PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: PIDA14981

Project Name	Albania Health System Improvement (P144688)
Region	EUROPE AND CENTRAL ASIA
Country	Albania
Sector(s)	Health (100%)
Theme(s)	Health system performance (100%)
Lending Instrument	Investment Project Financing
Project ID	P144688
Borrower(s)	Ministry of Finance
Implementing Agency	Ministry of Health
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	09-Oct-2014
Date PID Approved/Disclosed	21-Nov-2014
Estimated Date of Appraisal Completion	18-Nov-2014
Estimated Date of Board Approval	27-Jan-2015
Decision	

I. Project Context

Country Context

Albania experienced rapid economic development, joining the ranks of middle income countries in 2008. Between 1998 and 2008, Albania's macroeconomic environment was stable, economic growth averaged 6 percent, exchange rate and interest rates were stable, and inflation was anchored at the central bank's target of 3 percent. Unemployment decreased from 17 percent to 12.8 percent, and the poverty rate halved from 25.4 percent in 2002 to 12.4 percent in 2008. The global financial crisis severely affected Albania, with remittances and other inflows sharply declining. GDP growth slowed to an average of less than 3 percent between 2009 and 2012. A lack of structural reforms added to the difficult economic environment, resulting in a rapid deterioration of the country's fiscal position and the estimated debt to GDP ratio peaked at 70.5 percent in 2013. The recent sluggish economic growth has negatively affected poverty and placed an increased strain upon a large part of the population. LSMS 2012 data indicate that poverty rates increased to 14.3 percent. Labor Force Survey data on employment shows that 27 percent of Albanian households have at least one member who lost a job, versus a Europe and Central Asia (ECA) average of 18 percent. The new Government that took office in summer 2013 is committed to correcting economic imbalances, putting public finances on a sustainable path, and undertaking the necessary reforms to restore sustainable economic growth. The strong election mandate augurs well for political stability in the period ahead, as the authorities are keen on launching upfront policy and structural reforms.

Sectoral and institutional Context

Key health system performance indicators in Albania are mixed. While health outcomes are relatively strong by regional standards, financial protection of households against high out-of-pocket payments (OOP) is relatively weak, and quality of care is a significant concern. Life expectancy at birth in Albania reached 77 years by 2011 (80 for women and 74 for men), which compares favorably with other countries in the region. This is higher than in neighboring countries such as Serbia and Macedonia, and only about 3 to 5 years behind countries such as Greece and Italy. The Mediterranean diet has been posited as a major explanation for Albania's relatively good adult health indicators. Child health indicators suggest greater room for improvement. According to the 2008 Demographic and Health Survey (DHS), infant and neo-natal mortality were 18 and 11 per 1,000 live births, respectively, both of which are slightly higher than comparable statistics for other countries in South-Eastern Europe, with steady improvements during the 1990s appearing to slow down more recently. Noncommunicable and chronic diseases constitute the majority of the burden of disease, but the 1998 DHS found that most hypertensive adults were not aware of their condition.

Spending on the health sector (both public and total spending) remains below average, with high out of pocket costs. Albania spends 6 percent of GDP on health care, of which 43 percent comes from the public sector. Public spending on health was only 2.6 percent of GDP in 2013, the lowest among countries in the region, equivalent only to Romania. Out of pocket expenditures are among the highest in the region, accounting for 55 percent of total expenditures on health. These are spent for outpatient health services (45 percent), pharmaceuticals (45 percent), and inpatient services (10 percent). Albania has one of the highest rates of catastrophic health expenditure in the region, and up to 3% of households are pushed into poverty as a result of health spending. High OOP expenditures and limited financial protection are due to several factors: only about 61 percent of the population is covered by social health insurance; low quality of primary and secondary care leads many patients to seek care in tertiary hospitals or private sector; drug prices are high; drug shortages in public facilities often necessitate patients to purchase from private pharmacies; and unofficial payments remain common (10 percent of total OOP expenditures), particularly in public hospitals.

Government faces challenges to enhance revenue mobilization and the pooling of health care resources, expand insurance coverage, and reduce reliance on payroll taxes, in a difficult fiscal environment. The Health Insurance Institute (HII) initially financed primary care and certain pharmaceutical expenditures, but took on responsibility for hospital financing in 2010. A payroll tax of 3.4 percent, divided equally between employer and employee contributions, generates 21 percent of its revenue, with the rest financed by a budget transfer from MoH. Because of the negative impact of payroll taxes on labor and capital formation, the new government has proposed to increase the share of general revenues, with a longer term goal to shift toward general revenue financing. This will require creating fiscal space through general revenue mobilization and increased efficiency of expenditures. Reductions in payroll taxes would need to be sequenced with efforts to expand insurance coverage for the poor and informal sector.

Public spending in the health sector suffers from inefficiencies and inequities. First, public spending is dominated by hospital expenditures, amounting to over 57 per cent of all expenditures (much higher than OECD average of below 40 percent), with a disproportionate budget share going

towards specialized tertiary services. This reinforces the pattern of patients bypassing first and second level facilities to seek care at high-cost tertiary hospital. Second, although HII has been building its capacity for contracting and performance monitoring -- and introduced performance payments for primary care doctors -- hospital financing remain s mostly input based. A shift towards output-based approaches would help improve system-wide performance for quality and efficiency, particularly if accompanied by increased capacity by HII for active purchasing, and increased facility autonomy and accountability. Third, while the total number of hospital beds (1.1 per thousand population) is comparable to middle-income countries and below the EU average, bed occupancy rates at municipal and regional hospitals are low (40 percent in regional hospitals, and 30 percent in district hospitals), as are other hospital efficiency indicators. Fourth, inappropriate drug lists, inefficient purchasing, and reimbursement policies result in the public sector and patients spending too much on pharmaceuticals and medical supplies. Fifth, a combination of the above factors has contributed to a chronic problem of hospital payment arrears, which amounted to 4.5 billion lek in 2013 ($US 45 million), three-quarters of which were attributable to the Mother Theresa national referral hospital (Qendra Spitalore Universitare (QSUT)).

Hospital reforms are required to better plan and adapt service capacity to needs, strengthen management and governance, and improve efficiency and quality of care. Albania faces multiple constraints for improved hospital services. First, although hospitals receive a high proportion of total funding, rigid budget rules and limited discretion over human resources limit hospitals' productive use of assets and hamper effective service provision. Second, despite some good hospital managers, most hospital management teams have limited experience and capacity for performance-based management and planning. Third, existing inputs are used inefficiently, including poor maintenance of medical equipment, inappropriate staff allocations, and drug stockouts -- with a large percentage of drugs in the hospitals lost due to expiration, mishandling and pilferage. Fourth, the current hospital network needs to be rationalized. The 2010 Hospital Master Plan recommended that district hospitals should be reconfigured as Diagnostic Units/Health Centers, with a 10 bed day care facility attached. The 11 regional hospitals need to be rationalized and upgraded in accordance to their patient load and new role in referral system. Fifth, hospital workflows are hampered by inappropriate functional designs of old and outdated buildings, inappropriate equipment, poor sanitary facilities and unsafe patient, staff and technical service areas. Finally, the lack of a functioning referral system contributes to patients bypassing lower-level providers and seeking care directly in the specialized public facilities or the private sector.

The quality and outcome of clinical service provision in Albania is poor. The quality of medical care is highly variable across different providers, and contributes to sub-optimal health outcomes. Only about half of Albanian doctors gave correct diagnosis and treatment in response to hypothetical patient vignettes for common conditions. At the same time, patient management in hospital facilities is not structured, lacks clinical protocols, documentation and the monitoring of treatment outcomes. Clinical guidelines for five common conditions were developed under the Health Sector Modernization Project, but the application of these guidelines in not currently monitored. Staffing patterns and education for clinical, nursing and support staff need to be adapted to international standards.

Continued and accelerated use of information technology is needed to improve efficiency and quality. Current IT systems do not allow MOH, HII, or facility managers and physicians to regular monitor the quality and efficiency of care. For the most part, regional hospitals are without modern, complete, hospital information systems. Such systems are essential to improve patient

management, referrals, “track and trace” of pharmaceuticals within hospitals, put in place strengthened systems for provider payments and quality management, and to eventually strengthen the links between payments and quality.

II. Proposed Development Objectives

The proposed PDO is to contribute to: improving the efficiency of care in selected hospitals in Albania, improving the management of information in the health system, and increasing financial access to health services.

III. Project Description

Component Name

Improving Hospital Services

Comments (optional)

This component will aim at improving efficiency and quality of hospital services delivery in Albania. The component will finance technical assistance, training, study tours, civil works, goods and equipment to support the design and implementation of a sustainable hospital network with the appropriate infrastructure and human capital to deliver needs-based hospital services. Implementation will build on the results and concepts developed under the previous Bank-supported project (HSMP). Implementation will be phased to ensure the establishment of an appropriate legal and regulatory framework, management capacity and institution building, and to minimize disruptions in service delivery and access to services.

Component Name

Expanding Health Management Information System

Comments (optional)

A number of complementary and interrelated subcomponents will move HMIS forward on a number of critical fronts. The component will address the need for improved provider-based systems, focusing on the country’s regional hospital sector which significantly impacts the orchestration of services across the spectrum of care. It will place emphasis on strengthening referrals to/from both the primary care and tertiary care levels (QSUT). It will also addresses the need to provide the hospitals with a means of adopting the new provider payment methods. In addition, it will address the need for improved automation in the country’s health insurance payer, the HIF, where an improved health insurance information system will be placed.

Component Name

Supporting Health Financing Reforms

Comments (optional)

This component will address improvement of allocative efficiency and will support the shift towards output-based and performance-based financing for hospitals and primary care services. It will enable the expansion of health insurance coverage particularly for the poor, and the pooling of health care resources. It will improve the policies of pharmaceuticals which in turn will reduce high out-of-pocket expenditures on drugs and improve quality and efficiency.

Component Name

Monitoring and Evaluation, and Project Management

Comments (optional)

This component will support routine Project management, including fiduciary tasks, Monitoring and Evaluation (M&E), and audits of Project financial statements. It will finance Project operating costs

including translation, interpretation, equipment, supervision costs (transportation and per diem), staffing costs of the Project Coordination Unit (PCU), M&E, studies and surveys, and incremental costs for the PCU in the Ministry of Health. Monitoring the implementation of the reforms, including potential unintended consequences, will be supported under this component. Study tours are possible to countries where similar reforms are at an advanced stage of implementation and where significant results have been achieved.

IV. Financing *(in USD Million)*

Total Project Cost:	45.00	Total Bank Financing:	40.00
Financing Gap:	0.00		

For Loans/Credits/Others	**Amount**
Borrower	5.00
International Bank for Reconstruction and Development	40.00
Total	45.00

V. Implementation

The MoH will have overarching responsibility for the health sector and related policy oversight. The MoH will have fiduciary responsibility for the Project through a Project Coordination Unit (PCU) to be established within the MoH. The Deputy Minister of Health will be responsible for the overall Project oversight and coordination within the MoH and across key institutions, as has been the case in most other projects. Technical working groups may be established for each of the three main components to provide technical advice and coordination during implementation. Priority will be given to shifting technical responsibilities to staff in line departments of the MoH and other health system institutions. The Project will require clear implementation oversight, regular consultation with key stakeholders as well as decision making mechanisms to prevent and address bottlenecks. The Deputy Minister will also be responsible for taking decisions on strategic issues that may arise during implementation, in consultation with the Minister of Health.

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	**Yes**	**No**
Environmental Assessment OP/BP 4.01	x	
Natural Habitats OP/BP 4.04		x
Forests OP/BP 4.36		x
Pest Management OP 4.09		x
Physical Cultural Resources OP/BP 4.11		x
Indigenous Peoples OP/BP 4.10		x
Involuntary Resettlement OP/BP 4.12		x
Safety of Dams OP/BP 4.37		x
Projects on International Waterways OP/BP 7.50		x
Projects in Disputed Areas OP/BP 7.60		x

Comments (optional)

VII. Contact point

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