2001 by the globally-funded PHR*plus* Project for USAID/Tirana after in-depth consultations with the Albanian Ministry of Health (MOH) and other local counterparts, site visits to representative PHC centers and other facilities in several districts, and meetings with donor organizations working in the health care sector in Albania. PHR*plus* began implementation in Albania in early 2002 and phased out project support to activities in March 2005. PHR*plus* activities, jointly designed and implemented with local counterparts, proved extremely successful. Many interventions resulted in the development of concrete products and lessons learned through pilot implementation, which can inform the development of an integrated PHC delivery system that is affordable to the Albanian economy, hence reducing costs for future investments.

This report provides a summary of PHR*plus* work in Albania, one of the project's long-term country assistance programs. It is the first of two reports describing PHR*plus* activities in Albania. It focuses on the design and implementation of a PHC reform model in the Berat region in southern Albania, and presents recommendations for replication of the PHC reform model piloted in Berat. A subsequent report will provide an impact assessment of the pilot, describing findings from a baseline and follow-up survey in pilot and control districts. In addition, a CD-ROM-based toolkit is available that contains all of the products and tools developed by PHR*plus* to support efforts to strengthen primary health care in Albania.

Chapter 1 of the report briefly describes the country setting, including geographic, socio-demographic, economic, and political characteristics. Chapter 2 provides a profile of the population's health status and the health care system. Chapter 3 presents a situational analysis of primary health care in Albania from a systems perspective including financing, organization, human resources, information, quality, supplies, and drugs. Chapter 4 documents the design process of the pilot project aimed to improve the quality and efficiency of four PHC facilities in the Berat region. The chapter includes a description of the PHC reform model designed for Albania, the project's implementation approach using four facility pilots in the Berat and Kuçova districts in Berat region to test and refine the PHC reform model, and the project's monitoring and evaluation approach.

The pilot model comprised five components:

- ▲ Family medicine training for PHC providers;

- ▲ Service delivery reorganization and quality improvement (QI) activities;
- ▲ Financing, organization, and management;
- ▲ Health information system (HIS); and
- ▲ Community involvement.

For each component, Chapter 5 provides a situation analysis, the *PHRplus* Project strategy for the component, the pilot implementation process and results that demonstrated the feasibility of the proposed approach, and a description of tools developed during implementation.

Chapter 6 presents a framework for continued implementation of PHC reform, as well as recommended steps for implementing the reform in initial, mid-term, and long-term phases. The framework is consistent with the long-term strategy of the Ministry of Health and with lessons learned by the *PHRplus* Project in Albania. It also builds on successful approaches from PHC reform in other country settings. The chapter offers recommendations to Albanian stakeholders to continue to reform the health system to strengthen primary health care, using concrete strategies and tools that have been tested and proven successful in Berat region.

# 1. Country Setting

Albania is located in southeastern Europe on the Balkan Peninsula, and is bordered by Serbia and Montenegro to the north, Macedonia to the east, Greece to the south, and the Adriatic and Ionian seas to the west. Albania is slightly smaller than the state of Maryland, with an area of 28,748 sq km. In 2004, Albania's population was estimated to be slightly more than 3.5 million (CIA 2004). The country's population is younger than other European countries, with 29 percent of all Albanians 15 years of age or younger, compared with 18 percent in central and southern European countries as a whole. The total fertility rate has declined from 3.3 children in 1990 to 2.05 children in 2001, but still remains the highest in Europe. Albania's overall population has declined since 1989, reflecting the fertility decline and significant emigration. More than 300,000 people are estimated to have left Albania since 1992. There has been increasing migration from rural to urban areas within the country, with the prediction that 55 percent of the country's population will live in urban areas of Albania by 2009.

Albania is one of the poorest countries in Europe with an estimated gross domestic product (GDP) in 2003 of 745 billion Albanian Leks (ALL) leading to an approximate GDP per capita of US \$1,935. The GDP per capita seems to have increased significantly in 2004. Albania's GDP grew significantly in the 1990s, both in nominal and real terms. In constant prices, GDP grew more than 80 percent from 1992 to 2002, while GDP per capita increased more than seven times over 10 years. Government spending as a percentage of GDP remained within 28 percent to 34 percent between 1995 and 2001, but has since declined. It should be noted, however, that estimates are subject to significant measurement error because a large proportion of the country's economic activity lies outside the formal sector.

**Table 1: Macroeconomic Expenditure Indicators**

Indicators	1995	1996	1997	1998	1999	2000	2001*	2002*	2003**	2004**
GDP current prices (million ALL)	229,793	315,835	333,071	425,356	488,611	551,282	590,237	658,062	744,974	822,677
Population (thousands)	3,283	3,324	3,354	3,354	3,373	3,401	3,087	3,087	3,087	3,087
GDP/per capita (USD)	738	809	673	842	1,052	1,128	1,333	1,521	1,935	2,560***
Budgetary expenditure	77,134	87,596	100,730	141,628	165,692	170,621	190,496	192,517	144,842	150,489
Budgetary expenditure as % of GDP	34	28	30	33	34	31	32	29	19	18

Sources: Data from Ministry of Finance (MOF); Institute of Statistics (INSTAT), and International Monetary Fund (IMF) estimations; and Bank of Albania *Statistical Report March 2002* (for the years 1992-2001) and *Statistical Report March 2003*. When numbers differ in the two reports, the numbers from the most recent report have been used. All data on 1995 from the 2002 report. \* MOF and IMF staff estimates. \*\* Budgets, not actual expenditures; GDP and GDP per capita actual numbers from Bank of Albania *Governors' Report 2003* (April 2004). \*\*\* Actual, from Nano (2005).

Since 1990, after more than 40 years under an isolationist, communist government, the country has been experiencing significant social and political changes in its transition toward a market economy and a democratic government. This process was marked by social unrest in 1991-92 and again in 1997. In 1997, the civil disorder involved substantial destruction of property and infrastructure. In early 1999, 465,000 Kosovar refugees sought shelter in Albania during the NATO military action in Kosovo. These events put significant strain on the country's infrastructure and social institutions. While international aid has helped to repair most of the damage to the physical infrastructure incurred during the political crises and civil unrest of the 1990s, there has been no major civil service reform and the government remains unable to devote significant resources to social needs. The nascent parliamentary system is not yet capable of implementing reforms requested by the European Union (EU) as preconditions of future membership, despite the fact that EU membership is an objective that all parties and most Albanians share. Reforms, as reflected by new laws and by-laws, are fragmented, sometimes contradictory, and rarely implemented.

## 2. Health and Health Care in Albania

---

### 2.1 Health Profile

Albanian life expectancy was 75 years in 2001 (72 years for males and 78 years), despite relatively low levels of income and limited health services. Due to diet and lifestyle, Albania has one of the highest life expectancies in all of Europe (World Bank 2003). However, Albania is experiencing profound demographic and epidemiological transitions that impact the patterns of disease in the country. Prevalence of infectious disease (many of them vaccine preventable) is increasing, while the prevalence of chronic disease also is high (cardiovascular disease is the leading cause of death). The World Health Organization's (WHO's) Health for All Mortality Database shows higher rates of death due to circulatory system, ischemic heart disease, and cerebrovascular disease compared to other Western European countries. Death rates also have been increasing due to cancer, injury, and poison, with the rate approaching European averages.

The rise in chronic disease is expected to continue as harmful lifestyle habits associated with modernization appear to be increasing, coupled with greater numbers of Albanians migrating to cities.

Changing nutritional intake has seen an increase in the incidence of diabetes and hypertension in the population. Increased urbanization has contributed to an increase in deaths from some unnatural causes, such as traffic accidents. Furthermore, alcohol and cigarette consumption, though less than the regional average and neighboring countries, is increasing. As smoking rates for men and women (particularly among youth) rise, smoking-related diseases such as cancer and cardiovascular disease also will increase. Selected basic health indicators for Albania, Romania, and Bulgaria, along with Central and Southern European (CSE) regional averages for 2001, are shown in Table 2.

On the whole, Albania's health indicators are well below the average levels for the region. The country's hospital bed, nurse, and physician capacities are also low for the region. More favorable health indicators include reported immunization coverage for diphtheria, tetanus, and measles of well over 95 percent. Albania, however, faces difficult challenges overall in ensuring the health and empowerment of its future population as the country experiences a shift in disease patterns, poor maternal and child health, likely increased transmission of HIV/AIDS, a need for resources, and increasing poverty.

**Table 2: Basic Health Indicators for Albania, Romania, Bulgaria, and CSE, 2001**

Indicator	Albania	Romania	Bulgaria	CSE Average
Infant mortality rate*	24	20	14	-
Maternal deaths per 100,000 live births	23	34	19	13
Abortions per 1,000 live births	298	1157	750	646
Percentage of infants vaccinated against diphtheria	98	-	98	-
Percentage of infants vaccinated against tetanus	98	-	94	-
Percentage of infants vaccinated against measles	95	98	90	-
Pure alcohol consumption, liters per capita	1.79	6.32	6.01	7.72
Percentage of regular daily smokers in the population, age 15+ (2000)	39	21	-	32
Number of cigarettes consumed per person per year (2000)	744	-	2793	1738
Physicians graduated per 100,000	5.50	24.18	15.56	10.66
Physicians per 100,000	130 (2002)	190 (2002)	351 (2002)	360 (2002)
Nurses per 100,000	391	-	450	522
Number of hospital beds/100,000 population (1999)	300 (2002)	749	720	-

Sources: WHO 2003, except as noted. \*World Bank, 2003.

Note: CSE countries are Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, Slovenia, the former Yugoslav Republic of Macedonia, Serbia and Montenegro.

## 2.2 Health Care System

The Albanian health sector is in the midst of several important transitions. As described above, it is experiencing a dramatic shift in the kinds of diseases being experienced by its people. As the economy grows and the population ages, non-communicable and chronic diseases will become an ever-increasing share of the disease burden, requiring a shift in the kinds of resources devoted to diagnosis and cure. Second, it is still recovering from civil strife in 1997 and 1998, and from the demands of hosting thousands of refugees from Kosovo in 1999. During these years, the physical infrastructure of the health system deteriorated. Many facilities are now physically rehabilitated, but the PHC services available in health centers remain limited due to the lack of provider skills, supplies, basic equipment and other inputs. Third, Albania is a newly democratic state and has embarked on a process of deconcentrating authority to 12 regions that will replace 36 districts and will assume responsibility for managing government programs and allocating resources among the sectors. Within this context, the following sections discuss health care policy, health insurance, sector organization and infrastructure, and health expenditure and financing.

### 2.2.1 Policy

Since the fall of the communist regime in 1991, Albania has adopted a wide variety of policy documents, laws, and decrees that relate to health policy. For example, in 1993, the Ministry of Health issued a paper that identified two primary objectives of the government: first, to prevent further deterioration of basic health services; and second, to transform the health care system into a financially



sustainable system that can be managed efficiently and produce effective services. In addition, the MOH used the report to articulate several health policy goals, including guaranteeing full access to all preventive and most curative services at an affordable price, basing the health system on a primary health care foundation, introducing market elements into health care financing, and granting more managerial autonomy to districts and to health care regions. In addition, the MOH issued policy papers in 1999 and 2002 that reaffirmed the MOH's commitment to health care reform.

Over the past 10 years, Albania also has passed several laws and decrees to reform the health sector on a national scale. Some of the reforms have led to substantial changes in the organization and financing of health care services, including:

- ▲ Privatization of pharmacies and dental practices in 1993;
- ▲ Introduction of social health insurance in 1995 with the creation of the Health Insurance Institute (HII), a national statutory fund that covers general practitioners' (GPs') salaries, pharmaceuticals on the essential drug list, and (beginning in 2000) all primary health care costs in Tirana and funding for Durres Regional Hospital;
- ▲ Creation of the Tirana Regional Health Authority in 2000 to integrate PHC and public health programs;
- ▲ Amendment to health insurance law passed in 2002 to establish HII as the single source of finance for all primary health care in 2004 and all health care in 2005; and
- ▲ Lifting of restrictions on licensing of private providers of health care in April 2003.

In addition, Albania has been attempting to deconcentrate authority to 12 regions and to local governments, which will assume responsibility for allocating resources among and within sectors and for managing government programs. This has been guided by the Law on Organization and Functioning of Local Government (Law No. 8652, dated July 31, 2000). Decentralization has moved very slowly because of a lack of clarity regarding which roles and responsibilities would be delegated and a lack of capacity at the sub-national level. The health sector has remained centralized, with the only impact of decentralization being that the MOH is no longer funding operations and maintenance of PHC facilities.

The *Long-Term Strategy for the Development of the Albanian Health System* (Albanian MOH 2004) is the most recent attempt to develop a comprehensive health sector strategy. WHO plans to coordinate technical assistance in 2005 to help the government develop a detailed plan to implement the strategy.

---

### 2.2.2 Health Insurance

Government-sponsored health insurance in Albania is still fairly limited, both in terms of the population and the services it covers. Established in 1995 and managed by the HII, the scheme pays salaries to GPs (including family doctors), and offers patients free consultations with GPs and subsidies on more than 300 drugs. The scheme is financed by social taxes on wages (approximately 56 percent [HII 2004] however the formal economy is estimated to represent only 65.9 percent of total economic activity (reported in World Bank 2002a). Legally, the governmental scheme should cover all Albanian citizens, but in reality it does not. Many citizens are simply not covered, many who are eligible are unaware of their eligibility or are reluctant to sign up due to the tax burden, while others who have coverage lack documentation to verify their membership. Without such documentation, scheme members may find their access to free services or discounted drugs impeded.

Recent data from the 2002 Living Standards Measurement Survey (LSMS), conducted by the Albanian Institute of Statistics (INSTAT) with assistance from the World Bank, shows that approximately 39 percent of the country's population has the required insurance documentation (World Bank 2003). By law, all economically active individuals (employees, employers, the self-employed, or unpaid family workers) are obliged to contribute to the scheme, while the state bears responsibility for the contributions of children, full-time students, retirees, the disabled, the unemployed, pregnant women, and citizens under compulsory military service. Coverage among farmers, despite lower premiums set for them, is particularly low due to their inability to afford the scheme, their lack of awareness, or their lack of incentive to join (World Bank 2003). As of 2004, there were very few private health insurance plans available locally.

---

### 2.2.3 Organization and Infrastructure

The MOH accounts for nearly all health service delivery in Albania. There are three levels of health care in the country: primary, secondary, and tertiary. Primary health care is delivered in urban areas through primary health centers and maternal and child health centers, and, in rural areas, through health centers and ambulances (health posts). GPs and pediatricians typically staff PHC centers. Nurses and midwives typically staff ambulances. Polyclinics and hospitals offer secondary care, and they have specialized providers, instead of GPs, on staff. A handful of university institutions in Tirana provide tertiary care.

The civil unrest of 1997 had a significant impact on the health sector. In some areas, nurses and doctors fled their posts, municipalities ceased functioning, health facilities were looted for their equipment and supplies, and the physical infrastructure of the health system deteriorated significantly. Since that time, many facilities have been physically rehabilitated, often with support from USAID and other donors, but PHC services available in health centers are still limited due to the lack of water, electricity, supplies, and basic equipment. Since the fall of the communist regime in 1991, the numbers of polyclinics, PHC centers, and ambulances have all declined, as indicated in Table 3.

**Table 3: Number of Health Care Facilities, 1990, and 2000**

Type of Facility	1990	2000
Outpatient Care		
Polyclinics	60	53
Primary health care centers (incl. MCH centers)	1046	580
Ambulances	2196	1505
Total	3302	2138
Inpatient Care		
In rural areas	86	0
Total	160	50

Source: INSTAT 2002 and Albanian MOH 2002a.

The number of hospitals in the country has significantly decreased. In rural areas, the decline in the number of facilities has to an extent been aggravated by the migration of health workers from rural to urban locales. Although many of the institutions that closed were poorly equipped, their closure

exacerbated the problem of rural access to inpatient services. Albania has one of the lowest rates of hospital beds per inhabitant in all Europe; the number of beds per 100,000 inhabitants is half the average of the EU countries, and less than half the average of the countries in Central and Eastern Europe (CEE). Despite this, occupancy rates are reported to be low, except in long-stay hospitals. In the hospital in Berat, for example, the occupancy rate in 2002 was reported by the hospital to be only 50 percent.

Private sector involvement has been limited to pharmacies, specialist physicians, and dental clinics, though there are an unknown number of private clinics and laboratories. Eighty percent of pharmacists and dentists are employed in the private sector, but only 10 percent of the rest of the medical work force. The number of private service providers is rapidly growing, but few are licensed, and none are regulated or monitored by public authorities (Nuri 2002).

A special challenge for the reform of the health system is the integration of family planning and reproductive health services into PHC service delivery as appropriate. Previously, the policy was to offer these services only at maternities and women's consultation clinics. On average, there is one of these facilities in each of 36 districts in the country. UNFPA-supported efforts in the 1990s were based on a vertical model to ensure more rapid delivery of these important services, but, unfortunately, this has led to limited access to services in rural areas and a complete lack of family planning and reproductive health services and supplies provided in PHC facilities. Integration of these services would increase access to services and supplies, resulting in increases in the use of modern contraception and decreases in abortion rates, and may also contribute to increased sector efficiency.

---

## 2.2.4 Health Expenditure and Financing

Total public spending on health in Albania is low, estimated at around 2 percent of GDP in 2002 (Nuri 2002), compared to 5.8 percent on average for CEE countries as a whole. The increased priority placed on health in recent years is reflected in improvements in the level of per capita public health expenditure, which has increased from about 1,600 ALL in 1995 to almost 4,000 ALL in 2001, or from about US \$16 to about US \$28 – a 75 percent increase in spending and close to the increase in GDP per capita over this time period. Table 4 provides estimates of public health expenditures from 1995 to 2004.

**Table 4: Public Health Expenditure Indicators**

Indicators	1995	1996	1997	1998	1999	2000	2001*	2002*	2003**	2004**
Public health expenditure (million ALL)	5470	6,079	6,269	7,986	12,077	12,334	12,149	13,719	15,544	17,170
Public health expenditure as % of total budget	7.09	6.94	6.22	5.64	7.29	7.23	6.38	7.13	10.73	11.41
Public health expenditure as % of GDP	2.38	1.92	1.88	1.88	2.47	2.24	2.06	2.08	2.09	2.09
Public health expenditure per capita (ALL)	1,666	1,829	1,869	2,381	3,580	3,626	3,935	4,444	5,035	5,562

Sources: Data from Ministry of Finance (MOF); Institute of Statistics (INSTAT), and International Monetary Fund (IMF) estimations; and Bank of Albania *Statistical Report March 2002* (for the years 1992-2001) and *Statistical Report March 2003*. When numbers differ in the two reports, the numbers from the most recent report have been used. All data on 1995 from the 2002 report. \* MOF and IMF staff estimates. \*\* Budgets, not actual expenditures; GDP and GDP per capita actual numbers from Bank of Albania *Governors' Report 2003* (April 2004).

An estimated 48 percent of the public health budget was allocated to PHC services in 2002 (Fairbank and Gaumer 2003). However, that share represents a slight decline, from 52 percent in 1998. Moreover, the share of the PHC budget devoted to paying staff salaries has increased since 1998 at the expense of budget shares devoted to administration and operating expenses. These changes in the allocation of the health and PHC budgets, along with increases in the prices of water, electricity, and telephone services, are thought to have resulted in a substantial decline in the quality of PHC services.

Recently there have been a number of important developments in how PHC services are financed. Budget flows to fund PHC services have become fragmented into three major sources: the MOH, the HII, and local governments. While the MOH is still a major source of public funding for PHC and continues to be responsible for the technical supervision of medical personnel who work in PHC facilities, the operating costs of PHC centers and health posts became the responsibility of local government authorities in 2002.<sup>1</sup> As mentioned above, as part of government-sponsored health insurance, the HII pays the salaries of general practitioners on a contractual basis. In the short run, this transition is creating a challenging situation. There is concern that the money for PHC services flows through too many channels, causing roles and responsibilities to have become too fragmented; the availability of resources for operating expenses at the local level is plagued by uncertainty (though, more recently, these funds have been earmarked at the central level); and insufficient accountability exists among staff employed by the HII (i.e., GPs) and the MOH (i.e., specialists and nurses) (Fairbank and Gaumer 2003).

Although anecdotal and regional evidence seems to indicate that private and out-of-pocket payments are widespread in Albania, there are no reliable data on the magnitude of these payments. Estimates tend to vary widely, but all suggest that the majority of these payments are made in inpatient settings. According to a National Health Accounts exercise conducted by KPMG Consulting in 2000, out-of-pocket sources, excluding health insurance contributions, constituted 24.6 percent of total health expenditures in 1999 (KPMG Consulting and Albanian MOH 2001). The study estimated the magnitude of total household expenditures for 1999, including insurance contributions, to be 4,400 million ALL, or 29 percent of total health care financing. Unpublished rough estimates by the *PHRplus* Project, based on the number of visits to different health facilities and attempts to account for informal payments, point to an order of magnitude of out-of-pocket expenditures of approximately 13,700 million ALL in 2000. This would mean that households contributed more than half of the total health expenditures in 2000. Estimates from the Albanian Living Standards Measurement Survey in 2002 indicated that household expenditure on health care was quite large, representing between 1.8 and 3.4 percent of total GDP, and about 70 percent of the total health expenditures (including transportation) (World Bank 2003).

---

<sup>1</sup> This process started in the 1990s, but was not finalized until 2002.

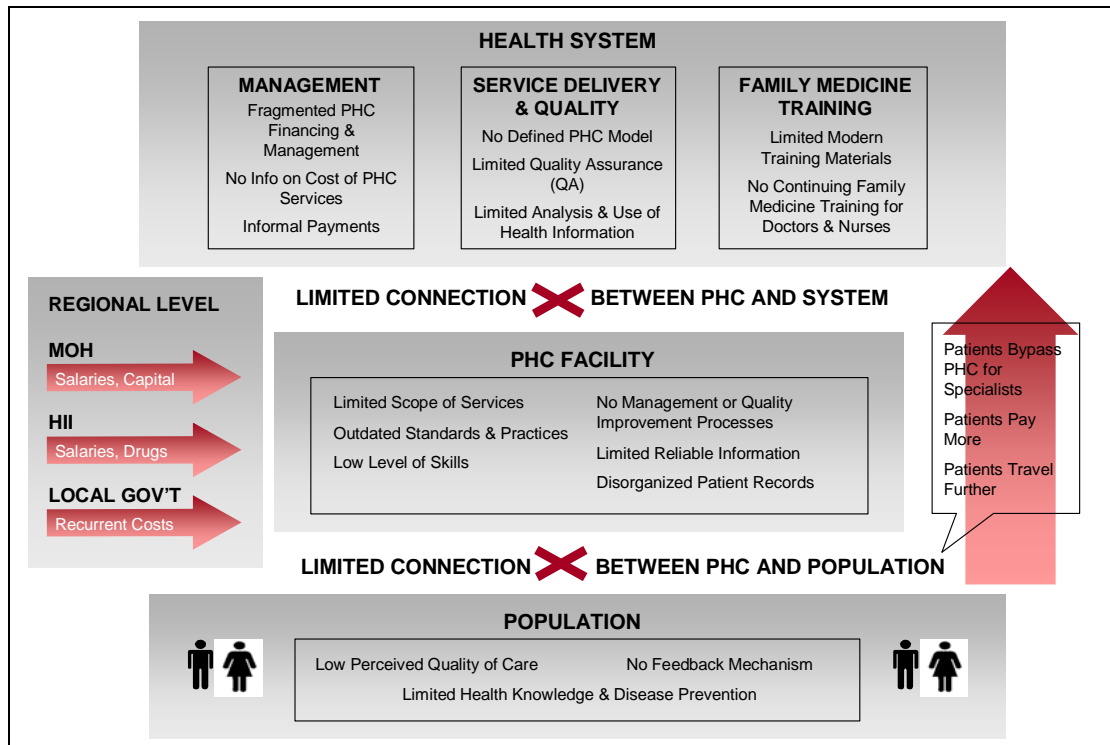
### 3. PHC Situation Analysis

In June 2001 at the request of USAID/Albania, a three-person PHR*plus* team assessed the Albanian health system, focusing on primary health care. PHC is mentioned in numerous strategies, policies, and decrees as a key government focus of health sector reform efforts in Albania. As described in the *Long-Term Strategy for the Development of the Albanian Health System* (Albanian MOH 2004), PHC is seen as the first point of contact of the patient with the health system, and should be considered the “foundation” of that system. Primary health care in Albania is provided by health centers and, in rural or remote areas, ambulances or health posts. PHC facilities are intended to supply health promotion and hygiene/epidemiology-related services, with strong support from the Institute of Public Health, a national institution independent of the MOH. General practitioners and pediatricians, along with nurses, staff health centers. Health workers who may or may not have had formal training staff ambulances.

According to MOH data for 2002, there are 550 health centers and 1,621 health posts throughout Albanian with a total of 1,561 physicians working in primary care, supported by 12,570 nurses and midwives. The vast majority of PHC facilities are public, financed by public expenditures. The share of private PHC providers is small and concentrated in Tirana and other urban locations. In 2002, 108 maternity consultation centers provided prenatal and postnatal care for pregnant women; prevention, detection, and treatment of reproductive health problems; and health promotion and education on women’s health issues and family planning. In the same year, there were 177 children’s consultation centers providing services to children under six, including growth and development monitoring, vaccine provision, and health promotion and education activities.

Despite a policy commitment to strengthen PHC, there are a number of problems affecting PHC provision in Albania. A graphic representation of the Albanian PHC system situation analysis is presented in Figure 1. PHC facilities historically have not received adequate operating funds, and, therefore, often do not have necessary equipment, sufficient stocks of supplies, or the ability to maintain their facility. Migration to urban areas and destruction of a number of PHC facilities in 1997 seem to have decreased equitable access to PHC for all. Although a number of PHC facilities have been renovated and reconstructed with donor assistance in the past five years, many facilities remain in poor condition and lack adequate heating and running water. Maternity and children’s consultation centers compete with and duplicate PHC facilities in providing basic services for women and children.

**Figure 1: Albania Health Care System Situation Analysis**



In terms of patient care, PHC facilities offer a limited scope of services in comparison with care offered in other countries at a comparable level. This is partly due to the lack of necessary equipment and supplies, and partly related to the low level of knowledge and skills of PHC practitioners. Over time, minimal funding for PHC, limited continuous medical training, and no foundation of evidence-based medicine upon which to build have contributed to a deterioration of provider skills and decreasing utilization rates. Patients self-refer to seek higher quality care, often incurring additional costs in terms of travel, time, and higher formal and informal fees. Low utilization of PHC does not allow doctors and nurses adequate patient volume to maintain knowledge and skills. PHC facilities in Albania have little management autonomy and lack processes to continuously improve quality of care. Disorganized patient records and limited reliable patient information and medical statistics also impede the provision of higher quality and more continuous patient care.

PHC facilities have limited connections with the broader health system. As noted above, financing and management of PHC has been fragmented due to recent decentralization efforts and the creation of a separate health payer. The Ministry of Health, the Health Insurance Institute, and local governments finance and manage PHC facilities in an uncoordinated fashion. Reimbursement is not based on cost of services, and neither facilities nor regional health authorities have the capacity to implement cost accounting systems to monitor spending, argue for additional reimbursement, or increase efficiency. Informal out-of-pocket payments are commonplace at all levels of the system and may account for more than public budget expenditures. The government of Albania had not defined a PHC model that specified which services should be offered or any quality standards. The MOH and local health departments do not have adequate quality assurance mechanisms in place, and do not analyze and use the health information that is available to them for informed decision making. In terms of ongoing medical training, Albania lacks modern training materials, especially in family medicine.

PHC facilities have limited connections with the populations they serve. As evident by the frequent bypassing of PHC and low utilization, the population perceives that quality of care is lacking in PHC facilities. A system focused on curative care rather than prevention has resulted in an ill-informed population with little and outdated knowledge on how to prevent and treat diseases, when to seek care, and how to use modern family planning methods. There are no mechanisms for the population to complain about health care service delivery or to provide information about their perceptions of quality and efficiency of care, in order for facilities to better respond to individual and community health needs.





## 4. Strategy to Strengthen PHC

After a thorough assessment and in-depth discussions with key stakeholders and other donors in June 2001, USAID and the *PHRplus* design team proposed a strategy to strengthen primary health care. The design team used a collaborative, consultative process that focused on key stakeholders. Albania's draft Health System Strategy 2000-2010 and the USAID Revised Strategic Plan for 2001-2004 identified many challenges, policy issues, and priorities in the health sector, and specifically related to PHC. The team explored these points through extensive interviews with people in the Ministry of Health in Tirana, visits to health facilities, and meetings with ministry staff, as well as physicians and nurses in the districts of Fier, Vlora, Kuçova, Berat, and Shkodra. The design team assessment and discussions with key health sector stakeholders led to the development of: 1) a model of care that focused on strengthening PHC; and 2) a process to implement the model in four pilot PHC facilities in Berat and Kuçova districts, two urban facilities and two rural facilities. The *PHRplus* Monitoring and Evaluation team then developed a framework to inform the specific design of key interventions and to monitor and evaluate project activities and impact.

---

### 4.1 PHC Model of Care

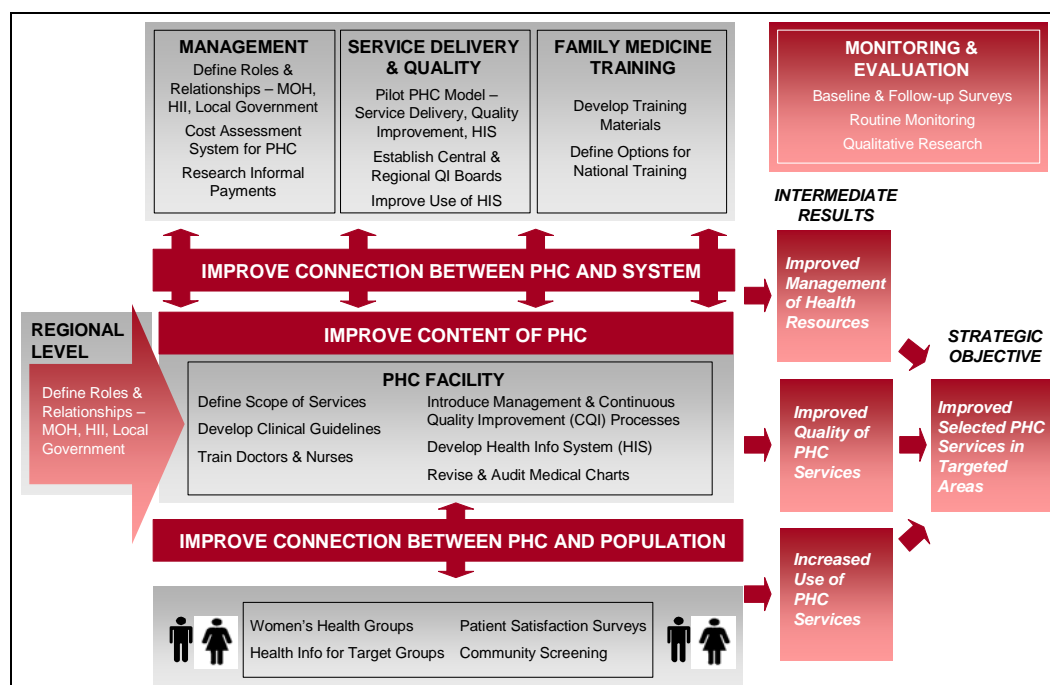
It is well established that primary health care interventions are cost-effective investments to improve health outcomes. In addition, PHC facilities in Albania are already more accessible to the population, especially in rural areas, reducing patients' time and travel costs. Finally, focusing on PHC is important when reforming a health system like the one inherited from the communist regime in Albania. Before patients can be expected to change their current care-seeking behavior of going directly to specialists, capacity to deliver high quality, efficient services at the PHC facility level has to be strengthened.

*PHRplus* Project interventions in Albania were designed to address the deficiencies in the PHC system described in Section 3 above. Interventions included:

- ▲ Support to the introduction of family medicine and development of family medicine training for PHC providers;
- ▲ Improvements in PHC service delivery in pilot facilities through provider training, facility management, quality improvement processes, and community involvement;
- ▲ Cooperation with government health authorities and local government officials to improve financial planning and resource allocation for PHC centers and to build capacity in health sector management and administration;
- ▲ Development of a facility-based health information system based on patient encounter data in order to provide the data needed to improve management of PHC; and
- ▲ Involvement of patients and communities in health care decision making.

The PHC model focused on improving the relationship between PHC providers and the population, as well as improving how PHC relates to the broader health system – in terms of regional- and central-level management and financing, service delivery and quality assurance, and family medicine training. Figure 2 provides a graphic representation of the PHR<sub>plus</sub> Albania PHC strategy, while Chapter 5 provides more details on each component of the model.

**Figure 2: PHR<sub>plus</sub> Albania Primary Health Care (PHC) Strategy**



## 4.2 Description of Pilot Implementation

Given the quickly changing policy environment in Albania and the lack of an approved comprehensive health policy or health sector strategy in 2001, PHR<sub>plus</sub> recommended a pilot implementation approach to the MOH and USAID. Pilot or demonstration sites provide concrete evidence to better inform the development of health policy and allow policymakers, system managers, and facility staff to gain hands-on experience in planning, implementing, and evaluating health reforms. Pilot approaches are designed to reduce risks associated with implementing complex health system reforms and help give time to build consensus about proposed policy reforms – in this case, mechanisms to improve PHC management, financing, and service delivery. It is important that pilot approaches are combined with seeking guidance and consensus at the national level and bringing policy and models back down to the implementation level. This creates a dynamic feedback loop that leads to concrete results at the pilot site and builds consensus and capacity at the national level.

The pilot reforms and the PHR<sub>plus</sub> Project’s program of assistance were designed and implemented with national and local stakeholders as a bottom-up approach to test reforms, build local capacity, and improve PHC. The strategy sought to maximize the advantages of pilots (e.g., minimize risk of trying out alternative arrangements, generate lessons learned, maintain greater control over implementation, build a nucleus of capacity, demonstrate tangible visible benefits) while avoiding the pitfalls of pilots (e.g., too

donor driven, impossible to replicate, absorb excessive resources, may stifle broader reforms) (PHR<sub>plus</sub> 2004). PHR<sub>plus</sub> added a monitoring and evaluation component to assess the design and implementation of the PHC model and its impact on health care utilization, providing data to stakeholders to inform further PHC reform and pilot activity replication efforts.

In the Berat and Kuçova districts of the Berat region, four PHC centers, two urban and two rural, were selected as pilot facilities. This region of the country was selected by USAID to build on USAID's investment in health center reconstruction under the Social Sector Rehabilitation and Support Program. The MOH endorsed this selection. The centers shared many of the problems described in Section 3, but had all been recently rehabilitated, with physical structural integrity, running water, and some basic equipment. Interruption of electricity, however, remained a problem in all sites. The two rural health centers were each staffed by one physician, while the urban facilities were staffed with five and six physicians respectively. Tables 5 and 6 provide an overview of key pilot facility information.

**Table 5. Pilot Facility Statistics (January 1, 2003–June 30, 2003)**

	Berat District		Kuçova District	
	Lapardha (rural)	Muzakaj (urban)	Havaleas (rural)	Llukan Prifti (urban)
Population served	4734	12813	3021	12876
Total visits	3058	12190	3474	9648
Visits per 1000 population	646	951	1150	749
Average visits / month	510	2032	579	1608
Total physician visits	1030	5582	1117	6415
Average visit / physician / month	172	233	186	178
Percentage of children (0-14)	39%	44%	42%	30%
Percentage of adults	61%	56%	58%	70%
Total number of injections	1537	1796	1738	2257
Percentage of nurse visits to give injections	76%	27%	74%	70%
Number of injections / total visits	0.50	0.15	0.50	0.23
Percentage of visits performed by doctors	34%	46%	32%	66%
Percentage of visits performed by nurses	66%	54%	68%	34%

Source: PHR<sub>plus</sub> HIS, June 2003.

**Table 6. Pilot Facility Staffing**

	Lapardha	Muzakaj	Havaleas	Llukan Prifti
Physicians – adults		3		4
Physicians – pediatricians		2		2
Physicians – both	1		1	
Nurse – works with doctor	0.33	5	0.33	5
Nurse – injections	0.33	3	0.33	1
Nurse – wound care	0.33	2	0.33	1
Nurse – well baby checks in the home	1.5	4		1.5
Nurse – immunizations	2.5			1.5
Midwife – home visits (well baby and prenatal)			1	
Midwife – work in maternity	2.5			
Vaccination report and distribution of vaccines	0.5			

Project implementation began in the four pilot sites in early 2002. Initial activities focused on introducing a simple health information system, agreeing on a uniform scope of services, developing clinical guidelines for key PHC services, training physicians and nurses, and identifying ways to better involve the population in their health care. The presence of PHR*plus* offices in Tirana and Berat facilitated a dynamic feedback loop between facility managers and regional authorities actually implementing reforms in selected pilot sites and key national stakeholders discussing health reform and PHC strengthening. These linkages have led to commitments to expand the PHC HIS and family medicine training, as well as continued dialogue on improving quality of care at the PHC level.

Many of the model's interventions, such as the development of quality improvement processes and a PHC HIS, initially focused on facility-based implementation in pilot sites in Berat region. Lessons learned and evidence resulting from pilot implementation informed larger scale roll-out and replication, with reduced reliance on external technical assistance. Several interventions, such as developing family medicine training programs and making suggestions to improve health sector financing and organization, were national in scope and required national support before demonstrating their feasibility through pilot implementation.

Efforts to fully pilot PHC financing and management reforms in Berat were stalled by the reluctance of national counterparts to separate pilot implementation from the revision and approval of health care financing laws. In addition, the MOH seemed hesitant to completely delegate the health purchasing function to the HII. In spite of this reluctance, PHR*plus* along with regional authorities and facility managers have made strides toward the development of management and costing tools for PHC facilities, an incentive payment scheme for providers, and a proposal for the organization of regional health authorities.

In June 2004, the PHR*plus* Project, in consultation with the USAID mission and Albanian authorities, completed pilot project implementation. PHR*plus* closed its Berat office and the local authorities in Berat and Kuçova have decided to carry on selected priority components of the pilot model

on their own, supported by the central government and *PHRplus*. *PHRplus* focused project activities since June to support institutionalization of PHC reforms in the Berat region and to begin informing countrywide PHC reform and replication using lessons learned from piloting. *PHRplus* assistance ended in March 2005, with many technical assistance activities handed over to local stakeholders and other USAID cooperating agencies.

---

### 4.3 Monitoring and Evaluation Strategy

As USAID’s global flagship health systems project, *PHRplus* was required to implement an Intensive Research and Demonstration Site where comprehensive health system reforms would be implemented and evaluated. Albania was the project’s only IRD site. With funding from USAID/Washington, the Monitoring and Evaluation unit of *PHRplus* conducted a baseline survey, a number of special studies, and a follow-up survey to measure project impact. Baseline survey findings were published in February 2004. Quantitative and qualitative studies on out-of-pocket and informal payments also were developed. The follow-up survey was conducted in the fall of 2004. Findings from the impact assessment will be published in May 2005.

The baseline survey helped inform technical assistance activities, and assess the design and implementation of the PHC model and its impact on health care utilization patterns. The baseline and follow-up surveys include both households and health care facilities in both intervention (Berat and Kuçova districts) and control areas (Fier district). Table 7 provides an overview of survey instruments. The design of assessment activities allows for two types of analysis. First, the performance of the health system before the implementation of the model can be compared with the performance after the provision of *PHRplus* technical assistance where the PHC model was implemented. Second, the performance of the health systems in the areas where the PHC model was implemented can be compared to the area where it was not implemented. The key aim of evaluation activities is to provide information to health sector decision makers at national and local levels on the effectiveness of the PHC model in Berat and Kuçova. Based on this experience, the MOH and regional authorities can make more informed decisions about how to design future PHC interventions and replicate successful activities in other regions of the country.

**Table 7. Description of Baseline and Follow-up Survey Instruments**

Facility Survey	Detailed facility and provider questionnaires were administered both in the PHC facilities supported by the model as well as in specialized clinics and hospitals that also offer delivery PHC services to the target populations.
Client Exit Interviews	Interviews were conducted with clients attending facilities in the areas regarding service utilization, social and economic status, and perceptions of service quality. These interviews were administered at both government-run facilities, and if appropriate, private facilities.
Household Survey	Data on health care utilization patterns and their social and economic determinants were collected from a representative sample of households in the three areas. Decisions on the specific types of health care use to be included in the survey instrument and the type of sampling strategy to be used were made in collaboration with the MOH and key counterparts. In addition, in order to inform the design of future cost-recovery strategies that the government may implement, the survey included questions on willingness to pay for health care services.



## 5. Description of the PHC Model by Component

The Albanian PHC model was designed and implemented as an integrated model set of interventions to address obstacles to achieving improved quality and efficiency of care in Albania. This chapter is divided into sections describing the five components of the PHC model: 1) family medicine training for PHC providers; 2) service delivery reorganization and quality improvement activities; 3) financing and organization; 4) health information systems; and 5) community involvement. The sections detail how each component of the model was designed and implemented, and key results, including the development of a series of tools designed to aid replication in Albania. Although the five components are presented separately, many activities overlap and are appropriately cross-referenced to avoid repetition.

### 5.1 Family Medicine Training for PHC Providers

An important component of the PHR*plus* integrated model was retraining of the general practitioners and nurses working in the four pilot sites. None of the pilot physicians had undergone specific training in the principles of family medicine, and in fact, most had not had any continuing professional development or training since completing medical school up to 40 years earlier. The educational background of nurses working in the four pilot sites varied considerably. While the current standard in Albania is high school plus three and a half years of university training, many pilot site nurses had received only minimal vocational training.

#### 5.1.1 PHC Physician Training

Lack of continuing professional development opportunities, limited institutionalization of evidence-based medicine, and low volume of utilization at PHC facilities left PHC physicians unprepared to provide high quality care to their patients. Successful implementation of any PHC reforms required significant retraining of PHC physicians. A careful assessment of the PHC environment and available resources in PHC facilities was conducted before designing a refresher-training program for physicians.

Beginning in 2002, PHR*plus* developed a curriculum (available in the companion PHR*plus* Toolkit) for the retraining of pilot physicians in collaboration with the Department of Family Medicine from the Medical School of Tirana University and expert consultants from the British nongovernmental organization (NGO) Partnership in International Medical Education (PRIME). Officials

#### RESULTS SUMMARY

In Berat region, PHR*plus* provided refresher training in family medicine topics to more than 70 physicians and 40 nurses. Thirty midwives and 213 nurses received additional training in reproductive health, family planning, and counseling skills.

Physician retraining resulted in a dramatic increase in PHC physician knowledge of evidence-based practices reflected in clinical practice guidelines. Knowledge, as reflected in multiple-choice questionnaires increased from 24 to 67 percent. Most physicians in the pilot program cited the training as the most valuable component of the PHR*plus* model. They described it as very important in upgrading their knowledge and skills.

PHC nurses also described their training as very valuable in helping them improve the care they provide to patients. They increased their knowledge and competence from a pre-test score of 40 percent to an average post-test score of 84 percent.

from the MOH and HII as well as the local MOH and HII directors in Berat and Kuçova approved the curriculum. The refresher training was based on the following principles:

- ▲ Introducing the philosophy and methodology of contemporary family medicine in line with EU recommendations;
- ▲ Increasing and improving the knowledge and clinical skills of doctors in pilot health centers;
- ▲ Encouraging a problem-based learning method, starting from signs and symptoms and discussing different clinical situations;
- ▲ Using PHC clinical practice guidelines (CPGs) as the basis for training, as they are accepted worldwide, represent the shortest way to achieve standardized, high quality, cost-effective PHC, and are considered a key to successful implementation of family medicine.

### **Initial Training for Pilot Site Physicians**

The training took place between January 2003 and September 2003. Sixteen physicians from the four primary care pilot sites in Berat and Kuçova and two general practitioners from Lezha completed the retraining course. The 10-month program consisted of 150 hours training in Berat in 24 sessions and four full weeks of clinical rotation in Tirana in a university attachment, which included hands on patient experience with skilled mentors. The training was structured around the teaching of CPGs for the key diagnoses and clinical problems addressed by PHC centers. *PHRplus* developed the CPGs in collaboration with the Family Medicine Department at the University of Tirana Faculty of Medicine, along with PRIME. Expanding physicians' clinical skills in patient examination and diagnosis through use of technology and tools such as the otoscope for ear examinations and ophthalmoscope for eye examinations considerably improved general practitioners' success at treating acute illnesses, managing long-term cases, avoiding over-use of more costly specialty care by making only appropriate referrals to other levels of the health care system – eventually contributing to achieving better patient outcomes.

One of the measures used to evaluate the effectiveness of the training was a comparison of pre- and post-test scores. Teaching staff developed the test, which included 111 multiple-choice questions. A comparison of test scores revealed impressive results. At the beginning of the retraining program, the average score on the test was approximately 24 percent correct. Following the completion of the course, the average test score was more than 67 percent correct. Most physicians in the pilot program cited the training as the most valuable component of the *PHRplus* model. They described it as very important in upgrading their clinical knowledge and skills.

### **Offering Training for All Physicians in Berat Region**

At the request of the local health authorities and physicians in the Berat, Kuçova and Skrapar districts, *PHRplus* repeated the pilot training curriculum in collaboration with the University of Tirana's Department of Family Medicine. All PHC physicians in Berat region were invited to attend the trainings provided by family medicine trainers from the department. Several of the original topics were combined, resulting in 20 topics. Each topic was offered three times with sessions held on Friday (10am-2pm and 3pm-7pm) and Saturday (8am-12noon), with the faculty staying overnight on Friday in Berat. The curriculum was offered over a five-month period, from October 2004 through February 2005. Attendance was impressive, with an average of 65 physicians attending one of the three sessions each week. These additional cycles of training demonstrate one model of providing training using the materials developed and tested by *PHRplus*, the Department of Family Medicine, and PRIME. This model uses local training capacity and accommodates physician work schedules.



## **Scale-up of Family Medicine Training for PHC Physicians**

On 7 May 2004, a Roundtable Discussion was held with key stakeholders regarding the scale-up of family medicine training for GPs throughout the country. *PHRplus* presented the pilot training and a draft plan for replicating the training throughout Albania. There was consensus on the curriculum developed by *PHRplus* and the use of a training-of-trainers (TOT) teaching method for scale-up. The group recommended that specific sessions be added to the curriculum on financial practice management and HII's drug protocols and guidelines.

Many of the key issues related to scale-up of the training were discussed by the roundtable participants in four breakout groups – oversight and coordination, funding, plan design, and legal and administrative issues. Key recommendations coming from the discussions included:

- ▲ A coordinating body, either the MOH or a physician organization, should be given clear authority to oversee the training and accreditation process;
- ▲ Ongoing physician education should be tied to an accreditation or re-licensing process;
- ▲ An approved set of standards of practice for PHC and a mechanism for ongoing revision of them should be developed and approved;
- ▲ A decision about which entity will establish standards and who will regulate and monitor the standards should be made;
- ▲ The government should take an active role in funding the education system, with the goal of achieving a government to donor ratio of funding of 60:40;
- ▲ Physicians should be expected to pay a portion of their education and ongoing professional development;
- ▲ The government employment contract with general physicians should include an incentive for trained physicians; and
- ▲ The TOT design, while practical, should include mechanisms to monitor the quality of training.

## **A Tool for Planning Future Family Medicine Training**

*PHRplus* developed two options for replication of the training for consideration by government stakeholders and future donors. One option is the TOT approach, which was presented at the 7 May Roundtable Discussion. A second approach, recommended by the local Berat health authorities and physicians and provided by *PHRplus* from October 2004 to February 2005, is a repeat of the pilot training for larger groups of physicians using existing in-country training expertise.

However, neither option includes a component of hands-on clinical training. Initial *PHRplus* pilot training included attachment at the University Hospital for participants – two weeks in internal medicine, one week in pediatrics, and one week in obstetrics and gynecology. The University Hospital-based clinical component was well received and appreciated by the participants, but did not provide experience in a family medicine outpatient environment. *PHRplus* recommends that the government and future donors support the development of model outpatient centers where family medicine specialists can preceptor medical students and GPs involved in refresher training.

## Option 1: Training of Trainers Approach

The TOT approach is built on the principle that the five core family medicine faculty members would train 74 trainers who would then train the 1,588 GPs<sup>2</sup> throughout Albania. An Excel spreadsheet (included in the Toolkit) was developed to explore the cost implications of many different assumptions of using a TOT model, along with a Word document describing the use of the spreadsheet. The model assumes that the core faculty members – the five trainers of trainers – would themselves be trained by outside consultants. *PHRplus* recommends the PRIME consultants, who helped develop the original curriculum for this role. PRIME physicians have been involved in the retraining of GPs in many countries and have been cooperating for some time with the Family Medicine Department of the Faculty of Medicine at the University of Tirana.

Next, the core faculty members would train the GPs selected as trainers. The model design group (*PHRplus* and members of the Family Medicine Department) assumed the core faculty would travel from Tirana to the various regions for this TOT. The trainers trained by the core faculty would then teach the GPs in their respective regions. The design group assumed class sizes of five or six in the model, and that the training would be conducted in a health center located near where the physicians live and work.

The simulation exercise assumed that Albania would be divided into 15 regions, based on geographic considerations and the number of physicians (see Table 8). Another key assumption, based on the experience in Berat, is that physicians would attend training sessions just one day a week. This once-a-week routine allows the training to be incorporated into the workweek of the Tirana-based core faculty, the trainers in the region, and the GPs.

**Table 8. Planned Number of Trainers and GPs to be Trained in Family Medicine**

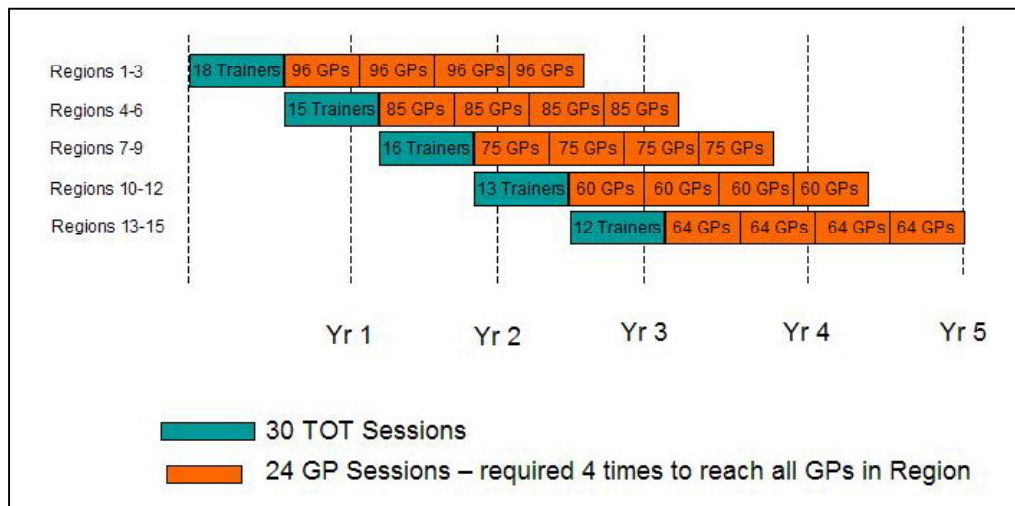
Region	Number of Trainers	Number of GPs
Berat	4	91
Korce	7	148
Elbasan	7	144
Durres	7	155
Gjrokaster	4	91
Vlore	4	91
Fier	8	164
Shkoder	4	68
Lezhe	4	68
Diber	5	100
Kukes	4	53
Tirana I	4	85
Tirana II	4	85
Tirana III	4	85
Tirana IV	4	85
Total	74	1514

<sup>2</sup> The number of physicians by district and by region obtained from MOH 2002 records.

Cost elements in the model include expenses for the core faculty – their initial training, a stipend for teaching trainers in the region, and travel expenses. These travel expenses vary greatly by region, which was taken into consideration in the model. Depending on the region, travel expenses can include one or two overnight stays and the associated costs. In addition to the core faculty expenses, the training of trainers also includes the expenses of local travel and a meal for the trainers, along with course material. The model includes a stipend for the trainers when they teach the GPs, along with local travel and meals. Overhead expenses of finance and accounting are included, along with central and regional coordination. The coordination, when done from Tirana, is expensive, because of the need to have someone go to each session to do paperwork and reimburse participants for their expenses. Collaboration with local government agencies could reduce this expense.

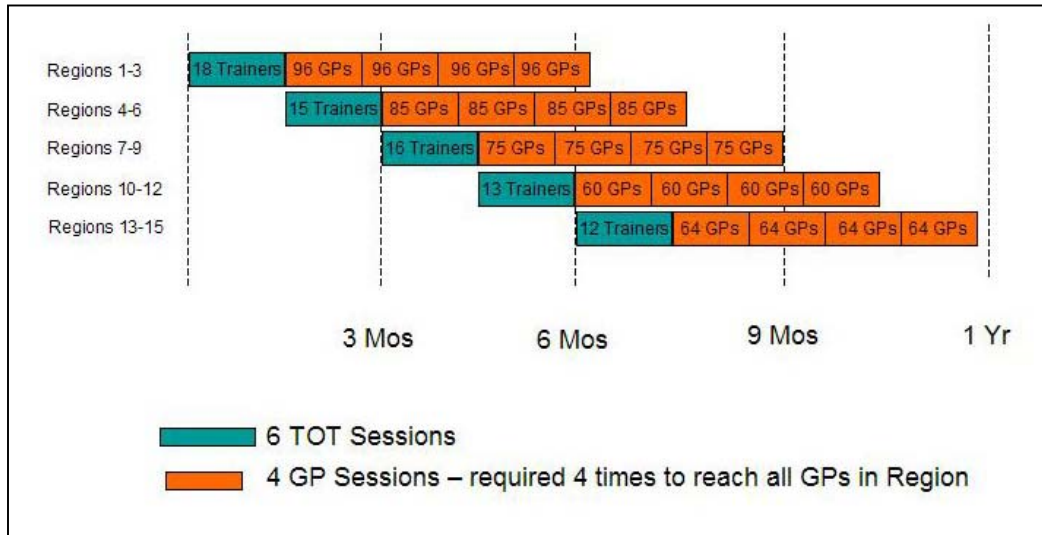
In all, the estimated cost of replicating the content of the 24-session training piloted by PHR*plus* for all GPs in Albania is approximately \$2,500,000 and would take approximately five years. The Excel spreadsheet included in the Tool Kit can be used to modify initial assumptions and determine cost implications using other assumptions. An illustrative timeline for implementation by region is shown in Figure 3.

**Figure 3: Time Sequence for Teaching 24 Modules of Family Medicine**



An alternative to duplicating the PHR*plus* pilot training involves teaching four sessions per year to all GPs in the country. This alternative also can be simulated using the Excel spreadsheet (using six TOT sessions and four GP sessions in Sheet 1), and involves teaching only four topics at a time. An illustrative timetable to implement this approach is shown in Figure 4.

**Figure 4: Time Sequence for Teaching 4 Modules in Family Medicine**



**Option 2: Replicating Pilot Training with Local Trainers**

As mentioned above, at the request of the local health authorities and physicians in the Berat, Kuçova, and Skrapar districts, PHR<sub>plus</sub> repeated the pilot training curriculum in collaboration with the Department of Family Medicine trainers. The response of the participants and faculty has been positive. This approach is significantly less expensive than the TOT approach. The full cost to PHR<sub>plus</sub> for offering the expanded training of 20 sessions (three times each) over five months for 65 physicians is estimated at US \$1,500 per topic, or \$30,000. The full cost of this option to reach all 1,500 GPs is estimated to be at least US \$700,000. Training in more remote regions may be considerably more expensive due to additional travel costs for faculty and participants.

**Advantages and Disadvantages of the Two Options**

Further discussion of the advantages and disadvantages of each training approach, including discussion of their cost and timeline, is needed before replicating training beyond Berat region. Table 9 provides an initial list of advantages and disadvantages of the two approaches for comparison.

**Table 9: Selecting an Approach to Replicate Physician Training**

	<b>TOT Approach</b>	<b>Local Trainer Approach</b>
Estimated cost for all 1500 GPs	US \$2,500,000 over 5 years	US \$700,000 to \$1,000,000 over 10 years
Advantages	<p>Takes five or six years to teach the 24 sessions in the PHR<i>plus</i> pilot model, reaching all GPs in the country, and serves as the basis for an ongoing system of continuing professional development;</p> <p>Makes a strong investment in the physicians chosen as trainers, rather than relying on the small core group of faculty at the Department of Family Medicine;</p> <p>Easy for the government and donors to share the costs of the program, with the gradual decrease in the need for outside funding;</p> <p>Compensates for lack of clinical training by the use of small class sizes.</p>	<p>Curriculum and faculty are established and well respected;</p> <p>Easy to replicate given current capacity and resources.</p>
Disadvantages	<p>Logistics and coordination are complicated;</p> <p>Quality of each session might vary based on the competence of the individual trainer, even though safeguards of faculty observers are included in the design.</p>	<p>Is a one-time training blitz;</p> <p>Might be difficult for the faculty to continue the teaching schedule for years at a time;</p> <p>Takes longer to train all GPs in Albania – assuming 150 physicians could be trained each year, it would take 10 years to reach every physician.</p>

---

### 5.1.2 PHC Nurse Training

PHC nurses also lacked continuing professional development opportunities. Nurses were under-trained and under-utilized. Discussion of a more substantial future role for nurses at all levels of the health care system, but especially for PHC, is needed in order to support continued investment in their professional development. The PHR*plus* staff worked with the Vlore University Nursing Faculty to design a curriculum to help bridge the gap in the educational backgrounds of the pilot site nurses (see Toolkit). The training course was provided to 40 PHC nurses from PHR*plus* pilot facilities in 21 full-day sessions between May and October 2003. Topics covered a wide variety of subjects, from taking vital signs, to water-borne illnesses in the community, to helping patients deal with pain and death. Nurses described their training as very valuable in helping them improve the care they provide to patients and it improved their knowledge from an average pre-test score of 40 percent to an average post-test score of 84 percent. In 2004, 30 midwives and 213 nurses were trained in the Berat region as part of a reproductive health awareness campaign that reached 2,667 women (see Section 5.5, Community Involvement).

---

### 5.1.3 PHC Provider Training Toolkit

PHC Physician Retraining Curriculum	A description of the content and format of PHC physician training
TOT Model Costing Tool	Excel spreadsheet for estimating the cost of the TOT Training Model and Instructions for using the spreadsheet
PHC Nurse Retraining Curriculum	A description of the content and format of PHC nurse retraining

---

## 5.2 Service Delivery Reorganization and Quality Improvement Activities

Under this component, PHR*plus* worked with facility staff and local authorities to define the scope of PHC services to be provided in Albania and developed a list of supplies and equipment necessary to provide those services. PHR*plus* helped pilot facilities design and implement a new medical records system, upgrade provider knowledge and skills in family medicine topics (described above), and develop clinical practice guidelines, referral guidelines and quick reference sheets. Implementation of QI processes followed a traditional QI framework – identifying key obstacles to improving quality of care and developing processes to address obstacles and measure improvement in a systematic and sustainable way. Quality management processes were established within facilities, paired with invigorated quality monitoring by external regional boards. Medical record and documentation standards and guidelines were established. In addition, PHR*plus* worked closely with facility staff to enable them to better use data collected from a new patient encounter form to monitor and eventually improve quality. Finally, a number of tools were introduced – a health information system, a patient satisfaction survey, and a chart auditing system – to continuously measure quality improvement.

### RESULTS SUMMARY

Service delivery reorganization activities resulted in a more defined scope of services for PHC and the development and use of 21 clinical practice guidelines for PHC sensitive conditions. Meeting requirements for medical charting improved in pilot sites from 52 percent to 89 percent in only four months.

In one month alone, according to chart audits, compliance with CPGs for hypertension, diabetes, asthma, tonsillitis, and lower respiratory infection increased anywhere from 2 percent to 15 percent. Overall compliance with the four guidelines averaged 75 percent. In one facility, use of the new guideline for lower respiratory infection and development of a related patient information sheet resulted in a decrease in the percent of visits where an antibiotic was prescribed from 40 percent to 24 percent.

In less than two years of implementation of QI approaches, pilot facilities were able to address many obstacles to quality improvement and better health facility management. Beyond the facility level, management processes to integrate QI measurement tools (QI boards) were created, laying the foundation for better integration of three levels of the system: PHC facility, regional, and central levels.

The PHR*plus* QI model ensured that pilot facilities had the necessary *inputs* to improve quality, established sustainable *processes* needed to improve quality, and provided support to begin working with facilities and providers to achieve improved *outcomes* in terms of better quality of care, improved service delivery, and improved patient health. Patients noticed the differences in quality of care as reflected in their surveys and providers felt more empowered to create systems to improve quality themselves. Improvements in quality were achieved in spite of limited overall health reform and lack of monetary incentives for the participating medical staff. The pilot QI activities demonstrated that internationally recognized improvement processes could be adapted and effectively implemented in the Albanian context.

---

### 5.2.1 Improving Management Capacity and Processes

The role of PHC managers, which ideally should be the driving force for service delivery and quality improvement, was minimal in 2002 when the pilot began. Because of the fragmentation of financing and confusion about supervisory roles, health center managers had very few delegated responsibilities and very little accountability. The role of the chief physician became more important as many of the steps were taken to create an environment more conducive to efficient service delivery, and after significant capacity building of facility managers in analyzing reports and identifying opportunities for improvement.

In collaboration with World Learning, PHR*plus* provided a three-day management workshop in November 2003 for doctors and nurses from pilot facilities. Dr. Elizabeth Barker, a certified family nurse

practitioner and diplomat of the American College of Health Care Executives, conducted the workshop. Topics discussed included management problem-solving techniques, position description formation, policy and procedure development, strategic planning, and continuous QI principles. *PHRplus* followed up with participants to help them apply what they learned in terms of defining roles and responsibilities for staff, improving patient flow, and developing QI plans and operations manuals.

The chief of the health center gradually assumed an important role in the QI process in the health centers. Implementation officers from the *PHRplus* Project worked with the chiefs to write QI reports (a sample report is included in the Toolkit). Each center agreed on a process and assigned responsibility for various aspects of quality improvement. A description of the committee developed at the Muzakaj Health Center is included in the Toolkit. Job descriptions for each member of the staff were developed, which included a section on quality improvement. For example, the chief of the health center has the responsibility to “assure that the center’s quality improvement plan is developed and implemented,” and to “actively participate in the quality improvement process through review of patient records.”

An important aspect of any continuous quality improvement process, which was missing in PHC centers prior to the *PHRplus* Project, is the feedback loop for the information generated at each center. Pilot sites reported that they always sent reports to the central level, but never had any follow-up or comparison of how they performed relative to other centers. Through the *PHRplus* initiative, PHC centers generated and analyzed data from the HIS reports, the medical record audit, and the patient satisfaction surveys. They compared their results with those of the other pilot sites. They set targets and compared results from month to month, which was also a new experience. Each center had a defined process for analyzing information and taking steps to improve quality. The urban centers had a QI committee that met monthly during the pilot. In the two rural centers, the entire staff was involved in the analysis of reports and decisions about steps to improve quality.

---

### 5.2.2 Defining the Services for PHC

The definition of the service delivery package was worked out in two phases. In the initial phase, the database of thousands of patient visits captured by the HIS by mid-2002 was used to select services based on the type of patients and health conditions encountered at the pilot PHC centers. The selection criteria included:

- ▲ Frequency of the condition among visits to the PHC centers;
- ▲ Degree of danger for the patient of the condition; and
- ▲ Capacity of the PHC center to address the condition.

This initial selection of services was done with facility staff, local MOH directors, and *PHRplus* staff and consultants. Upon learning further lessons from the interaction between patients, medical staff, and project staff, the project was ready to go through the second phase of the definition of PHC services, for example adding family planning services. The *PHRplus* Project worked with the MOH, the faculty of the Family Medicine Department at the University of Tirana, local stakeholder directors in Berat and Kuçova, pilot site physicians, and international family medicine consultants from PRIME to define the services for PHC that would be the focus of the four pilot sites. Those services are listed in the Toolkit.

---

### 5.2.3 Inputs to Begin Quality Improvement Activities

Some basic prerequisites to improving quality needed to be put in place before much progress could be made in the four pilots. After the scope of services for PHC was defined, a significant input was retraining PHC physicians and nurses to give them the knowledge and skills necessary to begin to implement an expanded scope of services (described in Section 5.1, Family Medicine Training for PHC Providers).

The pilot sites had been renovated with support from the government or USAID prior to selection by the PHR*plus* Project, so all had relatively good infrastructure. However, several sites were missing basic equipment needed to provide the approved list of PHC services. PHR*plus* purchased the necessary equipment, including sphygmomanometers, stethoscopes, tape measures, and scales.

The existing medical records were disorganized and inadequate for recording patient care. There was very little documented about each patient visit. The old records were organized by family, rather than by patient, and they were incomplete. For example, for a family of five, the file might contain information on only one or two members. There were no standard record forms: Information in the charts varied by physician, as did the format. While some physicians kept good written records in each patient file, others simply wrote the diagnosis and treatment in a patient registration book and made no notes in the chart. This poor record keeping had a negative impact on the quality of care given at the PHC level. Documentation of patient history, visits, and treatment plans is crucial for continuity of care, especially for monitoring chronic disease patients and child growth and development.

With assistance from the PHR*plus* Project, the four pilot facilities redesigned their patient charts. They also developed new systems for filing and storing them. New patient charts included four standard sections:

- ▲ Patient registration – name, address, gender, emergency contact information;
- ▲ Basic medical information – allergies, blood type, vaccination schedule;
- ▲ Patient history – medicines being taken, recent episodes of illness, information on smoking and alcohol consumption, reproductive history for women, family disease history; and
- ▲ Visit note – date of visit, patient complaints, examination results, diagnosis, treatment plan.

The new system introduced by the PHR*plus* pilot was well received by the pilot sites. The chart was shared with members of the MOH and HII and used by the government in the development of a new medical record booklet. The new record, which incorporated key features of the PHR*plus* medical record, was implemented by the HII in all PHC centers in Albania in early 2004.

---

### 5.2.4 Clinical Practice Guidelines

The stakeholders involved in the curriculum development for PHC physician training also were involved in the process of developing standards. Representatives of the Family Medicine faculty of the University of Tirana chose the topics for CPG development, based on the training curriculum. Expert Albanian clinicians wrote 21 guidelines in early summer 2003. They were then reviewed and approved by the broader group, including MOH representatives, representatives from PRIME and from the Family Medicine Department.



One-page summaries of the guidelines, called “Quick References,” were developed in late summer and fall of 2003 by quality consultants Geoffrey Pye and Maksim Jani (see Toolkit). These one-page physician job aids provided relevant information on risk factors, tips for screening, diagnosis, and recommended treatment. Like the CPGs on which they are based, the Quick References were based on internationally accepted and evidence-based medical practices. Each pilot site physician was given a copy of the Quick References. The one-page references also served as the basis for the referral guidelines, as well as for the charting guidelines and medical record audit system.

An important aspect of quality for PHC centers is the relationship and communication with specialists. Referral guidelines (see Toolkit) derived from the one-page summary of the CPGs, were reviewed and discussed in a series of meetings with the specialists serving the four pilot sites. In addition, the policy and procedure regarding referrals was discussed at each meeting (see Toolkit).

Ongoing revision of the CPGs is expected, as PHC physicians and specialists compare standards to actual practices. In some cases it is important for the practice to change, and in others the CPG needs to be modified. A good example of the process of adaptation and use of the CPGs is the guideline for asthma. The CPG includes the use of peak flow meters to monitor and treat asthma. A peak flow meter is an inexpensive piece of equipment that can be purchased by each asthma patient. Specialists and PHC physicians agree that this simple method of measuring the strength of a patient’s lungs is important in the treatment of asthma and that their practice needs to change to include this tool. The original CPG stated that referral to a specialist is indicated much later in the treatment process than occurs now. In meetings with PHC physicians and specialists, an agreement was reached to continue to refer patients earlier and modify the CPG to reflect this locally acceptable practice. In the future, as PHC physicians become more comfortable treating asthma through ongoing education and improved communication with specialists on treatment issues, the point of referral will probably be moved back to match the original CPG.

---

### 5.2.5 Measuring Compliance with CPGs

In order to sustain physician compliance with the clinical practice guidelines, PHR*plus* quality consultants developed manual chart audit tools based on the one-page “Quick References.” Charting guidelines were developed for each practice guideline, and educational sessions using case studies were held with the pilot site physicians.

The CPG audit process began in late 2003. But because the medical record documentation was limited, it was impossible to evaluate compliance with the practice guidelines. In January 2004, an audit for evaluating the adequacy of documentation was tested, revised, and implemented (see Basic Charting Techniques Audit in the Toolkit). The PHR*plus* quality consultants and implementation officers audited 20 charts per month for each physician, January through April of 2004. During the first month, 52 percent of the criteria were met. The percentage increased steadily to 69 percent in February, 81 percent in March, and 89 percent in April. The dramatic and rapid improvement occurred primarily as a result of sharing with each physician his/her results as compared with other physicians. No disciplinary action was needed. In fact, the auditing process was well accepted by doctors, and seen as very collaborative and supportive. This was in stark contrast to the top-down, unpopular, hierarchical control exercised by previous health care administrations.

The CPG audits began again in March, this time with success because of the improved medical record documentation. The five CPGs chosen for audit were hypertension, diabetes, asthma, tonsillitis, and lower respiratory tract infection (see Toolkit). Initially the PHR*plus* implementation officers and quality consultants performed the chart audits. PHC directors in each district have agreed to take over the audit process in the future. Table 10 shows the percent compliance for each guideline after a month.

**Table 10: Compliance with Practice Guidelines**

<b>Practice Guideline</b>	<b>Compliance in March</b>	<b>Compliance in April</b>
Hypertension	67%	69%
Diabetes	67%	69%
Asthma	5%	20%
Tonsillitis	69%	88%
Lower Respiratory Infection	62%	72%

Examining the reasons for non-compliance led to some interesting findings and illustrated the need for a broader mechanism to continuously review and approve CPGs for PHC. In two cases, where even initial compliance was low – asthma and lower respiratory tract infection – the chart audit revealed that pilot physicians disagreed with the standard of practice in the guidelines. Although it increased, compliance with the asthma standard remained very low, with 5 percent in March and 20 percent in April. The current standard of practice in Albania was for patients suspected of asthma to be diagnosed and treated by specialists. But the guideline assumed diagnosis and treatment at the PHC level, resulting in a very low level of compliance as physicians continued to refer. A second controversial CPG was lower respiratory tract infection in children. This guideline recommends that a confirming chest x-ray support the diagnosis; this was not done in any of the reviewed cases.

Compliance issues revealed the need to revisit the guidelines and to ensure that the supporting systems are in place that allow providers to be compliant. Guidelines should be consistent with evidenced-based medicine, but also with the role given to PHC physicians in Albania. Implementation in Berat led to questions, such as: Should the PHC physician diagnosis and treat asthma in Albania? If so, what additional education and equipment are needed? For lower respiratory infections, should a confirming x-ray be the standard of care? It is important that physicians at all levels (PHC, specialists, medical leadership) examine traditional practices (as in the need for x-ray), to see if they are evidence-based and cost-effective, and in line with health sector policy and strategies (for instance, increasing the scope of service for PHC).

PHR*plus* consultants and staff, as well as pilot site physicians, expressed satisfaction with the system for monitoring compliance. They cited the following advantages:

- ▲ The system is appropriate for peer review and for external review;
- ▲ The system is simple and audits can be done by physicians or by nurses;
- ▲ The system does not take a lot of time (review of one chart takes from three to 10 minutes, depending on the complexity of the record);
- ▲ The system focuses on specific CPGs, which is flexible and matches specific quality improvement goals set by the health centers and by the QI boards; and
- ▲ The system is objective, with different reviewers getting similar results.

---

## 5.2.6 Measuring Quality Improvement

The analysis and use of information was a very new activity for the health center staff. Prior to the PHR*plus* Project, the health centers had never received reports about their activities. There had been no opportunity to compare their results with other centers or to analyze trends, no feedback about their services from patients, and no feedback about documentation or compliance with standards. In addition to the chart auditing system that measured compliance with CPGs, PHR*plus* supported the four pilot PHC facilities to use other sources of data to routinely measure quality improvement and to use data to improve clinical and facility management. Other sources of data included the PHC HIS and patient satisfaction surveys.

QI reports were introduced (like the sample given in the Toolkit) in each pilot PHC facility, offering one solution to help the chief doctor and PHC providers in the pilot facility to examine results of chart audits, the HIS, and patient satisfaction surveys in a systematic and comprehensive way. The system included the generation of reports, analysis by the PHC center QI committee, action taken to make improvement, then subsequent review of results showing the impact of the action taken.

The HIS, discussed further in Section 5.4, Health Information System, was initiated in the four pilot sites in July 2002. HIS data can be used to measure productivity of each physician and each PHC center. It also can be used to monitor the services provided by each center. Patient diagnoses are tracked, along with patient demographics. Data are collected each time a patient is encountered in the facility. A nurse uses the Patient Encounter Form to register the data during or after the visit and data is entered into a database. Reports are generated in both English and Albanian and are distributed to and discussed with facility staff and with other local health authorities.

An example of how HIS data were used to improve quality involved reduction in the use of antibiotics. The HIS indicated that the use of antibiotics was very high, especially in the rural centers. In discussing the HIS results with pilot site physicians, the quality consultants realized that there was an over-use of antibiotics for viral respiratory infections. In response to this finding, a clinical practice guideline and quick reference for adult respiratory infections was developed and implemented in February 2004. Patient information sheets were made available for physicians to share with patients. After the intervention, the percent of visits where an antibiotic was prescribed decreased. The HIS system also was used to track the number of visits per day by physician, while monthly graphs they received gave them visible feedback regarding how their patient volume fluctuates each day.

In addition to the HIS, patient satisfaction surveys were introduced to help facilities monitor perceived quality among their clientele. The concept of seeking patient feedback, and using that feedback to improve quality, was new to both staff and patients. PHR*plus* staff, in cooperation with the pilot site staff, developed a form, which was tested in December and implemented in January 2004. All four pilot sites used results of the surveys to identify ways to improve quality. The PHC facility QI reports included a section on the use of patient satisfaction results and specifically addressed how the information was being used to improve quality. For example, at Muzakaj patients expressed dissatisfaction with long waiting times. The physicians implemented an appointment system for chronic patients, and the patient comments about waiting time decreased. At Llukan Prifti the patients complained about cleanliness in the center. In response, the chief of the center negotiated alternative storage for old medical records so that the entry hall of the center would be more inviting.

---

## 5.2.7 Institutionalizing Quality Monitoring Processes

In December 2003, the experience to date of the PHR*plus* pilot project created the right conditions for the creation of a Central QI Board. The board, initiated by the Deputy Minister of Health, was designed to provide strategic direction and oversight regarding the development and implementation of a system of quality improvement for PHC. Key board members included the Director of Primary Care, the Director of Ambulatory Care, representative of the HII, representative of the Health Promotion Unit of the Institute of Public Health, Chief of the Statistical Office of the MOH, as well as members of the PHR*plus* staff.

The objectives of the board included:

- ▲ Developing annual planning process and developing and/or revising strategic objectives for PHC quality;
- ▲ Making recommendations regarding the PHC service package;
- ▲ Approving the set of core indicators that should be used to monitor PHC centers; and
- ▲ Reviewing regional results of the QI system quarterly and providing feedback as needed.

The board agreed at its first meeting that the package of services for PHC should be those included in the contract between HII and PHC physicians. This definition included services that are currently not well defined nor offered in the PHC centers. As a result, the board has focused on clarifying the expectation and services to be offered by PHC facilities.

One area where expectations were not clear was environmental health or hygiene. The physician contract states that the physician should be aware of sanitary conditions of the coverage area; control the situation of potable water in the coverage area; and monitor hygiene of houses, toilets, and livestock shelters in the area. At the direction of the Central Board, the PHR*plus* staff worked with the Department of Environmental Health at the Institute of Public Health to clarify that there are no concrete, measurable duties of the physicians related to community hygiene. A recommendation was made to take these responsibilities out of the contract and make sure all contract expectations were measurable.

The Central QI Board established a Regional QI Board, which included the local MOH and HII directors as well as the chiefs of the pilot PHC centers. The regional board met monthly to provide direction to the four pilot centers to discuss development of facility quality improvement plans, review the monthly reports of the four pilot sites, and prepare a quarterly report for the Central Board.

The Central QI Board continued to meet following the completion of the PHR*plus* pilot activities. The board developed a set of indicators or standards that can be measured by the HIS, to allow a comparison by region on the performance of PHC. The following standards and/or trends to be monitored were approved at the December 2004 meeting of the Central Board:

- ▲ Chronic and acute care
  - △ Morbidity of cases by disease category
  - △ Productivity of physicians and nurses

- ▲ Maternal-child health
  - △ Prenatal care
    - △ One prenatal visit in the first trimester
    - △ Four prenatal visits during the pregnancy
  - △ Percentage of births with a skilled birth attendant
  - △ Well child visit
    - △ Two visits (doctor and nurse) during the first seven days
    - △ One visit / month by the nurse for the first year
  - △ Breastfeeding
    - △ Percentage of children exclusively breastfed during the first six months
  - △ Types and numbers of nurse referrals for children
    - △ Anemia
    - △ Rickets
    - △ Underweight
    - △ Developmental problems
    - △ Other
- ▲ Immunization coverage

PHR*plus* has designed reports to match the standards/trends requested by the quality board. These reports are available at the health center, district, regional, and central levels.

---

## 5.2.8 Service Delivery and Quality Improvement Toolkit

List of PHC Services	A sample list of services to be provided by a PHC facility in Albania
List of Basic Equipment	A list of equipment needed for primary care, along with the type of exam or diagnosis that cannot be done without the equipment
Quick References	One-page quick reference sheets based on Albanian clinical practice guidelines on common conditions for use by PHC providers (clinical practice guidelines are available only in Albanian)
Chart Audit Forms	Sample forms to guide routine audit of medical charts, including a form to assess basic charting technique, as well as forms for asthma, diabetes, hypertension, acute respiratory infection, and tonsillitis Documentation guidelines for use with the audit Excel spreadsheet for graphing audit results
Referral Guidelines	Summary guidelines for common conditions describing when to refer to specialists or hospital for use by PHC providers
Terms of Reference – PHC QI Committee	Terms of reference for a facility-level QI committee including purpose, objectives, members, and meeting schedule
Sample QI Report	A sample monthly report from a PHC facility providing a summary assessment of quality based on information from medical chart audits, patient satisfaction surveys, and the PHC health information system and recommendations on improving quality based on the assessment

---

## 5.3 Financing and Organization

---

### 5.3.1 Analysis of the Financing and Management Situation for PHC

PHR*plus* Project activities began with a comprehensive assessment of the health financing of PHC in Albania, along with suggested solutions and alternative approaches. Financing and management of PHC were fragmented, partly due to recent general administrative decentralization efforts and the creation of a separate health payer, the HII. The MOH, HII, and local governments contributed to the financing of PHC provision in a way that was not designed with the best coordination of management in mind. Due to the political commitment to decentralize authority, as well as health sector movement toward the separation of health providers and the health purchaser, the HII paid the salaries of GPs, the MOH paid nurse salaries and investments, and local governments financed facility operations and maintenance.

This fragmentation of health financing was an important cause for a division of management roles between the three actors, leading to different management of different parts of the system for health care provision. The system worked in an uncoordinated, ad hoc fashion. For example, doctors were dependent on the HII for their salaries, while the MOH supposedly supervised their clinical performance. However, the authority of the MOH was reduced because they no longer funded GPs, nor supervised them in a typical line management way. In addition, although doctors, nurses, and the MOH were often more informed about facility needs for operations and maintenance, local governments controlled the budget to cover these costs.

PHR*plus* was originally asked to address local budgeting and financial planning as part of its pilot facility PHC model. Based on the situation analysis, the original focus on local budgeting and financial planning had to be replaced by a more effective set of interventions. The project discovered that local administrative levels had very little to do with PHC facility budgeting or financial planning. Once budget allocations had been made at the central level, the control of funds largely remained with the Treasury. Facilities did not have capacity to collect or use cost data, nor to implement accounting systems or monitor expenditures. Consequently, facilities were not in a position to argue for improved funding or to figure out ways to increase efficiency. They did not have the capacity or incentive to do so. Even beyond the facility, central-level budgeting for provider payment was not based on performance and budgeting for operations and maintenance was not based on costs. Instead, salaries for GPs were based on a fixed system, with the main aim of creating incentives to keep GPs in rural areas where PHC facilities were being abandoned. Operations and maintenance reimbursements were simply based on historical budgets and mark-ups.

Private out-of-pocket expenditures were estimated to contribute a larger share than the total public budget to the total health expenditures, including pharmaceuticals. The biggest proportion of out-of-pocket expenditures was for drugs. Informal out-of-pocket payments were commonplace at all levels of the system, but more so at the inpatient level than at the PHC level.

---

### 5.3.2 Revised Financing and Management Approach

To identify more relevant interventions for the finance and management component, the project had an intense dialogue at the central level with the ministries of Health, Finance, and Local Government and Decentralization. Simultaneously, the project's pilot activities in the four facilities were very important to provide evidence of issues and concerns at the local and regional level. Based on this dual approach, PHR*plus*, in cooperation with the government of Albania and USAID, adjusted the finance and management component to better address the actual issues on the ground.

The new priority issues for the finance and management component were the overall financial system, the decentralization and organization of PHC, as well as more effective facility-level management based on improved health information systems and use of data (see Country Assistance Plan April 2003 and September 2004).

Based on the early findings and the adjusted work plans for the finance and management component, the *PHRplus* Project continuously adapted its interventions based on the policy dialogue and the pilot-based evidence. *PHRplus* worked in a number of ways to try to support the key government stakeholders to make improvements in the financing and management of the health system:

- ▲ Improving the existing HIS to provide data on the quality of PHC services and estimates of the cost of health care provision;
- ▲ Improving facility management based on evidence from the improved HIS;
- ▲ Moving towards a model of single-source financing to unify finance and management, and piloting this model in Berat region;
- ▲ Defining and implementing appropriate decentralization strategies in the health sector by creating a regional-level health authority (RHA); and
- ▲ Conducting quantitative and qualitative studies on informal payments to help key stakeholders design appropriate interventions to address this growing problem.

---

### 5.3.3 Using HIS Data for Better Management

*PHRplus* provided technical assistance in its pilot sites to implement an expenditure tracking system as part of the original pilot health information system. The expenditure tracking system provided data on the relationship between expenditures and volume of patients, useful information for improving PHC efficiency – including productivity of doctors. The proportion of budget funds spent on personnel and medications could be identified and used for simulations of variations in staffing, patient volume, and quality of service to compare financial outcomes among facilities under various assumptions. (See Toolkit for technical report: Costs and Utilization of Primary Health Care Services in Albania: A National Perspective on a Facility-level Analysis [Fairbank 2004]).

An analysis of average cost per visit in the four pilot facilities showed that staffing levels may be higher than needed, given current utilization rates. At a high volume facility, the average cost per visit was \$163, compared to \$814 at a low volume facility. Budgetary savings could be realized and productivity could be improved simply by reducing the number of staff employed. Expenditures on non-salary items were found to be extremely low, only 22 percent of total expenditures across the four facilities. The technical report presented a hypothetical illustration of such improved productivity from postulated changes in staffing and operations. It concluded with recommendations and observations about the requirements for, and the implications of, designing and implementing alternative PHC financing and management policies that are suggested. The results were presented during a national workshop on using PHC operational research to inform policy and implementation.

The HIS system tracked the number of visits by provider per day. The use of graphs tracking activity per day for each physician also greatly helped focus on the need for a scheduling system for patients, which was implemented in the urban pilot sites. An alternative method of payment for

physicians, based on a combination of productivity (from the HIS system) and the quality audit results, was also constructed and presented for discussion with physicians and HII officials.

---

### 5.3.4 Improving Facility Management

As mentioned in Section 5.2.1, Improving Management Capacity and Processes, PHR*plus* worked with the four pilot sites on facility management in collaboration with World Learning. After a three-day management workshop for doctors and nurses, PHR*plus* followed up with participants to help them apply what they learned in terms of defining roles and responsibilities for staff, improving patient flow, and developing quality improvement plans and operations manuals. Each pilot facility participated in strategic planning exercises and developed a work plan with specific objectives for their health center. The work plans included target dates and the person responsibility for the follow-up. Each month the plans were revised, with accomplishments recorded and new objectives set as appropriate. While health center staff were familiar with the development of work plans, the process of using and revising the plan each month was a new experience.

The formal QI process carried out in each pilot center was another example of management capacity building. Each center had a defined process for analyzing information from the HIS, the patient satisfaction survey, and the medical record audit. Each month they focused on using the information to make decisions aimed at improving service and quality.

PHR*plus* worked with selected physicians and health centers to develop business plans for autonomous health centers. The first step, an attempt at getting agreement with the MOH and HII on the vision for autonomy, was done through a series of meetings with Berat physicians and key central government officials. Work with individual physicians on the business plans proved difficult. Physicians were afraid of change and not ready to assume any financial risk or responsibility in the running of the health centers.

---

### 5.3.5 Single-Source Financing Pilot

PHR*plus* also provided technical assistance to the MOH and HII with a single-source financing reform pilot in the Berat region. The pilot was designed to help define roles and relationships for PHC in terms of management and supervision and to unify fragmented financing and management.

In October 2003, PHR*plus* was asked by the Deputy Minister of Health and the Director General of HII to provide technical assistance in the design and implementation of the pilot demonstration project (for 2004) in Berat region. PHR*plus* developed a technical proposal with them. The pilot was designed to demonstrate the effectiveness of unifying fragmented sources of financing, improving management of PHC at district and regional levels, and introducing incentives to improve quality and performance.

Political tensions and possible government reorganization in the fall of 2003 together with delayed revision of laws governing health financing throughout the spring and summer of 2004 made it hard to start the pilot of single-source financing. There is currently a government initiative to pass new laws regarding health financing, but no action was actually implemented by the government of Albania on piloting reforms in the Berat region.



---

### 5.3.6 Regional Health Authority

Albania is going through a transition process to decentralize government functions across all sectors and to reorganize and consolidate functions within sectors. Unlike other sectors, the health sector has maintained a district presence, rather than establishing regional representation or decentralizing to lower levels of self-government.

Over the past few years, the MOH and other stakeholders, guided by international expertise, have been discussing alternative ways to organize and manage the overall health sector as they revise and consolidate existing health legislation and plan for single-source financing for autonomous health care facilities through the HII. The Long-Term Strategy for the Development of the Albanian Health Sector (Albania MOH April 2004) and Article 29 of the draft “Act on Health on Regional Health Authorities” (29 July 2004) begin to describe a vision for this reorganization. The vision involves creating RHAs that:

- ▲ Consolidate existing district functions at the regional level to reduce redundancy and increase efficiency;
- ▲ Decentralize key MOH functions to the regional level to be more responsive to local health needs; and
- ▲ Do not allow RHAs to act as financial intermediaries between the HII and facilities.

PHR*plus* worked with local and central MOH officials to develop a proposal for establishing a regional health authority in Berat. The RHA will consolidate the district structures, add regional assessment and planning functions, and expand the quality monitoring and supervision for primary care. The relationship with the comparable regional office of HII is very important in the success of the RHA, as is the involvement of the community.

---

### 5.3.7 Informal Payments

PHR*plus*, with financial support from USAID/Washington, analyzed out-of-pocket payments reported in the 2002 Albania Baseline Survey. A special quantitative study (Hotchkiss, Hutchinson, Malaj, and Berruti 2004), based on the baseline data from the household survey in Berat, Kuçova, and Fier districts, suggested that out-of-pocket payments for care provided in government facilities were widespread but largely for inpatient care. It further suggested that social insurance coverage significantly reduced the likelihood of paying for medicines to treat acute and chronic health problems, but not of paying for consultations.

The project also conducted qualitative research to improve understanding of the practice of informal payments in Albania (Vian, Gryboski, Sinoimeri, and Hall Gifford 2004). The qualitative study found that the practice of informal payments for health services is more common in large towns and cities, and in inpatient care settings, particularly for surgery, childbirth, and gynecological care.

Factors reported to influence informal payments included low salaries of health staff; a belief that health is extremely important and worth any price; a desire to get better quality care; fear of being denied treatment or missing the opportunity to get the best outcome possible; and the tradition of giving a gift to express gratitude. Many providers felt that patients voluntarily give informal payments, while most public informants felt that informal payments were necessary to obtain services.

These findings will be important to bear in mind as Albania implements single source financing, considers introducing formal co-payments, and examines alternatives for reducing informal payments in the health sector.

### 5.3.8 PHC Financing and Organization Toolkit

Alternative Physician Pay	Proposal developed by PHR <i>plus</i> for paying physicians based on productivity and quality, as well as capitation.
Tool for Estimating Cost per Visit	Application of HIS to estimate cost per visit by facility
Regional Health Authority Proposal and Supporting Documents	Proposal for the decentralization of MOH functions to the prefecture level and supporting documents
Autonomous Group Practices	Sample documents describing autonomous group practices
Project Technical Reports	<p>Fairbank, Alan and Gary Gaumer. April 2003. <i>Organization and Financing of Primary Health Care in Albania: Problems, Issues, and Alternative Approaches</i>. Bethesda, Md: The Partners for Health Reform<i>plus</i> Project, Abt Associates. Inc.  <a href="http://www.phrplus.org/Pubs/Tech021_fin.pdf">http://www.phrplus.org/Pubs/Tech021_fin.pdf</a></p> <p>Hotchkiss, David R., Paul L. Hutchinson, Altin Malaj, and Andrés A. Berruti. August 2004. <i>Out-of-Pocket Payments and Utilization of Health Care Services in Albania: Evidence from Three Districts</i>. Bethesda, MD: The Partners for Health Reform<i>plus</i> Project, Abt Associates Inc.  <a href="http://www.phrplus.org/Pubs/Tech051_fin.pdf">http://www.phrplus.org/Pubs/Tech051_fin.pdf</a></p> <p>Vian, Taryn, Kristina Gryboski, Zamira Sinoimeri, and Rachel Hall Clifford. July 2004. <i>Informal Payments in the Public Health Sector in Albania: A Qualitative Study</i>. Bethesda, MD: The Partners for Health Reform<i>plus</i> Project, Abt Associates Inc.  <a href="http://www.phrplus.org/Pubs/Tech047_fin.pdf">http://www.phrplus.org/Pubs/Tech047_fin.pdf</a></p> <p>Fairbank, Alan. June 2004. <i>Costs and Utilization of Primary Health Care Services in Albania: A National Perspective on a Facility-level Analysis</i>. Bethesda, MD: The Partners for Health Reform<i>plus</i> Project, Abt Associates Inc.  <a href="http://www.phrplus.org/Pubs/Tech043_fin.pdf">http://www.phrplus.org/Pubs/Tech043_fin.pdf</a></p>

---

## 5.4 Health Information System

The Albanian PHC HIS was designed to inform and support interventions aimed at improving the quality of care and efficiency of PHC in Albania, beginning in four facilities in the Berat Region. MOH information system channels collected a large amount of data that was aggregated in Tirana, but was rarely analyzed or used for health system planning or quality assurance. Regional-, district-, and facility-level users did not receive feedback from the central levels after analysis. Health departments did not have adequate capacity to analyze or use health information for informed planning or decision making, or to monitor quality of care. Thus, limited and unreliable health information and medical statistics in Albania impeded the provision of higher quality and more continuous patient care.

---

### 5.4.1 Designing and Testing a PHC HIS for Albania

A PHC HIS was designed and introduced by the *PHRplus* Project in July 2002 to help facility, district, and regional managers to collect, analyze, and feed back the data necessary to make more informed clinical and managerial decisions. The Albania project began by adapting HIS tools developed and tested by *PHRplus* in Egypt. The adapted system initially introduced in four pilot health centers in Berat region was based on a one-page encounter form that captured data on every patient visit. The system was designed to use a scannable patient encounter form. The encounter form included patient characteristics (name, age, sex, insurance status), provider (doctor ID, nurse ID), visit characteristics (first visit or repeat, reason for visit, length of visit), diagnosis group, and disposition (referrals, prescriptions, lab tests). Equipment needed to support the HIS included a computer network, scanner, and printer.

The PHC HIS proved effective in the initial four pilot sites, producing routine reports and disseminating them to target user groups to contribute to improved planning and monitoring. From July 2002 to May 2004, more than 90,000 encounters were collected and analyzed. Routine reports by facility and by physician were generated monthly, and analyzed as part of the quality improvement activities in each health center.

---

### 5.4.2 Refining and Expanding the HIS

The idea of expanding the HIS system to other sites was discussed often during the two-year pilot. Collaboration on changes needed for expansion began in the fall of 2003. *PHRplus* invited all stakeholders to participate in discussions about reforming the system to be more effective in the Albanian context, including staff of the pilot health centers, the statistical department of the MOH, head of the reproductive health section of the MOH, head of ambulatory care of MOH, director of Information Technology at the HII, the Institute of Public Health, and the director of Primary Care at the MOH.

The stakeholders, alongside *PHRplus* management and HIS experts, agreed to streamline the HIS based on the following principles:

- ▲ Use a simple encounter form.

#### RESULTS SUMMARY

The PHC HIS was tested in four pilot sites. Responding to government interest in the system, the HIS was refined with local counterparts, resulting in:

- Costs for encounter forms have been cut in half
- Encounter forms are now completed in a third of the original time
- Data entry time has been cut by 40 percent
- Routine monthly reports are generated in less than five working days after month's end

After endorsement of the newly streamlined HIS by the Ministry of Health, its use has expanded from the initial four sites to 44 sites in less than six months, with plans and budget for nationwide expansion in place. USAID will continue to provide technical assistance to the expansion of the HIS through the ProShendetit Project.

- ▲ Capture essential PHC data to monitor PHC services.
- ▲ Use a manual data entry process that requires the use of only a numeric keypad.
- ▲ Require a double entry process to ensure the accuracy of a manual data entry method.
- ▲ Ensure that the HIS is user friendly, requiring minimal technical skill to operate and maintain.
- ▲ Design the HIS to work reliably without the need for technical intervention.
- ▲ Structure the HIS to operate on individual computers rather than through a network.
- ▲ Produce a basic set of reports that can be quickly generated in a user-friendly manner and at the lowest level possible.
- ▲ Design the system around the use of floppy disks for transferring data from each data entry computer “up the chain” to the central database to avoid relying on computer networks, dial up internet and e-mail connections, websites, handheld computers, etc.
- ▲ Design the system to handle electricity disruption without data loss.

As a result of the improvements, the revised encounter form is shorter and easier for doctors and nurses to complete. The change to the standard ICD-9 diagnosis codes and categories used by the HII makes it easier for physicians, since these are the same codes used on HII paperwork for patient prescriptions. Standard reports for the MOH previously completed manually can now be produced by the HIS because of a new special code feature. The HIS program uses either the patient code or a combination of birth date, sex, and facility, to identify the number of cases according to age group and/or sex. The patient’s name is not entered in the system, and no analysis or report showing the patient code is produced.

The new form also includes a special codes section, which provides a way to track activities and procedures, such as injections, immunizations, and wound care. Special codes can be very detailed, depending on the expected use of the information. For example, nurses enter a code for each type of immunization, providing a way to track this information.

In April 2004, the local and central government formally asked for technical assistance from PHR*plus* to implement the revised system in all the urban centers in the Berat and Kuçova districts of Berat region. The newly redesigned HIS was tested in the four original pilot sites in May 2004, with additional health centers in urban areas throughout the region added in phases. In August 2004, 18 health centers (46 physicians, 97 nurses) provided complete data for analysis at the health center, district, and regional levels. Four months of user experience indicated that:

- ▲ Costs for encounter forms were cut in half.
- ▲ Encounter forms were completed in a third of the original time.
- ▲ Data entry time was cut by 40 percent.
- ▲ Routine monthly reports were generated in less than five working days after month’s end.

In August 2004, the government requested the addition of all rural facilities in the Berat region. As of October, 44 health facilities (health centers, health posts, and women’s centers) were using the HIS system. In October 2004, at the request of the Deputy Minister of Health, a national workshop was held in Berat to introduce the HIS system to representatives from all regions of Albania. Also in October, the Minister of Health endorsed the system and made the expansion a priority for the 2005 budget. The Minister of Health requested the technical support of the USAID-funded primary care project “ProShendetit/ProHealth” for expansion of the system, but committed government financing for all aspects of the program, including equipment and ongoing expenses.

---

### 5.4.3 Using HIS Data

An HIS Technical Working Group was established centrally to decide on a basic data set required by PHC facilities. Based on the data requirements, the existing encounter form and list of special codes can be updated to ensure required data are captured. In November 2004 the Central PHC QI Board approved an initial set of indicators and trends to be monitored by the HIS system:

- ▲ Physician and nurse productivity;
- ▲ Morbidity;
- ▲ Percentage of births with skilled attendant;
- ▲ Frequency of well child visits during the first year;
- ▲ Percentage of pregnant women with first prenatal visit in the first trimester;
- ▲ Percentage of babies exclusively breastfed during the first six months of life; and
- ▲ Reasons for nurse referrals.

Data user groups in Berat, Kuçova, and Skrapar districts are meeting monthly to review reports and discuss issues related to the HIS system in general. These meetings have uncovered problems in completion of the encounter forms, which are being corrected. For example, one physician discovered she had been using the wrong code for two diagnoses, which resulted in her diagnosis report being inaccurate. Another physician discovered that her nurse was marking all patients as “referred,” making that report inaccurate. Another physician challenged the number of diabetic patients on his report, but discovered that the report was correct after a list was generated and checked with his registry.

---

### 5.4.4 Replicating the PHC HIS

Based on PHR*plus* experience to date, the prospects that the PHC HIS can be replicated throughout the entire country are very high. The system yields consistent data on PHC practices, at least at a basic level. The system infrastructure is well developed and flexible, does not require sophisticated technology, and ensures operation and back-up, given inconsistent electricity. The special codes section of the encounter form allows the system to collect additional information without changes to the computer program or encounter form. For example, currently laboratory services are not coded in the system, but with the addition of centers offering lab services, codes could easily be added to capture these procedures.

It is often tempting to design an HIS using the most advanced technology. The *PHRplus* HIS has been successfully implemented by keeping things simple and testing processes to ensure feasibility – collecting only data that will be used for quality monitoring and decision making, developing easy systems for data collection, entry, analysis, and reporting, and using an appropriate level of technology. ProShendetit, along with *PHRplus*, developed a detailed implementation plan to roll out the HIS system throughout Albania. *PHRplus* developed an HIS resources estimation tool (see below) to estimate the cost of equipment, ongoing supplies, training for physicians and nurses, training for regional system administrators, and training for data entry personnel to better inform the roll out process for both the government of Albania and ProShendetit.

---

#### 5.4.5 PHC HIS Toolkit

HIS Software	Available on demo CD
PHC HIS Resource Requirements Estimation Tool	An Excel spreadsheet that allows health authorities and managers to project potential costs of implementing the PHC HIS in their region
Description of PHC HIS Infrastructure	A short description of the “nuts and bolts” of the system, with explanations of the technical specifications, system hierarchy, data entry, data transfer, data security, reporting, and system administration
Encounter Form	The form used by PHC providers to record each patient encounter for entry into the system
Special Codes	The list of special codes used in completing the encounter form
Procedure for Completing the Encounter Form	A simple explanation for PHC providers to guide them through completing the encounter form
Procedure for Data Entry	A simple explanation for data entry personnel on creating “batches” of entries, entering encounter form data in batches into the system using a numeric keypad, and double entry procedures to ensure accuracy
Job Descriptions for Key Personnel	Sample job descriptions for regional and country functions
Sample Reports	<p>End-of-month (EOM) reports: A routine set of monthly reports that is generated by the HIS, including:</p> <ul style="list-style-type: none"> <li>Physician and nurse EOM reports, which include activity levels and comparison with other providers</li> <li>Facility EOM reports, including comparison of estimated cost per visit with other facilities</li> </ul> <p>A set of reports that can be printed on request:</p> <ul style="list-style-type: none"> <li>Visit Data and Case Data: Distribution of visits by gender, age, and insurance status</li> <li>Visits by Visit Type: Distribution of visits by type such as: chronic, acute, prenatal, family planning, well child, home visits, etc.</li> <li>Frequency of diagnoses by visits and by cases</li> <li>Sample Ministry of Health report on well baby visits</li> </ul>

---

## 5.5 Community Involvement

The *PHRplus* pilot included many elements aimed at reaching out beyond the PHC facility to better engage the population and communities in health care decision making. Activities under this component included:

- ▲ Outreach education for women and high school students;
- ▲ Screening for chronic diseases; and
- ▲ Eliciting feedback from patients about the services provided.

---

### 5.5.1 Outreach Education

*PHRplus* collected and reproduced health education material currently available in Albanian and made notebooks with copies of the materials for each pilot site. In partnership with the Institute of Public Health, *PHRplus* published a diabetic education poster that was distributed throughout Albania.

Outreach education for midwives, nurses, and women was carried out in two campaigns, both in collaboration with the Public Health and Primary Care Directorates in Berat. From January to July 2003, a campaign was conducted in the pilot PHC centers with the dual objectives of: 1) increasing midwives' knowledge in the areas of women's health, sexually transmitted diseases, and family planning; and 2) increasing community awareness of existing family planning services in their health centers. *PHRplus* developed an education manual for midwives as a part of the campaign (see Toolkit) and produced pregnancy wheels in Albanian (see Toolkit). The wheels, used for calculating the expected delivery date for pregnant women, are commonly used in other countries, but had not been produced in the Albanian language before. Poster and other educational materials were purchased for use during the campaign and then transferred to the local health authorities for continued use.

During the first campaign, 113 women in two rural communities, Havaleas (in the district of Kuçova) and Lapardha (district of Berat), were informed about family planning and women's health. In addition, 10 midwives in the Berat and Kuçova districts were trained to become community trainers. Following the successful education campaign in the pilot sites, the effort was expanded to all 12 urban and rural sites in the Berat district. A TOT approach was used to train 30 midwives, who in turn trained 213 nurses, who in turn educated 2,667 women on female anatomy, family planning, and sexually transmitted diseases. *PHRplus* recommends the continuation of the TOT model used for providing health education to communities.

A third women's health education initiative involved classes in a Berat high school for young women 16-18 years old. *PHRplus* provided materials, and a *PHRplus*-trained nurse midwife from the Berat Public Health Directory taught the classes. The school nurse supervisor was involved in the classes and plans to expand the program to other high schools in the district.

---

### 5.5.2 Screening for Chronic Diseases

A second successful technique used to engage the community, screening for chronic diseases, was piloted by the Lapardha Health Center. *PHRplus* designed a form (see Toolkit) for use with the electronic scanning used in the HIS. The screening identified 302 patients with high blood pressure and 226

patients at risk for diabetes. The doctor and nurses from the PHC center made follow-up visits to identified patients to make sure that the appropriate treatment was initiated.

While the patient screening worked well for the Lapardha Health Center, a modified process is recommended for scale-up throughout the country. Rather than having nurses complete a form that is then scanned and analyzed, nurses could be trained to identify the high-risk patients during the survey itself, saving the cost of the form and the scanning.

---

### 5.5.3 Patient Satisfaction Surveys

As mentioned in Section 5.2.6, Measuring Quality Improvement, another approach used to increase community involvement was the implementation of patient satisfaction surveys at each of the four sites. The concept of getting patient feedback was new to both staff and patients. PHR*plus* staff, in cooperation with the pilot site staff, developed the form (see Toolkit). The form was tested in December 2003 and implemented in January 2004. All four pilot sites responded to the feedback and addressed concerns raised by patients. The process was successful, but was highly dependent on the PHR*plus* staff. Following the end of the pilot period, the health centers chose not to continue the collection of surveys. Both health center staff and patients questioned the need for this feedback process. The assessment of the Albania PHR*plus* staff was that in general patients are not expected to have or voice an opinion about their care or the health center. This was thought to be a cultural pattern dating back to the communist regime.

PHR*plus* worked with the National Democratic Institute staff to improve our understanding of the reaction to the patient survey and got important insights for future efforts to have communities actively involved in their community health centers. The NDI recommendations, which PHR*plus* supports, include having professionally facilitated focus groups first with health center staff and then with the staff and representatives from the community to begin to identify the reasons why community involvement is important for the health center, and then to engage in a process of identifying community needs and the appropriate health center responses.

---

### 5.5.4 Community Involvement Toolkit

Patient Satisfaction Survey	A sample patient satisfaction survey for PHC patients and clients
Community Screening Form	A sample form to guide the conduct of community screenings by PHC providers
Family Planning Manual	A manual developed in Albanian for teaching family planning methods
Pregnancy Wheel	An Albanian version of the classic wheel used to calculate a pregnant woman's due date



## 6. Replication of Reforms

As described in the previous chapters, the *PHRplus* Project initiated PHC reform in Albania using a pilot or “bottom-up” approach, with initial activities focused at the health center level. Many lessons were learned about the design and implementation of specific components of the PHC model and about what works best in the Albanian context, as described in Chapter 5. The *PHRplus* pilot, often in close collaboration with MOH counterparts, designed excellent tools specific to the PHC setting in Albania, such as the HIS, the medical record chart audit, clinical practice guidelines, and referral guidelines. While the pilot approach is useful in the initial design of appropriate interventions and tools, it must inform and evolve into broader system level or “top down” interventions in order to cost-effectively roll out reforms nationally. Attempting to replicate PHC reforms health center by health center would be impractical – being prohibitively costly and taking years to complete. Improvements at the health center level would take place in a vacuum, without the support of the broader health system and would run the risk of quickly fading away. Broader changes in health policy, financing, and sector organization and management are needed to institutionalize and sustain PHC reform.

This chapter provides a framework for top-down implementation of PHC reform as well as recommended steps for implementing the reform in initial, mid-term, and long-term phases. The framework, focusing primarily on the role of the MOH in the PHC reform, also provides guidance for the Health Insurance Institute, the Ministry of Finance, and the Ministry of Local Government and Decentralization (MOLGD). The framework is consistent with the long-term strategy of the MOH and with the lessons learned by the *PHRplus* Project in Albania. It also builds on successful approaches from primary health care reform in other country settings. The chapter offers recommendations to Albanian stakeholders to continue to reform the health system to strengthen primary health care, using concrete strategies and tools that have been tested and proven successful in the Berat region. Some details are included, however, that are not yet reflected in the health laws and regulations and some that are still under debate.

---

### 6.1 Assumptions for Replication

In making recommendations for replication, *PHRplus* assumes that the MOH will continue to make the transition from its role as service provider to a new role of determining the national policies for health through extensive health planning, directing strategy development for the implementation of those policies, and establishing the systems and mechanisms for monitoring and improving health care quality. This shift in roles requires commitment and vision on the part of the MOH leadership, as well as a series of role changes within the MOH, so that change takes place in a strategic and orderly manner, does not negatively impact quality, and, if possible, continues to improve quality throughout the change process.

The framework for replication assumes that financing of a defined package of PHC services will eventually be through the HII-funded payroll tax. During the long process to reach the required levels of insurance revenues, the MOF will continue to provide budget funding to the health system through the HII. The MOH will continue to be funded by a general tax for providing public health services, health promotion, environmental health programs, and for health care policy and planning. The HII will be the single funding source for PHC centers that are contracted with the HII. Another assumption is that the

role of the HII as an informed purchaser of health care services will depend on information generated from mechanisms put in place by the MOH that can demonstrate or confirm the quality of services provided.

The framework for reform further assumes that the public health functions of the MOH will be carried out by independent regional health authorities organized at the prefecture level. Also, the relationships between the key institutions, such as MOH, RHAs, HII, and autonomous PHC practices, will be very interdependent during the reform process. The HII will contract directly with autonomous PHC practices if they meet standards and quality criteria set by the MOH and overseen by the RHAs. The patient will be at the center of the health care system, with patient rights strongly communicated to the public, and with the MOH and RHA using health education as a means to help drive the demand for patient rights.

## 6.2 PHC Reform Framework

Given the above assumptions, this section of the report offers a framework to help guide the PHC reform process. Reform of the system will not happen all at once. For instance, in the proposed reform, the MOH role would begin to shift as the PHC centers develop clinical and management capacity, and as the MOH regulatory mechanisms are put in place. Table 11 groups proposed reforms into key categories in column 1, and then suggests interventions that might be required in each category during three illustrative phases – initial reform, mid-term reform, and long-term reform. In reality, the shift will happen gradually, and probably not in neat, distinct phases; in addition, lessons may be learned in the earlier phases that will change what happens in the later phases. Still, the framework provides a roadmap for institutional roles and action steps.

**Table 11: Framework for Primary Care Reform: Suggested Phased Interventions**

<b>Proposed Reform Function / Area</b>	<b>Initial Phase Estimate: 2 years</b>	<b>Mid-term Phase Estimate: 2 years</b>	<b>Long-term Phase Estimate: 2-5 years</b>
MOH central policy and planning function	MOH plans for implementation of the Long-term Strategy.	MOH facilitates process for planning and monitoring progress of implementation that involves representatives from HII, local government, regions, parliament, donors, and consumers.	MOH continues annual operation planning process, and adds more extensive strategic planning every 3-5 years.
MOH central regulatory mechanism	District primary and public health directors survey facilities and monitor progress.	Inspection for government and private facilities takes place through a formal facility licensure program, which monitors minimum standards set by MOH.	Licensure and accreditation mechanisms are in place for PHC facilities and individual practitioners.
MOH central quality monitoring	The MOH Primary Care Quality Board/Directory sets required quality standards for PHC.	MOH/national quality coordination body conducts annual assessment and planning; sets national health QI priorities; and reviews regional reports to assess progress.	Results of key indicators are benchmarked with other countries. Objectives are focused on outcomes.
Regional health authorities (RHAs)	District primary and public health directories continue to implement MOH directives.	RHAs are established to provide support for more coordination and planning at the regional level. They report to the MOH and have advisory boards.	The RHA now reports to a Board of Directors, but continues to follow MOH guidelines and implement national programs.
Regional quality	Regional QI board established in coordination with central QI initiatives.	RHA quality inspectors support the facilities to achieve licensure status.	Licensure status is required for HII contracts.

Proposed Reform Function / Area	Initial Phase Estimate: 2 years	Mid-term Phase Estimate: 2 years	Long-term Phase Estimate: 2-5 years
	District public health and primary care directors monitor quality and support the facilities in meeting standards.	Facilities have QI processes and report monthly to RHA QI board.  Audits are expanded to include clinical practice guidelines.	An accreditation system is in place with a target date set for required accreditation.  Autonomous PHC practices have QI processes and report monthly to RHA QI Board.
Coordination with local government	Local government continues involvement in the central planning process and in the development of the implementation plan for PHC reform.	Local government leads the local process to agree on utilization targets for keeping health centers open, and on the development of plans for improving the use of health centers, or converting them to health posts, or closing them.	Local government is represented on the RHA Board, which at this stage is independent from the MOH, except for the implementation of national MOH programs.
Management transition for primary care facilities	MOH, HII, and local government coordinate their management roles and functions and reach agreement on required standards.	Health centers assume more management responsibilities, such as annual staff evaluations, QI, setting objectives, and monitoring progress.  RHAs continue to monitor and support facilities.	Autonomous PHC practices are run by a clinical director with administrative/financial management support.
Physician payment	A portion of physician pay is based on quality and productivity.	New payment approaches that reward performance objectives are implemented.	Autonomous PHC practices are held accountable for delivering the services contracted for by HII.
Basic education for primary care physicians and nurses	Basic education includes a focus on PHC.	All graduates are trained in basic skills.	Training includes clinical component at PHC sites.
Family practice specialty training	Definition of family practice model approved for PHC in Albania.	Residents have model outpatient practice site for training in Tirana.	Sites available in the various regions of the country.
Continuing education for PHC physicians and nurses	Government/donor TOT partnership formalized.	Government/donor partnership continued.	Continuous professional development (CPD) system established and required for licensure renewal.
Consumer involvement	Community awareness campaigns regarding PHC reform, patient right to choose physician, health insurance benefits.	Community involvement in annual planning process.  Feedback mechanism in place for individual communities – patient satisfaction surveys or focus groups.	Continued and increasing involvement of consumers in local health centers.
Private sector	Current information on private PHC facilities maintained by MOH.	Same licensure requirements, set by MOH, for private and public facilities.	Same accreditation requirements set by MOH.

The following implementation steps recommended by *PHRplus* are intended to give concrete examples of the ways tools developed by the *PHRplus* Project, in collaboration with Albanian counterparts, can be used to implement the series of changes that are needed in each phase of proposed reform. The recommendations are based on the situation in early 2005, when the initial phase of the reform plan is just starting to be implemented, and the final shape of reform may change considerably as lessons are learned during the process. The actual tools from the *PHRplus* Project are available on a CD or at [www.phrplus.org](http://www.phrplus.org) in the “Toolkit” Section.

---

## 6.3 Initial Reform Phase

As PHC reform involves financing and decentralization/local government issues, an important initial role for the MOH is to coordinate and build consensus around the important health issues for the country with key institutional partners, such as the HII, MOF, MOLGD, and Ministry of Education. Ideally the prime minister would appoint a government committee, chaired by the MOH that would be responsible for consensus building and coordination. This would ensure high-level political support for reforms and create participatory processes to ease implementation. There may not be agreement on all parts of PHC reform, but the initial steps will probably not be controversial. It is important to get agreement to move ahead on areas where there is consensus and to identify a process for resolving areas of disagreement.

After consensus is reached by the key institutions, the next step would be the development of an implementation plan for PHC reform. This could be part of the process of developing an implementation plan for the MOH's Long-Term Strategy, or could move ahead separately. During the PHR*plus* work in Berat the Primary Care Directory, the Reproductive Health Section, the Statistic Section, and the Institute of Public Health, as well as the local health authorities in Berat, demonstrated a strong interest and commitment to provider training, HIS, QI, and service delivery reforms. Therefore, it is likely that rapid progress can be made with this group of reforms, while it may take more time for agreement to be reached on the more controversial financing and legal issues.

---

### 6.3.1 Quality Improvement

The Central PHC QI Board, started in December 2003, already serves an important role in directing the QI activities of the USAID-sponsored PHR*plus* and ProShendetit Projects. Its role could easily be expanded to assist the Primary Care Directory in the oversight of the quality improvement aspects of the initial phase of PHC reform. If a Central Directory for Quality is established, the Primary Care QI Board would become part of that structure, but in the meantime could continue to provide assistance to the Primary Care Directory regarding the reform initiatives.

An early activity of the board would be to recommend required facility standards for approval and adoption by the Primary Care Directory. The RHA Section of the PHR*plus* Toolkit contains a sample survey form that could be used and revised as needed as standards are approved. The form, adapted from one in use in Albanian in the ProShendetit Project, includes areas of general organization, hygiene, drugs and contraceptives, service delivery, education materials, environment, and infection prevention. It also includes the PHR*plus* medical record audit to assess basic documentation, and a form for recording the basic equipment and supplies that are present and functioning at the health center. As PHR*plus* recommends that all public health and primary care directors incorporate quality monitoring and support to health centers for meeting standards into their roles, this survey tool could be completed by the directors as a first step in assessing compliance with facility standards, standards for medical record documentation, and necessary equipment and supplies.

The Berat region had a QI Board which supervised the QI activities of the four PHR*plus* pilot sites, and reported to the Central QI Board. The Regional Board, which included the local health directors (MOH, HII, Regional Hospital) and chiefs of the pilot centers, served an important role in identifying areas of concern, such as overuse of antibiotics and the need to improve the relationship between PHC physicians and specialists. PHR*plus* recommends that regional QI boards be set up to review the results of the surveys described above. The boards would help guide the corrective action needed to help all centers comply with the standards. The regional QI boards also could initially provide a forum for addressing issues such as the relationships between PHC physicians and specialists, development of

referral procedures and guidelines, communication between levels of care, and use of clinical practice guidelines for PHC.

The board would summarize the problems and concerns for the Central QI Board at least quarterly. The annual regional planning could begin with the regional QI boards, with recommendations made to the central level for specific objectives, routine monitoring, and budget priorities. The regional QI boards would become an important part of the RHA, once the RHAs are formed, but could begin functioning immediately to help the central MOH focus on quality measures and objectives.

---

### 6.3.2 PHC Health Information System

Information provided by the PHC HIS currently in place in the Berat region is an important tool providing a great opportunity to begin using information for policy, planning, and measuring quality. The HIS is purposely a very simple tool, and will not be sophisticated enough to meet the needs for PHC information in the long run. However, it is an excellent place to start. The HIS provides a practical way to track PHC services being delivered and to monitor some of the outcome indicators for PHC. This can be very useful in documenting the services delivered for HII contracts, and for regional and central planning. In addition, the reports and information generated by the HIS should be used by both the individual doctors and nurses, as well as by the regional and central QI boards to monitor the PHC services delivered and compliance with standards. The encounter form and procedures related to completion of the form and data entry are included in the HIS Toolkit.

The MOH has made the decision to implement the HIS system countrywide. The ProShendetit Project will support the government as it implements the system beyond the Berat region to the 11 other regions in the country. The logistical steps needed for successful implementation of the system are detailed in the HIS Resource Requirements Estimation Tool in the HIS Toolkit. Financial resources are required for printing the forms, while human resources are needed to maintain the systems, and to input and analyze data. Because the Berat region experienced difficulty in printing and maintaining sufficient inventory of encounter forms, PHR*plus* recommends central printing and distribution. Bulk printing costs one Lek per form, whereas individual municipalities and communes in Berat paid three to four Leke per form. Another important commitment at the central level is the creation of central and regional positions for supervising and ensuring the proper functioning of the HIS system. PHR*plus* developed job descriptions for these critical positions, which are included in the HIS Toolkit.

---

### 6.3.3 Interdependent Roles for MOH and HII

A good working relationship between the MOH and HII is fundamental to implementation of PHC financing reforms like single-source financing and performance-based payments. The basic principle, which must be agreed upon at the central level, is that the HII will use the information supplied by MOH to verify the quality of the services it is purchasing. Ultimately that will mean that the HII will only contract with physicians or health centers that are in compliance with MOH standards. In the short term, it is very important that the HII and MOH work together on the guideline or protocols to be used in PHC, and on the surveys and tools used to measure compliance. (See also Utilization and Health Insurance below.)

---

### 6.3.4 Basic PHC Services

Agreement on the package of PHC services, and the way health centers and/or physicians can demonstrate that the services were delivered, are two additional areas of collaboration between the MOH and HII. The package of PHC services developed by PHR*plus* may serve as a starting point for discussion and is included in the Service Delivery and QI Toolkit. It is important that the a measurable set of services, such as the one developed by PHR*plus*, are approved by the MOH and HII, and that reports are developed to demonstrate that a center has provided the package of services. Currently the PHC HIS generates *End-of-Month* reports for physicians and nurses that give detailed information about types of visits and procedures. The *Visits by Visit Type* report shows graphs of the types of visits. The immunization, prenatal, and well baby tracking reports show detailed activities in these important service areas. A combination of these reports could be used to document the package of services that can and should be delivered by PHC. A new report could be created that captures all the relevant information in a single report. PHR*plus* recommends that the MOH and the HII agree early in the PHC reform process on the method used to document the package of services delivered by each physician and health center.

---

### 6.3.5 Utilization of Health Centers

The PHR*plus* Project found that resources for PHC are inefficiently allocated (Fairbank 2004, pp. 27-30). In general, rural health centers are underutilized, and a more cost-effective use of health care resources could involve closing centers that are not used. It is very important politically for every commune to have a health center, and closing a center would not be an easy thing to do. But it is also reasonable for the MOH to work with other stakeholders, such as local government, to set recommended targets for the utilization of health centers, and to recommend the closure (or conversion to health post) of the center unless the targets are reached within a specified time period.

PHR*plus* recommends that the MOH lead a process to set targets and assist local governments to lead a process to evaluate the current reasons for low utilization. The doctor, nurse, community members, and local government should be involved, along with representatives from the MOH and HII. The process should involve a recommendation to close the center, convert it to a health post, or keep it open. If the recommendation is to keep the center open, it should be accompanied by a detailed action plan for increasing the center's use.

Another possibility for increasing utilization is for the HII to base part of the physician pay on a combination of productivity and quality. There is an application in the HIS system that could be used to calculate the pay (*Alternate Physician Pay Proposal* included in the Financing and Organization Toolkit). If physicians were paid at least in part according to the number of visits, they might be motivated to become more involved in the community in which they work, and identify solutions to increase the use of the health center.

---

### 6.3.6 Health Insurance Coverage

Reports from the Berat HIS indicate that 21 percent of the population using the health centers is not insured (see *Case Data Report* in group of sample reports in the HIS Toolkit). Reports run by community or local authorities show that in rural areas a lower percentage of patients are insured. Increasing the enrollment in the health insurance scheme would allow the scheme to work better, with more money available for salaries, equipment, supplies, drugs, etc. At the same time, higher enrollment levels would increase access to health services, perhaps reduce informal payments, and ease the financial burden on the participants in the scheme.

PHR*plus* recommends that MOH, HII, local government, and community leaders jointly carry out community awareness campaigns regarding the benefits of health insurance. Finding a way to allow people to enroll as part of the campaign would be helpful. The campaign should be piloted in one area, barriers to insurance identified, and problem areas addressed prior to conducting campaigns throughout the country. For example, the Berat rural physicians described the requirement to enroll in both social insurance and health insurance at the same time as a significant barrier, because of the cost of the social insurance. Perhaps the two could be separated, to allow families that cannot afford social insurance to still sign up for health insurance.

---

### 6.3.7 Basic Equipment

It is very important that the purchase and distribution of basic equipment to health centers be coordinated with the physician and nurse training, so that staff know how to use the equipment to provide the package of PHC services. For example, if diagnosis and treatment of asthma is included in the package of services provided by PHC, then peak flow meters must be available. If the equipment is not available, the PHC physicians should not be expected to diagnose and treat asthma. The *Basic Equipment List* in the Service Delivery Toolkit details the list of equipment needed, and the types of things a physician cannot do without the equipment. PHR*plus* recommends that a survey of available and functioning basic equipment be conducted by the public health and primary care directors. Once the extent of the problem is known, goals can be set for purchase and distribution. PHC staff who are not used to working with new equipment may need to be trained in its use.

---

### 6.3.8 Training for Doctors and Nurses

PHR*plus* provided general refresher training for nurses in the pilot sites, as well as maternal–child health training for midwives and nurses. Nurses carry out very key PHC prevention functions, such as immunization, well baby care, and prenatal care. The MOH, along with other donors, is focusing on these important areas of retraining for nurses. PHR*plus* recommends that information on the educational background of PHC nurses be collected and used to plan additional retraining needed.

Because of the varied backgrounds of nurses, it is important for emphasis to be placed on curriculum development in nursing schools. The development of a standardized test for all nursing graduates should be a requirement for nurse licensure. PHR*plus* recommends that the basic curriculum for nurse training be evaluated, and that specific content regarding PHC be included. The types and levels of nurse training need to be clarified and standard curricula and a consistent exam for licensure should be in place for all nursing schools. The MOH should take the necessary steps to get this process started, and be involved in the process as it moves forward.

PHR*plus*, along with the Department of Family Medicine in the Medical Faculty of the University of Tirana, and international consultants from PRIME, developed a curriculum for retraining physicians. This curriculum, based on clinical practice guidelines, was first implemented for physicians in the four PHR*plus* pilot sites and then for all the physicians in the region of Berat. PHR*plus* recommends that this curriculum be used to meet the need for initial retraining for PHC physicians, using the faculty from the Department of Family Medicine and the training of trainers (TOT) method for the retraining. This refresher training system can eventually become a mechanism for providing ongoing training for PHC physicians. An ongoing program for physician education, or Continuous Professional Development (CPD), is needed for physicians to maintain their clinical knowledge and skills. A cost-effective, TOT method for reaching all PHC physicians with four training sessions per year is described in the PHR*plus* Toolkit. A TOT workshop was held in the fall of 2004. The workshop was a joint venture of PRIME, the

Department of Family Medicine, and the ABC Health Center in Tirana. Ten trainers were trained and are eager to be part of an ongoing training program.

PHR*plus* recommends that the MOH take the lead in establishing some type of CPD program for PHC physicians. Over time the running of this program could be delegated to professional physician groups or NGOs. But the MOH should maintain an active role in determining the content of training sessions to make sure the content corresponds with national priorities for improving PHC. Attendance at the CDP sessions should be required, and should be part of the criteria used for eligibility for maintaining a contract with the HII.

---

### 6.3.9 Timeframe, Expense, and External Support for Initial Reform Phase

Based on our assessment of the current situation, we think the total reform as outlined here could be implemented over a period of 6-9 years. The initial reform phase could be done in two years. Depending on the success of the initial phase, the mid-term reform phase could take about two years as well. The long-term phase is harder to estimate, as it will depend on what the preceding phases have produced in terms of a conducive environment for the full implementation. Some parts of the long-term reform phase may have started in the mid-term phase, some of the mid-term phase steps may have been postponed, for example. Depending on such changes, the long-term phase is estimated to take between two and five years.

The timeframe for completing the initial reform phase depends on aggressive leadership by the MOH and on collaboration with the HII. With both of these factors present, the reforms in the initial phase could begin immediately, and, with the exception of physician retraining, could be completed within a two-year period. The physician retraining would take approximately five years to complete, assuming a donor partner is identified and planning begins immediately.

The consensus building and coordination described above would require strong political will on the part of both the MOH and the other government ministries. Ongoing technical assistance would be needed to support this process. Technical support also would be needed for local governments as they help rural communities identify ways to improve utilization of health centers and comply with standards set by the MOH.

The expense for the HIS is already part of the MOH's budget for fiscal year 2005. In addition, approximately 100 new data entry positions will be staffed by shifting and retraining existing PHC staff. New positions at the central and regional level need to be created. Assuming a strong central and local commitment, it will take approximately two years to fully implement the HIS. The USAID sponsored ProShendetit Project has agreed to provide technical support the HIS expansion, which will be invaluable in assuring a smooth implementation process.

The expense for physician retraining and for setting up the CPD process is the biggest expense in the initial phase. If the TOT approach is used, the cost of replicating the content of the 24-session training piloted by PHR*plus* for all GPs of Albania would be approximately US \$2,500,000 and would take approximately five years. The ProShendetit Project could help search for a donor partner to implement the TOT program. If this approach is then used to create an ongoing system of continuous professional development, the cost would be approximately US \$500,000 per year. The construction and development of PHC practice sites for the clinical training of medical students and family medicine specialist residents, and for the retraining of general physicians, is an important aspect of reform.



The expense for basic equipment and supplies depends on how much is needed for each center. The survey proposed for the district-level health directors would determine the equipment and supplies needed for all centers to meet the required standards. Equipment could be purchased over time through the normal budgeting process for urban and rural sites. Or if possible, a donor could be identified so that equipment could be purchased in a shorter time period.

Negotiation with an organization such as the World Bank for financing the package of reforms related to retraining and ongoing education, purchase of equipment, and construction of PHC practice sites throughout the country would be extremely advantageous for the reform to proceed without delays.

The training needed for district-level directors to assume their new role could take place as part of the normal work of the MOH and Primary Care Directory, although outside trainers and facilitators that could work with each district or region would expedite the process. The ProShendetit Project has expertise in this type of training, and is planning to provide it in their five targeted regions. The support needed for the establishment of the role of the Central and Regional QI Boards is again one of training and facilitation. This also might be provided by the ProShendetit Project if sufficient funds were available.

---

## 6.4 Mid-term Reform Phase

The timeframe for the mid-term reform is dependent on the consensus developed during the initial reform regarding the institutions needed and the goals for long-term PHC reform. During the mid-term phase, health laws and regulations would need to be passed to support the approved reform. Other areas that need to be addressed include the creation of regional health authorities, the establishment of autonomous PHC practices, financing of PHC practices, and regulations regarding individual and facility licensure.

If consensus is reached during the initial reform phase, then planning for the needed legal changes can begin immediately and be in place by the time the initial reforms are completed. The regulations and laws needed to allow the autonomy needed by autonomous PHC practices would then be passed during the mid-term phase. They would be consistent with a well-planned model based on successful piloting of autonomous PHC practices during the initial and/or early mid-term phase; pilot facilities should have met the following prerequisites: a) meet the basic standards set up by the MOH for PHC facilities, b) comply with medical record documentation standards, c) have the basic equipment and supplies, and d) complete the retraining program. Detailed sample documents describing autonomous PHC practices are included in the Financing and Organization Section of the Toolkit.

The newly created RHAs would represent a consolidation of the current district-level structure. The RHAs would still report directly to the MOH. (A shift from governance by MOH to governance by an independent regional board of directors would occur in the long-term phase of reform, once health centers have made the transition to autonomous PHC practices.) A proposal detailing the organization and structure of the RHA for the mid-term phase is given in the Financing and Organization Section of the Toolkit.

Once the basic standards for PHC facilities are agreed upon, and implemented in the government-supported PHC facilities, steps should be taken to establish a formal licensure process that would apply to both government and private PHC facilities.

The retraining and ongoing training of physicians would continue during the mid-term phase. The government would set a deadline by which all physicians practicing in government-supported sites would

be retrained. Physicians practicing in private sites should also be encouraged to participate in and pay a fee for the retraining. Retrained physicians would be recognized by a title and by an increase in pay.

PHR*plus* estimates two years for the mid-term phase to establish the RHAs and for pilot the autonomous PHC practices. The cost involved would include technical support for developing new laws and regulations, the cost of the physician training, and the cost of establishing the formal licensing system to apply to both public and private facilities. In addition, a long-term consultant adviser to support the implementation of RHAs would help them begin their new roles. A long-term advisor for each of the autonomous PHC practice pilots is also recommended.

---

## 6.5 Long-term Reform Phase

The long-term PHC reform phase would include the full transition of the MOH role to policy and planning, including oversight of the regulatory mechanism for assuring basic safety and ongoing quality improvement. This would be accompanied by the full functioning of the RHAs and the autonomous PHC practices. As part of the long-term reform, the RHAs would contract with the MOH for regional management and implementation of public health programs, but would report to a regional board of directors. The board of directors would hire and fire the RHA director, and would approve the annual budget request submitted to the MOH. Funding for the RHA would still come from the MOF, based on recommendations from the MOH.

Financial management training courses would be needed as more and more centers prepare to become or join autonomous PHC practices. The practices would contract with the HII to provide the basic set of PHC services covered by insurance. The contract terms would be very specific about required documentation of the services delivered, and about the quality requirements.

The formal accreditation process for facilities and individuals would be in place, with a time limit set by which all facilities must be accredited. The donor partnership for training, equipment, and practice site development would be phased out, as the government, professional groups, or NGOs take over the continuous professional development. Additional needs during this phase include support for the establishment of an accreditation process as the basis for facilities to contract with the HII.

The timeframe for the long-term reforms would be from two to five years, depending on the accomplishments in the first two phases. The retraining of physicians would be completed during this final phase, along with training in practice management and finance for individuals interested in management roles in the autonomous group practices.

## 7. Conclusions

Albania has taken the initial steps required to begin implementing widespread PHC reform. The MOH has developed a long-term health strategy with PHC as the foundation of the reformed health system, and is working with WHO to develop plans to implement the strategy. Donor organizations, including USAID through the *PHRplus* Project, have helped design and test interventions and tools to strengthen PHC services and to begin to improve quality of care. This report provides the government of Albania with a description of what the *PHRplus* Project, in close collaboration with local stakeholders, was able to accomplish in the Berat region. It describes the unique PHC model that was developed for Albania, how it was pilot tested in four PHC facilities, and how many of the successful components and tools developed are being replicated on a wider geographic scale. It also presents a framework for building on these initial efforts, in the short and long-term. With sufficient political commitment to PHC reform and a well-developed approach to begin implementing, Albania will be well on its way to improving the quality and efficiency of primary health care services for its entire population.



# Bibliography

- Albanian Ministry of Health. April, 2004. The Long-Term Strategy for the Development of the Albanian Health System. Tirana.
- Albanian Ministry of Health. 2002a. Health Map of Albania.
- Albanian Ministry of Health. 2002b. 10 Year Development Strategy of the Albanian Health System, Tirana.
- Albanian Ministry of Health. 1999. Albanian Health Sector Reform: A Position Paper on Policy and Strategies for Albanian Health Sector Reform. Tirana.
- Albanian Ministry of Health. 1993. A New Policy for the Health Care Sector in Albania. Tirana
- Bank of Albania. April 2004. Governors' Report 2003.
- Bank of Albania. March 2003. Statistical Report.
- Bank of Albania. March 2002. Statistical Report.
- CIA. 2004. World Factbook
- Fairbank, Alan and Gary Gaumer. April 2003. Organization and Financing of Primary Health Care in Albania: Problems, Issues, and Alternative Approaches. Bethesda, Md: The Partners for Health Reform*plus* Project, Abt Associates. Inc.
- Fairbank, Alan. June 2004. Costs and Utilization of Primary Health Care Services in Albania: A National Perspective on a Facility-level Analysis. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.
- Health Insurance Institute. 2004. Budget, FY 2005.
- Hotchkiss, David R., Paul L. Hutchinson, Altin Malaj, and Andrés A. Berruti. August 2004. Out-of-Pocket Payments and Utilization of Health Care Services in Albania: Evidence from Three Districts. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.
- Institute of Statistics (INSTAT), Albania. 2002. [Http://www.instat.gov.al](http://www.instat.gov.al).
- KPMG Consulting, Barents Group and Albanian Ministry of Health. 2001. Health Sector Finance Study: Final Report. Albania Tirana.
- Nano, F. Prime Minister Speech on Government of Albania 2004 Performance, 24 January 2005.
- Nuri, B. In: Tragakes, E., ed. 2002. Health Care Systems in Transition: Albania. Copenhagen: European Observatory on Health Care Systems.

Partners for Health Reform*plus*. February 2004. Primary Health Care Reform in Albania: Baseline Survey of Basic Health Service Utilization, Expenditures, and Quality. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

Partners for Health Reform*plus*. August 2004. The Role of Pilot Programs: Approaches to Health Systems Strengthening. Bethesda, MD: PHR*plus*, Abt Associates Inc.

USAID. Revised Strategic Plan for 2001-2004.

Vian, Taryn, Kristina Gryboski, Zamira Sinoimeri, and Rachel Hall Clifford. July 2004. Informal Payments in the Public Health Sector in Albania: A Qualitative Study. Bethesda, MD: The Partners for Health Reform*plus* Project, Abt Associates Inc.

World Bank. 2003. Albania Poverty Assessment Report. Washington, DC.

World Bank. 2002a. Doing Business Project. Washington, DC.

World Bank. 2002b. Living Standards Measurement Survey. Washington, DC.

World Health Organization. 2003. European Region Health for All Database.