Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No: PAD1058

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF EURO 32.1 MILLION
(US$ 40.0 MILLION EQUIVALENT)

TO THE

REPUBLIC OF ALBANIA

FOR A

HEALTH SYSTEM IMPROVEMENT PROJECT

January 20, 2015

Human Development Sector Unit
Southeast Europe Department
Europe and Central Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective December, 2014)

Currency Unit	=	Albanian (Lek)
US$1	=	112.63 Lek
US$ 1	=	0.80163534 Euro

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

ADT	Admissions Discharges and Transfers
AHSIP	Albania Health System Improvement Project
AHSIP	Albania Health System Improvement Project
ALOS	Average Length of Stay
BoDs	Board of Directors
CEB	Council of Europe Development Bank
CPS	Country Partnership Strategy
DA	Designated Account
DALY	Disability Adjusted Life Years
DFB	Department of Finance and Budgeting
DHS	Demographic and Health Survey
DRG	Diagnosis-Related Groups
EA	Environmental Assessment
EC	European Commission
ECA	Europe and Central Asia
EMPs	Environmental Management Plans
EU	European Union
FM	Financial Management
FMIS	Financial Management Information System
FMM	Financial Management Manual
GDP	Gross Domestic Product
GFIS	Government Financial Information System
GoA	Government of Albania
GSP	Global Service Provider
HDD	Health Data Dictionary
HDM	Health Data Model
HIF	Health Insurance Fund
HMIS	Health Management Information System
HMT	Health Management Teams
HSMP	Health System Modernization Project
IBRD	International Bank for Reconstruction and Development
ICB	International Competitive Bidding
ICD	International Statistical Classification of Diseases and Related Health Problems
ICR	Implementation Completion and Results Report
IDA	International Development Association
IEG	Independent Evaluation Group

IFR	Interim Financial Report
IMF	International Monetary Fund
INNs	International Nonproprietary Names
IPF	Investment Project Financing
IPH	Institute of Public Health
IRR	Investment Rate of Return
LSMS	Living Standard and Measurement Study
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Management Information System
MoF	Ministry of Finance
MoH	Ministry of Health
NCB	National Competitive Bidding
NCD	Non-Communicable Diseases
NEHR	National Electronic Health Record
NHIC	National Health Information Center
NHIS	National Health Information System
NIPH	National Institute of Public Health
NPV	Net Present Value
NSSED	National Strategy for Social and Economic Development
OOP	Out of Pocket Payments
OP	Operational Policy
PCU	Project Coordination Unit
PDO	Project Development Objectives
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PforR	Programs for Results
PHC	Primary Health Care
PHE	Public Health Expenditure
POM	Project Operational Manual
QSUT	Mother Theresa National Referral Hospital *(Qendra Spitalore Universitare)*
RHIS	Regional Hospital Information System
SAMP	Social Assistance Modernization Project
SCD	Systematic Country Diagnostic
SDC	Swiss Development Cooperation
SOEs	Statement of Expenditures
TVM	Time Value of Money
UHC	Universal Health Coverage
UNDB	United Nations Development Business
USAID	United States Agency for International Development
WHO	World Health Organization

Regional Vice President:	Laura Tuck
Country Director:	Ellen A. Goldstein
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Daniel Dulitzky
Task Team Leader:	Lorena Kostallari

ALBANIA
Health System Improvement Project

TABLE OF CONTENTS

Page

List of tables

PAD DATA SHEET

Albania

Albania Health System Improvement (P144688)

PROJECT APPRAISAL DOCUMENT

EUROPE AND CENTRAL ASIA

0000009074

Report No.: PAD1058

Basic Information		
Project ID P144688	EA Category B - Partial Assessment	Team Leader Lorena Kostallari
Lending Instrument Investment Project Financing	Fragile and/or Capacity Constraints [ ] Financial Intermediaries [ ] Series of Projects [ ]	
Project Implementation Start Date 28-Feb-2015	Project Implementation End Date 30-Oct-2020	
Expected Effectiveness Date 30-Jul-2015	Expected Closing Date 28-Feb-2021	
Joint IFC No		

Practice Manager/Manager	Senior Global Practice Director	Country Director	Regional Vice President
Daniel Dulitzky	Timothy Grant Evans	Ellen A. Goldstein	Laura Tuck

Borrower: Republic of Albania			
Responsible Agency: Ministry of Health			
Contact:	Milva Ekonomi	Title:	Deputy Minister
Telephone No.:	+355-362-937	Email:	mekonomi@moh.gov.al

Project Financing Data(in EURO Million)					
[X]	Loan	[ ]	IDA Grant	[ ]	Guarantee
[ ]	Credit	[ ]	Grant	[ ]	Other

Total Project Cost:	36.10	Total Bank Financing:	32.10
Financing Gap:	0.00		

Financing Source	Amount
Borrower	4.00
International Bank for Reconstruction and Development	32.10
Total	36.10

Expected Disbursements (in EURO Million)

Fiscal Year	2016	2017	2018	2019	2020	2021				
Annual	1.00	3.50	8.75	8.75	8.00	2.10				
Cumulative	1.00	4.50	13.25	22.00	30.00	32.10				

Institutional Data

Practice Area / Cross Cutting Solution Area

Health, Nutrition & Population

Cross Cutting Areas

[ ] Climate Change
[ ] Fragile, Conflict & Violence
[X] Gender
[ ] Jobs
[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	100		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	100
Total		100

Proposed Development Objective(s)
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.

Components

Component Name	**Cost (EURO Millions)**
Improving Hospital Services	15.10
Expanding Health Management Information System	13.60
Improving the Health Financing System	2.40
Monitoring and Evaluation, and Project Management	0.92

Compliance

Policy

Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [ ]	No [X]

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**

Legal Covenants			
Name	**Recurrent**	**Due Date**	**Frequency**
National Health Information Center		30-Jul-2016	

Description of Covenant

The Borrower shall establish the National Health Information Center no later than 12 months after effectiveness.

Name	Recurrent	Due Date	Frequency
Retroactive Financing			

Description of Covenant

No withdrawal shall be made for payments made prior to the date of the Loan Agreement except that withdrawals up to an aggregate amount not to exceed a hundred thousand Euros (€100,000) may be made for payments made prior to this date but on or after January 1, 2015 for Eligible Expenditures.

Conditions		
Source Of Fund	**Name**	**Type**
IBRD	Project Coordination Unit (PCU)	Effectiveness

Description of Condition

The Borrower has established a Project Coordination Unit and recruited staff with qualifications and experience under terms of reference and with resources satisfactory to the Bank.

Source Of Fund	Name	Type
IBRD	Project Operational Manual (POM)	Effectiveness

Description of Condition

The Borrower has prepared and adopted, in form and substance satisfactory to the Bank, a Project Operational Manual.

Team Composition

Bank Staff

Name	Title	Specialization	Unit
Johanne Angers	Senior Operations Officer	Institutional Arrangements	GHNDR
Bekim Imeri	Senior Social Development Specialist	Safeguards	GSURR
Jose C. Janeiro	Senior Finance Officer	Senior Finance Officer	CTRLA
Timothy A. Johnston	Program Leader	Program Leader	ECCU4
Lorena Kostallari	Senior Operations Officer	Task Team Leader	GHNDR
Esma Kreso	Senior Environmental Specialist	Safeguards	GENDR
Jonida Myftiu	Financial Management Specialist	Financial Management	GGODR
Benedicta T. Oliveros	Procurement Analyst	Procurement	GGODR
Marvin Ploetz	Junior Professional Associate	Junior Professional Associate	GHNDR

Nightingale Rukuba-Ngaiza	Senior Counsel	Senior Counsel	LEGLE

Non Bank Staff

Name	Title	City
Paolo Giribona	Medical Equipment Consultant	Triestre
Jack Langenbrunner	Consultant	Jakarta
Dennis Streveler	ICT/HMIS/Business Systems	Honolulu

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments

I. STRATEGIC CONTEXT

A. Country Context

1. **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.

2. **The global financial crisis severely affected Albania, with remittances and other inflows sharply declining**. Gross Domestic Product (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. The Living Standard and Measurement Study (LSMS) 2012 data indicate that poverty rates increased to 14.3 percent. Labor Force Survey data on employment show that 27 percent of Albanian households have at least one member who lost a job, as compared with a Europe and Central Asia (ECA) average of 18 percent.

3. **The new Government that took office in the fall of 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 electoral mandate augurs well for political stability in the period ahead, as the authorities are keen on launching upfront policy and structural reforms.

B. Sectoral and Institutional Context

4. **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 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 FYR Macedonia, and 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 higher than comparable statistics for other countries in South-Eastern Europe, with steady improvements during the 1990s appearing to slow down more recently. Rates of ante and post natal care are high, and maternal mortality is only slightly higher than the ECA regional average (21 versus 18 per 100,000 live births) (World Bank Gender Statistics, 2013). Non communicable and chronic diseases (NCDs) constitute the majority of the burden of disease, but the 2008 DHS found that most hypertensive adults were not aware of their condition.

5. **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 payments (OOP) are among the highest in the region, accounting for 55 percent of total expenditures on health. These are spent on 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. In 2012, health spending represented 10 percent of total spending for the poorest quintile of households (an increase from 7 percent in 2007) and up to 6 percent 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 (and half of the poorest quintile) 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, as are copayments for drugs by the insured; drug shortages in public facilities often result in patients having to purchase from private pharmacies; and unofficial payments remain common (10 percent of total OOP), particularly in public hospitals. More Albanians report making informal payments for health services than for any other sector. According to the 2011-2015 National Strategy on Gender Equality and Reduction of Gender Based Violence and Domestic Violence, 87 percent of women and 80 percent of men ages 15-49 report having had at least one problem with access to health care, and a smaller share of women than men are covered by health insurance. Improvements to the overall health system from this project are expected to benefit both men and women, with the possibility of shrinking the slight gaps that do exist.

6. **The Government faces a number of challenges in a difficult fiscal environment**. **These include, enhancing revenue mobilization, pooling health care resources, expanding insurance coverage, and reducing reliance on payroll taxes.** The Health Insurance Institute (HII) initially financed primary care and certain pharmaceutical expenditures only, but took on the 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 increasing the share of general revenues, with a longer term goal of shifting toward general revenue financing. This will require creating fiscal space through general revenue mobilization and increased efficiency of expenditures. Reductions in payroll taxes will need to be sequenced with efforts to expand insurance coverage for the poor and informal sector.

7. **Public spending in the health sector suffers from inefficiencies and inequities.** A recent Public Finance Review identified several sources of inefficiencies. First, public spending is dominated by hospital expenditures, amounting to over 57 percent of all expenditures (much higher than the 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 hospitals. Second, although HIF has been building its capacity for contracting and performance monitoring -- and introduced 20 percent performance payments for primary care -- both hospital and primary care financing are mostly

based on historic line-item budgets. A shift towards output-based approaches would help improve system-wide performance for quality and efficiency, particularly if accompanied by increased HIF capacity for strategic purchasing, and increased facility autonomy and accountability. Third, while the total number of hospital beds (3.07 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 equivalent), three-quarters of which were attributable to the Mother Theresa national referral hospital (*Qendra Spitalore Universitare* (QSUT)).

8. **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 barriers to 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. 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 to them. The 11 regional hospitals need to be rationalized and upgraded in accordance with their patient load and their new role in the referral system. Fifth, although some regional hospitals have been upgraded in the past decade, 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.

9. **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. According to recent analysis of quality of clinical care, only about half of Albanian doctors gave the 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 and referral guidelines, documentation and the monitoring of treatment outcomes. Clinical guidelines for five common conditions were developed under the Health Sector Modernization Project (Credit 4154-AL, closed on June 30, 2012), but the application of these guidelines is not currently monitored. Staffing patterns and education for clinical, nursing and support staff needs to be adapted to international standards.

10. **Continued and accelerated use of information technology (IT) is needed to improve efficiency and quality.** Current IT systems do not allow MoH, Health Insurance fund (HIF), or facility managers and physicians to regularly 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. In addition, foundational activities for the development of the Health Management Information System (HMIS), such as the Health Data Dictionary, Health Data Model, are currently missing and need to be established. The existing health insurance information system needs to be improved and adapted to the on-going reforms of the HIF.

11. **Despite previous external support, there is still a large unfinished agenda of health sector reform.** From 1995 to 2013, the Government of Albania (GoA), the World Bank, USAID, Swiss Development Cooperation, Italian Cooperation and Austrian Government financed a series of programs in support of health sector reform. The latest World Bank supported "Health System Modernization Project" (HSMP) aimed to (i) improve physical and financial access to high quality primary health care (PHC); (ii) improve client's capacity to formulate and implement health policies and reform; and (iii) improve hospital governance and management. The IEG Project Performance Assessment Report assessed the outcome of the Project as "Moderately Unsatisfactory". Despite progress in a number of areas as a result of HSMP support, improvements to PHC service quality (especially related to unnecessary use of hospitals), hospital management and governance and health financing reform at the hospital level, were considered modest while out of pocket expenditures for the poor increased. However, the HSMP support provided a number of building blocks, including: the Hospital Master Plan, successful design and implementation of performance contracts with PHC facilities, and strengthening MoH and HIF capacity to formulate financing policy. These have served as the basis for the design of the proposed Project. In addition, Project design was informed by recent analytic work on the health sector, including the 2014 Public Finance Review, and secondary analysis of the 2012 Albania Living Standards Measurement Survey.

C. Higher Level Objectives to which the Project Contributes

12. **The 2010 Country Program Strategy (CPS) includes health sector reform as one of the key priorities under the second pillar, "Broadening and Sustaining Social Gains."** As highlighted in the CPS, the government has initiated reforms to improve health care service delivery and financing. However, serious problems remain with respect to: (i) regional imbalances and unequal access; (ii) payment systems that are unsuited to promoting cost containment or efficient resource use; and (iii) weak sector management capabilities. The proposed Project would directly address these issues and fully support the 2010 CPS as well as the 2012 CPS progress report, which included this project in the proposed lending operations. The World Bank is finalizing a Systematic Country Diagnostic (SCD) for Albania, which will serve as the basis for the next Country Partnership Framework between the World Bank and the Government of Albania. The Project design is informed by the SCD findings and priorities.

13. **The project is also directly aligned with the Government's health sector reform strategy and will support the implementation of the Government's reform agenda.** Health is a key priority in the current National Strategy for Social and Economic Development (NSSED). The NSSED emphasizes policy interventions to improve health care services,

improve public accountability, provide a sound basis for long-term growth, and continue structural reforms aimed at improving health service delivery. The new Government is updating the NSSED, but has demonstrated strong commitment to undertaking reforms in several key areas, including improving health financing systems and hospital services, pharmaceutical reforms, and moving toward universal coverage through expanding social health insurance.

14. **The Project also addresses the Bank's Twin Goals** by increasing financial access to health care services, especially for poor and vulnerable population, and improving the efficiency of health spending and services.

II. PROJECT DEVELOPMENT OBJECTIVES (PDO)

A. PDO

15. 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.

B. Project Beneficiaries

16. **The main beneficiaries include the overall population of Albania which will benefit from:** (i) improvements in the efficiency of hospital care services, and (ii) improved financial protection from health expenditures, resulting from more effective health insurance coverage and reduced drug prices. It is anticipated that specific population groups, including those with priority chronic diseases, will benefit from improved primary care and reduced copayments for essential, low-cost medicines. This will reduce OOP expenditures and improve treatment compliance. Moreover, health sector stakeholders will benefit from capacity building (training and technical advice), as well as other Project support. An estimated 700 staff in state government institutions, including the QSUT and regional hospitals will benefit from training and capacity building activities.

17. **Gender.** The Albania Health System Improvement Project is gender-sensitive and addresses certain gender-related aspects of health care. The Project will address specific aspects like maternal and reproductive health services, mainly at the hospital level. Performance incentives to improve hospital care service delivery will motivate improvements in quality of Maternal and Child Health (MCH) services. Project's support for health management information will improve gender disaggregated monitoring of services. Performance indicators (including percentage of poor covered by health insurance, health experts trained, etc.) will be disaggregated to the extent possible, in order to track gender inequalities.

C. PDO Level Results Indicators

18. The proposed PDO indicators are as follows:

- Total number of acute care beds in selected district hospitals rationalized according to the Hospital Master Plan;

- Percentage of inpatients in the selected regional hospitals, whose admission and discharge are both performed electronically;
- Reduction in average prices for: (a) 10 most common prescription medicines; and (b) 10 most expensive hospital medicines;
- Percentage of poor covered by health insurance.

III. PROJECT DESCRIPTION

A. Project Components

19. To improve access and efficiency of health care services in Albania, the Project will support:

a) reforming the hospital sector by creating a sound legal framework and management structure for efficient service provision, strengthening performance management and planning, overcoming operational constraints in service delivery, supporting rationalization of the hospital network, and strengthening the referral system;

b) improving monitoring and management of service quality and efficiency through the establishment of a health management information system and of a medical equipment management and maintenance system; and

c) reforming the health financing and provider payment systems, improving capacity of the HIF for strategic purchasing, strengthening systems for efficient purchasing/distribution of pharmaceuticals and medical supplies, and assessing options to expand insurance coverage within the available fiscal space.

20. The Swiss Development Cooperation (SDC) is currently developing a project to support strengthening the quality of PHC, which will complement the focus of this proposed Project on hospitals, cross-cutting systems, and health financing. The Project will also be coordinated with and will complement the support from Austrian Cooperation on electronic medical records; Italian Cooperation on hospital payment systems; and Council of Europe Development Bank (CEB) on upgrading of QSUT. In addition, the Project will be closely coordinated with the current IFC support related to improving laboratory tests quality and reliability, as well as laboratory service delivery to the population, through a Public Private Partnership (PPP) arrangement.

21. The proposed Project will include the following components:

Component 1: Improving Hospital Services (Euro 15.10 million; US$ 18.80 million equivalent)

22. **This component aims to improve efficiency and quality of hospital services delivery in Albania**. The component will finance technical assistance, training, study tours, civil works, and goods to support the design and implementation of a sustainable hospital network with the appropriate infrastructure and human capital to deliver needs-based hospital services, and to

strengthen autonomy and accountability for hospitals and managers. Implementation will build on the results and concepts developed under the previous Bank-supported project (HSMP).

Sub-component 1.1: Strengthening the Albanian Network of Hospital Services (Euro 2.72 million; US$ 3.4 million equivalent)

23. **This sub-component will address inefficiencies in hospital services, including management weaknesses and overuse of services at tertiary level; underutilization of district and regional hospitals; poor coordination of care across outpatient and inpatient services; as well as the need for access to functioning outpatient services.** It will also address the efficiency and quality of hospital services under the current system, including the lack of a functioning referral system (which encourages patients to generally bypass lower-level providers and to seek care directly in the specialized public facilities) and poor patient management in hospital facilities. It will strengthen outpatient services, and improve needs-based planning of hospital infrastructure and human resources. Finally it will establish results-based management systems for essential hospital services, patient management, clinical services, outcomes, and accountability.

24. **The sub-component will finance technical assistance, capacity building and equipment for the following sets of activities:** (i) updating the existing Hospital Master Plan; (ii) piloting implementation of the revised Master Plan in at least three pilot regions (including the transformation of district hospitals into primary care/diagnostic facilities); (iii) assessment and improvement of the current management of the QSUT; (iv) elaboration of an appropriate legal and regulatory framework for hospital services, to provide increased autonomy and accountability; (v) training and capacity building for hospital management teams, MoH, HIF, and other supervising agencies on service planning, resource allocation, performance management, and implementation monitoring and contracting; (vi) development of benchmarks and indicators for profiling comparative hospital performance (MIS/quality monitoring system), establishing baseline data and systems for monitoring; (vii) updating, implementing, and monitoring of clinical guidelines, clinical pathways, and standards for referrals from primary to outpatient secondary services to inpatient and tertiary services; (viii) developing National Health Accounts to support the budget analytical work in the health sector; and (ix) piloting patient-based social accountability mechanisms to enhance patient feedback and reduce informal payments – such as establishment of hot lines and cell-phone based feedback mechanisms, study on informal payment, publishing ranking of hospitals based on performance, etc.

Sub-component 1.2: Improving hospital infrastructure and the management of medical equipment (Euro 12.38 million; US$ 15.40 million equivalent)

25. **This sub-component will finance the physical rehabilitation and upgrading of hospital infrastructure and medical equipment, based on the updated Hospital Master Plan.** The Plan does not currently envisage closing any facilities (or adding new ones), but most likely hospital beds would be reduced or reallocated in accordance with service requirements, and appropriate mechanisms established to reallocate staff. There will be upgrading of infrastructure and equipment in three regions, based on a strategic plan prepared by the hospital management and regional authorities, and aligned with the overall Hospital Master Plan. The

Pediatric hospital in Tirana (within the QSUT) will also be upgraded. This will be implemented in conjunction with management and payment reforms to improve efficiency. Moreover, based on the priorities identified in the updated Hospital Master Plan and hospital strategic plans, this sub-component may also finance medical equipment for other regional hospitals to ensure that their activities can be performed in a satisfactory manner.

26. **This sub-component will also finance a number of activities related to management of medical equipment.** These include: (i) the development of a medical equipment maintenance strategy; and (ii) the establishment of a National Center with the mandate to manage all medical equipment in the public sector in Albania.[1] Considering the specific situation and the limited budget, the adoption of a mixed model is envisaged as the most cost-effective approach to the maintenance problem. According to this model, the first-level maintenance would be performed by in-house technicians, while for medium and high complexity maintenance the MoH would contract a global service provider (GSP). Funding under this sub-component will include technical assistance, training, and physical assets.

Component 2: Expanding the Health Management Information System (Euro 13.60 million; US$ 16.95 million equivalent)

27. **A number of complementary and interrelated subcomponents will move HMIS forward on a number of critical fronts.** The component addresses 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 places emphasis on strengthening referrals to/from both the primary care and tertiary care levels (QSUT). It also addresses the need to provide the hospitals with a means of adopting the new provider payment methods, which are being organized under sub-component 3.1. In addition, it addresses the need for improved automation in the country's health insurance payer, the HIF, where an improved health insurance information system will be placed. Finally, it provides the foundational activities to support these developments, and an institutional home to support and sustain them in the long run.

Sub-component 2.1: HMIS/eHealth Foundational Activities and Establishing the National Health Information Center (NHIC) (Euro 2.68 million; US$ 3.35 million equivalent)

28. **HMIS systems are increasingly interdependent and interoperable.** Thus it is important to stress overall coordination in the design and implementation of these systems, as well as to create, at a technical level, the means for these "new generation" systems to "talk to one another" through internet technologies. To accomplish this goal of closer integration of systems, this sub-component includes the following sets of activities:

- ***Creating the Master Plan for HMIS/eHealth activities (2015-2019) and the first version of the Albania Health Data Dictionary (HDD) and Health Data Model (HDM).*** The sub-component will finance technical assistance for supporting the MoH in developing the HMIS Master Plan. The Master Plan will provide the overall framework to develop, improve coordination between development partners, and provide the "big

[1] It is proposed to house this center under the National Health Information Center, as indicated under the HMIS component.

picture" view of where the country plans to focus its investments. It will also support the creation of the first HDD and HDM in the country, through financing technical assistance and training for the MoH staff.

- ***Creating the first version of the Essential Registries for Albania's HMIS*.** The sub-component will finance technical assistance to support the MoH in establishing the essential registries, which are a set of important documents, shared between different applications. The registries will include health facilities, health workers and biomedical equipment and the interrelation between them.

  The NHIC is the focal point for eHealth/HMIS activities in Albania – enhancing sustainability of the initiatives and providing modern user support tools.

- **This sub-component will also finance capacity building, small rehabilitation works, goods and IT equipment to support:** (i) expanding, updating and enforcing the Health Data Dictionary (HDD) and the Health Data Model; (ii) upgrading the building of the NHIC; (iii) consolidating the current small data centers (including those for MoH, the HIF, and the IPH), into one Health Data Center; (iv) creating a Training Center with a capacity of 50 persons, with appropriate equipment to support in-person training, synchronous online training as well as the creation of materials for asynchronous training; (v) providing user support and systems maintenance by establishing a Help Desk within the NHIC; and (vi) supporting Biomedical Engineering and Maintenance.

Sub-component 2.2: Implementing Regional Hospital Information Systems (Euro 9.30 million; US$ 11.60 million equivalent)

29. **This sub-component will finance capacity building and goods, training and IT equipment, to support the establishment of a modern Hospital Information System in selected regional hospitals (RHIS).** While the country begins the process of rationalizing and repurposing its hospitals, it is the right moment to also install modern hospital information systems in selected hospitals. The Project will support selected hospitals to introduce automated systems. This will include the following steps: (i) "*management" functions* first, including Admissions Discharges and Transfers (ADT), outpatient registration, bed management, medical records locator and an interface with HIF for claims/encounters reporting; (ii) clinical functions, including clinical laboratory order and resulting functions, radiology order and resulting functions, and pharmacy prescribing functions; and (iii) the creation of a clinical summary for each patient, focusing particularly on tracking targeted chronic disease(s). This will later lead to the establishment of a true electronic medical record (beyond the scope of the project). The electronic medical record would be established with collaboration from and coordination with the Austrian Cooperation support, which focuses on creating a National Electronic Health Record (NEHR)**.**

30. **The NHIS interfaces will be particularly important and prominent.** This includes the various interfaces from the NHIS to the HIIS at HIF, the referral link to/from Primary Care, the referral link to tertiary care. Such linkages are important for promoting better continuity-of-care.

Particular importance will be given to creating the mechanism to monitor "inappropriate" admissions and referrals.

Sub-component 2.3 Implementing a new Health Insurance Information System (HIIS) for the Health Insurance Fund (HIF) (Euro 1.62 million; US$ 2.0 million equivalent)

31. **This sub-component will finance IT systems and capacity building for HIF staff, ensuring that HIF is prepared to deal with aspects of financial management, as well as to automate the health insurance claim processing based on the chosen Provider Payment methods.** Moreover, a new protection system featuring fraud and abuse detection will need to be introduced, as the HIF oversees ever larger segments of the healthcare delivery system in the country.

Component 3: Improving the Health Financing System (Euro 2.40 million equivalent; US$ 3.0 million equivalent)

32. **This component will address improvement of technical and 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 for pharmaceuticals, which in turn will reduce high out-of-pocket expenditures on drugs and improve quality and efficiency.

Sub-component 3.1: Payment Reform (Euro 1.70 million; US$ 2.10 million equivalent)

33. **The sub-component will finance technical assistance, capacity building, and workshops, to support the reform of the payment system in primary and hospital care.**

34. ***Payment Reform in PHC.*** The Project will support the HIF to move towards risk-adjusted primary care capitation payments (from the existing historic budgets with caps), in which "money follows the patient" and incentives are strengthened to provide key services, particularly for the poor; improve service quality; and reduce unnecessary referrals. The total amount of funds allocated to any single primary care provider or facility will be based on the average per capita amount (or base rate) and number of enrolees, adjusted for population risk profile and performance indicators. The Project will support monitoring and evaluation of payment reforms, and further strengthen the "pay-for-performance" approach introduced under the previous project, including priority services such as immunization and the management of NCDs such as hypertension, diabetes, etc. SDC will finance complementary support to improve the quality of primary care.

35. ***Payment Reform for hospital-delivered health care.*** The Project will fund the development and introduction of global budgets and a case-based payment system for hospitals, including incentives to improve quality of care. To do this, the early years of the Project will follow a phased approach, including support for information infrastructure, diagnostic and procedure coding systems; hospital costing and cost accounting systems; the introduction of global hospital budgets; development and testing of the case based software grouper, followed by

piloting and phased implementation of budgets based on diagnosis-related groups (DRGs). The Italian Cooperation will provide complementary support on hospital payment reforms.

Sub-component 3.2: Support to the HIF for strategic purchasing, improved coverage and pharmaceutical reform (Euro 0.70 million; US$ 0.90 million equivalent)

36. **The sub-component will finance technical assistance, training and workshops to support organizational development of the HIF.** This will enable it to be a more strategic purchaser of services over the next few years, and to assess costs and options to expand insurance coverage. The Project will support: (i) capacity development in the areas of management, organization, actuarial forecasting, financial and risk management, information technology, provider payment systems, and quality assurance; and (ii) technical assistance to develop expenditure and revenue model projections under various scenarios relating to expanding insurance coverage to the poor and informal sector, and options for shifting to tax-based financing in the future. Support for HMIS under sub-component 2.4 will complement the activities of this component. This will include equipment, training and technical support to allow the HIF to mature into a strategic purchaser.

37. **In addition, the sub-component will finance technical assistance, training and workshops, to support the Government in designing and piloting innovative pharmaceutical policies.** This will include the following main activities: (i) revising the existing drug list based on clinical and cost-effectiveness criteria, and strengthening capacity and transparency in decision making around reimbursement of new drugs. This will include training on processing drug applications and capacity building in reviewing Health Technology Assessments; (ii) further reducing prices for multi-source drugs through strengthening reference pricing, competition, and revised margins to retailers and wholesalers to encourage dispensing of lower cost drugs. There will also be an initiative to reduce costs of patented original drugs through innovative financing mechanisms such as Risk Sharing agreements; (iii) improve generic promotion strategic plan, and enhanced monitoring of prescription and dispensing practices; and (iv) improving treatment compliance and reducing OOP expenditure through revision of copayments, and targeted reductions or waiving of copayments for low-cost drugs essential for the management of chronic diseases.

Component 4: Monitoring, Evaluation and Project Management (Euro 0.92 million equivalent; US$ 1.15 million equivalent)

38. **This component will support routine Project management, including fiduciary tasks and Monitoring and Evaluation (M&E).** 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 MoH. Since reforms of health service delivery run the risk of being misunderstood by various stakeholders affected by it, this component will support a strong communication strategy. It would aim at appropriately explaining the reform to health professionals and population at large. 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.

B. Project Financing

39. **The Project will be in the form of an Investment Project Financing (IPF), to be implemented over a period of five years.** The instrument is appropriate for the proposed operation because it will finance capacity building and investments, critical for implementing key sector reforms. Meanwhile, the Government will finance 37 percent of all rehabilitation works under the Project. In addition, a Retroactive Financing in the amount of Euro 100,000 was requested during negotiations by the Borrower and approved by the Bank to finance the establishment of the PCU. The establishment of the PCU and recruitment of a project manager, financial management specialist and procurement specialist is a condition of effectiveness. Recruitment of the PCU staff will be in accordance with applicable Bank procurement procedures.

40. **Program for Results (PforR) was considered as a lending instrument but was found not to be appropriate due to the much higher capacity requirements for monitoring and implementation, which currently do not exist.** The experience from the Social Assistance Modernization Project (SAMP), the first results-based operation in Albania, showed the importance of having adequate capacity for robust monitoring and evaluation as the Government needs to provide proof that results have been achieved. Thus, it is critical for the Government to have a robust monitoring system that already produces the kind of information needed for verification of results. Whilst the Project plans to establish through a robust health management information system, currently there is not an adequate monitoring system, and as such a results-based approach would not be appropriate at this stage. In addition, the establishment of an HMIS under the Project would need to be financed by Government funds for a results-based instrument. Experience from SAMP indicates that fiscal constraints could seriously impede the availability of Government funds for such an investment, which would then negatively impact the Project. There is potential for large delays in implementation and resultant risk to the achievement of project outcomes. Finally, given the capacity constraints on the ground, technical assistance is crucial in strengthening the implementation capacity and to achieve the desired results in the sector. Thus, taking into account the constraints on technical assistance under the PforR instrument, which would likely prolong the preparation of the project and may threaten the current momentum for reforms, an IPF was considered to be the most appropriate instrument for the proposed Project.

C. Project Cost and Financing

Table 1: Project Costs by Component (In EURO million)

Project Components	Project cost	IBRD Financing	% Financing
1. Improving Hospital Services	19.10	15.10	79
2. Expanding Health Information System	13.60	13.60	100
3. Improving the Health Financing	2.40	2.40	100
System	0.92	0.92	100
4. M&E, and Project Management			
Total Project Costs	**36.02**	**32.02**	89
Front-End Fees	0.08	0.08	
Total Financing Required	**36.10**	**32.10**	89

D. Lessons Learned and Reflected in the Project Design

41. Key lessons learned from the Implementation Completion and Results Report (ICR), IEG Project Performance Assessment Report of the last Bank-supported health project, and recent health sector analytic work include the following:

- **Complex reforms require strong government ownership, a well-sequenced roadmap, and regular monitoring of reform progress and outcomes.** Particular attention needs to be paid to developing implementable plans that recognize constraints and challenges, and absorptive capacity, allow for appropriate pacing, as well as establishing systems to monitoring reform implementation.
- **The capacity of the Government to absorb technical assistance and implement complex institutional changes needs to be carefully evaluated** to ensure knowledge transfer and a sustainable impact of the activities started under a project.
- **The development and integration of health information systems in the health sector is complex.** Dedicated teams that work in close collaboration with information users are essential, and should be set up as the project is being prepared. Technical assistance should be timely and integrated into such teams.
- **Close coordination with development partners is critical**.
- **Since both the PCU and the Bank have limited in-house capacity for the review of technical specifications and bid evaluation reports of medical equipment**, procurement plans should ensure adequate time for the review of bidding documents and bid evaluation reports.
- **The design and implementation of pilots to test and fine-tune reforms and the establishment of well-functioning management information system, are critical to the**

reform process, as they can accommodate learning, provide evidence and benefits of such reform and garner political support.

42. These lessons have been incorporated by: (i) focusing Project support mainly on reforming hospital services, HMIS and health financing, while strongly coordinating efforts with other development partners, such as SDC (on primary care), Austrian Cooperation (on HMIS), Italian Cooperation (on hospital financing), CEB (on QSUT infrastructure) and IFC (on hospitals' laboratories); (ii) including significant, focused technical assistance and capacity building activities; (iii) including management information system as a key pillar under project support, while ensuring the establishment of a special team to work on HMIS, strongly supported by technical assistance; (iv) designing the implementation of pilots and/or phased implementation in key areas of reform, including a Hospital Master Plan and provider payment reform in primary and hospital care; and (v) taking an integrated approach to key reforms. For example, efforts to strengthen hospital governance and performance will include strengthening hospital autonomy and both "top down" and "bottom up" accountability (e.g., revising legal framework, strengthening hospital boards, strengthening social accountability mechanisms); HMIS; hospital financing and payment systems; and a phased approach to implementing the Hospital Master Plan, including financing equipment and upgrades based on regional reform plans. To reduce OOP spending for the poor, the Project will support reforms to expand insurance coverage for the poor, reduce high costs of medicines, reduce unofficial payments in hospitals, strengthen the referral system, and increase incentives for service provision and quality through payment and financing reforms.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

43. **The Project will be implemented over a period of five years.** The MoH has overarching responsibility for the health sector and related policy oversight. The MoH will have fiduciary responsibility for the Project through its Project Coordination Unit (PCU). 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. Details of Project institutional and implementation arrangements will be set out in a Project Operational Manual (POM). The adoption by the MoH of a POM that is acceptable to the Bank will be a **condition of effectiveness**.

44. **A Project Coordination Unit (PCU) will be established within the MoH to support implementation.** The Deputy Minister of MoH will be the overall Project Coordinator. The PCU, headed by the Project Manager, will include core staff responsible for fiduciary and safeguard management, and will include a limited number of technical staff (component and

activity coordinators) who will coordinate activities planned under each of the components. The Project Manager will have a defined level of responsibility for operational issues. The PCU will monitor and evaluate the Project results framework and will include core staff responsible for technical and fiduciary management, such as a full-time Project Manager, an IT coordinator, a civil engineer, a procurement specialist and financial management specialist. The establishment of the PCU and selection of its key staff (Project Manager, and financial and procurement specialists) with qualifications and experience satisfactory to the Bank is a **condition of effectiveness**.

B. Results Monitoring and Evaluation

45. **The PDO level and intermediate outcome indicators will be monitored using routine reporting systems, clinical audits, administrative and service delivery records, and household surveys.** Project indicators have been selected on the basis of strong alignment to Project activities and the PDO, and will be at least partially attributable to the Project. M&E under the Project will be integrated into the regular monitoring functions of the MoH and relevant institutions. The Project will also strengthen systems for performance management and monitoring of higher-level impact and clinical outcome indicators by policy makers and facility managers. If systems are not in place to collect data on other key indicators of importance to the Project, or if current reporting systems are unreliable, the Project will support the establishment or strengthening of such monitoring systems. Once these systems are improved, key indicators may be added at mid-term review, and/or integrated into performance monitoring 'dashboards' or scorecards for hospitals and primary health centers. The overall responsibility for monitoring and evaluation will rest with the MoH, with HIF responsible for monitoring specific components or sub-components. Collection of household survey data will rely on national surveys, with additional technical or financing support if needed. The PCU coordinator will also be responsible for bringing together the progress reports, monitoring the key performance indicators and results in collaboration with HIF and IPH, and communicating with the Bank on progress according to the frequency of reports indicated in Annex 1.

C. Sustainability

46. **While the Project supports the overarching goal of improving the efficiency and quality of public hospital services, the complexity of reforms proposed under the Project makes it difficult to quantify all the fiscal and financial impacts.** The Project's support in strengthening the Albanian health system (and in particular, the public hospital services) will yield benefits both in the short run and the long run. A Net Present Value (NPV) analysis, for a discount factor of 6 percent and average annual GDP growth rate of 4 percent, shows more than US$16 million in net benefits over 2015-2030 period cycle (see Annex 6). This value does not, however, capture the entire benefits of the Project. The fiscal and financial sustainability of the Project will be realized primarily through efficiency gains and cost savings expected from the Project. While the implementation of the HMIS will make the health system more modern, reliable and efficient, the execution of the Hospital Master Plan for hospital rationalization will ensure a much more redistributive focus on health, help free up resources, and cut down inefficient public sector spending on health. Likewise, the Project's support for health financing reforms, including performance-based provider payment reforms, will ensure a cost effective

approach to health financing and create much-needed fiscal space. Similarly, the Project's support for the design of innovative pharmaceutical policies and for the development/implementation of the Health Insurance Information System (HIIS) is likely to bring significant cost savings. These are of paramount importance in enabling Albania to move towards universal health coverage (UHC). It is expected that all these interventions will collectively help make the referral network more effective. This will not only help the government curb its public sector spending but will also help reduce private OOP, which currently constitute approximately 55 percent of the total spending on health.

47. **The MoH is the lead implementation agency for this Project.** The Project supports capacity building activities within the MoH, HIF and other public agencies to design, implement and manage activities supported through this Project and beyond. This ensures domestically initiated health sector reforms are sustained beyond the lifetime of the proposed Project. The Project therefore anticipates no major issues with the project's institutional sustainability.

V. KEY RISKS AND MITIGATION MEASURES

48. **Overall risks to the proposed project are considered *substantial,* as summarized in Table 2 below and detailed in the Operational Risk Assessment Framework (Annex 4).** Since the risks can be only partially mitigated within the proposed Project, a substantial level of residual risk is anticipated. The key risks are summarized below under several themes, with further details provided in Annex 4.

Table 2: Summary of Risk Ratings

Risk Category	**Rating**
Stakeholder Risk	**Substantial**
Implementing Agency Risk	**Substantial**
- Capacity	Substantial
- Governance	Substantial
Project Risk	**Moderate**
- Design	Moderate
- Social and Environmental	Low
- Program and Donor	Low
- Delivery Monitoring and Sustainability	Substantial
Overall Implementation Risk	**Substantial**

49. **Stakeholder and Political Economy Risks.** Given the challenges associated with the complexity of the reforms, risks related to Government commitment and political stability may present challenges for implementation. There is a risk that a change of leadership (i.e. the reform champions in relevant institutions moving or leaving the Government) during Project implementation, may result in a possible lack of commitment and loss of momentum in the reform program implementation. Strong political leadership, consultations with interest groups to build broad based ownership, and a communications campaign would go some way towards

mitigating this risk, but cannot eliminate it. The proposed Project will support wide-reaching consultations, including with members from the political opposition to build broad-based ownership.

50. **In addition, implementation of the Hospital Master Plan could face adverse reactions from beneficiaries of local/district hospitals that are expected to go through transformation.** Similarly, the introduction of professional hospital managers and hospital boards could create tensions in an environment traditionally dominated by the medical profession, which could limit health providers' willingness to cooperate. The Government is committed to the implementation of the Hospital Master Plan and has clear plans for nationwide outreach campaigns. Moreover, the proposed Project (under Sub-component 1.1) will support the GoA in developing and implementing a communications campaign for all stakeholders as well as citizen engagement to help explain the rationale for the changes. At the hospital level, management boards are expected to include representatives from the medical profession and would help partially mitigate the tensions. The Project will support the establishment of a comprehensive health MIS. This will encourage transparent decision making processes and minimise some of the related concerns.

51. **Capacity and institutional risks.** The capacity constraints at MoH and its subordinate entities may lead to delays in implementation. In particular, weak capacity in both fiduciary aspects (Financial Management and procurement) and for monitoring of results may negatively impact Project implementation. To alleviate potential coordination issues, high level officials from MoH will be appointed as focal points to coordinate the activities under the proposed Project. In addition, the proposed Project will support the establishment of an HMIS and hiring of qualified fiduciary expertise to mitigate risks related to capacity constraints. Setting up new agencies (i.e. the National Agency for the HMIS, National Agency for medical equipment, etc.) may be a risk as it may result in lack of clarity around institutional roles. The proposed Project will support MoH in defining and communicating clear definitions of roles and responsibilities with respect to existing and new institutions.

52. **Governance**: Governance related risk is considered substantial. Experience from previous Bank's operation in the health sector talks about few investigated cases for fraud and collusion. Major identified areas of risks are drafting of technical specifications and collusion risks in the design phase of the medical IT system. This may pose a threat to the effective use of Bank's financing. The project design addresses these concerns and has ring fenced areas of risks

VI. APPRAISAL SUMMARY

A. Economic and Financial (if applicable) Analysis

53. The economic analysis estimates the development impact of the Project, and uses cost-effective and cost-benefit analysis methods to do so. Using these methods, the analysis finds that the Project will bring significant benefits by addressing the existing inefficiencies in the health system. More importantly, the Project will bring benefits through savings in terms of Disability Adjusted Life Years (DALYs). The costs and benefits of the Project interventions have been estimated over the 2015–2030 period. An average GDP growth rate scenario, which assumes a

GDP growth rate of 4 percent, results in a NPV of approximately US$16 million using a high 6 percent time value of money (TVM) for the period considered. The same analysis shows an estimated Investment Rate of Return (IRR) of 13.89 percent, and most of these benefits will occur in the first half of the fifteen year period. A complete description of the analysis is presented in Annex 6.

B. Technical

54. The technical approaches used in the project are based on relevant international experiences, key sector goals of the Albanian Government, as well as previous experiences with the health sector reforms. Technical approaches include the proposed methodology to improve allocative efficiency and shift towards output-based and performance-based financing for hospitals and primary care service (capitation reforms in primary care and DRGs for hospital care); establishing results-based management systems for essential hospital services, patient management, clinical services, outcomes, and accountability. The Project also focuses on priority areas for the sector, such as: hospital management weaknesses and overuse of services at tertiary level; underutilization of district and regional hospitals; the lack of a functioning referral system, limited health insurance coverage, particularly for the poor, as well as improvement of pharmaceuticals' policies to reduce high out-of-pocket expenditures on drugs and improve quality and efficiency.

C. Financial Management

55. A financial management assessment was carried out to determine the financial management implementation risk and to help establish adequate financial management arrangements for the proposed operation. While all agencies involved in the proposed Project will be responsible for technical implementation of Project activities, fiduciary responsibilities will remain in MoH. The most significant strength is the extensive experience the current Director of MoH Budget and Finance (executing officer) has in financial management of budget institutions and his excellent track record in supervising the previous Bank-supported Health project. However, there is low capacity among other accounting staff in the finance section, due to a lack of familiarity with Bank disbursement and FM requirements and due to limited number of staff. Areas that require further strengthening were discussed and recommendations and complementary actions were provided to ensure that the Project is implemented within a sound fiduciary environment and meets the minimum requirements under OP 10.00, namely: (i) recruitment of a qualified financial management specialist, that will be provided by the Project management budget in component 4; (ii) periodic and on-the-job training of the FM staff during implementation in Bank financial management and disbursement procedures; (iii) document the financial management procedures, including internal controls in the Financial Management Manual (FMM) that is the part of the POM; and (iv) purchase of an accounting software so that it is capable of generating Interim Un-audited Financial Reports (IFRs) and capture accounts of the proposed project. The recruitment of fiduciary staff (FMS and procurement) is part of the establishment of the PCU, which is a **condition of effectiveness**. Disbursements from the loan proceeds will flow to the Designated Account (DA) maintained in the Bank of Albania (the Central Bank) and will be based on statements of expenditures and records submitted. Other

allowed disbursement methods will include reimbursements, direct payment and special commitment. The annual audit reports for the project financial statements will be provided to the Bank on an annual basis within six months after the end of each fiscal year. The audit reports will be made publicly available as per the World Bank Policy on Access to Information. The details of the FM and Disbursement arrangements under the proposed Project are provided in Annex 3.

D. Procurement

56. The overall fiduciary risk for Albania's financial management and procurement arrangements is considered significant (Country Fiduciary Assessment Update, 2006). The Bank, together with other development partners, has been providing support to the Government in mitigating the risks through continued dialogue and provision of fiduciary workshops and training activities.

57. Key risks identified during the procurement capacity assessment include: (i) there is no existing PCU at the time of appraisal; (ii) weak capacity in the MoH, HIF, and NHIC in preparing Terms of Reference or technical specifications for some of the required consulting services and medical equipment to be procured; (iii) quality of technical designs may lead to delays in contract implementation; (iv) lack of expertise may lead to delays in completing evaluation of bids; and (v) delays in contract award due to complaints. Measures to mitigate these risks have been identified and are outlined under the relevant section in Annex 3.

E. Social (including Safeguards)

58. **The social impacts of the proposed Project are expected to be positive, and include extensive and improved access to health services, improved quality of health services delivery, gender-sensitive health services, improved public awareness of healthy lifestyles and of NCDs, etc.** Indirect benefits could also include employment, a more efficient health systems, etc.

59. **The Project will not require any land takeover or cause physical relocation.** The hospital within the University Hospital Center of Tirana (Pediatric) will be upgraded within the existing perimeter of their current premises. Expected temporary negative social impacts of the construction phase can be easily mitigated through minimizing nuisance from the excessive noise and dust, managing movement of construction vehicles and machinery, demarcating and fencing the construction sites, and excluding scattered piling of construction materials and waste outside the boundaries of construction sites.

60. **The PCU will be responsible for the oversight of any citizens complain over construction.** The POM will provide mechanisms to allow citizens to address issues during construction. Such measures include: local information campaigns on works and grievance mechanisms for local communities regarding inconveniences related to works, etc. The POM will also specify who in the PCU will be accountable to handle potential grievance. The Project will finance piloting social patient-based accountability mechanisms to enhance patient feedback. In addition, the Project will finance study on informal payment and will publish

ranking of hospitals based on performance. Gender-based analysis with be mainstreamed in the establishment of the social accountability mechanisms as well as in the study. The feedback will be analyzed based on gender. In addition, Project activities monitoring mechanism will disaggregate beneficiary-based indicators on gender. In case that analysis shows feedback that is sensitive to gender, follow up activities will be undertaken to address this.

F. Environment (including Safeguards)

61. **Project activities will include upgrading and refurbishment works in one hospital within the University Hospital Center of Tirana (Pediatric).** The existing structures will be subject to refurbishment that will allow modernization and improvement of service delivery. The scope of works triggers OP 4.01 on Environmental Assessment, due to potential noise, dust and construction waste during works. All of these impacts have been addressed through a Checklist Environmental Management Plan (EMPs) that have been prepared and disclosed in July 2014. The checklists will be re-disclosed prior to the start of works. Since these are existing structures with all existing connections and waste collection practices with the scale of works being relatively minor, there are no foreseen long-term or substantial environmental impacts that are associated with this project. The project may also include additional and relatively small-scale refurbishment works in other locations beyond the Pediatric hospital. For all such works, a similar approach will be conducted, while the disclosed Checklist EMP will be used for guidance of site-specific Checklist EMPs for each specific site.

Annex 1: Results Framework and Monitoring

Country: Albania

Project Name: Health System Improvement Project (P144688)

Results Framework

Project Development Objectives

PDO Statement

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.

These results are at

Project Development Objective Indicators

Indicator Name	Baseline	Cumulative Target Values									
		YR1	YR2	YR3	YR4	YR5	YR6	YR7	YR8	YR9	End Target
Total number of acute care beds in selected district hospitals rationalized according to the Hospital Master Plan* (Text)	0	170	280	480	650						800
Percentage of inpatient in the selected regional hospitals whose admission and	0.00	0.00	0.00	15.00	35.00						50.00

discharge are performed electronically (Percentage)											
Reduction in average prices for: (a) 10 most common prescription medicines; and (b)10 most expensive hospital medicines* (Text)	0	3	6	11	18						25
Percentage of poor enrolled in the health insurance system (disaggregated by gender) (Percentage)	50.00	52.00	55.00	58.00	60.00						65.00

Intermediate Results Indicators

		Cumulative Target Values									
Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	YR6	YR7	YR8	YR9	End Target
Hospital with Board of Directors (Number)	0.00	0.00	3.00	7.00	13.00						15.00
Hospitals with	0.00	0.00	0.00	3.00	9.00						15.00

social accountability mechanisms installed (Number)											
Medical equipment management and maintenance plans developed (Text)	No	0	Agency set up	Training provided	Plans developed						Implemented
Number of clinical protocols and guidelines updated and implemented for management of chronic diseases (Text)	5 clinical guidelines developed but not implemented	5 clinical guidelines updated	Guidelines implemented and monitored in one region	Guidelines implemented and monitored in 3 regions	Guidelines implemented and monitored in 7 regions						Guidelines implemented and monitored in all regional hospitals
Master Plan for eHealtlh/HMIS activities developed and executed (Text)	No	Master Plan developed	Yes (HDD, HDM, and essential registries created)	Yes	Yes						Yes
National Health Information Center (NHIC) established and operational (Text)	No	No	Yes partly (Biomed engineering and maintenance unit set up)	Yes partly (Health Desk/Training Center established)	Yes (NHIC becomes operational)						Yes (NHIC fully operational)
Number of	0.00	0.00	2.00	4.00	6.00						7.00

regional hospitals with Information System established and functional (Number)											
PHC's adopting performance-based capitation payment system (Text)	0	Capitation on design developed	Capitation adopted	20	100						200
Hospitals implementing provider payment reform (Text)	0	0	7 (Implementation of global budget - one line item)	15 (Implementation of global budget - one line item)	7 (Case mixed costing)						15 (Global Budget adjusted by case mixed)
Percentage of claims using newly set up HIIS processed (Text)	0	Requirements study completed	HIIS system in place	Yes (first claim processed)	35						50
Health Insurance Organization "Road Map" developed and implemented (Text)	No	No	Developed	Implemented	Yes						Yes
Proportion of cheapest generic copies dispensed	38.00	38.00	50.00	60.00	70.00						80.00

of all INN for top 10 off patented drugs (Percentage)											
HIF experts and selected health personnel receiving training (on hospital management, coding, costing, business development plans and quality assurance); (disaggregated by gender) (Number)	0.00	24.00	78.00	132.00	137.00						137.00

Indicator Description

Project Development Objective Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
Total number of acute care beds in selected district hospitals rationalized according to the Hospital Master Plan*	Following the recommendations of the Hospital Master Plans, district hospitals in three selected regions will be transformed into outpatient clinics or PHC. The indicator will be measured as no. of hospital acute care beds closing at district hospitals.	Annual	HIF/MoF	HIF/MoF
Percentage of inpatient in the selected regional hospitals whose admission and discharge are performed electronically	Established HIS in selected hospitals will generate electronic data on patients' admissions and discharges. It allows collecting information on the utilization of hospital services and quality of care coordination	Annually	Survey	HIF/MoH
Reduction in average prices for: (a) 10 most common prescription medicines; and (b)10 most expensive hospital medicines*	There exist potential space in reducing medicine prices, which will improve patient access to drugs and reduce the OOP. Strengthening reference pricing, encouraging dispensing of lower cost drugs and the implementation of Risk Sharing agreements are some of the measures that should produce the required reduction.	Annually	Survey	HIF/MoH
Percentage of poor enrolled in the health insurance system (disaggregated by gender)	Government policy is moving towards universal health coverage. This will be supported by the project, aiming at expanding current people coverage with the health insurance by particularly focusing on poor people. Monitoring of the indicator will be closely related with	Bi-annually	HIF	HIF/MoH

	the database of the Ndihma Ekonomike program (main poverty targeted program), implemented by the Ministry of Labor and SocialAffairs.			

Intermediate Results Indicators

Indicator Name	Description (indicator definition etc.)	Frequency	Data Source / Methodology	Responsibility for Data Collection
Hospital with Board of Directors	The regional hospitals will establish Board of Directors (BoDs). The BoDs will help in improving the management and governance of the hospitals.	Annually	MoH (Hospitals)	MoH
Hospitals with social accountability mechanisms installed	Social accountability mechanism could include: hot lines, suggestion/complaint mechanisms, etc.	Annually	MoH (Hospitals)	MoH
Medical equipment management and maintenance plans developed	Based on the medical equipment maintenance strategy, plans will be developed at regional level	Annually	MoH (Hospitals)	MoH
Number of clinical protocols and guidelines updated and implemented for management of chronic diseases	Clinical guideline is a set of systematically developed statements involving through evaluation of evidence, to assist clinicians and patients to make decision about appropriate health care for specific clinical circumstances. The implementation of clinical guidelines allows a better management of resources, improves quality in treatment and will improve the utilization of the referral system. They will be monitored at facility level and HIF.	Annual	MoH/HIF/Hospitals	MoH
Master Plan for eHealtlh/HMIS activities developed and executed	The Master Plan will outline and detail out all the activities that will be undertaken as a part of the HMIS. The plan will be	One-time, end of Project first	MoH	MoH

	developed in the first year, and as per the plan, other foundational activities for HMIS will be undertaken in the subsequent years.	year		
National Health Information Center (NHIC) established and operational	NHIC will be deemed complete once: (a) HDD is used by health service providers, (b) small data centers are consolidated, (c) a training center is established, and (d) a Help Desk is established	End of third year (monitoring reports will track progress in the 1st and 2nd years)	MoH	MoH
Number of regional hospitals with Information System established and functional	The regional hospital information system will be implemented in several hospitals; number would vary based on the funds availability. This will allow the NHIC and HIF to collect detailed data and information on these hospitals.	Annual	MoH	MoH
PHC's adopting performance-based capitation payment system	The value refers to the number of PHCs adopting capitation based payment system. The indicator will be achieved in phases. Pay-for-performance includes fee for services, or initiatives that would positively affect the quality of primary care.	Annual	HIF	MoF/HIF
Hospitals implementing provider payment reform	The value refers to the number of hospitals that implement provider payment reform. The reform will include the implementation of global budget, and some form of case-mixed payment (e.g., DRGs).	Annual (Initiatives towards payment reform traced annually)	HIF	MoH/HIF
Percentage of claims using newly set up HIIS processed	The processing of the first claim suggests the establishment of a function information system for the HIF. The first	Annual	HIF	HIF

	claim using the newly set up HIS is expected to be processed at the beginning of the third year. The first two years will be devoted towards completion of the HIIS Requirements Study and the procurement of the HIS system components.			
Health Insurance Organization "Road Map" developed and implemented	The “Road Map” maps out how the HIF will proceed towards its goal of becoming a strategic purchaser.	One time	HIF	HIF
Proportion of cheapest generic copies dispensed of all INN for top 10 off patented drugs	This indicator monitors prescription and dispensing practices as part of a generic promotion strategy, leaded by the MoH	Annually (reflected in annual reports)	HIF/MoH	HIF/MoH
HIF experts and selected health personnel receiving training (on hospital management, coding, costing, business development plans and quality assurance); (disaggregated by gender)	Refers to the total number of experts (disaggregated by gender) receiving training on hospital management, to the number of experts who will be trained on coding, costing and business development and on quality assurance.	Annually	Annually (reflected in annual reports)	HIF/MoH

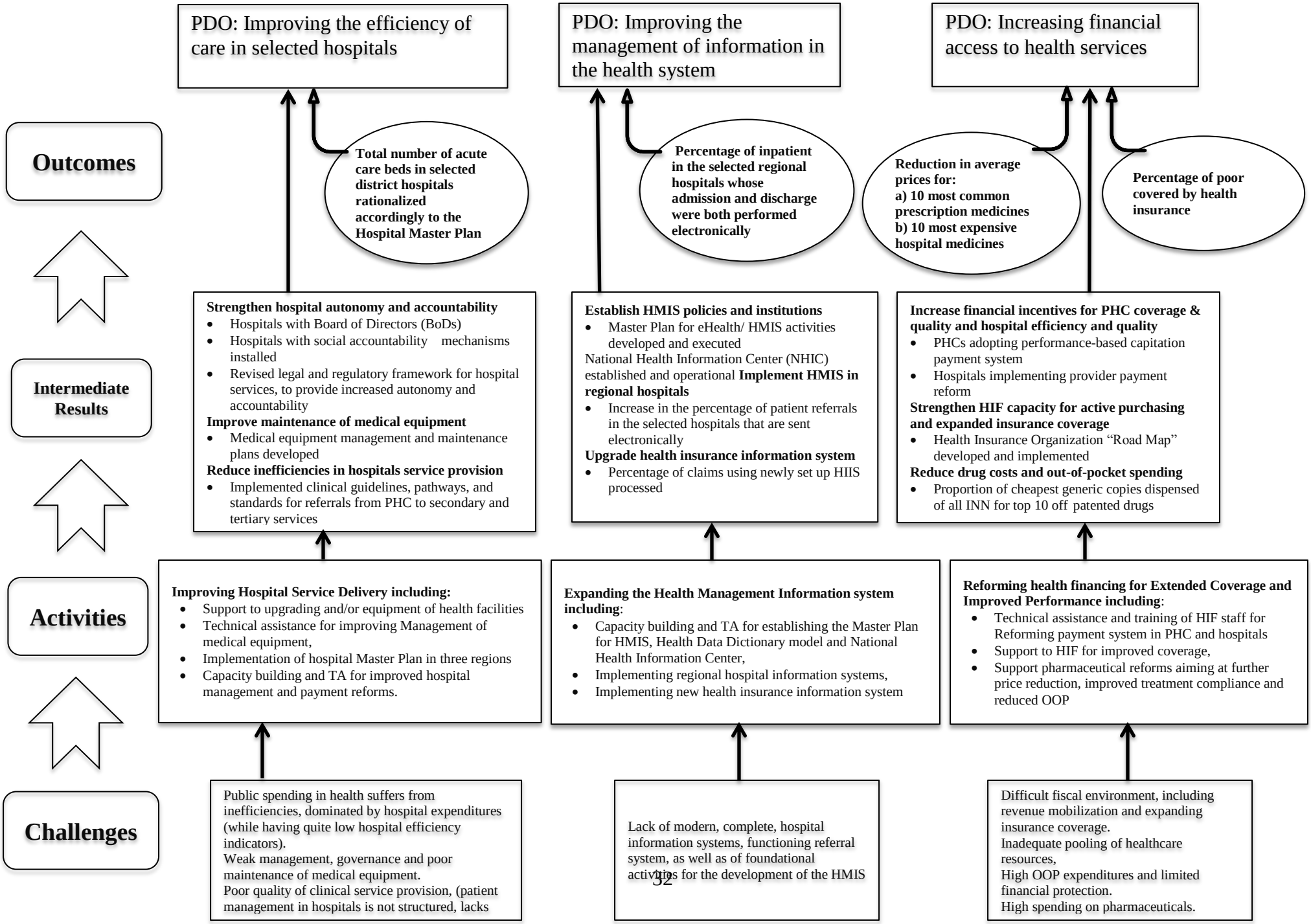
Description of the Indicators

Indicator Type	Indicator Name	Indicator Description
PDO	Total number of acute care beds in selected district hospitals rationalized according to the Hospital Master Plan	Following the recommendations of the Hospital Master Plans, district hospitals in three selected regions will be transformed into outpatient clinics or PHC. The indicator will be measured as no. of hospital acute care beds closing at district hospitals.
PDO	Percentage of inpatients in selected regional hospitals whose admission and discharge are performed electronically	Established HIS in selected hospitals will generate electronic data on patients' admissions and discharges. It allows collecting information on the utilization of hospital services and quality of care coordination.
PDO	Reduction in average prices for: (a) 10 most common prescription medicines; and (b)10 most expensive hospital medicines	There exist potential space in reducing medicine prices, which will improve patient access to drugs and reduce the OOP. Strengthening reference pricing, encouraging dispensing of lower cost drugs and the implementation of Risk Sharing agreements are some of the measures that should produce the required reduction.
PDO	Percentage of poor enrolled in the health insurance system (disaggregated by gender)	Government policy is moving towards universal coverage. This will be supported by the project, aiming at expanding current people coverage with the health insurance by particularly focusing on poor people. Monitoring of the indicator will be closely related with the database of the Ndihma Ekonomike program (main poverty targeted program), implemented by the Ministry of Labor and Social Affairs.
Intermediate	Hospitals with Board of Directors (BoDs)	The regional hospitals will establish Board of Directors (BoDs). The BoDs will help in improving the management and governance of the hospitals.
Intermediate	Social accountability mechanisms installed in hospitals	Social accountability mechanism could include: hot lines, suggestion/complaint mechanisms, etc.
Intermediate	Medical equipment management and maintenance plans developed	Based on the medical equipment maintenance strategy, plans will be developed at regional level
Intermediate	Number of clinical protocols and guidelines updated and implemented for the management of chronic diseases	Clinical guideline is a set of systematically developed statements involving through evaluation of evidence, to assist clinicians and patients to make decision about appropriate health care for specific clinical circumstances. The implementation of clinical guidelines allows a better management of resources, improves quality in treatment and will improve the utilization of the referral system. They will be monitored at facility level and HIF.
Intermediate	Master Plan for eHealth/ HMIS activities developed and executed	The Master Plan will outline and detail out all the activities that will be undertaken as a part of the HMIS. The plan will be developed in the first year, and as per the plan, other foundational activities for HMIS will be undertaken in the subsequent years.
Intermediate	National Health Information Center (NHIC) established and operational	NHIC will be deemed complete once: (a) HDD is used by health service providers, (b) small data centers are consolidated, (c) a training center is established, and (d) a Help Desk is established
Intermediate	Number of regional hospitals with Information System established and functional	The regional hospital information system will be implemented in several hospitals (number would vary based on the funds available). This will allow the NHIC and HIF to collect detailed data and information on these hospitals
Intermediate	PHCs adopting performance based	The value refers to the number of PHCs adopting capitation based payment system. The

	capitation payment system	indicator will be achieved in phases. Pay-for-performance includes fee for service, or initiatives that would positively affect the quality of primary care.
Intermediate	Hospitals implementing provider payment reform	The value refers to the number of hospitals that implement provider payment reform. The reform will include the implementation of global budget, and some form of case-mixed payment (ex. DRGs).
Intermediate	Percentage of claims using newly set up HIIS processed	The processing of the first claim suggests the establishment of an information system for the HIF. The first claim using the newly set up HIS is expected to be processed at the beginning of the third year. The first two years will be devoted towards completion of the HIIS Requirements Study and the procurement of the HIS system components.
Intermediate	Health Insurance Organization "Road Map" developed and implemented	The "Road Map" maps out how the HIF will proceed towards its goal of becoming a strategic purchaser.
Intermediate	Proportion of cheapest generic copies dispensed of all INN for top 10 off patented drugs	This indicator monitors prescription and dispensing practices as part of a generic promotion strategy, led by the MoH and the HIF.
Intermediate	HIF experts and selected health personnel receiving training (disaggregated by gender)	Refers to the total number of experts (disaggregated by gender) receiving training on hospital management, to the number of experts who will be trained on coding, costing and business development and on quality assurance

Project Results Chain

Country goals: Decreased mortality and morbidity; improved efficiency, equity, and quality of health services; and reduced out-of-pocket and catastrophic health spending



Annex 2: Detailed Project Description

ALBANIA: Health System Improvement Project

Component 1: **Improving Hospital Services (Euro 15.1 million)**

1. **This component aims to improve the governance, 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.

2. **Implementation will build on the results and concepts developed under the previous project.** 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.

Sub-component 1.1: Strengthening the Albanian Network of Hospital Services

3. **This sub-component will address inefficiencies in hospital services, including management weaknesses and overuse of services at tertiary level; underutilization of district and regional hospitals; poor coordination of care across outpatient and inpatient services; as well as the need for access to functioning outpatient services.** It will also address the efficiency and quality of hospital services under the current system, including the lack of a functioning referral system (which encourages patients to generally bypass lower-level providers and to seek care directly in the specialized public facilities) and poor patient management in hospital facilities. It will strengthen outpatient services, and improve needs-based planning of hospital infrastructure and human resources. Finally it will establish results-based management systems for essential hospital services, patient management, clinical services, outcomes, and accountability.

4. **The sub-component will finance technical assistance, capacity building and equipment for the following sets of activities:** (i) updating the existing Hospital Master Plan; (ii) piloting implementation of the revised Master Plan in at least three pilot regions (including the transformation of district hospitals into primary care/diagnostic facilities); (iii) assessment and improvement of the current management of the QSUT; (iv) elaboration of an appropriate legal and regulatory framework for hospital services, to provide increased autonomy and accountability; (v) training and capacity building for hospital management teams, MoH, HIF, and other supervising agencies on service planning, resource allocation, performance management, and implementation monitoring and contracting; (vi) development of benchmarks and indicators for profiling comparative hospital performance (MIS/quality monitoring system), establishing baseline data and systems for monitoring; (vii) updating, implementing, and monitoring of clinical guidelines, clinical pathways, and standards for referrals from primary to outpatient secondary services to inpatient and tertiary services; (viii) developing National Health Accounts to support the budget analytical work in the health sector and (ix) piloting patient-based social accountability mechanisms to enhance patient feedback and reduce informal payments – such as: establishment of hot lines and cell-phone based feedback mechanisms, study on informal payment, publishing ranking of hospitals based on performance, etc.

External Governance under the Project

5. **The sub-component will support all 15 regional hospitals (11 regional hospitals and 4 hospitals in Tirana) to accomplish the following five main steps**:

Step 1: Establish Boards of Directors.

Step 2: Create new entities that are non-profit, community based organizations owned by the State, but operated by Boards of Directors accountable to the community.

Step 3: Governance of the 15 hospitals to be the shared responsibility of the Boards of Directors with the community.

6. **The introduction of Boards of Directors for hospitals is strongly recommended as an early step**. Boards will be established for each of the 11 regional hospitals, and in Tirana perhaps one board for the tertiary, maternity hospitals and one for the Sanatorium. The boards could consist of about 9-12 members. The recommendation to establish Boards of Directors is based on several factors. One is that international experience suggests that such a governance body provides value to the management of hospitals and tends to make the operation of hospitals more transparent. The Durres Hospital was established as a pilot site and a board was created. This has demonstrated a positive effect on the operations of this hospital as evidenced by its lower costs and higher productivity. Furthermore, a governance structure is an important element in increasing accountability among the hospital management team and staff.

7. **The members of each board will be appointed in accordance with the law, based on their positions as representatives of some other organization such as the HIF, MoH, municipality, University, etc.** The members may have 3-year terms and 3 or 4 members would change each year. This is to ensure some continuity of the board membership as two-thirds of the board will return from the previous year, while new ideas may be brought annually by the 3-4 new members.

8. **New board members will undergo a training program upon appointment. The training would cover many topics such as conducting meetings and strategic planning as well as management.** Examples of similar training programs can be found at http://www.managementhelp.org/boards/index.htm #anchor97797. Arrangements with local universities to deliver the training could be envisaged as part of their Community Extension Program. Training could be delivered to a group of board members.

9. **The role and duties of the boards should be documented and would include factors such as**:

- Represent the people served by the hospital,
- Select and appoint a Hospital Manager according to an open and transparent competitive process,
- Annually assess the performance of the Hospital Manager and based on the results, terminate or renew his/her contract for another year,
- Review major decisions of the hospital based on recommendations of the Hospital Manager after appropriate analysis by the staff,
- Review and approve the budget, monthly performance of hospital expenditures as compared to the budget, and
- Review and approve capital construction or acquisition of major equipment, etc.

10. **The boards could have subcommittees for special topics such as finance, capital construction and equipment, and quality of care.** A subcommittee could comprise 3 or 4 board members and 2 or 3 senior staff of the hospital.

Internal Management of Hospitals under the Project

11. **It is critical that the management capacity of hospitals improves, whether by recruiting new people through a transparent process conducted by the Boards of Directors, or by training existing hospital managers.** As noted in the governance section above, it must be acknowledged that the Durres Regional Hospital has made significant improvements over the past 10 years or so as a pilot project. Having continuity of hospital management is a significant ingredient of achieving improved hospital performance. The performance of the Durres Hospital is considerably better than that of other regional hospitals. It has the second highest occupancy rate and the lowest number of beds per thousand populations of all the regional hospitals in spite the large influx of visitors during the summer months. It also has one of the lowest hospital budget to population ratios.

12. **There are three main reasons why improved hospital management is required**. These all relate to hospital funding:

i. Commitment and planning is needed in order to obtain accurate and timely information from the hospitals.
ii. Hospital funding models are intended to have features which create incentives or disincentives for hospitals to act in certain ways. If management is not strong enough to understand the implications of different funding models and to adjust their operations to take advantage of their features, then a major part of the purpose is lost.
iii. Any hospital funding model requires certain information and a part of the value of collecting this information is for the hospital managers to assess their own performance and perhaps compare it to that of others.

13. **Hospital managers with poor management skills, no local oversight and/or an expectation that their position may be terminated are unlikely to improve over time**.

Step 4: Boards of Directors are assigned the responsibility of selecting and appointing hospital managers according to an open and transparent competitive process.

Step 5: Establish an Accountability Tracking System using M&E indicators.

Creating Hospital Performance and Accountability Tracking Under the Project

14. **Monitoring and evaluation will be established under this sub-component to address accountability.** System wide accountability requires that government ensures that the best available people are appointed to the Boards of Directors of hospitals in order to make the boards accountable for the selection of qualified candidates as Hospital Managers.

15. **Performance measures are one more element in the process in order of improving transparency and accountability.** They may be collected at different levels and provided to different audiences.

16. **At the regional level, some measures would include**:

- Health care resources available, i.e., beds, doctors, nurses, etc.

- Rates of certain procedures, i.e. Caesarian sections,
- Outcomes of various procedures, i.e. mortality due to child birth, etc.
- Hospital performance such as infection rates, readmissions due to infection, etc.

17. **At the hospital or clinical levels, some measures would include**:

- Management of financial data such as cost per bed, per patient day, per meal, etc.
- Clinical cost data such as cost per natural delivery, per hernia treatment, etc.
- Among clinicians, the rate of prescription use, of laboratory use, etc.
- In operating rooms, the time required to clean up and prepare for the next procedure.

18. **At the patient level, patient surveys would be used to measure**:

- Cleanliness of the hospital,
- Courtesy of staff and care shown for patient concerns,
- Privacy of discussion between patient and provider,
- Waiting time before seeing the doctor.

Sub-component 1.2: Improving hospital infrastructure and management of medical equipment

19. **This sub-component will finance the physical rehabilitation and upgrading of hospital infrastructure and medical equipment, based on the updated Hospital Master Plan.** The Plan does not currently envisage closing any facilities (or adding new ones), but most likely hospital beds would be reduced or reallocated in accordance with service requirements, and appropriate mechanisms established to reallocate staff. There will be upgrading of infrastructure and equipment in three regions, based on a strategic plan prepared by the hospital management and regional authorities, and aligned with the overall Hospital Master Plan. The Pediatric hospital in Tirana (within the QSUT) will also be upgraded, based on the design already prepared by the Council of Europe Bank (CEB). This will be implemented in conjunction with management and payment reforms to improve efficiency. Moreover, based on the priorities identified in the updated Hospital Master Plan and hospital strategic plans, this sub-component may also finance medical equipment for other regional hospitals to ensure that their activities can be performed in a satisfactory manner.

20. **This sub-component will also finance a number of activities related to management of the medical equipment.** These include: (i) the development of a medical equipment maintenance strategy; and (ii) the establishment of a National Center with the mandate to manage all medical equipment in the public sector in Albania.[2] Considering the specific situation and the limited budget, the adoption of a mixed model is envisaged as the most cost-effective approach to the maintenance problem. According to this model, the first-level maintenance would be performed by in-house technicians, while for medium and high complexity maintenance the MoH would contract a global service provider (GSP). The Government has committed the equivalent of US$5.0 million to financing implementation of the medical equipment maintenance strategy through the national budget. Funding under this sub-component will include technical assistance, training, and physical assets.

21. **The adoption of a mixed model is envisaged as the most cost-effective approach to the maintenance problem given the specific situation and limited budget.** The activation of a global maintenance pilot in some selected health facilities and, according to results, the possible extension of the service to all hospitals through a PPP model is identified as a strategic priority by the MoH. According to

[2] It is proposed to house this center under the National Health Information Center, as indicated under the HMIS component.

this model, the first-level maintenance would be performed by in-house technicians, while medium- to highly-complex maintenance problems would be contracted to a GSP.

22. **The implementation of this sub-component will be phased as follows**:

- Updating of the medical equipment inventory for all health facilities and collection of relevant data in a management system fully integrated with the national HMIS.
- Analysis of inventory data and selection of the health facilities for the pilot.
- Definition of the technical requirements for maintenance services.
- Monitoring of the global contract (by the National Agency and by hospital-based clinical engineers).

Component 2: Expanding Health Management Information System (HMIS)/eHealth (Euro 13.6 million)

23. **The focus of this component is on improving the accuracy and timeliness of clinical, financial and administrative information within and between the regional hospitals in Albania.** Regional hospitals play a vital role in providing all/most secondary care in the country. As such they are positioned between the vital primary healthcare delivered in the health units and the tertiary care delivered at Nene Teresa Hospital in Tirana (QSUT).

24. **Today few computer systems exist in the regional hospitals and those that do cannot communicate with each other.** This communication is especially important as it is the main conduit for referrals from primary care as well as for referrals to tertiary care. Those referrals are currently rather informal and can be easily bypassed, resulting in patients accessing more expensive care than is needed.

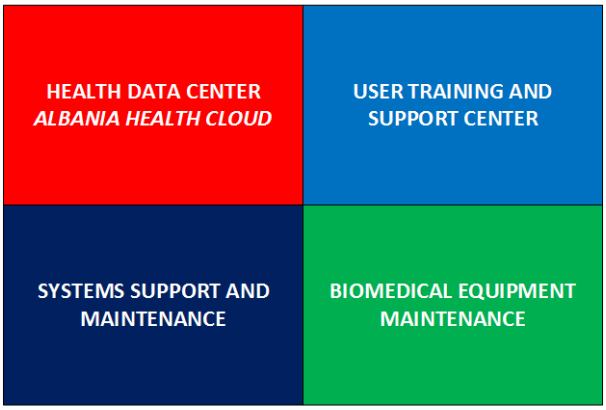
25. **The focus of this component is to bind these hospitals closer to each other and to integrate the various levels of care in an attempt to improve continuity-of-care and quality of care**.

Sub-component 2.1: HMIS/eHealth Foundational Activities and Establishing the National Health Information Center (NHIC)

26. **To provide closer integration of systems, this sub-component includes the following main sets of activities**:

- Creating a Master Plan for HMIS/eHealth Activities (2015-2019) and creating the first version of the Albania Health Data Dictionary (HDD) and Health Data Model (HDM). A Master Plan is necessary in order to orchestrate a longer-term strategy for HMIS/eHealth in the country. It can also help the government to better coordonate activities of its development partners by creating new synergies and avoiding possible duplications and redundancies. The Health Data Dictionary and Health Data Model are the fundamental data modeling activities which lead to a "standard language" allowing the various MoH computer systems to communicate with each other. It involves creating common definitions, formats, and forms, etc.
- Creating a first version of the Essential Registries for Albania's HMIS. A key element underpinning a modern, efficient HMIS/eHealth architecture is a set of common tables that are created and updated once, but accessed by many applications. The tables include a list of all facilities (Facilities), all health workers (Health Workers – physicians, nurses, pharmacists, technicians, etc.), and Biomedical Equipment.

27. **The NHIC is the focal point for eHealth/HMIS activities in Albania – enhancing sustainability of the initiatives and providing modern support tools for its users.** The Center has a number of responsibilities (as shown in the diagram):



1. *The operation and maintenance of the Health Data Center*, a modern computing environment in which potentially all the servers and network management equipment of the MoH can be stored. The Project will suppport upgrading of the building of the NHIC which location is alreadyb determined by the MoH. Fast, reliable Internet services will be vital for this Center. Likewise a backup center will also be created, using a "hot backup" scheme to assure load balancing of demand from users and allowing almost instantaneous cutover should one center fail. This Center provides the MoH with an opportunity to consolidate its data centers, now housed informally in hospitals, as well as being housed at the HIF and IPH. The Center will have minimal personnel requirements, with a staff of two persons being physically present at the Center to "run" it, and the rest of the administrative, clinical and statistical staff working remotely at their usual workstations.

2. *A Training Center* will focus on User Training and perhaps other types of training (e.g. hosting Continuing Medical Education, Continuing Nursing Edutation, etc.) as needed. The training center will have capacity for 50 people, with appropriate equipment to support in-person training, synchronous online training as well as the creation of materials for asynchronous training. The Training Center will also have the responsibility of maintaining, expanding, updating and enforcing the Health Data Dictionary (HDD) and Health Data Model as changes naturally occur.

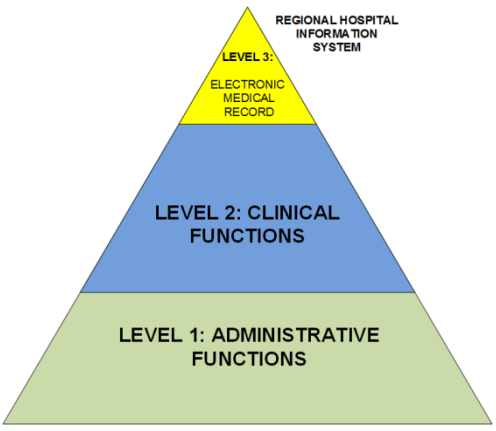
3. To assure maintainability of hardware and software, a *Systems Support and Maintenance Unit* is also proposed providing quick response to user problems, a help desk to answer user questions, and a small supply depot with spares to ensure that the workstations and printers continue operating normally.

4. *The Biomedical Equipment Maintenance Unit* will also be housed in the Center. This will oversee the preventive maintenance of vital biomedical equipment as well as overseeing any repairs that are needed. The status of each piece of equipment will be stored in the Essential Registry/Biomedical Equipment which is being created under Component 2.1.

28. **Taken together, the National Health Information Center will become the modern hub of activity for HMIS/eHealth in the country.** It will be the utility which powers the applications supported by this proposed Project, as well as preparing the country for powering future applications as well.

Sub-component 2.2: Implementing a Regional Hospital Information Systems (RHIS)

29. **A Hospital Information System is the control center of any modern hospital without which good hospital management is impossible**.



30. **This sub-component will finance technical assistance, goods, including IT equipment, and training to establish a modern RHIS in selected regional hospitals.** Project support will be provided according to the following steps: (i) establishing "*management" functions*, including ADT (Admissions Discharges and Transfers), outpatient registration, bed management, medical records locator and interface to the HIF for claims/encounters reporting; (ii) developing clinical functions, including clinical laboratory order and resulting functions, radiology order and resulting functions, and pharmacy prescribing functions; and (iii) creating a clinical summary for each patient, focusing particularly on tracking targeted chronic disease(s).

31. **The RHIS will be characterized by the following requirements**:

- Together with other sources, it will help populate the National Electronic Health Record (NEHR) which is being proposed under the "Austrian Project[3]" for Albania. As such, coordination with the Austrian Project is paramount.
- The RHIS will be run from the Health Data Center (as part of the National Health Information Center proposed under Component 2.3) where the servers and applications will be housed. Thus this subcomponent will utilize a "cloud-computing" approach to serving the hospitals of Albania. This will simplify the maintenance tasks as well as provide security "utility-like" data services to the hospitals.
- The RHIS will communicate with the HIF for the passing of eligibility, claims, rejected claims and payment information (the exact nature of this communication will depend on the choice(s) of provider payment methods made under Component 1).
- The RHIS will have an extended referral communication capability which will allow upward and downward referrals to/from primary care and to/from tertiary care. The system will attempt to detect "inappropriate" referrals and "inappropriate" admissions, based on criteria supplied to it by the MoH. The benefit of an improved referral mechanism is to improve cost-efficiency but also to improve continuity-of-care, especially for Albania's ever-increasing load of chronic disease patients.
- The RHIS will communicate with the MoH providing recent utilization and quality reports. These statistics will compose a kind of dashboard so that the MoH can see and compare performance on several key indicators across its regional hospital domain.
- The RHIS will be secure and protect patient confidentiality. It will need to be able to fend off cyber-security attacks as well as provide a very high uptime reliability (at least 99 percent uptime).
- The RHIS will be compliant with the new Health Data Dictionary and Health Data Model being created under Component 2.1.

Sub-component 2.3 Implementing a new Health Insurance Information System (HIIS) for the Health Insurance Fund (HIF)

32. **As new provider payment methods are introduced, as payments to hospitals and primary care centers increase in complexity, it is vital that the country's insurance funder, the Health Insurance Fund (HIF) is equipped with a modern payment information system.** This system is meant to organize, process, report and manage the Fund by running its "claims factory" – claims come in,

[3] The "Austrian Project" came from a recent bilateral agreement between Austria and Albania. Under the terms of the agreement a National Electronic Health Record will be developed and will contain critical medical information for each Albanian citizen. Support from the proposed Project will greatly contribute to providing data to the NEHR. It is therefore critical to establish close coordination between the two Projects as both should comply with the new Health Data Dictionary and Data Model. Likewise it will be essential that the implementation plan of both Projects be closely coordinated as well.

they are adjudicated, the appropriate claims are paid, and the Fund itself is safeguarded from potential fraud and abuse as well as providing actuarial projections to ensure the Fund's solvency.

33. **This sub-component will finance the procurement of a payment informaton system and capacity building for HIF staff, ensuring that HIF is prepared to deal with future complexity in its financial management**.

34. **Specific characteristics of the HIIS will include**:

- Accepting claims electronically (eClaims) from providers.
- Adjudicating a large percentage of these claims automatically with no/minimal human intervention.
- Processing the majority of claims, thus minimizing the need for each region to adjudicate its own claims.
- Reporting daily on the operations of the HIF and providing a dashboard of indicators to the Director and his/her staff to assure them that the processing is proceeding properly.
- Complying with the new Health Data Dictionary and Health Data Model being created under Component 2.1.

Component 3: Improving the Health Financing System (Euro 2.4 million)

35. **This component will address improvement of allocative efficiency and the shift towards output-based and performance-based financing for hospitals and primary care services, sustainable revenue mobilization, and the expansion of health insurance coverage and pooling of health care resources.** It will also address improvement of critical pharmaceutical policies.

Sub-component 3.1: Supporting Payment Reform

36. **This sub-component will finance technical assistance, capacity building, and workshops, to support the payment system reforms in primary and hospital care**. The right payment systems can drive both greater allocative and technical efficiency. Indeed, Albania has called for a set of powerful payment systems to help create a more efficient and equitable financing system.

37. **The sub-component will help develop skills as well as the improved collection and utilization of data for decision making on quality, and strategic payment of services.** It will assess current payment models in primary care. This is currently biased toward historic utilization with budget caps. It will also support the HIF to move towards primary care capitation[4].

38. **During implementation, the Project may also develop "pay-for-performance" approach for priority services in areas such as management of hypertension, diabetes, immunization, management of NCDs, and potentially MCH services.** This sub-component will be implemented following these steps:

[4] Capitation is defined as one payment for one defined service package for one person (per capita) for one defined period of time (the four "1"s). The overall average is sometimes referred to as the "base rate". The total amount of funds allocated to any single primary care provider or facility would be the average per capita amount (or base rate) multiplied by the number of enrolees. A fundamental principle of capitation is to de-link payment from historic utilization or historic budget amounts. De-linking payment from utilization also is important to begin to shift primary care resources to areas where utilization historically has been low, but health need is in fact high.

Step 1: The HIF regularly undertakes reviews to determine how PHC facilities are completing the costing information. This will be combined with efforts to improve the training of staff responsible for costing services.

Step 2: Standardized costing reports must be submitted annually. The HIF would audit a 5 percent sample of facilities to ensure accuracy and standardization of reporting. The HIF will take steps to verify that the costing methodology is being applied as instructed and is consistent across all facilities before being used for funding purposes.

Step 3: A cadre of coding experts will be trained and accredited.

Step 4: HIF to begin introducing Capitation. Capitation may be introduced gradually both as part of the control functions of the managers and according to the number of facilities. The capitation payment should be adjusted for case-mix and urban-rural differentials.

Step 5: Each PHC facility manager develops annual business plans and monitoring indicators.

Step 6: Pay for performance models are developed and tested.

Step 7: The HIF introduces pay for performance after evaluations.

As part of the move to PHC capitation, the project will integrate P4P indicators and payments. Some things are already in place related to P4P. The project will offer additional objectives of P4P for greater autonomy and to improve payment reform, further strengthening what has been started already.

The project will begin with a baseline study in Year 1, to pick up steps already forward. About 20% of funding for PHCs is allocated for P4P indicators currently and this could move to up to 30% under the project. Two methods of P4P payment will be considered – to the health center and specific payment for doctors. Costs of the 3-4 most expensive or highly prevalent diseases such as diabetes and hypertension will be analyzed. A focus on MCH care will be considered as well.

In December 2014, the country will initiate its baseline check-ups. This will provide good baseline data, and HIF will connect it with other data in current public registries in the MOH.
Steps for the P4P will follow:

- Baseline data collection and analysis to start in Year 1;
- Identify 4-5 areas to focus on such as hypertension, diabetes, MCH;
- Assess evidence and models from Europe, for possible use in Albania;
- Develop criteria for sites;
- Bring together stakeholders for review and consensus;
- Design the first phase (Year 2);
- Implement in selected centers (Year 2 and 3);
- Evaluate in Year 4 and scale up.

39. **The Project will also fund the development and introduction of a case-based payment system for hospital care.** In the early years of implementation, the Project will focus on information infrastructure as outlined in the HMIS component. This will be followed by the development and testing of the software grouper to be piloted and subsequently implemented.

40. **Hospital funding and payment systems are based on timely, accurate and proper information in at least two areas: costing and clinical experience.** For clinical information, Albania will need to develop the data dictionary and introduce ICD-10 (International Classification of Diseases, 10th version). It has introduced a discharge summary form, but will need to develop and train a cadre of clinical coding experts at the facility level. The coding standards can adopt the standards from the World Health Organization (WHO).

41. **The HIF is currently using ICD-9 for collection and reporting of clinical and diagnostic information.** Most countries are now using ICD-10 as the standard. While there is not a great difference in the benefits to be gained from the two systems at the present time, it would be appropriate to upgrade to ICD-10 for Albania. The HIF has introduced a process of collecting information at the hospital level in order to cost services, as well. Once the data is entered into a standardized software program, it is then submitted to the HIF. This is intended to enable the HIF to obtain information on the cost of services in the hospitals. It is imperative that hospitals use a consistent approach to data collection and entry, for both clinical and cost data. The HIF has prepared and circulated a set of directions to address this issue. In other countries, the Chart of Accounts defines the revenues and costs, which are reflected in financial statements and reports from the hospitals. Similarly, there is a Chart of Statistics which standardizes all statistics to be collected and reported on by all hospitals.

42. **Costing information is necessary to support any hospital funding model. Descriptions of the costing methodology implemented by the HIF and associated instructions are provided to all costing units in hospitals.** However, ensuring the correct application of the methodology by costing units is uncertain, but can be redefined during the Project.

43. **Albania will use the limited data that are currently available when initially introducing the case payment model.** Depending upon the data available, the number of cases assigned to each department could be based on an average. The disadvantage of this approach is that hospitals may be discouraged and refuse cases that cost more than the payment level and therefore move towards accepting only those cases that will be profitable. The advantage of using this approach is to create some familiarity with the case payment method.

44. **The Project is designed to implement a global budget** – 1 line item – in year 2 of Project implementation, as a first step before case mix payment. The HIF will have to make a choice whether to pay hospitals in advance or retrospectively in Year 2 of the Project. Advance payment means that the budget allocation to each hospital will be calculated prior to the start of the year. The great advantage of this is that the HIF will be able to distribute its available funds in amounts that ensure that total HIF budget will not be exceeded.

45. **The Global budget should be monitored closely and a performance measurement system should be put in place to ensure that hospitals are meeting expectations.** This will require additional information and the continued development of performance indicators to assess and evaluate the performance of hospital management.

46. **By Year 3, the Project should move to the desired end result of development and utilization of a funding model based on Diagnosis-Related Groups (DRG) or case mix costing at least in part.** This is a useful approach for comparing the volume of activity between hospitals despite the many different procedures. A DRG system provides the tool for hospital management; it also allows the HIF to compare between hospitals. DRG is partly used for hospital funding and planning in most developed countries. The cost and time of development a DRG model is based on whether it is possible utilizing the data available in HIF or if the HIF adopts a version modified from an existing DRG system (i.e.,

Australia, United States). Many countries in Europe have modified the Australian software grouper, such as Germany and Slovenia.

47. By the end of the Project, the HIF continues working toward a DRG style of hospital funding, and does so in an incremental way, with its own data, but learning from data and grouping systems from neighboring countries, whenever possible.

Quality Assurance and Provider Payment

48. **Successful payment system reforms depend upon good quality assurance systems. The HIF is encouraged to cooperate with the Ministry of Health and the National Centre of Quality, Safety and Accreditation of Health Institutions to ensure continued development of a national system of accreditation.** This will be one of the main methods of measuring and promoting a quality health care system. Most countries separate the encouragement and enforcement of quality from the funding agency so as to avoid the perception that quality is being promoted as a financial matter. If a hospital does fail to achieve accreditation over time, the appropriate agency, probably the Ministry of Health could force the removal of the Board of Directors and replace them with a new board whose first point of business would be to determine if the Hospital Manager is capable of leading the hospital to accreditation and if not, to replace him or her.

49. **The HIF will introduce a requirement in the Hospital Contract Letters** that hospitals will achieve accreditation status within 3 years in order to gain a financial incentive or to avoid financial penalties at a later date.

50. **The HIF will develop quality assurance systems** in conjunction with new payment systems including processes to review unnecessary admissions, a superficial assessment of care needs while in the hospital, premature discharge, and readmissions within 90 days.

51. **In addition to influencing fund allocations, part of the purpose of collecting detailed utilization information from hospitals, is to be able to generate performance indicators.** These may be created both for financial performance and for quality purposes.

Sub-component 3.2: Support to the Health Insurance Fund (HIF) for strategic purchasing, improved coverage and pharmaceutical reform

52. **This sub-component will support the organizational development of the HIF.** The HIF has made significant steps forward in terms of pooling of funds, starting with contracting and will begin paying case-based groups according to the number of admissions. The new leadership envisions that the HIF becomes more of a strategic purchaser of services over the next few years.

53. **The pooling and integration of funds will allow the HIF to become an effective and equitable purchaser of services, with minimal administrative overhead.** Observers agree that the HIF must encourage primary health care services to develop as a gatekeeper to ensure that only necessary cases are referred to a higher level of care in order to increase efficiency. Currently too much spending goes to hospital care (around 57 percent as compared with 29 percent in Canada and less than 40 percent in most Western European countries).

54. **The sub-component will finance technical assistance, training and workshops to support organizational development to enable the HIF to be a more strategic purchaser of services over the next few years, and to assess cost and options to expand insurance coverage.** The Project will support capacity in areas of management, organization, financial and risk management, information technology,

provider payment systems, and quality assurance. HMIS support under Sub-component 2.4 will complement activities of this component, including equipment, as well as training and technical support to allow the HIF to mature into a strategic purchaser.

Revising the current payroll system towards greater reliance on General Revenues: Extending Coverage

55. **Furthermore, this sub-component will support the Government's plan to move the HIF to a less diversified revenue base with a greater reliance on general revenues.** The Project will provide technical assistance to develop expenditure and revenue models looking at projections under various scenarios. The MoF will be an important partner for this sub-component. This will effectively de-link coverage and contributions, a stumbling block in many countries moving to Universal Health Coverage. Technical assistance will assist in developing expenditure and revenue models projections under various scenarios for expanding insurance coverage to the informal sector, and studying options for future shifting towards general revenues.

Pharmaceutical Policies to Improve Efficiency

56. **In addition, the sub-component will finance technical assistance, training and workshops, to support the Government in the design and piloting of innovative pharmaceutical policies.** This will include the following main activities: (i) revising the existing drug list based on clinical and cost-effectiveness criteria, and strengthening capacity and transparency for decision making regarding reimbursement of new drugs, including training to process drug applications and capacity building in reviewing Health Technology Assessments; (ii) further reducing prices for multi-source drugs through strengthening reference pricing, competition, and revised margins to retailers and wholesalers to encourage dispensing of lower cost drugs, and reduce costs of patented original drugs through innovative financing mechanisms such as Risk Sharing agreements; (iii) improve rational prescribing generic promotion strategic plan and enhanced monitoring of prescription and dispensing practices; and (iv) improving treatment compliance and reducing OOP expenditure through revising copayments, and targeted reductions or waiving of copayments for low-cost drugs essential for management of chronic diseases.

List of Hospitals (according to priority) and Project support

Regional Hospitals	District Hospitals	HMIS (RHIS) (Establishment)	Hospital Master Plan (Implementation)	Project support to hospital reform (provided to all regional hospitals)
Durres	Kruje	1	1	➢ Supporting the elaboration of an appropriate legal and regulatory framework for hospital services, to provide increased autonomy and accountability ➢ Providing training and capacity building for hospital management teams, MoH, HIF, and other supervising agencies on service planning, resource allocation, performance management, and implementation monitoring and contracting ➢ Developing benchmarks and indicators for profiling comparative hospital performance (MIS / quality monitoring system Further developing clinical guidelines, clinical pathways, and standards for referrals from primary to outpatient secondary services to inpatient and tertiary services ➢ Piloting social patient-based accountability mechanisms to enhance patient feedback and reduce informal payments, such as: the establishment of hot lines and cell-phone based feedback mechanisms, undertaking a study on informal payment, publishing ranking of hospitals based on performance ➢ Support the HIF to move towards risk-adjusted primary care capitation payments ➢ Support monitoring and evaluation of payment reforms, and further strengthen "pay-for-performance" approach for priority services in selected areas such as the control of hypertension, diabetes
Elbasan	Gramsh Librazhd Peqin	2	2	
Shkodra	Malesi e Madhe Puke	3	3	
Lezhe	Lac Mirdite	4		
Berat	Skrapar Kucove	5		
Gjirokaster	Permet Tepelene	6		
Kukes	Has Tropoje	7		
Shefqet Ndroqi		8[5]		
Vlore	Sarande Delvine			
Korce	Devoll Kolonje Pogradec			

[5] Based on availability of funding the project will support 12 regional hospitals

Regional Hospitals	District Hospitals	HMIS (RHIS) (Establishment)	Hospital Master Plan (Implementation)	Project support to hospital reform (provided to all regional hospitals)
Materniteti 1				➢ Fund the development and introduction of global budgets and a case-based payment system for hospitals ➢ Support for information infrastructure, diagnostic and procedure coding systems; hospital costing and cost accounting systems; the introduction of global hospital budgets; development and testing of the software grouper, followed by piloting and phased implementation of budgets based on diagnosis-related groups ➢ Supporting the assessment and improvement of QSUT management
Fier	Lushnje Mallakaster			

Annex 3: Implementation Arrangements

ALBANIA: Health System Improvement Project

Project Institutional and Implementation Arrangements

Project Administration Mechanisms

1. **The Project will be implemented over a period of five years.** The MoH has overarching responsibility for the health sector and related policy oversight. The Health Insurance Fund (HIF) and the National Health Information Center (NHIC) will also be responsible for, or will contribute to, technical implementation of specific Project components or sub-components. The MoH will have fiduciary responsibility for the Project through a Project Coordination Unit (PCU) which will be established within MoH. The Deputy Minister of Health, as Project Coordinator, will be responsible for the overall Project oversight and coordination within the MoH and across key institutions (e.g., HIF, NHIC) 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. 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. Details on Project institutional and implementation arrangements will be set out in a Project Operational Manual (POM). The adoption by the MoH of a POM that is acceptable to the Bank will be **a condition of effectiveness**.

2. **The PCU will include core staff responsible for fiduciary and safeguard management**, and will include a limited number of technical staff (component and activity coordinators) who will coordinate activities planned under each of the component. The Project Manager will have a defined level of responsibility regarding operational issues. The PCU will monitor and evaluate the Project results framework.

3. **The Project Coordination Unit will produce brief quarterly reports that will be shared widely within the Ministry and key stakeholders.** Consulting services will be provided to support Project implementation and build capacity of the MoH and other key agencies. Project review meetings chaired by the Deputy Minister of Health/Project Coordinator will take place on a quarterly basis to discuss Project implementation progress and address issues that may hinder its implementation, with participation from relevant technical staff (technical group members) and representatives from implementing agencies.

4. **Key institutions which will have an important role during Project implementation are as follows**:

- **Ministry of Finance** (MoF) oversees the execution of the budget and ensures allocation of resources to the sector. The MoF plays a crucial role in the verification and adoption of health sector budgets. It is also responsible for the collection and disbursement of tax revenues, serving both the MoH and the HIF. The MoF will support the introduction of reforms, such as those proposed in the Project, that can potentially increase efficiency and limit the escalation of public expenditures in health. Furthermore, the project will support the Government's plan to move

towards general revenues. The MoF will be an important partner for the sub-component on supporting HIF for strategic purchasing and improved coverage.

- **Ministry of Health** (MoH) and its line departments provides regulatory and policy guidelines for the health sector reforms and is responsible for the stewardship and technical oversight of the health sector as a whole. The MoH has shown ownership and commitment through active dialogue with the Bank and has already begun efforts towards reform implementation. While the MoH has overarching responsibility for the health sector and related policy oversight, it will, through its PCU, have fiduciary responsibility for the Project and will ensure technical implementation of all components with other key agencies.

- **Health Insurance Fund** (HIF) is a national public entity that provides mandatory health insurance to Albanian citizens and is responsible for financing health care institutions. It initially financed primary care and certain pharmaceutical expenditures, but since 2010 it has taken over the responsibility for hospital financing. The HIF and its organizational units are providing and implementing mandatory health insurance. It is a legal entity with the status of a mandatory social insurance organization which exercises rights and provides funding for mandatory health insurance. The HIF is managed by the insured who are equally represented on the Managing Board in proportion to the type and number of insured. The HIF Director is appointed by the Managing Board, following a public competitive process, with Government prior approval. Please refer to Annex 2 for more details on the HIF functions and responsibilities.

- **National Health Information Center** (NHIC). The project will support the establishment of a NHIC, as a strong institutional home for a variety of activities surrounding the design, implementation and support of the HMIS, including a Help Desk for user support and systems maintenance. In addition, a National Agency for Management and Maintenance of Biomedical Equipment will be established within the NHIC.

- **Hospital Management Teams** (HMT). Non-profit community-based organizations will be created, operated by Boards of Directors of regional hospitals. The Boards could consist of about 9-12 members, appointed in accordance with the law, based on their positions as representatives of other organization such as HIF, MoH, Municipality, University, etc. Board members will undergo a training program when they are appointed. The Boards will have subcommittees for topics such as finance, capital construction and equipment and quality of care. Boards of Directors are assigned the responsibility of selecting and appointing hospital managers based on open and transparent competitions. At some point in the future, consideration may be given to further extending the responsibility of the regional hospital boards and managers to include other health services in the region, such as primary care, mental health and other services.

Financial Management, Disbursements and Procurement

Financial Management

5. **A financial management assessment was carried out to determine the financial management implementation risk and to help establish adequate financial management arrangements for the proposed operation.** Areas that require further strengthening were discussed and recommendations and complementary actions were provided to ensure that the Project is implemented within a sound fiduciary environment and meets the minimum requirements under OP 10.00, including: (i) recruitment of a qualified financial management specialist, that will be provided by the project management budget in component 4; (ii) periodic and on-the-job training of the FM staff during implementation in Bank

financial management and disbursement procedures; (iii) document the financial management procedures, including internal controls in the FMM; and (iv) purchase of an accounting software so that it is capable of generating Interim Un-audited Financial Reports (IFRs) and capture accounts of the proposed project. The significant strengths that would provide a basis for reliance on the project financial management system include: (i) FM arrangements similar to the previous projects implemented and found to be adequate; (ii) no significant issues arisen in the audits of the previous project implemented by the MoH; and (iii) MoH Budget and Finance director experienced in implementation of Bank projects . Overall, the financial management risk level is assessed 'moderate'.

6. **Country PFM status**. Albania has participated in a number of detailed reviews of its public financial management (PFM) systems**,** among them two Public Expenditure and Financial Accountability (PEFA) assessments (2006 and 2011), a Public Expenditure Review (2006), a Public Finance Review (2013), annual EU-SIGMA reviews, and other analysis by the World Bank, the IMF, the EC, and other organizations. The various reviews have plotted the significant progress Albania has made in improving PFM. The last PEFA assessment for Albania from 2011 concluded that Albania has a fiscal and budget management system that is functioning adequately, in the sense that the system has enabled the government to finance and execute a budget that delivers public services to the general population. Albania scores relatively well on comprehensiveness and classification of the budget, basic treasury operations (including budget, and payroll controls), financial reporting/transparency and public access to government budget and financial information. Lagging areas, as identified in the 2011 PEFA assessment, include: (i) multi-year perspective in fiscal planning and policy formulation; (ii) internal audit; (iii) implementation of the integrated financial management information system (FMIS); and (iv) scope and nature of the external audit function.

7. **Use of country systems.** The proposed Project aims to utilize the improvements in the functionalities of the Albanian Government Financial Information System (GFIS) for fund flows, accounting and reporting. The assessment's preliminary conclusion is that the Project will be fully mainstreamed through GFIS only when the following requirements are met: (1) MoH is directly connected to the system, system access and appropriate training is provided to the Project staff in accordance with their defined role; (2) appropriate Project coding in the Government Chart of Accounts and generation of acceptable Interim Financial Reports (IFRs) are enabled; (3) the MoH and MoF commit to honor and settle liabilities recorded in the system for expenditures under the Project in a timely manner. Once the Bank team receives evidence that the above requirements have been addressed, the use of the system will be considered for Project accounting, reporting and fund flows. Currently, MoH is included in the system extension roll-out plan. However, there is no clear indication when the process will be completed.

8. **Financial management staff.** While all agencies involved in the proposed Project will be responsible for technical implementation of Project activities, fiduciary responsibilities will remain in MoH. These agencies will submit requests for payments to MoH with duly approved invoices and acceptance evidence on goods, works and deliverables, as applicable. Overall responsibility for the Financial Management function under the proposed project will be with the Director of the Division for Budget Planning and Finance (executing officer) in MOH. The MoH Budget and Finance director has an excellent track record in supervising the previous Bank supported Health project. However, there is low capacity among other accounting staff in the finance section, due to lack of familiarity with Bank Disbursement and FM requirements and limited number of staff. For this purpose an additional qualified and experienced financial management specialist (FMS) would be required to support the section, in taking over the expected additional workload. This will be provided through the project management budget in Component 4. The hiring of fiduciary staff (FMS and procurement) is part of the establishment of the PCU, which is **a condition of effectiveness**. During Project implementation, periodic and on-the-

job training on Bank disbursement and financial management will be provided to the finance staff as part of the Bank training program.

9. **Budgeting and counterpart funding.** The operation will rely on country public budget and planning systems. The MoH will be responsible for the preparation of the Project medium term forecasts and annual budgets, in line with the approved implementation plans and procurement plans, throughout the life of the proposed project. The process will be aligned with the Ministry budgeting process, and the Project budget and forecast will be included within the MoH budget and forecast, where identified and monitored separately. The project annual budget requests will be based on the forecasts and technical inputs, provided by the procurement specialist as well as agencies involved in the Project. The Project annual budgets will be reviewed and approved by the director of DFB, MoH Secretary General, and finally by the Deputy Minister. Project budget will include investment spending forecast to be financed by the loan proceeds and counterpart funds.

10. **Accounting and maintenance of accounting records.** A financial management software acceptable to the Bank will be purchased for project use. The Project funds will be accounted separately and Project chart of accounts will be defined based on Project activities. The accounting and reporting software should be able to identify committed amounts for each consultant/supplier and the respective liability, as well as to support transactions in currencies other than the functional currency (Lek) and reporting currency (EUR). Until the purchased software is purchased, installed and fully operational, spreadsheet based accounting and recording will be used, for this purpose it is recommended that procurement of the software start immediately following the project effectiveness. Accounting records for all project expenditure will be maintained by category and component. Periodic reconciliation will be performed between general ledger and Project bank accounts and WB disbursement data.

11. **Internal controls.** The MoH is already operating under the adequate internal control framework defined by the regulations of the MoF for budget organizations. The proposed project will have a separate POM and it will include FM section covering key internal control mechanisms to be followed by the staff in the application and use of project funds. This will elaborate the fiduciary controls, fund flows, documentation flow and roles and responsibilities of the key implementing agencies. The Financial Management Manual (FMM) will provide a detailed description of processes (budgeting, execution of expenditure, recording, reporting, auditing) and will depict the key control activities that will ensure proper verification, authorization and documentation of all project expenditure, proper contract financial monitoring, adequate segregation of functions, job descriptions for staff with different authority levels. The manual will also describe procedures for ensuring completeness of accounting transactions, reliability of accounting data, and regular financial reporting.

12. **Periodic financial reporting.** Quarterly IFRs, the format and content of which will be defined in the FMM, will be submitted to the Bank within 45 days of the end of each quarter. The annual project financial statements will be prepared in accordance with International Public Sector Accounting Standards on a cash basis. The reports will be prepared in EUR. The first quarterly IFRs will be submitted after the end of the first full quarter following the initial disbursement.

13. **Annual audit.** The project financial statements will be audited annually by independent auditors acceptable to the Bank. The auditor for the project will be appointed annually by the MoF as part of an overall agreement for the audit of the non-revenue earning Bank-financed portfolio in Albania. The audit service fee is covered by MoF. Specific terms of reference based on International Standards on Auditing are used for the Projects covered by this agreement and are cleared annually by the Bank. The audited project financial statements will be submitted not later than six months after the end of the reporting period. The MoH will have to disclose the audit reports for the project within one month of their receipt from the auditors, by posting the reports on the website. Following formal receipt of these reports, the

World Bank will make them publicly available according to World Bank Policy on Access to Information.

Disbursements

14. **The loan proceeds will be disbursed on the basis of standard Bank disbursement methods for investment projects.** A Designated Account (DA) denominated in EUR will be opened at the Bank of Albania, specifically for this project, where the Bank will advance loan proceeds.

15. Project funds will flow from the Bank, either (i) via DA, which will be replenished on the basis of documentation specified in the Disbursement Letter; or (ii) by using the direct payment method or the Special Commitment. Once the funds have been deposited in the DA, the Treasury Department at MoF, at the MoH request, will transfer loan proceeds from DA to two project bank accounts that will be opened in a commercial bank, acceptable to the Bank, to make Project expenditure payments to third parties i.e. consultants, contractors and suppliers. These bank accounts (one denominated in EUR and one Albanian Lek) will be managed by MoH.

16. The borrower has committed to jointly finance project activities provided under component 1 related to physical rehabilitation and upgrading of hospital infrastructure works. Joint financing of activities means that all contracts under this specific expenditure category will be financed jointly by loan proceeds and counterpart funds at the determined rate. These contracts will be procured in accordance with the requirements set forth in the Bank Procurement Guidelines. Counterpart funds financed from the MoH domestic budget, allocated to finance project expenditures, would be secured through preparation of annual budget of the MoH. Counterpart funds will flow via the Treasury system.

17. **The Bank will require either copies of the original documents evidencing eligible expenditures ("Records") or summary reports of expenditure ("Summary Reports") as specified in the Disbursement Letter.** Records include such documents as invoices and receipts or a statement of expenditure summarizing eligible expenditures paid during a stated period. Further details on the project disbursement arrangements will be provided in the Project Disbursement Letter.

Table 3: Expenditure Categories

Category	**Amount of the Loan Allocated (expressed in Euros)**	**Percentage of Expenditures to be financed (inclusive of Taxes)**
(1) Works	6,760,000	63%
(2) Goods, Non-Consulting services	18,360,000	100%
(3) Consultant Services, Training and Operating Costs	6,500,000	100%
(4) Front-end Fee	80,250	
(5) Unallocated	399,750	
Total	**32,100,000**	

Procurement

18. **Procurement Arrangements.** The Project Coordination Unit (PCU) within the MoH will be established before project effectiveness. The PCU, which will be in charge of procurement and financial activities, will be staffed by a Project Manager, Procurement Consultant, Financial Management Consultant, IT Specialist, Engineer and Office Assistant. Terms of Reference for the PCU staff and their selection will be subject to the Bank's review and no objection. The PCU will report directly to the Deputy Minister. A Project Operational Manual (POM) will be prepared by the MoH which will define the steps, service standards, responsibilities and accountability of PCU staff and management for carrying out project activities. In addition, technical staff from HIF and NHIC could be appointed as members of the evaluation committee depending on the expertise required for the procurement package to be reviewed.

19. **Procurement under the proposed Project will be carried out in accordance with the World Bank's Guidelines**: "*Procurement of Goods, Works, and Non-Consulting Services Under IBRD Loans and IDA Credits & Grants by World Bank Borrowers*" (January 2011) and "*Guidelines Selection and Employment of Consultants Under IBRD Loans and IDA Credits & Grants by World Bank Borrowers*" (January 2011), and the provisions stipulated in the Legal Agreement. The World Bank Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credit and Grants dated October 15, 2006 and revised on January 2011, would also apply.

20. **Risk Rating:** The procurement risk is assessed as "substantial". The following measures were agreed to mitigate the risks and maintain the implementing team's capacity:

Description of Risk	Risk Rating	Mitigation Measures	Residual Risk Rating
Weak capacity at the MoH and HIF to prepare technical specifications for the Regional Health Information System (RHIS) and the medical equipment to be procured.	S	MoH will hire consultants to assist the PCU in preparing technical specifications for medical equipment and a consulting firm will be hired to prepare design & technical specifications for the RHIS.	M
Weak capacity at the MoH and HIF to prepare Terms of Reference for selection of consulting firms.	S	The Bank team will provide sample TORs to the PCU, which in-house experts can use to formulate TORs for the project. Close involvement of Bank technical expert in the review of the TOR for hiring such consultants.	M
Unsatisfactory quality of technical designs for RHIS and works contracts may lead to contract implementation delays.	S	The Bank team to prior review relevant contracts. Technical designs are prepared by qualified consultants hired under the project. MoH also to hire engineer to monitor and supervise works in addition to the	M

Description of Risk	Risk Rating	Mitigation Measures	Residual Risk Rating
		consulting firm for supervision services.	
Delays in bid evaluation and contract award due to complaints.	S	The Bank team to prior review critical bidding documents and ensure that technical specifications are not restrictive. Procedure on responding to complaints will be laid out in the POM. Bid Evaluation Committee should be comprised of experts in the relevant field. Selection criteria for EC members will also be described in the POM.	M
Incomplete filing of procurement-related documentation.	S	Allocation of space and cabinets for proper and complete filing of all procurement related documents. Responsibility for filing of procurement documents will be specified in the TOR as the responsibility of the Procurement Consultant.	M

21. **Procurement Thresholds.** The following thresholds for implementing agency with substantial risk rating will apply to the project: Works - US$10 million; Goods - US$1 million; IT System and Non-Consulting Services - US$1 million; Consultant (Firms) - US$500,000; and Consultant (Individuals) - US$200,000.

22. **Procurement Methods**. The following methods may be used for procurement of goods, works and non-consulting services: International Competitive Bidding (ICB), National Competitive Bidding (NCB), Shopping (SH), and Direct Contracting (DC). Procurement for all ICB procedures will use the Bank's Standard Bidding Documents (SBD). Smaller value contracts, as needed, will be procured using the Standard Bidding Documents for Goods through NCB (August 2014) and Standard Bidding Documents for Works through NCB (November 2013), or Shopping using ITQ for Goods (June 2011) and Works (May 2011), depending on the cost estimate of the package. Copies of all these standard bidding documents will be provided to the PCU.

23. ***Procurement of Goods, Works, and non-consulting services***. Goods and non-consulting services to be procured include: medical equipment (US$7 million), Health Data Center IT equipment (US$1.5 million), Supply and Installation of Regional Hospital Information System (RHIS) (US$11.4 million), and Health Insurance Information System software and hardware (US$1.8 million). Works include rehabilitation of Pediatric Hospital (QSUT) and rehabilitation of infrastructure of selected hospitals (US$2.5 million).

24. **Selection Methods for Consultant:** The following methods may be used for the selection of consultants: Quality and Cost-Based Selection (QCBS), Quality-Based Selection (QBS), Least-Cost Selection (LCS), Fixed Budget Selection (FBS), Selection based on Consultants Qualifications (CQS), Individual Consultant Selection (IC), and Single Source Selection (SSS) of consulting firms and

Individual Consultants. The World Bank's Standard Request for Proposals will be used. All Terms of Reference, irrespective of prior/post review status, are subject to Bank's review and no objection.

25. ***Selection of Consultants.*** Consultants envisaged to be selected under the project include: Review of the existing Hospital Master Plan (US$0.4 million), Review of the Hospital Legal Framework (US$1.0 million), and QSUT international management team support (US$1.5 million).

26. **Post-review Percentages and Frequency.** In addition to the prior review supervision to be carried during the Bank team's supervision mission, post review by the Bank' procurement specialist will be carried out on a sample basis (15 percent of number of contracts) once per year. Physical inspection will also be conducted for at least 10 percent of the contracts.

27. **Procurement Files.** The PCU will maintain complete procurement files, which will be reviewed by Bank supervision missions. All procurement related documentation that requires the Bank's prior review will be cleared by the Procurement Specialist and relevant technical staff. Procurement information will be recorded by the Procurement Specialist at the PCU and submitted to the MoH and the Bank as part of the semi-annual IFRs and annual progress reports.

28. **General Procurement Notice (GPN).** The GPN will be published after Board approval.

Procurement Plan

	Project Name: Albania Health System Improvement Project						
	Project ID Number: P144688		Credit No:				
Date	December 23, 2014						
Update date:							
Package Nr.	Description of Contract Package	Procurement Type	Procurement method	Year	Prior/ Post	Estimated cost of the Project, EURO (Bank financing)	Estimated cost of the Project, EURO (Total with Govt. financing)
Component 1: Improving Hospital Services						**15,110,000.00**	**18,960,000.00**
Sub-componen	**nt 1.1: Strenghtening the Albanian Network of Hospital Services**					**2,730,000.00**	**2,730,000.00**
A.1.1.1	Review of the Existing Hospital Master Plan	CS	QCBS	1	Prior	240,000.00	240,000.00
A.1.1.2	Review of the hospital legal framework including the establishment and implementation of training program for Board of Directors	CS	QCBS	1	Prior	640,000.00	640,000.00
A.1.1.3	Legal services for non-profit community based organizations	CS	IC	2	Post	10,000.00	10,000.00
A.1.1.4	Establish an Accountability Tracking system using M&E indicators: to develop M&E accountability	CS	CQS	2 or 3	Post	80,000.00	80,000.00
A.1.1.5	TA to the MoH Management on Health Reform	CS	QCBS		Prior	240,000.00	240,000.00
A.1.1.6	Improving patient management, facility management and accountability: International TA using administrative data to improve quality and performance	CS	IC	3	Post	40,000.00	40,000.00
A.1.1.7	Improving patient management, facility management and accountability: International TA social accountability mechanisms in the EU and globally	CS	QCS	2	Post	80,000.00	80,000.00
A.1.1.8	QSUT international management team support	CS	QCBS	1	Prior	1,200,000.00	1,200,000.00
A.1.1.9	QSUT management assessment & preparation of TOR for the international management team	CS	IC		Post	80,000.00	80,000.00
A.1.1.10	Public Communication Campaign on Hospital Master Plan	CS	CQS		Post	40,000.00	40,000.00
A.1.1.11	Developing National Health Accounts	CS	CQS		Post	80,000.00	80,000.00
Sub-component 1.2: Improving hospital infrastructure and the management of medical equipment						**12,380,000.00**	**16,230,000.00**
A.1.2.1	Review of existing design for Pediatric, preparation of technical specifications and cost estimates	CS	CQS		Post	120,000.00	120,000.00
A.1.2.2	Rehabilitation of Pediatric Hospital (QSUT)	W	ICB		Prior	4,000,000.00	6,350,000.00
A.1.2.3	Rehabilitation of infrastructure of selected hospitals under HMP	W	NCB		Prior	2,500,000.00	4,000,000.00
A.1.2.4	Medical Equipment for Hospitals	G	ICB		Prior	5,600,000.00	5,600,000.00
A.1.2.5	Biomedical Engineering Application Software	G	SH		Post	20,000.00	20,000.00
A.1.2.6	Medical Equipment Management Team to provide TA, Training & Study Tours	CS	CQS		Post	140,000.00	140,000.00

Component 2: Expanding the Health Management Information System (HMIS)						**13,600,000.00**	**13,790,000.00**
Sub-component 2.1: HMIS/eHealth Foundational Activities & National Health Information Center						**2,680,000.00**	**2,870,000.00**
A.2.1.1	Creating the Master Plan for HMIS/eHealth Activities (2016-2020) & Health Data Dictionary	CS	CQS		Post	160,000.00	160,000.00
A.2.1.2	Upgrading of the NHIC building	G	NCB		Post	320,000.00	510,000.00
A.2.1.3	Creating the first version of the Essential Registries for HMIS, including implementation and update mechanisms populating and validating registries	CS	CQS		Post	200,000.00	200,000.00
A.2.1.4	Design services for Health Date Center architecture & topology, CRM, help desk/user support center & training center and CRM system	CS	QCBS		Prior	280,000.00	280,000.00
A.2.1.5	Health Data Center IT equipment	G	ICB		Prior	1,200,000.00	1,200,000.00
A.2.1.6	Design of Biomedical Equipment Maintenance Unit and IT equipment maintenance	CS	IC		Post	120,000.00	120,000.00
A.2.1.7	Furniture and Furnishing for NHIC	G	NCB		Prior	320,000.00	320,000.00
A.2.1.8	IT Capacity building	CS	CQS		Post	80,000.00	80,000.00
Sub-componen	**nt 2.2:Implementing Regional Hospital Information Systems**					**9,300,000.00**	**9,300,000.00**
A.2.2.1	Requirements Study & Prepare Tender	CS	CQS		Prior	200,000	200,000
A.2.2.2	Supply and Installation of Regional Hospital Information System (RHIS) including training	G	ICB		Prior	9,100,000	9,100,000
Sub-componen	**nt 2.3: Implementing a new Health Insurance Information System for the HIF**					**1,620,000.00**	**1,620,000.00**
A.2.3.1	Health Insurance Information System (HIIS) procurement: Software, Networking Hardware, Main hardware shared at NHIC	G	ICB		Prior	1,400,000.00	1,400,000.00
A.2.3.2	Capacity building: Training on HIF business processes as a factory & automated claims shop	CS	IC		Post	120,000.00	120,000.00
A.2.3.3	Requirements Study, High-level Conceptual Design	CS	CQS		Post	100,000.00	100,000.00
Component 3:	**Health Financing Reform for Extending Coverage & Improving Peformance**					**2,454,000.00**	**2,454,000.00**
Sub-component 3.1: Payment Reform						**1,722,000.00**	**1,722,000.00**
A.3.1.1	Develop annual business plans, automization strategy, monitoring indicators and provider Payment Reform in Primary Health Care including workshops and study tours	CS	QCBS	1	Prior	400,000.00	400,000.00
A.3.1.2	Provider Payment Reform in Hospital, inclidog study tours in Europe and high level workshops in Europe for 50 people, 2 days	CS	QCBS	1	Prior	240,000.00	240,000.00
A.3.1.2	Develop DRG hospital funding and impact model at HIF, annual business plans, monitoring indicators and provider Payment Reform in Hospitals	CS	CQS	1	Post	170,000.00	170,000.00
A.3.1.3	Software in about 100 PHCs	G	NCB	1	Post	400,000.00	400,000.00
A.3.1.4	Review of coding system for diagnosis and procedures of pharmaceutical, PHCs and hospitals	CS	CQS	1	Post	90,000.00	90,000.00
A.3.1.5	DRG Grouper Software	G	ICB	2 or 3	Prior	240,000.00	240,000.00

A.3.1.6	Develop P4P for performance models and introduce P4P with evaluation of the pilots	CS	CQS	4	Post	150,000.00	150,000.00
A.3.1.7	Develop quality assurance systems in conjunction with new payment systems	CS	IC	4	Post	32,000.00	32,000.00
Sub-component 3.2: Support to the HIF for Strategic Purchasing, improved coverage and pharmaceutical reform						**732,000.00**	**732,000.00**
A.3.2.1	Restructuring of existing reimbursed drug list & development HTA capacity for staff in chage of reviewing submissions from companies that seek reimbursement for medicine (MOH, HIF)	CS	CQS	1	Post	108,000.00	108,000.00
A.3.2.2	Development generic drugs promotion campaign & training of staff in regional committees	CS	CQS	2	Post	80,000.00	80,000.00
A.3.2.3	Piloting expanded coverage of outpatient drug benefit package	CS	CQS	3	Post	48,000.00	48,000.00
A.3.2.4	Development of Health Insurance Organization "Road Map" including study tours	CS	CQS		Post	160,000.00	160,000.00
A.3.2.5	Training abroad of HI organization experts, management/claims auditing expeerts, fraud detection experts, management dashboards	CS	QCBS		Prior	160,000.00	160,000.00
A.3.2.6	Performance Measurement System	CS	CQS		Post	56,000.00	56,000.00
A.3.2.7	Moving to general revenue/expenditure and revenue model including training/workshop	CS	CQS		Post	120,000.00	120,000.00
Component 4. Monitoring & Evaluation and Project Management						**955,000.00**	**955,000.00**
A.4.1.1	Project Manager	CS	IC		Prior	75,000.00	75,000.00
A.4.1.2	Office Assistant	CS	IC		Post	40,000.00	40,000.00
A.4.1.3	Procurement Consultant	CS	IC		Prior	70,000.00	70,000.00
A.4.1.4	Financial Management Consultant	CS	IC		Prior	70,000.00	70,000.00
A.4.1.5	IT Consultant	CS	IC		Prior	70,000.00	70,000.00
A.4.1.6	Supervising Engineer (2)	CS	IC		Prior	80,000.00	80,000.00
A.4.1.7	Project Audit	CS	LCS		Post		
A.4.1.8	Office equipment for PCU	G	SH		Post	150,000.00	150,000.00
	Unallocated					**400,000.00**	**400,000.00**
Total						**32,119,000.00**	**36,159,000.00**

GAC Filter for the Health System Improvement Project

29. **What is the track record of the leadership in the sector? Are there any alleged or confirmed corruption cases or conflicts of interest?** A new government was established in 2013 and a new and comprehensive process for developing the Government's policy priorities was established. This process included identifying priority objectives, carrying out assessments through well-defined indicators, and preparing roadmaps and concrete action plans to be implemented by the relevant line ministries. The MoH is committed to improving the efficiency and quality of health care services in Albania through strengthening: (i) management, governance, and quality assurance systems for public hospitals; and (ii) health financing, purchasing, maintenance, and information technology systems. Good governance of this sector is essential.

30. **Corruption in Albania** is a serious problem. Albania ranked 113th of 176 countries in the Transparency International 2012 Corruption Perceptions Index, tied with Ethiopia, Guatemala, Niger, and Timor-Leste. Corruption is still considered one of the most problematic challenges when establishing a business in the country. For example, compared to other countries in the region, Albania has the highest level of company expectation of having to give gifts to secure a government contract. Although corruption in Albania is still considered highest among the Balkan countries, the European Commission's Albania 2013 Progress Report does note some progress in many areas, most notably in political party financing. The government had adopted a national anti-corruption plan for the period 2011-2013 which, in 2012 saw the High Inspectorate for Declaration and Auditing of Assets and the Supreme State Audit sign a memorandum of understanding aimed at combating corruption. This established a database on suspected corrupt practices in the public administration. In 2012, the Albanian government also approved changes to the Albanian Constitution which included restrictions on the immunity of high-level public officials and judges.

31. **However, the European Commission's report points out that the effects of these initiatives have yet to be felt, and the rate of convictions is still too low.** Companies should note that corruption is reportedly widespread in the judiciary, which lacks independence, efficiency and accountability. This potentially leads to slow and inefficient handling of commercial disputes. Anti-corruption initiatives lack both enforcement and adequate tracking of corruption investigations and prosecutions. In May 2013, the Extractive Industries Transparency Initiative (EITI) board declared Albania fully compliant with the EITI Standard. EITI compliance ensures an effective and transparent process for annual disclosure and reconciliation of all revenues from Albania's extractive sector. This development might pave the way for increased investment in a sector that has until now been rife with corruption. This has, in the past, discouraged foreign companies from entering the market.

32. **According to the Investment Climate Statement 2013, companies in Albania continue to experience non-transparent processes when competing for public tenders.** This occurs despite the transparency provisions of the PPL and the introduction of e-procurement. According to the report, the legislation's application is hampered by a number of problems, including corruption in drafting tender documents. According to the European Commission's Albania 2013 Progress Report, there have been improvements in the public procurement review system. The PPL was amended and further measures were taken to ensure transparency of public procurement procedures, such as the e-procurement system.

33. ***What is the track record of the Ministry of Health in procurement under Bank-financed projects?*** The MoH has established some procurement capacity, having implemented the Health System Modernization Project. However, based on lessons learned from the Project, the procurement environment will remain to be a major challenge for the reasons set out earlier in the procurement section above.

34. **Who are the project stakeholders? Who are the beneficiaries of the existing system? Who are the winners and losers of the proposed changes?** As noted above, while key decisions will be made by 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. The main beneficiaries include the overall population of Albania who will benefit from the: (i) improvements in efficiency and quality of hospital care services, and (ii) the expansion of the health insurance coverage. In addition, health sector stakeholders will benefit from capacity building (training and technical advice), as well as other Project support. Key stakeholders include: hospitals at regional level, which will benefit from improved infrastructure and capacity. Project beneficiaries also include key institutions, such as: MoH, the HIF and the Institute of Public Health.

35. Proposed mitigating measures in Procurement are provided in the procurement section of this Annex.

Environmental and Social (including safeguards)

36. **The social impacts of the proposed Project are expected to be positive, and include extensive and improved access to health services, improved quality of health service delivery, gender-sensitive health services, improved public awareness of healthy lifestyles and of non-communicable diseases, etc.** Indirect benefits could also include employment, more efficient health systems, etc.

37. **The Project will not require any new land development or any physical relocation.** One hospital in the University Hospital Center of Tirana (Pediatric) will be upgraded within the existing perimeter of their current premises. Expected temporary negative social impacts associated with the construction phase can be easily mitigated through minimizing nuisance from the excessive noise and dust, managing movement of construction vehicles and machinery, demarcating and fencing of construction sites, and excluding scattered piling of construction materials and waste outside the boundaries of construction sites.

38. **The PCU will be responsible for the oversight of any potential social safeguard issues such as displacement of homes or businesses (formal or informal), potential loss of income due to blocked streets or closure of businesses, shops etc. during construction.** The POM will provide mitigation measures to address these issues. Such measures include: social assessment, commitment that no private land will be acquired, local information campaigns on works and grievance mechanisms for local communities regarding inconveniences related to works, etc. The POM will also specify who in the PCU will be accountable for implementing these measures and for ensuring compliance.

39. **Project activities will include reconstruction and refurbishment works in one hospital.** The existing structure will be subject to refurbishment that will allow modernization and improvements in service delivery. The scope of works triggers OP 4.01 on Environmental Assessment, due to the potential for noise and dust generation, and for construction waste during works. All of these impacts have been addressed through a Checklist Environmental Management Plan (EMP). This has been prepared and disclosed in July 2014. The checklist will be re-disclosed prior to the start of works. Since these are existing structures with existing connections and waste collection practices, and given that the scale of works is relatively minor, no long-term or substantial environmental impacts are foreseen.

Monitoring & Evaluation

40. **Progress on results will be monitored through routine data/administrative records (including financial management records) and through progress reports from relevant bodies.** Primary responsibility for data collection will rest with the PCU, HIF and NIPH. The PCU will also be responsible for bringing together the progress reports, monitoring the key performance indicators and results in collaboration with HIF and NIPH, and communicating with the World Bank on progress with a frequency of reports as indicated in Annex 1. Consensus among key stakeholders on the formulation of indicators and monitoring arrangements will be developed during Project preparation. Collection of household survey data will rely on national surveys, with additional technical or financing support if needed.

41. **Monitoring and evaluation under the Project will be integrated into the regular monitoring functions of the MoH, HIF and NIPH.** The Project will also strengthen systems for performance management and monitoring of performance indicators at central, municipality and facility level. If systems are not in place to collect data on other key indicators of importance to the Project, or if current

reporting systems are unreliable, the Project will support the establishment or strengthening of such monitoring systems, including specific surveys (related to hospital performance, etc).

Role of Partners

42. **The Project will seek to harmonize activities with other development partners in order to avoid duplication of activities and ensure consistent support to the MoH and the sector.** Key areas that are complementarity to existing health sector development partners are: the support of primary care reform, offered by the SDC, the Austrian Government support to the HMIS, the Italian Government support for hospital payments, the CEB for the overall design of the QSUT, and the IFC support for laboratories. Potential synergies have been accounted for in the proposed Project activities. The PCU will ensure participation in existing collaboration mechanisms. Regular meetings to discuss health sector activities will also take place with the main Development Partners.

Annex 4: Operational Risk Assessment Framework (ORAF)

ALBANIA: Health System Improvement Project

Project Stakeholder Risks						
Stakeholder Risk	**Rating**	**Substantial**				
Risk Description: 1.1.1 The Project stakeholders are the Ministry of Health (MoH), Health Insurance Fund (HIF) and the Ministry of Finance (MoF). Changes in the leadership of these institutions could negatively affect Project implementation, if the new leadership does not support the reforms. 1.1.2 Implementation of the Hospital Master Plan could lead to adverse reactions from beneficiaries of local/district hospitals that are expected to go through transformation or closure. 1.1.3 The introduction of professional hospital managers and hospital boards could create tension in an environment traditionally dominated by the medical profession and limit their willingness to cooperate	**Risk Management:** 1.1.1 The proposed Project will try to build broad based ownership and participation in developing Project activities. In addition, the team will work with a wide range of technical experts in the MoH and MoF. During Project preparation and implementation, wide ranging consultations are planned, including with members from the political opposition.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	In Progress	Both	☑		Continuous
	Risk Management: 1.1.2 The Government has committed itself to the implementation of the Hospital Rationalization Plan and has clear plans for organizing outreach campaigns at national level. In addition, the Project will support communication campaigns and citizens engagements during the process.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	In Progress	Both	☑		Continuous
	Risk Management: 1.1.3 The project will include activities to support extensive communication with all stakeholders during the change process. Management boards are also expected to include representatives from the medical profession. In addition, the introduction of a comprehensive health management information system would support evidence-based decision making and transparency in hospital management.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	Not Yet Due	Implementation	☐	28-Apr-2017	

Implementing Agency (IA) Risks (including Fiduciary Risks)						
Capacity	**Rating**	**Substantial**				
Risk Description: 3.1.1 The MoH has capacity constrains which may affect the overall Project implementation. 3.1.2 There is weak fiduciary capacity (FM and procurement) in the implementing agency. 3.1.3 Monitoring the results of the Project may be difficult, due to lack of appropriate data.	**Risk Management:** 3.1.1 MoH high level officials will be appointed as focal points, responsible for coordination of activities under each Project component. There is already strong commitment, directly from the Minister of Health, to ensure smooth and quick Project preparation and implementation.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	In Progress	Both	☑		Continuous
	Risk Management: 3.1.2 The Bank team will ensure that qualified fiduciary expertise will be hired to handle fiduciary management. Also, the Bank's fiduciary team will provide close supervision on the fiduciary aspects during Project implementation.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Both	Not Yet Due	Implementation	☐	30-Apr-2015	
	Risk Management: 3.1.3 The Project will support the establishment of the HMIS, which will also help monitoring of Project related indicators.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	Not Yet Due	Implementation	☐	29-Apr-2016	
Governance	**Rating**	**Substantial**				
Risk Description: 3.2.1 Setting up new agencies (i.e. the National Agency for the Health Management Information System, National Agency for the medical equipment, etc.) may bring ambiguity about institutional roles.	**Risk Management:** The proposed Project will provide substantive support to the MoH in establishing the new agencies, including clear definition of their role and responsibilities.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Both	Not Yet Due	Implementation	☐	30-Apr-2015	

	Risk Management: 3.2.2 The Project Operations Manual (POM) will be adopted by the MoH by Project effectiveness and will clearly define institutional arrangements as well as the roles and responsibilities of all parties involved in the Project. The POM will also provide a clear description of procurement procedures and methods to be followed. In addition, the Bank team (both FM and procurement) will continuously provide close supervision. The Bank team will also maintain the dialogue with relevant Government agencies (e.g. the state audit agency) and provide training on Bank project-specific guidelines for procurement and FM					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Client	Not Yet Due	Implementation	☐	30-Apr-2015	
Project Risks						
Design	**Rating**	**Moderate**				
Risk Description: 4.1.1 The Project design covers a wide number of activities. While the design is not too complex, considering the existing capacity, it may still present a burden on the MoH during Project implementation. 4.1.2 Including the establishment of the HMIS under the Project, may lead to implementation delays/procurement issues.	**Risk Management:** 4.1.1 The MoH has already started the reform process in a number of areas (i.e. hospital rationalization, establishing the structures for the HMIS and management of medical equipment at national level), hence Bank support will focus mainly on their implementation. Meanwhile, during Project preparation, the team will streamline the design as much as possible.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Both	In Progress	Both	☑		Continuous
	Risk Management: 4.1.2 There is a common risk of delays related to IT procurement in general. However, in previous similar projects in Albania this risk has been quite low. Moreover, the Bank team will have an IT expert on board during project preparation and implementation, in orderto mitigate the risk.					
	Resp:	**Status:**	**Stage:**	**Recurrent:**	**Due Date:**	**Frequency:**
	Both	In Progress	Both	☑		Continuous

<table>
<tr><td>Social and Environmental</td><td colspan="6">Rating Low</td></tr>
<tr><td rowspan="3">Risk Description:

Minor risks associated with the noise, dust and construction waste generated during reconstruction works in the hospitals that can impact the quality of environment if not managed properly. Risks old equipment that will be replaced under the project.</td><td colspan="6">Risk Management:

A Checklist Environmental Management Plan has been developed, identifying all associated environmental impacts and mandating measures for mitigating all such impacts. This Checklist EMP as well as guidance on proper disposal of old equipment will be part of the standard bidding documents for all works and equipment procurement under the project.</td></tr>
<tr><td>Resp:</td><td>Status:</td><td>Stage:</td><td>Recurrent:</td><td>Due Date:</td><td>Frequency:</td></tr>
<tr><td>Client</td><td>Not Yet Due</td><td>Both</td><td>☑</td><td></td><td>Continuous</td></tr>
<tr><td>Program and Donor</td><td colspan="6">Rating Low</td></tr>
<tr><td rowspan="3">Risk Description:

Donor coordination may be problematic and have adverse effects in the overall sector support</td><td colspan="6">Risk Management:

Currently there are a few potential donor in the health sector - the Swiss Development Cooperation and the Austrian Cooperation, Italian Cooperation and Council of Europe Bank, with which the Bank team is keeping very close coordination. SC activities cover complementary areas and are not overlapping with the proposed project activities</td></tr>
<tr><td>Resp:</td><td>Status:</td><td>Stage:</td><td>Recurrent:</td><td>Due Date:</td><td>Frequency:</td></tr>
<tr><td>Bank</td><td>In Progress</td><td>Both</td><td>☑</td><td></td><td>Continuous</td></tr>
<tr><td>Delivery Monitoring and Sustainability</td><td colspan="6">Rating Substantial</td></tr>
<tr><td rowspan="5">Risk Description:

4.4.1 The project team may not be able to establish a proper M&E system to monitor project results and demonstrate that the Project is reaching its development objectives.
4.4.2 Government changes may result in reversal of the reform agenda established by the proposed Project.</td><td colspan="6">Risk Management:

4.4.1 The Project will support the establishment of the HMIS, which will also help to monitor Project related indicators.</td></tr>
<tr><td>Resp:</td><td>Status:</td><td>Stage:</td><td>Recurrent:</td><td>Due Date:</td><td>Frequency:</td></tr>
<tr><td>Client</td><td>Not Yet Due</td><td>Implementation</td><td>☐</td><td>29-Apr-2016</td><td></td></tr>
<tr><td colspan="6">Risk Management:

4.4.2 The
The Project team will work with a wide range of technical experts in the MoH and MoF. In addition, during Project preparation and implementation, wide ranging consultations are planned, including with members from the political opposition.</td></tr>
</table>

	Resp: Client	**Status:** In Progress	**Stage:** Both	**Recurrent:** ☑	**Due Date:**	**Frequency:** Continuous
Other (Optional)	**Rating**					
Risk Description:	**Risk Management:**					
	Resp:	**Status:**	**Stage:**	**Recurrent:** ☐	**Due Date:**	**Frequency:**
Other (Optional)	**Rating**					
Risk Description:	**Risk Management:**					
	Resp:	**Status:**	**Stage:**	**Recurrent:** ☐	**Due Date:**	**Frequency:**

Overall Risk		
Overall Implementation Risk:	**Rating**	**Substantial**
Risk Description: The overall implementation risk is substantial and mainly related to the relative newness of the reforms, the implementation capacity of the client, system issue of fraud and corruption and governance in the health sector.		

Annex 5: Implementation Support Plan

ALBANIA: Health System Improvement Project

Strategy and Approach for Implementation Support

1. **Implementation Strategy:** The strategy for the Implementation Support Plan will include regular dialogue with the Government, joint review (MoH and Bank) of the Project implementation and regular oversight of the Project fiduciary activities. Regular dialogue will facilitate early identification of problems and obstacles, which could delay implementation and would enable timely provision of technical advice and support to remove such obstacles. Joint reviews will take place at least twice a year, aimed at reviewing the progress and achievement of agreed results. During each of the reviews, the type of implementation support that is needed will be identified, followed by joint decisions on specific necessary assistance.

Fiduciary Requirements

2. **Financial Management.** As part of its Project implementation support missions, the Bank will conduct risk-based financial management within the first year of Project implementation, and then at appropriate intervals based on the assessed risk and performance of the Project. During Project implementation, the Bank will supervise the Project's financial management arrangements in the following ways: (a) review the Project's Interim Un-audited Financial Reports (IFRs) as well as the Project's annual audited financial statements and the auditor's management letters and remedial actions recommended in the auditor's management letters; and (b) during the Bank's on-site missions, review the following key areas: (i) Project accounting and internal control systems; (ii) budgeting and financial planning arrangements; (iii) disbursement arrangements and financial flows, including counterpart funds, as applicable; and (iv) any incidences of corrupt practices involving Project resources. The Bank's on-site financial management implementation support and supervision will be conducted by the Bank-accredited Financial Management Specialist.

3. **Procurement supervision.** Prior review supervision will be carried out by the Bank in accordance with the procurement thresholds. In addition and in compliance with the results of the capacity assessment of the Implementing Agency, there will be two supervision visits every year to carry out post review of procurement actions. These visits will include informal training for procurement specialists of the PCU/MoH.

4. The PCU will maintain complete procurement files, which will be reviewed by Bank supervision missions. All procurement related documentation that requires the Bank's prior review will be cleared by the Procurement Specialist and relevant technical staff. Procurement information will be recorded by the Procurement Specialist at the PCU and submitted to the MoH and the Bank as part of the semi-annual IFRs and annual progress reports.

Implementation Support Plan

Implementation Timeline and Support

Time	Focus	Skills Needed	Partner Role
Bi-yearly	Technical Review: All components Fiduciary Oversight: Financial Management Procurement Safeguards Oversight: Environmental performance and socially responsible performance	Health Financing and Hospital Specialists; Health Economist; Sr. Operations Officer and other key consulting services (i.e., IT specialist; Medical Equipment Specialist) Financial Management Specialist/ Procurement Specialist Safeguards Specialist	N/A
Regular support by TTL and field-based staff	Technical Review: All components Fiduciary Oversight: Financial Management Procurement Safeguards Oversight: Environmental performance and socially responsible performance	Health Financing and Hospital Specialists (field-based staff and international staff), Health Economist, and Operations Specialist Financial Management Specialist/ Procurement Specialist Safeguards Specialist	N/A

Skills Mix Required

Skills Needed	Number of Staff Weeks per Financial Year (FY)	Number of Trips per FY	Comments
Task Team Leader	20	0	TTL based in the field
Health Specialist	6	2	Trips to be combined with other Project support
Health Economist	4	2	Trips to be combined with other Project support
Senior Operations Officer	4	1	Trips to be combined with

Skills Needed	Number of Staff Weeks per Financial Year (FY)	Number of Trips per FY	Comments
			other Project support
Health Information Systems Specialist	4	2	Trips to be combined with other Project support
Safeguards Specialist	3	1	Staff based in the field, as may be needed
Procurement Specialist	4	2	Staff based in HQ. Trips to be combined with other Project support.
Financial Management Specialist	4	0	Staff based in the field

Annex 6: Economic and Fiscal Analysis

ALBANIA: Health System Improvement Project

1. **The economic and fiscal analyses carried out during the preparation of the project covered:** (i) the estimation of the project's development impact; (ii) the rationale for public involvement; (iii) the World Bank's contribution to the project; and (iv) the fiscal impact and sustainability of the project.

Estimation of the Project's development impact

2. **Given the wide range and the complexity of reforms to be supported by the Project, this analysis recognizes the difficulty of trying to monetize all the benefits anticipated from the Project.** Where possible, the analysis attempts to offer some quantitative estimates of the benefits. The analysis takes two approaches. First, it offers a rationale for the Project intervention through a comparison between the current 'Before Project' scenario and the 'After-Project' scenario for selected interventions supported by the Project. For this, the analysis uses a cost-effectiveness method. Second, given the changing epidemiological profile of the country and increasing incidence of non-communicable diseases (NCD), the analysis makes an estimate of the overall project effects in terms of Disability Adjusted Life Years (DALYs) averted. For this, the analysis uses a cost benefit analysis method.

3. **The proposed core interventions under the Project are in line with the recommendations detailed in the World Bank report, *Getting Better: Improving Health System Outcomes in Europe and Central Asia*.** As highlighted in the report, the project supports interrelated reforms in the areas of: (i) provider payment; (ii) provider autonomy; (iii) information for effective decision-making; (iv) health financing; and (v) management and governance. While all the interventions will not immediately lead to better health outcomes, they are indispensable not only to modernize but also to improve the quality and efficiency of service delivery of the Albanian health system.

Analysis

a. Cost Effectiveness Analysis:[6] Issues and Rationales

The Health Referral System

Current Status	**After Project: *the Rationale***
More than twice as many cases in 2012 were handled at tertiary facilities (87,832) than at district hospitals (43,433). The fact that the cost per case at tertiary facilities is the highest (ALL 56,902) and that only the most complicated cases need treatment at this level underscores the presence of severe allocative inefficiencies.	The lack of a functioning referral system (which leads to patients generally bypassing lower-level providers and seeking care directly in the specialized public facilities or the private sector, even though this involves high out of pocket payments) perpetuates the low allocative efficiency in the Albanian health system. In 2012, the average bed occupancy rates in regional and district hospitals stood at 38 percent and 28 percent respectively. The average cost per case treated in 2012 was higher at district hospitals (ALL 47,271) than the regional hospitals (ALL 37,504).[8] This is in spite of the fact that interventions at regional hospitals are more complex.

[6] This method has been used to carry out the economic and fiscal analysis of two of the World Bank supported health projects in Romania and Croatia. The projects were approved recently.

[8] *Albania Public Finance Review*. World Bank, Report # 82013 - AL. April 2014.

Current Status	After Project: *the Rationale*
The number of cases treated in the different hospital types suggests that patients bypass primary and secondary care facilities to seek care at high-cost tertiary hospitals. This was confirmed during a World Bank mission to the regional hospital in Elbasan and the Sanatorium hospital in Tirana. Representatives from the hospitals said that inappropriate admissions[7] ranged anywhere between 40 to 80 percent.	The project will adopt a multi-pronged approach to addressing the referral system. First, the project will support the development of standardized referral protocols. The standards and protocols for referrals developed under the project will be key in ensuring that conditions that can be treated in less resource-intensive primary healthcare settings will be actually dealt there. Second, the implementation of the hospital rationalization plan will result in reorganization and, where possible, improvements to the physical conditions of district hospitals and more efficient use of resources. Third, the implementation of a modern Health Management Information System (HMIS) will generate up-to-date data on the trends in hospitals (on patients and otherwise). Therefore, it will enable hospitals to better address the referral issue. Fourth, the project will address management inefficiencies by supporting hospital governance and management reforms.

Augmenting Health Management Information System (HMIS)

Current Status	After Project: *the Rationale*
While a Health Information System exists in Albania, the current system is extremely limited in its capacity and scope. Regional hospitals in Albania have little to no computer assistance. The vast majority of the transactions and activities in the hospitals are still paper based. This has meant huge time and monetary costs, and efficiency losses in the performance of the health sector. The current weak health information systems make it harder to monitor, incentivize and improve service coverage and quality, and to formulate evidence-based policy.	The introduction and implementation of the HMIS in 7 of the 13 regional hospitals will enable efficiency gains by: (i) avoiding paper medical records, (ii) avoiding redundant diagnostic tests, (iii) cutting down on the volume of radiological services, (iv) promoting the cost effective use of prescription drugs, (v) enhancing the productivity of the medical staff, and (vi) decreasing the average length of stays in hospitals. The HMIS will also help increase efficiency gains in health financing reforms multifold. By creating a solid database on health, the implementation of HMIS will (i) promote a greater exchange of health information, (ii) avoid adverse drug events, (iii) foster the practice of evidence-based medicine, (iv) generate data for research and ultimately, support evidence based policy making in the healthcare sector in Albania.
Evidence A vast majority of the high-income countries already have some form of modern health information system in place. The growing number of middle income countries adopting Health Information Systems gives credence to their role in strengthening national health systems and informing effective policy making. An assessment[9] undertaken by the Ministry of Health, Zambia,[10] on the country's health information system found that the system has done a commendable job of catering to the appetite for health information from senior managers, policy makers, donors and NGOs. The information/data	

[7] Admissions incurred as a result of inappropriate referrals and self-referrals. Inappropriate referral occurs when physicians at lower levels of care (such as PHC) recommend patients to visit higher levels of care (i.e. regional hospitals) for a treatment that could have been easily treated by them. Inappropriate self-referral occurs when patients bypass PHCs and decide to visit hospitals even though they could have received the same treatment at the PHCs.

[9] *Assessment of the Health Information System in Zambia*, Ministry of Health, Zambia, April 2007.

[10] The World Bank has classified Zambia as a middle-income country.

derived from the HIS has been critical in planning, budgeting and resource allocation at various levels of the country. Recognizing the country-specific shortcomings in implementing the system, the assessment notes areas of improvement but on the whole, found the role of the HIS to be very useful. Similarly, the US Congressional Budget Office estimates that the potential net benefits that could arise from successful nationwide implementation of health information system in the US could be as high as 4% ($80 billion) of the total spending ($2 trillion) on health.[11] Other countries in the European region including Croatia, Ukraine and Moldova have successfully implemented health information systems sub-nationally (Croatia) and nationally (Ukraine and Moldova).[12]

It is worth noting that the establishment of a health information system does not automatically imply success for the system. It is paramount to ensure that the information systems are designed and implemented, keeping in mind the country/local context. This was evident in the Philippines where a public health information system was designed "according to a Western model that assumed the presence of skilled programmers, skilled project managers, a sound technological infrastructure, and a need for information outputs like those used in an American health care organization."[13] The reality on-the-ground, in Philippines was of course very different, and the information system failed to produce any concrete results.

Provider Payment

Current Status	**After Project: *the Rationale***
Hospitals and primary care services in Albania have traditionally been funded on the basis of historical, line-item budgets that do not encourage cost containment or efficient use of resources. While there have been some attempts to move towards capitation-based payment for primary care, the progress is slow. The current payment models do not provide adequate incentives for cost-effective approaches to improving the quality of health services.	The project will support provider payment reforms in both the primary and higher levels of health care. For primary care, it will support initiatives towards capitation-based payment whereas for hospital care, it will support initiatives towards case-based payment. Both case-based and capitation-based provider payment systems are recognized as relatively effective payment approaches for controlling hospitals/primary care costs.[14] The use of a prospective, case-based payment system in hospitals would allow sharing of risks between payer and providers and would align incentives for improving efficiency. More importantly, it provides an ideal transition towards DRG-based payment. The expected positive effects of introducing a case based payment system are: (i) improved overall efficiency (both allocative and technical efficiency) of public spending for acute hospital care; (ii) enhanced transparency allocation of resources to facilities; and (iii) reduced average length of stay at hospitals. Similarly, primary care provider reform will entail output-based contracting mechanisms linking payments to the population enrolled, adjusted by risk-factors, plus performance bonuses linked to the quality of care and preventive services delivered. The expected positive effects of provider payment reform at the primary care are: (i) improved quality of care and patient outcomes for the conditions linked to performance bonus; and (ii) enhanced transparency and equity in the allocation of resources to PHCs.

[11] *Evidence on the Costs and Benefits of Health Information Technology*, Congressional Budget Office, May 2008.
[12] *Case Studies from Moldova and Ukraine: Success Factors for the Implementation of Information Systems*. Swiss TPH Spring Symposium. May 2012.
[13] Heeks, R. *Health Information Systems: Failures, Success and Improvisation*. International Journal of Medical Informatics. 2006.
[14] Carrin, G. and Hanvoravongchai, P. *Provider Payments and Patient Charges as Policy Tools for Cost Containment: How Effective Are They in High Income Countries?* Human Resources for Health. 2003.

Evidence

Capitation-based payment models, often in blended forms, are proven to be effective in improving the quality of primary care. In Ontario, Canada, the use of these models has "improved timely access to continuous primary care, and created an incentive structure for providers, that are more consistent with the system's objectives in primary care than the traditional fee-for-service model."[15] Middle income countries such as Thailand, Estonia, Romania, among others, have quite successfully implemented the capitation-based payment model for primary care, and the models have been critical in enabling these countries to make the transition towards the universal health coverage (UHC). Similarly, the British National Health Service (NHS) has practiced capitation-based payment for primary care for many years. Sweden has achieved great success with a blended model of provider payment, with capitation-based payment representing the significant proportion.[16] For hospital care, the case-based payment models are proven to be effective in improving the quality of inpatient care. The introduction of case-based payment in Croatia, for example, has improved efficiency (as measured by declines in average length of stay) without compromising on the quality of the care.[17] The majority of the high-income European countries have some kind of case-based payment system in place and have generally been successful. In the UK, a case-based prospective payment system led to a "reduction in unit costs and length of stay in the NHS hospitals" and a "faster increase in the proportion of elective care provided on a day-case basis."[18]

Hospital Governance and Management

Current Status	**After Project: *the Rationale***
Hospital autonomy in Albania clearly remains limited, and accountability mechanisms are weak. Though the regional hospital in Durres has been selected as a pilot site for more provider autonomy, the actual autonomy granted is limited. While the hospital is allowed to roll over unused funds from one fiscal year to the next, hospital management essentially has no more discretion over HR than other hospitals. A comprehensive approach is needed to strengthen both hospital autonomy and accountability (including improved capacity and oversight of hospitals boards), to build capacity of facility managers, and to prioritize recruitment of strong managers as hospital directors.	The project will support training and capacity building for hospital management teams, MoH, HII, and other supervising agencies. These measures will enable providers, regulators and the purchasing agency alike to assume their new responsibilities. In particular, providers will learn to respond to their newly granted autonomy. Further, the project will support the implementation of the existing Hospital Master Plan (developed under the previous Bank project) accompanied by the elaboration of an appropriate legal and regulatory framework for hospital services. These new legal and regulatory frameworks serve to provide more flexibility to hospitals in the management of resources (human resources, goods and also financial services).

[15] Blomqvist, A., Kralj, B., and Kantarevic, J. *Accountability and Access to Medical Care: Lessons from the Use of capitation Payments in Ontario*. Howe Institute. E-Brief. 2013.
[16] Esmail, N. *Lessons from Abroad: A Series on Health Care Reform. Health Care Lessons from Sweden*. Fraser Institute. May 2013.
[17] Bogut, M. Voncina, L. and Yeh, E. *Impact of Hospital Provider Payment Reforms in Croatia*. World Bank Policy Research Working Paper, 5992. May 2012.
[18] Charlesworth, A. Hawkins, L. and Marshall, L. *NHS Payment Reform: Lessons from the Past and Directions for the Future*. February 2014.

Evidence

A study[19] on the effect of hospital management reforms in the 1980s in Denmark, part of which included granting greater autonomy to departmental managers, suggests a correlation between departmental autonomy in management and budgeting, and output levels. The same study suggests that management reforms in 1994 in France led to an increased emphasis on the importance of planning by the hospitals. In examining the effect of hospital autonomy in Kenya, another study[20] found that increased autonomy for Kenyatta National Hospital (through reforms in the early 90s) benefited the country's national health system in significant ways. The increased autonomy led to a decrease in outpatient attendance, improvement in technical efficiency and quality of care, as well as in the ability to negotiate, plan and implement health projects. In Uganda,[21] greater autonomy of the public and not-for-profit hospitals (PNFP) has resulted in: (i) better drug availability at PNFP hospitals, (ii) better ability of PNFP hospitals to manage the personnel function, (iii) more efficient use of staff, and (iv) higher level of cost-discovery. Similarly, public hospitals in the Czech Republic, England, Estonia, Israel, Norway, Portugal and Spain have been reorganized to provide an increased level of decision-making autonomy.[22]

Pharmaceutical Policies

Current Status	**After Project: *the Rationale***
According to a recently completed technical review of the Albanian Pharmaceutical Policy,[23] pharmaceutical spending accounted for more than 45% of the total out-of-pocket (OOP) expenditures on health. The review points to the steady rise of HIF expenditure on reimbursed medicines since 2008, the persistence of high wholesale markup prices, the absence of well-defined guidelines for introducing new medicines, the lack of competitive incentive schemes for generics manufacturers, and the lack of adequate oversight in the implementation of International Nonproprietary Names (INNs) prescribing.	The project will provide technical assistance and capacity building support to reform the pharmaceutical sector. The support will enable the government to rationalize pharmaceutical expenditures, improve reimbursement decision-making, and increase access to essential medicines. More importantly, the support will enable the government to realize efficiency gains through cost savings. The technical assistance and the capacity building will be instrumental in helping the government: (i) generate savings and ensure value-for-money for public health expenditures on medicines, (ii) control the growth of expenditure on medicines, (iii) reduce very high rates of copayments for medicines through financial stimuli and administrative measures, (iv) increase the quality, effectiveness and transparency of reimbursement decision making, (v) improve access and coverage for lifesaving medicines and, (vi) promote rational prescribing of medicines.

[19] Chawla, M. Govindaraj, R. Berman, P. Needleman, J. *Improving Hospital Performance through Policies to Increase Hospital Autonomy*. Harvard School of Public Health. 1996.
[20] Collins, D. Njeru, G. Meme, J. *Hospital Autonomy in Kenya: The Experience of Kenyatta National Hospital*. Harvard School of Public Health. 1996.
[21] Ssengooba, F. Atuyambe, L. Mcpake, B. Hanson, K. Okuonzi, S. *What Could be Achieved with Greater Public Hospital Autonomy? Comparison of Public and PNFP Hospitals in Uganda*. Public Administration and Development, 22, 415-428. 2002.
[22] Eurohealth: Quarterly of the European Observatory on Health Systems and Policies. *Governing Public Hospitals.* Vol. 19, No. 1, 2013.
[23] *Technical Assistance: Review of Albania's Pharmaceutical Policy*, Draft Report – July 2014, World Bank.

Evidence

The review of the Albanian Pharmaceutical Policy points towards the need to revisit some key pharmaceutical policies. By drawing on regional practices (from countries such as FYR Macedonia, Croatia, Serbia, and Bulgaria), the review suggests large cost savings. The review makes the following estimates.

In 2013, the HIF paid: (a) 43,820 Lek for 200 mg Metoprolol tablets. If the same quantity of Metoprolol had been dispensed in 100 mg tablets instead, the HIF would have saved a total of 35,056 Lek, (b) 53,771,040 Lek for 160 mg Valsartan tablets. If the same amount of Valsartan had been dispensed in 80 mg tablets instead, the HIF would have saved as much as 32,262,624 Lek, (c) 57,223,896 Lek for Exforge tablets. If the same amount of valsartan and amlodipine had been dispensed individually, the HIF would have saved as much as 47,495,833 Lek. Data on expenditure of Caduet were not available for analysis, (d) 55,214,604 Lek for 10 mg Bisoprolol tablets and 37,620,494 Lek for 5 mg Nebivolol tablets. Had beta blocking agents been price referenced, the HIF would have saved a total of 26,170,974 Lek only on 1 DDD equivalent concentrations, (e) 36,745,066 Lek for 80 mg valsartan tablets, 29,602,079 for 150 mg Irbersartan tablets and 180,800,031 Lek for 20 mg Olmesartan tablets. Had Sartans been price referenced according to the DDD price of losartan, the HIF would have saved a total of 215,403,873 Lek only on 1 DDD equivalent concentrations of valsartan, Irebersartan and Olmesartan.

b. Cost Benefit Analysis

4. **Costs Considered**. All the investment costs associated with the project and financed by the Bank are accounted for. This amounts to US$45 million.

5. **Benefits Considered**. The beneficial impact of improving the Albanian Health System, primarily by improving the quality and efficiency of public hospital services, is estimated using the Disability Adjusted Life Years (DALYs), which represent the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.

The other assumptions used in the cost-benefits analysis are listed below:

6. **Effect on Non Communicable Diseases (NCD)**. It is assumed that the cumulative effect of an improved health system translates into health benefits through a decrease in NCD.

7. **Discount Rate**. The costs and benefits are discounted at a rate of 6 percent (the projected inflation of 3 percent[24] plus the time value of money valued at 3 percent). A higher discount rate of 9 percent (reflecting a discount rate of 6 percent and the time value of money of 3 percent) is also applied to verify the sensitivity of the results to this assumption

8. **Period Considered**. The cost-benefits of the interventions are calculated over the 2015-2030 period.

9. **Population Covered**. It is assumed that the effects of the intervention will be shared nationwide and therefore, the whole population (around 2.9 million people) is assumed to be affected.

10. **Population Projection Figures**. The population projection figures are based on the 2011 Albanian Census projection. The projection assumes a medium fertility, medium mortality and medium migration scenario.

[24] The inflation projection is based on the IMF, World Economic Outlook, April 2014.

11. **Expected Disbursement of the Investments**. The funds provided by the Bank are expected to follow the disbursement schedule as shown in the table below. The government funds are not explicitly taken into account in the NPV and IRR analysis.

Table 4: Expected Disbursement

Year	2015	2016	2017	2018	2019	2020
Disbursed Amount (US$ '000)	250	8,000	12,000	12,750	11,500	500
Disbursement (Percent)	0.56	17.78	26.67	28.33	25.56	1.11
Cumulative Disbursement (Percent)	0.25	18.33	45.00	73.33	98.89	100.00

12. **The benefits from the interventions are estimated using the impact on population health status measured in terms of DALYs from NCD.** The additional assumptions made in the economic analysis of these interventions are:

- Reduction in DALYs**:** DALYs have a built-in age weighting and discount rate of 3 percent. The reduction in DALYs upon Project completion in 2020 from the integrated interventions supported by the Project is conservatively set at 0.4 percent across all NCD. The reductions in diseases from the interventions of the project took the conservative values for interventions from the Disease Control Priorities Project.

- Counterfactual Scenario for DALYs: The baseline DALYs were calculated for the various conditions from WHO estimates for the Eastern and Central Asia region, adjusted for the population size of the project (2.9 million people) and the age structure of Albania (from 2011 Albania Census). These include the forward-looking projections of DALYs averted (that is, healthy life years gained) from 2015 to 2030.

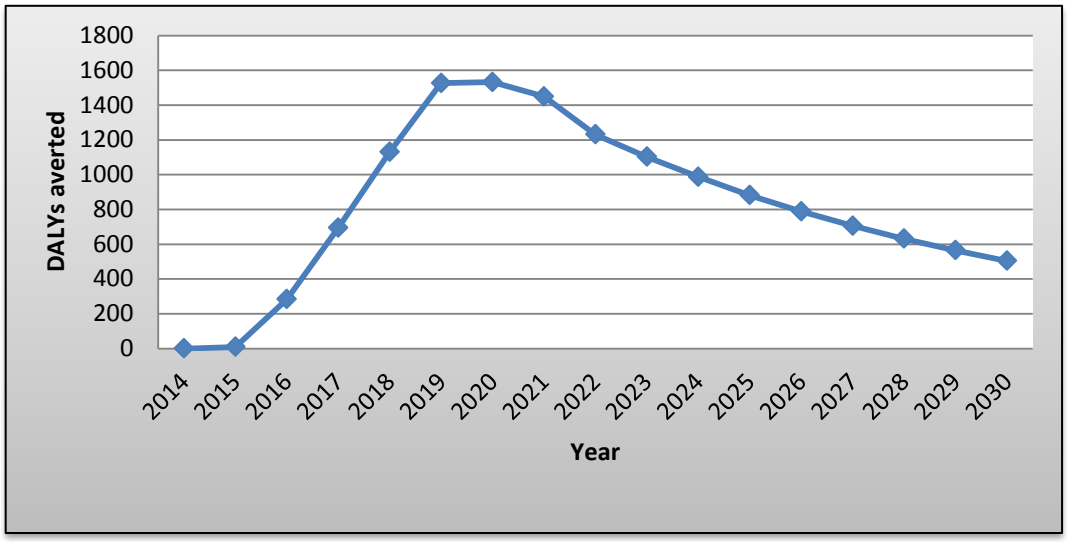
- Valuation of DALYs: Each DALY saved is valued in yearly per capita income (using a starting value of $4,100 for 2013). It is worth noting that the Disease Control Priorities Project and Copenhagen Consensus guidelines mention three times per capita income as a still conservative estimate for the value of each DALY averted. Studies of valuation of life in the United States even utilize much higher values for a year of life that would produce more extreme results.

- Discount Rates for DALYs: The monetary value of future stream of health benefits (i.e. annual DALYs saved) is discounted at 3 percent (a higher rate of 6 percent is used for the sensitivity analysis), per guidelines from WHO and the Disease Control Priorities Project.

- GDP Growth: An annual growth rate of 4 percent in real per capita GDP is used, being more conservative than the estimates provided by the International Monetary Fund (IMF). The IMF, World Economic Outlook[25] projects that Albania is going to see an average annual real GDP growth rate of 4.24 per cent.

[25] The IMF, World Economic Outlook, April 2014.

Total DALYs averted by year compared to Europe and Central Asia Counterfactual projections, Baseline scenario



- Expected Benefits from the Interventions

13. **Table 5 below presents the net present value (NPV) and investment rate of return (IRR) calculations for the project supported interventions.** The NPV of the project investments is largely positive and the IRR is estimated to be 13.89 percent. The analysis uses an estimated annual real GDP growth rate of 4 percent.

Table 5: NPV and IRR of the Project

Average GDP Growth	TVM Discount Factor	NPV (in US$ 000s)	IRR[26]
(4%)	3 %	25,875	13.89%
	6 %	16,072	

The Rationale for Public Involvement

14. **All the entities involved in the project activities are public sector entities.** A general tax-financing scheme (as envisaged by the government and supported under the Project) for healthcare is a common means of providing financial protection to the population in developed countries due to well-established market failures in the health sector. The Project does not involve the introduction of new programs that could be alternatively performed by the private sector, but instead strengthens existing government programs (enhanced PHC and a rationalized hospital sector) and ongoing reforms (establishment of health information systems and the positioning of the HII as a strategic purchaser) in order to alleviate binding constraints to public sector performance.

The World Bank's Contribution to the Project

15. **The support provided by the World Bank for this Project builds on the well-established**

[26] Net of inflation

partnership with the Government of Albania in general and in particular the Ministry of Health. Recently, the Albania Health System Modernization Project was closed. The proposed new Project supports the on-going and future health sector reforms, and will improve the capacity of the MOH and the HIF to effectively formulate and implement health policies and reforms in provider payments to improve governance and management in the hospital sector. Health reform is at the top of the Albanian policy agenda as identified in the current Country Partnership Strategy (CPS). In fact, the CPS states improvements in the effectiveness of social protection systems and key health services as one of the five main challenges facing Albania. Furthermore, "strengthened public expenditure management" and "regulatory and institutional reforms to boost competitiveness and investment" also figure among the main challenges identified and are also being addressed by the Project. The World Bank has a great deal of experience in capacity building for general health policy and in particular provider payments.

MAP


IBRD 33359R1
MONTENEGRO
KOSOVO
FYR MACEDONIA
GREECE
GREECE
ALBANIA
Adriatic Sea
North Albanian Alps
Maja Jezercë (2693 m)
Valbona
MALSI E MADHE
TROPOJË
Bajram Curri
Han i Hoti
To Podgorica
Koplik
Lake Scutari
Fierzë
Drin
HAS
Krumë
To Prizren
SHKODËR
PUKË
Shkodër (Scutari)
Koman
Pukë
Fush Arrëz
Kalimash
Kukës
KUKËS
Buna
LEZHË
MIRDITË
Zall-Rec
Shëngjin
Drinit Bay
Lezhë
Rubik
Rrëshen
Kurbneshi
Drin i Zi
Peshkopi
Lake Ulzës
Shkopet
Ulëz
Burrel
Fushë Kuge
Rodonit Bay
LAÇ
Laç
DIBRA
MAT
Mamurras
Krujë
Lalëzit Bay
KRUJË
Fushë Krujë
Bulquizë
BULQIZË
DURRËS
Durrës
Vorë
Shijak
TIRANË (TIRANA)
TIRANË
Durrësit Bay
Ibë
Krrabë
Librazhd
To Struga
LIBRAZHD
KAVAJË
PEQIN
Elbasan
Vidhës
Pegin
Cërrik
Perrenjas
Lake Ohrid
ELBASAN
Karavastasë Bay
LUSHNJË
Lushnjë
Kajan
Gramsh
POGRADEC
Pogradec
Lake Prespa
KUÇOVË
GRAMSH
Kuçovë
FIER
Fier
Marinzë
Berat
Patos
Ballsh
BERAT
Malig
KORÇË
Korçë
Bilisht
DEVOLL
Little Lake Prespa
Kafaraj
Vjosë
MALLAKASTER
SKRAPAR
Çorovodë
Selenice
Vlorë
Vlorës Bay
TEPELENË
Krahës
Mavrovë
VLORË
Tepelenë
Këlcyrë
PËRMET
KOLONJË
Ersekë
Përmet
Vjosë
Pindus Mountains
GJIROKASTËR
Gjirokastër
DELVINË
Delvinë
To Ioánina
Sarandë
Kakavija
SARANDË
0 10 20 30 40 Kilometers
0 10 20 30 Miles
19°E
20°E
21°E
42°N
41°N
40°N
ALBANIA
SELECTED CITIES AND TOWNS
DISTRICT CAPITALS
NATIONAL CAPITAL
RIVERS
MAIN ROADS
RAILROADS
DISTRICT BOUNDARIES
INTERNATIONAL BOUNDARIES
This map was produced by the Map Design Unit of The World Bank. The boundaries, colors, denominations and any other information shown on this map do not imply, on the part of The World Bank Group, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries.
JULY 2009